GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 20, 2024

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

RE: License #: AS500283894
Investigation #: 2024A0604025
North Meadows

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 #:	AS500283894
Investigation #:	2024A0604025
Complaint Receipt Date:	09/16/2024
Investigation Initiation Date:	09/16/2024
Report Due Date:	11/15/2024
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:	North Meadows
Facility Address:	28400 Bordman Road Richmond Township, MI 48062
Facility Telephone #:	(586) 784-8890
Original Issuance Date:	08/29/2006
License Status:	REGULAR
Effective Date:	06/27/2023
Expiration Date:	06/26/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility has inadequate staffing and caregivers. Staff have been found sleeping on shift. Residents have been isolated to rooms and found wandering outside.	Yes
A man was found in staff Adriennes's bedroom.	No
Residents are not receiving pain medication.	No
There is a lack of resident hygiene.	No
Residents are missing cigarettes.	No
The home's television, stove and air conditioner are broken.	No
There is not enough seating for residents in living room and dining room.	No
The shower does not meet ADA requirements.	No
Furniture that was infested with bed bugs has been on side of home for several months.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/16/2024	Special Investigation Intake 2024A0604025
09/16/2024	Special Investigation Initiated - Letter Email to Adult Protective Services (APS) worker, Emly Poley re: APS referral. No intake for address. Do not have resident name
09/18/2024	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Staff, Sherry Duncan, Area Manager, Shawneesha Cooper, Resident A, Resident B, Resident C, Resident D and Resident E
09/19/2024	APS Referral Adult Protective Services (APS) referral made
09/19/2024	Contact - Document Sent Email to William Gross requesting employee and resident records
09/25/2024	Contact - Document Received Email from William Gross with employee records and resident records

10/01/2024	Contact - Document Received Received APS referral denial letter by email
10/31/2024	Contact- Document Sent Email to William Gross requesting current staff list and oven repair invoice. Received return email from William Gross with staff list and invoice.
11/01/2024	Contact- Document Sent Email to William Gross
11/04/2024	Contact- Document Received Email from William Gross. Sent return email
11/06/2024	Contact- Document Sent Email to William Gross
11/18/2024	Contact- Document Sent Email to William Gross
11/20/2024	Exit Conference Completed exit conference with William Gross by phone. Left message and received return text messages.

ALLEGATION:

- **The facility has inadequate staffing and caregivers. Staff have been found sleeping on shift. Residents have been isolated to rooms and found wandering outside.**
- **A man was found in staff Adriennes's bedroom.**

INVESTIGATION:

I received a licensing complaint regarding North Meadows on 09/16/2024. It was alleged that approximately two and a half months ago, the caregiver employed at the facility was working seven days a week without respite, continuously being promised by management, William Gross, that help was being recruited, while not being paid for hours worked. That employee is no longer working at the facility after demanding safer working conditions, not receiving them, and being let go from the company. Over the past month, there has been inadequate caregivers employed at the facility and the caregiver that is currently residing at the facility, Adrienne, is unable to handle the level of care needed for six residents. It is observed that there is a decline in the residents' overall health and level of care being provided. The Complainant has noticed lack of hygiene, isolation of residents to their rooms, and complaints from residents of not receiving their pain medication. Resident's cigarettes are suddenly missing and being

reported to us by Adrienne that other residents are stealing and smoking them, but that would seem impossible since it is the caregiver's responsibility to hold the packs and distribute at the appropriate smoke times. Last week staff, Adrienne, was found sleeping in her room with the door closed while residents were left alone in the living room and kitchen. The front door to the facility was unlocked and open. Adrienne was unavailable to give resident pain medication. Resident was found on the ground, outside next to a garbage can. Several other residents were wondering the property close to the road. Resident was pulling the garbage cans up from the road when he fell. This is unacceptable and unsafe. A truck has been parked on side of house for several weeks. There are piles of furniture on the side of the house that have been there for over five months that were removed for being infested with bed bugs. Staff, Adrienne, was found in her room and a man was seen in her bed that does not live at that facility. Adrienne identified man as a "client of hers" and that she provides home health care for him. He was clearly hiding out in her room and did not belong there. Additionally, the only men she should be providing health care for are the men residing in that facility.

Other concerns are that the main television is not working for several days, the stove/ oven in the facility has been broken for over a week, the air conditioner has been broken for two days. There is not enough seating in the facility for six residents, caregivers and visitors. There is only one couch and one recliner chair. The kitchen table is too small for the residents, and they literally touch elbows during mealtimes. With the use of walkers and wheelchairs, it is incredibly unsafe and very difficult to move around the dining table. These concerns continue to go unheard and unaddressed by management, William Gross. Over the past month, there has been a critical decline in care to every resident at that facility. Management, William Gross, claims to be working on staffing and being more present at the facility while these changes are underway, but we are not seeing much of William or adequately qualified caregivers to provide safe and individualized care to six residents. Also, the community bathroom shower is an extremely high fall risk due to the showers age, width, and height. It has not been updated properly to accommodate ADA standards.

