GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 20, 2022

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

RE: License #: AL500066534
Investigation #: 2022A0990022
Haven Adult Foster Care Home

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
3026 W. Grand Blvd.
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 #:	AL500066534
Investigation #:	2022A0990022
Complaint Receipt Date:	05/25/2022
Investigation Initiation Date:	05/27/2022
Report Due Date:	07/24/2022
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:	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:	11/23/2021
Expiration Date:	11/22/2023
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
There is one staff member helping eighteen residents during the day and night shift.	No
The staff will have other residents help the physically challenged adults (residents) to get around.	Yes
A resident was going for a walk without permission. The one staff member left all the residents alone to run after this person and was gone about ten to fifteen minutes.	No
The residents have been missing meals and only have lunch and dinner or just breakfast and lunch. Some residents may only be eating one meal per day.	Yes

III. METHODOLOGY

05/25/2022	Special Investigation Intake 2022A0990022
05/26/2022	APS Referral Adult Protective Services (APS) complaint denied at intake.
05/27/2022	Special Investigation Initiated - On Site I conducted an unannounced onsite investigation. I interviewed home manager Mary Gill, Resident A, Resident B and attempted to interview Resident C. I observed several residents that were seated to eat lunch. I briefly interviewed the licensee designee Chuck Cryderman who arrived at the home.
05/27/2022	Contact - Document Received I received documents requested during onsite via email from Mr. Cryderman.
07/11/2022	Contact - Telephone call made I conducted a phone interview with Relative B.
07/11/2022	Contact - Document Received I reviewed Resident B documents.

07/13/2022	Contact - Telephone call made I conducted a phone interview with Relative A.
07/13/2022	Contact - Document Sent I requested additional documents from Mr. Cryderman. I received and reviewed the documents on 07/15/2022.
07/15/2022	Contact - Telephone call made I conducted a phone interview with Mr. Cryderman
07/15/2022	Contact - Document Received I reviewed Resident A documents requested.
07/15/2022	Contact - Telephone call made I called direct care staff Linda Adams. No answer received and voice mail box was full. I sent an SMS text. No response received to date.
07/15/2022	Contact - Telephone call made I conducted a phone interview with direct care staff Jasmine Wright.
07/15/2022	Contact - Document Received I reviewed resident Assessment Plans.
07/18/2022	Contact - Telephone call made I contacted Macomb County Sherriff's Department.
07/20/2022	Exit conference I conducted an exit conference with Mr. Cryderman.

ALLEGATION:

There is one staff member helping eighteen residents during the day and night shift.

INVESTIGATION:

On 05/25/2022, the special investigation was re-assigned from the assigned licensing consultant. The complaint was received via email. In addition to the above allegation, it was reported that Haven is a licensed adult foster care home that houses 18 vulnerable adults for mental health and other unknown reasons.

On 05/27/2022, I conducted an unannounced onsite investigation. I interviewed home manager Mary Gill, Resident A, Resident C and attempted to interview Resident B (non-

verbal). I observed several residents that were seated to eat lunch. I briefly interviewed the licensee designee Chuck Cryderman, who arrived at the home. I received copies of the staff schedules, menu, and resident register.

Mary Gill-manager, said that she has been employed at the home since April 2022 however, she has worked for Mr. Cryderman for 10 years at various adult foster homes. Ms. Gill said that she works 11AM to 7PM with another staff person who was present named Linda Adams. I observed Ms. Adams cooking and serving lunch to the residents. Ms. Gill said that there are 18 residents living in the home and two are not present today because they were at workshop program. Ms. Gill said that some staff work a 24-hour schedule on the weekends which begins at 8AM Friday and ends on 8AM Sunday. Ms. Gill said that there are two staff always assigned during the day shift and one staff for the night shift.

I interviewed Resident A. Resident A said that there are always two staff working in the home.

I interviewed Resident C. Resident C said that there are always two staff present in the home. Resident C said that he feels that there is enough staff in the home to care for him and the other residents.

I interviewed Chuck Cryderman, licensee designee. Mr. Cryderman was informed of the allegations. Mr. Cryderman described that the home consists of high functioning residents. Mr. Cryderman said that two of the residents that live here attend workshop and one resident has a job in the community. During the day there are usually 14 residents in the home. Mr. Cryderman said that he has two staff working the day shift and one staff working at night.

