GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 9, 2025

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

RE: License #: AL500066534
Investigation #: 2026A0617003
Haven Adult Foster Care Home

Dear Mr. Gross:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. A previous recommendation for revocation was made in SIR #2025A0617020, which remains in effect. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Eric Johnson
Adult Foster Care Licensing Consultant
Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems
3026 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 #:	2026A0617003
Complaint Receipt Date:	11/07/2025
Investigation Initiation Date:	11/07/2025
Report Due Date:	01/06/2026
LicenseeName:	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?
Former staff member Ms. Tia, neglected residents by sleeping and staying in her vehicle instead of supervising them, raising serious safety concerns about residents being left unsupervised and at risk in emergencies.	Yes
Home manager Maha left in the middle of the night and left residents unsupervised.	Yes

III. METHODOLOGY

11/07/2025	Special Investigation Intake 2026A0617003
11/07/2025	Special Investigation Initiated - Telephone TC to complainant
11/07/2025	APS Referral Adult Protective Services referral received - denied by APS
11/17/2025	Contact - Telephone call received I interviewed an anonymous health care professional who works closely with the Haven Adult Foster Care facility.
11/18/2025	Inspection Completed On-site I completed an unannounced onsite investigation. I interviewed staff Mariah Davis, Resident A, Resident B, Resident C, Resident D and Licensee Designee William Gross via phone.
11/18/2025	Contact - Telephone call made TC to Maha Ibrahim
11/19/2025	Contact - Telephone call made TC to Maha Ibrahim
11/19/2025	Contact - Document Received I received staff schedules for October and November 2025, staff files

11/19/2025	Contact - Telephone call made to Tia Skyes
11/19/2025	Contact - Telephone call made TC to Tia Skyes
11/20/2025	Contact - Telephone call made TC to Tia Skyes
12/05/2025	Contact - Telephone call made I interviewed staff Ms. Bineta Diakite.
12/05/2025	Contact - Document Received I received screen shots of text messages between the anonymous health care professional and Maha.
12/05/2025	Contact - Telephone call made TC to Tia Skyes
12/05/2025	Contact - Telephone call made TC to Maha Ibrahim
12/08/2025	Exit Conference I conducted an exit conference with licensee designee William Gross to discuss the findings of this report.

ALLEGATION:

- **Former staff member Ms. Tia, neglected residents by sleeping and staying in her vehicle instead of supervising them, raising serious safety concerns about residents being left unsupervised and at risk in emergencies.**
- **Home manager Maham left the home in the middle of the night and left residents unsupervised.**

INVESTIGATION:

On 11/07/25, I received a complaint regarding the Haven Adult Foster Care home. According to the complaint in the past, Ms. Tia was a staff person at Haven AFC. Ms. Tia was in the vehicle asleep and not looking after the residents. Ms. Tia would come into the house to provide snacks, lunch, breakfast and dinner. Ms. Tia would then go back to her vehicle. Ms. Tia would come in and out of her vehicle. The residents were not safe while Ms. Tia was in the vehicle. Nothing happened to the residents while Ms. Tia was in her vehicle. There were concerns whether a resident fell or if a fire started in the house there was no staff person present with Ms. Tia being in her vehicle. If something had happened in the home the residents would not have been safe. There were concerns about the residents' safety and well-being.

On 11/17/25, I received another complaint regarding the Haven AFC home. According to the complaint, there are at least 15 residents reside at Haven AFC home. Most of the residents can care for themselves independently but need some assistance with their daily living skills. Maha is the manager of Haven AFC home. Sometime this week, Maha left the residents alone in the middle of the night. Maha was overworked and there was no one to relieve her so she quit and left the residents alone. Maha did make someone aware prior to her leaving but it is not believed that anyone came before she left. It is unknown how long the residents were left alone. None of the residents were harmed.