I completed an unannounced onsite investigation on 09/18/2024. I interviewed Staff, Sherry Duncan, Area Manager, Shawneesha Cooper, Resident A, Resident B, Resident C, Resident D and Resident E. During the onsite investigation, I observed residents on the porch, in living room and in their bedrooms. Residents were not isolated to their bedrooms or close to the road.

On 09/18/2024, I interviewed Staff, Sherry Duncan. She stated that there are currently five residents at North Meadows. She started two days ago and has not met other staff. Ms. Duncan stated that she has had a clearance before but was not fingerprinted when she started. Ms. Duncan stated that she is CPR/First Aid trained, however, her training needs to be renewed. She indicated that she has not had a TB test or medical statement completed since starting at North Meadows. Ms. Duncan stated that she has her own cigarettes and indicated that she was not aware of any missing cigarettes. Ms. Duncan indicated that one staff is sufficient to care for residents. None of the residents

use wheelchairs or walkers. Ms. Duncan stated that residents are not wandering near the road and that they stay near porch.

On 09/18/2024, I interviewed Health Care Area Manager, Shawneesha Cooper. I informed Ms. Cooper of allegations. Ms. Cooper did not have any information regarding staffing concerns.

On 09/18/2024, I interviewed Resident A. He indicated that staff are available to help him when needed. Staff get the garbage cans by the road. He did not report any concerns regarding the home.

On 09/18/2024, I interviewed Resident B. He stated that he has lived at North Meadows going on two years. He stated staff are hard to remember because they come and go quickly. Staff help him when needed. He has not gone to road to get garbage cans, but it might have been an assigned task. He stated that he may or may not have noticed staff with visitors. Resident B stated that residents have visitors come to the home. Resident B stated that he absolutely has no concerns regarding the home.

On 09/18/2024, I interviewed Resident C. He stated that he has lived at North Meadows for three years and it is going “pretty good”. He gets bored. Resident C indicated that staff help him with anything that he needs assistance with. Resident C stated that just residents have visitors at the home. He did not have any concerns.

On 09/18/2024, I interviewed Resident D. He stated that he has lived at North Meadows for a couple years. He thinks it is a nice home. He stated that staff do not have visitors at the home. He did not know staff names. Staff cook and give him medications. Resident D stated that residents are never up by the road or ask to bring garbage cans up to house. He stated that the staff does that.

On 09/18/2024, I interviewed Resident E. He started that he is doing “ok”. He stated that he is unsure of staff names because they change every hour. He stated that he is thinking about going home. He indicated that staff do not have visitors.

On 09/25/2024, I received copy of September 2024 staff schedule from licensee designee, William Gross. The schedule indicates that staff are working 24 hours shifts from 8:00 am to 8:00 am next day. Staff are scheduled for up to five days in the row. The home has a bedroom available for staff working overnight.

On 10/31/2024, I received an email from licensee designee, William Gross. He indicated that staff, Adrienne Calhoun Gondeck, is no longer working at North Meadows. She left when Sherry Duncan started. On 11/04/2024, Mr. Gross indicated that he was not aware of any of the allegations regarding staff, Adrienne, and again stated that she is no longer working at the facility.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	The Complainant alleged that staff, Adrienne, was found sleeping at the home when residents were awake and that a man was found in her room that she identified as a “client of hers”. In addition, residents were reported to be outside near the road. None of the residents interviewed were able to identify any individuals visiting staff at the home. Also, no residents reported being near the road. Residents stated that staff help them when needed but are changing frequently. On 10/31/2024, licensee designee, William Gross stated that Adrienne is no longer working at the home. The September 2024 staff schedule indicated that staff are working 24-hour shifts for up to five days in a row. The home does have a bedroom for staff living part-time at the home. However, staff should be available to provide 24-hour care and supervision. Resident assessment plans do not indicate that live in caregiver will not be providing direct supervision during sleeping hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are not receiving pain medication.

INVESTIGATION:

On 09/18/2024, I interviewed Staff, Sherry Duncan. She was not aware of any residents not receiving pain medication. She stated that Resident A is prescribed Tramadol for pain and can take medication as needed at 8AM, 2 PM, and 8PM. She stated that Resident D is prescribed Tylenol as needed. Resident D will say his back hurts and she will ask him if he needs something for pain.

