GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 23, 2024

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

RE: License #: AG500066337
Investigation #: 2024A0604020
Ridgeway

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,

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 #:	AG500066337
Investigation #:	2024A0604020
Complaint Receipt Date:	06/12/2024
Investigation Initiation Date:	06/14/2024
Report Due Date:	08/11/2024
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:	Ridgeway
Facility Address:	72188 Russ Road Richmond, MI 48062
Facility Telephone #:	(586) 727-7650
Original Issuance Date:	05/31/1995
License Status:	REGULAR
Effective Date:	08/15/2022
Expiration Date:	08/14/2024
Capacity:	31
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED AGED

II. ALLEGATION(S)

	Violation Established?
There is a Spanish speaking employee passing medications that are only in English. Staff is unable to communicate with the residents due to not speaking English.	No
Staff may not be legal to work in United States or have had background checks.	Yes
Two males are working the same shift without a female present.	No
Building is too hot for residents and staff. The building is humid and floors are slippery due to humidity.	Yes
Resident O received a double dose of her medication.	No
Resident I is not receiving her insulin.	No
There are multiple medication errors due to untrained staff. Staff do not have access to medication book.	Yes
Guardian and provider are not being notified of resident hospitalizations and death.	Yes
Staff did not have batteries for blood pressure cuff.	No
Staff are drinking and sleeping on the job. They are speaking inappropriately to residents, dressing inappropriately and a boyfriend is visiting.	Yes
Resident J locks himself in bathroom and staff do not have keys.	No
Facility only has one bathroom working. Residents are not receiving showers.	Yes
Preparation of food is unsanitary. Cook does not wash his hands after he smokes. Food is overcooked and expired can goods are served.	No
Additional Findings	Yes

III. METHODOLOGY

06/12/2024	Special Investigation Intake 2024A0604020
06/14/2024	Special Investigation Initiated - On Site Completed unannounced onsite investigation. Interviewed Staff, Jocey William, Janene Wackler and Kimberlee Mitchell and Resident D, Resident H, Resident J, Resident K and Resident L.
06/14/2024	Contact - Document Sent Email to William Gross. Requested staff list, schedules and fingerprinting clearances

06/15/2024	Contact - Document Received Email from William Gross
06/19/2024	Contact - Document Received Email from William Gross. Received clearances, schedules and staff list
06/20/2024	Contact - Document Sent Email to and from William Gross. Sent LARA heat advisory information and recommendations
06/21/2024	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Home Manager, Kimberlee Mitchell, Staff Hanson Lowry, Jim Sealey and Jocey William, Resident D, Resident G, Resident M and Resident N.
06/21/2024	Contact- Document Received Received email from Manager, Kimberlee Mitchell with picture of fan added to bedroom. Sent return email.
07/01/2024	Contact- Document Received Email from William Gross re: staff issue. Sent return email.
07/01/2024	APS Referral Adult Protective Services (APS) referral made on 07/01/2024 was denied and sent to licensing. Dismissed intake #201508. Adding allegations to open investigation.
07/09/2024	Contact- Document Sent Email to and from APS Worker, Emily Poley
07/09/2024	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Staff Serena Wisner, Jocey William and William Gross, Resident I, Resident J and Resident O. Resident Q did not want to be interviewed. Staff Shawneesha Cooper and Ana Amador present.
07/09/2024	Contact- Document Sent Email to and from William Gross. Requested medication logs
07/10/2024	Contact- Document Sent Email to and from William Gross and Kimberlee Mitchell. Received copy of incident report.

07/10/2024	Contact- Document Received Email from William Gross with insulin D/C script
07/11/2024	Contact- Document Received Email from William Gross
07/15/2024	Contact- Document Received Email from APS Worker, Emily Poley
07/16/2024	Contact- Document Received Email from Complainant
07/17/2024	Contact- Document Sent Email to William Gross. Second request for medication logs. Received return email with medication logs from William Gross
07/17/2024	Inspection Completed On-site Meeting with William Gross, Shawneesha Cooper, Ana Amador and Home Manager Kimberlee Mitchell at Ridgeway to discuss special investigations and concerns
07/17/2024	Contact- Document Sent Email to APS Worker, Emily Poley
07/18/2024	Contact- Document Received Email from APS Worker, Emily Poley. Sent return email.
07/19/2024	Contact- Document Sent Email to Nurse Practitioner, Stacy Conn re: resident medications
07/21/2024	Contact- Document Received Email from Nurse Practitioner, Stacy Conn
07/23/2024	Contact- Document Received Email from Complainant. Sent return email.
07/26/2024	Contact- Document Received Email from Complainant. Sent return email.
07/29/2024	Contact- Document Received Email from Manager, Kimberlee Mitchell. She has resigned from position. Sent return email.
07/29/2024	Contact- Document Sent Email to and from William Gross

07/29/2024	Contact- Document Received Email from APS Worker, Emily Poley. Sent return email.
07/30/2024	Contact- Document Sent Email to and from William Gross re: resident funds and follow up appointment
07/30/2024	Contact- Document Received Email from APS Worker, Emily Poley. Sent return email.
08/01/2024	Contact- Document Received Email to and from Nurse Practitioner, Stacy Conn re: resident hospitalization and appointment follow up
08/01/2024	Inspection Completed On-site Unannounced onsite investigation with APS Worker, Emily Poley. Interviewed Staff, Anna Amador, Lisa Taylor, Resident I, Resident J, Resident O and Resident P
08/01/2024	Contact - Document Sent Email to and from APS Worker, Emily Poley with guardian letter
08/01/2024	Contact- Document Sent Email to William Gross
08/01/2024	Contact - Document Received Received fax and email with letter from Guardian, Marlana Geha. Requesting new cost of care due to change in services provided.
08/02/2024	Contact- Document Received Email from Marlana Geha's office
08/02/2024	Contact- Document Sent Email to Nurse Practitioner, Stacy Conn
08/02/2024	Contact- Telephone call made TC to Guardian, Marlana Geha. Left message and received return call.
08/02/2024	Contact- Document Sent Email to and from William Gross
08/05/2024	Contact- Document Received Email from Ana Amador. Received receipts for food purchases, additional fan and air conditioner

