GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 15, 2024

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

RE: License #: AG500066337
Investigation #: 2024A0604017
Ridgeway

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.

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 #:	AG500066337
Investigation #:	2024A0604017
Complaint Receipt Date:	04/17/2024
Investigation Initiation Date:	04/19/2024
Report Due Date:	06/16/2024
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:	Ridgeway
Facility Address:	72188 Russ Road Richmond, MI 48062
Facility Telephone #:	(586) 727-7650
Original Issuance Date:	05/31/1995
License Status:	REGULAR
Effective Date:	08/15/2022
Expiration Date:	08/14/2024
Capacity:	31
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED AGED

II. ALLEGATION(S)

	Violation Established?
There are residents not getting Xanax and Morphine as prescribed.	No
Residents are not allowed to use the landline to contact their guardians.	Yes
There is a lack of food and supplies at facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/17/2024	Special Investigation Intake 2024A0604017
04/17/2024	APS Referral Referral received from Adult Protective Services (APS). Referral denied and sent to licensing.
04/19/2024	Special Investigation Initiated - On Site Completed unannounced onsite investigation. Interviewed Staff, Janene Wackler, Jim Sealy, Resident D, Resident E, Resident F, Resident G, Resident H
04/22/2024	Contact- Document Received Received incident report by email. Resident A passed away on hospice on 04/21/2024.
05/01/2024	Contact - Document Sent Email from Complainant 2. Sent return email.
05/01/2024	Contact - Telephone call made TC to Complainant 2
05/01/2024	Contact- Telephone call made TC to Manager, Stacy Conn
05/02/2024	Contact - Document Sent Email to and from William Gross. Received receipts for supply purchases.
05/03/2024	Contact - Document Sent

	Email to and from William Gross. Received receipts by email for food and supply purchases.
05/03/2024	Contact - Document Received Email from Complainant 2. Sent return email.
05/08/2024	Contact - Face to Face Face to Face Meeting with William Gross at Ridgeway
05/08/2024	Contact - Document Received Email to and from William Gross
05/08/2024	Exit Conference Completed face to face exit conference with William Gross at Ridgeway
05/25/2024	Contact - Document Received Email from William Gross
05/30/2024	Contact - Document Sent Email to William Gross
06/03/2024	Contact- Document Sent Email to William Gross. Received return email.
06/05/2024	Contact- Document Sent Email to William Gross. Received return email with prescription and resident register.
06/06/2024	Contact- Document Sent Email to William Gross. Follow up re: exit conference

ALLEGATION:

There are residents not getting Xanax and Morphine as prescribed.

INVESTIGATION:

I received a licensing complaint regarding Ridgeway on 04/17/2024. The Complainant alleged that there are 27 vulnerable adults (names unknown) that reside at the Ridgeway. The adults that reside there are diagnosed with dementia and other unknown mental and physical health issues. The adults are supposed to take prescription medication. Some of the residents there have legal guardians. It is unknown if any of the residents have a Power of Attorney. The staff at Ridgeway home are the residents' caregivers. There is a lack of food in the home. On 04/16/2024, Ridgeway only had

oatmeal, black coffee, and water for breakfast for their residents. While most of the residents there do not eat breakfast, some do. There was nothing else in the home for the residents to eat. It is unknown what the residents are fed for lunch or dinner, but they do have a cook (name unknown) that prepares meals for the residents there. Due to the lack of food in the home, some of the staff bring food for the residents in on their own. The staff at Ridgeway oversee the residents' medication. One of the residents is supposed to get Morphine every 2 hours, however, the staff at Ridgeway stated she only needs Morphine every 4 hours, so this resident does not receive her medication as prescribed. Another resident there is prescribed Xanax monthly, but her mediation sometimes comes up short. While it is unknown if the staff at Ridgeway is taking the residents Xanax for personal reasons, there are concerns they may be. It is unknown how, or if, the residents there are affected if they do not receive their medication as prescribed. The residents there are unable to access their own medication as it is kept in a lock box. The staff at Ridgeway home do not allow their residents to use the landline to call their legal guardians. It was reported they are unable to call their legal guardians because the landline was not being charged. It is unknown how a landline is charged or if any of the residents there have cell phones. The capacity for residents at the Ridgeway Adult Foster Care home to house is 20 residents. As of 04/16/2024, they have 27 residents Chuck Cryderman, the owner of Ridgeway, hired outside staff to check on the home, ensure there is food in the home, and the residents are cared for appropriately. Mr. Cryderman is aware of the lack of food and did send a lot of meat over a couple weeks ago, but there are concerns that is now gone. It is unknown if Mr. Cryderman is aware of the medication, the residents not being allowed to use the landline to call their legal guardians, or if he is aware they are over capacity.