On 07/11/2022, I conducted a phone interview with Relative B. Relative B said that there is adequate staffing at the home however, there is a high staff turnover. Relative B said there are two staff daily and one staff at night.

On 07/13/2022, I conducted a phone interview with Relative A. Relative A said that she has not been inside of the home in some time because they had a visit restriction due to bed bugs (investigated special investigation #2022A0617002 & #2022A0617012). Relative A said that due to the bed bug infestation she has not visited the home and is not aware of the staffing. Relative A recalls that they use to have two or more staff working especially over the weekends.

On 07/15/2022, I conducted a phone interview with direct care staff Jasmine Wright. Ms. Wright has been employed since April 2022. Ms. Wright said that there are two staff assigned to the day shift and one staff assigned from 8PM to 11AM. Ms. Wright denied that there is less than two staff working in the home during waking hours.

On 07/15/2022, I reviewed the staff schedule. I observed for the month of May 2022, there was adequate staffing of two staff during the day shift and one staff at night.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	Based on the investigation, there is insufficient information to support that there is inadequate staffing. According to the home manager Ms. Gill, there are always two staff assigned during the day shift and one staff for the night shift. Resident A said that there are always two staff working in the home. Resident C said that there are always two staff present in the home. Relative B said that there is adequate staffing. Relative A said in the past there was always two staff present during the day shift. Direct care staff, Ms. Wright denied that there is less than two staff working in the home during waking hours. I reviewed the staff schedules and there are two staff during the day shift and one staff at night.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The staff will have other residents help the physically challenged adults (residents) to get around.

INVESTIGATION:

On 05/25/2022, it was additionally reported that there are many times where the morbidly obese residents are needing help to get around and struggling to get up the steps. One resident had a cast on his arm and was helping another resident who had a cane while staff watched this, observing but not getting involved.

On 05/27/2022, I conducted an unannounced onsite investigation. I interviewed home manager Mary Gill, Resident A, Resident C and attempted to interview Resident B. Resident B is non-verbal. I interviewed the licensee designee Chuck Cryderman who arrived at the home.

Ms. Gill said that the home is two levels and the one resident that has mobility issues, their bedroom is on the first floor. Ms. Gill said that Resident B sleeps on the first floor and he uses a cane and a walker. There are stairs at the entrances as well as wheelchair ramps therefore, Resident B does not access stairs. Ms. Gill said that there are no residents who are morbidly obese, but Resident B is overweight. Ms. Gill denied that other residents assist Resident B with mobility.

I interviewed Resident A. Resident A said that he no longer helps other residents in the home because he broke his arm and is unable to. Resident A said that he had a cast on his arm because of falling on black ice while shoveling the snow this past winter. Resident A said that he had a cast on his arm, but it has now been removed. Resident A said that prior to his arm fracture he helped Resident B shower, dress, and groom. Resident A and Resident B are roommates. Resident A said that Resident B's guardian would ask to speak to him via Resident B's cell phone at times and ask him to care for Resident B such as reminding him to shampoo his hair. Resident A also helped lift Resident B because the manager Ms. Gill said that Resident B was too heavy for her to lift. Resident A said that Resident B is heavy and does walk with a cane. Resident A said that he likes living in the home except helping to care for Resident B.

I interviewed Resident C. Resident C said that he does not assist with helping to care for other residents. Resident C said that he does do the dishes as a chore. Resident C has not observed other residents helping other residents.

Mr. Cryderman said that there are no residents that uses a wheelchair and there is only one resident that uses a cane.

On 07/11/2022, I conducted a phone interview with Relative B. Relative B said that there are no morbidly obese residents however, Resident B has gained weight since living in the home. Relative B said that she has relayed to staff that they need to cut his carbs and sweets as he is gaining weight. Relative B said that Resident B has leg braces, and he does not walk stairs. Relative B said that Resident B lives on the first floor and does not utilize the second floor of the home. Relative B said that Resident B does need assistance with mobility and may need assistance getting up and down stairs. Relative B denied that other residents are providing care for Resident B. Relative B described that his roommate may assist him with zipping up his coat or a helping hand when he is getting off the bus as he attends program two times a week.

On 07/11/2022, I reviewed Resident B documents. I reviewed Resident B's *Assessment Plan*. Resident B needs assistance with mobility from staff. Resident B requires assistance with ADL's and has leg braces and has problems with balance (uses a cane).

