GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 16, 2026

Gary Ray
Genesee Manor, Inc.
30002 Saint Martins
Livonia, MI 48152

RE: License #: AS820384154
Investigation #: 2026A0901022
Genesee Manor I

Dear Gary Ray:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 (313) 456-0380.

Sincerely,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820384154
Investigation #:	2026A0901022
Complaint Receipt Date:	02/19/2026
Investigation Initiation Date:	02/24/2026
Report Due Date:	04/20/2026
Licensee Name:	Genesee Manor, Inc.
Licensee Address:	30002 Saint Martins Livonia, MI 48152
Licensee Telephone #:	(313) 949-2501
Administrator:	Michele Ray
Licensee Designee:	Gary Ray
Name of Facility:	Genesee Manor I
Facility Address:	30002 Saint Martins Livonia, MI 48152
Facility Telephone #:	(248) 426-0735
Original Issuance Date:	05/24/2017
License Status:	REGULAR
Effective Date:	11/24/2025
Expiration Date:	11/23/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A had a bruise and scrape on his nose and chest of unknown origin.	Yes

III. METHODOLOGY

02/19/2026	Special Investigation Intake 2026A0901022
02/19/2026	Referral - Recipient Rights
02/24/2026	Special Investigation Initiated - On Site
03/03/2026	Contact - Telephone call made Staff, Joseph Izuegbunam
03/03/2026	Contact - Telephone call made Staff, Josiah Travis
03/03/2026	Contact - Telephone call made Staff, Christopher Williams
03/05/2026	Adult Protective Services Referral
03/06/2026	Contact - Telephone call made Staff, Mario Harris
03/06/2026	Contact - Telephone call made Supports coordinator, Deshawn Graves
03/06/2026	Contact - Telephone call made Staff, Damonta Lathan
03/06/2026	Contact - Telephone call made Staff, Joseph Izuegbunam
03/09/2026	Contact - Telephone call made Staff, Damonta Lathan

03/09/2026	Contact - Telephone call made Staff, Presley Harris
03/09/2026	Contact - Telephone call made Staff, Zachary Tate
03/09/2026	Contact - Telephone call made Supports coordinator, Deshawn Graves
03/16/2026	Contact - Telephone call made Supports coordinator, Deshawn Graves
03/16/2026	Contact - Telephone call made Supervisor, Lee Wayna
03/16/2026	Contact - Telephone call made Faith Connections
03/16/2026	Contact - Telephone call made Licensee designee, Gary Ray
03/16/2026	Contact - Document Received Email, reprimand and verification of training
03/16/2026	Exit Conference Licensee designee, Gary Ray
04/06/2026	Contact - Telephone call made Supervisor, Lee Wayna
04/15/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A had a bruise and scrape on his nose and chest of unknown origin.

INVESTIGATION:

On 02/24/2026, I conducted an onsite inspection at the facility. The home manager, Gene Hamilton, was present and I interviewed him. He stated the allegation was true. Gene explained that the incident occurred on a weekend, and staff who worked during that time did not know what happened. Gene indicated that Resident A requires 2:1 staffing at all times, therefore staff should have been aware of how he injured himself. He also clarified that Resident A only had a scrape on his nose.

Gene provided me with a copy of the incident report. It was dated 02/13/2026 at 6:00 a.m. and written by staff, Joseph Izuegbunam. It indicated he noticed a bruise on Resident A's nose and cheeks, and the bruises were not on his face on the previous morning shift.

During the onsite inspection on 02/24/2026, I observed Resident A. He is nonverbal. He had a faint scrape on his nose that appeared to be going away. I did not observe anything on his cheeks. I interviewed staff, Tremont Henderson, who said he was Resident A's lead caregiver Monday-Thursdays. He stated Resident A did not injure himself during his shift leading up to 02/13/2026 and that he did not notice any bruises on him during that time. I also interviewed staff, John Pitman. He had no idea how resident A injured himself and said someone is supposed to always be with him. He also said Resident A did not have a history of self-injurious behavior.

On 03/03/2026 and 03/06/2026, I made telephone calls and left voice messages for Joseph, but the calls were not returned.

On 03/03/2026, I made a telephone call to staff, Josiah Travis. He reported seeing a bruise on Resident A's nose on 02/12/2026 but stated he did not know what happened and did not see Resident A injure himself.

On 03/06/2026, 03/09/2026, and 03/16/2026, I made telephone calls and left voice messages for Resident A's supports coordinator, Deshawn Graves, from Neighborhood Services Organization (NSO), but the calls were not returned.

On 03/06/2026, I made a telephone call to staff, Mario Harris. He stated he worked the weekend on 02/13/2026 but was not assigned to Resident A and did not notice any marks on him.

On 03/06/2026 and 03/09/2026, I made telephone calls to staff, Damonta Lathan, but the calls were not returned.

On 03/09/2026, I made a telephone call to staff, Presley Harris. He stated he worked 02/13/2026 from 8:00 a.m.-8:00 p.m. and Resident A did not injure himself and he did not see any bruises.

On 03/09/2026, I made a telephone call to staff, Zachary Tate. He stated he was not assigned to Resident A. He reported working 02/14/2026 and 02/15/2026 but stated he did not see any marks on Resident A and was not aware of him injuring himself.

On 03/16/2026, I made a telephone call to Faith Connections, Resident A's guardian case management company. I was told by the receptionist that his guardianship expired in February, and they were no longer assigned to him. She suggested I contact NSO.

On 03/16/2026, I made a telephone call to NSO and was told Deshawn no longer worked there. I was re-directed to the supervisor, Lee Wayna. I left a voice message, but the call was not returned. I left another voice message on 04/06/2026, and that call was not returned.

On 03/16/2026, I made a telephone call to the licensee designee, Gay Ray. He stated the administrator, Michele Ray, had more information and added her to the call. Michele explained that Resident A requires 2:1 staffing. On the day of the incident, one of the staff assigned to him called off work. Therefore, staff, Damonta Lathan, worked alone with him. Damonta took Resident A to the bathroom to give him a shower. He realized he did not have Resident A's clothes and left him alone, while he went to retrieve them. When he came back, the shower handle was on the floor. Michele assumed that Resident A accidentally hit himself in the face with it. Michele stated the lead direct care staff, Ena Dickerson, failed to assign another staff person to work with Damonta.

During the telephone call with Gary and Michle on 03/16/2026, I conducted an exit conference and informed them the complaint will be substantiated. They conveyed they understood. Michele stated both staff were given written reprimands and re-trained on their job responsibilities as 1:1 and 2:1 caregivers. Michele later emailed me copies of the written reprimands and verification of training.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on the information obtained during this investigation, Resident A was not provided with the supervision and protection he requires. For his safety, he requires 2:1 staffing. On 02/12/2026, the facility was short of staff and only one person was assigned to him, resulting in him being left alone in the bathroom and injuring himself.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend the status of the license remains unchanged.

_____04/15/2026
Regina Buchanan Date
Licensing Consultant

Approved By:

04/16/2026
_____
Ardra Hunter Date
Area Manager