GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 9, 2026

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

RE: License #: AG500066337
Investigation #: 2026A0604003
Ridgeway

Dear Mr. Gross:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Kristine Cilluffo

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

THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AG500066337
Investigation #:	2026A0604003
Complaint Receipt Date:	10/13/2025
Investigation Initiation Date:	10/14/2025
Report Due Date:	12/12/2025
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:	1ST PROVISIONAL
Effective Date:	11/08/2024
Expiration Date:	05/07/2025
Capacity:	31
Program Type:	PHYSICALLY HANDICAPPED

	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Residents are being abused and receiving inadequate care due to untrained staff and understaffing.	No
Residents are not being changed or showered regularly. Clothing and linens are dirty.	Yes
Resident was found unchanged, covered in feces and pressure wounds are getting worse.	Yes
Resident left facility and owner refused to call 911.	Yes
Staff are aware that resident is being sexually abused.	No
The facility has unsanitary water that smells.	No
Bathrooms and showers are in poor condition.	Yes
There are bugs throughout the facility.	No
Staff are stealing medications.	No
Residents are not receiving their medications.	Yes
The facility is not serving nutritious meals or adequate food portions.	Yes

III. METHODOLOGY

10/13/2025	Special Investigation Intake 2026A0604003
10/14/2025	Contact - Document Sent Email to William Gross. Received return email. Scheduled to complete renewal inspection today, however, licensing complaint received.
10/14/2025	Special Investigation Initiated - On Site Completed onsite investigation. interviewed Licensee Designee, William Gross, Staff, Lisa Taylor, Ana Amador, Kyra Shepherd, Penny Lovett, Resident B, Resident C and Resident D.
10/14/2025	APS Referral Made referral to Adult Protective Services (APS). Referral denied.
10/16/2025	Contact - Document Sent Sent document request to William Gross by email
10/20/2025	Contact- Document Received

	Received resident records, employee records, resident register, pest control invoices, shower schedules and menus by email from William Gross.
10/22/2025	Contact- Telephone call received Received message from APS Worker, Nuha Shamoon. Referral denied, however, APS already has open APS case for Resident A
10/23/2025	Contact- Telephone call made Left message for APS Worker, Nuha Shamoon
10/29/2025	Contact- Document Sent Email to APS Worker, Nuha Shamoon. Received return email.
10/31/2025	Contact- Document Received Received intake #207973. Dismissed- Special Investigation (SI) already exists. Add allegations to current investigation.
10/31/2025	Contact - Document Sent Email to and from APS Worker, Amanda Wietcha
11/03/2025	Contact - Document Received Email from APS Worker, Amanda Wietcha
11/04/2025	Contact - Document Sent Email to APS Worker, Amanda Wietcha
11/04/2025	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed William Gross, Cook Domonjie Smith, Resident E and Resident G.
11/05/2025	Contact- Document Received Email from APS Worker, Amanda Wietcha
11/06/2025	Contact- Document Sent Email to William Gross. Requested resident records
11/07/2025	Contact- Document Received Received intake #208072. Dismissed- SI already exists. Add allegations to current investigation.
11/07/2025	Contact- Document Sent Email to William Gross
11/07/2025	Contact- Telephone call received

	Received message from Licensee Designee, William Gross. Returned call.
11/10/2025	Contact- Document Received Received email from William Gross with resident records. Received resident records, incident reports and medication administration records. Sent email to William Gross.
11/12/2025	Contact- Document Received Email from William Gross. Sent return email.
12/08/2025	Contact- Document Received Received intake #208450. Assigned to Licensing Consultant, LaShonda Reed.
12/09/2025	Contact- Document Received Received intake #208464. Intake assigned to Licensing Consultant, LaShonda Reed. Intake re-assigned to Kristine Cilluffo upon return from leave on 12/11/2025 to dismiss and add allegations to open investigation.
12/12/2025	APS Referral APS referral denied
12/15/2025	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Licensing Designee, William Gross, Home Manger, Penny Lovett and observed Resident H
01/03/2026	Contact - Document Received Received resident and staff records by email from William Gross
01/06/2026	Contact- Document Sent Email to and from Wiliam Gross
01/07/2026	Contact- Document Received Received intake #208812. Dismissed- SI already exists. Add allegations to open investigation.
01/29/2026	Contact- Document Received Received intake #209164. Dismissed- SI already exists. Add allegations to open investigation.
01/29/2026	APS Referral APS referrals denied

01/29/2026	Contact- Document Sent Email to and from APS Worker, Emily Poley. APS referral made on 12/12/2025 denied.
01/30/2026	Contact- Document Sent Email to APS Worker, Jasmine Martin- Morris
02/02/2026	Contact- Document Received Received additional information from intake for Intake #209164
02/02/2026	Contact- Document Sent Email to APS Worker, Emily Poley. Received return email. APS referrals denied.
02/02/2026	Contact- Document Received Received email from APS Worker, Jasmine Martin- Morris. Sent return email.
02/02/2026	Contact- Document Sent Email to William Gross. Sent request for additional resident and employee records. Received return email.
02/03/2026	Contact - Document Sent Email to APS Worker, Amanda Wietecha. Received return email. Substantiated APS case regarding staff at Ridgeway.
02/03/2026	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Home Manager, Penny Lovett, Staff, Jenna Pierson, Cook Margaret Evenson, Resident D, Resident E, Resident I, Resident J, Resident K, Resident L, Resident M and Resident N.
02/03/2026	APS Referral
02/04/2026	Contact- Document Sent Email to Amanda Wietecha
02/04/2026	APS Referral Referral assigned for investigation
02/04/2026	Contact- Document Sent Email to William Gross. Requested additional documents. Received return email.
02/04/2026	Contact- Document Sent Email to William Gross re: resident bathrooms

02/05/2026	Contact- Document Sent Email to William Gross. Sent technical assistance regarding resident hygiene and resident’s self-administering medications
02/05/2026	Contact- Document Received Received email from intake with additional information
02/09/2026	Contact- Document Received Emails from William Gross with additional resident and employee records
02/19/2026	Contact- Document Received Email from William Gross with updates and pictures of bathroom repairs and meals
02/20/2026	Contact- Document Sent Email to William Gross. Received return email
02/23/2026	Contact- Document Sent Emails to APS Worker, Jasmaine Martin- Morris. Received return email.
04/09/2026	Exit Conference Completed exit conference with Licensee Designee, William Gross. Notified Mr. Gross of findings and recommendation.

ALLEGATION:

- **Residents are being abused and receiving inadequate care due to untrained staff and understaffing.**
- **Residents are not being changed or showered regularly. Clothing and linens are dirty.**
- **Resident was found unchanged, covered in feces and pressure wounds are getting worse.**
- **Resident left facility and owner refused to call 911.**
- **Staff are aware that resident is being sexually abused.**

INVESTIGATION:

I received licensing complaint regarding Ridgeway on 10/13/2025. The Complainant alleged that residents are abused and the facility has uncertified staff. Complainant alleged that the facility is violating the maximum capacity of 20 residents as there are 25 residents at the facility. Ridgeway is licensed as a congregate facility with a capacity of

up to 31 residents. The Complainant stated that the facility is providing unproper care because four individuals who are “mentally sick really bad” need to be attended to 24/7 and staff are not caring enough for other residents. The food is small portions, and some food is uncooked. Residents have received only half a bowl of soup and chili. Snacks consist of two to three cookies, one graham cracker, small bag of gummies, and half a glass of drink. The facility has terrible cooking appliances and kitchen. There are bugs though out the facility. Facility has well water that stinks and smells of sulfur. They cannot drink it, but they still serve it. They have to buy bottled water because facility will not supply it. They cannot take a shower because of the stink. Complainant has concern regarding water and legionnaires disease. Everything is rusty, and showers are unbearable. People wear diapers and pee in them and the staff tells them to go change, the staff does not assist residents with mental health issues with washing them up. The residents change by themselves and still stink. “Pissed diapers” are thrown in uncovered garbage cans. There are unhealthy living conditions and abuse of not feeding residents a proper nutritional meal. The owner does not care. The owner tells them not to give the proper amount or uncooked food. Showers are only given twice a week and the people stink. Medications are dropped. It is unsafe in this place. Resident A has a guardian that will not assist with moving them to a new placement.