On 07/13/2022, I conducted a phone interview with Relative A. Relative A said that Resident A is currently in a rehabilitation facility due to being hospitalized for a recent fall. Relative A described that Resident A has been in and out of the hospital the last

few weeks. Relative A said that a resident (name not provided) told her confidentially that Resident A fell on the wet kitchen floor last month after another resident name unknown) mopped the floor leaving it too wet. Relative A said that Resident A broke his arm a few months ago because he was taking out the trash and fell into the dumpster. Resident A was responsible for shoveling the snow and mowing the lawn. Relative A said that Resident A's specific chores were not told to her, but Relative A believes that Resident A should not be doing the chores that he was doing. Resident A was scrubbing bathrooms as well. Relative A is not aware of Resident A physically helping other residents in the home. Relative A said that Resident A has now been injured twice on the property and she believes that the homeowner's insurance should be covering his medical bills. Relative A is considering moving Resident A to a smaller facility due to his recent decline in health because of the falls. Relative A spoke to the manager about the fall, and they informed her that Resident A did not fall because of a wet floor but he tripped.

On 07/15/2022, I conducted a phone interview with Mr. Cryderman. Mr. Cryderman said that Resident A did not fracture his arm because of falling on ice. Mr. Cryderman said that Resident A fractured his arm on 03/30/2022 because he fell inside of the home and agreed to send the incident report. Mr. Cryderman said that Resident A wore a cast and was seen by an orthopedic surgeon and the cast was removed. Mr. Cryderman said that on 06/21/2022 Resident A fell because of being ill and was hospitalized. Resident A is currently in a rehabilitation facility because there is water around his heart cavity, he is due to return to the home next Friday. Mr. Cryderman said that the only resident that mops the kitchen and dining room floor is Resident D. Mr. Cryderman denied that Resident A fell while doing chores or because of another resident doing chores.

I reviewed Resident A documents. I reviewed Resident A's hospital discharge summary dated 03/31/2022 from Henry Ford Macomb Hospital (HFM). Resident A was diagnosed with a fall resulting in a humorous fracture and treated with immobilization. I reviewed the incident report (IR) dates 03/30/2022 that documented that at 8:30AM Resident A was taking his breakfast plate into the kitchen and lost his balance and fell hitting his head and transferred to HFM. I reviewed Resident A's IR dated 06/07/2022 that documented that at 7:20pm Resident A was very confused, could not stand, pale colored and slurred speech. Resident A was transferred to HFM and was admitted. The discharge paperwork documented that he was hospitalized from 06/08/2022 to 06/14/2022 and diagnosed with a fever, decrease of all blood cells, low blood potassium, underweight, elevated liver enzymes, and watermelon stomach. I reviewed an IR dated 06/21/2022 which documented that Resident A was lethargic, leaning to the left and unable to stand.

On 07/15/2022, I conducted a phone interview with direct care staff Jasmine Wright. Ms. Wright said that the residents do not assist in the care of other residents Ms. Wright was not employed in March of 2022 when Resident A fractured his arm. Ms. Wright had no knowledge of Resident A falling on a wet floor. Ms. Wright said that she is aware of one fall Resident A had in which, he tripped inside of the home. Resident B lives on the

lower level of the home and does not access stairs. Ms. Wright said that Resident B uses a cane and at times when he gets off the bus from workshop, one of the other residents assists him with stepping on the bus. Ms. Wright said that staff assists Resident B in the home.

On 07/15/2022, I reviewed Resident A, Resident C and Resident D's *Assessment Plans*. I observed for chores, was checked "yes" and a comment documented as tolerated.

On 07/18/2022, I contacted the Macomb County Sherriff's Department to inquire if there had been police runs for a resident falling on ice this year and/or 2021. I was informed that there had not been any calls for any resident falling on ice. I provided Resident A's information and no police runs were made for this resident.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	It was alleged that there is a morbidly obese resident that has mobility issues and is being assisted by a resident that wears a cast. Resident B is the resident in the home that has mobility issues and is very overweight. It was determined that Resident A was the alleged resident that was assisting with the care of Resident B. Resident A and Resident B are roommates. Resident B needs assistance with mobility. Resident B requires assistance with ADL's and wears leg braces and has problems with balance (uses a cane). Resident A said that prior to his arm fracture he helped Resident B shower, dress, and groom. Relative B described that Resident B's roommate (Resident A) may assist him with zipping up his coat or a helping hand when he is getting off the bus as he attends program two times a week. Mr. Cryderman and staff Ms. Gill and Ms. Wright deny that Resident A helps to care for Resident B. Ms. Wright said that Resident B uses a cane and at times when he gets off the bus from workshop one of the other residents assists him with stepping off the bus. Resident A, Resident C and Resident D are completing chores in the home that are not addressed in their *Assessment Plans*.