09/03/2024	Contact- Document Received Email from APS Worker, Emily Poley
09/10/2024	Contact- Document Received Emails from APS Worker, Emly Poley. APS received another referral
09/10/2024	Contact- Document Received Intake #202403 dismissed by AFC Consultant LaShonda Reed. SI already exits
09/12/2024	Contact- Document Received Email from Ana Amador with guardianship paper requested by APS Worker, Emily Poley
09/13/2024	Contact- Document Received Email from Guardian, Marlana Geha's office
09/16/2024	Contact- Document Sent Email to APS Worker, Emily Poley. Received return email. APS denied referral as they have open case.
09/17/2024	Contact- Document Sent Email to Marlana Geha's office
09/27/2024	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed new Home Manager, Demarus Mullins, Staff Kalista Martin and Resident R for SI #2024A0604027
09/27/2024	Contact- Telephone call received Returned call from Marlana Geha
10/04/2024	Contact- Document Sent Email to APS Worker, Emily Poley. Received return email. APS is not substantiating
10/04/2024	Contact- Telephone call made TC to Hospice Nurse, Merissa, from The Care Team
10/22/2024	Contact- Document Sent Email to William Gross re: recommendation and findings
10/23/2024	Exit Conference Completed exit conference with Licensee Designee, William Gross by phone.

ALLEGATION:

- **There is a Spanish speaking employee passing medications that are only in English. Staff is unable to communicate with the residents due to not speaking English.**
- **Staff may not be legal to work in United States or have had background checks.**
- **Two males are working the same shift without a female present.**

INVESTIGATION:

I received a licensing complaint regarding Ridgeway on 06/12/2024. It was alleged that employees hired are Spanish speaking only, cannot communicate with residents or staff without using their phone as translation. Many residents cannot communicate with a phone translator, they have disabilities where many cannot read or speak clearly. Medications are in English and unable to given out by someone who only speaks Spanish. New employees are not legal to work in the United States, no background checks or fingerprinting have been done. Joel is one of the staff who only speaks Spanish. Two males are working the same shift without a female present.

On 06/20/2024, a second complaint was received regarding Ridgeway. It was alleged that there is little air movement through the building during the extreme heat, there is only one small air conditioner working in dining area. The building is humid, and floors are slippery due to humidity. Building is too hot for residents and staff. On 06/21/2024, additional complaint information was received. It is alleged that there is no air-conditioning throughout the building, humidity is high and makes the floors slippery. The preparation of food is unsanitary, the cook goes outdoors to smoke, does not wash his hands upon returning to the building, the food is overcooked. Facility continues to have illegal employees fill in that only speak Spanish and cannot communicate with the residents.

On 07/02/2024, a third complaint was received. It was alleged that staff is working 14-21 plus days in a row without a day off, some are working double 16hr shifts back-to-back to back with enough time in between to rest.

On 07/02/2024, a fourth complaint was received. Stephanie Brown and Joslyn Griffin are two employees at Ridgeway Adult Foster care who are currently suspended due to their actions at the home. Joslyn had her boyfriend spend the night at the home which is not allowed. Joslyn dresses inappropriately and revealing. She has threatened to palm slap a staff member. Joslyn has been showing sexually explicit videos of her and her boyfriend to staff and residents. Joslyn runs around threatening to harm residents and staff. On 06/29/2024, Stephanie did not pass medication to Resident Q. Stephanie was drunk on shift. She slept the whole shift and refused to pass medication. She also disconnected the cameras in the common area so she could sleep. Then unplugged the camera in the medication room. It is unknown what she did in the medication room.

They are still investigating. They are checking med logs. Joslyn has been sleeping on the job. Joslyn uses inappropriate language towards residents. Resident S is a resident who is on hospice. Joslyn is telling people Resident S is going to die. Joslyn called Resident J a, “shit head” then asked if it was abuse. Stephanie drinks on the job. They have been suspended. They are not allowed on the premises. On 07/09/2024, additional complaint information was received. It was alleged that on 06/28/2024, Resident O received a double dose of two of her prescribed medications from staff. There was not enough snacks left in the facility for residents by upper management. Resident S recently returned to Ridgeway from the hospital. Ridgeway staff was supposed to have morphine ready for Resident S, due to Resident S being in hospice care. The facility was not able to properly prepare for Resident S’s discharge back into the facility. Over the weekend of 06/29/2024, staff did not have batteries for blood pressure cuffs for residents' blood pressure to be checked. The main office's locks were recently changed and access to that office has not been given to floor staff at the facility over the weekend. Resident J locks himself in the bathroom at times. Keys to open the bathroom are typically locked in the main office when office staff leaves for the day. This creates a safety hazard at the home. Another resident, Resident I, recently ran out of insulin.

On 07/16/2024, a fifth complaint was received. It was alleged that patient died under the care of Heart-to-Heart Hospice, Provider was never notified by the facility of the patient’s death. Additional information was received from intake on 07/16/2024 and it was alleged that patient was sent to the hospital and returned a couple of days later, again provider was never informed of either patient being sent out or her return.

On 07/17/2024, a sixth complaint was received. Certain staff has not had access to the medication book when passing meds for the past several days, they have had to contact other staff members on what amount of insulin to give to the residents that need insulin. There is expired canned goods that are being used.

On 08/01/2024, a seventh complaint was received. Facility only has one bathroom working for the past week. Facility does not have enough staff to run the place. Only have four staff because others have quit. Monitor after hours staff for non-English speaking to work nights and weekends, they tend to hide them when they know the state will not show up. Residents not receiving showers. Multiple medication errors due to not having trained staff. Residents feel like prisoners.

I completed an unannounced onsite investigation on 06/14/2024. I interviewed Staff, Jocey William, Janene Wackler and Kimberlee Williams, Resident D, Resident H, Resident J, Resident K and Resident L.

On 06/14/2024, I interviewed Staff, Jocey William. She indicated that they have at least two staff per shift. She stated that Staff, Joel, speaks Spanish. He works midnights and uses a translator app to communicate. He always works with someone else. Ms. William indicated there was one occasion that two men were scheduled without a female staff, however, the mistake was caught, and a female was scheduled.

On 06/14/2024, I interviewed Nurse/Manager, Janene Wackler. She was in the process of training new Manager, Kimberlee Mitchell during the onsite investigation. They indicated it was Ms. Mitchell's first day. Ms. Wackler stated that there are always at least two staff on shift. She was not aware of two males being on shift without a female present. She stated that all staff have been fingerprinted and the new manager has been fingerprinted. Ms. Wackler stated that Staff, Joel, uses translator app and works on midnights however, there is always two staff present.

On 06/14/2024, I interviewed Resident D. She indicated that staff help her and that there is a female staff available to assist with showers. Resident D stated that staff speak English at the facility.

