GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 24, 2025

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

RE: License #: AS500267724
Investigation #: 2025A0604006
Griffith Home

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) 972-9136.

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

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|---|---|
| **License #:** | AS500267724 |
| | |
| **Investigation #:** | 2025A0604006 |
| | |
| **Complaint Receipt Date:** | 03/24/2025 |
| | |
| **Investigation Initiation Date:** | 03/25/2025 |
| | |
| **Report Due Date:** | 04/23/2025 |
| | |
| **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:** | Griffith Home |
| | |
| **Facility Address:** | 73600 Church Street Armada, MI 48005 |
| | |
| **Facility Telephone #:** | (586) 784-8890 |
| | |
| **Original Issuance Date:** | 07/19/2004 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 02/14/2025 |
| | |
| **Expiration Date:** | 02/13/2027 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A has been unable to attend church. | Yes |
| Resident A's contact with family is being blocked including phone calls and visitation. | No |
| Resident A is not receiving proper medical care in the home and has had medication stopped and missed medical appointments. | No |
| Licensee has made false statements to the police and the court that Relative 1 touched Resident A inappropriately during a visitation. The allegations were not reported to APS. | No |
| Resident A's home is being sold because she has no funds since entering facility. | No |
| There is staff at home that is not working legally and does not speak English. | No |
| The home does not have any groceries or laundry detergent. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

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|---|---|
| 03/24/2025 | Special Investigation Intake<br>2025A0604006 |
| 03/25/2025 | Special Investigation Initiated - On Site<br>Completed unannounced onsite investigation. Interviewed Staff, Sheila Washinski and Resident A. |
| 03/25/2025 | APS Referral<br>Referral made to Adult Protective Services (APS) |
| 03/26/2025 | Contact - Document Received<br>Email from APS Worker, Jasmaine Martin- Morris. Sent return email |
| 03/27/2025 | Contact - Telephone call received<br>Returned call from Complainant |
| 03/27/2025 | Contact - Document Sent<br>Email to APS Worker, Jasmaine Martin- Morris. Received return email. |
| 04/04/2025 | Contact - Telephone call received<br>Returned call from Armada Police Chief, Richard Maierle |

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|---|---|
| 04/04/2025 | Contact - Document Received<br>Email from APS Worker, Jasmine- Martin Morris. APS has no concerns. Sent return email. |
| 04/04/2025 | Contact - Document Received<br>Received resident records and court order by email from William Gross. Sent return email. |
| 04/10/2025 | Contact - Document Received<br>Email from APS Worker, Debra Johns. Sent return email. |
| 04/18/2025 | APS Referral<br>Made APS referral re: new intake |
| 04/18/2025 | Inspection Completed On-site<br>Completed unannounced onsite investigation. Interviewed Staff, Sheila Washinski, Resident A, Resident B and attempted to interview Resident C. |
| 04/18/2025 | Contact - Document Sent<br>Email to William Gross |
| 04/29/2025 | Contact - Document Sent<br>Email to William Gross requesting records |
| 05/02/2025 | Contact - Document Received<br>Received licensing documents by email from William Gross |
| 05/02/2025 | Contact - Document Sent<br>Sent email to William Gross |
| 05/06/2025 | Contact - Document Received<br>Received employee records by email from William Gross |
| 05/19/2025 | Contact- Document Sent<br>Email to William Gross requesting additional information re: medical records and funds. Received return email from William Gross |
| 05/22/2025 | Contact- Document Received<br>Email from William Gross with prescription and weight record for Resident A. |
| 05/23/2025 | Contact- Document Received<br>Email from Shiela Washinski. Sent return email. |

