GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 10, 2024

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

RE: License #: AS500267724
Investigation #: 2024A0604022
Griffith Home

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) 975-5053.

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 #:	AS500267724
Investigation #:	2024A0604022
Complaint Receipt Date:	06/20/2024
Investigation Initiation Date:	06/24/2024
Report Due Date:	08/19/2024
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:	Griffith Home
Facility Address:	73600 Church Street Armada, MI 48005
Facility Telephone #:	(586) 784-8890
Original Issuance Date:	07/19/2004
License Status:	REGULAR
Effective Date:	02/14/2023
Expiration Date:	02/13/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Employee that only speaks Spanish is passing medication and communicates with residents using a phone translator.	No
Additional Findings	Yes

III. METHODOLOGY

06/20/2024	Special Investigation Intake 2024A0604022
06/24/2024	Special Investigation Initiated - On Site Completed unannounced onsite investigation. Interviewed Staff Sheila Washinski, Shawneesha Cooper, Resident A, Resident B and Resident C. Staff, Daniela Cueva, left prior to being interviewed.
06/24/2024	Contact - Document Sent Email to and from William Gross
06/24/2024	Contact - Telephone call made Left message for William Gross
07/02/2024	Contact - Document Received Received employee records from William Gross
08/27/2024	Contact - Document Sent Email to William Gross. Requested staff schedules and phone numbers
08/29/2024	Contact- Document Received Received staff schedules and phone numbers from William Gross
08/30/2024	Contact- Document Sent Email to William Gross
08/30/2024	Contact- Telephone call made Returned call from William Gross
08/30/2024	Contact- Telephone call made TC to Fola Mataao. Unable to leave message.

08/30/2024	Contact- Telephone call made Left message for Daniela Cueva
08/30/2024	Exit Conference Completed exit conference with William Gross by phone

ALLEGATION:

Employee that only speaks Spanish is passing medication and communicates with residents using a phone translator.

INVESTIGATION:

I received a licensing complaint regarding Griffith Home on 06/21/2024. It was alleged that an employee speaks only Spanish is passing medications, cannot communicate with residents and staff and is using phone as interpreter. Several of the residents have dementia and no longer understand or can read. Residents are having anxiety over the communication barrier.

On 06/24/2024, I completed an unannounced onsite investigation. I interviewed Staff Sheila Washinski, Shawneesha Cooper, Resident A, Resident B and Resident C. Staff, Daniela Cueva, left prior to being interviewed.

On 06/24/2024, I interviewed staff, Shiela Washinski. She stated that she has worked at Griffith Home since March 2024. Ms. Washinski stated that she was the Home Manager. She stated that Danny Cueva was the direct care worker on shift and is passing medications. She indicated that Ms. Cueva can speak English and does not use translator app. Ms. Washinski introduced me to Ms. Cueva and I informed them that I would interview her during onsite. When I asked to interview Ms. Cueva, I was told by the Health Care Area Manager, Shawneesha Cooper, that she left home due to an emergency. I was unable to interview her to determine if she was able to communicate in English, however, did not observe her using a translator app. Ms. Washinski stated that staff, Fola Matteo, works on Wednesdays and Thursdays and does not use a translator app to communicate. She indicated that they did have a staff, Lorena, who filled in during an emergency one day who used a translator app. Lorena does not regularly work at the home. On 06/24/2024, I completed an unannounced onsite investigation at licensees' home, Greenwood Lodge, and found Staff, Lorena Andrade, working alone. Ms. Andrade spoke Spanish and was unable to communicate without the use of translator app on her cell phone.

On 06/24/2024, I interviewed Health Care Area Manager, Shawneesha Cooper. She stated that direct care worker, Daniela Cueva, left due to an emergency. Ms. Cueva was identified as the only direct care worker on shift at beginning of onsite. Ms. Cooper

stated that she is a certified CNA and can pass medications. She stated that Sheila is also available to help her. Ms. Cooper indicated that she did not have any knowledge of Spanish speaking staff passing medications. I informed her that Lorena Andrade was found passing medications prior to onsite at Greenwood Lodge and can only communicate using translator app. I requested Ms. Cooper to follow up on this issue immediately.

On 06/24/2024, I interviewed Resident A. Resident A stated that she has lived in the home for two months. She stated that it is going “ok”. Resident A stated that the staff speak English. She receives her medications and can ask questions about medications. Resident A stated that everybody at home is good to her.

On 06/24/2024, I interviewed Resident B. Resident B has lived in home since February 2024 and stated she is doing “ok”. She stated that all staff speak English and do not use translator app. She stated that she is receiving all her medications.

On 06/24/2024, I interviewed Resident C. She has lived in the home since May 2023. She stated that she has no problems communicating with staff. All staff speak English. She indicated that she is getting all her medications as prescribed and has no concerns. Resident C indicated that everybody at home is really great.

On 06/24/2024, I reviewed resident medications logs with Home Manager, Shiela Washinski. Medication logs had initials DC (Daniela Cueva) and (Fola Matteo) FM. The initial S or 5 was also found on medication log on 06/12, 06/13, 06/14. This initial is used when William and Shawneesha are on schedule.

On 08/29/2024, I received staff schedules from Wiliam Gross for June, July and August 2024. Staff, Lorena Andrade, does not appear on any of the schedules. Ms. Andrade’s date of hire is listed as 06/17/2024 on her training record. On 07/03/2024, I received email from Mr. Gross stating that she was no longer nworking for them. It is unknown which dates she worked at Griffith Home.