I completed an onsite investigation on 10/14/2025. I interviewed Licensee Designee, William Gross, Staff, Lisa Taylor, Ana Amador, Kyra Shepherd, Penny Lovett, Resident B, Resident C and Resident D.

On 10/14/2025, Licensee Designee, William Gross reported that Resident A was in the hospital. Resident A went to McLaren Macomb on 10/11/2025 for a psychiatric evaluation. It is believed that he will be going to a nursing home today. The change in placement is likely permanent, and he will not be returning to Ridgeway. On 10/20/2025, I received copy of Resident A’s resident information record, resident assessment plan, and health care appraisal. Resident information record confirmed Resident A was discharged from facility on 10/11/2025.

On 10/14/2025, I interviewed Staff, Lisa Taylor. She stated that Resident A was making complaints regarding facility and swearing at staff. He was refusing to eat. They had taco salad to eat and he stated, “I don’t want this shit”. She indicated that soiled residents are changed and soiled briefs are disposed of when residents are changed.

On 10/14/2025, I interviewed Licensee Designee, William Gross. He stated that there are currently 22 residents at Ridgeway. He indicated that they currently have three staff, cook and manager on duty. He was present with his wife, Ana Amador. He stated that Resident E, Resident I, Resident K and Resident L need assistance with brief changes. Staff assist residents and briefs are wrapped up and put in the garbage. He stated that residents receive a shower two times a week minimum. If residents have an accident, they give them additional bathing as needed.

On 10/14/2025, I interviewed Staff, Kyra Shepherd. She stated that she has worked at Ridgeway since March 2025 and has been trained. She indicated that she had no

concerns. She stated that there are four residents that receive assistance with brief changes. They dispose of briefs in garbage when residents are changed. She believed there was an issue with afternoon shift not changing residents timely, however, it is better now. Midnight and day shift were regularly changing residents. She stated that residents are for sure bathed two times a week and more often if necessary. They have one resident that is bathed three to four times a week. She stated that Resident A did not like an afternoon staff. He did not like portion sizes and would complain that other residents stink.

On 10/14/2025, I interviewed Staff, Penny Lovett. She stated that she has worked at Ridgeway for almost a year. She has received training. She had no concerns. She stated that any concerns she does have are addressed. She went to management about flies and they had a pest control company come out. She stated that she has never seen residents abused by staff. She stated that staff are helping residents with brief changes. She does not find that residents are left soiled. She stated that Resident J has to be bribed or convinced to let staff change him. Briefs are disposed of in the dumpster. She stated that they have a shower schedule for residents. Residents shower about three times a week. Residents are scheduled for two showers per week, however, they can shower whenever they want. Certain residents need assistance or help getting dressed.

On 10/14/2025, I interviewed Resident B. He stated that he is doing “good”. He has lived at Ridgeway for more than a year. He stated that staff assist him when needed with hygiene and showers. Staff are always available when they need help.

On 10/14/2025, I interviewed Resident C. She stated that she has lived at Ridgeway for two years. She stated that she had surgery and it is “going good”. She stated that staff help her when needed. After her surgery staff assisted her with showers and toileting. There are always staff available. Resident C stated that residents can shower any time. They receive showers twice a week but can shower more if they ask. She has no concerns.

On 10/14/2025, I interviewed Resident D. She stated that she has lived at Ridgeway for three to four years. She stated that she is doing “ok” and had no concerns. She stated that things have changed quite a bit at facility. She indicated that staff are always available and assist her with bathing and hygiene when needed. She showers twice a week on Wednesdays and Saturdays. She can ask to shower more if needed. She stated that the staff are “real good” and she has never seen residents abused.

On 10/20/2025, I received copies of shower schedules for September 2025 and October 2025. The schedules indicate that residents are scheduled for two showers per week. The schedule also indicates if the resident receives a bed bath.

On 10/20/2025, I received requested employee records for Penny Lovett and Kyra Shepherd by email from Licensee Designee, William Gross. Employee records included copy of identification, application, medical/TB test, receipt of job description and

personnel policies, reference checks and CPR/First Aid Training. Additional trainings completed included The Basics of Your Job, The Rights of the People We Serve, Incident Reports, Fire Safety “Must Know” Information, Environmental Emergencies, Fire Prevention, Bloodborne Pathogens and Exposure Control, Infection Control, Signs of Illness and What To Do About Them, Personal Care and Hygiene, Basic Food and Nutrition Information, Introduction to Medications and Medication Administration and Documentation. Both staff have clearances in the Workforce Background Check system.

On 10/29/2025, I received email from APS Worker, Nuha Shamoon. She stated that she spoke with Resident A’s guardian, and this is his “M.O.”, and he has been moved from AFC to AFC. Resident A has issues with every placement. Resident A did complain about the food portions, but he had no concerns regarding the showers. He stated that the home had more residents than was allowed (25 instead of 20). His guardian moved him from the hospital. The manager, Penny Lovett, stated that they always gave him extra, but he was very picky on who cooked the food. If it was something he did not like he would not eat.

I received a second licensing complaint regarding Ridgeway on 10/31/2025. It was alleged that staff members are stealing medications from the clients and clients are going without their medications. There is an 80 percent completion rating for the residents to get their medications. The food in the home is locked up so residents do not have access to it. The clients are not being changed properly. Clients are having their briefs changed and then are being put back in a urine-soaked bed. The clients dirty clothing is being put back in their dresser drawers and not being cleaned. The kitchen has roaches. Showers are not happening but maybe once every week. One unknown resident stated that they are only being showered twice a month. There are days of laundry that are not being cleaned. There is one resident, named (Resident E), that has a degenerative disease where she cannot move. Staff are aware that Resident E is being sexually abused by other residents and are not doing anything to stop it. When the State of Michigan comes out to the facility, staff are doing everything they can to hide their downfalls and clean the home up. Managers are telling staff to force residents out of their beds to bathe them even if it voids their rights. Baths are not being completed. There are little bits of old feces all over the facility. Most of the people in the home do not have the cognitive ability to be interviewed. Resident E is the only resident that has the ability to speak.

On 11/03/2025, I received email from APS Worker, Amanda Wietecha. She indicated in terms of sexual abuse, while Resident E coded it as sexual abuse, it does not meet statutory requirements for sexual abuse. She shared that Resident F, has memory issues and crawled into bed with Resident E. Resident E told him to leave and he did. There was no inappropriate touching and no forceable contact. Resident E however feels that was sexual abuse. There are no concerns for other residents.

On 11/04/2025, I completed an unannounced onsite investigation. I interviewed Licensee Designee, William Gross, Cook Domonjie Smith, Resident E and Resident G. Resident F was not present during onsite investigation.

On 11/04/2025, I interviewed Resident E**.** She stated that she moved to Ridgeway in January. She lived alone previously and did everything by herself. She stated that the facility needs handicapped accessible bathrooms. She receives bed baths and is bathed about twice a month. She took a shower one time. She stated that her laundry is done. Her bedding is washed when she receives a bed bath. She stated that Resident F tried to climb into her bed one night. He also tried to pull roommate, Resident G, out of bed. He was also found sleeping in the empty bed in their room. She stated that he was taken out of facility last night and is not expected to return. She stated that staff usually help her with brief changes. She believes they can be understaffed at times.

On 11/04/2025, I interviewed Resident G. She stated that she is doing “ok”. She has lived at Ridgeway for 10 years. She showers twice a week and does not need help. She indicated that Resident F did try to pull her out of bed. She did not report any other concerns.

