GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 19, 2024

William Gross
Haven Adult Foster Care Limited
73600 Church Road
Armada, MI 48005

RE: License #: AS500338676
Investigation #: 2024A0604021
Greenwood Lodge

Dear Mr. Gross:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
Detroit, MI 48202
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500338676
Investigation #:	2024A0604021
Complaint Receipt Date:	06/20/2024
Investigation Initiation Date:	06/20/2024
Report Due Date:	08/19/2024
Licensee Name:	Haven Adult Foster Care Limited
Licensee Address:	73600 Church Road Armada, MI 48005
Licensee Telephone #:	(586) 784-8890
Administrator:	William Gross
Licensee Designee:	William Gross
Name of Facility:	Greenwood Lodge
Facility Address:	34845 Weber Road Richmond, MI 48062
Facility Telephone #:	(586) 784-8890
Original Issuance Date:	05/20/2013
License Status:	REGULAR
Effective Date:	11/20/2023
Expiration Date:	11/19/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There is a Spanish speaking employee passing medications that are only in English. Staff is unable to communicate with the residents due to not speaking English.	Yes
Staff may not be legal to work in United States or have had background checks.	Yes
Resident C is exhibiting sexually inappropriate behaviors towards Resident D and staff do not plan to do anything about it.	No
Additional Findings	Yes

III. METHODOLOGY

06/20/2024	Special Investigation Intake 2024A0604021
06/20/2024	Special Investigation Initiated - Letter Email to William Gross
06/24/2024	APS Referral Referral to Adult Protective Services (APS). Referral denied.
06/24/2024	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Staff, Lorena Andrade, Resident A, Resident B and Resident C
06/24/2024	Inspection Completed On-Site Completed unannounced onsite investigation at Griffith Home. Requested Health Care Area Manager, Shawneesha Cooper, to address medication passing at Greenwood Lodge
06/24/2024	Contact - Telephone call made Left message for William Gross regarding medication concerns
06/24/2024	Contact - Document Sent Email to and from William Gross. Requested employee records
07/02/2024	Contact - Document Received Email from William Gross with employee records

07/03/2024	Contact - Document Sent Email to and from William Gross
07/17/2024	Contact - Face to Face Face to Face Meeting with William Gross, Shawneesha Cooper, Ana Amador and Kimberlee Mitchell at Ridgeway to discuss special investigations
08/09/2024	Contact- Document Received Received 2nd intake regarding Greenwood Lodge. Dismissed intake #202003 and added allegations to open investigation
08/09/2024	Contact- Document Sent Email to and from APS Worker, Debra Johns
08/09/2024	Contact- Telephone call made TC to APS Worker, Debra Johns
08/12/2024	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Home Manager, Maria Herrera, Resident C, Resident D and Resident E
08/12/2024	Contact- Document Sent Email to Licensee, William Gross
08/13/2024	Contact- Document Sent Email to and from APS Worker, Debra Johns
08/13/2024	Contact- Document Received Email from William Gross
08/16/2024	Contact- Document Received Received staff schedules from William Gross
08/29/2024	Exit Conference Attempted exit conference with William Gross by phone. Call failed. Email to William Gross with recommendation and findings.
08/30/2024	Contact- Document Received Received email from William Gross
08/30/2024	Exit Conference Returned call from William Gross. Completed exit conference with William Gross by phone.

ALLEGATION:

There is a Spanish speaking employee passing medications that are only in English. Staff is unable to communicate with the residents due to not speaking English.

INVESTIGATION:

I received a licensing complaint regarding Greenwood Lodge on 06/20/2024. It was alleged that there is only Spanish speaking employee that is passing medications that are only in English. Staff is unable to communicate with the residents due to not speaking English. The staff may not be legal to work in the United States or have had background checks.

On 08/09/2024, I received a second licensing complaint regarding Greenwood Lodge. It was alleged that Resident D has a male roommate in the home, Resident C, that is entering her room and staring at her while she sleeps. Resident C is also entering Resident D's bathroom while she is showering. The most recent incident of Resident C entering the bathroom while Resident D was in the shower was on 06/09/2024. Resident C has not made any physical contact with Resident D that is known. Resident C will ask Resident D if she has ever breast fed. Resident C has asked Resident D if he can lick her buttocks. Resident C also was heard saying to Resident D that he likes to hear her fart because it turns him on. Resident C has been observed rubbing himself while staring at Resident D. Staff at the group home and the owner of the home know about Resident C's behaviors and do not plan to do anything about it. Resident C makes Resident D very uncomfortable and she is scared that he may do something.

