



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

May 7, 2019

Charles Cryderman  
Haven Adult Foster Care Limited  
73600 Church Road  
Armada, MI 48005

RE: License #: AS500267724  
Investigation #: **2019A0604008**  
**Griffith Home**

Dear Mr. Cryderman:

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 (248) 975-5053.

Sincerely,

A handwritten signature in cursive script that reads "Kristine Cilluffo".

Kristine Cilluffo, Licensing Consultant  
Bureau of Community and Health Systems  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 285-1703

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS500267724
<b>Investigation #:</b>	2019A0604008
<b>Complaint Receipt Date:</b>	01/02/2019
<b>Investigation Initiation Date:</b>	01/02/2019
<b>Report Due Date:</b>	03/03/2019
<b>Licensee Name:</b>	Haven Adult Foster Care Limited
<b>Licensee Address:</b>	73600 Church Road Armada, MI 48005
<b>Licensee Telephone #:</b>	(586) 784-8890
<b>Administrator:</b>	Charles Cryderman
<b>Licensee Designee:</b>	Charles Cryderman
<b>Name of Facility:</b>	Griffith Home
<b>Facility Address:</b>	73600 Church Street Armada, MI 48005
<b>Facility Telephone #:</b>	(586) 784-8890
<b>Original Issuance Date:</b>	07/19/2004
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	02/14/2017
<b>Expiration Date:</b>	02/13/2019
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Female resident cries all day and owner will not move her to more suitable placement.	No
Food served is expired and portions are very small.	Yes
Owner does not allow residents to use the phone.	No
Residents purchase their own cigarettes but owner only allows them to smoke one cigarette every two hours.	No
Residents are not allowed to use blankets during the day even if cold.	No
The staff members at the home stay on shift for two or three days at a time. The staff members must sleep on the couch as there are not bedrooms for the staff members.	Yes
Owner does not allow residents to use the phone.	No
Additional Findings	Yes

## III. METHODOLOGY

01/02/2019	Special Investigation Intake 2019A0604008
01/02/2019	Special Investigation Initiated - Telephone Left message for Complainant. Received return call.
01/03/2019	Inspection Completed On-site Completed unannounced onsite investigation at Griffith House and Timberland Lodge. No one present at Timberland Lodge. Interviewed Cec Ball at Griffith House and received copy of house rules.
01/04/2019	Contact - Face to Face Face to Face interview with Chuck Cryderman at Timberland Lodge and Greenwood Lodge. Onsite investigation at North Meadows.
01/08/2019	Contact - Document Received Received emails from Cec Ball with menus, staff and resident list, Resident A prescription and resident weight records.
03/06/2019	Contact- Document Sent Email to and from Cec Ball
03/08/2019	Contact- Telephone call made Left message for Relative 1

03/12/2019	Contact- Telephone call received Received return message from Relative 1
04/18/2019	Contact- Telephone call made Left message for Relative 1
04/25/2019	Exit Conference Completed exit conference by phone with Adult Foster Care (AFC) Licensing Consultant, LaShonda Reed and Chuck Cryderman.

**ALLEGATION:**

**Female resident cries all day and owner will not move her to more suitable placement.**

**INVESTIGATION:**

I received a complaint regarding the Griffith Home on 01/02/2019. The complaint was also regarding additional homes operated by Haven Adult Foster Care including Timberland Lodge, Greenwood Lodge, North Meadows, C & C and Gates AFC. The complaint indicated that an Adult Protective Services referral was made on 01/01/2019 and denied.

The complaint alleged that Charles Cryderman is the Owner of Haven Adult Foster Care Limited and owns the Greenwood Lodge, Griffith, North Meadows, Timberland Lodge, C&C, and Gates AFC. It is believed that Mr. Cryderman owns other homes as well. There are believed to be at least six residents in each home, their names are unknown. There are concerns that the residents at the home are not treated well and are limited in what they can do as Mr. Cryderman has set rules for the home. Mr. Cryderman does not allow the residents to talk on the phone and make calls. The residents in the homes purchase their own cigarettes if they smoke and Mr. Cryderman only allows them to smoke one cigarette every two hours. The residents are not allowed to use a blanket during the day even if they are cold as this is a house rule. Mr. Cryderman has the food prepared offsite and taken to the homes each day. The food that is being served to the residents is expired. The mayo, jelly, cake mix, and ketchup has an expiration date of 2017, and the brownie mix that is being served expired in 2015. The food portions for the homes are very small. One pound of hamburger is supposed to feed six residents and a caregiver in the home. The portion sizes per individual in the home are an ice cream scoop. The staff members at the home stay on shift for two or three days at a time and then rotate off. The staff members sleep at the home and must sleep on the couch as there are not bedrooms for the staff members. At the Griffith Home there is a female resident who has dementia and cries all day long. Mr. Cryderman will not move this resident to a more suitable home.