On 11/18/25, I completed an unannounced onsite investigation. I interviewed staff Mariah Davis, Resident A, Resident B, Resident C, Resident D and licensee designee William Gross via phone.

According to Ms. Mariah Davis, it is only her second day working and she is not aware of anything regarding Ms. Tia. Ms. Davis stated that there are no printed staff schedules, but she had a text indicating what days she would be working over the next two weeks. I reviewed the text, and it showed that there are only two staff members (Mariah Davis and Bineta Diakite) working over the next two weeks. Ms. Davis reported that she only had CPR, first aid medication administration, housekeeping and emergency evacuation trainings thus far, but she was working alone for 48 hours straight.

According to Resident A, he is not aware of staff Tia leaving the residents alone.

According to Resident B, Tia would leave the residents in the home while she would go to her car to smoke cigarettes. Resident B stated that she would leave residents for approximately an hour at a time, and residents would not have access to her unless they went outside to get her.

According to Resident C, Tia would go sit in the care a lot and leave the residents alone without supervision. Tia would be gone at least an hour each time she went outside, and she would go out there several times a day.

According to Resident D, Tia would leave and go outside to sit in her car for hours at a time. She would leave residents unattended to look after themselves. Resident D stated that the more mobile residents would help the less mobile residents with things they may need like getting water.

According to Mr. William Gross, Tia is a former employee, but he is not aware of her leaving the residents alone. Mr. Gross could not indicate when Ms. Tia’s last day working at the facility, how long she had been employed or contact information for Ms. Tia. Mr. Gross stated that he would look into that information and email it to me.

On 12/5/25, I interviewed staff Ms. Bineta Diakite. According to Ms. Diakite, she started working at the facility on 11/7/25 and she has no knowledge of the staff member Ms. Tia.

I made attempts to contact Ms. Tia Skyes, but I was unsuccessful.

On 11/17/25, I interviewed an anonymous health care professional who works closely with the Haven Adult Foster Care facility. According to the health care professional, she is a nurse practitioner at Great Lakes Medical Group in Eastpointe and works under Dr. Mohamad Rahbar. She works remotely and round monthly and as needed in three group homes that William Gross owns or runs: Ridgeway, Griffith and New Haven. On 11/14/25, Friday evening the health care professional stated that she notified Maha the Manager at New Haven group home that she was going to be stepping down as of January 2026. Maha then told the health care professional that she no longer works at the facility. The health care professional had just spoken with Maha two days prior, so the health care professional asked about the timing of Maha giving notice and if it was two weeks. According to the health care professional, Maha said “I wish but no I unfortunately just walked out. It was too much. I can’t go in every shift without knowing when I’ll leave. I left late at night while the residents were sleeping and notified management beforehand.” The health care professional stated that from what she knows, there was no relief person there when Maha left and she has no idea when a relief person arrived after she left. According to the health care professional, there are many people in this house, and although they didn’t meet the criteria of vulnerability according to Adult Protective Services, they all require some type of supervision or assistance and should not be left alone.

On 11/18/25, I completed an unannounced onsite investigation. I interviewed staff Mariah Davis, Resident A, Resident B, Resident C, Resident D and licensee designee William Gross via phone.

According to Ms. Mariah Davis, it is only her second day working and she is not aware of anything regarding Maha, leaving the residents unattended.

According to Resident A, he has no knowledge of Maha, leaving the residents alone. Resident A stated that he was sleeping on the night of the alleged incident.

According to Resident B, Maha left after dinner last week for about an hour but came back. Later that evening she left again and was not seen again after that. Resident B is not aware of anyone coming to replace her.

According to Resident C, he is not aware of Maha leaving the resident alone. Resident C reported that he was sleeping.

According to Resident D, Maha quit and left residents alone late in the evening last week. Resident D stated that the residents went all night and most of the morning

without staff. Resident D stated that Maha left around midnight and did not say anything to the residents.

