



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 17, 2026

Claudiu Marit
5670 Greer Road
West Bloomfield, MI 48324

RE: License #: AS630418219
Investigation #: 2026A0602015
Ahava of Bloomfield Hills

Dear Mr. Marit:

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,

A handwritten signature in cursive script that reads "Cindy Berry". The signature is fluid and elegant, with the first and last names clearly distinguishable.

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3044 West Grand Blvd
2nd Floor Annex, Suite 2-730
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630418219
Investigation #:	2026A0602015
Complaint Receipt Date:	06/04/2026
Investigation Initiation Date:	06/08/2026
Report Due Date:	08/03/2026
Licensee Name:	Claudiu Marit
Licensee Address:	1825 Hiller Road West Bloomfield, MI 48324
Licensee Telephone #:	(248) 760-6543
Administrator:	Claudiu Marit
Licensee Designee:	Claudiu Marit
Name of Facility:	Ahava of Bloomfield Hills
Facility Address:	1694 W. Long Lake Rd Bloomfield Hills, MI 48302
Facility Telephone #:	(248) 760-6543
Original Issuance Date:	05/16/2024
License Status:	REGULAR
Effective Date:	11/16/2024
Expiration Date:	11/15/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff did not change Resident A's wound care bandage every 24 hours as recommended. The bandage was not changed for two weeks; last changed on 05/22/2026 causing a buildup of dead skin.	Yes
Sometime around May 30 and May 31, 2026, staff manhandled Resident A while changing her clothing. Resident A received a large bruise covering the entirety of her upper left arm.	No

III. METHODOLOGY

06/04/2026	Special Investigation Intake 2026A0602015
06/08/2026	APS Referral Adult protective services referral received.
06/08/2026	Special Investigation Initiated - Telephone Call made to APS.
06/12/2026	Contact - Document Received Received email from assigned APS worker, Tamiesha Williams.
06/15/2026	Inspection Completed On-site Interviewed the LD, Claudiu Marit, director of nursing, Noel Hancock, and staff member Tamechi Shaw.
07/08/2026	Contact – Telephone call made Call made to Resident A's daughter - no answer.
07/08/2026	Contact – Telephone call received Spoke with APS worker Estelita Horton.
07/08/2026	Contact – Telephone call made Message left for staff member Jaslin Allen.
07/08/2026	Contact – Telephone call made Message left for staff member Michelle Jackson.
07/30/2026	Contact – Telephone call made Spoke with Ms. Horton.

07/30/2026	Contact – Telephone call made Spoke with Ms. Allen.
07/30/2026	Contact – Telephone call made Spoke with Ms. Jackson.
08/03/2026	Contact – Document received Received an email from Ms. Horton.
08/28/2026	Contact – Telephone call made Call made to Resident A's daughter – no answer.
08/31/2026	Exit Conference Held with the licensee designee, Claudiu Marit.
09/01/2026	Contact – Telephone call received Spoke with Resident A's daughter.

ALLEGATION:

- **Staff did not change Resident A's wound care bandage every 24 hours as recommended. The bandage was not changed for two weeks; last changed on 05/22/2026 causing a buildup of dead skin.**
- **Sometime around May 30 and May 31, 2026, staff manhandled Resident A while changing her clothing. Resident A received a large bruise covering the entirety of her upper left arm.**

INVESTIGATION:

On 6/04/2026, a complaint was received and assigned for investigation alleging that staff did not change Resident A's wound care bandage every 24 hours as recommended. The bandage was not changed for two weeks; last changed on 05/22/2026 causing a buildup of dead skin. It is further alleged that sometime around May 30 and May 31, 2026, staff manhandled Resident A while changing her clothing. Resident A received a large bruise covering the entirety of her upper left arm.

On 6/15/2026, I conducted an unannounced on-site investigation. Upon my arrival at the home, Ms. Shaw refused to allow me into the home. She said she had to contact Mr. Marit and closed the door in front of me. While waiting outside at the front door, a visitor arrived, looked at my badge and asked why I was standing outside. He opened the door, entered the home and asked Ms. Shaw why she did not allow me in the home. Ms. Shaw stated, "I don't know if he wants her in the home." The visitor invited me inside the home. I called Mr. Marit, he apologized and arrived at the home within a few minutes. I interviewed Mr. Marit and staff member Tamechia Shaw. Mr. Marit stated Resident A no longer resides in the home as her daughter removed her from the home.