I contacted the Complainant by phone on 01/02/2019. The Complainant stated that she knows someone who has provided her with information regarding the homes. She stated that she has been inside Timberland Lodge, Gates AFC and Greenwood Lodge. She does not know where food is prepared, however, has been at home when very small portion sizes were being served. She stated that one pound of hamburger was served to all the residents and staff at Gates AFC.

I completed an unannounced onsite investigation at the Griffith Home on 01/03/2019. I interviewed Cec Ball and received a copy of house rules. I observed one resident present during the onsite investigation. Resident B is non-verbal and on hospice.

Ms. Ball stated that there is a resident at the home that cries often. Resident A has dementia and will cry daily. She often has no tears. She was recently seen by a psychiatrist who increased her prescription for Lexapro. I received a copy of prescription for Resident A's Lexapro dated 11/14/2018.

I interviewed Chuck Cryderman on 01/04/2019. He stated that Resident A does cry often. She may cry if she is hungry. They are able to redirect her when she starts to cry.

I attempted to contact Resident A's guardian, Relative 1, by phone on 03/08/2019 and 04/18/2019.

<b>APPLICABLE RULE</b>	
<b>R 400.14305</b>	<b>Resident protection.</b>
	<b>(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.</b>
<b>ANALYSIS:</b>	There is not enough information to determine that Resident A's personal needs are not being met in the home. Mr. Cryderman and Ms. Ball both stated that Resident A does cry often. Resident A has dementia and has been seen by a psychiatrist who has increased her prescription for Lexapro.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**Food served is expired and portions very small.**

**INVESTIGATION:**

On 01/03/2019, I interviewed Cec Ball. She stated that food is prepared at their congregate home, Ridgeway. Food is delivered in containers on Mondays, Wednesdays

and Fridays. Food is portioned out at the home. Some items such as sides, sandwiches or eggs are made at the home. Food is purchased at Weeks meat market and other local stores. Ms. Ball stated that expired food is not served to her knowledge. She stated that residents are allowed seconds and receive decent portions of food.

I observed food in the refrigerator and cupboards at the Griffith home on 01/02/2019. I found expired ketchup, mustard, salad dressing, jelly and canned goods. Items had expired in 2017 and 2018. I observed prepared meals in Ziploc containers. The containers were labeled with dates. I observed a container of cabbage soup for dinner and a very small amount of hamburger meat that was to be used to make spaghetti.

I interviewed Chuck Cryderman. He stated that main part of meal is prepared at Ridgeway. For example, if a roast beef would be prepared at Ridgeway and then home would prepare sides and vegetable. He stated that they have a full time cook at Ridgeway. Meals are prepared on Monday, Wednesday and Friday and baking is done on Tuesday and Thursdays. Mr. Cryderman stated that staff can contact him if they feel they are not getting enough food for home. He stated that each resident gets three and a half ounces of protein that should be measured out by cook. Residents are allowed to have seconds. Residents get three meals a day and also get snacks such as cookies, jello, fruit, milk and coffee at 10:00 am and 2:00 pm. Mr. Cryderman stated that shopping is done at Save A Lot, Week, ENS and IGA in Armanda. Mr. Cryderman was aware that expired food was found at the Griffith Home on 01/02/2019. He stated that it was a mistake that expired food was not caught and rotated out. He stated that food was immediately gone through to discard any expired products.

<b>APPLICABLE RULE</b>	
<b>R 400.14402</b>	<b>Food service.</b>
	<b>(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.</b>
<b>ANALYSIS:</b>	I observed food in the refrigerator and cupboards at the Griffith home on 01/02/2019. I found expired ketchup, mustard, salad dressing, jelly and canned goods. Items had expired in 2017 and 2018.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.14313</b>	<b>Resident nutrition.</b>
	<b>(2) Meals shall meet the nutritional allowances recommended pursuant to the provisions of "Appendix I:</b>

	<b>Recommended Dietary Allowances, Revised 1980" contained in the publication entitled "Basic Nutrition Facts: A Nutrition Reference," Michigan Department of Public Health publication no. H-808, 1/89. This publication may be obtained at cost from The Division of Research and Development, Michigan Department of Public Health, P.O. Box 30195, Lansing, Michigan 48909.</b>
<b>ANALYSIS:</b>	There is not enough information to determine that residents are not getting enough food at the Griffith Home. According to Mr. Cryderman and Ms. Ball, food is prepared at Ridgeway and delivered to the homes. I observe an adequate amount of food in the home.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**Owner does not allow residents to use the phone.**

**INVESTIGATION:**

On 01/03/2019, I interviewed Cec Ball. She stated that residents can ask to use main line if they do not stay on the phone for hours. Residents can receive calls. Residents need to have a calling card.

I interviewed Chuck Cryderman. He stated that residents are allowed to make phone calls. He has a flat rate phone plan. He stated that residents did not have to use calling cards to make phone calls.

