GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 30, 2026

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

RE: License #: AS500338676
Investigation #: 2026A0604009
Greenwood Lodge

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

License #:	AS500338676
Investigation #:	2026A0604009
Complaint Receipt Date:	01/12/2026
Investigation Initiation Date:	01/14/2026
Report Due Date:	03/13/2026
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:	Greenwood Lodge
Facility Address:	34845 Weber Road Richmond, MI 48062
Facility Telephone #:	(586) 784-8890
Original Issuance Date:	05/20/2013
License Status:	REGULAR
Effective Date:	04/04/2025
Expiration Date:	04/03/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff are not properly trained.	No
Owner took resident to bank for rent money and told bank resident was incompetent.	No
The owners speak to the residents in a demeaning manor.	No
The water for showers does not get hot.	Yes
Chemicals are kept in the kitchen and are not locked up.	No
The stove is broken.	Yes
The home is not following menus. The home does not have the ingredients to make what is on the menus.	No
Medications are kept in a cupboard that can be easily opened.	No
Resident has clothes with holes in them and owner refuses to provide new clothing.	No
Owners told staff not to contact EMS for resident with high blood pressure. Staff were told to wait for doctor coming the next day.	No

III. METHODOLOGY

01/12/2026	Special Investigation Intake 2026A0604009
01/13/2026	APS Referral Referral received from Adult Protective Services (APS). APS denied referral and sent to licensing.
01/14/2026	Special Investigation Initiated - On Site Completed unannounced onsite investigation. Interviewed Staff, Shantique Oliver, Resident A, Resident B, Resident C and attempted to interview Resident D.
01/14/2026	Contact- Document Sent Email to William Gross. Requested he address water temperature and requested resident and staff information.
01/15/2026	Contact- Document Received Email from William Gross. Maintenance is addressing water temperature and bathrooms. Received copy of resident register and staff list.

01/19/2026	Contact - Document Received Received videos by email from William Gross of bathrooms and water temperature corrections.
01/20/2026	Contact - Document Sent Email to and from William Gross
03/24/2026	Contact- Document Sent Email to William Gross. Requested additional staff and resident records.
03/27/2026	Contact- Document Email from William Gross with licensing documents including employee records, menus, funds forms, Resident E appointment record and health care appraisal. Sent return email.
03/29/2026	Contact- Document Received Email from William Gross with resident records including updated resident register, assessment plans, resident information records and resident care agreements.
03/30/2026	Contact- Document Sent Email to William Gross
03/30/2026	Exit Conference Completed exit conference with Licensee Designee, William Gross

ALLEGATION: Staff are not properly trained.

INVESTIGATION:

I received a licensing complaint regarding Greenwood Lodge on 01/12/2026. The Complainant alleged that there are six residents residing at the Greenwood Lodge AFC home. The residents have different diagnoses including mental health concerns, cognitive impairments, and physical limitations. The residents are unable to reside independently, but they require minimal care. Some of the residents have legal guardians. The home is owned by three owners: William Gross, Mia Amador, and Ana Amador. A resident has been asking for new pants and shirts for a while due to his clothing having holes in them. The owners refuse to provide the resident with clothing because they have reported the resident does not have any client spending available. The resident is without proper clothing. Two days ago, a resident's blood pressure was over 200/110, and the resident was displaying some symptoms of a stroke. The owners advised the home staff not to contact emergency services. The owners reported the concerns could wait until the doctor came into the home the following day. The owners

make menus for the food options. However, they do not provide the home with the correct food for the options on the menu to be made. One resident was behind on their rent because they did not have a card. The resident was taken to the bank by the owner. While there, the owner tried to oversee everything. The owner also told the bank teller that the resident was incompetent, which he is not. The resident does not have a legal guardian. The owner was only concerned about getting their money for the rent. The stove in the home is broken. The water for showers does not get hot. The cupboards that medication is stored in does not lock properly and can easily be opened. Chemicals are kept in the kitchen and not locked up. Staff members are not properly trained and start work without being trained on what to do. The owners speak to the residents and about them in demeaning manners. The owners had a previous location shut down by the state due to the treatment of residents. Some of the residents were moved to Greenwood Lodge. The poor treatment of residents continues by the owners.

I completed an unannounced onsite investigation on 01/14/2026. I interviewed Staff, Shantique Oliver, Resident A, Resident B and Resident C. I attempted to interview Resident D, however, he indicated that he did not want to be interviewed. Residents at Greenwood Lodge moved to the home on 12/16/2025 after the Haven Adult Foster Care Home was closed. On 03/27/2026, Licensee Designee, William Gross reported that all residents were moved from Greenwood Lodge. On 03/29/2026, a copy of the updated resident register was received. All residents were moved from Greenwood Lodge on 02/25/2026. Mr. Gross stated that all residents were discharged due to changes in placement needs and/or transitions to other appropriate settings. He stated that each resident was discharged in accordance with licensing requirements, with proper coordination and documentation. The home is currently empty.