On 11/04/2025, I checked dresser and closets in Resident E and Resident G’s bedroom. They did have clean clothing and bedding available.

On 11/04/2025, I interviewed Licensee Designee, William Gross. He stated that Resident F was sent out for a psychiatric evaluation yesterday and went to McLaren Macomb. Resident F had a medication change recently and was not listening and walking around. I interviewed Mr. Gross again during investigation after interviewing Resident E. Mr. Gross confirmed that Resident F walked outside of building and was missing for about one hour. The police department responded and he was found walking down the street. He was then sent to hospital.

On 11/10/2025, I received copies of assessment plans, health care appraisals, resident information records and September 2025, October 2025 and November 2025 medication administration records for Resident E, Resident F and Resident G by email from William Gross. Resident F’s assessment plan under alert to surroundings indicates that he has confusion and may need reminders or redirect.

On 11/10/2025, I received incident reports for Resident F from William Gross by email. Incident report dated 10/20/2025 indicates that he was found in Resident E’s room. Corrective action indicates that they will speak with doctor to adjust medication and caregivers to keep a closer eye on him to make sure he does not go in her room. Incident reported dated 10/22/2025 indicates that Resident F wandered outside while passing meds. Staff called 911 and will meet with psychiatric nurse to adjust medications and reduce behaviors. Incident report dated 11/01/2025 indicates that Resident F pushed another resident and knocked him to floor. Residents were separated. Incident report dated 11/03/2025 indicates that Resident F continuously tries to leave the facility. Report states, “He damages property. Theres been multiple time he

got out and the police had to bring him back". He gets real combative with staff as well as residents and inappropriately grabbing them. Report indicates that he was sent out for a psychiatric evaluation at McLaren Macomb. Corrective action states to move Resident F to a smaller home, North Meadows, to keep a closer eye on him.

A third licensing complaint was received on 11/07/2025. It was alleged that Resident F was sent to the hospital with no history from facility. The Complainant alleged that facility management cannot be reached. When they are reached, wrong information was provided. The Complainant alleged that the facility is declining accepting patient back without issuing a 30-day notice. On 11/07/2025, I spoke to Licensee Designee, William Gross, by phone. Licensee has not refused to accept resident back and placement arrangements have been made. Resident F will be moving to another one of licensees' homes, North Meadows, that is more suitable. Resident moved to North Meadows on 11/07/2025.

A fourth licensing complaint was received on 12/09/2025. It was alleged that Resident H moved into the facility on 11/24/2025 on hospice from home. The Complainant alleged that on 12/03/2025, Resident H was found sitting in a soaking wet diaper of pee and poop, which she smelled of poop, pee and BO. She had feces on her hands, clothes and bedding. Complainant stated that Resident H was changed and cleaned up, she has pressure ulcers now on her butt cheeks. On 12/05/2025, Resident H's hospital bed air mattress was not plugged in and operating along with her hospital bed being placed incorrectly so you were unable to raise the head of the bed for her to safely eat or drink anything. The bed and air mattress were fixed. Resident H was wearing Wednesday's clothes still and she was soaking wet with urine. Pressure ulcers on butt are getting worse and now she has a stage two pressure ulcer on the heal of her foot. Ulcers are not being treated or taken care of, these were not there two weeks ago, and when at home or respite through Accent Care hospice. They are not taking care of wounds or properly changing diapers or positioning the patient. They also are not cleaning, bathing, changing clothes, doing normal hygiene care for the patient or oral mouth care. They are not checking that equipment works probably for safety for the patient that the patient has been using for the last two weeks. There is documentation of ulcers, and urine soaked bed and also Accent Care hospice was taking care of her at home before she moved here so they have documentation stating her skin assessments. This facility should also have documentation from two weeks ago when she was admitted about her skin assessments she is through another different hospice through this facility.

I completed an unannounced onsite investigation on 12/15/2025. I interviewed Licensee Designee, William Gross, Home Manager Penny Lovett and attempted to interview Resident H.

On 12/15/2025, I interviewed Licensee Designee, William Gross. Mr. Gross was leaving facility when I arrived and indicated his Home Manager, Penny, would be able to provide additional information regarding complaint. Mr. Gross believed that Resident H's former caregiver was making allegations because she was upset regarding no longer

providing her care. Resident H receives hospice care. He stated that Resident H’s son stopped visits with the former caregiver.

On 12/15/2025. I interviewed Home Manager, Penny Lovett. Ms. Lovett stated that she has been the home manager since 11/11/2025. She stated that Resident H receives hospice care and she has spoken to the hospice and social worker regarding Resident H’s care. There are times that Resident H will refuse medications, refuse to eat and not let staff change her. She will scream “go”. Resident H now has a catheter. Ms. Lovett indicated that Resident H has limited verbal ability, and staff must guess what she is trying to say. Ms. Lovett stated that brief changes are done every two hours. If Resident H refuses, staff will go back and try again but they cannot restrain resident to change her if she refuses. She stated that if Resident H does not want to be changed, she will clench legs and pull up blanket. She has never seen resident covered in feces. She was not sure how often staff change her clothing. Ms. Lovett stated that resident’s former caregiver came to visit and started to move resident, rearrange room and was snapping pictures of her. Resident H’s son said that she can no longer visit. Ms. Lovett stated that St. Croix hospice is providing services. She is seen regularly by nursing and hospice aide. Resident H’s bed sores are not getting worse. A hospice aid comes to the facility and bathes and changes resident twice a week. Staff will also assist with bathing as needed.

On 12/15/2025, I observed Resident H. Resident H had limited verbal ability and was unable to answer questions regarding investigation. Resident H was observed watching television in bed. Resident H appeared clean and was wearing clean pajamas. Bedding and linens also appeared to be clean. I did not observe any urine or feces on Resident H or her bedding. Resident H had a catheter bag. I reviewed Resident H’s hospice notes during onsite investigation. I did not find any concerns reported by hospice and notes indicated that Resident H is being seen regularly by the hospice nurse.

On 01/03/2026, I received resident records for Resident H including copy of assessment plan, resident care agreement, resident information record, health care appraisal, November 2025 and December 2025 medication administration records and hospice notes. Resident H received care from St. Croix Hospice. Resident H was seen by nursing on 11/25, 11/26, 12/02, 12/04, 12/08, 12/09, 12/12, 12/16, 12/18, 12/22 and 12/24. Nursing note from 11/26/2025, indicates that brief was changed and patient comfortable in bed. Nursing note dated 12/09/2025 indicates that Resident H had catheter inserted. Nursing note dated 12/22/2025 indicates that patient had soiled brief upon arrival.

On 02/09/2026, I received additional St. Croix Hospice records for Resident H including notes, visit schedule and physician orders. Hospice visit schedule indicated that Resident H was seen by nurse on Tuesdays and Thursdays and Aide on Wednesdays and Fridays. Notes are also included from visits with Chaplain. Note dated 12/03/2025 stated staff was completing bathing care just as they arrived. Note dated 12/17/2025 indicates that brief was changed and catheter care provided, however, could not bathe due to no hot water. Note dated 01/08/2026 from nurse stated they discussed

medication with Penny. Patient having behaviors with changing becoming combative. Note on 01/14/2026 indicates that patient bathed yesterday, repositioned and changed patient.

A fifth licensing complaint was received on 01/07/2026. It was alleged that Resident F walked out of the facility and was missing. Owner was instructed to call 911 and according to referral source he blew it off and reported staff was looking for the client. Staff left the facility to look for client leaving other residents and concern that other residents are not receiving adequate care. Within that week this is the third time the client has left. This is no longer an issue as the client mentioned has been moved to a smaller facility and no longer having the elopement issues and his medication has been adjusted. Intake is regarding incident that occurred on 11/04/2025. Resident no longer resides at facility. Resident F moved to licensee's North Meadows home on 11/07/2025. On 02/02/2026, I received an email from APS Worker, Jasmine Martin- Morris. She indicated that this case was substantiated under another case where Resident F was mentioned. She stated that Resident F was moved to another home that best fits his needs.