Complainant alleged that facility is over capacity, however, Ridgeway is licensed as a congregate home and has a capacity of 31 residents. On 06/05/2024, I received a copy of resident register which indicates there are currently 25 residents at Ridgeway.

On 05/01/2024, I received a second complaint from Complainant 2. Complainant 2 stated that since new owner has taken over Ridgeway, the facility is not getting supplies. Staff have had to bring supplies that they need. They need cleaning supplies, laundry soap, dish soap, wipes, gloves, and diapers. They are also not getting fresh food. William Gross or his staff, Anna, will bring supplies but they do not get enough.

I completed an unannounced onsite investigation on 04/19/2024, I interviewed Staff, Janene Wackler, Jim Sealy, Resident D, Resident E, Resident F, Resident G, Resident H.

On 04/19/2024, I interviewed Manager, Janene Wackler. She stated that Resident A is on hospice with Heart to Heart. She is prescribed Morphine as part of her comfort pack medications as needed. The nurse indicated that Morphine does not need to be scheduled at this time. Resident A's Morphine is prescribed every two hours as needed. I observed Resident A's April 2024 medication log. The medication log listed Morphine as a PRN, every two hours as needed. Resident A was only given morphine 3 times in April 2024. Resident C is also on hospice and is prescribed Morphine as part of her

comfort pack medication every 4 hours. Resident C's April 2024 medication log indicated that she had not taken any Morphine that month. On 06/05/2024, I received copy of prescription which indicated that Resident C was prescribed Morphine as needed on 04/10/2024.

On 04/19/2024, I reviewed Resident C's April 2024 medication log during onsite the investigation. Her 6:00 am medications were not initiated by staff on day of investigation. Medications not initiated included Metoprolol Succ ER 50 mg and Citalopram 10 mg. Also, medication log indicated to check and chart blood pressure-HR-T-SP02 twice daily and 6:00 am check was not initiated by staff. Resident A's April 2024 medication log also indicated to do check twice daily and 6:00 am check was not initiated by staff.

Ms. Wackler stated that Resident B is prescribed Xanax. There have been no missing pills. Ms. Wackler stated that Resident B had run out before, however, they were able to get a refill right away. Ms. Wackler stated that Resident B is currently at the hospital.

On 04/19/2024, I interviewed Resident D. She stated that she has lived at Ridgeway for three years and it is going "ok". Resident D stated that she is getting all her medications. She did not have any concerns.

On 04/19/2024, I interviewed Resident E. He had limited verbal ability. He indicated he lived at Ridgeway for 10 years and he is doing ok. Resident E indicated that he is getting his medications.

On 04/19/2024, I interviewed Resident F. She stated that she has lived at Ridgeway for two to three years. Resident F indicated that she gets all her medications.

On 04/19/2024, I interviewed Resident G. She has lived at Ridgeway for 3 years. She indicated she had concerns including issues with her guardian and getting financial statements from guardian. She also indicated that two years ago she fell and was on floor for long period of time and was once told by manager she had a smell. Resident G also stated that traps were set up at the facility for pest control. Resident G indicated that she is getting all her medications at facility.

On 04/19/2024, I interviewed Resident H. She stated that she is getting all her medications.

On 04/19/2024, I attempted to interview Resident I. Resident I did not want to be interviewed.

On 04/22/2024, I received an incident report by email from Ridgeway. Resident A passed away on 04/21/2024. She was under the care of Heart-to-Heart Hospice.