	Resident C said that he does the dishes as a chore. Relative A said that Resident A was responsible for shoveling the snow and mowing the lawn at one point. Relative A said that Resident A's specific chores were not told to her, but Relative A believes that Resident A should not be doing the chores that he was doing. I observed that for chores for Resident A, Resident C and Resident D, was checked "yes" and a comment documented "as tolerated." I did not observe that the chore comments were not specific nor how the participation of chores performed contributes to the resident's physical and behavioral needs and well-being and competency of the individual.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

A resident was going for a walk without permission. The one staff member left all the residents alone to run after this person and was gone about 10 to 15 minutes.

INVESTIGATION:

On 05/25/2022, in addition to the above allegation it was reported that this a resident had gotten out one time and it is unknown if the resident was harmed because of this.

On 05/27/2022, I conducted an unannounced onsite investigation. I interviewed home manager Mary Gill, Resident A, Resident C and attempted to interview Resident B. I interviewed the licensee designee Chuck Cryderman who arrived at the home.

Ms. Gill said that Resident C snuck out of the home two months ago and walked across the road while she was on shift with Linda Adams. Ms. Gill immediately saw him standing outside which and went outside to direct him back inside.

I interviewed Resident A. Resident A said that Resident C has gotten out of the home many times. Resident A said that he leaves to go try to buy cigarettes. Resident A said that Resident C leaves the home, does not tell staff and is unsupervised.

I interviewed Resident C. Resident C admitted to leaving the home one time without permission. Resident C said that while staff were in the kitchen area, he left out of the front door. Resident C said that he walked five to six blocks to go to the store to buy cigarettes or a vape pen. Resident C said that he did not have enough money to make the purchase. Staff Mary came outside and asked him where he was going and asked him to come inside. Resident C was talked to about leaving from the home and understands that he is not to leave the home without supervision or permission.

Resident C said that he has not left the home since that one incident. I reviewed Resident C's *Assessment Plan* and it indicated that he smokes cigarettes outside.

Mr. Cryderman described that the home consists of high functioning residents.

On 07/11/2022, I interviewed Relative B. Relative B said that she has no knowledge of a resident eloping from the home.

On 07/13/2022, I interviewed Relative A. Relative A said that she has no knowledge of a resident eloping from the home.

On 07/15/2022, I interviewed direct care staff Jasmine Wright. Ms. Wright said that she has no knowledge of a resident eloping from the home.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	The home manager Ms. Gill said that Resident C snuck out of the home two months ago and walked across the road. Resident C admitted to leaving the home one time without permission. Resident C said that while staff were in the kitchen area, he left out of the front door. Staff Mary came outside and asked him where he was going and asked him to come inside. Although, Resident C admitted to sneaking out of the home, there is not enough evidence to support that the staff was negligent. Resident C smokes cigarettes outside and it is highly likely that he could have left while outside smoking as he admitted to leaving without permission to go buy more tobacco products.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The residents have been missing meals and only have lunch and dinner or just breakfast and lunch. Some residents may only be eating one meal per day.

INVESTIGATION:

On 05/25/2022, in addition to the above allegation, it was reported that the residents have missed meals three or four times in the past three to four weeks. This happens because the staff are so bogged down.

On 05/27/2022, I conducted an unannounced onsite investigation. I interviewed home manager Mary Gill, Resident A, Resident B and attempted to interview Resident C. I observed several residents that were seated to eat lunch. I interviewed the licensee designee Chuck Cryderman who arrived at the home. I received copies of the staff schedules, menu, and resident register. I observed the food supply and a staff person preparing lunch which was macaroni and cheese with ham pieces and fudge brownies.

I interviewed Resident A. Resident A said that there are meals cooked in the home. Resident A said that staff prepares all the meals and he at times chooses not to eat his meals. Resident A indicated he had for breakfast this morning, cereal, toast, and coffee. Resident A said that he eats snacks daily.