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|---|---|
| 05/27/2025 | Contact- Document Received<br>Email from Sheila Washinski |
| 05/28/2025 | Contact- Document Sent<br>Email to Sheila Washinski. Received return email. Sent technical assistance re: managing resident funds to Ms. Washinski and William Gross |
| 05/29/2025 | Contact- Document Received<br>Email from William Gross |
| 05/30/2025 | Contact- Document Sent<br>Email to William Gross |
| 06/11/2025 | Contact- Document Sent<br>Sent follow up email regarding Resident A medical records to Sheila Washinski and William Gross |
| 06/13/2025 | Contact- Document Received<br>Email from Sheila Washinski |
| 06/13/2025 | Contact- Document Received<br>Received fax from licensee with additional medical records for Resident A |
| 06/16/2025 | Contact- Document Sent<br>Email to Sheila Washinski. Received return email. |
| 06/23/2025 | Contact- Document Sent<br>Email to William Gross |
| 06/24/2025 | Exit Conference<br>Completed face-to-face exit conference with William Gross at North Meadows |
| 06/26/2025 | Contact- Document Received<br>Received fax from Sheila Washinski with incident report |

**ALLEGATION:**

**Resident A has been unable to attend church.**

**INVESTIGATION:**

I received a licensing complaint regarding Griffith Home on 03/24/2025. A written complaint was sent to LARA by the Complainant with multiple allegations regarding the licensee and Resident A's guardian, George Heitmanis. Licensing does not investigate allegations regarding guardians. It is alleged that facility and guardian have engaged in severe medical neglect, elder abuse, illegal isolation, financial exploitation, misuse of resident funds, religious discrimination and law violations regarding the care of Resident A. In regard to elder abuse and medical neglect, the Complainant alleges that the home has refused to provide dental care for over a year, causing Resident A to suffer severe pain, choking incidents and malnutrition due to her inability to eat properly. The facility staff cancelled all existing medical appointments and stopped her thyroid medication. It is also alleged that Resident A was bedridden for two weeks after another resident fell on her and the facility refused to take her to hospital. It is also alleged that the home has engaged in illegal social isolation and visitation violations. The Complainant alleges that the facility blocked all family contact for six months, deleted family contacts, blocked phone calls and threatened police action for contact attempts. It is alleged that the home violated religious rights and prevented Resident A from attending church for over a year. The home has refused to provide communion, confession or any catholic religious services. The home gives excuses that there is no transportation but refused paid overtime to take her. After complaints, they took her to an empty church on a Wednesday morning at 9:00 am where she could not receive sacraments.

It is further alleged that the home and guardian have engaged in financial exploitation and misuse of resident funds. Resident A entered the facility with $16,000.00 in her bank account. Guardian and facility refused to use her own money for medical care and is now claiming she has no money and is using this as an excuse to justify selling her home. It is also alleged that the home and guardian have made false statements to police and court and have engaged in witness tampering. The Complainant alleged that they have lied to the court and made false allegations. A police report was made alleging that staff, Sheila Washinski, made false allegations that she and William Gross witnessed Relative 1 "gooseing" (full hand deep into her behind area) (Resident A) during visitation. APS was not contacted by licensee regarding the alleged incident. Judge ruled that Heitmanis and Haven are not mandatory reporters but this contradicts their legal responsibility to report suspected abuse. The complaint included a copy of the police report dated 01/29/2025 and emails regarding visitation.

I received a second licensing complaint regarding Griffith Home on 04/17/2025. Complainant 2 alleged that there is an individual who works at home who does not speak English and is not working legally. They do not provide any groceries in the homes or laundry detergent. The 15-year-old daughter does bookwork and payroll.

They tell you to contact her for almost everything. The same complaint was also made regarding licensee's other homes including Ridgeway, North Meadows, Gates AFC and Pineview Manor.

I completed an unannounced onsite investigation on 03/25/2025. I interviewed Staff, Sheila Washinski and Resident A.