According to Mr. Gross, Maha contacted him on 11/13/25 around 9pm and requested that someone come to relieve her because she was having a mental breakdown. Mr. Gross stated that he and his wife arrived prior to Maha leaving and stayed all night with the residents until the next morning when staff Bineta arrived to relieve them.

On 11/19/25, I received staff schedule from Mr. Gross for October and November 2025. The staff schedule did not include job titles or hours' work with the exception of 11/13/25. According to the staff schedule, on 11/13/25, Maha worked from 8am to 9pm and Mr. Gross worked at 9pm with no end time.

On 12/05/25, I interviewed Ms. Bineta Diakite. According to Ms. Diakite, Mr. Gross contacted her on 11/13/25 during the evening and asked if she could come early the next day because Maha quit. Ms. Diakite stated that she arrived at the facility around 6am on the 14th and when she arrived Mr. Gross was there.

On 12/05/25, I received screen shots of text messages between the anonymous health care professional and Maha. According to the messages sent on 11/14/25 at 5:48pm, Maha stated that she quit yesterday. When asked by the health professional did Maha give a two weeks' notice, Maha replied and stated, "I wish but no I unfortunately just walked out. It was too much. I can't go in every shift not knowing when I'll leave. I left late at night while the residents were sleeping and notified management beforehand". In another message, the health care professional stated to Maha that Maha could get charged with abandonment of vulnerable individuals, and Maha replied stating, "I frankly don't care either way, but even so they 100% overworked me and provided me with no relief person so they can fight me if they want".

On 12/08/25, I conducted an exit conference with licensee designee William Gross to discuss the findings of this report. Mr. Gross did not answer and a voicemail was left.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.**

ANALYSIS:	According to Residents B, C and D, staff Tia would leave the residents in the home while she would go to her car to smoke cigarettes. Residents B, C and D stated that she would leave residents for an extended amount of time, and residents would not have access to her unless they went outside to get her. The residents were left unsupervised for extended periods of time while Tia would be outside in her vehicle, putting vulnerable adults at an increased risk of danger. According to Residents B and D, Maha quit and left residents alone late in the evening. According to the health care professional, Maha said “I wish but no I unfortunately just walked out. It was too much. I can’t go in every shift without knowing when I’ll leave. I left late at night while the residents were sleeping and notified management beforehand.” The health care professional stated that from what she knows, there was no relief person there when Maha left and she has no idea when a relief person arrived after she left. According to the screen shots of text messages between the anonymous health care professional and Maha, on 11/14/25 at 5:48pm, Maha stated that she quit yesterday. When asked by the health professional did Maha give a two weeks’ notice, Maha replied and stated, “I wish but no I unfortunately just walked out. It was too much. I can’t go in every shift not knowing when I’ll leave. I left late at night while the residents were sleeping and notified management beforehand”. According to the staff schedule the facility currently only has two staff members who work 24-hour shifts. Staff are working multiple consecutive days per week, which is unstainable. There are insufficient alternative staff to relieve the current staff when breaks are required for supervision, personal care, and protection of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.639	**Staff records.**
	(3) A licensee shall maintain for 90 days a daily work schedule and assignments that includes all of the following: **(b) Job titles.** **(c) Hours or shifts worked.**
ANALYSIS:	I received the staff schedules from Mr. Gross for October and November 2025. The staff schedule did not include job titles or hours' worked with the exception of 11/13/25. According to the staff schedule, on 11/13/25, Maha worked from 8am to 9pm and Mr. Gross worked at 9pm with no end time.
CONCLUSION:	**VIOLATION ESTABLISHED**

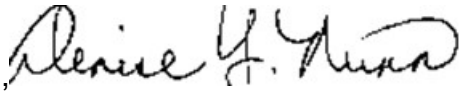
IV. RECOMMENDATION

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

12/08/25

Eric Johnson — Date
Licensing Consultant

Approved By:



12/09/2025

Denise Y. Nunn — Date
Area Manager