On 06/24/2024, I completed an unannounced onsite investigation. I interviewed Staff, Lorena Andrade, Resident A, Resident B and Resident C.

On 06/24/2024, I attempted to interview staff, Lorena Andrade at the home. Ms. Andrade spoke limited English and relied on a translator app on her cell phone to communicate. Ms. Andrade indicated that she passes medications in the home and showed me where the medications and medication logs were located. Ms. Andrade demonstrated how she matches pill packs to medications in log. I observed medication logs and saw that medications were initiated by staff as administered for 06/24/2024.

On 06/24/2024, I interviewed Resident A. He stated that staff, Lorena Andrade, communicates with translator app on her cell phone. He stated that she passes medication. Resident A indicated that the home manager, Maria speaks English.

On 06/24/2024, I interviewed Resident B. He stated that staff, Lorena Andrade, communicates with an app on her phone. He stated that he has not had any issues with her using the app to communicate. He indicated that she also passes medications.

On 06/24/2024, I interviewed Resident C. He stated that staff use an app to communicate. He can communicate with staff through the cell phone app.

On 07/03/2024, I received an email from William Gross. He indicated that Lorena is no longer working for them and they have hired a new staff whose clearance is pending. He stated that they no longer have non- English-speaking staff.

On 08/12/2024, I interviewed home manager, Maria Herrera. She stated that she does not do the hiring. Ms. Herrera stated that all current staff speak English and do not use a translator app. She stated that they do have maintenance workers who use translator app. Ms. Herrera stated that Lorena was being trained and worked for about three weeks. She indicated that they have had a lot of staff turnover, however, all staff are trained and have medical, TB test and background checks.

On 08/16/2024, I received staff schedules by email from William Gross for June, July and August 2024. Staff, Lorena, only appears on the June 2024 schedule. The schedules indicate that staff are working 24 hour shifts from 8:00am-8:00 am next day. The week of onsite investigation Staff, Syrina, was listed on schedule from 06/22/2024-06/26/2024. Lorena was not listed on schedule for 06/24/2024, when I found she was working alone during unannounced onsite investigation. Lorena is listed on schedule from 06/17/2024-06/20/2024. The schedule indicates that she is training with Syrina from 06/17/2024-06/18/2024 and that William is available to help with translation. The schedule indicates that Maria is available to help with translation from 06/19/2024-06/20/2024. The 06/15/2024-06/28/2024 staff schedule is the only schedule provided that includes note that individual is scheduled to help with translation if there are issues.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(e) Any scheduling changes.**
ANALYSIS:	Staff schedule provided for June 2024 was not accurate. On 06/24/2024, I completed an unannounced onsite investigation and found Staff, Lorena Andrade, working alone. There was not a second staff present to assist with translation. During the week of the onsite investigation, Staff, Syrina was the only staff listed on schedule from 06/22/2024-06/26/2024. Syrina was not present on 06/24/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(1) Direct care staff shall not be less than 18 years of age and shall be able to complete required reports and follow written and oral instructions that are related to the care and supervision of residents.
ANALYSIS:	On 06/24/2024, Staff Lorera Andrade, was working alone at Greenwood Lodge. Ms. Andrade was unable to communicate without the use of a Spanish to English translator app on her cell phone.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	On 06/24/2024, Staff Lorera Andrade, was working alone at Greenwood Lodge. Ms. Andrade and residents confirmed that she is passing medications in the home. Ms. Andrade is unable to communicate without the use of a translator app on her cell phone. All resident medications and medication records are solely in English. There is also concern regarding Ms. Andrade's ability to contact emergency services for assistance due to her limited English and need of Spanish to English translator app to communicate. On 07/03/2024, Licensee William Gross indicated that Lorena Andrade is no longer working at home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff may not be legal to work in United States or have had background checks.

INVESTIGATION:

On 07/02/2024, I received employee records by email from William Gross. Mr. Gross did not provide a workforce background check for Lorena Andrade as requested. On 07/03/2024, I received an email from William Gross. He indicated that Lorena is no longer working for them, and they have hired a new staff whose clearance is pending. He stated that they no longer have non- English-speaking staff.