On 03/25/2025, I interviewed Staff, Sheila Washinski at the home. She stated that Resident A has been placed in the home for approximately one year. Her guardian is the Heitmanis Law Group. She stated that the guardian has no concerns regarding the home. Ms. Washinski stated that they have been battling Relative 1 who has filed multiple complaints in court regarding the home and guardian. The Armada Police Department, Sterling Heights Police Department and APS have all been involved. Ms. Washinski had a file folder of court records and reports regarding Resident A. Ms. Washinski stated that the request for Resident A to attend church is coming from Relative 1. He wants to be the one to take her. She stated that they had transportation to take Resident A to church on Wednesdays at 9:00 am. Ms. Washinski stated that Resident A attended one Wednesday and refused to go a second time. She was confused and said she did not know where they were taking her. Resident A also said she preferred to go on Sundays and did not want to go on Wednesdays.

On 03/25/2025, I interviewed Resident A. She stated that she has been unable to attend church. Resident A indicated that she said she wanted to go to Sunday mass. They took her to church one time on a Wednesday; however, the church does not have mass on Wednesdays. Resident A stated that someone was supposed to pick her up and take her to church, however, she only went one time.

On 04/04/2025, I received a copy of Resident A's resident information record and assessment plan dated 04/30/2024. Record indicates that Resident A has been placed at the Griffith Home since 04/30/2024. Resident A's religious preference is listed as Roman Catholic. Resident A's assessment plan dated 04/30/2024 states that Resident A participates in religious practice and indicates, "Christian/Activities coordinator will encourage".

On 04/04/2025, I received an email from APS Worker, Jasmine- Martin Morris. Ms. Martin-Morris indicated that she had no concerns that would keep her investigation open.

On 04/04/2025, I received incident reports regarding Resident A from licensee designee, William Gross by email. An incident report dated 03/20/2025 indicates, "After a supervised visitation (Resident A) informed me not to schedule any Wednesday church masses for her. She would rather go on Sundays". The report also indicates that after many conversations regarding scheduling the transportation team and their willingness to attend mass with her. All she kept saying is, I want to go on Sundays. Corrective measures taken indicate that they followed her wishes and cancelled Wednesday church masses with their transportation team. The report does not state

that any efforts were made for Resident A to attend mass on Sundays. The incident report dated 02/05/2025 indicates that Resident A refused to go to church on Wednesday when the driver came and picked her up. Action taken indicates that transportation will keep trying and church is every Wednesday at 9:00 am at St. Mary's Mystical Rose in Armada, MI. Corrective action also indicates that they will put notes on Resident A's calendar to help her with appointments. An incident report dated 01/29/2025 indicates Debbie Cryderman attended church services with Resident A and that they scheduled every Wednesday at 9:00 am for Resident A to be taken to church services.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14304** | **Resident rights; licensee responsibilities.** |
| | **(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:**<br>**(h) The right to participate in the activities of social, religious, and community groups at his or her own discretion.** |
| **ANALYSIS:** | Resident A has been placed at Griffith Home since 04/30/2024. On 03/25/2025, Resident A requested to attend Sunday mass. Staff, Sheila Washinski and Resident A, both stated that Resident A attended church on one occasion on a Wednesday. Resident A has expressed that she does not want to attend church on Wednesdays. There have been no reported efforts to take Resident A to Catholic mass on Sundays. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Resident A's contact with family is being blocked including phone calls and visitation.**

**INVESTIGATION:**

On 03/25/2025, I interviewed Staff, Sheila Washinski. Ms. Wasinski stated that there is a court hearing scheduled for 04/09/2025 regarding Relative 1's visitation. She indicated that anyone could visit Resident A, however, there is a court order that Relative 1's visitation must be supervised by someone at the Griffith Home. Resident A has declined other family members' calls and has not wanted to see them. Ms. Washinski stated that Resident A has other children, however, only wants to visit Relative 1 and her

grandsons. They have not blocked any visits and would only tell family no if Resident A declines visit.

