



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 15, 2026

Kimberly Wozniak
Walnut Ridge Senior Living
4352 Breton Rd SE
Kentwood, MI 49512

RE: License #: AH410413166
Investigation #: 2026A0627002

Dear Kimberly Wozniak:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

A handwritten signature in black ink that reads "Rick Brummette".

Rick Brummette, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT**

I. IDENTIFYING INFORMATION

| | |
|---------------------------------------|--|
| License #: | AH410413166 |
| Investigation #: | 2026A0627002 |
| Complaint Receipt Date: | 08/14/2025 |
| Investigation Initiation Date: | 08/22/2025 |
| Report Due Date: | 10/13/2025 |
| Licensee Name: | Kentwood Care Operations LLC |
| LicenseeAddress: | 144 940 Monroe Ave NW Grand Rapids, MI 49503 |
| Licensee Telephone #: | (616) 308-6915 |
| Administrator: | Mechelle Genigeski, Administrator |
| Authorized Representative/ | Kimberly Wozniak, Authorized Repr. |
| Name of Facility: | Walnut Ridge Senior Living |
| Facility Address: | 4352 Breton Rd SE Kentwood, MI 49512 |
| Facility Telephone #: | (616) 288-4151 |
| Original Issuance Date: | 04/13/2023 |
| License Status: | REGULAR |
| Effective Date: | 08/01/2025 |
| Expiration Date: | 07/31/2026 |
| Capacity: | 131 |
| Program Type: | AGED ALZHEIMERS |

II. ALLEGATION(S)

| | Violation Established? |
|---|-------------------------------|
| Resident A fell out of her bed and when she was assisted back to bed by 2 staff members the resident's arm made a popping noise and the injury was never evaluated. | No |
| Additional Findings | No |

II. METHODOLOGY

| | |
|------------|--|
| 08/14/2025 | Special Investigation Intake 2026A0627002 |
| 08/22/2025 | Contact - Face to Face |
| 1/15/2026 | Exit Conference via email |

ALLEGATION: Resident A fell out of her bed and when she was assisted back to bed by 2 staff members the resident's arm made a popping noise and the injury was never evaluated.

INVESTIGATION:

On 08/12/2025, the Bureau of Community and Health Systems received a complaint from Adult Protective Services alleging that Resident A had fallen off of her bed and that when facility staff went to help the resident back to bed, a popping noise was heard, the resident screamed out in pain and the resident did not have a medical evaluation for the injury.

On 08/22/2025, an onsite investigation was conducted where I interviewed Mechelle Genigeski, Executive Director, who reported that Resident A, subject of complaint, resides in the facility's Memory Care Unit and did not fall on August 5th, did not show any signs or symptoms of being injured and did not experience a dislocated shoulder. The Executive Director reported that Resident A did have inappropriate attention focused upon her by a former staff member whose actions are as follows; the former staff member lavished extraordinary attention upon Resident A, going so far as to tell Resident A's daughter that she, a former staff member, had her granddaughter named after Resident A. The former staff member eventually was fired on 08/07/2025 for leaving her assignment on 08/06/2025. The Executive Director reported further inappropriate events included on 08/08/2025 when the former staff member returned to the facility to ask for her job back and was

declined. This staff member came back into the facility again on the afternoon of Sunday 08/10/2025 and was seen trying to access the medication cart on the Memory Care Unit. Staff on duty at the time ordered the former staff member to leave the facility, then notified Resident A's family, SP 1, the Wellness Director, and the Executive Director. The Executive Director reported that since that happened staff have been instructed to call the police if the former staff member came back to the facility.

On 08/22/2025 I toured the facility's Memory Care Unit with the Executive Director and SP 1. The residents there were clean, well dressed and appeared content. I approached and interviewed Resident A. Resident A was clean, well dressed, holding a toy doll, sitting and visiting with a group of other residents. She was confused but pleasantly conversational. Resident A denied having any shoulder pain nor did she present any evidence of having had a recent shoulder injury (i.e. no arm sling, moving her right shoulder and arm without difficulty, spontaneously smiling and having no evidence of being in any discomfort). Resident A did not appear to have any injuries.

| APPLICABLE RULE | |
|------------------------|---|
| R 325.1921 | Governing bodies, administrators, and supervisors. |
| | (1) The owner, operator, and governing body of a home shall do all of the following: (c) Assure the availability of emergency medical care required by a resident. |
| ANALYSIS: | Interview and observation revealed no evidence that Resident A had been injured as alleged. The facility is compliant with this rule. |
| CONCLUSION: | VIOLATION NOT ESTABLISHED |

III. RECOMMENDATION

I recommend no change in the status of the license.



10/29/25

Rick Brummette
Licensing Staff

Date

