GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

Maryann Lavender
Good Samaritan Specialized Care, LLC
5633 Embassy Street
Kalamazoo, MI 49009

RE: License #: AS390417602
Investigation #: 2025A0578045
Good Samaritan West G. Ave

Dear Maryann Lavender:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390417602
Investigation #:	2025A0578045
Complaint Receipt Date:	08/12/2025
Investigation Initiation Date:	08/12/2025
Report Due Date:	10/11/2025
Licensee Name:	Good Samaritan Specialized Care, LLC
Licensee Address:	5633 Embassy Street Kalamazoo, MI 49009
Licensee Telephone #:	(269) 341-3195
Administrator:	Maryann Lavender
Licensee Designee:	Maryann Lavender
Name of Facility:	Good Samaritan West G. Ave
Facility Address:	2331 West G. Avenue Kalamazoo, MI 49006
Facility Telephone #:	(269) 341-3195
Original Issuance Date:	09/20/2024
License Status:	REGULAR
Effective Date:	03/20/2025
Expiration Date:	03/19/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's medications are taken out of their pharmacy provided packaging before Resident A's medication administration time.	No
Resident B's clobazam 20MG and clonazepam .5MG were not provided for Resident B during a leave of absence.	Yes

III. METHODOLOGY

08/12/2025	Special Investigation Intake 2025A0578045
08/12/2025	Special Investigation Initiated - Telephone
08/12/2025	APS Referral
08/13/2025	Special Investigation Completed On-site -Interview with direct care staff Victoria Robinson. Interview with Resident A.
09/09/2025	Additional Allegations Received
09/09/2025	Special Investigation Completed On-site
09/09/2025	Contact-Telephone -With licensee designee Maryann Lavender.
09/09/2025	Contact-Telephone -With Saginaw County Community Mental Health Authority recipient rights supervisor Judy Sausedo.
09/09/2025	Contact-Documentation Reviewed -*Medication Delivery Verification Sheet* for Resident B.
09/09/2025	Contact-Documentation Reviewed -*Medication Release Form for Resident Leave of Absence* for Resident B, dated 05/29/2025.
09/09/2025	Contact-Documentation Reviewed -*Medication Administration Records* for Resident B, May 2025.
09/09/2025	Contact-Documentation Reviewed -*Office of Recipient Rights Report of Investigative Findings*, Saginaw County Community Mental Health Authority.

09/19/2025	Contact-Documentation Reviewed -*AFC Licensing Division Incident/Accident Report* dated 05/29/2025.
09/19/2025	Contact-Documentation Reviewed -Body camera footage, Kalamazoo Township Police.
09/29/2025	Contact-Telephone -With Advanced Health Pharmacy.
09/29/2025	Exit Conference -With licensee designee Maryann Lavender.

ALLEGATION:

Resident A's medications are taken out of their pharmacy provided packaging before Resident A's medication administration time.

INVESTIGATION:

On 08/12/2025, I received the allegations from Complainant by telephone. Complainant reported that medications are "pre-popped" at this facility or taken out of their pharmacy provided containers and placed in a temporary container before the prescribed medication administration time for residents. Complainant reported these allegations specifically involved Resident A. Complainant could not provide specific dates of when the allegations occurred.

On 08/13/2025, I completed an unannounced investigation on-site at this facility and interviewed direct care staff Victoria Robinson regarding the allegations. Victoria Robinson reported working at this facility for over a year and serving as the home manager. Victoria Robinson denied that any medications are "pre-popped" or stored in any container besides a pharmacy provided container with a label that identifies the resident and the medication dosage. Victoria Robinson reported that "pre-popping" medications or staging resident medications in another container until they are administered to residents is not allowed. Victoria Robinson explained how medications are kept in a locked cabinet and maintained in pharmacy provided bubble packs that are labeled by the pharmacy and specific to each resident. While at the facility, I inspected the medication cabinet and observed all medications to locked and stored in their pharmacy supplied blister packs with the appropriate label information.

While at the facility, I interviewed Resident A regarding the allegations. Resident A acknowledged receiving daily medications from direct care staff and denied ever

being provided with his medications prior to their administration times or in an unlabeled storage container. Resident A denied ever observing medications at this facility unsecured or stored in containers not provided by the pharmacy or labeled. Resident A denied having any additional concerns.