On 07/02/2024, I received clearance for Maria Herrera dated 02/27/2023. The clearance was completed for Ridgeway. A workforce background check was not provided for Greenwood Lodge.

APPLICABLE RULE	
MCL 400.713	**License required; application; forms; investigation; on-site evaluation; issuance or renewal of license; disclosures; maximum number of persons; stating type of specialized program; issuance of license to specific person at specific location; transferability of license; sale of facility; notice; items of noncompliance; refusal by department to issue or renew license; conditions; unlicensed facility; violation as misdemeanor; penalty; receipt of completed application; issuance of license within certain time period; inspections; report; criminal history and records check; storage of fingerprints in automated fingerprint identification system database; convictions; "completed application" defined.**
	(3) Before issuing or renewing a license, the department shall investigate the activities and standards of care of the applicant and shall make an on-site evaluation of the facility. On-site inspections conducted in response to the application may be conducted without prior notice to the applicant. On-site inspections conducted for renewing a license may be conducted within 12 months before the expiration date of the current license without impact on the license renewal date or the license fee. Subject to subsections (9), (10), and(11), the department shall issue or renew a license if satisfied as to all of the following: **(e) The good moral character of the licensee or licensee designee, owner, partner, director, and person responsible for the daily operation of the facility. The applicant is responsible for assessing the good moral character of the employees of the facility. The person responsible for the daily operation of the facility shall be not less than 18 years of age.**

ANALYSIS:	On 06/24/2024, I completed an unannounced onsite investigation. Staff, Lorena Andrade, was at Greenwood Lodge working alone. A workforce background check was not completed for Ms. Andrade. On 07/02/2024, I received a clearance for Maria Herrera dated 02/27/2023. The clearance was completed for Ridgeway. A workforce background check was not provided for Greenwood Lodge. Ms. Herrera needs to be fingerprinted for the correct home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident C is exhibiting sexually inappropriate behaviors towards Resident D and staff do not plan to do anything about it.

INVESTIGATION:

On 08/09/2024, I interviewed APS Worker, Debra Johns, by phone. She stated that she interviewed Resident D at her day program. Resident D stated that Resident C never hurt or touched her. Resident D's bedroom was moved upstairs and Resident C's bedroom is downstairs. Ms. Johns stated that Resident D told her that she heard Resident C say "bra" and that he said her birthday cake turned him on. Ms. Johns indicated that APS does not plan on substantiating allegations at this time.

On 08/12/2024, I completed an unannounced onsite investigation at Greenwood Lodge. I interviewed home manager, Maria Herrera, Resident C, Resident D and Resident E.

On 08/12/2024, I interviewed home manager, Maria Herrera. She stated that Resident C is diagnosed with schizophrenia and dementia. She stated that Resident C has made sexual comments to Resident D and female workers. She and owner, William Gross, have spoken to Resident C about this behavior, however, he continues due to his dementia. She stated that Resident C also hears voices. Ms. Herrera indicate that Resident C has made comments about being aroused and made inappropriate comments such as, "Do you want to lick my butthole?" and "Do you take care of yourself when you are horny?". Ms. Herrera stated that the most recent incident occurred on 08/04/2024. Resident D made a cake for her birthday and Resident C stated that he was getting sexually aroused after he ate the cake. Resident C was told his comment was not nice. Resident C did try to go in bathroom when Resident D was in the shower. Ms. Herrera stated that there are two female residents in the home. He has not done anything to other female residents. He seems to only be obsessed with Resident D. Ms. Herrera stated that they try to keep Resident C and Resident D separate. Resident D's bedroom was moved upstairs where she does not have to share a bathroom with Resident C. Resident C's bedroom is downstairs. They also redirect Resident C when

he makes inappropriate comments. Ms. Herrera stated that she believes Resident C would be better in a home with all males, however, his guardian does not want him moved.

On 08/12/2024, I interviewed Resident C. He stated that he has lived at the home for about three years, and it is going excellent. He stated that he went into Resident D's bedroom to view her artwork. He was being a friend. Resident C indicated that staff told him he was not supposed to go in her bedroom. Resident C stated that he has not seen any other residents go into Resident D's bedroom or bathroom. He stated that he has not made an inappropriate comment to Resident D and has not heard others make any inappropriate comments towards her. Resident C stated that he has never done anything sexual. He stated that another lady came and talked to him about two weeks ago about sexual comments, and he is scared that he will have to move. Resident C stated that he has stayed out of Resident D's bedroom. Resident C indicated that he feels safe in home.