On 01/14/2026, I interviewed Staff, Shantique Oliver. She stated that the home has six residents. There are four residents home and two residents are at day program. She stated that she has only worked at Greenwood Lodge for two to three weeks. She has received training and was fingerprinted. She stated that the other staff recently quit. They are interviewing a new staff, Olivia, tomorrow.

On 03/27/2026, I received requested employee records for Staff, Shantique Oliver and Oliver Thompson from Licensee Designee, William Gross by email. Mr. Gross provided copies of driver’s license, application, receipt of personal polices and job description, initial medicals, communicable disease/TB screening, training records and CPR/First certification for both staff. Trainings completed included The Basics of Your Job, The Rights of the People We Serve, Incident Reports, Fire Safety, Environmental Emergencies, Fire Prevention, Infection Control, Prevention and Containment of Communicable Diseases, Personal Care, Supervision and Protection, and Hygiene, Basic Food and Nutrition Information, Special Diets, Food Safety and Storage, Introduction to Medications, Medication Administration and Documentation and Resident Behavior Interventions. Both staff have also received workforce background checks, which was confirmed in the workforce background check system.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(5) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be trained and competent in all of the following areas before performing assigned tasks independently: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases including recognizing signs of illness.** **(h) Food safety, which includes food storage, preparation, distribution, and serving in a safe manner.** **(i) Nutrition and special diets.**
ANALYSIS:	There is no information to determine that staff are not properly trained. Licensee Designee, William Gross, was able to provide employee records for staff that included training records. The trainings completed included CPR/First Aid, Basics of Your Job, The Rights of the People We Serve, Incident Reports, Fire Safety, Environmental Emergencies, Fire Prevention, Infection Control, Prevention and Containment of Communicable Diseases, Personal Care, Supervision and Protection, and Hygiene, Basic Food and Nutrition Information, Special Diets, Food Safety and Storage, Introduction to Medications, Medication Administration and Documentation and Resident Behavior Interventions.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Owner took resident to bank for rent money and told bank resident was incompetent.**
- **The owners speak to the residents in a demeaning manor.**

INVESTIGATION:

On 01/14/2026, I interviewed Staff, Shantique Oliver. She indicated that she never works with another staff, however, she has never seen residents mistreated. Staff are nice to residents.

On 01/14/2026, I interviewed Resident A. He stated that he moved to Greenwood Lodge from Haven Adult Foster Care. He stated that it is going “pretty good”. Staff treat him well and are really kind. He stated that all of them are nice and are awfully friendly. He stated that he is his own guardian. His aunt and brother help out. His aunt takes care of his money.

On 01/14/2026, I interviewed Resident B. He stated that he is doing “ok”. He has lived at Greenwood Lodge for a few weeks and it is better than living at Haven Adult Foster Care. He stated that staff treat him well. He has no concerns. He stated that his daughter handles his finances. He has never been taken to the bank by owner.

On 01/14/2026, I interviewed Resident C. He stated that he is doing “ok”. He moved to Greenwood Lodge from Haven Adult Foster Care. He stated that the staff are awesome. He has had no issues with staff. He stated that he does not have a guardian. He stated that the owner took him to the bank recently. He did not give him any money at bank. The owner told the teller that he did not know what was going on. Resident C stated that he got out $200.00 of his own money to hold himself. He stated that he has not given any money to the owner. On 03/27/20206, I received funds forms for Resident C. Form indicates that Resident C made two payments for rent on 12/15/2025 and 01/15/2025.

APPLICABLE RULE	
R 400.637	**Handling of resident funds and valuables.**
	(11) A licensee, staff, volunteers, members of the household, and their family members cannot accept, take, or borrow money, resident funds, or valuables from a resident, even with the consent of the resident.
ANALYSIS:	On 01/14/2026, I interviewed Resident C who stated that he was taken to the bank by owner. Resident C stated that he did not give any money to the owner. Resident C stated that during the visit to the bank he got out $200.00 of his own money to hold himself. He is his own guardian. Resident C is no longer residing at Greenwood Lodge.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(a) Use any form of punishment.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks.** **(iv) Threats.**
ANALYSIS:	There is no information to determine that staff or owners are speaking to residents in a demeaning manor. On 01/14/2026, I interviewed Resident A, Resident B and Resident C. All three residents reported being treated well by Greenwood Lodge staff. Residents are no longer residing at Greenwood Lodge.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **The water for showers does not get hot.**
- **Chemicals are kept in the kitchen and are not locked up.**
- **The stove is broken.**

INVESTIGATION:

On 01/14/2026, I interviewed Staff, Shantique Oliver. She stated that the stove works. There is one broken burner. She indicated that the home does have hot water for the residents to take showers. Ms. Oliver indicated that all the residents took showers today so that may have affected water temperature. She also stated that water can take a while to heat up. She stated that cleaning products are stored under the sink in kitchen. Residents are not allowed alone in kitchen and the kitchen door locks. I observed standard cleaning products and soap under the kitchen sink.