On 09/09/2025, I reviewed this allegation with licensing designee Maryann Lavender. Maryann Lavender denied the allegations, or hat Resident medications are ever “pre-popped” or dispensed in any kind of temporary container. Maryann Lavender reported training her direct care staff specifically about avoiding this practice.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A, licensee designee Maryann Lavender and direct care staff Victoria Robinson, as well as observations made during an unannounced investigation on-site and a review of pertinent documentation relevant to this investigation, there was not enough evidence to substantiate the allegation that Resident A's prescribed medication was not kept in the original pharmacy supplied container.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B’s clobazam 20MG and clonazepam .5MG were not provided for Resident B during a leave of absence.

INVESTIGATION:

On 09/09/2025, additional allegations were received from a second Complainant. Complainant reported that when Resident B was discharged from this facility on 05/29/2025, two medications were missing and not provided. Complainant identified these medications as clobazam 20MG and clonazepam .5MG. Complainant reported

after checking with the pharmacy that provides Resident B's medication to this facility, both medications were delivered to the facility prior to Resident B's discharge. Complainant reported having a recording of the interaction when Resident B's medication was transferred to Guardian B1 by licensee designee Maryann Lavender but declined to provide this recording, stating the incident would be reviewed by a lawyer.

On 09/09/2025, I interviewed licensee designee Maryann Lavender regarding the allegations. Maryann Lavender reported being aware of the allegations. Maryann Lavender reported that Resident B was going on a home visit when his medications were counted and provided to Guardian B1. Maryann Lavender reported Resident B's Clobazam 20MG may not have been identified on the *Medication Release Form for Resident Leave of Absence* for Resident B, but this medication was still provided to Resident B. Maryann Lavender clarified the missing Clobazam 20MG was stapled together with other medications and missed when preparing Resident B's medications. Maryann Lavender denied that Resident B had missed any of his prescribed medications for any reason. Maryann Lavender reported this allegation was also investigated by Saginaw County Community Mental Health Authority. Maryann Lavender reported having body camera footage from law enforcement that documented the transfer of medications to Guardian B1. Maryann Lavender reported this was initially thought to be a home visit for Resident B, but Resident B never returned to this facility.

On 09/09/2025, I reviewed the details of the allegations with Judy Sausedo, recipient rights supervisor for Saginaw County Community Mental Health Authority. Judy Sausedo confirmed that Resident B and Guardian B1 were not provided with Resident B's Clobazam 20MG or Clonazepam .5MG. Judy Sausedo reported having facility documentation that supported this allegation. Judy Sausedo reported for these reasons; her office established a violation of Resident B's rights.

On 09/09/2025, I reviewed the *Office of Recipient Rights Report of Investigative Findings* provided by Judy Sausedo, recipient rights supervisor for Saginaw County Community Mental Health Authority. The *Office of Recipient Rights Report of Investigative Findings* documented receiving a *Medication Documentation Error Report* from this facility relating to Resident B. The *Office of Recipient Rights Report of Investigative Findings* documented that initially Guardian B1 identified that Resident B's Clobazam 20MG was not provided, but during an interview, Guardian B1 reported Resident B's Clonazepam .5MG was also missing and not provided prior to Resident B's leave of absence.

On 09/09/2025, I reviewed the *Medication Release Form for Resident Leave of Absence* for Resident B. The *Medication Release Form for Resident Leave of Absence* was dated 05/29/2025 and included the following medications: acetaminophen 325MG, 85 Count, lacusomide 200MG, 36 Count, lacusomide 100MG, 35 Count, levetiracetam 1000MG 75 Count, Phenobarbital 97.2MG 72 Count, and Vitamin D 50L 50ML Count. I noted the *Medication Release Form for*

Resident Leave of Absence did not document or record Resident B's Clobazam 20MG or Clonazepam .5MG.

On 09/09/2025, I reviewed the *Medication Delivery Verification Sheet* for this facility provided by Saginaw County Community Mental Health Authority rights office supervisor Judy Sausedo. The *Medication Delivery Verification Sheet for Resident B documented that Resident B's* Clobazam 20MG and Clonazepam .5MG were delivered to this facility on 05/12/2025.