On 06/14/2024, I interviewed Resident H. She indicated that there is always a female staff present. She stated that she does not need assistance. Resident H stated that Joel uses a translator app to communicate. He works midnights with someone else.

On 06/14/2024, I interviewed Resident J. He stated that he does not know who helps him. He indicated that staff speak English but there is new staff that do not speak English.

On 06/14/2024, I interviewed Resident K. She stated that there is always female staff available to help. She indicated that there is always staff that speak English. She stated that they do have some new staff and was not sure if they speak English.

On 06/14/2024, I attempted to interview Resident L. He did not want to be interviewed.

On 06/19/2024, I received email from William Gross. He stated that they were short staffed, so they had Joel, their Spanish speaker and family friend step in for a few days. He was always paired with someone who spoke English, and they have done interviews and are having new people start to fill in the gap.

On 06/19/2024, I received May and June 2024 staff schedules from William Gross. There have been at least two staff scheduled for day, afternoon and midnight shifts and weekdays have manager and cook during day shift. There appears to be a female scheduled during each shift.

On 06/19/2024, I received Workforce Background Checks for staff. Clearances were not provided for staff listed on the schedule including Joel, Paugi, Syrina and Michelle (last names unknown). Three staff did not have Workforce Background Checks for Ridgeway but were fingerprinted for another facilities. Hanson Lowry had clearance for North Meadows, Bruce Grubb had clearance for Haven Adult Foster Care Home and Stacy Conn had clearance for Griffith Home.

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:	On 06/19/2024, I received Workforce Background Checks for staff. Clearances were not provided for staff listed on the schedule including Joel, Paugi, Syrina and Michelle (last names unknown). Three staff did not have Workforce Background Checks for Ridgeway but were fingerprinted for another facilities. Hanson Lowry had clearance for North Meadows, Bruce Grubb had clearance for Haven Adult Foster Care Home and Stacy Conn had clearance for Griffith Home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.2407	**Staffing.**
	(1) The ratio of staff to residents shall be adequate to carry out responsibilities defined in the act and in these rules and staff ratios shall conform with requirements set by the department following study by the department and advice from the council.
ANALYSIS:	There is not enough information to determine that there has not been an adequate number of staff at Ridgeway or staff scheduled alone that only speak Spanish. I completed unannounced onsite investigations on 06/14/2024, 06/21/2024, 07/09/2024, 08/01/2024 and 09/27/2024. During onsite investigations, I found there was always at least two English speaking staff as well as female staff on shift.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.2407	**Staffing.**
	(3) A responsible person, capable of immediately responding to emergencies, shall be on the premises of each living unit of a congregate facility during sleeping hours although the person need not be awake and dressed.
ANALYSIS:	There is not enough information to determine that there has not been an adequate number of staff at Ridgeway. Staff and residents reported that Staff, Joel, does not speak English and uses translator app. However, it was reported that he was always scheduled with another English-speaking staff.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.2413	**Residents; personal care.**
	(7) A resident's dignity and privacy shall be respected in all areas. Female residents requiring assistance in activities such as dressing, bathing, and personal hygiene shall be assisted by or in the presence of another female.

ANALYSIS:	There is not enough information to determine that the facility has scheduled male staff without a female present. All residents interviewed indicated that there is female staff at the facility. There were no reports of a male assisting a female resident with personal hygiene. I completed unannounced onsite investigations on 06/14/2024, 06/21/2024, 07/09/2024, 08/01/2024 and 09/27/2024. During onsite investigations, I found there was always female staff on shift.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Building is too hot for residents and staff. The building is humid and floors are slippery due to the humidity.

INVESTIGATION:

On 06/20/2024, I emailed licensed Designee, William Gross, heat advisory information from LARA. The information was sent out by LARA to providers due to weather forecasts predicting extremely high temperatures and humidity throughout the state.

On 06/20/2024, I received email from William Gross. He alleged that terminated Nurse/Home Manager, Stacy Conn, took the A/C units with her when she left. He stated that they should not have trusted her to enter building. Mr. Gross indicated that he is reaching out to staff to buy more A/C units and humidifiers ASAP. He also stated that they have a large fan that can be used.

On 06/21/2024, I completed an unannounced onsite investigation at Ridgeway. I interviewed Home Manager, Kimberlee Mitchell, Staff Hanson Lowry, Jim Sealy and Jocey William.

On 06/21/2024, I observed that there were fans in hallway and most resident bedrooms. I requested Ms. Mitchell to provide a fan for residents that did not have one. Ms. Mitchell emailed picture of fan added to bedroom on 06/21/2024. There were air conditioning units in common area. There were also damp rid bags hung in hallway for humidity. The facility was warm and the thermometer measured 78.6 degrees Fahrenheit.

On 06/21/2024, I interviewed Home Manager, Kimberlee Mitchell. She stated that they have two air conditioning units and a dehumidifier running in basement. She had a fan in office area. She stated that Roberto and Anna visited the facility last night and brought another air conditioning unit. Ms. Mitchell stated that the kitchen is really hot for the cook, Jim. She indicated that they have water for residents and fans all around the building. They have not had any heat related illnesses.

On 06/21/2024, I interviewed Staff, Hanson Lowry. He stated that they have fans for residents. He has not received any complaints from residents being too hot.

On 06/21/2024, I interviewed Staff, Jocey William. She stated that the building was very hot. One resident was saying it was too hot for them. They brought two new fans yesterday; however, the rest have been there. They also added damp rid for the slippery floor.

On 06/21/2024, I interviewed Cook, Jim Sealey. He stated that the facility does not have central air and gets pretty warm. He indicated two new fans were added to the end of the hallway.

On 06/21/2024, I interviewed Resident D. She stated that it is freezing in her room at night. Resident D was covered in a blanket.

On 06/21/2024, I interviewed Resident G. She stated that it was warm in building but now it is cool. She stated that they brought in new fans yesterday.

On 06/21/2024, I interviewed Resident M and Resident N who were sharing a room. They indicated that they temperature in room was ok now, however, the last couple days were hot. They did not have a fan in their room. I requested Home Manager, Kimberlee Mitchell, to get residents a fan.

