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 #: 2026A0617005
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 #:	2026A0617005
Complaint Receipt Date:	12/01/2025
Investigation Initiation Date:	12/01/2025
Report Due Date:	01/30/2026
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?
Resident A gave himself five times his prescribed insulin on 11/22-11/23/2025, resulting in hospitalizations for dangerously low blood sugar.	Yes

III. METHODOLOGY

12/01/2025	Special Investigation Intake 2026A0617005
12/01/2025	Special Investigation Initiated - Telephone TC to complainant
12/01/2025	APS Referral Adult Protective Services referral received - assigned worker is Debra Johns. Ms. Johns opened an investigation in regards to Resident A.
12/01/2025	Contact - Document Received Statement from April Provenzino
12/01/2025	Contact - Document Received Statement from Jeff Yaroch
12/01/2025	Contact - Document Received Statement from Resident A guardian
12/04/2025	Inspection Completed On-site I conducted an unannounced onsite investigation at the facility. I interviewed staff Mariah Davis, Resident A and staff Bineta Diakite via phone.
12/07/2025	Contact - Document Sent Email sent to Resident A guardian
12/07/2025	Contact - Document Sent email sent to Mr. Gross

12/07/2025	Contact - Document Sent Email sent to Mr. Yaroach
12/08/2025	Contact - Document Received A copy of Resident A's discharge notice was received from Resident A's guardian
12/08/2025	Contact - Document Received I received an email from Mr. Gross
12/08/2025	Exit Conference I conducted an exit conference with licensee designee William Gross to discuss the findings of this report.
12/09/2025	Contact - Document Received Email Received from Resident A guardian
12/09/2025	Contact - Telephone call made I spoke with Mr. Gross

ALLEGATION:

Resident A gave himself five times his prescribed insulin on 11/22-11/23/2025, resulting in hospitalizations for dangerously low blood sugar.

INVESTIGATION:

On 12/01/25, I received a complaint about the Haven Adult Foster Care facility. According to the complaint, Resident A (60) is currently not his own decision maker and resides within an AFC Home. Resident A receives guardianship services through Saint Clair County Public Guardian. Resident A is diagnosed with cognitive impairment and diabetes. On 11/22/2025, Resident A's blood sugar was observed to decrease significantly (into the 40s) and the staff at the AFC were encouraged to provide him with crackers and to monitor his blood sugar. Resident A's Dexcom was also not working at the time, so he was encouraged to check his blood sugar with the glucometer that was left for him. Shortly after, Resident A's blood sugar continued to decrease to the point where it could not be read (too low). When attempting to check his blood sugar with the glucometer, Resident A became confused, sweaty, speechless and unable to check his blood sugar. As a result, Resident A was admitted to the ER so that medical attention could be provided to address his concern. On 11/23/2025, Resident A's blood sugar was observed to decrease again and the staff at the AFC were encouraged to provide him with juice and to monitor his blood sugar. Further, when discovering what insulin was utilized - it was discovered that Resident A drew himself 30 units (5x the dosage = 150 units) of insulin with a pin needle independently even though he is not supposed to complete this task. Further, it is not recommended to use a syringe with a pin needle due to the risk of overdose.

On 11/25/25, I received the following statement from the facility's Nurse Practitioner, April Provenzino:

> "I am the nurse practitioner who rounds in this facility monthly and as needed for our assigned patients. This is a summary of the medication error issue that was addressed and witnessed by me:
> On Saturday, November 22, 2025, at 3:05pm I was notified that Resident A blood sugar was low, into the 40s. I questioned the worker about what was going on and why Resident A's blood sugar would be so low at this time since he gets the insulin in the morning. She brought the phone with her to Resident A's room and put me on speaker phone. Resident A told me that he had put a spoonful of sugar into a cup, and it was not working because he was still going low. I told the worker to get him a peanut butter sandwich. I talked with him about what was going on while she was gone and how he was feeling, and I asked what he had to eat that day. She returned with the peanut butter sandwich for him, and I told her to monitor his sugar every 15 minutes until it was going up and above 70. I received another call at 3:11pm that the blood sugar was not reading on his Dexcom monitor, that it still said low. She said that Resident A was sweating, not feeling good and wanted to go to the hospital. She put him on speaker and I told him to get the glucometer I had left with him and check his own blood sugar so we could see what it was, he was noticed to be very confused, not able to talk to me or follow my commands so I told the worker to call 911 to which she said she will now and we hung up. I called the facility at 4:27pm and EMS was still there. I asked the worker to send me a picture of the insulin that he received and asked her to confirm the amount that he was given in the medication record. Since EMS was still there, I was told she would do that as soon as she could. At 4:49pm, I received a text message with a picture of the insulin given and the picture was of the correct insulin, Humulin R. Thereafter she called me on the phone, and I told the worker that the insulin was correct, and the dose was correct and I was not sure why it went that low because he had been fine for a long time without any issues. I then was able to talk with the EMS worker and advised that the insulin he received was noted to be 30 units of the correct insulin, so I was not sure what was going on. EMS plan was to take him to the hospital.
>
> On Sunday (11/23/25) at 2:53pm, I received a call from Mariah at New Haven facility that Resident A's blood sugar was low again, into the 40s. I questioned what was going on and why now for two days in a row his blood sugar was this low, that it did not make sense to me. I was told by Mariah that she did not administer any insulin, that it was given in the morning by the worker she relieved. I told her what to do and what to give to him to correct the blood sugar and that his blood sugar needed to be monitored every 15 minutes and that if it went too low again, he would need to be sent out. I asked to talk with Resident A, so he was put on speaker phone, and I questioned him about the insulin and what is different all of a sudden for the last two days, I asked did he eat breakfast and lunch, etc. He then tells me that he did his own injection and removed 30 units of insulin from the pen with a syringe and gave it to himself. I told him that

he cannot remove insulin from the pen and he said, "oh yes you can, there is a spot at the tip that you can insert the needle." I then told Mariah that he should not receive any more insulin, to monitor his blood sugars every 15 as we had just discussed, make sure he was getting glucose sources and that I would be at the facility later to see Resident A and figure out what was going on. Around 3:00pm I received Resident A's hospital discharge instructions from William Gross. I then notified William by text that I was going to New Haven facility to sort out what was going on with him and look for pen needles because Resident A told me on the phone that there were none and that he's administering his own insulin which I don't think he's supposed to do, and he is getting the insulin out of the pen with a syringe, which I don't think you're supposed to do either. That pen is to be used to dial up to the number and then administer. He's been on the same dose for quite a while and we have never had issues like this, especially two days in a row." William replied to keep him posted.

I (Health Care Professional, April Provenzino) arrived at the facility around 6:00pm (11/23/25). Mariah showed me the locked-up insulin in the fridge. I took the insulin out and to where Resident A was sitting at the table. I removed the cap and there is a message on the pen clearly stating not to use a syringe to remove insulin that could result in overdose. I asked him why he was drawing up insulin from a pen with a syringe, and he said that there were no pen needles. I then asked him why he was drawing up his own insulin and had he done that before and he said, "yesterday." I then asked if this is what he did yesterday also. He said yes that he took 30 units out of the pen yesterday as well and gave it to himself. I explained to both Resident A and Mariah that the dosing in the pen is different than a vial and that he received too much but I did not know at that time the exact calculations. Mariah and I then left to look for pen needles because I was never informed prior to today that there were no pen needles and wanted to make sure they weren't in a location I knew them to be previously. We went to the office, and no pen needles were found. I told Mariah that Resident A was not to receive any insulin until the pen needles were delivered and that he was not supposed to be drawing up any insulin from any source. Since it was Sunday and I was unsure when the pen needles would be delivered. I went to the facility medication record and crossed out the PM dose of insulin for 11/23/25 and the AM dose of insulin for 11/24/25 and signed the medication log. Mariah asked what she should do if his blood sugar went low and I left her with instructions for that and that she could call me at any time and I would direct her with what to do and that she could call me at any time for questions. I left the facility around 7pm and Resident A was fine; his blood sugar was in the 90s and he was sitting up at the dining table. I then sent a text message to William after I left notifying him of what I found via text, "I just saw Resident A. They ran out of pen needles yesterday and whoever was there let Resident A stick the insulin syringe into the pen and take out 30 units and then give it to himself. This insulin is not supposed to be dispensed this way and there is a sticker right on the pen saying do not remove with the syringe this can result in overdose. Plus, we don’t know how much he drew even though he said it was 30 units. This all makes sense given

the last two days he has gone too low with his blood sugar, coinciding with this. Both of the doses were from the morning. I told the worker the insulin has to be held until the pen needles, get there so I'll have to get an order for them in the morning to the pharmacy. And whoever is the covering worker, she should not let Resident A give his own insulin to himself."