On 03/25/2025, I interviewed Resident A. She indicated that she cannot go outside by herself and wants to go outside to get fresh air. She stated that Sheila does not like Relative 1 and is trying to keep him away from her. He has to beg and argue to come and see her. He can visit; however, visits must be supervised, and they watch everything. Resident A would like to visit Relative 1 alone. She stated that anyone else can come visit her, however, they live far out. She has not had any issues visiting anyone else besides Relative 1. During the onsite investigation, I observed that Resident A had her own cell phone in her room to make phone calls. She indicated that she can talk to Relative 1 on the phone. Resident A also indicated that Sheila reported that Relative 1 put his hands down her pants and touched her during a visitation, however, this never happened. She expressed that she was very upset that this allegation was made and that Relative 1 would never do that.

On 04/04/2025, I received a copy of the court order from licensee designee, William Gross by email. The court order is dated 01/22/2025 and indicates that Relative 1 is ordered to not communicate with the guardian, Heitmanis Law Group, more than once a week by email only. All emails must be respectful without any vulgar or profane language. The order indicates that limitation does not apply to emergency situations. Order advises Relative 1 that restrictions on visitation were imposed by the court and not be Heitmanis Law Group or any other third-party. If Relative 1 would like to alter visitation, in any fashion, a petition needs to be filed with the court and served on all interested parties. The order also states that visitation shall continue to be supervised by group home personnel at such time or place as the group home deems appropriate. Any visitation may be ended by (Resident A) at any time. As with the instructions with respect to visits (Relative 1) may not use any profane, vulgar, or inappropriate language or gestures during any visitation or telephone contact.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14304** | **Resident rights; licensee responsibilities.** |
| | **(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:**<br>**(k) The right to have contact with relatives and friends and receive visitors in the home at a reasonable time. Exceptions shall be covered in the resident's assessment plan. Special consideration shall be given to visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.** |

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| **ANALYSIS:** | There is not enough information to determine that the Griffith Home is blocking visitation and phone calls with Resident A's family. On 03/25/2025, I observed that Resident A had her own cell phone in her room to make phone calls. She stated that she has only had issues trying to visit Relative 1. She indicated that she could talk to Relative 1 on the phone. On 04/04/2025, I received a copy of the court order from licensee designee, William Gross by email which indicates Relative 1's visitation must be supervised by home and all restrictions have been imposed by the court. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ALLEGATION:**

**Resident A is not receiving proper medical care in home and has had medication stopped and missed medical appointments.**

**INVESTIGATION:**

On 03/25/2025, I interviewed Staff, Sheila Washinski. She indicated that Resident A is receiving medical care while at the Griffith home. Resident A was at the hospital two days ago for high blood pressure. Resident A has dementia. Ms. Washinski indicated that they have never stopped any of Resident A's medications on their own. Resident A has refused medications before. Ms. Washinski stated that HomeMD comes to the home and sees residents. Resident A has had bloodwork; urine samples and her medications are reviewed regularly. Ms. Washinski stated that Resident A needed dentures when she arrived at the home. She was not comfortable when they took her to the first appointment. They took her to another dental office that she had been to in 2018. During the appointment, she ended up waiting a very long time in the x-ray room and then refused treatment. They set up another appointment and she refused to go. They are trying to set up another appointment. She has not received her dentures as of this time.

On 03/25/2025, I interviewed Resident A. She indicated that she needs dentures. She stated that she has not had teeth done. She went once for teeth, and they kept her on the bed waiting for three hours and she was never seen. The office said there was an insurance issue. Resident A indicated that the home needs to make another appointment to get dentures. Resident A indicated that she is getting medications every day, but she is not sure what they are giving her. Resident A stated that she is not seeing a doctor. She indicated that she has not seen a doctor in years and no doctor visits the home. Resident A stated that she had a doctor in Clinton Township, MI.

On 04/04/2025, I received incident reports regarding Resident A by email from licensee designee, William Gross. An incident report dated 03/23/2025 and attached discharge paper emergency room indicates that Resident A was seen at McLaren Macomb on

03/23/2025 for hypertension. An incident report dated 02/19/2025 indicates that Resident A refused to attend dental appointment. Incident report 02/07/2025 indicates that Resident A decided she waited too long at appointment and refused x-rays. An incident report dated 11/01/2024 indicates that Resident A refused to be seen at the dentist's office. She was yelling, arguing and not comfortable. She wants to be seen by the dentist from her past and refused treatment.