A sixth licensing complaint was received on 01/29/2026. The Complainant alleged that that they have only two staff on for at least 25 residents and they are trying to squeeze 30 in the building. For the amount of care a lot of the residents need, Complainant does not think they can have that many people for how little staff. Most places have one staff for six to eight residents depending on level of care. Resident E never gets bed bathed and does not always get her medicine. Half the time they fail to even give her food or a snack. They do not go check on her and change her. She has to call the house phone the majority of the time to get assistance. Resident H who passed away, nobody would ever change. Hospice would come out of there pissed and showing the manager how she found Resident H. The manager would pull out her phone and take picture of it and send it to their employee group chat and say, "this is absolutely unacceptable" and nothing changed. Resident J also has multiple soiled briefs on because he tries to change himself but forgets about the part he has to take the old one off. There has been times he had three dirty soiled briefs on at a time. Resident K has had more and more bruises on him and Complainant is unsure if it is from him hitting himself on something or from residents beating him up because they are all super rude to him.

The Complainant alleged that everyday people go without getting changed. Ask Resident L and Resident M how safe they feel taking a shower or even simply getting out their chairs onto the toilet in some of their bathrooms because they have no bars in them. Go look at how crowded they have people in their rooms. They will make staff work alone, if staff works with Jenna or Penny the manager, they are working alone. People will not come in and the managers nor owners will come in and make staff that has second jobs or kids at home work 16-hour shifts. Most of the time they will not pay overtime unless you ask them too. They have made staff work full shifts alone. The manager will say she is figuring out coverage and then never call back or answer calls. They had a resident named (Resident D) fall on the floor and the EMS was leaving before the manager finally reached out to staff to see what was going on. They have

had people finish out their schedule thinking they are going to be scheduled on the next one then all of a sudden they must be fired because they remove them from their little group chat they have and do not schedule them again but fail to tell them they are even fired. It was alleged that caregiver, Jenna, is never seen doing anything. She is always doing something with the medications or manager things because the manager cannot do it all on her own making it where the other caregiver on is the only one on the floor, one against 25-27 people. The Complainant is not sure how many residents they have there now. There is a lot of residents there that never get showered, never get their clothes changed and never get regularly changed. They also all get their “shit stolen” from them. The facility is overcrowded and understaffed. They do not train their staff. Their manager has no idea what she is doing. The owners are “full of shit” making it seem like Ridgeway is perfect for people’s family and they are going to be treated so well but they are lying. They have diabetics that are constantly being filled with sugar because all they buy is processed foods and sugary foods and drinks. Most mornings all they get to eat is a bowl of cereal and one piece of toast. There is barely enough food to go around for how many residents there are and instead of moving they add more to the pile. They have a resident named Resident I that harasses staff and residents, and he will “piss and shit himself” all day and then refuse to change or shower and the other residents have to put up with that. They had to send him out for psych one day because he was putting his hands on the ladies and even trying to lick the female caregiver’s neck. There wasn’t even a manager on duty.

I completed an unannounced onsite investigation at Ridgeway on 02/03/2026. I interviewed Home Manager, Penny Lovett, Staff Jenna Pierson, Cook Margaret Evenson, Resident D, Resident E, Resident I, Resident J, Resident K, Resident L, Resident M and Resident N.

On 02/03/2026, I interviewed Home Manger, Penny Lovett. She stated that there are currently 23 residents at Ridgeway. Today they have two caregivers, a manager and a cook on shift. She believed a complaint was made because a staff was let go. She indicated that Resident J can be violent and has hit staff members. She has called hospice regarding his behavior numerous times. The hospice nurse reported he was wet when she arrived. She stated that they cannot force a resident to allow staff to change their brief. Staff do assist him and do checks every two hours. They have found him with a double brief when he has changed himself. She stated that Resident M does receive assistance from staff with brief changes and has also refused assistance. He uses a urinal. She indicated that there are bars in the showers for residents. She stated that Resident E is her own guardian. She receives weekly bed baths and they are never missed. Ms. Lovett stated that Resident E will pick and choose who she allows to take care of her. She will deny care and will not get out of bed. She receives meals, however, will not eat if she does not like what is served. She indicated that staff assist Resident E with brief changes and they are never missed. Resident E has a bell that she can ring for staff assistance.

Ms. Lovett stated that Resident H passed away on hospice on 01/16/2026. Hospice did come in and report she was wet. Ms. Lovett stated that at times Resident H would

clench her legs together and not allow staff to change her. Ms. Lovett stated that she told staff that Resident H needed to be changed every two hours. She addressed the issue and it was taken care of. Ms. Lovett believed that she did send text to staff when the former caregiver visited and complained resident had not been changed. She stated that she probably sent text to staff indicating that hospice said Resident H needed to be changed. Ms. Lovett indicated that she could not find text messages in her phone during the onsite investigation. I requested that Ms. Lovett email or text me copies of messages once found, however, they have not been received. She stated that Resident K loses balance but does not necessarily fall. He has no known bruises. Resident A pushed him once. She indicated that Resident K never hits himself. Ms. Lovett stated that other residents will yell at him because he will ask nasty questions or stand in the middle of the room and shout. He changes himself and receives assistance with showers. She stated that Resident L is his own guardian. He refuses showers. He receives services from Home MD and wound care. He refuses to let staff assist him with showers. She believed he last showered 1 ½- 2 weeks ago. She stated that that he is going home on 02/12/2026. Ms. Lovett indicated that Resident L had a strong smell when I went to his bedroom to interview him. Resident L was observed to have three roommates. Ms. Lovett stated that she was not present when Resident D fell. She believed that Resident D fell out of her wheelchair about three to four months ago. Ms. Lovett believed that Resident D had a bruise and no serious injuries. EMS was called when she fell. She stated that Resident I was sent for a psychiatric evaluation and receives services through the VA. He steals and has grabbed staff. She stated that he knows what he is doing. He needs prompts from staff, however, will change himself. He has walked in the dining room with feces on him. He will clean himself up when he is redirected. She indicated that he can shower himself, however, staff do double check and make sure he showered adequately. She indicated that the allegations regarding Resident I are all true.

Ms. Lovett stated that she is working with licensee on a check list for each shift to divide tasks. She stated that no rooms at Ridgeway have more than four residents. They have two bedrooms with four residents and other bedrooms have one to three residents in bedroom. She indicated that there have been no shifts with only one staff. If a staff calls in or leaves, they will be immediately replaced. She stated that laundry is done daily. Residents change their clothes daily or every other day.

On 02/03/2026, I interviewed Resident E. She is her own guardian. She stated that she is doing “fine”. She stated that most of the time she gets the assistance that she needs. She stated that she receives bed baths but could not tell me the last time she received one. She believed it may have been since December. She indicated that she refused the last time she was offered a bed bath because she did not have clean bedding. Her bedding needs to be washed alone. Resident E was not found to have an odor or dirty bedding or clothes. Resident E indicated that staff will assist her with brief changes when she requests it. Resident E stated that she can call the house phone if she needs assistance or has a doorbell she can ring. It depends on who is working as to how long it takes them to respond. Resident E also had concern regarding water quality.

On 02/03/2026, I interviewed Resident M. He is his own guardian. He stated he was doing “ok”. He also stated that he is going crazy and that he is “peeing too much”. He became visibly upset during onsite investigation and stated that he did not want to go out and see a doctor.

On 02/03/2026, I interviewed Resident N. She is her own guardian. She stated that she “hates” it here. She has been at Ridgeway since the end of October 2025 and is totally broke. She pays $3,000.00 per month and has $100.00 left over. She has to buy her own briefs and snacks with that money. She plans to go to a rehab program. Resident N stated that she is receiving her medications, however, they will run out when waiting on refills. Her bedding and clothes were last changed about four to five days ago. She has not been bathed in a little over two weeks. Resident N and her roommate Resident E are both bedbound. Resident E indicated that this is not true and Resident N only moved in the room two weeks ago and she has seen her get two bed baths. Resident N stated that staff assist her with brief changes about every three hours. It is hit or miss. She has a doorbell to call staff if she needs assistance. Staff do a couple checks daily, however, there are no regular checks.

