GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 12, 2025

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

RE: License #: AG500066337
Investigation #: 2025A0990021
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 was recommended in Special Investigation Report #2024A0604020 dated 10/23/2024, which remains in effect.**

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) 972-9136.

Sincerely,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AG500066337 |
| | |
| **Investigation #:** | 2025A0990021 |
| | |
| **Complaint Receipt Date:** | 07/16/2025 |
| | |
| **Investigation Initiation Date:** | 07/16/2025 |
| | |
| **Report Due Date:** | 09/14/2025 |
| | |
| **Licensee Name:** | Haven Adult Foster Care Limited |
| | |
| **Licensee Address:** | 73600 Church Road<br>Armada, MI 48005 |
| | |
| **Licensee Telephone #:** | (586) 784-8890 |
| | |
| **Administrator:** | William Gross |
| | |
| **Licensee Designee:** | William Gross |
| | |
| **Name of Facility:** | Ridgeway |
| | |
| **Facility Address:** | 72188 Russ Road<br>Richmond, MI 48062 |
| | |
| **Facility Telephone #:** | (586) 727-7650 |
| | |
| **Original Issuance Date:** | 05/31/1995 |
| | |
| **License Status:** | 1ST PROVISIONAL |
| | |
| **Effective Date:** | 11/08/2024 |
| | |
| **Expiration Date:** | 05/07/2025 |
| | |
| **Capacity:** | 31 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED<br>TRAUMATICALLY BRAIN INJURED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| On 7/2/2025, Resident A suffered severe facial burns from a firework while wearing oxygen. Yet, the facility failed to seek medical care, inadequately treated his injuries, and never informed his family. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 07/16/2025 | Special Investigation Intake<br>2025A0990021 |
| 07/16/2025 | Special Investigation Initiated - On Site<br>The investigation was initiated on 07/11/2025 and corrected the license #. |
| 07/16/2025 | Contact - Telephone call made<br>I conducted a phone interview with Willaim Gross, licensee designee (07/15/2025). |
| 07/16/2025 | Contact - Telephone call made<br>On 07/15/2025, I left a detailed message with Relative A. |
| 08/25/2025 | Contact - Document Received<br>I reviewed Resident A's resident record. |
| 08/25/2025 | Contact - Telephone call made<br>I called direct care staff Nicole Sterling. The number was disconnected. |
| 08/25/2025 | Contact - Telephone call made<br>I conducted a phone interview with direct care staff Penny Lovett. |
| 08/25/2025 | Contact - Telephone call made<br>I conducted a phone interview with direct care staff Andreanna Veach. |
| 08/25/2025 | Contact - Telephone call made<br>I called direct care staff Jenna Pierson. The mailbox was full, and a message could not be left. |

| | |
|---|---|
| 08/25/2025 | Contact - Telephone call made<br>I left a brief message for direct care Alenna Jock. No return call to date. Staff |
| 08/29/2025 | Contact - Telephone call received<br>I conducted a phone interview with Relative A. |
| 08/29/2025 | Contact - Telephone call made<br>I conducted a phone interview with Resident A. |
| 08/29/2025 | Contact - Telephone call made<br>I left a detailed voice message with direct care staff Joey Strange. |
| 08/29/2025 | Contact - Telephone call made<br>I called the direct care staff Kaitlynn Marsh. No message left because voice mail was full. |
| 08/29/2025 | Exit conference<br>I conducted an exit conference with Mr. Gross. |
| 09/09/2025 | APS referral<br>An adult protective services (APS) referral was made. |

**ALLEGATION:**

**On 7/2/2025, Resident A suffered severe facial burns from a firework while wearing oxygen. Yet, the facility failed to seek medical care, inadequately treated his injuries, and never informed his family.**

**INVESTIGATION:**

On 07/16/2025, I initiated the investigation on 07/11/2025. The complaint was entered under the incorrect license number. I conducted an on-site visit to the incorrect adult foster home. NOTE: An onsite was not conducted because the resident moved out of the facility before the complaint was assigned. Furthermore, there were no witnesses to interview regarding the incident as Resident A was sitting outside alone when the incident occurred. This is also supported by the written incident report.

