GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 10, 2021

Charles Cryderman
Haven Adult Foster Care Limited
73600 Church Road
Armada, MI 48005

RE: License #: AS740248863
Investigation #: 2022A0990001
Gates AFC

Dear Mr. Cryderman:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

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,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS740248863
Investigation #:	2022A0990001
Complaint Receipt Date:	10/01/2021
Investigation Initiation Date:	10/01/2021
Report Due Date:	11/30/2021
Licensee Name:	Haven Adult Foster Care Limited
Licensee Address:	73600 Church Road Armada, MI 48005
Licensee Telephone #:	(586) 784-8890
Administrator:	Charles Cryderman
Licensee Designee:	Charles Cryderman
Name of Facility:	Gates AFC
Facility Address:	400 Burns Road Kimball, MI 48074
Facility Telephone #:	(810) 367-8079
Original Issuance Date:	06/28/2002
License Status:	REGULAR
Effective Date:	04/02/2021
Expiration Date:	04/01/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility is financially exploiting Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

10/01/2021	Special Investigation Intake 2022A0990001
10/01/2021	APS Referral Adult Protective Services (APS) referral denied at intake.
10/01/2021	Special Investigation Initiated - Letter I emailed Charles Cryderman and requested several documents regarding Resident A. The documents were reviewed on 12/06/2021.
10/05/2021	Contact - Document Received I received requested documents from Mr. Cryderman.
10/15/2021	Inspection Completed On-site I interviewed Resident A and direct care staff Julius Seymour. I observed a total of six residents.
11/01/2021	Contact - Telephone call made I left a detailed message with the Public Guardian (PG). The PG called back and left voice message afterhours.
12/06/2021	Contact - Telephone call made I conducted a phone interview with the PG.
12/06/2021	Contact - Telephone call made I conducted a phone interview with the Reporting Person (RP).
12/06/2021	Contact - Document Sent I emailed Mr. Cryderman follow-up questions regarding Resident A's documents. Mr. Cryderman responded on 12/08/2021. An exit conference was scheduled for 12/09/2021.

12/07/2021	Contact - Telephone call received I received a phone call from Resident A.
12/09/2021	Exit conference I conducted an exit conference with Mr. Cryderman.

ALLEGATION:

The facility is financially exploiting Resident A.

INVESTIGATION:

On 10/01/2021, I received the complaint via email. In addition to the above allegation, it was reported that Resident A has a court appointed legal guardian. Resident A has some mental or cognitive impairments. Resident A is on disability for his impairments. The AFC home is financially exploiting resident A. Resident A is paying over $3000 dollars a month for care, and he receives about $3900 a month. Resident A believes that he is paying too much for the amenities provided. Resident A feels that the home is a prison because the home wants too much control over what he does on a day-to-day basis. Resident A has lived in the home for 3-4 months. Resident A feels that his guardian does not care about how he feels. Resident A is placed into facilities without the guardian checking them out prior.

On 10/15/2021, I conducted an onsite investigation and interviewed Resident A and direct care staff Julius Seymour. I observed six residents in total. Resident A said that he has a public guardian (PG). Resident A said that he does not like the current placement because there is nothing to do and it’s in a rural area when he likes living in the Detroit area. Resident A is paying $3000 per month and $100 per day for transportation to and from appointments. Resident A said that he receives a total of $3900 because he is a veteran. Resident A receives $450 biweekly in personal allowance. Resident A said that his concern is that he did not have a choice in the placement and was not told how much he would have to pay to live at the home. Resident A said that he is aware that he has a legal guardian, and he does not have a good relationship with his guardian. Resident A believes that he is placed in the home because he used to be a heavy alcohol drinker. Resident A said that his last drink was in May 2021. Resident A has been in other group homes and has had some problems in those placements.

I interviewed Julius Seymore-direct care staff said that Resident A’s funding is handled through his guardianship. I reviewed Resident A’s and the other five resident’s records. I observed that Resident A has a legal guardian, and his finances are with a conservator. I reviewed Resident A’s Assessment Plan and there were no needs documented for Section 1 for the Social/Behavioral Assessment except for needing assistance in the community. I observed that Resident A’s *Health Care Appraisal* documented that some of his diagnosis were Alcohol Abuse, Schizophrenia and

Intermittent Incontinence. I did not observe any of Resident A's diagnoses addressed in the *Assessment Plan*. I observed that Resident A pays $3000 monthly for the cost of care and $20 per hour for transportation. Resident A' s *Resident Funds Part II* transaction form accurately documents deposits of $3000 monthly and withdraws $300 monthly for cost of care beginning July 2021 when he was placed in the home.

I observed five other residents' cost of care and the average basic fee was $1908.58 (excluding Resident A's cost of care).