I interviewed Resident C. Resident C said that he ate Lucky Charms cereal, two pieces of toast and had coffee for breakfast. Resident C said that yesterday for lunch he ate hot dogs but did not recall what he had for dinner but confirmed that he had dinner. Resident C said that he gets enough to eat, does not miss meals, and likes that a staff person named Brittany makes large pancakes. Resident C said that he feels safe in the home and well cared for.

I observed an abundance of food supply in the fridge, freezer, and pantry. I observed staff sitting in the dinning room area eating lunch.

On 07/11/2022, I conducted a phone interview with Relative B. Relative B stated that Resident B has gained weight since living in the home. She has relayed to staff that they need to cut his carbs and sweets as he is gaining weight. Relative B has not observed nor heard of meals being missed in the home.

On 07/13/2022, I conducted a phone interview with Relative A. Relative A said that there are no concerns with meals other than Resident A does not each much and has lost weight. Relative A said that she has purchases Boost supplemental drinks for Resident A and brings him extra snacks such as peanut butter.

On 07/15/2022, I reviewed the menu for May 2022 and the meals were balanced for breakfast, lunch, and dinner. I observed that snacks are provided at 10AM, 2PM and 7PM which consists of the following choices: pudding cup, cake with fruit, fresh fruit when available, Jell-O cup, popcorn, and coffee/teas/juice.

On 07/15/2022, I conducted a phone interview with direct care staff Jasmine Wright. Ms. Wright said that the residents are provided three balanced meals daily including

snacks. Ms. Wright said that the only way a resident misses a meal is of they choose to do so.

On 07/20/2022, I conducted an exit conference with Mr. Cryderman. Mr. Cryderman and I discussed the findings in detail. Mr. Cryderman said that there are no lawn mowers at the home and he hires a company to do lawn care therefore, Resident A never cuts the lawn or shovels the snow. We discussed Resident A's interpretations of chores and assisting his roommate Resident B and boundaries need to be discussed with Resident A as he likes to assist. Mr. Cryderman said that Resident A functions at or around age 12 year. Mr. Cryderman said that Resident A will return from a rehabilitation facility on 07/22/2022. Mr. Cryderman said that Resident A tends to create untrue stories. Mr. Cryderman was informed of the violation and agreed to be more specific as to what chores a resident would perform and to document this on their *Assessment Plan* as well ensure that the residents guardians agree to the specific chores assigned. I informed Mr. Cryderman that the chores should be assigned based on their ability to perform such tasks. Mr. Cryderman and I discussed making a chore chart and noting this in the plan. Mr. Cryderman added that there is a high staff turnover however, he does show his staff appreciation to boost morale and retention. Mr. Cryderman added that Resident C passed away last week while smoking a cigarette on the porch. Mr. Cryderman said that prior to his passing he discussed with Resident C about him smoking as he likes to wake-up in the middle of the night to smoke on the porch. According to the Medical Examiner's Office, Resident C died of natural causes and an IR was sent to the assigned licensing consultant when this occurred. Mr. Cryderman agreed to submit a corrective action plan. Mr. Cryderman said that the bed big issue has been resolved and will draft a memo to inform the family members that may not be aware that visitation to the home is no longer restricted. Mr. Cryderman said that Orkin company is treating the home monthly for bed bugs.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on this investigation, there is insufficient information that the residents are not being provided adequate meals. Based on interviews with direct care staff Ms. Gill and Ms. Wright they deny that the residents are not provided three or more meals. Relative A and Relative B both deny that there are issues with lack of food. Relative B described that Resident B is gaining weight. Resident A and Resident C said that they are provided three or meals per day.

	I observed an adequate food supply during my unannounced onsite investigation on 05/27/2022. I observed residents eating lunch as staff was preparing upon my arrival. I observed the menu was adequate with balanced meals.
CONCLUSION:	VIOLATION NOT ESTABLISHED

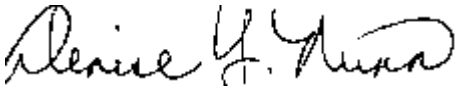
IV. RECOMMENDATION

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

07/20/2022

LaShonda Reed Date
Licensing Consultant

Approved By:



07/20/2022

Denise Y. Nunn Date
Area Manager