On Monday (11/24/25) I called the pharmacy to discuss the insulin dosing with the pharmacist and confirmed that removing 30 units from a pen with a syringe would result in a dose of 5x the amount if the same units were given. The formulation of insulin in a pen is 500 units in 1 ML and in a syringe and vial it is typically 100 units in 1 ML. The scheduled dose was 30 units which were noted as given. By using a syringe to remove 30 units from a pen he actually received 150 units of Humulin R on Saturday and Sunday.

I did notify his guardian of this issue as well on Monday afternoon. He is currently under the care of St. Clair Public Guardian. I called to notify them of error identified and the ER visit. Resident A's guardian told me that Resident A was given his 30-day notice earlier in the month to move out so that was in process."

On 11/26/25, I received the following statement from Jeff Yaroch of the New Haven fire department:

We observed another issue relating to resident care, specifically the need for intervention by a visiting nurse. On 11/21/2025, we were called to assist a resident who was having difficulty attaching his Dexcom glucose monitoring device. On duty staff did not appear to be knowledgeable in the use of this device and a visiting nurse was not present. The resident did not have any medical complaints at this time but requested that his Dexcom be replaced. The New Haven Fire Department is a medical first responder agency and this is not a procedure we are trained in. Richmond Lenox EMS arrived and they placed the device. The resident was not transported to the hospital.

The next day, November 22, 2025, the New Haven FD and Richmond Lenox EMS were called back for the same resident who was now calling for low blood sugar. The New Haven Fire Department staff who responded reported that the on-duty staff was of no assistance regarding the residents' medical information and there was no report of a visiting nurse on scene. The resident was treated then transported to the hospital. We are also concerned about the on-duty staff's inability to provide emergency medical responders with medical information regarding their residents.

On 11/28/25, I received the following statement from Mr. William Gross:

On 11/21/2025, Resident A called 911 on his own. On 11/22/2025, Resident A asked to be sent to the hospital, and we spoke with the Nurse Practitioner that works with us to take care of the residents. She agreed to send him out. Regarding the medical information for EMS and Fire Department, the staff has been trained however they are newer to the house and our procedures. We will retrain the staff.

All in all, we want to make sure that every resident gets immediate medical attention. We are learning from our previous conversations if the Nurse Practitioner cannot respond in a quick manner. We look to have emergency medical services to fill the gap as soon as possible. We do speak with the Nurse Practitioner on an on-going basis and only look to call 911 if we need to and it is an emergency. Unfortunately, since the residents are independent, they call on their own. We are in the process of switching medical providers to a larger company. We have used this company in other buildings and have been successful. This change should work better for all parties.

On 12/01/25, I received the following statement from Resident A's guardian:

> Resident A had given himself 5 times the amount of insulin he is supposed to take. The owner, William Gross, will not explain why the resident had possession of his insulin and why he was giving it to himself. This happened two days in a row, 11/22-11/23/2025, resulting in Resident A having to go to the hospital each day. Resident A's blood sugar dropped to 40 both days from him giving himself his own insulin and giving himself 5 times the amount. The time he has lived there since February of 2025, he has never given himself his own medication nor did he even have access to it. I received an eviction from the owner the same week for unsubstantiated reasons and then this happened. Resident A has been making his own complaints and calls, and the Nurse Practitioner and I feel this is the reason why he is being evicted by the owner. I asked William Gross as to what took place and what happened, and he only responded asking when he was moving out.

On 12/04/25, I conducted an unannounced onsite investigation at the facility. I interviewed staff Mariah Davis, Resident A and staff Bineta Diakite via phone.