On 08/12/2024, I interviewed Resident D. She indicated that Resident C has made inappropriate comments towards her. Resident D stated that Resident C said her birthday cake was so good that it sexually aroused him. She also indicated that he tried to go in the bathroom when she was showering, and Resident A stopped him. She believes this happened on two occasions. Resident D stated that her bedroom was moved upstairs a couple weeks ago, and she has a bathroom upstairs that she does not have to share with Resident C. Resident D indicated that staff correct Resident C and tell him not to say things when he is inappropriate. Resident D indicated that she likes having her bedroom upstairs now and she feels like Resident C is doing better. Resident D stated that she feels safe in the home and did not have any additional concerns.

On 08/12/2024, I interviewed Resident E. She stated that Resident C is her friend. He has not made any inappropriate comments to her. She has not heard him make inappropriate comments to others. Resident E stated that no one has tried to enter the bathroom while she was using it. Resident E stated that she really likes living at the home and has no concerns. She indicated that thins are going well.

On 08/13/2024, I received an email from licensee designee, William Gross. He indicated that they have separated Resident C and Resident D's bedrooms by having her move upstairs and try to have them eat at different times. They also plan to change the lock on bathroom door.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(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.

ANALYSIS:	There is not enough information to determine that staff are not providing protection and safety. Home Manager, Maria Herrera and Resident D, indicated that Resident C has made sexually inappropriate comments and tried to enter bathroom while Resident D was in it. Ms. Herrera stated that they have discussed behavior with Resident C and redirect him when he says inappropriate things. Action has been taken to keep Resident C and Resident D as separate as possible. Resident D's bedroom has been moved upstairs and Resident C's bedroom is downstairs. Resident D has a bathroom upstairs that she does not have to share with Resident C. The home should continue to evaluate compatibility of residents and possible change of placement if behavior does not improve or escalates.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

On 06/24/2024, I requested employee records from licensee designee, William Gross for Maria Herrera and Lorenda Andrade. I requested copies of application, reference checks, medical statement/TB test, workforce background checks and training. On 07/02/2024, licensee designee, William Gross emailed employee records. Home manager, Maria Herrera did not have verification of initial medical/TB test, reference checks or verification of training for CPR, resident rights, safety and fire prevention and prevention and containment of communicable diseases. Staff, Lorenda Andrade's CPR/First Aid training card from the American Health Care Academy was dated 06/24/2024, the day of this record request and onsite inspection when Ms. Andrade was found to be working alone.

I completed an exit conference with Licensee Designee, William Gross on 08/29/2024. I attempted exit conference by phone, however call failed. I sent email to Mr. Gross with findings and recommendation for provisional license. I informed Mr. Gross that a copy of the special investigation report would be mailed once approved and that a corrective action plan would be requested. I also informed him that I would contact him if he had any questions. On 08/30/2024, I completed an exit conference with William Gross by phone.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before

	performing assigned tasks, which shall include being competent in all of the following areas: **(c) Cardiopulmonary resuscitation.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	On 07/02/2024, licensee designee, William Gross emailed employee records. Home manager, Maria Herrera did not have verification of training for CPR, resident rights, safety and fire prevention and prevention and containment of communicable diseases. Staff, Lorenda Andrade's CPR/First Aid training card from the American Health Care Academy was dated 06/24/2024, the day of record request and onsite inspection when Ms. Andrade was found to be working alone.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.
ANALYSIS:	On 07/02/2024, licensee designee, William Gross emailed employee records. Home manager, Maria Herrera did not have an initial medical statement in her employee record.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.
ANALYSIS:	On 07/02/2024, licensee designee, William Gross emailed employee records. Home manager, Maria Herrera did not have verification of TB test in her employee record.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(f) Verification of reference checks.**
ANALYSIS:	Home manager, Maria Herrera, did not have verification of reference checks in employee records provided on 07/02/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

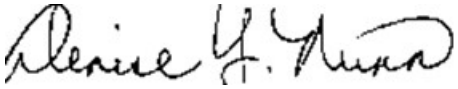
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend issuance of a provisional license.

08/30/2024

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



09/19/2024

Denise Y. Nunn — Date
Area Manager