On 05/01/2024, I interviewed Manager/Nurse Practitioner, Stacy Conn, by phone. She stated that there have been no issues with medications coming up short. Resident A

was on hospice and was given morphine in comfort pack. The morphine was not scheduled. Resident A has since passed away. Also, Resident B who was prescribed Xanax did not return from hospital. Resident B passed away while she was at the hospital. Resident B was admitted to hospital on 04/16/2024 and passed away at hospital on 04/21/2024.

On 05/08/2024, I had a face-to-face meeting with new owner, William Gross, at Ridgeway. He indicated that he was not aware of any medication issues at Ridgeway or missing medications. He stated that he is meeting with staff and is working to improve communication.

APPLICABLE RULE	
R 400.2415	**Health care of residents.**
	(4) All prescription medication shall be prescribed by a licensed physician. Medication shall be administered and safeguarded in accordance with the instructions of a resident's physician.
ANALYSIS:	There is not enough information to determine residents are not getting Xanax and Morphine as prescribed. Resident A and Resident C were prescribed Morphine as part of comfort pack medications by hospice. The Morphine was prescribed as needed and not scheduled to be given every two hours. Also, Resident B was reported to be prescribed Xanax, however, was hospitalized and passed away at the hospital during the investigation. Staff interviewed were not aware of any reports of missing medication. Resident A and Resident C's medication logs did have missing staff initials. On 04/19/2024, I reviewed Resident C's April 2024 medication log during onsite the investigation. Her 6:00 am medications were not initiated by staff on day of investigation. Medications not initiated included Metoprolol Succ ER 50 mg and Citalopram 10 mg. Also, medication log indicated to check and chart blood pressure-HR-T-SP02 twice daily and 6:00 am check was not initiated by staff. Resident A's April 2024 medication log also indicated to do check twice daily and 6:00 am check was not initiated by staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are not allowed to use the landline to contact their guardians.

INVESTIGATION:

On 04/19/2024, I interviewed Manager, Janene Wackler. She stated that they are currently having issues with phone/Wi-Fi. There have been issues with incoming calls for about one day. During the unannounced onsite investigation, I observed a technician was at the facility from Xfinity working on the connection issues. Ms. Wackler indicated that residents can use landline, however, they have to limit calls sometimes during business hours to make sure they can receive calls. Ms. Wacker stated that they have two landlines. Residents can make phone calls after 4:00 pm. They can also contact their guardians/attorneys before 4:00 pm if that is when they can be reached.

On 04/19/2024, I interviewed Resident D. She stated that she can use the phone at Ridgeway. Resident D stated that her phone use is never restricted.

On 04/19/2024, I interviewed Resident E. He had limited verbal ability. He indicated that he gets phone calls.

On 04/19/2024, I interviewed Resident F. She stated that she can use the phone. Resident F indicated that the facility does not restrict phone calls.

On 04/19/2024, I interviewed Resident G. She stated that she is not able to use the phone and has not asked to use it. She stated that her guardian does not want her to use the phone or mail.

On 04/19/2024, I interviewed Resident H. She has her own cell phone and can make phone calls.

On 05/01/2024, I interviewed Manager, Stacy Conn, by phone. Ms. Conn stated that they have a house rule that residents must have a calling card to make phone calls. Residents can ask their guardians to send them calling cards. Residents can receive phone calls at the facility and they have a landline that residents can use.

On 05/02/2024, I received email with William Gross. He indicated they should now have two functional phone lines and a fax line. He also indicated that he would speak to the staff and get more details regarding the calling card issues because the phone lines they have do not take calling cards.

On 05/08/2024, I had a face-to-face meeting with new owner, William Gross, at Ridgeway. He indicated that residents can have access to phones during normal hours. He indicated that he would review phone usage with staff and the use of calling cards.

APPLICABLE RULE	
R 400.2418	**Resident activities.**
	(2) A resident shall have daily, private access to and use of a telephone for local calls. Similar access is to be granted for long distance calls which are made collect or for which charges are otherwise met by the resident. When pay telephones are provided in congregate facilities, a reasonable amount of change shall be available in the congregate facility to enable residents to make change for telephoning purposes.
ANALYSIS:	The facility has an inconsistent phone usage policy for residents. William Gross, Staff Janene Wackler, and residents interviewed stated that residents are allowed to use phones to make calls at facility. However, Manager Stacy Conn stated that residents must have a calling card to make outgoing calls and that residents can request calling cards from their guardians. Mr. Gross indicated that their phones do not take calling cards. Residents should be provided with consistent and accurate information on phone usage and informed of any charges for calls.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There is a lack of food and supplies at facility.