When I arrived at the facility around 11am, staff did not let me in, as no one answered the door when I knocked. I let myself in and called out for staff, but no one responded. Residents told me that staff were upstairs in the staff bedroom with the door locked. I was told that I would have to go upstairs and knock on the door and wait for staff to come out. I was in the home for 10 to 15 minutes and staff never came down and was not aware that I was in the facility. I had to go upstairs and knock on the staff bedroom door and wait for her to respond. Staff Mariah Davis reported that she was in her room folding her personal laundry during her down time and if residents needed her, they would have to come knock on the door and she would assist them. The facility is a two-story building with resident rooms on both floors. There are residents on the first floor who have mobility issues and are not able to go upstairs to knock on the staff bedroom door.

According to Ms. Mariah Davis, on the date of the incident, she was not present, but staff Bineta Diakite was. Ms. Davis stated that on the day of the incident, Ms. Diakite allowed Resident A to draw and administer his own insulin. Ms. Davis stated that

Resident A is not supposed to draw his own insulin. Ms. Davis stated that she did not have any documentation from a medical professional allowing Resident A to administer his own medication. Ms. Davis stated that although she was trained in medication administration when she was hired, staff were not trained on how to administer Resident A's insulin until 11/24/25. Ms. Davis stated that although she wasn't trained until 11/24, she knew what to do because she had experience assisting her grandfather with his insulin use. Ms. Davis stated that staff always allow Resident A to administer his own medication but on the date of the incident, the facility was out of the appropriate pen needles required to draw Resident A's insulin and he used an incorrect syringe needle.

Ms. Davis stated that Resident A was given a discharge notice due to him needing a higher level of care but there was not a copy in his file. Ms. Davis stated that the notice was provided to Resident A's assigned nurse.

According to Resident A, on 11/22, he self-administered too much insulin medication. Resident A stated that he used a syringe needle because the facility was out of the appropriate pen needles. Resident A stated that staff Bineta is new and did not know how to administer his insulin, so he had to do it himself. Staff would provide him with the insulin; he would draw the insulin and administer it himself. According to Resident A, he gave himself too much insulin two days in a row due to Bineta not knowing how to administer the medication. Resident A stated that he does not have experience drawing his own medication and he has not been trained in how to do so. Resident A stated that he has dementia, and it impacts his memory. According to Resident A, staff are now trained in how to administer the medication, but he still injects himself after staff draws the appropriate amount.

According to Ms. Bineta Diakite, she began working at the facility on 11/7/25 and since that time, Resident A has always administered his own insulin medication. Ms. Diakite stated that she would give the medication to Resident A and he would draw the insulin medication and inject it himself. On 11/22, after Resident A took the medication, he didn't feel well and started sweating heavily. Ms. Diakite called the Nurse Practitioner April Provenzino for assistance. Ms. Provenzino spoke with Resident A and asked him to check his blood sugar levels. According to Ms. Diakite, Resident A was unable to check his levels, and she did not know how to check, so Ms. Provenzino told Ms. Diakite to call EMS. On the next day 11/23/25, Resident A's glucose monitoring system arrived at the facility, but Ms. Diakite or Resident A did not know how to use the system. Therefore, Resident A called EMS for assistance. Ms. Diakite stated that she was trained in how to administer Resident A's insulin medication on 11/24/25.

While onsite, I reviewed Resident A's Medication Administration Record (MAR). According to the MAR on 11/21 and 11/22, Resident A's insulin was initialed by staff Bineta Diakite. On 11/23, Resident A's AM insulin medication was initialed by Ms. Mariah Davis. However, Ms. Davis reports that she was not the one to administer the medication, Ms. Diakite was the one who administered the medication. I also observed

the staff schedule and according to the schedule, Ms. Diakite worked on 11/21 and 11/22. I also reviewed Resident A's hospital discharge documentation. According to the documentation, Resident A was seen at McClearn Macomb Emergency Department on 11/22/25 for Hypoglycemia-symptomatic. According to the documents, Resident A was diagnosed with Syncope and Hypoglycemia.