An APS referral was made due to Resident N’s allegations. On 02/23/2026, I received email from APS Worker, Jasmine Martin-Morris. She stated that as of right now she is not substantiating allegations regarding Resident N. She checked her lease and she agreed to pay the dollar amount for rent and for her briefs. She also checked medication cabinet and at the time of the complaint all of her medications were refilled. There is also a showering and bedding chart and the first week of February, the client refused.

On 02/03/2026, I interviewed Assistant Manager, Jenna Pierson. She stated that she has worked at Ridgeway for over a year. She stated that Resident N received a bed bath last week. One of the newer girls did it. She is also getting a bed bath today. She indicated that residents are typically bathed twice a week. She stated that they try to split showers up between shifts. Some residents prefer different times of day for showers. She stated that she had no concerns and believes things are getting better at Ridgeway from when she first started.

On 02/03/2026, I interviewed Resident D. She stated that she did have fall at Ridgeway. The lid on the toilet was not tight and she fell off. The toilet seat came completely off. She stated that this happened in the bathroom with green toilet and wooden lid. She stated that she hurt her shoulder and leg when she fell. EMS came and checked her out. She did not go to the hospital. She is doing good now. She stated that she does her own hygiene and toileting.

On 02/03/2026, I interviewed Resident J. He stated that he was doing “ok” and everything is “perfect”. He stated that staff help him. Staff assist him with brief changes and showers.

On 02/03/2026, I interviewed Resident K. He stated that things are “going good” at the facility. He is getting the assistance he needs. He has to ask staff for help. He indicated

that he does not take medication. He stated that he has no bruises. Staff and residents are being nice to him. He did not report being beat up by any residents.

On 02/03/2026, I interviewed Resident L. Home Manager indicated that Resident L currently has strong odor as he is refusing to shower. Resident L stated that he is moving out in a week and a half. He has lived at Ridgeway for three months and is going home. He indicated that the facility is not diabetic friendly as advertised. He stated that he cannot get his wheelchair in the bathroom. He stated that the staff would assist him with shower whenever he asks, however, he is reluctant to ask for assistance because of safety. He also has a walker he can use. He stated that he can use the bathroom by himself. Resident L stated that other residents are stealing things from his bedroom. Another resident came into his room and stood over him. He has seen one resident try to hit someone with a cane and a resident taking their pants off. Other residents at the facility are unsanitary so he tries to stay away from them and eat when others have left the dining room. He has seen blood and feces on other residents. He stated that his bedding has been changed three or four times. They were changed within the last week. He stated that unsanitary residents go through their clean clothes. He indicated that he believes staff are trying but are overwhelmed and undertrained. He receives wound care from a provider that comes out to the facility. They have not come out to change his bandage since Saturday.

On 02/03/2026, I interviewed Resident I. He stated that he has lived at Ridgeway for three years and is doing alright. He stated that he does not need any help. He is getting his medications. He stated that he can shower on his own and does not need assistance with toileting or brief changes.

On 02/09/2026, I received copies of November 2025, December 2025 and January 2026 staff schedules. Schedules indicate that two staff are being scheduled for each day, afternoon and midnight shift. Home Manager and cook are scheduled for day shifts during the week.

On 02/09/2026, I received resident records for Resident D, Resident E, Resident I Resident J, Resident K, Resident L, Resident M and Resident N including copies of resident information records, assessment plans, resident care agreements, weight records and incident reports. Resident E's assessment plan indicates she is incontinent of bowel and bladder and needs reminders about toileting. Resident E was reported to wear briefs. Plan indicates that staff assist with bathing. Resident J's assessment plan indicates that staff will assist with toileting, bathing and personal hygiene. There is note next to toileting that states sometimes difficult depending on behaviors- manage offer PRN to take effect. Note next to bathing states difficult depending on behavior will sponge bathe if cannot shower. Resident L's assessment plan indicates that he needs help to go to the bathroom and with bathing. Resident I's assessment plan indicates that staff oversee his toileting and bathing as needed. Resident N's assessment plan indicates she needs assistance with toileting and bathing. Note states if no shower to give bed bath instead.

On 02/09/2026, I received copies of shower schedules for November 2025, December 2025 and January 2026. Schedules indicate that residents are being scheduled for showers twice a week.

On 02/09/2026, I received employee files for Jenna Pierson and Penny Lovett. Mr. Gross provided copies of driver's license, application, receipt of personal polices and job description, initial medicals, communicable disease/TB screening, training records and CPR/First certification for both staff. Additional trainings completed included: The Basics of Your Job, The Rights of the People We Serve, Incident Reports, Fire Safety, Environmental Emergencies, Fire Prevention, Infection Control, Prevention and Containment of Communicable Diseases, Personal Care, Supervision and Protection, and Hygiene, Basic Food and Nutrition Information, Special Diets, Food Safety and Storage, Introduction to Medications, Medication Administration and Documentation and Resident Behavior Interventions. Both staff have also received workforce background checks. Penny Lovett had updated job description for Home Manager.

APPLICABLE RULE	
R 400.633	**Direct care staff; qualifications and training.**
	(5) 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 trained and competent in all of the following areas before performing assigned tasks independently: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases including recognizing signs of illness.** **(h) Food safety, which includes food storage, preparation, distribution, and serving in a safe manner.** **(i) Nutrition and special diets.**

ANALYSIS:	There is not enough information to determine that residents are being abused due to untrained staff. I requested employee files for Staff, Penny Lovett, Kyra Shepherd and Penny Lovett. Licensee Designee, William Gross, provided employee records and required training including current CPR/First Aid for staff.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.** **(b) 12 residents for small group and family homes.**
ANALYSIS:	There is not enough information at this time to determine that Ridgeway does not have adequate staffing per shift. As of 02/03/2026, Ridgeway had 23 residents. They are licensed for up to 31 residents. Staff schedules and interviews indicated that there are two staff being scheduled for each day, afternoon and midnight shift. During the day shift, there is also a manager and cook scheduled during the week.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Resident J has not been provided with personal care as required in assessment plan. On 02/03/2026, I interviewed Home Manager, Penny Lovett. Ms. Lovett confirmed that Resident J has been found with more than one brief on. Resident J's assessment plan indicates that staff should be assisting Resident J with toileting, bathing and personal hygiene. There is note next to toileting that states sometimes difficult depending on behaviors- manage offer PRN to take effect. Note next to bathing states difficult depending on behavior will sponge bathe if cannot shower. There is not enough information to determine that resident left facility and owner refused to call 911. However, Resident F was not provided with adequate supervision and protection at Ridgeway as incident report noted Resident F would leave facility and police had to bring him back multiple times. Resident F's assessment plan under alert to surroundings indicates that he has confusion and may need reminders or redirect from staff. On 11/10/2025, I received incident reports for Resident F from William Gross by email. Incident report dated 11/03/2025 indicates that Resident F continuously tries to leave the facility. Report states, "He damages property. Theres been multiple time he got out and the police had to bring him back". He gets real combative with staff as well as residents and inappropriately grabbing them. Report indicates that he was sent out for a psychiatric evaluation at McLaren Macomb. Corrective action states to move Resident F to a smaller home, North Meadows, to keep a closer eye on him.. Resident F no longer resides at Ridgeway. Resident F was moved to another home on 11/07/2025. There is no information to determine that staff were aware resident was being sexually abused. Resident F was reported to have entered into the bedroom of Resident E and Resident G. He attempted to get into bed with Resident E and tried to pull Resident G out of bed. Resident E also reported that he was found in extra bed in their bedroom. However, no sexual abuse was reported by either resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(2) A licensee shall ensure the resident receives or has access to all of the following: **(a) Bathing at least weekly.** **(b) Toileting as needed.** **(c) Assistance with resident hygiene as needed.**