APPLICABLE RULE	
R 400.2431	**Home environment.**
	(5) Dining, bath, sitting, living, and recreation rooms shall be maintained by an adequate central heating system or its equivalent at a temperature range of 68-72 degrees Fahrenheit during nonsleeping hours.
ANALYSIS:	On 06/21/2024, I completed an unannounced onsite investigation during daytime hours. The temperature in common area measured 78.6 degrees Fahrenheit. Staff and residents interviewed stated that the facility had brought in additional fans and air conditioners the day before. There was a heat advisory during the time the complaint was received.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Resident O received a double dose of her medication.**
- **Resident I is not receiving her insulin.**
- **There are multiple medication errors due to untrained staff. Staff do not have access to medication book.**
- **Guardian and provider are not being notified of resident hospitalizations and death.**
- **Staff did not have batteries for blood pressure cuff.**

INVESTIGATION:

On 07/09/2024, I completed an unannounced onsite investigation. I interviewed Staff, Serena Wisner and Jocey William. During the onsite investigation, I observed that the staff had access to medication log which was kept in the medication room with medication cart. I reviewed medication logs with staff. Staff indicated that they only had access to the current July 2024 medication logs.

On 07/09/2024, I interviewed Serena Wisher. She stated that she has worked at facility for one month and is medication trained. She can access medication logs. She was not aware of Resident O receiving double dose of medication. She believed that Resident I ran out of insulin and that the manager is waiting for the refill. She attempted to contact manager for additional information during onsite, however, manager did not answer. She stated that manager was likely sleeping due to working a late shift. Ms. Wisher stated that they now have rechargeable batteries for blood pressure cuff.

On 07/09/2024, I interviewed Staff, Jocey William. She can access medication logs. She stated that she was not aware of Resident O receiving double dose of medication. She also was not sure when Resident I's insulin was being refilled. Ms. William indicated that they have working blood pressure cuff.

On 07/09/2024, I interviewed Resident O. She stated that she is getting medication as prescribed. Resident O denied getting a double dose of her medication. She stated that she is doing "ok" at facility. On 08/01/2024, I interviewed Resident O with APS Worker, Emily Poley. Resident O again stated that she is getting her medication as prescribed.

On 07/09/2024, I interviewed Resident I. She stated that she believed she received her insulin last night. She also stated that the court has ordered "starvation" for her. Resident I indicated that she is having tooth and gum pain. Resident I stated that medication is not helping and indicated it hurts to eat. She has not observed any inappropriate behavior from staff.

On 07/09/2024, I reviewed Resident I's July 2024 medication log during onsite investigation. Resident I's medication log had no initials for insulin for July 2024. Resident I's medication log was not initiated by staff in July 2024 for Humalog 100

Units- Inject six units subcutaneously before meals and at bedtime, Insulin Aspart 100 Unit/m Novolog U-100 Insulin-aspart- Per sliding scale. Resident I's July 2024 medication log was also missing staff initials on 07/06/2024 for Buspirone 5 mg tab (6PM), Docusate Sodium 100 mg (8PM), Famotidine 20 mg (8PM), Haloperidol 10 mg (8PM) and Senna-Time tab 8.6 mg (8PM). Buspirone 5 mg tab was handwritten for a second time on log with no instructions, however, included same administration times of 6:00 am and 6:00 pm. Staff initials were missing on 07/06/2004 for 6AM and 6PM.

On 07/09/2024, I reviewed Resident C's July 2024 medication log. Resident C's medication log was missing staff initials for the following medications:

- Losartan Pot Tab 25 mg- 07/06
- Metoprolol Succ Er 50 mg- 07/06
- Olanzapine Tab 5 mg- 07/05 (8PM), 07/06
- Citalopram 10 mg (no instructions listed)- 07/06
- Quetiapine Fumarate 25 mg (no instructions listed)-07/07

On 07/09/2024, I reviewed Resident D's July 2024 medication log. Resident D's medication log was missing staff initials for the following medications:

- Quetiapine Fumarate 50 mg- 07/06
- Simvastatin 40 mg tab- 07/06
- Vitamin C tab 1000 mg- 07/01

On 07/09/2024, I reviewed Resident H's July 2024 medication log. Resident H's medication log was missing staff initials for the following medications:

- Clobazam 10 mg tab- 07/06, 07/07
- Divalproex 250 er tab- 07/06 (12PM, 8PM), 07/07 (12PM), 07/08 (8PM)
- Hydroxyz Hcl Tab 10 mg- 07/06
- Levetiracetam Tab 500 mg- 07/06 (8PM)
- Sm Vit C tab 1000 mg- 07/06 (8PM)

On 07/09/2024, I reviewed Resident N's July 2024 medication log. Resident N's medication log was missing staff initials for the following medications:

- Atorvastatin 20 mg tablet- 07/06
- Benztropine Tab 1 mg- 07/006 (8PM)
- Resident N's medication log indicates to check and chart blood pressured twice a day. His blood pressure was only taken once per day on 07/05, 07/06, 07/08. Log also indicates that his blood sugar should be taken twice a day. It was only taken once on 07/05 and 07/08 and was not taken on 07/06.
- Eliquis 5 mg tab- 07/06 (8PM)
- Famotidine 20 mg tab- 07/06 (8PM)

- Lithium Carb 300 mg Cap- 07/06- Medication log instructions state to take capsule by mouth twice daily (9am and 5pm). Administration times are listed on log as 6:00 am and 6:00 pm.
- Melatonin Tab 5 mg- 07/06
- Metoprolol Tar Tab 25 mg- 07/06 (8PM), 07/08 (6AM)
- Midodrine 10 mg tab- 07/06 (8PM), 07/08 (6AM, 12PM)
- Olanzapine Tab 15 mg- 07/06
- Refresh Tears- 07/01 (4PM, 8PM), 07/05 (8PM), 07/06 (4PM, 8PM), 07/07 (6AM, 12PM)

On 07/09/2024, I reviewed Resident Q's July 2024 medication log. Resident Q's medication log was missing staff initials for the following medications:

- Amlodipine 10 mg- 07/01, 07/02, 07/04. 07/07, 07/08
- Asprin 81 mg Tab- 07/01, 07/03, 07/04, 07/05, 07/06
- B-12 2500 Mcg- 07/01, 07/03, 07/04, 07/05, 07/06
- Bupropion Er 100 mg- 07/01, 07/03, 07/04, 07/05, 07/06
- Donepezil HCL 10 mg- 07/01, 07/02, 07/06, 07/07, 07/08
- Duloxetine 60 mg- 07/01, 07/06
- Lisinopril 20 mg- 07/01, 07/06
- Memantine 10 mg 07/01, 07/02 (8PM), 07/04 (8PM), 07/06 (6AM) 07/07 (8PM), 07/08 (8PM)
- Mybertrig 25 mg- 07/01, 07/06
- One Daily Vitamin- 07/01, 07/06
- Rosuvastatin 20 mg- 07/01, 07/02, 07/04, 07/07, 07/08
- Vitamin D3- 07/01, 07/06
- Metformin HCL 500mg Monday-Friday- 07/01, 07/02, 07/04, 07/05
- Metformin HCL 500 mg- Saturday and Sunday- 07/06, 07/07

