GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 8, 2025

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

RE: License #: AL500066534
Investigation #: 2025A0617018
Haven Adult Foster Care 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

A previous recommendation of revocation was made in SIR #2025A0617020, which remains in effect.

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,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500066534
Investigation #:	2025A0617018
Complaint Receipt Date:	07/10/2025
Investigation Initiation Date:	07/10/2025
Report Due Date:	09/08/2025
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:	Haven Adult Foster Care Home
Facility Address:	58483 Pasco New Haven, MI 48048
Facility Telephone #:	(586) 749-3822
Original Issuance Date:	07/11/1995
License **Status:**	REGULAR
Effective Date:	11/02/2023
Expiration Date:	11/01/2025
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was hospitalized on 07/07/2025 after neglect of his infected foot ulcer at a poorly maintained and unsafe foster care home.	Yes
Resident C is not receiving his medication.	No
The facility has bed bugs.	No
Facility ramps are broken and Resident B was injured.	No

III. METHODOLOGY

07/10/2025	Special Investigation Intake 2025A0617018
07/10/2025	Special Investigation Initiated - Telephone TC to complainant
07/16/2025	Contact - Telephone call made TC to Resident A guardian
07/16/2025	Inspection Completed On-site I completed an unannounced onsite investigation at the facility. I interviewed facility manager Maha Ibrahim, Resident B, C, D, E, F, G, and H.
08/28/2025	Contact - Telephone call made TC to Resident A guardian
09/23/2025	Contact - Telephone call made I interviewed Resident A's guardian
09/23/2025	Contact - Telephone call made I interviewed facility nurse April Provenzino
09/23/2025	Contact - Document Received I received pictures of Resident A foot from nurse April Provenzino

09/24/2025	Exit Conference I conducted an exit conference with licensee designee William Gross to discuss the findings of this report.

ALLEGATION:

Resident A was hospitalized on 07/07/2025 after neglect of his infected foot ulcer at a poorly maintained and unsafe foster care home.

INVESTIGATION:

On 07/10/25, I received several complaints regarding the Haven AFC home. According to the complaints, Resident A (66) resides in Haven Adult Foster Care Home with 14 other residents. Resident A is autistic and has an ulcer wound in his right foot. Resident A has been complaining to the owner of the foster care home about his right foot, but the owner continued to ignore his concerns. On 07/07/2025, Resident A's social worker from Macomb County visited Resident A and saw that Resident A's ulcer was infected, so she contacted the EMS and had them to transport Resident A to the hospital. Resident A's legal guardian is his sister, who resides in Arkansas.

The next complaint indicated that the ramps in both entryways are broken which causes the adults in the home to fall. There is a wooden ramp outside of the home at the main entrance. One of the wooden parts of the ramp is sticking straight up. Resident B has fallen as a result. He scraped his knee, and it required bandages. Staff have also fallen due to the broken ramps.

The next complaint indicated that staff are advised by the home manager Maha to throw away Resident A medication and sign or document that he is receiving the medication. It is unknown if this has caused harm or further sickness to Resident C.

The last complaint indicated that the home has bedbugs.

On 07/16/25, I completed an unannounced onsite investigation at the facility. I interviewed facility manager Maha Ibrahim, Resident B, C, D, E, F, G, and H.

During the onsite investigation I interviewed facility manager Maha Ibrahim. According to Ms. Ibrahim, Resident A got a blister on his foot on 07/01/25. Ms. Ibrahim stated that Resident A told her that his shoes gave him the blister. Ms. Ibrahim told him not to put pressure on it or mess with it until she consulted with the nurse. Ms. Ibrahim stated that she contacted the facility nurse April Provenzino and left a message. Ms. Ibrahim was off for the next four days and when she returned to work on 07/07/25, Resident A's blister had worsened. Ms. Ibrahim then contacted the nurse again and sent her pictures of Resident A's foot. The nurse instructed Ms. Ibrahim to send Resident A to the hospital. Ms. Ibrahim stated that Resident A is still in the hospital and is not returning to the facility. Ms. Ibrahim was unsure of where Resident A was transferring to. Ms. Ibrahim provided me with a copy of the incident report. According to the incident report,

Resident A had a large blister on his foot that he complained had worsened over the weekend and was causing him pain/difficulty walking. Ms. Ibrahim sent a picture to April Provenzino NP, who advised that considering how it looked and his condition as a diabetic that he needed to go to the hospital immediately. According to the incident report, Resident A's guardian was not contacted.