on 6/03/2026. He said he created an electronic system for he and his employees to use to document information regarding the residents and to communicate with one another. He said there appears to have been a breakdown in communication between staff and the nurse, Noel Hancock. He went on to state that Ms. Hancock would be able to provide detailed information regarding the incident and called her during the on-site investigation. Ms. Hancock stated on 5/20/2026 Resident A had a biopsy on her right arm. When her daughter brought her back to the facility after the procedure, she informed her that the bandage needed to be changed every 24 hours. Ms. Hancock said she never received anything from the treating physician providing discharge instructions, but she documented the instructions the daughter provided in the staff binder. Ms. Hancock went on to state that she was not made aware that Resident A's bandage was not being changed daily until her daughter informed her during a visit (exact date unknown). On 6/02/2026, Resident A was picked up by her daughter for a doctor's appointment. The daughter texted Ms. Hancock (with picture attached) and reported a large bruise on Resident A's left arm. Ms. Hancock spoke with the staff members Tamechia Shaw, Michelle Jackson and Jaslin Allen as they were the staff who assisted Resident A prior to her appointment. Ms. Shaw, Ms. Jackson and Ms. Allen reported to Ms. Hancock they did not observe any bruises on Resident A.

Ms. Shaw stated on 5/20/2026 Resident A's daughter took her to have a biopsy done on her arm and when she returned, she had a small bandage on her arm. Ms. Shaw said she was unaware that Resident A's bandage needed to be changed daily. She said staff use an electronic system to communicate with one another and to document any new changes or issues with the residents daily. There was nothing documented in the system regarding changing Resident A's bandage nor did the nurse communicate this to staff. Ms. Shaw went on to state that on 6/02/2026 she got Resident A dressed for an appointment with her daughter. She did not notice any bruises on Resident A's arm. Resident A returned from her appointment while the music therapist was conducting an activity with the other residents. Resident A appeared to be in a good mood and was singing along during the activity. Later that same day, Resident A's daughter removed her from the home and called to report that Resident A had a bruise on her arm. Ms. Shaw said she did not see the bruise until the daughter sent a picture to the nurse.

On 6/16/2026 Mr. Marit submitted copies of Resident A's wound care instructions, progress notes, documentation forms, staff schedules for the months of May and June 2026, pictures of Resident A's wound and bruised arm, health care appraisal, assessment plan, and a psychiatric evaluation dated 5/23/2026. The undated wound care instructions document that Resident A received a pressure dressing (several pieces of white gauze secured with tape). The bandage was to be removed and the wound cleaned after 24-48 hours. The wound was to be cleaned daily for 7 days after surgery.

On 5/20/2026 a progress note was written by Andrea Douglas, FNP-BC documenting that Resident A was seen by Dr Svetlana Mishulin for squamous cell carcinoma of the right forearm s/p Mohs surgery. She received 6 intact sutures to the right forearm, with no swelling, draining, warmth, or pain with the initial dressing to remain intact for at least

24-48 hours. Caregivers to monitor daily for infection and a follow up appointment with the dermatologist in 2 weeks.

On 5/22/2026, a documentation form written by Ms. Hancock documented that directions for care were shared with her via text by Resident A's daughter. This information was verbally shared with in-house caregiver, and the documentation of needed wound care was placed in the binder with all supplies placed in the medication cart. Attached to this progress note were the instructions for wound care.

On 5/31/2026, a documentation form written by Ms. Allen documented that Resident A was a little confused in the morning and had the same clothes on from the day before and her pants were wet. Ms. Allen redirected her to change her clothes, gave her a shirt and helped her change her pants and put her shoes on. Resident A got upset while Ms. Allen was assisting. Resident A and Ms. Allen sat on the bed while Ms. Jackson sat in the chair and they explained that they were only trying to help her and not hurt her. They wanted her to have clean clothes for her visit with her daughter. Resident A was fine the remainder of the day.

On 6/02/2026, a documentation form written by Ms. Hancock documented that Resident A's daughter sent her a picture via text of a left upper arm with a bruise. The text stated the bruise happened over the weekend, but she was unsure if it was the night shift. It was noted that staff member Jazlin Allen reported that she had problems getting Resident A dressed in the morning because Resident A wanted to wear the same clothes and Ms. Allen wanted her in new clothes. Ms. Allen stated Resident A was wet after using the bathroom and was resistant to a clothing change, but with the help of the night shift staff, they were able to get her into dry clothing without incident. Ms. Jackson stated she recalled assisting Ms. Allen with dressing Resident A into clean, dry clothes and that it took some time and redirection, but they were able to get her into dry clothes without any problems. In addition, Ms. Shaw reported that she helped Resident A get dressed on the morning of 6/02/2026 and she did not see any bruises on her arms. Attached to the documentation form was a picture of a bruised left arm.