On 09/18/2024, I interviewed Resident A. He indicated that he is getting his medications. He stated that he does not take pain medication.

On 09/18/2024, I interviewed Resident B. He indicated that staff give him his prescribed medications. He stated that he does not take any pain medication.

On 09/18/2024, I interviewed Resident C. He stated that he gets all the medications he is supposed to.

On 09/18/2024, I interviewed Resident D. He indicated that staff give him his medications. Resident D stated that he is in constant pain. He does not believe that his pain medications work.

On 09/18/2024, I interviewed Resident E. He stated that he does not feel any pain. He indicated that he has not asked for pain medication.

On 09/25/2024, I received copies of residents September 2024 medication logs from William Gross by email. Resident A's medication log indicated that he is prescribed Tramadol for pain. Resident D is prescribed Tylenol and Ibuprofen as needed for pain. Medication notes are being maintained when residents are given medication for pain.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	There is not enough information to determine that residents are not being given medications as prescribed. Residents interviewed stated that they are receiving their medications. Medication logs are being maintained in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

There is a lack of resident hygiene.

INVESTIGATION:

On 09/18/2024, I completed an unannounced onsite investigation, I observed all five residents of the home. All the residents were dressed and appeared to have adequate hygiene. I interviewed Staff, Sherry Duncan. Ms. Duncan stated that residents shower every other day and can shower on their own. Resident B only needs someone to stand with him.

On 09/18/2024, I interviewed Resident A. He indicated that staff are available to help him when needed. He can also shower when needed.

On 09/18/2024, I interviewed Resident B. He stated that the shower is working and did not report any concerns regarding hygiene.

On 09/18/2024, I interviewed Resident C. Resident C indicated that staff help him with anything that he needs assistance with.

On 09/18/2024, I interviewed Resident D. He stated that he can shower when he needs to.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	There is not enough information to determine that there is a lack of resident hygiene currently. On 09/18/2024, I completed an unannounced onsite investigation. Residents were dressed and adequately groomed. Residents interviewed stated that they can shower when needed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Residents are missing cigarettes.

INVESTIGATION:

On 09/18/2024, I interviewed Staff, Sherry Duncan. Ms. Duncan stated that she has her own cigarettes and indicated that she was not aware of any missing cigarettes.

On 09/18/2024, I interviewed Resident A. He stated that he has no missing cigarettes.

On 09/18/2024, I interviewed Resident B. He stated that he has no missing cigarettes.

On 09/18/2024, I interviewed Resident C. He stated that he has no missing cigarettes. He does not smoke.

On 11/04/2024, I received email from William Gross. He stated that they buy cigarettes in bulk and hold extra cigarettes in storage. He stated that residents have access to at least one pack of cigarettes. Mr. Gross indicated that there have been no reports of residents missing cigarettes.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	There is not enough information to determine that staff have taken residents cigarettes. None of the residents interviewed reported missing cigarettes.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **The home's television, stove and air conditioner are broken.**
- **There is not enough seating for residents in living room and dining room.**
- **The shower does not meet ADA requirements.**
- **Furniture that was infested with bed bugs has been on side of home for several months.**

INVESTIGATION:

On 09/18/2024, I completed an unannounced onsite investigation. I interviewed Staff, Sherry Duncan. Ms. Duncan indicated that the air conditioning is working, and she was not aware of it ever being broken. The home felt to be at an adequate temperature during the onsite investigation. Ms. Duncan was not aware that the home had a previous bed bug infestation. The stove top is working but the oven is broken. I observed that the television was on and in working order. I observed that the living room had a couch, love seat and chair for residents. The fabric of loveseat was very worn. The home has a dining room table and chairs for six residents. There is adequate seating for a capacity of six residents in the living room and dining area. I also observed the homes shower. The home has a standard size shower. I did not observe any residents in the home using a walker or wheelchair. I did observe that the shower had rust staining. On 09/25/2024, I received email from Licensee Designee, William Gross, with picture verifying the shower had been cleaned. During onsite, I did find that Resident C's bedroom had a very strong smell of urine.

On 09/18/2024, I observed that there were three chairs and a mattress outside, on the left side of the home. Furniture was previously placed on the side of the home due to a bed bug infestation in March 2024 (see Special Investigation Report #2024A0604013 dated 07/10/2024). On 09/25/2024, I received email from Licensee Designee, William Gross, with picture verifying that furniture has been removed from the side of the home.

On 09/18/2024, I interviewed Resident A. He stated that the air conditioning is working. There have been no bed bugs at the home recently. He did not have any issues regarding the home.

On 09/18/2024, I interviewed Resident B. He has not seen any bed bugs recently. He stated that the air conditioning works at the home. The home is an “ok” temperature.