On 09/23/25, I interviewed facility nurse April Provenzino. According to Ms. Provenzino, Resident A was seen by the foot doctor a few days prior to getting the blister. Ms. Provenzino stated that she went on vacation and while on vacation, on 07/02/25, Ms. Ibrahim left her a voicemail regarding Resident A getting a blister. When Ms. Provenzino returned to work on 07/07/25, she was contacted by Ms. Ibrahim informing her that Resident A's blister had worsened. According to Ms. Provenznio, Ms. Ibrahim sent her a picture of Resident A's foot. Ms. Provenznio stated that his foot looked very bad and requested that he be sent to the hospital immediately. Ms. Provenznio stated that Resident A is diabetic and that could have contributed to the quick progression of the blister. Ms. Provenzino provided me with the picture of Resident A's foot that was provided to her by Ms. Ibrahim.

On 09/23/25, I interviewed Resident A's guardian. According to Resident A's guardian, she lives in Kansas and doesn't have regular contact with the facility. She stated that she was not made aware of the blister on her brother's foot or that he was sent to the hospital. Resident A's guardian stated that she was made aware that her brother was in the hospital by the hospital social worker. According to Resident A's guardian, the hospital's social worker felt that Resident A should not return to the facility due to the condition of his foot. The hospital social worker found Resident A new placement. Resident A's guardian did not have the name or contact information for the hospital social worker. Resident A's guardian stated that Resident A had to have surgery on his foot due to the injury, but he is recovering well.

APPLICABLE RULE	
R 400.15310	**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:	Resident A had a blister that caused him pain and discomfort. The facility did not take immediate action to get him medical assistance. Therefore, Resident A was in pain and discomfort for several days before being sent to the hospital. As a result of the injury, Resident A was required to have surgery.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident C is not receiving his medication

INVESTIGATION:

During the onsite investigation, I conducted a medication audit, and I reviewed the medications for Residents B, C, D, E, F, G and H. I found no medication errors.

According to Ms. Ibrahim, there have not been any issues with Resident C's medication.

During the onsite investigation I interviewed Resident C. According to Resident C, there are no issues or concerns with his medications.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	During the onsite investigation, I conducted a medication audit, and I reviewed the medications for Residents B, C, D, E, F, G and H. I found no medication errors.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The facility has bed bugs.

INVESTIGATION:

According to Ms. Ibrahim, the facility continues to utilize a pest control program provided by Orkin pest control. Ms. Ibrahim stated that Orkin comes to the facility monthly. Ms. Ibrahim provided me with documentation showing that Orkin was last at the facility on

07/11/25 and on 06/30/25 before that. According to the reports, there are no active bed bugs in the home.

According to Resident B, there are no bed bugs in the home at the present time. He has no concerns about bedbugs.

During the onsite investigation, I interviewed Resident F. According to Resident F, the facility bedbug issue has gotten better. Resident F stated that he hasn't seen any bedbugs in a long time.

During the onsite investigation, I interviewed Resident G. According to Resident G, the home does not have bedbugs anymore. He could not remember the last time he saw a bedbug and stated he had no concerns at this time.

During the onsite investigation, I interviewed Resident H. According to Resident H, there are no bedbugs in the home anymore. Pest control comes out monthly and there are no issues to report.

During the onsite investigation, I did not observe any bedbugs in the facility.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	The facility continues to utilize a pest control program through Orkin Pest control. Residents and staff both report there have not been any bedbug activity lately. During the onsite investigation, I did not see any bedbugs.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Facility ramps are broken and Resident B was injured.

INVESTIGATION:

During the onsite investigation, I observed two wooden ramps outside of the facility. The ramps appeared to be in good condition with no visible damage. I walked up and down both ramps with no issues or concerns.

According to Ms. Ibrahim, there have not been any issues with the ramps and no resident injuries have been reported. Ms. Ibrahim stated that Resident B walks fine with no issues, and he has not been injured.

During the onsite investigation, I interviewed Resident B. According to Resident B, he has never fallen or been injured on the ramps. He stated that he has no concern with regards to the ramps.

On 09/24/25, I conducted an exit conference with licensee designee William Gross to discuss the findings of this report. Mr. Gross did not answer and I left a voicemail.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	During the onsite investigation, I observed two wooden ramps outside of the facility. The ramps appeared to be in good condition with no visible damage. I walked up and down both ramps with no issues or concerns. Resident B reported that he has not fallen or been injured on the ramps and has no concerns at this time.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend that the current recommendation of revocation per SIR #2025A0617020 remains in effect.

09/23/25

Eric Johnson Date
Licensing Consultant

Approved By:

10/08/2025

Denise Y. Nunn Date
Area Manager