On 6/02/2026 at 6:00 pm, two documentation forms were written by care manager, Amanda Beeler. The first form documented that Resident A resided in the home from 5/05/2026 to 6/02/2026. Resident A's daughter informed Ms. Shaw that her mother only gets one shower per week since she is resistant and often refuses them. Staff wash Resident A up thoroughly each morning in the bathroom while she sits on the toilet and assists her with dressing as needed. Staff could not redirect Resident A on several occasions regarding showering as she was aggressive and combative. The second form documented that on 6/02/2026 at 10:30 am Resident A's daughter picked her mother up for a doctor's appointment. At 11:24 am the daughter called Ms. Hancock and reported bruising on Resident A's left arm. Ms. Beeler contacted Ms. Shaw as she had worked that day between the hours of 7 am and 7 pm. Ms. Shaw reported that she stood by for assistance as Resident A changed and did not provide any assistance. There were no bruises observed on either of Resident A's arms. Ms. Beeler then called Ms. Jackson who worked the night prior (5/30/2026) and was there the morning of

(5/31/2026). Ms. Jackson reported that she did not observe any bruises on Resident A. Ms. Beeler called Ms. Allen who worked the day shift on 5/29/2026, 5/30/2026 and 5/31/2026. She reported that she did not observe any bruises during her shifts. She said on 5/31/2026 Resident A was very resistant to changing her clothes, but she and Ms. Jackson redirected her several times and were able to get her to cooperate and get dressed.

On 6/03/2026, a documentation form written by Ms. Hancock documented that on 5/22/2026 the wound on Resident A's right arm from the Mohs procedure was cleaned and dressed per instructions with wound care supplies left in the medication cart in Resident A's medication drawer. Caregiver was told that the dressing needed to be changed daily and that the instructions were in the binder. According to the progress note, on 6/03/2026 it was verified that the caregivers were aware of the wound care supplies in the medication cart drawer. Attached to this documentation form was a picture of the wound on Resident A's right forearm and a note indicating that the original bandage was removed without difficulty and the wound was redressed according to post surgical directions. The wound appeared to be clean and still had several stitches in place.

On 6/15/2026, Ms. Shaw documented that she did not observe any bruises on Resident A as she assisted her with getting dressed. She had breakfast, left and returned happy and jolly.

According to the staff schedules reviewed, staff member Ms. Shaw worked on 5/30/2026, 5/31/2026, 6/01/2026, 6/02/2026, and 6/03/2026 between the hours of 7 am and 7 pm and Ms. Jackson worked on 5/30/2026, 5/31/2026, 6/01/2026, 6/02/2026, and 6/03/2026 between the hours of 7 pm and 7 am.

According to the psychiatric evaluation completed on Resident A and dated 5/23/2026, Resident A ambulates with the assistance of a walker, has a diagnosis of age related cognitive decline, adjustment disorder with anxiety, right eye coloboma and presented with scattered thoughts. Resident A admitted to noticing her cognitive decline and reported that speech is becoming more difficult for her.

On 6/15/2026, I reviewed a picture of Resident A's left arm. There was a dark purple bruise on the inside of her left forearm just below her elbow that covered half of her forearm. The top and around the edge of the bruise was a light red color and the skin was slightly peeling in some areas.

On 7/30/2026, I spoke with Ms. Horton by telephone. Ms. Horton stated a police report was filed and she spoke with Detective VanKerckhove. The detective informed her that he interviewed all parties and does not have enough evidence to prove physical abuse; however, not changing Resident A's bandage speaks for itself. Ms. Horton said she will be substantiating for neglect and abuse and that her case will soon be closed.

On 7/30/2026, telephone interviews were conducted with staff members Jaslin Allen and Michelle Jackson. Ms. Allen stated she did assist Resident A with getting dressed, but she did not have any bruises on her arm the weekend of 5/30/2026. She said Resident A is very active and can still get herself dressed so she allowed her to put her shirt on, and she assisted her with putting her bottoms on. Ms. Allen was asked if Resident A had fallen anytime during that weekend and she said no. She went on to state that she works 12 hours shifts and Resident A did not fall during her shift. She said just as she explained to the detective, no one abused or harmed Resident A while she was there. Ms. Allen stated the nurse was responsible for changing the gauze on Resident A's arm, not her.

Ms. Jackson stated she did not observe any bruises on Resident A the weekend of 5/30/2026 and 5/31/2026. She said she is usually the person to wash Resident A up, but she was giving her a hard time. During the next shift, Ms. Allen assisted Resident A with getting dressed and she gave her a hard time as well. She observed Ms. Allen talking to Resident A explaining that she was trying to help her get dressed but Resident A did not want to be touched at all that day by anyone. She did not observe Ms. Allen being rough with Resident A nor did she see her fall during her shift. Ms. Jackson stated as far as Resident A's bandage being changed, she was not responsible for it and knew nothing about it.

On 8/03/2026, I received a picture (from Ms. Horton) of Resident A's wound as well as the bandage that had been removed. The wound was closed and appeared to be very dry with dead skin flaky from it. The bandage was dated 5/22 with the initials NH. The bandage was soiled with what appeared to be thick, dark colored dead skin.