I reviewed house rules. The house rules state, "All long distance phone calls must be reverse charges or calling card. Incoming calls are allowed but not after 9:00 pm.

<b>APPLICABLE RULE</b>	
<b>R 400.14304</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident</b>

	<b>for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.</b>
<b>ANALYSIS:</b>	There is not enough information to determine that residents are not allowed to use the telephone. Cec Ball stated that residents need a calling card, however, Mr. Cryderman stated that residents do not need to use a calling card with his phone plan. It is recommended that the licensee update staff and residents on policy regarding phone calls and need for calling cards.
<b>CONCLUSION:</b>	VIOLATION NOT ESTABLISHED

**ALLEGATION:**

- **Residents purchase their own cigarettes but owner only allows them to smoke one cigarette every two hours.**
- **Residents are not allowed to use blankets during the day even if cold.**

**INVESTIGATION:**

On 01/03/2019, I interviewed Cec Ball. She stated that it is correct that residents can only smoke one cigarette every two hours. It is in a resident's assessment plan and house rules.

I reviewed the house rules. House rules state, "Smoking is to be outside only and at designated times and areas. Anyone smoking in the facility will automatically become a non-smoker."

I interviewed Chuck Cryderman. He also stated that smoking policy is one cigarette every two hours. They hold cigarettes and light cigarettes for residents. He stated that all homes have the same smoking policy and it is listed in house rules.

Resident B was observed in the living room and was covered with a blanket. Ms. Ball stated that residents are allowed to use blankets in the living room. Ms. Ball stated that she believes this allegation may have been made because one day Mr. Cryderman made a comment about everyone being covered with blankets in the living room. He did not say that residents were not allowed to use blankets.

I interviewed Chuck Cryderman. He stated that about a month ago at the Griffith home all of the residents were covered in blankets in the living room. He stated he asked what was going on because everyone was covered up so he turned the heat up. Mr. Cryderman stated that there is no rule that residents cannot use blankets in the living room.

<b>APPLICABLE RULE</b>	
<b>R 400.14304</b>	<b>Resident rights; licensee responsibilities.</b>
	<p><b>(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:</b></p> <p style="padding-left: 40px;"><b>(j) The right of reasonable access to and use of his or her personal clothing and belongings.</b></p>
<b>ANALYSIS:</b>	<p>According to Mr. Cryderman and Ms. Ball, residents can only smoke one cigarette every two hours. However, house rules state, "Smoking is to be outside only and at designated times and areas".</p> <p>There is not enough information to determine that residents are not allowed to use blankets during the day or in living room. I completed an unannounced onsite investigation and observed Resident B in the living room covered in a blanket. Ms. Ball and Mr. Cryderman stated that there are no rules regarding residents use of blankets in the home. It is believed that Mr. Cryderman's comment regarding residents using blankets in the living room may have been misinterpreted.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**The staff members at the home stay on shift for two or three days at a time. The staff members must sleep on the couch as there are not bedrooms for the staff members.**

**INVESTIGATION:**

On 01/03/2019, I interviewed Cec Ball. Ms. Ball stated that staff at the Griffith Home work for one to three days at a time. Staff sleep in the living room on the couch.

I interviewed Mr. Cryderman. He stated that staff are on shift for three days maximum. He stated that staff at the Griffith home sleep in the living room on the couch. He stated that he would need to have to find an area for staff to sleep as this has been the staff sleeping arrangement for years.

<b>APPLICABLE RULE</b>	
<b>R 400.14408</b>	<b>Bedrooms generally.</b>
	<b>(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.</b>
<b>ANALYSIS:</b>	The living room in the Griffith Home is being used for sleeping purposes by staff. Staff work at the home for one to three days at a time.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

I reviewed resident weight records for the Griffith Home. Resident B was not weighed from April 2016- November 2017. Weight record states that Resident is unable to stand on scale. Resident B began being weighed by hospice in December 2017. Resident C was not weighed from June 2018- January 2019. Resident C's weight record also states that she is unable to stand on scale.

I completed an exit conference by phone with Licensee Designee, Chuck Cryderman on 04/24/2019. I informed him of the violations found and that a corrective action plan would be requested. I also informed him that a copy of the special investigation report would be mailed one approved.

<b>APPLICABLE RULE</b>	
<b>R 400.14310</b>	<b>Resident health care.</b>
	<b>(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.</b>
<b>ANALYSIS:</b>	Resident B was not weighed from April 2016- November 2017. Resident C was not weighed from June 2018- January 2019. Weight records indicate that they were unable to stand on scale.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Contingent upon an acceptable corrective action plan, I recommend no change in the license status.



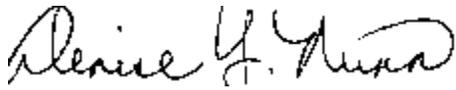
04/29/2019

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Kristine Cilluffo  
Licensing Consultant

Date

Approved By:



05/07/2019

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Denise Y. Nunn  
Area Manager

Date