On 07/15/2025, I conducted a phone interview with William Gross, licensee designee. Mr. Gross provided the correct name of the facility in which Resident A lived. Mr. Gross described Resident A as "totally independent". Mr. Gross said that Resident A is now living independently in his own apartment. Mr. Gross said that he has heard that Resident A smokes cigarettes, and he is on oxygen. Mr. Gross said that no staff observed the fireworks incident as Resident A was sitting alone outside when it happened. Mr. Gross noted that Resident A's legal guardian is Relative A. Resident A

was discharged from the facility on 07/4/2025. Mr. Gross said that Relative A was aware of the burning incident, but medical care was refused.

On 08/25/2025, I reviewed Resident A's resident record. I reviewed Resident A's *Assessment Plan*, *Health Appraisal*, and *Incident Report*. Resident A is diagnosed with COPD, has hearing loss, and is ambulatory. Resident A used oxygen. Resident A moves independently through the community, can follow instructions, and is independent with ADLs with minimum assistance.

I reviewed the incident report written by direct staff member Nicole Sterling on 07/03/2025 at 8:30 PM. Resident A was sitting on the backyard porch and informed staff that he was hit in the face by a neighbor's fireworks. Resident A reported that he ripped off his oxygen mask immediately. Staff observed Resident A's face swollen and blistered with black soot. Resident A refused medical treatment. The incident report documented that Relative A was notified on 07/04/2025.

I reviewed a written statement from direct care staff, Penny Lovett. Ms. Lovett documented that on Friday, 07/4/2025, she observed that Resident A's nose and ear were swollen with small blisters. Resident A said that he was ok. He informed Ms. Lovett that the neighbor's fireworks hit him while he was sitting in the backyard with his oxygen tank and mask on. Resident A refused medical care because he did not want to be prevented from moving out of the facility. The statement documented that later that morning, Relative A arrived to pack his belongings and informed them that Resident A would be moving out the next day, 07/05/2025. Resident A explained what happened to his face to Relative A. Ms. Lovett suggested to Relative A that he be seen by the doctor, and Relative A said, "She wasn't too worried about it because he seemed to be fine". On 07/05/2025, Relative A came to pick up Resident A to move out. Ms. Lovett wrote that she suggested multiple times that Resident A should have been seen because the blisters appeared worse. Resident A became frustrated and said that he would go to the doctor after settling into his new place.

On 08/25/2025, I conducted a phone interview with direct care staff Penny Lovett. I conducted a phone interview with direct care staff Penny Lovett. Ms. Lovett said that she observed the blisters on Resident A's face when she passed his medications. Resident A told her that the neighbor's firecracker hit him in the face. Resident A refused medical attention. Ms. Lovett said that Relative A was present and was packing Resident A's belongings to leave for the planned discharge.

On 0/25/2025, I conducted a phone interview with direct care staff member Andreanna Veach. Ms. Veach was not present the day the firecracker hit Resident A but was aware of the incident. Ms. Veach said that she observed scabbing on his nose.

On 08/29/25025, I conducted a phone interview with Relative A. Relative A said that Resident A lived at the facility for a little over one year. His discharge was planned because she wanted him closer to where she lived. Resident A is living independently in his own apartment. Relative A said that Resident A told her that, as he

was sitting in the backyard of the facility, a firework was fired at him in the face. Relative A said that she observed burns on the side of his nose, face, and neck. Relative A said she was concerned about how he was burned on the nose when he wore an oxygen mask. Relative A said no one contacted her about the incident the day it occurred. Relative A said that she observed the burns when she arrived at the facility. Relative A is concerned that the staff only cleaned his face and did not seek medical attention. The staff also placed a bandage on his face. Relative A said that the burns were severe, and Resident A was hospitalized for two days. Resident A was also diagnosed with low oxygen because he was not wearing his oxygen mask due to burns on his nose. Relative A is Resident A's legal guardian.