On 07/09/2024, I received Resident T's July 2024 medication log. Resident T's medication log was missing staff initials for the following medications:

- Budes/Formot Aer 160-4.5 Symbicort- 07/01 (6PM), 07/02(6PM), 07/05(6PM), 07/06, 07/07 (6AM)
- Magnesium Oxide 420 mg tab- 07/05 (8PM), 07/06(8PM)
- Sodium Chloride 1 gm- 07/05 (8PM), 07/06 (8PM)
- Resident T's medication log also indicated that he should have his blood pressure checked and charted twice daily. His blood pressure has only been taken one time per day in July 2024 and was not taken on 07/04/2024 per medication log.

On 07/09/2024, I reviewed Resident U's July 2024 medication log. Resident U's medication log was missing staff initials for the following medications:

- Oscal 500- 07/04

- Risperidone Tab 1mg- 07/06 (8PM)
- Risperidone Tab 2 mg- 07/06 (8PM)
- Vitamin D3 1,000 unit tab- 07/06 (8PM)
- Citalopram 40 mg (no instructions)- 07/01 (4PM), 07/06 (4PM)
- Atorvastatin 10 mg tab- 07/03, 07/04, 07/05, 07/06
- Benztropine Tab 1 mg- 07/01
- Lorazepam Tab 0.5 mg- 07/06 (8PM), 07/08(6AM)
- Metoclopramide 10 mg tab indicates that medication should be given 3 times daily. The times 6:00 am and 8:00 pm are listed and middle time is crossed out in black marker. The medication log indicates that on 07/06 the medication was only given one time at 6:00 am.
- Metoprolol Tar Tab 25 mg- 07/02
- Olanzapine Tab 10 mg- 07/06
- Resident U's medication log indicates that their blood pressure should be checked and charted twice per day. Blood pressure was only taken once per day from 07/01-07/05, and not taken on 07/06/2024.

On 07/09/2024, I reviewed Resident V's July 2024 medication log. Resident V's medication log was missing staff initials for the following medications:

- Divalproex 250 mg- 07/04 (6AM), 07/06 (8PM)
- Furosemide Tab 40 mg- 07/06 (8PM)
- Metformin Tab 500 mg Er- 07/06
- Metoprolol Tar Tab 50 mg- 07/06 (8PM)
- Quetiapine Tab 300 mg- 07/06
- Tamsulosin Cap 0.4 mg- 07/08
- Amlodipine Besylate 5 mg- 07/06, 07/07, 07/08
- Ammonium Lactate 12% lotion- 07/01, 07/06, 07/07, 07/08
- Atorvastatin 10 mg tab- 07/06
- Triamcinolon 0.1% Ointment indicates to apply 1 small amount topically twice daily. Medication is not initiated as given by staff at all during July 2024.

On 07/09/2024, I reviewed Resident W's July 2024 medication log. Resident W's medication log was missing staff initials for the following medications:

- Atorvastatin Tab 20 mg- 07/06
- Mirtazapine Tab 7.5 mg- 07/06
- Zinc Sulfate Tab 220 mg- 07/09 (6AM)
- Ariprazole 2 mg tab- 07/01, 07/08

On 07/09/2024, I reviewed Resident X's July 2024 medication log. Resident X's medication log was missing staff initials for the following medications:

- Aspirin 81 mg- 07/01
- Folic Acid- 400 mg- 07/01

- Losartan potassium 50 mg- 07/01
- Memantine HCL Er 28 mg- 07/01
- Rexulti 2 mg- 07/01
- Rosuvastatin 10 mg- 07/01
- Sertraline Hcl- 07/01
- Trazadone Hcl 50 mg- 07/01, 07/02
- Vitamin B-12 500 mcg- 07/01, 07/06, 07/08

On 07/09/2024, I requested staff to contact Licensee Designee, William Gross while I was at facility due to concerns that medication log indicated that Resident I had not received insulin in July 2024. Mr. Gross arrived at facility with Ana Amador and Shawneesha Cooper. I requested Mr. Gross to investigate Resident I's insulin immediately. He stated that he believed the medical provider had been contacted regarding medication. I sent a follow up email to Mr. Gross on 07/09/2024 and again requested he update me regarding inulin and that Resident I be seen by doctor immediately if she has not been given insulin as prescribed. I also requested that they follow up with doctor as Resident I reported significant tooth and gum pain during interview, making it difficult for her to eat.

On 07/09/2024, I received an email from William Gross. He indicated that Resident I's insulin had not been filled due to need for prior authorization approval. He indicated that on 05/29/2024, pharmacy sent a prior authorization request to Nurse Practitioner, Stacy Conn and that the prior authorization has not been completed. He indicated that Manager, Kimberlee Mitchell, contacted the pharmacy again on 07/02/2024 and the pharmacy indicated they would contact doctor again regarding prior authorization. He stated that on 07/09/2024, Area Manager, Shawneesha Copper, contacted the pharmacy as was told they have not heard from Nurse Practitioner to complete the prior authorization. Mr. Gross indicated that he reached out to Dr. Rahbar who oversees Ms. Conn and called the guardian. He stated that he is waiting to hear from guardian and that Ms. Conn contacted him and stated she has submitted multiple authorizations. Mr. Gross stated that Ms. Conn visited resident within the past month and is aware of the issue. Mr. Gross indicated that they will be tracking Resident I's blood sugar in the interim and if it gets too high, they will send her to the hospital. Resident I is currently doing well.

On 07/10/2024, I received email from licensee designee, William Gross. Mr. Gross sent a copy of prescription dated 07/10/2024 from Nurse Practitioner, Stacy Conn, discontinuing insulin for Resident I.

On 07/10/2024, I received email from William Gross with medical consultation report for Resident I. The report indicates that Resident I was seen by Nurse Practitioner, Stacy Conn on 06/26/2024 for constipation.