ANALYSIS:	Based on residents' briefs not being changed as necessary and residents' strong odors, there is a preponderance of evidence to establish that residents are not getting adequate assistance with hygiene. Shower schedules provided indicate that residents are being scheduled for showers at least twice a week. However, Penny Lovett indicated that some residents are refusing showers or bed baths. This has resulted in residents going unbathed for multiple days at a time. On 02/03/2026, Home Manager, Penny Lovett stated that Resident H passed away on hospice on 01/16/2026. Hospice did come in and report she was wet. Ms. Lovett stated that at times Resident H would clench her legs together and not allow staff to change her. Ms. Lovett stated that she told staff that Resident H needed to be changed every two hours. She addressed this issue and it was taken care of. Ms. Lovett believed that she did send text to staff when the former caregiver visited and complained resident had not been changed. She stated that she probably sent text to staff indicating that hospice said Resident H needed to be changed. Ms. Lovett indicated that she could not find text messages in her phone during onsite investigation. I requested that Ms. Lovett email or text me copies of messages once found, however, they have not been received. Ms. Lovett confirmed that Resident J has been found with more than one brief on. Resident J's assessment plan indicates that staff should be assisting Resident J with toileting, bathing and personal hygiene. There is note next to toileting that states sometimes difficult depending on behaviors- manage offer PRN to take effect. Note next to bathing states difficult depending on behavior will sponge bathe if cannot shower. Ms. Lovett stated that Resident L is his own guardian. He refuses showers. He refuses to let staff assist him with showers. She believed he last showered 1 ½- 2 weeks ago. She stated that that he is going home on 02/12/2026. Ms. Lovett noted that resident would have a strong smell when I went to his bedroom to interview him. Resident E and Resident N also reported being bathed infrequently. Resident N reported inconsistent brief changes. Staff reported that both residents have at times refused assistance. Resident E stated that she refused last bed bath because she did not have clean bedding.

CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.669	**Linens.**
	(1) A licensee shall provide all of the following: **(a) Clean bedding in good condition that includes a minimum of a fitted sheet, top sheet, pillowcase, and blanket or comforter for each bed.** **(b) At least 1 standard bed pillow that is comfortable, clean, and in good condition for each resident.** **(c) Bath towels and washcloths.**
ANALYSIS:	Resident E, Resident L and Resident N all reported that their bed linens are not being washed on a regular basis.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(3) A licensee shall assist the resident in obtaining clothing that fits, is clean, and is seasonally appropriate.
ANALYSIS:	There is no information at this time to determine that residents do not have adequate clothing. Residents were observed to be dressed appropriately and there was clothing available in closets and dressers.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibiliites.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.

ANALYSIS:	There is no information to determine that staff were aware a resident was being sexually abused. On 11/04/2025, I interviewed Resident E. Resident E stated that Resident F tried to climb into her bed one night. He also tried to pull roommate, Resident G, out of bed. Resident F was also found sleeping in the empty bed in their room. Resident E stated that Resident F was taken out of facility last night and is not expected to return. On 11/04/2025, I interviewed Resident G. She indicated that Resident F did try to pull her out of bed. There were no reports that Resident F inappropriately touched Resident E or Resident G.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **The facility has unsanitary water that smells.**
- **Bathrooms and showers are in poor condition.**
- **There are bugs throughout the facility.**

INVESTIGATION:

The water source for Ridgeway has been inspected by Department of Environment, Great Lakes, and Energy (EGLE). On 05/13/2025, I received a copy of EGLE's Deficiency Violation Notice Sanitary Survey Report for Ridgeway dated 05/08/2025. The survey identified potential risks that may adversely affect drinking water quality. The report indicated that the survey of the water system identified deficiencies with the source, distribution system and operator compliance. On 08/07/2025, Licensee Designee, William Gross, indicated that he was still working on a plan to implement corrections. As of 09/03/2025, the licensee had not corrected deficiencies by the extended deadline of 08/30/2025, however, submitted a wavier request on 08/29/2025.

On 10/20/2025, I received email from Shamsul Fahim, EGLE District Engineer. He stated, "EGLE's Warren district office (DWEHD) has approved Ridgeway's request for an extension regarding the two outstanding deficiencies (means to measure water level & emergency injection tap) identified during the 2025 Sanitary Survey/Inspection. Since no immediate threats to public health related to potable water were determined, we set the compliance deadline for Ridgeway to install the necessary items by May 2028 Sanitary Survey."

On 10/14/2025, I interviewed Staff, Lisa Taylor. She indicated that they have only had issues with flies at Ridgeway.

On 10/14/2025, I interviewed Licensee Designee, William Gross. He indicated that they have had no issues with pest control other than flies. They receive pest control services from The Bug Guy. He stated that there are no issues with showers. Ms. Amador stated that they are in the process of remodeling bathrooms.

On 10/14/2025, I interviewed Staff, Kyra Shepherd. She stated that the tub was leaking in bathroom that was being remodeled. It was finished yesterday.

On 10/14/2025, I interviewed Staff, Penny Lovett. She stated that any concerns she does have are addressed. She went to management about flies and they had a pest control company come out.

On 10/14/2025, I interviewed Resident B. He stated that there are no bugs at facility other than quite a few flies. He indicated that sometimes the floors need cleaning.

On 10/14/2025, I interviewed Resident C. She stated that she has not seen any bugs or flies at facility. She stated that the bathrooms are fine and are clean. She has no concerns.

On 10/14/2025, I interviewed Resident D. She indicated that the bathrooms are clean.

On 10/20/2025, I received copies of pest control invoices from Licensee Designee, William Gross by email. Invoices indicate that Pest Corp Plus Home Services, LLC provided services at Ridgeway on 07/24/2025, 08/16/2025 and 09/26/2025. Invaders noted on invoices include mice, bees, spiders and ants.

On 11/03/2025, I received email from APS Worker, Amanda Wietecha. Ms. Wietecha indicated that she did go to the kitchen and through some counters and drawers and did not see any roaches as reported.

On 11/04/2025, I completed an unannounced onsite investigation. I did not observe any roaches or bugs in the kitchen at the time of investigation. I did not observe any pest control issues at facility.

On 11/04/2025, I interviewed Cook, Domojie Smith. She indicated that there are no roaches or bugs in kitchen.

On 11/04/2025, I interviewed Resident E. She indicated that the only bugs she has seen are flies. She purchased a fly strip and asked staff to hang it over her bed.

On 11/04/2025, I interviewed Resident G. She stated that there are flies in her room and dining room. They have fly strips in her bedroom.

On 02/03/2026, I observed all four resident bathrooms at Ridgeway. I observed hand bars in all the shower/bath areas.

I observed Bathroom #1 had a green toilet. The top of toilet tank is missing and is covered by a wooden box painted partially green with chipped edges. I also observed chipped tiles on the wall to the left of toilet. The bathroom vent fan was also not secured to celling. Bathroom #1 is the bathroom that Resident D reported that she fell in when toilet seat fell off.

On 02/09/2026, I received copy of incident report by email regarding Resident D's fall. Incident report dated 10/19/2025 indicates that staff heard a big bang and Resident D had fallen off the toilet. They tried to lift her but were hurting her arm. EMS was called to help get her up and she had small cut on side that was cleaned. Corrective action indicates that she is not going to use that restroom with the seat on it and staff also securely put the seat back on.

I observed Bathroom #3 had a toilet chair with rusted metal. I observed chipped flooring in shower and hole in fiberglass around shower knob. The shower had a stained shower mat and rusted/stained ceiling tiles in shower area.

I observed Bathroom #4 did not have a shower curtain.