On 8/31/2026, I conducted an exit conference with the licensee designee Claudiu Marit by telephone. I informed Mr. Marit of the investigative findings and recommendation documented in this report. I told Mr. Marit that staff clearly failed to change Resident A's bandage and clean her wound daily as stated in the wound care instructions. I also explained to Mr. Marit that it is more likely than not that Resident A sustained a bruise on her left forearm while in the home. Although staff reported having no knowledge of the bruise, on 6/02/2026 Resident A's daughter picked her up around 10:30 am and sent a picture of Resident A's bruised left forearm to Ms. Hancock around 11:24 am on this same date. The size and color of the bruise suggest that it could not have occurred on 6/02/2026 between 10:30 am and 11:24 am while out with her daughter. Mr. Marit sent three short videos of Resident A on 6/02/2026 before she left with her daughter (around 8:30 am), as she was leaving the home with her daughter (around 10:30 am), and after she returned (around 5:49 pm). Resident A was wearing long sleeves that were partially rolled up but due to the angle of the videos, I was unable to clearly see her left arm. Mr. Marit stated he understood and would submit a corrective action plan upon receipt of this report.

On 9/1/2026 I received a return call from Resident A's daughter. Resident A's daughter stated she visited her mother on 5/31/2026 on the patio at the home. Ms. Allen was working at the time of the visit and stated Resident A gave her a hard time that morning

because she did not want to change her clothes. On 6/02/2026 she picked her mother up for an appointment to have her stitches removed. While at the doctor's office, the bandage was removed and it was observed that it had not been changed since 5/22/2026. Resident A was scheduled to have another biopsy on her left arm and when the doctor raised her sleeve, this is when the large bruise was observed. Resident A's daughter stated she immediately took a picture and sent it to Ms. Hancock. Resident A's daughter went on to state that she does not know how her mother obtained the bruise as all the staff report not knowing what happened and the other residents residing in the home all suffer from some form of cognitive impairment. Resident A was removed from the home on 6/02/2026.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment plan and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on the information obtained during the investigation, there is sufficient information to determine that Resident A's bandage was not changed daily as instructed and that she sustained a bruise to her left forearm. Ms. Hancock stated she informed staff that Resident A's bandage needed to be changed daily and put a copy of the wound care instructions in her binder. She said she was made aware of the bruise to Resident A's left arm when her daughter sent her a picture on 6/02/2026. Ms. Shaw stated on 5/19/2026 Resident A had a biopsy done on her arm and there was a small bandage in place. She denied knowing that the bandage needed to be changed daily. Therefore, she did not change it. Ms. Shaw also stated she had no knowledge of a bruise on Resident A's arm until 6/02/2026 when her daughter informed Ms. Hancock. Ms. Allen and Ms. Jackson both stated they did not change Resident A's bandage as it was not their responsibility to do so, and they did not observe any bruises on her arm. According to the staff documentation notes reviewed, Resident A's bandage was only changed and cleaned one time and that was by Ms. Hancock on 5/22/2026.

	Although staff reported having no knowledge of a bruise on Resident A's arm until 6/02/2026, the bruise was dark purple on the inside of her left forearm just below her elbow that covered half of her forearm. The top and around the edge of the bruise was a light red color and the skin was slightly peeling in some areas. Due to the size and color of the bruise, it is more likely than not that Resident A sustained the bruise prior to leaving with her daughter on 6/02/2026.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on the information obtained during the investigation, there is insufficient information to determine that the bruise on Resident A's arm was a result of staff not providing safety and protection to her while residing in the home. Ms. Hancock stated she was made aware of the bruise on Resident A's left arm on 6/02/2026 when her daughter sent her a picture. Ms. Shaw stated she had no knowledge of a bruise on Resident A's arm until 6/02/2026 when her daughter sent a picture of the bruise to Ms. Hancock. Ms. Allen and Ms. Jackson both stated they worked on 5/30/2026 and 5/31/2026, assisted Resident A with getting dressed and did not observe any bruises on her arm. Although staff were unable to provide an explanation, it was clear that Resident A had a dark purple bruise on the inside of her left forearm just below her elbow. The bruise was large enough to cover half of her forearm. The top and around the edge of the bruise was a light red color and the skin was slightly peeling in some areas. The origin of the bruise remains unknown.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

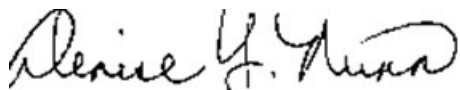


Cindy Berry
Licensing Consultant

9/01/2026

Date

Approved By:



09/17/2026

Denise Y. Nunn
Area Manager

Date