On 08/30/2024, I attempted to interview Staff, Fola Mataao, by phone. Message indicated that phone was not accepting calls at this time and I was unable to leave a message.

On 08/30/2024, I attempted to interview Staff, Daniela Cueva, by phone. I left a message for Ms. Cueva requesting return call.

On 08/30/2024, I interviewed licensee designee, William Gross, by phone. He indicated that Lorena had not worked at Griffith Home alone. He stated that it is the location of their main office and there are other staff there. He stated that Daniela Cueva is no longer working for them.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(1) Direct care staff shall not be less than 18 years of age and shall be able to complete required reports and follow written and oral instructions that are related to the care and supervision of residents.
ANALYSIS:	On 06/24/2024, I completed an unannounced onsite investigation at Griffith Home. I did not find any staff using a translator app during onsite investigation. Resident A, Resident B and Resident C stated that they can communicate with staff at the home. Home Manager, Sheila Washinski, indicated that they did have a staff, Lorena, who filled in during an emergency one day who used a translator app. There is not enough information at this time to determine that Lorena worked alone or was passing medications.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(e) Any scheduling changes.**
ANALYSIS:	Staff schedules provided did not include scheduling changes. On 07/03/2024, Home Manager, Sheila Washinski, stated that Lorena Andrade used translator app and has worked at the home. On 08/29/2024, I received staff schedules from Wiliam Gross for June, July and August 2024. Staff, Lorena Andrade, does not appear on any of the schedules. Ms. Andrade's date of hire is listed as 06/17/2024 on her training record. On 07/03/2024, I received an email from Mr. Gross stating that she was no longer working for them. It is unknown which dates she worked at Griffith Home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/03/2024, I received employee records by email from Wiliam Gross for Staff, Sheila Washinski, Fola Mataao, Daniela “Danny” Cueva, and Shawneesha Cooper. Applications, reference checks, medical/TB tests, clearances and trainings were requested. A workforce background check was not provided for Staff, Daniela Cueva. Also, Shawneesha Cooper did not have a clearance for Griffith Home. Her workforce background check was for Gates AFC. Staff, Lorena Andrade, was reported to have worked at Griffith Home for at least one day. A clearance was requested for Ms. Andrade for Greenwood Lodge special investigation and was not provided.

Sheila Washinski did not have a medical statement, TB test or trainings. William Gross indicated in email that she is house secretary and does not do caregiving or pass medications. Ms. Washinski identified herself during onsite as Home Manager.

I completed an exit conference with licensee designee, William Gross, by phone on 08/30/2024. I informed him of the violations found and that a corrective action plan would be requested. I also informed him that I would contact him if there were any changes to recommendation or findings and that a copy of the special investigation report would be mailed once approved.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) 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 competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**

ANALYSIS:	Staff, Daniela Cueva's initials are found on June 2024 medication logs as early as 06/01/2024. Ms. Cueva's date of hire is listed as 06/19/2024 on her training record. It appears that Ms. Cueva was working at the home prior to her training being completed and the incorrect date of hire was provided to licensing. Her trainings were completed between 06/19/2024-06/21/2024. Her CPR/First Aid training certificate is dated 06/24/2024, the date of the onsite investigation.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	June 2023 medication logs indicate that Staff, Daniela Cueva, was passing medications as early at 06/01/2024. Her training record indicates that she did not receive training on Introduction to Medications and Medication Administration and Documentation until 06/21/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
MCL 400.713	**License required; application; forms; investigation; on-site evaluation; issuance or renewal of license; disclosures; maximum number of persons; stating type of specialized program; issuance of license to specific person at specific location; transferability of license; sale of facility; notice; items of noncompliance; refusal by department to issue or renew license; conditions; unlicensed facility; violation as misdemeanor; penalty; receipt of completed application; issuance of license within certain time period; inspections; report; criminal history and records check; storage of fingerprints in automated fingerprint identification system database; convictions; "completed application" defined.**
	(3) Before issuing or renewing a license, the department shall investigate the activities and standards of care of the applicant and shall make an on-site evaluation of the facility. On-site inspections conducted in response to the

	application may be conducted without prior notice to the applicant. On-site inspections conducted for renewing a license may be conducted within 12 months before the expiration date of the current license without impact on the license renewal date or the license fee. Subject to subsections (9), (10), and(11), the department shall issue or renew a license if satisfied as to all of the following: **(e) The good moral character of the licensee or licensee designee, owner, partner, director, and person responsible for the daily operation of the facility. The applicant is responsible for assessing the good moral character of the employees of the facility. The person responsible for the daily operation of the facility shall be not less than 18 years of age.**
ANALYSIS:	A workforce background check was not provided for Staff, Daniela Cueva. Also, Shawneesha Cooper did not have a clearance for Griffith Home. Her workforce background check was for Gates AFC. Staff, Lorena Andrade, was reported to have worked at Griffith Home for at least one day. A clearance was requested for Ms. Andrade for Greenwood Lodge special investigation and was not provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the physician's knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.
ANALYSIS:	Home Manager, Sheila Washinski, did not have a medical statement in employee file provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.
ANALYSIS:	Home Manger, Sheila Washinski, did not have a TB test in employee file provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

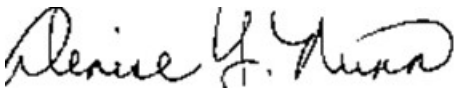
IV. RECOMMENDATION

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

08/30/2024

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



09/10/2024

Denise Y. Nunn — Date
Area Manager