GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 27, 2025

Tanya Haven-Rowe
Haven-Rowe LLC
12273 Farrand Rd.
Montrose, MI 48457

RE: License #:	AS250418241
Investigation #:	2025A0872047
	New Haven

Dear Tanya Haven-Rowe:

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 (517) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS250418241
Investigation #:	2025A0872047
Complaint Receipt Date:	07/28/2025
Investigation Initiation Date:	07/28/2025
Report Due Date:	09/26/2025
Licensee Name:	Haven-Rowe LLC
Licensee Address:	12273 Farrand Rd. Montrose, MI 48457
Licensee Telephone #:	(810) 639-6578
Administrator:	Tanya Haven-Rowe
Licensee Designee:	Tanya Haven-Rowe
Name of Facility:	New Haven
Facility Address:	7448 E. Maple Ave Grand Blanc, MI 48439
Facility Telephone #:	(810) 771-1015
Original Issuance Date:	09/05/2024
License Status:	REGULAR
Effective Date:	03/05/2025
Expiration Date:	03/04/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 07/27/2025, Resident A was having a behavior and was hitting staff Amy Kadera. Staff Kadera hit Resident A on the arm, causing a red mark.	Yes

III. METHODOLOGY

07/28/2025	Special Investigation Intake 2025A0872047
07/28/2025	Special Investigation Initiated - Letter
07/28/2025	Referral - Recipient Rights This complaint was referred to GHS RRO, Matt Potts
07/28/2025	APS Referral I made an APS complaint
08/13/2025	Inspection Completed On-site Unannounced
08/15/2025	Contact - Document Sent I emailed the LD requesting information related to this complaint
08/19/2025	Contact - Document Received AFC documentation received
08/19/2025	Contact - Telephone call made I interviewed staff Amy Kadera
08/27/2025	Exit Conference I conducted an exit conference with the licensee designee, Tanya Haven-Rowe
08/27/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 07/27/2025, Resident A was having a behavior and was hitting staff Amy Kadera. Staff Kadera hit Resident A on the arm, causing a red mark.

INVESTIGATION: On 08/14/2025, I conducted an unannounced onsite inspection of New Haven Adult Foster Care facility, and I interviewed Resident A. Resident A was seated in a recliner in the common area of the home. I asked Resident A if he wanted to go into a private room and he said no. I reviewed the allegations with Resident A and he said, “I hit her first.” Resident A said that he has lived at this facility for “awhile” and knows all the staff. According to Resident A, a couple weeks ago, he and staff Amy Kadera were in the kitchen by the garbage can. Resident A said that he was angry, so he spit at Staff Kadera, hit a wall, and hit Staff Kadera. Resident A told me that Staff Kadera hit him on the arm, causing a red mark and said that she also grabbed his neck. Resident A stated that this is the first time any of the staff has ever harmed him and said that he feels safe at this facility. Resident A said that he should not have spit at her or hit her and said, “Everybody needs to keep their hands to themselves.”

On 08/19/2025, I interviewed staff Amy Kadera via telephone. Staff Kadera said that she has worked at New Haven AFC since October 2024 and she typically works 2nd shift. I reviewed the allegations with her, and she confirmed that there was an incident that took place between her and Resident A on 07/27/2025. Staff Kadera said that she was working on that date, and Resident A had been having a bad day all day. Staff Kadera stated that Resident A was trying to get into the bathroom, but the door was locked from the inside and although she was trying to unlock it, Resident A got angry and began hitting her. Staff Kadera told me that she began getting frustrated so she threw up her hands and said, “Will you stop hitting me?” and when her hands came down, she accidentally hit his arm, causing a red mark. According to Staff Kadera, she did not intentionally hit Resident A and she did not grab him by the neck. Staff Kadera stated that Resident A calmed down once she got the door unlocked, he used the bathroom, and the rest of the shift was uneventful. Staff Kadera said that when 3rd shift staff came on duty, she reported what had happened and she documented the incident in Resident A’s behavior documentation log and in the staff notes.

On 08/25/25, I reviewed an Incident/Accident Report (IR) dated 07/27/2025 completed by staff, Kayla Rowe. According to this report, “(Resident A) reported to staff that Amy [Amy Kadera] hit him and grabbed his arm as well as the back of his neck. (He) had a visible red mark on his right arm. Amy also reported to staff that she ‘swatted’ him.” Management contacted AFC Licensing, Recipient Rights, and Guardian A1. The corrective measures taken were, “Amy was suspended and (Guardian A1) was contacted.”

I reviewed the behavior documentation log dated 07/27/2025 completed by staff, Amy Kadera. According to this document, Resident A kept trying to get into the bathroom, but the door was locked. Staff Kadera was trying to unlock the door, but Resident A kept hitting her. Staff Kadera wrote, “Tried redirecting he kept hitting I swatted his arm away to stop hitting me and he does have a mark on his arm.”

I reviewed a staff note dated 07/27/2025 completed by staff, Amy Kadera. According to this document, “(Resident A) still yelling at me and trying to hit me. I pushed swatted his arm away from me and there is a spot on his arm. Something is wrong with the lock on the guys bathroom I was trying to get it unlocked so he could use the bathroom, and he kept hitting me telling me he is going to beat my ass. I finally got the door opened for him to use the bathroom. I think we need a new lock for it.”

When I spoke to staff, they all said that the lock was not faulty. Since it locks from the inside, someone (probably a resident) locked it and then closed it. There was another bathroom that Resident A could have used but he was fixated on using that one.

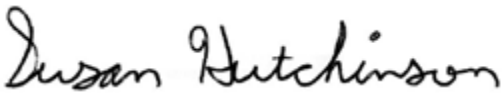
On 08/27/2025, I conducted an exit conference with the licensee designee (LD), Tanya Haven-Rowe. I discussed the results of my investigation and explained which rule violation I am substantiating. LD Haven-Rowe said that as a result of this incident, staff Amy Kadera’s employment will be terminated. LD Haven-Rowe agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Resident A told me that staff Amy Kadera hit him on the arm and grabbed him by the neck. He said that he had a red mark on his arm after the incident. According to the IR dated 07/27/25, Resident A reported to staff Kayla Rowe that staff Amy Kadera hit him on the arm and grabbed his arm and neck. Staff Rowe observed a red mark on Resident A’s arm. Staff Kadera documented in the behavior documentation log that Resident A was hitting her, so she swatted his arm, causing a red mark. Staff Kadera documented in the staff log that Resident A was yelling at her and trying to hit her, so she pushed/swatted his arm away from her and left a spot on his

	arm. Staff Kadera reported to me that Resident A was hitting her. She said that she got frustrated and she threw her hands up, asking him to stop, and when her arms came down, she accidentally hit his arm. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

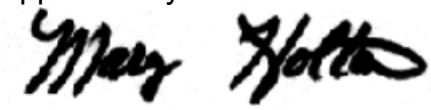
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



August 27, 2025

Susan Hutchinson Licensing Consultant	Date

Approved By:



August 27, 2025

Mary E. Holton Area Manager	Date