On 12/06/2021, I conducted a phone interview with the Public Guardian (PG). The PG said that she was not aware of the allegations nor has Resident A expressed concerns regarding his money or placement. The PG said that Resident A is veteran with a long history of substance abuse with crack cocaine and chronic alcoholism. Due to Resident A's diagnosis, he requires a higher level of care and supervision. The PG said that during her tenure as the PG of Resident A (3-4 years) he has been in several different placements and had had many behavioral issues including suicidal and homicidal ideations and psychosis. Resident A has threatened to kill her in the past. The PG said that Resident A has a history of medication non-compliance and sneaking out of placements to use drugs and alcohol. When Resident A is using drugs, he is extremely obnoxious and has many issues specifically being placed with younger African American males. The PG said that Resident A has been in inpatient substance abuse treatments several times. Resident A has a fiduciary that pay for his cost of care. The PG said that Veterans Hospital referred Resident A to Mr. Cryderman's home because he has a long history of working with veterans. The PG said that it was decided that Resident A needed to be placed in a rural area due to his history of eloping to buy and use drugs/alcohol since Resident A needs to live in an area that has less access to drugs and alcohol. The PG said that Resident A has a debit card for his allowance and the home does not handle his personal monies. The PG said that Resident A blows his personal allowance on ordering food and paying for his girlfriends. The PG believes these allegations are stemming from his inability to pay the girlfriend's rent due to his higher level of cost of care. The PG said that yesterday she received notification from the court that Resident A has petitioned to remove her as the guardian and the court date is in January 2022.

On 12/06/2021, conducted a phone interview with the Reporting Person (RP). The RP said that the group home is taking advantage of Resident A by financially exploiting him. The RP said that Resident A is buying most of his own food and does not believe the amenities afforded in the home are up to par for the money he is paying monthly. The RP is concerned that the PG places him into homes that she has never visited or will visit. The RP said that the home tells Resident A how to spend his personal money. The RP said that Resident A is the process of ending the guardianship and has an upcoming court date on 11/06/2022. Resident A is coherent and does not need a guardian. The RP said that Resident A has not had a drink in over a year. The RP said that Resident A has had fights at prior placements, but most have been "hole in the walls" and people financially exploit him.

On 12/07/2021, I received a phone call from Resident A. Resident A expressed that he has an upcoming hearing to end his guardianship. Resident A inquired if I could assist him with the Zoom court hearing. I informed Resident A that the home would have to assist with the Zoom meeting.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(11) A licensee shall obtain prior written approval from a resident and his or her designated representative before charges are made to a resident's account.
ANALYSIS:	Based on the investigation there is no evidence to support that the licensee is making charges to Resident A's account. Resident A's Resident Care Agreement signed by the PG documents the monthly fee of $3000 per month. I observed that Resident A's Funds Part II deposits and withdraws $3000 per month. Resident A has access to his own personal allowance through biweekly deposits to his debit card. According to the PG, Resident A's cost of care is indicative to the level of care that he requires for chronic substance abuse and psychosis.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/15/2021, I interviewed Resident A and direct care staff Julius Seymour. I observed six residents in total. Resident A said that the toilet in one of the bathrooms does not flush. I observed in bathroom #1 that the toilet was not flushing. Mr. Seymour said that the toilet has been this way for a few days. I observed Mr. Seymour attempting to plunge the toilet however, the water was not receding.

On 12/09/2021, I conducted an exit conference with Mr. Cryderman. We discussed in great detail Resident A's *Resident Care Agreement* and *Health Care Appraisal* because the PG provided greater information to licensing during the phone interview as to why Resident A's cost of care was significantly higher than the other residents which is due to his higher behavioral needs and substance abuse issues. Mr. Cryderman said that Resident A was referred to him by the Veterans Hospital (VA) in Detroit. Mr. Cryderman said that he has several residents that receive services through the VA and many clients are referred to him for placement. Mr. Cryderman said that at the time of Resident A's admission and to date, he was not aware that Resident A had severe behavior issues related to his diagnoses of schizophrenia and substance abuse as the

PG informed licensing. Mr. Cryderman said that Resident A's *Health Care Appraisal* documents these diagnoses however, the PG did not add this information as a need of Resident A at the time of admission.

Mr. Cryderman said that he does not control Resident A's personal allowance and the money that Resident A receives is loaded to his personal debit card. Mr. Cryderman was informed that he needed to revise this on the *Resident Care Agreement* by checking "Do not agree" to safekeep/manage Resident A's funds for personal allowance which was check marked inaccurately as that they control and manage Resident A's personal funds. Mr. Cryderman also stated that he has not met the PG personally and all the forms completed at admission were sent to the PG and she sent them back signed. I advised Mr. Cryderman to complete the *Assessment Plan* with guardians to ensure that the questions and needs are addressed accurately for residents. Mr. Cryderman agree to do this from now on. Mr. Cryderman said that many public guardians have several clients and are difficult to reach for signatures and information. I also provided technical assistance with Mr. Cryderman regarding emergency placements (Resident A was an emergency placement from the VA). Mr. Cryderman was informed that he had 15 calendar days to complete Resident A's *Assessment Plan* and the *Health Care Appraisal* within 90-days of admission date. Mr. Cryderman agreed to update Resident A's *Assessment Plan* and *Resident Care Agreement*. Mr. Cryderman was not aware of these needs because the guardian signed the Assessment Plan without acknowledging the resident's needs.

Mr. Cryderman said that the toilet has been repaired. Mr. Cryderman said that he was not informed about the toilet issue until after I did an onsite. Mr. Cryderman was informed of this violation and sent a video of the toilet flushing properly which was snaked and plunged by staff and is now working properly.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	On 10/15/2021, I observed the toilet in bathroom #1 was not flushing. According to Mr. Cryderman staff repaired the toilet shortly after the onsite inspection.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED (BUT CORRECTED)** Special Investigation Report #2019A0990033 dated 11/19/2019 and corrective action plan approved on 11/21/2019.

IV. RECOMMENDATION

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

12/09/2021

LaShonda Reed — Date
Licensing Consultant

Approved By:

12/10/2021

Denise Y. Nunn — Date
Area Manager
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