



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 5, 2026

Gena Payne
Passion and Caring Home for the Elderly
570 E. Grand Blvd.
Detroit, MI 48207

RE: License #: AH820260951
Investigation #: 2026A0627028
Passion and Caring Home for the Elderly

Dear Licensee:

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 #:	AH820260951
Investigation #:	2026A0627028
Complaint Receipt Date:	01/28/2026
Investigation Initiation Date:	02/20/2026
Report Due Date:	03/27/2026
Licensee Name:	Passion and Caring Home for the Elderly, LLC
Licensee Address:	570 E. Grand Blvd Detroit, MI 48207
Licensee Telephone #:	(313) 923-0170
Administrator:	Gena Payne
Authorized Representative/	Gena Payne, Authorized Repr.
Name of Facility:	Passion and Caring Home for the Elderly
Facility Address:	570 E. Grand Blvd. Detroit, MI 48207
Facility Telephone #:	(313) 923-0170
Original Issuance Date:	11/18/2003
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	46
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility did not have a masks when requested, residents could not sit with visitors due to the visitor seating area being roped off, the cook is often late, the residents do not get proper food, and the residents had to wear jackets due to low temperatures.	No
Additional Findings	No

III. METHODOLOGY

01/28/2026	Special Investigation Intake 2026A0627028
02/20/2026	Special Investigation Initiated - On Site

ALLEGATION: The facility did not have a mask when requested, residents could not sit with visitors due to the visitor seating area being roped off, the cook is often late, the residents do not get proper food, and the residents had to wear jackets due to low temperatures.

INVESTIGATION:

On 1/26/25 the Bureau of Community and Health Systems received an anonymous complaint alleging that the facility did not have a mask when requested, residents could not sit with visitors due to the visitor seating area being roped off, the cook is often late, the resident's do not get proper food, and the residents had to wear jackets due to low temperatures.

On 2/20/26, I went onsite to investigate the allegations. I interviewed the Administrator, Gena Payne, who told me that there is construction that is ongoing for the fire suppression system. The dining area is at the front of the facility where the main entrance is and is a possible reason for it to feel cooler. The Administrator reported that the facility has a 46-bed capacity and a current census of 17. Upon walking into the facility, a sign in the window asks that visitors wear a mask. The administrator reported that they have masks and are readily available for visitors to ask for one. I observed several boxes of masks in the Administrator's office while interviewing for this investigation. The Administrator reported that she is very safety

conscious about visitors coming unannounced and will turn visitors away if they do not have an appointment to see a resident.

I asked the Administrator about the visitor area being roped off on or about December 15, 2025. The Administrator replied that the furniture in the sitting area had been steam cleaned and needed to dry for a couple of days. The admin reported that she did that to get ready for the Christmas holiday coming up and routinely has the furniture steam cleaned every 3 months.

The Administrator took me on a tour of the facility. There were several residents sitting in the dining area of the facility waiting for lunch. The Administrator reported that she serves soul food to her population and traditionally the main meal of the day is served at 1:00pm with breakfast at 9:00am and a later meal at 5:00pm. When asked if the cook has any problems with tardiness, the Administrator replied no that the cook does not have any attendance problems. I asked Resident B in the dining area if they have any problems with meals being late because the cook is late and he denied meals being late stating, "We all know what time meals are served and they pretty much stick to that schedule." I inquired with Residents C and D and how they liked the food served at the facility. Both replied that the food was excellent and they always get all they want to eat.

I interviewed Resident A sitting in the dining area about whether or not she feels cold here and she replied that she knows it's chilly, but she wears a sweater to come eat her meals. I observed that it did feel a little cold, but it wasn't prohibitive to being in the dining area or the visiting area. There were another 8 residents sitting there waiting for lunch and visiting with each other. When Resident A was asked if she feels cold when she is in her room, she replied, "No" that her room and the other areas of the building are warm. The Administrator continued with the tour of the rest of the facility and in all other areas of the building it was noted to be comfortably warm.

APPLICABLE RULE	
R 325.1922	Admission and retention of residents.
	(3) At the time of an individual's admission, a home or the home's designee shall complete a written resident admission contract between the resident and/or the resident's authorized representative, if any, and the home.

	The resident admission contract shall, at a minimum, specify all of the following: (a) That the home shall provide room, board, protection, supervision, assistance, and supervised personal care consistent with the resident's service plan. (g) The resident's rights and responsibilities, which shall include those rights and responsibilities specified in MCL 333.20201(2) and (3) and MCL 333.20202.
ANALYSIS:	Based on interviews, documents reviewed, and observations made, there was no evidence to substantiate the allegations.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend no change to the status of the license.



3/5/2026

Rick Brummette
Licensing Staff

Date

Approved By:



03/31/2026

Andrea L. Moore, Manager
Long-Term-Care State Licensing Section

Date