On 01/14/2026, I interviewed Resident A. He stated that the water is hot enough for showers.

On 01/14/2026, I interviewed Resident B. He stated that they have hot water for showers. He stated that there was an issue with pipe leaking and water was too hot, however, the issue was fixed quickly.

On 01/14/2026, I interviewed Resident C. He stated that there was an issue with the water not getting hot. The tank would be out when toilet was flushed.

On 01/14/2026, I observed stove in kitchen. Front right burner on stove is broken. Coils of burner are broken and not flush with top of stove.

On 01/14/2026, I measured the water temperature with a digital thermometer. I found the water temperature in Bathroom #1 to be 144.5 degrees Fahrenheit, Bathroom #2 55.8 degrees Fahrenheit and Bathroom #3 56.3 degrees Fahrenheit.

On 01/14/2026, I sent email to William Gross**.** I informed Mr. Gross of findings regarding bathrooms and water temperatures. I requested Mr. Gross to address water temperature as none of the bathrooms were within range of 105-120 degrees Fahrenheit as required. On 01/19/2026, I received videos by email from William Gross of bathrooms and water temperature corrections.

On 03/29/2026, I reviewed copies of resident assessment plan, resident care agreements and resident information records. None of the resident assessment plans reviewed indicated that residents cannot have access to cleaning products/soap or that cleaning products are required to be kept in locked location.

APPLICABLE RULE	
R 400.645	**Environmental health.**
	(3) A licensee shall provide hot and cold running water under pressure. A licensee shall maintain the hot water temperature for a resident's use at a range of 105 degrees Fahrenheit to 120 degrees Fahrenheit at the fixture.
ANALYSIS:	On 01/14/2026, I measured the water temperature with a digital thermometer in bathrooms. The water temperature was found to be between 55.8 and 144.5 degrees Fahrenheit. Water temperature should be maintained between 105 to 120 degrees Fahrenheit.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.645	**Environmental health.**
	(7) Poisons, caustics, and other dangerous materials must be stored and safeguarded in nonresident, non-food preparation areas, and storage areas.

ANALYSIS:	On 01/14/2026, I completed an unannounced onsite investigation. I observed standard cleaning products and soap stored in cupboard underneath the kitchen sink. Staff, Shantique Oliver, stated that cleaning products are stored under the sink in kitchen. Residents are not allowed alone in kitchen and the kitchen door locks. None of the resident assessment plans reviewed indicated that residents cannot have access to cleaning products/soap or that cleaning products are required to be kept in locked location.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.665	**Food Service**
	(8) Kitchen appliances must be properly installed and maintained according to the manufacturer's instructions.
ANALYSIS:	On 01/14/2026, I observed that the front right burner on oven is broken.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The home is not following menus. The home does not have the ingredients to make what is on the menus.

INVESTIGATION:

On 01/14/2026, I interviewed Staff, Shantique Oliver. She stated that they have a menu to follow and write in what is actually served. The residents were observed eating fish sticks and a fruit parfait for lunch during the onsite investigation. Ms. Oliver believed the home has an adequate amount of food. She stated that they had chicken alfredo for dinner last night and will have meatloaf tonight. She switched the days the meatloaf and chicken alfredo on menu were served and will document on menu. I observed that the home had ingredients available for dinner. Ms. Oliver had pictures of dinner on phone and stated that owner will ask for pictures of meals.

On 01/14/2026, I interviewed Resident A. He stated that he gets enough food to eat. He stated that the home follows a menu.

On 01/14/2026, I interviewed Resident B. He stated that he is getting enough food to eat. Resident B indicated that the home seems to be following a menu.

On 01/14/2026, I interviewed Resident C. He stated that the food is good. Resident C stated he has no idea if the home is following a menu. He does not pay attention to that.

On 01/14/2026, I observed January 2026 menu in kitchen. Menu did have substitutions noted. Meatloaf was listed for dinner on 01/13/2026 and chicken alfredo for dinner on 01/14/2026 as Ms. Oliver reported. Lunch for 01/14/2026 was listed as fish sticks, bread/butter, salad, water/milk. Substitution was not yet noted that fruit parfait was served, however, residents were being served lunch during investigation.