On 02/19/2026, I received email from Wiliam Gross with pictures of bathroom repairs that he has started. Shower curtain, toilet chair and mat have been replaced. Also, the vent fan was repaired. Pictures appear to have some type of patching on shower knobs and tile. Mr. Gross indicated that a new toilet tank lid was ordered for Bathroom #1, however, was too small and a new one has been ordered.

APPLICABLE RULE	
R 400.645	**Environmental health.**
	(1) The water supply must be of potable, reliable quality and from an approved source.
ANALYSIS:	There is not enough information at this time to determine that the water at Ridgeway is unsanitary. The water source has been approved by EGLE and the licensee has until May 2028 to correct deficiencies.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.645	**Environmental health.**
	(6) An insect, rodent, or pest control program must be maintained and carried out in a manner that continually protects the health of residents.

ANALYSIS:	There is not enough information to determine at this time that there are bugs throughout facility. There were no pest control issues observed. There were no roaches observed in the kitchen. The only bugs reported were flies. Invoices indicate that Pest Corp Plus Home Services, LLC provided services at Ridgeway on 07/24/2025, 08/16/2025 and 09/26/2025. Invaders noted on invoices include mice, bees, spiders and ants.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for health, safety and well-being of residents.
ANALYSIS:	On 02/03/2026, I observed Bathroom #1 had a green toilet. The top of toilet tank is missing and is covered by a wooden box painted partially green with chipped edges. I also observed chipped tiles on the wall to the left of toilet. The bathroom vent fan was also not secured to celling. Bathroom #1 is the bathroom that Resident D reported that she fell in when toilet seat fell off. I observed Bathroom #3 had a toilet chair with rusted metal. I observed chipped flooring in shower and hole in fiberglass around shower knob. The shower had a stained shower mat and rusted/stained ceiling tiles in shower area. On 02/19/2026, I received pictures from William Gross showing bathroom repairs have begun.
CONCLUSION:	**VIOLATION ESTABLISHED**
APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.

ANALYSIS:	On 02/03/2026, I observed Bathroom #4 did not have a shower curtain. On 02/19/2026, I received picture from William Gross by email showing curtain has been replaced.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Staff are stealing medications**
- **Residents are not receiving their medications.**

INVESTIGATION:

On 11/04/2025, I interviewed Resident E. Resident E stated that she takes medication every eight hours. Staff did not give her 11:00 pm dose last night due to an issue with Resident F. Resident E stated that she has her own backup supply if needed. Resident E did not show me where she had backup supply of medication. I informed Licensee Designee, William Gross, to ensure all medications are kept in a locked location and not self-administered without physician authorization. She stated that staff are not stealing medications.

On 11/04/2025, I reviewed Resident E's medication log. I observed that on 11/03/2025 Resident A's 10:00 pm doses of Baclofen 5 mg and Nictoine Td patch were not initiated as administered by staff.

On 02/03/2026, I interviewed Resident E a second time regarding medications. She stated that she takes one pill every eight hours. She does not always get it on time. On one occasion, staff handed her all three pills at once. She has a few back up pills in her room if needed. Resident E showed me a wallet with a small pill container located inside. During onsite investigation, I notified home manager of pills and indicated they need to be put in locked location and resident needs physician authorization to administer own medication. I also notified Licensee Designee, William Gross.

On 02/04/2026, I received email from Licensee Designee, William Gross. He stated that pills have been removed from Resident E's room. They are speaking with doctor regarding authorization. On 02/09/2026, I received copy of order from Resident E's medical provider dated 02/09/2026. Order states that Resident E may self-administer all medications as facility reports they will safeguard the medications and remind her.

On 11/04/2025, I interviewed Resident G. She stated that she is getting her medications.

On 11/04/2025, I interviewed Licensee Designee, William Gross. He stated that there have been no complaints regarding staff stealing medications or issues with missing medications. I reviewed resident medication logs with Mr. Gross. Medications were observed to be stored in locked medication cart in medication room.

On 11/05/2025, I received email from APS Worker, Amanda Wietcha. She indicated that she spoke with the CEO, William, and he did share Resident E's medical log and shared that a dose was missed because of Resident F going missing for a period of time. Based on that alone, she will be substantiating her case.

On 11/10/2025, I received copies of assessment plans, health care appraisals, resident information records and September, October 2025 and November 2025 medication administration records for Resident E, Resident F and Resident G by email from William Gross. Resident E's assessment plan indicates that staff will administer her medication. Licensee Designee, William Gross, indicated in email that Resident E does not have access to any medications and that she is given medications by caregivers. Medications were initiated as administered by staff on medication logs.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	While there is no information at this time to determine that medications are not being given because they are being stolen by staff there is sufficient evidence to show that Resident E did not get her medication as prescribed from staff. On 11/04/2025, I completed an unannounced onsite investigation. Resident E stated that she was not given her evening dose of medication by staff because they were having a issue with Resident F. She stated that she has her own backup supply of medication to take if needed. Licensee Designee, William Gross, was notified as medication must be kept in locked location and resident needs physician authorization to self-administer medication. On 11/04/2025, I reviewed Resident E's medication log. I observed that on 11/03/2025 Resident A's 10:00 pm doses of Baclofen 5 mg and Nictoine Td patch were not initiated as administered by staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	On 02/03/2026, I completed an unannounced onsite investigation. I interviewed Resident E. Resident E showed me a wallet with a small pill container located inside. During onsite investigation, I notified home manager of pills and indicated they need to be put in locked location and resident needs physician authorization to administer own medication. I also notified Licensee Designee, William Gross. On 02/04/2026, I received email from Licensee Designee, William Gross. He stated that pills have been removed from Resident E's room. On 02/09/2026, Resident E received an order to self-administer her own medications. Her medications must still be kept in a locked location.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility is not serving nutritious meals or adequate food portions.

INVESTIGATION:

On 10/14/2025, I interviewed Staff, Lisa Taylor. Ms. Taylor indicated that residents are served breakfast, lunch and dinner and are given seconds if they have enough.

On 10/14/2025, I interviewed Licensee Designee, William Gross. He was present with his wife, Ana Amador. They both indicated that they have not received any complaints regarding food.

On 10/14/2025, I interviewed Staff, Kyra Shepherd. She stated that food portions could be bigger. She stated that they had cereal and toast for breakfast. Sometimes there are eggs and bacon. Lunch can be a sandwich and juice. Sometimes there is not enough to go around for seconds, however, they do have snacks like cookies, crackers and fruit.

On 10/14/2025, I interviewed Staff, Penny Lovett. Ms. Lovett stated that the food portions are decent and not too small. She stated that if there is not enough for seconds, they can offer residents something else like leftovers. They also have snacks such as vanilla wafers, Jello pudding, brownies, cakes, crackers packs and cheese balls.

On 10/14/2025, I interviewed Resident B. He stated that he gets enough food to eat. He last had cream of wheat for breakfast, hot dogs for lunch and stew for dinner. He stated there are snacks available such as Cheeze-Its.

On 10/14/2025, I interviewed Resident C. She stated that she gets enough food to eat. She stated that portions are “ok” and sometimes there is more for seconds. She stated that they have graham crackers and cookies for snacks. Breakfast is usually oatmeal, cream of wheat, or cereal. Lunch and dinner include hot dogs, hamburgers and pizza. She indicated that she would like if they were served less rice and more mashed potatoes.

On 10/14/2025, I interviewed Resident D. She indicated that food portions are small. Breakfast is usually oatmeal or cereal. Sometimes they get bacon and eggs. Lunch and dinner include spaghetti, goulash and pizza. There are not seconds available. They do have snacks they can eat such as cookies and chips. She uses her own money to purchase more food.

On 10/14/2025, I observed the food available in kitchen. The facility had an adequate supply of food including milk, eggs, cheese, juices, chicken, frozen vegetables, cake mixes, bread, Jello, canned goods, coffee and tortillas. I observed a tuna sandwich and chips being served for lunch.