On 04/04/2025, I received Resident A's HomeMD medical records by email from licensee designee, William Gross. Records indicate that Resident A was seen on 07/09/2024, 08/29/2024, 09/05/2024, 09/19/2024, 09/24/2024, 10/08/2024 and 02/10/2025. A copy of Resident A's health care appraisal was also received. Resident A had a current health care appraisal dated 04/29/2024.

On 04/04/2025, I received Resident A's medication logs for January 2025, February 2025 and March 2025. The logs note that Resident A has refused some medications as indicated by Ms. Washinski. Resident A's March 2025 medication log lists Acetaminophen 500 mg - take two tablets by mouth every 8 hours. The medication log is not initialed by staff as administered in March 2025 for this medication. On 05/22/2025, I received an email from William Gross who indicated that Acetaminophen 500 mg was changed to a PRN because Resident A was refusing to take it. Notes from HomeMD indicate that a verbal order was given to the Home Manager for Acetaminophen 500 mg to be changed from a scheduled medication to a PRN because Resident A was refusing to take it.

On 04/18/2025, I completed an unannounced onsite investigation. I interviewed Staff, Sheila Washinski. She stated that Resident A had a dentist appointment to get dentures on 04/11/2025 at 10:00 am. She had a follow-up appointment scheduled for 04/21/2025 at 9:00 am.

On 04/18/2025, I interviewed Resident A. She confirmed that she went to the dentist since the last onsite investigation.

On 05/22/2025, I received an email from licensee designee, William Gross with copy of prescription for Resident A's thyroid medication, Levothyroxine 150 MGG, dated 02/13/2025. Mr. Gross indicated that Resident A's thyroid medication was never stopped by the home. Mr. Gross indicated that Resident A has not had any choking incidents and they have continued attempts to get Resident A dentures, but she has wanted to cancel appointments. Mr. Gross indicated that Resident A was never bedridden for two weeks after another resident fell on her. She was seen by HomeMD after the incident. Resident A had x-rays taken and everything was fine. Resident A continues to be seen by HomeMD. I also received a copy of Resident A's weight record. Resident A's weight record indicates that she entered the facility weighing 136.5 and weight as of 05/01/2025 was 140.

On 06/26/2025, I received additional medical records for Resident A from HomeMD by email from licensee designee, William Gross. Resident A was also seen by HomeMD on 02/21/205, 03/13/2025, 03/24/2025 and had x-rays completed on 02/12/2025.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14310** | **Resident health care.** |
| | **(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.** |
| **ANALYSIS:** | There is not enough information to determine that Resident A is being medically neglected while residing at the Griffith Home. Resident A had a current health care appraisal dated 04/29/2024 and has been seen on a regular basis by HomeMD. The home was able to provide medical records verifying that Resident A has had regular medical care. The home has also continued to make efforts to get Resident A's dentures, and she had an appointment on 04/11/2025. There is not enough information to determine that not having dentures has caused choking incidents or malnutrition. Resident A's weight record did not show any significant weight loss and home did not have any incident reports regarding choking. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

| **APPLICABLE RULE** | |
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| **R 400.14312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.** |
| **ANALYSIS:** | There is not enough information to determine that the home has stopped any of Resident A's medications on their own, including her thyroid medication, Levothyroxine. The home provided a current prescription for medication dated 02/13/2025. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