On 08/29/2025, I conducted a phone interview with Resident A. Resident A said that he lived in a basement apartment. Resident A described that he was the only high-functioning resident who lived at the facility. Resident A said that he lived there because of his COPD diagnosis. Resident A described that in the evening, he would sit in the backyard area to feed the wildlife. Resident A said that on 07/02/2025, at around 9:30 PM, a firework came from the neighbor's area and hit him on his face. He immediately took off his oxygen mask; however, he was on fire. He was able to get the fire out. He went into the facility, stopped at the laundry room, and went to the sink to wash his face with cold water. Resident A said that a staff member came into the laundry room and asked what was happening. Resident A noted that the other residents were already in bed when this occurred. Resident A said that the staff person was going to call 911, but he insisted that they did not because he didn't want his move date to be prolonged. Resident A said that Relative A saw the burn the following day and took him to the emergency room. Resident A believed that he had 3$^{rd}$ or 4$^{th}$ degree burns. Resident A noted that overall, the staff treated him well when he lived there.

On 08/29/2025, I conducted a phone interview with home manager Demarus Mullins. Ms. Mullins had been the home manager for about one year. Ms. Mullins said that she was not working on the day of the fireworks incident. Ms. Mullins said that Resident A was known to sit out in the back area to feed the animals. Resident A was also caught smoking cigarettes several times, and staff have confiscated lighters from him. Ms. Mullins said that her staff reported to her on the night of the incident that they observed Resident A with soot on his face. He told the staff person that a fireworks hit his face. At that time, no blisters or wounds were observed. Ms. Mullins said that the staff had asked him several times if he wanted medical attention, but he refused. Ms. Mullins said that Resident A was anxious to move out as Relative A had put in a 30-day discharge notice. Ms. Mullins said the next day, Ms. Lovett told her that Resident A had blisters on his face. Ms. Mullins said that Relative A was present at that time. Ms. Mullins said that Relative A signed in to the facility on 07/04/2025 at 11 AM and on 07/05/2025 at 11:07 AM. Ms. Mullins said that the burns appeared worse on the 5th, and this is when Relative A decided to take Resident A to the hospital. Resident A moved out on 07/05/2025.

On 08/29/2025**,** I conducted an exit conference with Mr. Gross. Mr. Gross was informed of the findings. It was discussed that Relative A became aware of the burns on

07/04/2025 but did not seek medical attention until 0705/2025. However, the staff did not inform Relative A about the burns on 07/03/2025 when the incident occurred. Mr. Gross agreed to submit a corrective action plan.

| **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:** | Based upon the investigation, there is sufficient evidence to support that Resident A's legal guardian, Relative A, was not informed of the firecracker accident on 07/03/2025 when it occurred. Although Relative A observed the burns on 07/04/2025 and did not seek medical care until 07/05/205, the facility was still required to report the incident immediately. Resident A refused medical attention; however, he has a legal guardian. Resident A suffered severe burns to his face and had low oxygen. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **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:** | Based on the investigation, there is insufficient evidence to support the fact that the staff did not protect Resident A. Resident A sat in the backyard of the facility every evening. Resident A is highly functional. Resident A said that a firecracker from the neighbor's home hit him on the face. He immediately pulled his oxygen mask off and went to the facility to flush his face. Per Resident A's *Assessment Plan*, he moves independently throughout the community and is ambulatory. Resident A moved into his own apartment after being discharged from the facility. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

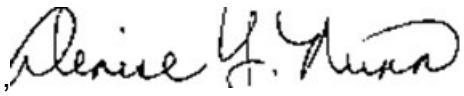
## IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status. A six-month provisional license was recommended in Special Investigation Report #2024A0604020 dated 10/23/2024, which remains in effect.

09/09/2025

LaShonda Reed — Date
Licensing Consultant

Approved By:



09/12/2025

Denise Y. Nunn — Date
Area Manager