On 10/20/2025, I received copies of menus for September 2025 and October 2025. The licensee also provided a copy of a diabetic menu. No substitutions were noted on menus.

On 11/04/2025, I interviewed Cook, Domojie Smith. Residents are being served chili, vegetables, cupcake and salad for lunch. She has not received any complaints from residents.

On 11/04/2025, I interviewed Resident E. Resident E stated that the “food sucks”. They have lots of processed food with lots of preservatives such as hot dogs, pizza, pork and beans which causes loose bowels. She is buying some of her own food.

On 02/03/2026, I interviewed Home Manager, Penny Lovett. Ms. Lovett stated that she has a budget every month for food. Regular and diabetic menus are provided. They provide diabetic options; however, sometimes diabetic residents will get their own food delivered. They get grocery deliveries on Mondays and Tuesdays. She believes they have enough food and encourages a healthy diet for all residents. She stated that

residents are served a variety of things for breakfast such as eggs, toast, pancakes, coffee, cream of wheat, oatmeal, bananas and cantaloupes. She indicated that sometimes the portions do seem small, however, have improved from when she first started. Residents can have seconds if available. There are snacks available if there are no seconds and residents also have bins for their own food.

On 02/03/2026, I interviewed Resident E. Resident E initially stated she was not discussing food. She then stated that they feed her like a two-year-old. Lunch today was taco salad with no taco sauce. She refused breakfast because it was cream of wheat with no milk, sugar or butter. They sometimes have better options.

On 02/03/2026, I interviewed Resident N. She indicated that the food is terrible. For lunch they had taco salad. The portions are very small, and she has lost a lot of weight. Resident N stated that breakfast today was cream of wheat with no milk. She refused to eat it and ate two of her own cookies for breakfast. On 02/09/2026, I received a copy of Resident N's weight record. Weight record indicates that Resident N has lost two pounds since admission. It indicated she weighed 252 upon admission on 10/27/2025. She weighed 250 on 01/01/2026 and refused weight on 02/03/2026.

On 02/03/2026, I interviewed Assistant Manager, Jenna Pierson. Ms. Pierson indicated that the food portions are "ok". She stated that residents can be picky and do not like certain things. For breakfast they had cream of wheat, toast and cereal. She did not see any fruit served. She stated that she had no concerns and believes things are getting better at Ridgeway from when she first started.

On 02/03/2026, I interviewed Resident D. Resident D stated that the facility does not have enough groceries and the portions are small. She had cream of wheat and coffee for breakfast. They had taco salad for lunch.

On 02/03/2026, I interviewed Resident J. He stated that he is getting enough food to eat. He has not eaten his lunch yet.

On 02/03/2026, I interviewed Resident K. He stated that he is getting enough food to eat. He believed he had cereal for breakfast and a BLT for lunch. He stated that the portions are "ok".

On 02/03/2026, I interviewed Resident L. He indicated that he needs a diabetic diet and that the facility is not diabetic friendly as advertised. He averages a meal a day. He cannot get food that meets his dietary needs, and they are not feeding him properly. He did not have breakfast because he did not want what they tried to serve him. He had a taco salad for lunch. Breakfast is full of sugar, and they use regular milk and he would prefer almond milk. They have no diabetic menu. He refuses non-diabetic options. On Saturday, Sunday and Monday they tried to give him peanut butter and jelly sandwiches which are full of sugar. On 02/09/2026, I received a copy of Resident L's weight record. Record indicates Resident L weighed 221 upon admission on 10/28/2025 and refused

being weighed in November 2025, December 2025 and January 2026. On 02/02/2026, his weight is recorded as 199. There is note on record to talk to Home MD.

On 02/03/2026, I interviewed Resident I. He stated that there is not enough food and they get small portions. For breakfast they have eggs and cereal. He had cereal for lunch. He would like more food to eat. He had no other concerns other than the food. On 02/09/2026, I received a copy of Resident I's weight record. Record indicates Resident L weighed 135 upon admission on 10/02/2024. On 02/03/2026, his weight is recorded as 181.85.

On 02/03/2026, I interviewed Cook, Margaret Evenson. She stated that she has been the cook at Ridgeway for two months. She stated that she has enough groceries for meals. Sometimes they do run out of things, today they ran out of milk. She indicated that the midnight shift made a pot of cream of wheat and toast for breakfast today. They have other things to serve for breakfast such as cereal, oatmeal and eggs. She stated that residents were not served fruit with breakfast today, however, she did have fruit cups that she could have put out. They had taco salad and chips for lunch, and she is making meatloaf and green beans for dinner. She did not have February 2026 menus. She stated that she can adjust what is served for diabetic residents and has a diabetic cookbook at home that she could use to come up with diabetic menu. She also does not use extra salt in her cooking.

On 02/03/2026, I observed that a food delivery was being made during the onsite investigation. It was reported that the food delivery was from the Eastern Market. I observed bread, chicken and canned goods in the kitchen. The cook was making meatloaf for dinner. I observed a regular and diabetic January 2026 menu posted in the kitchen. There was no February menu available. There was a board on refrigerator that listed lunch as taco salad and dinner as meat loaf, mashed potatoes and veggie. The meatloaves were observed being prepared in the kitchen.

On 02/09/2026, I received copies of November 2025, December 2025 and January 2026 regular and diabetic menus for Ridgeway. Substitutions were listed on November 2025 and December 2025 menus. No substitutions were noted for January 2026.

On 02/19/2026, I received email from William Gross with pictures of food prepared at Ridgeway. Pictures included plates and large trays of food that included a large salad, goulash, meatloaf, mixed vegetables, macaroni and cheese, soup/crackers with fruit, rice and sweet potatoes. He also indicated that he updated chef checklist to ensure food quality and proper menu documentation.

I completed an exit conference with Licensee Designee, William Gross, on 04/09/2026. I sent Mr. Gross an email and notified him of violations found and recommendation for revocation of license. I also informed Mr. Gross that a copy of special investigation report would be mailed, and he would be offered the opportunity for a compliance conference. I requested that he contact me if he had any questions or if he has questions after receiving and reviewing report.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	On 02/03/2026, I completed an unannounced onsite investigation. It was reported that cream of wheat and toast were served for breakfast and a taco salad for lunch. There was no protein, fruit or dairy served with breakfast. The Cook, Margaret Evenson, stated that fruit cups were available, however, they were not put out and that the facility was out of milk. Resident D, Resident E, Resident I, Resident L and Resident N all reported that portion sizes are small and/or had concerns with the food quality.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference**
	(5) A resident who has a prescribed diet by an appropriately licensed health care professional shall be provided that diet.
ANALYSIS:	On 02/03/2026, I interviewed Resident L. He indicated that he has a diabetic diet and that the facility is not diabetic friendly as advertised. He is being offered options that are full of sugar such as peanut butter and jelly sandwiches. On 02/03/2026, residents reported being served cream of wheat and toast for breakfast and taco salad for lunch. There was not a separate diabetic diet option served. On 02/03/2026, I interviewed Cook, Margaret Evenson. She did not have a diabetic menu available for February 2026. She stated that she can adjust what is served for diabetic residents and has a diabetic cookbook at home that she could use to come up with diabetic menu.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference**
	(6) Menus, excluding special diets, must be written at least 1 week in advance and posted. Any change or substitution must be documented.
ANALYSIS:	On 02/03/2026, I completed an unannounced onsite investigation. There was not a February 2026 menu posted for residents. I observed a regular and diabetic January 2026 menu posted in the kitchen on the side of the refrigerator. There was a board on refrigerator that listed lunch as taco salad and dinner as meat loaf, mashed potatoes and veggie.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Based on the home currently being on a provisional license and the home receiving several intervening quality of care violations, I recommend revocation of the license.

Kristine Cilluffo 04/09/2026

Kristine Cilluffo Date
Licensing Consultant

Approved By:

Jay Calewarts For 04/09/2026

Denise Y. Nunn Date
Area Manager