GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 12, 2024

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

RE: License #: AS740248863
Investigation #: 2024A0580037
Gates AFC

Dear William 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. 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 (517) 643-7960.

Sincerely,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS740248863
Investigation #:	2024A0580037
Complaint Receipt Date:	05/23/2024
Investigation Initiation Date:	05/28/2024
Report Due Date:	07/22/2024
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:	Gates AFC
Facility Address:	400 Burns Road Kimball, MI 48074
Facility Telephone #:	(810) 367-8079
Original Issuance Date:	06/28/2002
License **Status:**	REGULAR
Effective Date:	04/02/2023
Expiration Date:	04/01/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Employees cannot communicate due to only speaking Spanish.	Yes
Resident A has not been showered in 6 days. Resident B's catheter bag so full its backing back into the tube.	No
Additional Findings	Yes

III. METHODOLOGY

05/23/2024	Special Investigation Intake 2024A0580037
05/28/2024	APS Referral Referred to APS.
05/28/2024	Special Investigation Initiated - Letter Email sent to the complainant.
05/30/2024	Contact - Telephone call received Phone call from the complainant.
06/05/2024	Inspection Completed On-site Unannounced onsite.
06/05/2024	Contact - Face to Face Interview with Resident A.
06/20/2024	Contact - Telephone call made Call to Wiilliam Gross, Licensee Designee.
06/30/2024	Contact - Document Received Documents and phone contact info received.
07/08/2024	Contact - Telephone call made Spoke with Relative A.
07/08/2024	Contact - Telephone call made Call to Relative B.
07/09/2024	Contact - Telephone call made

	Spoke with Mary Ann Suski, Clinical Director at Bay Nursing Home Health and Hospice.
07/10/2024	Contact - Telephone call made Call to William Gross.
07/11/2024	Contact - Telephone call made Spoke with Bay Nursing Home Health and Hospice RN, Janelle Richards.
07/11/2024	Contact - Document Received Physician's Order for Resident B received.
07/11/2024	Contact Email from William Gross.
07/12/2024	Exit Conference Exit conference with LD Gross.

ALLEGATION:

Employees cannot communicate due to only speaking Spanish.

INVESTIGATION:

On 05/23/2024, I received a complaint via BCAL Online Complaints.

On 05/28/2024, I made a referral to Adult Protective Services (APS) sharing the allegations.

On 05/28/2024, I sent an email to the complainant, requesting contact for additional information.

On 05/30/ 2024, I spoke with the complainant who shared that she gained the information alleged in this complaint, when interviewing for a job at the facility.

On 06/05/2024, I conducted an unannounced onsite inspection at Gates AFC. Contact was made with, Shaneesha Cooper, who identified herself as the Health Assessment Coordinator. Staff Cooper was observed while conducting an intake assessment for a new resident moving in. This intake was being conducted at the dining room table while another resident was eating lunch.

Staff in the home observed feeding Resident A her lunch identified herself as Pilw (last name unknown) via telephone translator. She was unable to speak English. An

additional staff member observed in the home, identified herself as Karla Pilco via telephone translator as well. She too is unable to speak English.

On 06/05/2024, while onsite, I interviewed Resident A, who indicated that she is not able to speak Spanish, however, she has come to understand some Spanish since residing in the home. Resident B was out of the facility, currently in the hospital. Resident C was observed in her room while sleeping in her bed. Resident C was observed in what appeared to be her nightgown. She briefly woke and shook her head no, when asked if she was willing to be interviewed.

On 07/10/2024, I spoke with Licensee Designee (LD), William Gross, regarding the allegations. LD Gross stated that he is half Mexican and speaks fluent Spanish, therefore it was a business decision to hire Spanish speaking staff. LD Gross was informed that while he is able to speak fluent Spanish his residents do not and require staff that are able to communicate with them directly. LD Gross indicated that there are no longer any Spanish speaking staff working at the home.

On 07/11/2024, I spoke with Bay Nursing RN, Janelle Richards, who shared that during her time working with Resident B, who previously resided in the facility, she encountered a language barrier due to Spanish speaking staff who used a phone application to communicate.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	It was alleged that employees cannot communicate due to only speaking Spanish. LD Gross regarding the allegations. LD Gross stated that he is half Mexican and speaks fluent Spanish, therefore it was a business decision to hire Spanish speaking staff. While onsite, I observed Resident A being fed her lunch by a staff who identified herself as Pilw via telephone translator due, due to being unable to speak English. An additional staff member observed in the home, identified herself as Karla Pilco via telephone translator as well. She too is unable to speak English. Resident A stated that she is not able to speak Spanish and understands some Spanish since residing in the home.