On 09/18/2024, I interviewed Resident C. He stated that the air conditioning was not working but has his window open.

On 09/18/2024, I interviewed Resident D. He stated that the air is not working. He stated that there are no bed bugs in the home.

On 09/18/2024, I interviewed Resident E. He stated that they home sprayed for bed bugs. He indicated that I would have to ask staff about air conditioning as he was unsure if it was broken.

On 09/25/2024, I received an email from licensee designee, William Gross. He indicated that the air conditioning at the home is working well and has been working. He stated that a local appliance company will be fixing the oven tomorrow morning.

On 10/31/2024, I received an email from William Gross with copy of an invoice from Michigan Appliance Repair dated 09/24/2024. Mr. Gross indicated in an email that they had oven inspected, however, repairman suggested they get a new one instead. They purchased one off of Facebook Marketplace and it is working well.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	On 09/18/2024, I completed an unannounced onsite investigation. I observed that the television was working, and home was an adequate temperature. There is not enough information to determine that the home’s air conditioning is broken. Staff, Sherry Duncan and licensee designee, William Gross, indicated that the air conditioning has been in working order. The home’s oven was broken during the investigation. However, the stove top was available to heat food. On 09/24/2024, the oven was inspected by Michigan Appliance Repair and later replaced.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(13) A yard area shall be kept reasonably free from all hazards, nuisances, refuse, and litter.
ANALYSIS:	On 09/18/2024, I observed that there were three chairs and a mattress on the left side of the home. Furniture was previously placed on the side of the home due to bed bug infestation in March 2024. Licensee sent a picture verifying that the furniture was removed on 09/25/2024.
CONCLUSION:	**VIOLATION ESTABLISHED (BUT CORRECTED)**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	On 09/18/2024, I completed an unannounced onsite investigation. I observed that the fabric on the loveseat in living room was worn and in need of replacement or repair. In addition, during the onsite investigation I found that Resident C's bedroom had a very strong smell of urine.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14405	**Living space.**
	(3) Living, dining, bathroom, and sleeping areas used by residents who have impaired mobility shall be accessible and located on the street floor level of the home that contains the required means of egress.

ANALYSIS:	There is not enough information to determine that the home does not have a shower that meets ADA requirements to accommodate residents. The home has a standard sized shower. I did not observe any residents using a wheelchair or walker.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14405	**Living space.**
	(8) A home shall have dining space that can accommodate all residents of the home at the same time.
ANALYSIS:	On 09/18/2024, I completed an unannounced onsite investigation. The home has a dining room table with six chairs. There is adequate dining space to meet the capacity of six residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 09/25/2024, I received employee records, staff list and schedule by email from William Gross. Employee records were received for Sherry Duncan, Adrienne Calhoun-Gondeck and Natalya Singleton. I received copies of application, two reference checks, medical/TB test, workforce background checks and training records. Staff, Sherry Duncan, was hired in September 2024 and has 30 days to complete medical statement. She did not have TB test completed at time of hire. Her TB test was dated 09/19/2024. Also, her CPR/First Aid Training was dated 09/23/2024 and Ms. Duncan was working alone on 09/18/2024. Staff, Natalya Singleton was on schedule alone on 09/01/2024. Ms. Singleton did not complete CPR/First Aid training until 09/06/2024.

I completed an exit conference with Licensee Designee, William Gross, by phone on 11/20/2024. I left a message for Mr. Gross informing him that a copy of special investigation report would be mailed once approved and a corrective action plan would be requested. I received a return text message from Mr. Gross confirming he would contact me if he had any questions regarding report once received. I also emailed Mr. Gross the recommendation and findings on 11/18/2024.

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: **(b) First aid** **(c) Cardiopulmonary resuscitation.**
ANALYSIS:	On 09/18/2024, I completed an unannounced onsite investigation. Staff, Sherry Duncan was working alone at North Meadows. Her CPR/First Aid training was not completed until 09/23/2024. Staff, Natalya Singleton was on schedule alone on 09/01/2024. Ms. Singleton did not complete CPR/First Aid training until 09/06/2024.
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:	On 09/18/2024, I completed an unannounced onsite investigation. Staff, Sherry Duncan, was working at facility. Ms. Duncan did not have a TB test completed until 09/19/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

11/20/2024

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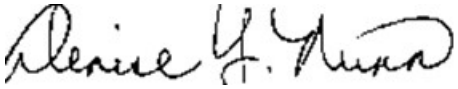
Kristine Cilluffo — Date
Licensing Consultant

Approved By:



11/202024

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Denise Y. Nunn — Date
Area Manager