On 07/10/2024, I received copy of incident report by email from Kimberlee Mitchell. I requested that report be signed by licensee, William Gross, and resent. Incident report notes that Resident S passed away on Heart-to-Heart hospice on 07/05/2024. The

report indicates that Home Manager, Kimberlee Mitchell and Heart to Heart Hospice were notified. The report does not note a day or time that guardian was contacted.

On 07/17/2024, I had face to face meeting with licensee designee, William Gross, Ana Amador, Shawneesha Cooper and Kimberlee Mitchell at Ridgeway. I received copy of Resident P's discharge papers from Henry Ford Hospital. The discharge papers indicate that Resident P was at hospital from 07/08/2024 - 07/10/2024 for Abdominal Pain and Emesis. The discharge instructions state to follow up with primary care physician within the next three days and to continue taking the rest of her prescribed home medications. The licensee did not have verification that guardian was contacted when Resident P was hospitalized, or that Resident P was seen for follow up with primary care physician within three days of discharge. Licensee Designee, William Gross and his staff expressed difficultly working with primary care physician, Dr. Rahbar and his Nurse Practitioner, Stacy Conn. He believes that better medical care can be provided to residents by other providers. He is in process of contacting resident guardians to try to switch their medical providers. Mr. Gross indicated that he believes the high number of complaints is due to him terminating Stacy Conn as Home Manager. She remained Nurse Practitioner for many of the residents after she was terminated as Home Manager. He alleged that she may have been stealing and that there were missing supplies. He alleged that staff were intentionally making medication errors in book and then reporting them to try and get facility in trouble. Mr. Gross stated that all medications have been accounted for, however, some staff would pass medications and then intentionally not sign. He indicated that Ms. Conn was calling facility after hours to keep track of what was happening. Licensee also indicated during meeting that they have both manual and digital blood pressure cuffs for staff to use.

On 08/01/2024, I sent email to Nurse Practitioner, Stacy Conn. She confirmed that her and guardian had not been notified about Resident P's hospitalization. She also indicated that the last evening she seen Resident I is when she complained of tooth/dental pain and stated she needs to get her teeth pulled. She told Resident I she would reach out to her guardian and let them know she needs to see a dentist. Ms. Conn indicated that she never received a reply from her guardian. No staff ever informed her Resident I was having dental pain or eating problems.

On 08/01/2024, I completed unannounced onsite investigation with APS Worker, Emily Poley. We met with Staff, Ana Amador and Interim Manager, Lisa Taylor in manager's office. I observed several medications in office including boxes of pill packs on floor, pill packs on chair, packs of medication on bookshelf, packs of medication on top of cardboard box and bottles of medication on floor. Ms. Amador and Ms. Taylor stated that there was a recent delivery and staff was going through medications and discarding some, I informed staff that medications need to be secured in a locked cabinet or drawer as the office can be locked, however, there are people coming in and out of this room.

On 09/13/2024, I received email from guardian, Dr. Marlana Geha's office. The email indicated that Resident P was sent to the hospital on 07/08/2024, with no calls to their office to inform them. Resident P was sent with no Letters of Guardianship. Dr. Geha spoke with William Gross, the new owner, to resolve this and send the Letters of Guardianship, which he stated he would. This did not happen.

APPLICABLE RULE	
R 400.2402	**Change in health and accidents.**
	(1) If an accident or sudden adverse change in a resident's physical condition or adjustment occurs, a congregate facility shall obtain needed care immediately and notify the responsible relative and the individual or agency responsible for placing and maintaining the resident in the congregate facility.
ANALYSIS:	Resident P's discharge papers from Henry Ford Hospital. indicate that Resident P was at the hospital from 07/08/2024 - 07/10/2024 for Abdominal Pain and Emesis. Both guardian, Marlana Geha, and nurse practitioner, Stacy Conn, indicated that they were not notified about Resident P's hospitalization. On 07/17/2024, A face to face meeting was held with licensee designee, William Gross, and staff at Ridgeway. They did not have any information regarding guardian and medical provider being contacted. In addition, Resident P was not seen for follow up appointment with primary care doctor within three days as instructed in discharge papers.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.2405	**Deaths of residents.**
	When a resident dies, a congregate facility licensee or administrator shall notify immediately the resident's physician, the next of kin or legal guardian and the person or agency responsible for placing and maintaining the resident in the congregate facility. Statutes applicable to the reporting of sudden or unexpected death shall be observed. The death shall be reported to the department within 72 hours.

ANALYSIS:	Resident S's death was not reported within 72 hours. Resident S passed away on 07/05/2024 on Heart-to-Heart hospice. An incident report was not sent to licensing until 07/10/2024. The report does not include a date or time that the guardian was notified.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.2415	**Health care of residents.**
	(4) All prescription medication shall be prescribed by a licensed physician. Medication shall be administered and safeguarded in accordance with the instructions of a resident's physician.
ANALYSIS:	Resident medication logs have multiple errors. On 07/09/2024, I reviewed medication logs for Resident C, Resident D, Resident H, Resident I, Resident N, Resident Q, Resident T, Resident U, Resident V, Resident W and Resident X. Multiple staff initials were missing from medication logs as well as missing instructions. Also, Resident N was missing checks on medication log for blood pressure and blood sugar. Resident T and Resident U were missing checks for blood pressure. On 07/09/2024, I reviewed Resident I's July 2024 medication log during onsite investigation. Resident I's medication log had no initials for insulin for July 2024. Resident I's medication log was not initiated by staff in July 2024 for Humalog 100 Units- Inject six units subcutaneously before meals and at bedtime, Insulin Aspart 100 Unit/m Novolog U-100 Insulin-aspart- Per sliding scale. Resident I's insulin was discontinued the next day by Nurse Practitioner, Stacy Conn. Resident I's July 2024 medication log had Buspirone 5 mg tabs listed twice. Buspirone 5 mg tab was handwritten for a second time on log with no instructions, however, included same administration times of 6:00 am and 6:00 pm. Resident N's July 2024 medication log indicates they are prescribed Lithium Carb 300 mg cap. Medication log instructions state to take capsule by mouth twice daily (9am and 5pm). Administration times are listed on log as 6:00 am and 6:00 pm. Resident U's July 2024 medication log indicates they are prescribed Metoclopramide 10 mg tabs and that medication

	should be given 3 times daily. The times 6:00 am and 8:00 pm are listed and middle time is crossed out in black marker. The medication log indicates that on 07/06 the medication was only given one time at 6:00 am. In addition, on 08/01/2024, I completed unannounced onsite investigation with APS Worker, Emily Poley. I observed several packs of resident medications throughout the office. Staff reported that they were in the process of going through medications and discarding some, however, medications were observed on bookshelf, chair, floor, and in boxes.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR # 2024A0604017 dated 07/15/2024**