	Bay Nursing RN, Janelle Richards, stated that during her time working with Resident B, who previously resided in the facility, she encountered a language barrier due to Spanish speaking staff who used a phone application to communicate. Based on the interviews conducted with LD Gross, Resident A, Bay Nursing RN, Janelle Richards, and an observation of Karla Pilco and Pilw identified as the Spanish speaking staff in the home, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A has not been showered in 6 days. Resident B's catheter bag so full its backing back into the tube.

INVESTIGATION:

On 06/05/2024, while onsite, Resident A was initially observed while being fed lunch at the dining room table. Once finished eating, I interviewed Resident A in her room regarding the allegations. Resident A denied the allegations, stating that she receives a shower twice a week, on Mondays and Thursday's. The onsite visit took place on a Wednesday. Resident A was observed as clean and adequately groomed.

The AFC Assessment Plan for Resident A was reviewed while onsite. The assessment plan indicates that Resident A is blind and requires someone to help her wash her hair and feet when bathing. It also indicates that Resident A is able to complete her own personal hygiene with staff assistance. The plan is not signed and dated by Relative A or the Licensee/Licensee Designee.

The Assessment Plan for Resident B was reviewed while onsite. The plan indicates that Resident B has a catheter for urine and caregiver assistance for toileting. Resident B is wheelchair bound and cannot move without caregiver assistance.

On 06/20/2024, I spoke with William Gross, license designee, informing him of the allegations. LD Gross denied the allegations that Resident A was not bathed for 6 days. LD Gross also denied the allegations that Resident B's catheter bag so full its backing back into the tube. LD Gross indicated that Resident B went to the hospital due to having blood in his catheter. He did not return to the AFC home after his 6/5/2024 hospitalization. LD Gross also shared that Resident B is his own guardian who was placed in his home directly from the hospital.

On 06/30/2024, I received a copy of the incident report dated 06/02/2024. The report states that Resident B had his catheter replaced by his home health care nurse. Due to the catheter change he had a blood clot in the tube and UTI. Staff called 911 and had him sent to the hospital. Corrective measures include communicating with the home health care better as to the symptoms Resident B is having.

On 07/08/2024, I spoke with Relative A, assigned Power of Attorney (POA) for Resident A, who stated that Resident A is very particular about her hygiene. Relative A has no concerns with Resident A's hygiene. Resident A has not expressed that she has not received her showers as required.

On 07/08/2024, I placed a call to Relative B. A voice mail message was left requesting a return call.

On 07/09/2024, I spoke with Mary Ann Suski, Clinical Director at Bay Nursing, who shared that Resident B was receiving occupational and physical therapy home health services from their program beginning 4/24/2024 (while residing at MediLodge of Richmond, located in Macomb County). Resident B's services followed him to his new placement at Gates AFC and ended effective 6/2/2024 when he was transferred to the hospital. Director Suskie was able to confirm that Resident B had a Physician's Order, effective 5/2/2024, that required caregivers to irrigate his Catheter. Director Suski is not aware if lack of cleaning caused Resident B's most recent hospitalization and will refer to her staff for more information.

On 07/11/2024, Bay Nursing RN, Janelle Richards, shared that on 05/02/2024, she obtained a Physician's Order, effective 5/2/2024, that required caregivers to irrigate Resident B's Catheter on a daily basis. RN Richards trained staff in the home how to conduct the flushes. Upon returning the following week, she inquired regarding how the flushes were going and staff indicated that it had not been done since she's last visited. RN Richards reminded staff that the flushes should be done daily. The following visit she changed Resident B's catheter, and some blood was detected. Staff were instructed to contact Bay Nursing if the blood worsened, which it did. As a result, he was sent to the hospital. There was no concern regarding Resident B's catheter being full and backing back into the tube. Their agency has not received an additional referral for services.

On 07/11/2024, I received a copy of the Bay Nursing Physician's Order for Resident B, dated 05/02/2024. The order instructs caregivers to irrigate Foley catheter with 60cc normal saline daily.

On 07/11/2024, I received an email from LD Gross indicating that his staff did not track on paper, the daily cleaning of the catheter.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A has not been showered in 6 days and Resident B's catheter bag so full its backing back into the tube. Resident A denied the allegations. Resident A was observed as clean and adequately groomed, during the onsite. The AFC Assessment Plans for Resident A for both Residents A and B were reviewed. LD Gross denied the allegations that Resident A was not bathed for 6 days. LD Gross also denied the allegations that Resident B's catheter bag so full its backing back into the tube. Bay Nursing RN, Janelle Richards, stated that there was no concern regarding Resident B's catheter being full and backing back into the tube. Relative A has no concerns with Resident A's hygiene. Resident A has not expressed that she has not received her showers as required. Relative B did not respond. Based on interviews conducted with Resident A, Relative A, Janalle Richards, RN at Bay Nursing, LD William Gross and a review of the assessment plans for Residents A and B, there is not enough information to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/30/2024, I received an emailed copy of the 1st Aid training completed by direct staff Anna Opal, Hiff Fabre, Marlon Massey, Britni Jordan, Karla Pilco and Tammy Saxarra. This training was completed online and certified by the American Health Care Academy.