INVESTIGATION:

On 04/19/2024, I interviewed Manager, Janene Wackler. She indicated that residents are getting more fruits and vegetables now that there is a new owner. She used to hardly see any. Ms. Wackler indicated that residents had pizza for lunch today, but she was unsure what was served for breakfast. She stated that residents did eat a lot of pasta, but food seems to be getting better. Residents get eggs now and usually had cereal before new owner. Ms. Wackler indicated that there is not a lot of variety but believed that that residents get enough food to eat and that choices are improving.

On 04/19/2024, I interviewed Cook, Jim Sealey. He stated that they served cold cereal, toast, and canned fruit for breakfast. They had pizza for lunch. I observed boxes of Little Cesars pizza in the kitchen. Mr. Sealey indicated that he is not short on food, and he has enough food to cook residents. He stated that they do not have any fresh fruits or vegetables currently. I did observe some lettuce and packages of carrots and celery in the refrigerator. I also observed chicken nuggets, large packages of meat including ground beef, several loaves of bread, cheese, milk, eggs, and canned food.

On 04/19/2024, I reviewed copy of April 2024 menu at Ridgeway. Breakfast on 04/19/2024 was listed as cold cereal with milk, fruit, milk, coffee/tea and juice. Lunch was listed as pancakes with syrup, fruit, milk, coffee/tea. Dinner was listed as meatloaf, mashed potatoes, cake, milk, coffee/tea. I did not observe any substitutions on menu. The substitution of pizza for lunch was not noted on menu.

On 04/19/2024, I interviewed Resident D. She stated that she is getting enough food to eat. They had cereal for breakfast and pizza for lunch. Resident D stated that they also get fruits and vegetables.

On 04/19/2024, I interviewed Resident E. He indicated that he gets enough food to eat. He likes the goulash.

On 04/19/2024, I interviewed Resident F. She stated that she gets enough food to eat. She had frosted flakes and milk for breakfast and pizza for lunch. She likes fried chicken and wishes they would serve steak. Resident F stated that sometimes they get fruits and vegetables to eat.

On 04/19/2024, I interviewed Resident G. She stated that she gets enough food to eat. They had cereal, toast and coffee for breakfast and pizza for lunch. Resident G stated that she has talked to people and food is better at Ridgeway than it was 2.5-3 years ago.

On 04/19/2024, I interviewed Resident H. She stated that she gets enough food to eat and did not have any concerns. Resident H stated that she did not want breakfast today and she had pizza for lunch. She indicated that they do get served fruits and vegetables.

On 05/01/2024, I received a second complaint from Complainant 2. Complainant 2 stated that since new owner has taken over Ridgeway, the facility is not getting supplies. Staff have had to bring supplies that they need. Staff need cleaning supplies, laundry soap, dish soap, wipes, gloves, and diapers. They are also not getting fresh food. William Gross or his staff, Anna, will bring supplies but they do not get enough. On 05/01/2024, I sent email to Mr. Gross to notify him of the alleged lack of supplies at Ridgeway.

On 05/02/2024, I received an email from William Gross. He indicated that food and supply purchases have been made and he would provide receipts. Mr. Gross emailed receipt from Detroit Wholesale and Produce dated 04/29/2024 for a bulk purchase of meat, fruit, and vegetables and indicated he would send additional receipts the next day.

On 05/03/2024, I received email from Mr. Gross with receipts from Sam’s Club dated 04/08/2024, 04/17/2024, 04/22/2024, 04/30/2024, Dollar Tree dated 04/26/2024 and Kroger dated 04/29/2024 and 04/30/2024. The receipts included purchases of food,

cleaning products and personal care/hygiene products. Mr. Gross also provided an email from Adult Diapers 365 Store for an online order for briefs, gloves, tape, pullups, and wipes dated 04/23/2024. Mr. Gross indicated in his email that the purchases were made for Ridgeway. On 05/03/2024, I sent email to Mr. Gross to notify him that it was reported that Ridgeway was specifically out of laundry soap, dish soap, elbow macaroni, fruits, and vegetables and requested that he confirm with Ridgeway that they have needed supplies.