| APPLICABLE RULE | |
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| **R 400.14312** | **Resident medications.** |
| | **(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:**<br>**(b) Complete an individual medication log that contains all of the following information:**<br>**(i) The medication.**<br>**(ii) The dosage.**<br>**(iii) Label instructions for use.**<br>**(iv) Time to be administered.**<br>**(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** |
| **ANALYSIS:** | On 04/04/2025, I received Resident A's medication logs for January 2025, February 2025 and March 2025. Resident A's March 2025 medication log lists Acetaminophen 500 mg - take two tablets by mouth every 8 hours. The medication log is not initialed by staff as administered in March 2025 for this medication. On 05/22/2025, I received an email from William Gross who indicated that Acetaminophen 500 mg was changed to a PRN because Resident A was refusing to take it. Notes from HomeMD indicate that a verbal order was given to Home Manager for Acetaminophen 500 mg to be changed from a scheduled medication to a PRN because Resident A was refusing to take it. Resident A's medication log was not updated to reflect this change. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Licensee has made false statements to police and court that Relative 1 touched Resident A inappropriately during visitation. The allegation was not reported to APS.**

**INVESTIGATION:**

On 03/25/2025, I interviewed Staff, Sheila Washinski. She indicated that she did witness Relative 1 "goose" Resident A during a visitation. She stated that the incident was reported to her guardian and court determined that it did not have to be reported to APS.

On 04/04/2025, I spoke to Armada Police Chief, Richard Maierle, by phone. Chief Maierle was aware of the ongoing conflict between Relative 1 and AFC home as well as allegation that Relative 1 touched Resident A inappropriately during a visit. He did not believe the incident occurred. He believed the incident should have been reported to APS by licensee if it happened.

On 06/24/2025, I had face to face meeting with Licensee Designee, William Gross. He stated that it is his policy for incidents of abuse and/or neglect to be reported to APS. He stated that he did not actually witness the incident and only heard that it occurred.

On 06/26/2025, I received a copy of incident report by email from Sheila Washinski dated 10/21/2024. The incident report states, "(Resident A and Relative 1) were talking by his parked car on street in front of Griffith Home. William Gross and I were standing behind the fence in front yard. (Relative 1) walked around his car and goosed (Resident A). She jumped and cried out. (Relative 1) said goodbye to (Resident A) and left." Report states that Sheila Washinski thought Relative 1's actions were inappropriate and reported Relative 1's actions to guardian Heitmanis.

I reviewed a copy of police report from the Armada Police Department dated 01/29/2025. Relative 1 made report regarding Resident A's care and allegation made against him. The report indicates that Wiliam Gross stated he only saw Relative 1 hugging Resident A and could not make statement as to where he put his hand. Sheila Washinski was also interviewed and stated that Relative 1 "goosed" Resident A and she felt it was very inappropriate. Both Mr. Gross and Ms. Washinsski indicated that this incident was reported to Resident A's guardian. Resident A's guardian was also interviewed and felt that the incident was not sexual in nature and did not need to be reported to APS. Police report indicates that they believe incident should have been reported to APS as believed to be required by law.

I reviewed a copy of email written by Sheila Washinski regarding visitation dated 10/21/2024. Ms. Washinski's email states that William Gross witnessed Relative 1 goosing Resident A in front of them all.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14207** | **Required personnel policies.** |
| | **(1)A licensee shall have written policies and procedures that include all of the following:**<br>**(a) Mandatory reporting, including reporting that is required by law.** |
| **ANALYSIS:** | There is not enough information to determine that false allegations were made to the police and court by the licensee. Staff, Sheila Washinski, has continued to allege that Relative 1 touched Resident A inappropriately during a visit, however, appears to be the only witness to the incident. Resident A |

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| | denies the incident occurred. Ms. Washinski stated in an email dated 10/21/2024 that William Gross also witnessed the incident, however, although it appears he was present, he reported he did not actually witness where Relative 1 put his hand. Resident A's guardian reported to police that the incident was not reported to APS because it was not believed to be sexual in nature. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ALLEGATION:**

**Resident A's home is being sold because she has no funds since entering facility.**

**INVESTIGATION:**

On 03/25/2025, I interviewed Staff, Sheila Washinski. She stated that they have no access to Resident A's money. Guardian, George Heitmanis, is trying to sell Resident A's home and Relative 1 is trying to block the sale. They are mailed checks for Resident A's care. Ms. Washinski stated that they are not holding any cash for Resident A.