On 07/10/2024, I spoke with LD Gross informing him that online only training completed by staff does not allow the staff to demonstrate their competency. LD Gross indicated that he is in the process of becoming a certified CPR/1st Aid Trainer.

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.**
ANALYSIS:	Staff 1st Aid training was completed online and certified by the American Health Care Academy. This training did not allow staff to demonstrate skill proficiency to a certified instructor. There is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 06/30/2024, I received an emailed copy of the CPR training completed by direct staff Anna Opal, Hiff Fabre, Marlon Massey, Britni Jordan, Karla Pilco and Tammy Saxarra. This training was completed online and certified by the American Health Care Academy.

On 07/10/2024, I spoke with LD Gross informing him that online only training completed by staff does not allow the staff to demonstrate their competency. LD Gross indicated that he is in the process of becoming a certified CPR/1st Aid Trainer.

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: **(c) Cardiopulmonary resuscitation.**

ANALYSIS:	Staff CPR training was completed online and certified by the American Health Care Academy. This training did not allow staff to demonstrate skill proficiency to a certified instructor. There is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 06/05/2024, while onsite, staff in the home observed feeding Resident A her lunch, identified herself as Pilw via telephone translator. She is unable to speak English. An additional staff member observed in the home, identified herself as Karla via telephone translator. Staff Shaneesha Cooper was identified as the English-Speaking staff on duty.

On 07/08/2024, I received a copy of the background checks conducted for direct staff member listed on the schedule as employees having worked on various days throughout the months of May and June 2024. The staff schedule observed, effective 05/25/2024 shows that staff Karla Pilco worked on 06/04/2024-06/07/2024. On 06/06/2024 and 06/07/2024, Karla Pilco is shown as the only staff working the midnight shift. Licensee Gross was unable to produce verification of a background check for staff Karla Pilco, indicating that she only worked for a short time and is no longer employed.

On 07/10/2024 I spoke with LD Gross who stated that he has no idea who Pilw is and assumes she was a visitor. LD Gross was informed that based on the observation of Pilw feeding Resident A and transferring her to her room, she was not a visitor. LD was unable to provide a last name. LD Gross indicated that he did not complete a background check for staff Karla Pilco due to her 10-days on conditional employment. He did not complete and ICAT background check because he did not about the system.

On 07/11/2024, LD Gross indicated that Pilw was applying for a job as a recommendation from staff Karla Pilco, however he did not move forward.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.

ANALYSIS:	Staff Karla Pilco began working on 06/04/2024. The staff schedule observed, effective 05/25/2024 shows that staff Karla Pilco worked on 06/04/2024-06/07/2024. On 06/06/2024 and 06/07/2024, Karla Pilco is shown as the only staff working the midnight shift. No ICHAT or fingerprint background check was completed prior to working alone with residents. Pilw was observed feeding Resident A during the 06/05/2024 onsite inspection. LD Gross indicated that Pilw was applying for a job as a recommendation from staff Karla, however he did not move forward. LD Gross is not able to provide verification of a background check Karla Pilco or Pilw. There is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 06/05/2024, while onsite, I observed the assessment plans for Residents A and B. The plan for Resident A is not signed and dated by her Guardian or the Licensee Designee.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	The assessment plan for Resident A is not signed and dated by her Guardian, nor the Licensee/Licensee Designee. The plan for

	Resident B is signed by Resident B effective 04/30/2024. The assessment plan is signed by the LD, however, it is not dated. There is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 06/05/2024, while onsite, I observed that the last menu in the home was posted on 05/31/2024.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	The menu observed posted in the home on 06/05/2024 was not written 1 week in advance. The menu ended on 05/31/2024. There is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 06/05/2024, while onsite, an observation of the property revealed that the rear wheelchair exit was obstructed by overgrown grass. A photo was taken.

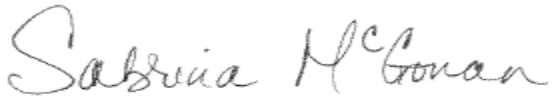
APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(2) A means of egress shall be arranged and maintained to provide free and unobstructed egress from all parts of a small group home.

ANALYSIS:	The rear exit of the home did not provide free and unobstructed egress due to overgrown grass. There is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/12/2024, I conducted an exit conference with Licensee Designee, William Gross. LD Gross was informed of the findings of this investigation.

IV. RECOMMENDATION

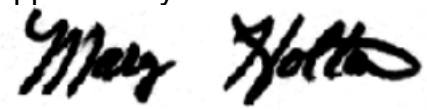
Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.



July 12, 2024

Sabrina McGowan Date
Licensing Consultant

Approved By:



July 12, 2024

Mary E. Holton Date
Area Manager