On 09/09/2025, I reviewed the *Medication Administration Records* for Resident B for May 2025. The *Medication Administration Records* for Resident B documented that Resident B was prescribed Clobazam 20MG, two tablets by mouth at bedtime and Clonazepam .5MG, one tablet by mouth twice daily for three days. The *Medication Administration Records* for Resident B documented that Resident B had been receiving all of his medications with no evidence of missing medications.

On 09/19/2025, I reviewed the *AFC Licensing Division Incident/Accident Report* related to the allegations. The *AFC Licensing Division Incident/Accident Report* documented that on 05/29/2025, Resident B's Clonazepam was not listed on the Medication Release Form when transferring medications to Guardian B1. The *AFC Licensing Division Incident/Accident Report* documented the Clonazepam medication was included in this transfer, but the Clonazepam medication was stapled to Resident B's Levothyroxine, and the amount of Clonazepam medications were added to the Levothyroxine medication count. The *AFC Licensing Division Incident/Accident Report* documented that attempts were made to inform Guardian B1 of this incident.

On 09/19/2025, I reviewed the body camera footage obtained from Kalamazoo Township Police and provided by Maryann Lavender. The body camera footage included metadata that indicated this body camera footage was copied and saved on 06/11/2025 by Maryann Lavender. No additional metadata was available for this video. The body camera footage provided a date of 05/29/2025 and documented Maryann Lavender providing Guardian B1 with Resident B's medications and requesting that Guardian B1 sign for these medications. The body camera footage documented that Guardian B1 refused to sign for the medications and was redirected by law enforcement, who stated that Guardian B1 could simply leave without the medications if she did not want to sign for them. The body camera footage documented Guardian B1 reviewing the paperwork and asking were Resident B's 20MG of Onfi (Clobazam) medication was. The body camera footage documented that Maryann Lavender responded that these were "all of" Resident B's medications. The body camera footage documented that Guardian B1 responded, "so does this mean you were not giving it to him?" and Maryann Lavender is again heard informing Guardian B1 that these were all Resident B's medications. The body camera footage documented Maryann Lavender informing Guardian B1 they were not provided with much notice of Resident B being discharged from the facility and having to arrange another time for Resident B's clothing and belongings. The body

camera footage documented that Maryann Lavender also informed Guardian B1 of the discharge paperwork and Guardian B1 asked that the items be mailed to her as she was not returning.

On 09/29/2025 I contacted Advanced Health Pharmacy regarding the allegations. Advanced Health Pharmacy acknowledged being contacted by Guardian B1 regarding the allegations and contacting licensee designee Maryann Lavender to determine what had happened. Advanced Health Pharmacy confirmed Resident B's Clobazam 20MG and Clonazepam .5MG were delivered to the facility and as a controlled substance, they were unable to bill to have the medications delivered again. Advanced Health Pharmacy reported the licensee designee was reporting Resident B would be returning to the facility while Guardian B1 reported Resident B would not be returning to this facility. Advanced Health Pharmacy reported Resident B was closed out of their system and transferred before having to determine any other solutions for Resident B's medications.

On 09/29/2025, I completed an exit conference with Maryann Lavender. Maryann Lavender reported she was only aware of the allegations relating to Resident B's Clobazam 20MG and was unaware the Clonazepam .5MG was not provided to Resident B or Guardian B1. I informed Maryann Lavender this Clonazepam .5MG was also not listed on the *Medication Release Form for Resident Leave of Absence* for Resident B but was included on the *Medication Delivery Verification Form* recorded on 05/13/2025. Maryan Lavender reported not knowing what had happened to the Clonazepam .5MG that was delivered to this facility and administered to Resident B while at this facility. Maryann Lavender did not dispute my findings.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Based upon my investigation, which consisted of interviews with licensee designee Maryann Lavender and direct care staff Victoria Robinson, as well as observations made during an unannounced investigation on-site and a review of pertinent documentation relevant to this investigation, Maryann Lavender did not assure that Resident B and Guardian B1 were provided with all the appropriate information, medication and instructions related to Resident B's Clobazam 20MG and Clonazepam .5MG medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

 09/30/2025

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Eli DeLeon Date
Licensing Consultant

Approved By:

 09/30/2025

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Dawn N. Timm Date
Area Manager