On 03/25/2025, I interviewed Resident A. She indicated that people are trying to sell her home. She does not want her home to be sold.

On 04/04/2025, I received copy of Resident A's Funds Part 1 and 2 form by email from licensee designee, William Gross. Funds Part 1 form dated 02/25/2025 indicates that the licensee is managing Resident A's payment for AFC and cash. A Funds Part 2 form was provided that has "other" checked for type of account and "Resident Funds" is written on form. Funds Part 2 indicates that checks are being received for Resident A and balance as of 03/03/2025 was $681.00. The funds forms do not indicate where these resident funds are being held. A second Funds Part 2 form was received that documents the licensee receiving monthly payment for adult foster care services.

On 05/27/2025, I received an email from Staff, Sheila Washinski. She stated, "All monies of (Resident A) is handle through Heitmanis her guardian who sends us checks for Room and Board via paying invoice and $50.00 check for Client Spending which is deposited in client spending account; we have a check book in the main office @Griffith to be distributed as needed. Resident Funds Part I is updated every month as residents receives their funds". On 05/28/2025, I received an email from Ms. Washinski. She stated, "All residents' that have Client Spending checks are deposited into the same company account under Haven AFC Client Spending. Each resident has their own Resident Funds Part II form which is updated with each payment and spending. William opened an account for (Resident A) but closed it because it is too much work to have each resident having their own individual accounts". On 05/28/2025, I informed both Mr. Gross and Ms. Washinski that a resident's account shall be individual to the resident. If resident funds are deposited into a licensee's account, the resident must be forwarded

those funds within 5 working days. I also provided information from the technical assistance manual.

On 06/24/2025, I had face to face meeting with William Gross. He indicated that resident funds were removed from the account and were being held in cash. Mr. Gross was informed that he cannot hold more than $200.00 in cash for each resident. Mr. Gross stated that Resident A's home has been sold by the guardian, however, he had no involvement in sale of the home.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14315** | **Handling of resident funds and valuables.** |
| | **(5) All resident funds, which includes bank accounts, shall be kept separate and apart from all funds and monies of the licensee. Interest and dividends earned on resident funds shall be credited to the resident. Payments for care for the current month may be used by the licensee for operating expenses.** |
| **ANALYSIS:** | Resident A's funds were being held in licensee's account. Staff, Sheila Washinski, stated that client spending checks are being deposited into the same company account under Haven AFC Client Spending. The main office has a checkbook, and funds are distributed as needed. There is no information to determine that the licensee had any involvement in selling Resident A's home. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14315** | **Handling of resident funds and valuables.** |
| | **(9) A resident's account shall be individual to the resident. A licensee shall be prohibited from having any ownership interest in a resident's account and shall verify such in a written statement to the resident or the resident's designated representative.** |
| **ANALYSIS:** | Resident A does not have an individual account for her funds. Resident A's funds were being held in licensees' account. Staff, Sheila Washinski, stated that client spending checks are being deposited into the same company account under Haven AFC Client Spending. The main office has a checkbook, and funds are distributed as needed. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**There is staff at home that is not working legally and does not speak English.**

**INVESTIGATION:**

On 04/18/2025, I completed an unannounced onsite investigation. I interviewed Staff, Sheila Washinski, Resident A, Resident B and attempted to interview Resident C.

On 04/18/2025, I interviewed Staff, Sheila Washinski. She stated that all staff at Griffith Home speak English. No staff are using a translator app to communicate with residents. I observed a second English-speaking staff in the home during onsite investigation.

On 04/18/2025, I interviewed Resident A. She stated that all staff speak English. She can communicate with staff at the home. No staff are using a translator app to communicate.

On 04/18/2025, I interviewed Resident B. She stated that she has lived in the home since January 2025 and it is going good. She stated that she can communicate with all staff at the home. She stated that some staff may speak a second language, but she is able to communicate with them. She did not have any concerns.