On 03/27/2026, I received record of Greenwood Lodge menus for December 2025, January 2026 and February. Substitutions are noted on menus for each month.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(6) Menus, excluding special diets, must be written at least 1 week in advance and posted. Any change or substitution must be documented.
ANALYSIS:	There is not enough information to determine that menus are not being followed. On 01/14/2026, I completed an unannounced onsite investigation. The home had a January 2026 menu available. Substitutions were noted on menu. Residents were observed eating fish sticks for lunch which was listed on the menu. I also received record of menus for December 2025, January 2026 and February 206 which noted substitutions.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Medications are kept in a cupboard that can be easily opened.

INVESTIGATION:

On 01/14/2026, I interviewed Staff, Shantique Oliver. She stated that they received a medication cart yesterday and all medications have been moved to cart. During the onsite investigation, I observed a locked medication cart in dining area. Behind the medication cart are locked cupboards where the mediations were previously stored. The cupboards required a key to be opened; however, medications are no longer stored in this location.

On 01/14/2026, I interviewed Resident A. He stated that he gets all his medications. He takes medications in the AM and PM. He stated that staff also take his vitals.

On 01/14/2026, I interviewed Resident B. He stated that he is getting all his medications.

On 01/14/2026, I interviewed Resident C. He stated that he has no medications. They only take his blood pressure.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	On 01/14/2026, I observed that medications are being stored in a locked medication cart in the dining area. Medications were previously stored in cupboards that were also able to be locked.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident has clothes with holes in them and owner refuses to provide new clothing.

INVESTIGATION:

On 01/14/2026, I interviewed Staff, Shantique Oliver. She stated that families provide clothing for residents. She stated that there are no residents in need of new clothing.

On 01/14/2026, I interviewed Resident A. He stated that he has enough clothing to wear.

On 01/14/2026, I interviewed Resident B. He stated that he has enough clothing to wear.

On 01/14/2026, I interviewed Resident C. He did not report any concerns regarding clothing.

On 01/14/2026, I observed Resident A, Resident B, Resident C and Resident D during the onsite investigation. I did not observe any of the residents wearing clothes with holes in them. Residents also had clothing available in their bedrooms.

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(3) A licensee shall assist the resident in obtaining clothing that fits, is clean, and is seasonally appropriate.
ANALYSIS:	There is not enough information to determine that residents do not have adequate clothing available. On 01/14/2026, I completed an unannounced onsite investigation and did not observe any residents wearing clothes with holes in them. Residents interviewed did not report any concerns regarding clothing. Residents are no longer residing at Greenwood Lodge.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Owners told staff not to contact EMS for resident with high blood pressure. Staff were told to wait for doctor coming the next day.

INVESTIGATION:

On 01/14/2026, I interviewed Staff, Shantique Oliver. She stated that about a week and a half ago Resident E had high blood pressure. Ms. Oliver stated that Resident E gets worked up. He had a new doctor coming to see him the next day. She indicated that the staff who quit was working when his blood pressure was high. Ms. Oliver stated that she was not aware of anyone thinking that Resident E should be sent to the hospital.

On 03/27/2026, I received email from Licensee Designee, William Gross. He stated that the caregiver at the time took Resident E's blood pressure and it measured high. He believes that the blood pressure machine was not working correctly. Resident E had a doctor's appointment on 12/20/2025 and his blood pressure was fine with no issues. Mr. Gross provided copy of appointment record from Great Lakes Medical Group, PC dated 12/20/2025. Resident E's blood pressure was found to be 122/82. Record indicates that Resident E has hypertension and to continue Lisinopril and to monitor blood pressure. A copy of current health care appraisal dated 12/20/2025 was also provided. There were no incident reports completed for Resident E when requested.

I completed an exit conference on 03/30/2026. I sent email to Licensee Designee, William Gross. I informed him of the violations found at this time and that a corrective action plan would be requested. I also informed him that a copy of the special investigation report would be mailed once approved. I requested Mr. Gross to contact me if he had any questions or has questions once reviewing report.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	There is not enough information at this time to determine that Resident E was not sent to hospital for high blood pressure when needed. Staff, Shantique Oliver, reported that Resident E was found to have high blood pressure and had an appointment with medical provider the next day. She was not aware of anyone believing that Resident E should have been sent to hospital. Licensee Designee, William Gross, also believed that the blood pressure machine was not working properly. Mr. Gross provided copy of appointment record from Great Lakes Medical Group, PC dated 12/20/2025. Resident E's blood pressure was found to be 122/82. Record indicates that Resident E has hypertension and to continue Lisinopril and to monitor blood pressure. Resident E is no longer residing at Greenwood Lodge.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

Kristine Cilluffo 03/30/2026

Kristine Cilluffo Date
Licensing Consultant

Approved By:

Jay Calewarts For 03/31/2026

Denise Y. Nunn Date
Area Manager