ALLEGATION:

- **Staff are drinking and sleeping on the job. They are speaking inappropriately to residents, dressing inappropriately and a boyfriend is visiting.**
- **Resident J locks himself in bathroom and staff do not have keys.**

INVESTIGATION:

On 07/01/2024, I received email from licensee designee, William Gross. Mr. Gross wanted to report concerns regarding staff, Jozlyn and Stephanie (last names unknown). He indicated that these two staff in addition to Stacey Conn are maliciously traying to have him lose license due to retaliation for letting her go. Mr. Gross stated that there have been reports these two staff allowing boyfriend to spend the night, inappropriate clothing, sleeping, medication errors and other inappropriate behaviors. He also stated that yesterday they found someone had broken into their locked office and a police report was filed. I informed Mr. Gross that a report needs to be made to APS if abuse/neglect is being alleged by staff. On 07/01/2024, Mr. Gross confirmed that both Jozlyn and Stephanie were taken off schedule. Both staff no longer work for Ridgeway.

On 07/09/2024, I interviewed Serena Wisher. She stated that they always have access to key if Resident J locks himself in bathroom. There are keys available in office, medication room and kitchen.

On 07/09/2024, I interviewed Staff, Jocey William. She indicated that they have access to keys if Resident J locks himself in bathroom There are keys in kitchen and medication room.

On 07/09/2024, I interviewed Resident I. She has not observed any inappropriate behavior from staff.

On 07/09/2024, I interviewed Resident J. He stated that he has not been locked in bathroom recently. He indicated that maybe a month ago he was stuck inside bathroom for a couple hours. He kept knocking and staff opened door. Resident J denied that he has been called any names by staff. He indicated that he has not seen any inappropriate behavior from staff. He did not have any concerns regarding facility.

On 07/09/2024, I interviewed Resident O. She has not observed staff doing anything inappropriate.

On 07/09/2024, I attempted to interview Resident Q. Resident Q did not want to be interviewed.

On 09/27/2024, I completed unannounced onsite investigation I interviewed new Home Manager, Demarus Mullins, Staff Kalista Martin and Resident R for pending SI #2024A0604027. They did not report any concerns regarding current staff at Ridgeway.

On 10/04/2024, I interviewed Hospice Nurse, Merissa, from The Care Team. She indicated that she has not seen any concerns regarding staff at Ridgeway.

APPLICABLE RULE	
R 400.2412	**Care of residents.**
	(4) A resident shall be treated with dignity, and his personal needs, including protection and safety, shall be attended to at all times.
ANALYSIS:	There is not enough information to determine that Resident J locks himself in bathroom and staff do not have keys. Staff interviewed stated that they have access to bathroom keys if needed. On 07/01/2024, I received email from licensee designee, William Gross. Mr. Gross wanted to report concerns regarding staff, Jozlyn and Stephanie (last names unknown). He indicated that these two staff in addition to Stacey Conn are maliciously trying to have him lose his license due to retaliation for letting her go. Mr. Gross stated that there have been reports these two staff allowing a boyfriend to spend the night, inappropriate clothing, sleeping, medication errors and other inappropriate behaviors. On 07/01/2024, Mr. Gross confirmed that both Jozlyn and Stephanie were taken off schedule and have since been terminated.
CONCLUSION:	**VIOLATION ESTABLISHED (BUT CORRECTED)**

ALLEGATION:

Facility only has one bathroom working. Residents are not receiving showers.

INVESTIGATION:

On 08/01/2024, I completed an unannounced onsite investigation with APS Worker, Emily Poley. Staff, Ana Amador, and Interim Manager, Lisa Taylor, were present. Staff indicated that the facility currently has three working bathrooms. Residents can use the staff bathroom in the kitchen. During the onsite investigation, I observed bathrooms. Bathroom #1 appeared to be in process of having repairs made and toilet was removed. Bathroom #2 was also reported by staff to be currently out of order. I also observed the staff bathroom that was in kitchen area. The bathroom did have a shower; however, the shower was filled with many items making it unusable.

On 08/01/2024, I interviewed Resident I. She stated that she can shower every day or every other day with one bathroom being down.

On 08/01/2024, I interviewed Resident J. He indicated that he could shower once a day.

On 08/01/2024, I interviewed Resident O. She indicated that she could shower whenever she wants. She can still take shower with one bathroom not working.

On 08/01/2024, I interviewed Resident P. She stated that she can shower weekly.

APPLICABLE RULE	
R 400.2413	**Residents; personal care.**
	(2) A resident shall receive a bath or shower weekly and be afforded the opportunity for daily bathing.
ANALYSIS:	There is not enough information to determine that residents are not able to shower weekly or do not have the opportunity to shower daily. None of the residents interviewed stated that they did not bathe weekly or have access to shower.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.2431	**Home environment.**
	(8) A toilet, lavatory, and bathing or showering facility shall be provided for each 8 adults in a congregate facility including live-in staff and residents. At least 1 toilet and

	lavatory shall be provided on each floor having resident bedrooms.
ANALYSIS:	On 08/01/2024, I completed an unannounced onsite investigation with APS worker, Emily Poley. During the onsite investigation, Bathroom #1 and Bathroom #2 were out of order. Staff indicated that residents could use the staff bathroom in kitchen, however, the shower was filled with items and clearly not in use. The facility did not have enough working bathrooms for a capacity of 30 residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Preparation of food is unsanitary. Cook does not wash his hands after he smokes. Food is overcooked and expired can goods are served.

INVESTIGATION:

On 06/21/2024, I interviewed Home Manager, Kimberlee Mitchell. She stated that she has not viewed any unsanitary food preparation. She stated that the Cook, Jim, does smoke but she has seen him wash his hands. Ms. Mitchell indicated that she has not seen any issues with food but there is not a big variety. She stated that they have the same meat a lot, pork loin, and she does see fruits and vegetables being served. She has also seen fresh watermelon and canned fruit cocktail and canned vegetables. She has not seen any inedible food.

On 06/21/2024, I interviewed Cook, Jim Sealey. He stated that they have dish detergent and hand soap. There is a bathroom in kitchen where he can wash his hands. No one smokes and does not wash their hands. During the onsite investigation, I observed that the kitchen was clean and there was hand soap and dish soap available. The kitchen floor was not slippery.