On 04/18/2025, I attempted to interview Resident C. She indicated that she did not want to talk.

On 05/02/2025, I requested employee file for Staff, Meia Jackson, based on staff list provided by Mr. Gross. I received employee records by email from William Gross by email on 05/06/2025. I received copy of Ms. Jackson driver's license, social security card, application, TB test, training records, references, job description and workforce background check.

| **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:** | There is not enough information to determine that staff at the home do not speak English or are not working legally in the country. On 04/18/2025, I completed an unannounced onsite investigation. Staff and residents reported that there are no staff at the home that do not speak English. Licensee designee, William Gross, was also able to provide the requested employee |

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| | records which included identification and workforce background checks. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

| **APPLICABLE RULE** | |
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| **R 400.14204** | **Direct care staff; qualifications and training.** |
| | **(2) Direct care staff shall possess all of the following qualifications:**<br>**(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**<br>**(b) Be capable of appropriately handling emergency situations.** |
| **ANALYSIS:** | There is not enough information to determine that there is staff at the home that do not speak English. On 04/18/2025, I completed an unannounced onsite investigation. Staff and residents reported there are no staff at the home that do not speak English. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ALLEGATION:**

**The home does not have any groceries or laundry detergent.**

**INVESTIGATION:**

On 04/18/2025, I completed an unannounced onsite investigation. I observed residents eating lunch at the dining room table when I arrived at the home. I interviewed staff, Sheila Washinski. She stated that they order groceries every single Monday. Groceries are delivered to the home. Ms. Washinski indicated that residents may get upset if they run out of a specific food, however, there is always food in the home. They also follow a menu. Ms. Washinski indicated that they have laundry detergent available, and residents have plenty of clean clothes. They wash each resident's clothes separately and each resident has a laundry day where their items are washed. During the onsite investigation, I observed food in the refrigerator and cupboards. The home had food including fruit, canned goods, yogurt, ice cream, meat, tuna, pasta and cake mixes. I also observed laundry soap and Downy fabric softener in the laundry area.

On 04/18/2025, I interviewed Resident A. She indicated that they eat breakfast, lunch and dinner. She gets enough food to eat and so far, the food is good. Resident A indicated that her laundry is getting done. Staff do the laundry, and she has enough clean clothes to wear.

On 04/18/2025, I interviewed Resident B. She stated that they eat breakfast, lunch and dinner. She gets enough food to eat. She indicated that her laundry gets done and the home is really good about doing laundry. She has enough clothes to wear.

I completed a face-to-face exit conference with licensee designee, William Gross, on 06/24/2025 at North Meadows. I discussed the allegations with Mr. Gross and informed him of the findings and recommendation. I also informed him that a copy of the special investigation report would be mailed once approved.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14313** | **Resident nutrition.** |
| | **(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.** |
| **ANALYSIS:** | There is not enough information to determine that there are not groceries available in the home. On 04/18/2025, I completed an unannounced onsite investigation. I observed an adequate amount of food available in the home. Resident A and Resident B also reported that they have breakfast, lunch and dinner and get enough food to eat. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14314** | **Resident hygiene.** |
| | **(5) A licensee shall afford a resident with opportunities, and instructions when necessary, to routinely launder clothing. Clean clothing shall be available at all times.** |
| **ANALYSIS:** | There is not enough information to determine that there is no laundry detergent available in the home. On 04/18/2025, I completed an unannounced onsite investigation. I observed laundry soap and fabric softer in the laundry area. Resident A and Resident B both stated that staff do their laundry, and they have enough clean clothes to wear. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

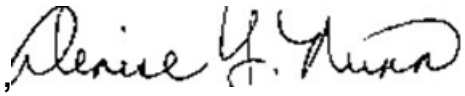
## IV. RECOMMENDATION

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

07/07/2025

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



07/24/2025

Denise Y. Nunn — Date
Area Manager