On 05/08/2024, I had a face-to-face meeting and exit conference with new owner, William Gross, at Ridgeway and observed food in kitchen with Mr. Gross and Cook, Jim Sealey. Mr. Gross indicated that he is trying to order in bulk and add more fruits and vegetables to menu. Ms. Sealey indicated that he sometimes has enough fruits and vegetables for residents. Mr. Gross had picture of case of strawberries that was recently delivered, however, Mr. Sealey showed there was only one package left. Cans of fruit cocktail that were delivered were also gone. Mr. Gross indicated that there is a $1,600.00 food order coming. I observed food in the kitchen including meat, bread, eggs, cabbage, corn, beans, potatoes, and spaghetti sauce. I also observed supplies in storge room, laundry area and basement. The facility did have supply of briefs, gloves, wipes, dish soap and cleaning supplies. There was a box of laundry detergent in laundry area. Mr. Gross indicated that he will be meeting with staff and is working to improve communication. On 06/06/2024, I sent follow up email to Mr. Gross regarding findings and informed him that a copy of the special investigation report would be mailed once approved.

APPLICABLE RULE	
R 400.2471	**Quality of meals.**
	(1) A minimum of 3 regular, nutritious, attractively prepared meals shall be provided daily. No more than 15 hours shall elapse between the evening and morning meal. Meals shall be of proper form, consistency, and temperature. Meals shall meet the general requirements for nutrition published by the department or currently found in the recommended daily dietary allowances, food and nutrition board, national academy of science.

ANALYSIS:	The facility should ensure that they have enough nutritious foods available, including fruits and vegetables, to provide to residents on a consistent basis. Complainant and Complainant 2 both indicated that there is a lack of nutritious food at facility. Complainant indicated that on 04/16/2024, Ridgeway only had oatmeal, black coffee, and water for breakfast for their residents. Complainant 2 stated that there is a lack of fresh food at facility. On 04/19/2024, I interviewed Manager, Janene Wackler. She indicated that residents are getting more fruits and vegetables now that there is a new owner, but she used to hardly see any. On 04/19/2024, Cook, Jim Sealey stated that they did not have any fresh fruits or vegetables currently. I did observe some lettuce and packages of carrots and celery in the refrigerator. On 05/08/2024, Ms. Sealey indicated that he sometimes has enough fruits and vegetables for residents. Mr. Gross had picture of case of strawberries that was recently delivered, however, Mr. Sealey showed there was only one package left. Cans of fruit cocktail that were delivered were also gone. Mr. Gross stated that he is working to buy food in bulk.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.2474	**Meal Planning.**
	(1) Menus shall be written 3 days prior to the serving of the meal. Any change or substitution shall be noted and considered as a part of the original menu.
ANALYSIS:	On 04/19/2024, I reviewed copy of April 2024 menu at Ridgeway. Breakfast on 04/19/2024 was listed as cold cereal with milk, fruit, milk, coffee/tea and juice. Lunch was listed as pancakes with syrup, fruit, milk, coffee/tea. Dinner was listed as meatloaf, mashed potatoes, cake, milk, coffee/tea. There were no substitutions noted on menu. The substitution of pizza for lunch was not noted on menu.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.2412	**Care of residents.**
	(4) A resident shall be treated with dignity, and his personal needs, including protection and safety, shall be attended to at all times.
ANALYSIS:	On 05/08/2024, I had face to face meeting at Ridgeway and observed supplies at facility. The facility did have supply of briefs, gloves, wipes, dish soap and cleaning supplies. There was a box of laundry detergent in laundry area. Mr. Gross should continue to work on communication with facility to ensure enough supplies are purchased.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

06/06/2024

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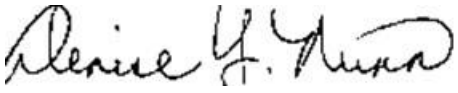
Kristine Cilluffo Date
Licensing Consultant

Approved By:



07/15/2024

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Denise Y. Nunn Date
Area Manager