On 08/01/2024, I completed an unannounced onsite investigation with APS Worker, Emily Poley. We observed food in the kitchen and storage area. I did not find any expired food or canned goods at facility. There were also snacks for residents.

APPLICABLE RULE	
R 400.2471	**Quality of meals.**
	(1) A minimum of 3 regular, nutritious, attractively prepared meals shall be provided daily. No more than 15 hours shall elapse between the evening and morning meal. Meals shall be of proper form, consistency, and temperature. Meals shall meet the general requirements for nutrition published

	by the department or currently found in the recommended daily dietary allowances, food and nutrition board, national academy of science.
ANALYSIS:	There is not enough information to determine that food preparation is unsanitary. I completed an unannounced onsite investigation on 06/14/2024, 06/21/2024, 07/09/2024, 08/01/2024 and 09/27/2024. During onsite investigations, I have not observed the kitchen to be dirty or observed any unsanitary food preparation. Also, on 08/01/2024, I observed food in the kitchen and storage area. No expired food or canned goods were observed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/17/2024, I had a face-to-face meeting with licensee designee, William Gross, Ana Amador, Kimberlee Wiliams and Shawneesha Williams at Ridgeway to discuss special investigations. During the meeting, Mr. Gross alleged that all resident funds went missing after nurse practitioner, Stacy Conn, was terminated. He also alleged that she may have been stealing supplies and misusing supply money. Mr. Gross indicated that a police report had not been made. I informed Mr. Gross that a police report should be made regarding missing funds and that guardians should be notified. Mr. Gross did not know which residents were missing funds.

On 07/30/2024, I received an email from William Gross. He indicated that they do not have list of residents missing funds because Ms. Conn took list when she came into the office on 06/06/2024. Mr. Gross stated that a police report was made on 07/22/2024 and that the Michigan State Police are investigating.

On 08/01/2024, I completed an unannounced onsite investigation with APS Worker, Emily Poley. Staff, Ana Amador, stated that secretary was working on information regarding resident funds. She believes funds went missing the end of May 2024. I requested to review current residents' funds being held at facility. Ms. Amador stated that they were being kept in locked box in office. Ms. Amador and staff present were unable to open lockbox during onsite where funds were allegedly being held.

On 09/27/2024, I spoke to Guardian, Dr. Marlana Geha by phone. She is the guardian for Resident E, Resident L, Resident N and Resident P. Ms. Geha stated that Ridgeway holds cash for her residents at the facility. Ms. Geha stated that she was not aware that resident funds were missing. She was never contacted by Ridgeway regarding the missing resident funds.

On 10/04/2024, I received email from APS Worker, Emily Poley. Ms. Poley indicated that they did not substantiate due to them rectifying concerns.

APPLICABLE RULE	
R 400.2421	**Residents' funds; access; safekeeping.**
	(1) A resident shall have access to and use of personal funds belonging to him in reasonable amounts, including immediate access to at least 5.00 of his personal funds. Exceptions shall be subject to provisions of the assessment plan.
ANALYSIS:	On 07/17/2024, licensee designee William Gross alleged that resident funds were taken by Nurse Practitioner, Stacy Conn. He had not made a police report and guardians were not notified. On 08/01/2024, I requested to review current resident funds. Ana Amador and staff present were unable to open box where funds were allegedly being stored. The residents did not have access to at least $5.00 of their personal funds.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.2457	**Resident funds and valuables.**
	The resident funds and valuables record shall indicate the date and receipt number of all deposits and dispersals, and the amount and description of monies or valuables or both given for safekeeping for each resident. It shall also include any written authorization by the resident for charges made by the congregate facility to the fund.
ANALYSIS:	On 08/01/2024, I requested to review current resident funds. Ana Amador and staff present were unable to open the box where funds were allegedly being stored. The facility was unable to provide any resident funds records.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.2412	**Care of residents.**
	(2) Residents shall be assured privacy and protection from moral, social, and financial exploitation.

ANALYSIS:	Residents have not been protected from financial exploitation at Ridgeway. On 07/17/2024, licensee designee William Gross alleged that resident funds were taken by nurse practitioner, Stacy Conn. It should be noted that no information or evidence has been provided to prove Ms. Conn took the resident funds. Mr. Gross has been unable to provide information as to who is missing funds and how much money was taken. A police report was not made until 07/22/2024 until Mr. Gross was instructed to report the missing funds. Also, on 08/01/2024 staff present were unable to access resident funds being held at facility. The residents did not have access to their funds being held.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 08/01/2024, I completed an unannounced onsite investigation with APS Worker, Emily Poley. During the onsite investigation there was a strong smell of urine throughout the building. Also, the bedrooms were unkept and many of the beds were in disarray. One of the beds was soaked in urine. I also observed two beds in Resident O's room that needed repair. The beds are sagging in middle and had duct tape on them.

On 09/03/2024, I received email from APS Worker, Emily Poley. She indicated that she was at facility last week and there was a big improvement from prior visit. She stated that floors and tabletops were clean and there was no urine smell. Some of the residents had new bed frames and one bathroom was repaired. Ms. Poley indicated that she spoke to a couple new staff who stated that things are getting better.

I completed an exit conference with Licensee Designee, Willam Gross, on 10/23/2024 by phone. Mr. Gross is aware of recommendation for provisional license and findings and indicated that he would like to work with licensing to get back to a regular license. I informed Mr. Gross that a copy of special investigation report would be mailed once approved.

APPLICABLE RULE	
R 400.2431	**Home environment.**
	(2) Furnishings and housekeeping standards shall be such that a congregate facility presents a comfortable, clean, and orderly appearance.

ANALYSIS:	On 08/01/2024, I completed an onsite investigation with APS worker, Emily Poley. There was a strong smell of urine throughout the building. Also, the bedrooms were unkept and many of the beds were in disarray. One of the beds was soaked in urine. I also observed two beds in Resident O's room that needed repair. The beds are sagging in the middle and had duct tape on them.
CONCLUSION:	**VIOLATION ESTABLISHED**

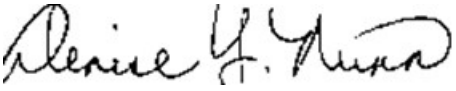
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action, I recommend issuance of a provisional license.

10/23/2024

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



10/23/2024

Denise Y. Nunn — Date
Area Manager