On 12/08/25, I received a copy of the discharge notice dated 11/17/25 from Resident A's guardian that was sent to her by Mr. Gross on 11/17/25. The notice stated, "This letter serves as formal written notice that you are in violation of your signed written agreement with Haven AFC LLC. Surrender possession of your room within thirty (30) days of the date of this notice." There were no reasons for discharge listed.

On 12/08/25, I received an email from Mr. Gross stating that the reason for Resident A's discharge notice was due to a change in his care needs and Resident A is 60 days late on rent.

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.

On 12/09/25, I received an email from Resident A's guardian. According to Resident A's guardian, she can provide an accounting of Resident A's account and it will show that he is not behind on rent. Resident A's guardian stated, "In fact, Mr. Gross had a verbal agreement with one of our other case managers when Resident A moved to his facility, that we would pay him monthly towards what he owed once we received his funds. Mr. Gross was also aware that we did not pay AFC homes security deposits and yet, he is still trying to charge a security deposit. Resident A's care needs have not changed and that information came from the Nurse Practitioner herself. The only time there was a change in Resident A's health was when he had possession of his vial of insulin on 11/22/2025 and 11/23/2025, administering his own medications and this was just 5 days after he was issued an eviction. We have not once been notified of any changes in Resident A's needs until I pushed back on the reasons of him being past due on his rent. Resident A does have a tendency of making phone calls to report things he feels aren't in order. In fact, Resident A is one of the people who reported the fires that happened over the summer."

On 12/09/25, I spoke with Mr. Gross. Mr. Gross stated that Resident A's care has changed due to him waking up during the night and requiring insulin. I informed Mr. Gross that Resident A has required insulin since he was admitted to the facility in February 2025. Mr. Gross stated that Resident A has dementia, and the home is a lower care home and can't handle residents with dementia. However, the home has a program type for mental illness. Mr. Gross could not provide details on what additional care needs Resident A requires that is beyond basic AFC care as providing insulin is a part of medication administration.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	According to Nurse Practitioner Ms. April Provenzino, Resident A, staff Mariah Davis and Bineta Diakite, Resident A draws and administers his own medication. As a result, on two consecutive days Resident A gave himself five times the correct amount of insulin, which caused him to seek medical attention and go to the emergency room.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(3) Giving, taking, or applying of prescription medications must be supervised by a licensee, administrator, or direct care staff unless otherwise directed by an appropriately licensed health care professional in writing.
ANALYSIS:	According to Nurse Practitioner Ms. April Provenzino, Resident A, staff Mariah Davis and Bineta Diakite, Resident A draws and administers his own medication. It is not documented in writing from a licensed health professional that Resident A can administer his own medications. As a result on two consecutive days, Resident A gave himself five times the correct amount of insulin, which caused him to seek medical attention and go to the emergency room.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	According to staff Mariah Davis and Bineta Diakite, although they were trained in medication administration when they were hired, staff were not trained on how to administer Resident A's insulin until 11/24/25. According to the Medication Administration Record, staff Mariah Davis administered Resident A's medication without proper training from 11/17/25 to 11/24/25. Staff Bineta Diakite administered Resident A's medication without proper training from 11/07/25 to 11/24/25.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.687	**Resident admission and discharge policy; house rules; change of residency; provision of resident records.**
	(4) A licensee shall provide a resident and resident's designated representative with a 30-day written notice before discharge from the facility. The notice must state the reasons for discharge and a copy of it be sent to the Resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	I received a copy of the discharge notice from Resident A's guardian. The notice dated 11/17/25, stated "This letter serves as formal written notice that you are in violation of your signed written agreement with Haven AFC LLC. Surrender possession of your room within thirty (30) days of the date of this notice." There were no reasons for discharge listed.
CONCLUSION:	**VIOLATION ESTABLISHED**

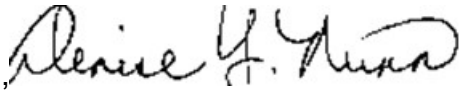
IV. RECOMMENDATION

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

12/09/25

Eric Johnson — Date
Licensing Consultant

Approved By:



12/09/2025

Denise Y. Nunn — Date
Area Manager