



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

January 05, 2026

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

RE: License #: AS390417602  
Investigation #: 2026A0578002  
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,

A handwritten signature in black ink, appearing to read 'Eli DeLeon', written in a cursive style.

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**

<b>License #:</b>	AS390417602
<b>Investigation #:</b>	2026A0578002
<b>Complaint Receipt Date:</b>	11/06/2025
<b>Investigation Initiation Date:</b>	11/07/2025
<b>Report Due Date:</b>	01/05/2026
<b>Licensee Name:</b>	Good Samaritan Specialized Care, LLC
<b>Licensee Address:</b>	5633 Embassy Street Kalamazoo, MI 49009
<b>Licensee Telephone #:</b>	(269) 341-3195
<b>Administrator:</b>	Maryann Lavender
<b>Licensee Designee:</b>	Maryann Lavender
<b>Name of Facility:</b>	Good Samaritan West G. Ave
<b>Facility Address:</b>	2331 West G. Avenue Kalamazoo, MI 49006
<b>Facility Telephone #:</b>	(269) 341-3195
<b>Original Issuance Date:</b>	09/20/2024
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/20/2025
<b>Expiration Date:</b>	03/19/2027
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A is walking independently without staff assistance and is falling.	No
Resident A has difficulties eating and is not provided with a pureed diet.	No
Resident A is not regularly bathing.	No
Resident A has rotting teeth and toenails and has not had an appointment with a dentist or podiatrist.	No
Direct care staff are not ensuring that Resident A is taking his medication.	No
Resident A is not provided with his needed briefs.	No
Additional Findings	Yes

**III. METHODOLOGY**

11/06/2025	Special Investigation Intake 2026A0578002
11/07/2025	Special Investigation Initiated - On Site
11/07/2025	APS Referral
11/07/2025	Special Investigation Completed On-site- Interview with direct care staff Jennifer Lavender. Observation of Resident A.
11/07/2025	Contact-Telephone -Interview with licensee designee Maryann Lavender.
11/07/2025	Contact-Documentation Reviewed- <i>Care Flow Sheet</i> for Resident A, dated 06/26/2025.
11/07/2025	Contact-Documentation Reviewed- <i>AFC Health Care Appraisal</i> for Resident A, dated 07/07/2025.
11/07/2025	Contact-Documentation Reviewed- <i>Discharge Instructions</i> for Resident A, dated 07/07/2025.
11/17/2025	Additional Allegations received.
11/20/2025	Special Investigation Completed On-site- Interview with direct care staff Shaclaire Lewis. Interview with direct care staff Gloria Jackson.

11/20/2025	Contact-Documentation Reviewed- Medication Administration Records for Resident A.
11/20/2025	Contact-Telephone- Interview with licensee designee Maryann Lavender.
12/29/2025	Exit Conference with licensee designee Maryann Lavender.

**ALLEGATION: Resident A is walking independently without staff assistance and is falling.**

**INVESTIGATION:**

On 11/06/2025, I received this complaint through LARA-BCHS-Complaints@michigan.gov. Complainant reported Resident A is diagnosed with dementia and is identified as a “fall-risk.” Complainant added that Resident A has limited verbal skills and is hard of hearing. Complainant reported that Resident A has no known guardian or power of attorney. Complainant alleged that Resident A had fallen four or five times in the last two weeks because Resident A is walking without assistance from direct care staff.

On 11/07/2025, I completed an unannounced investigation on-site at this facility and interviewed direct care staff Jennifer Lavender regarding the allegations. Jennifer Lavender reported Resident A had only lived at this facility for a few months. Jennifer Lavender reported Resident A’s stay at this facility was only intended to be temporary, but Resident A has continued to reside at this facility. Jennifer Lavender acknowledged that Resident A was identified as a fall risk when he was admitted to this facility. Jennifer Lavender denied that Resident A had experienced any falls at this facility and reported direct care staff assist Resident A with the use of a gait belt, and the use of this gait belt prevents Resident A from falling. Jennifer Lavender reported that she believed this gait belt was ordered by Resident A’s physician from the U.S. Department of Veterans Affairs.

I attempted to interview Resident A but was unsuccessful due to language delay and comprehension.

While at the facility, I interviewed licensee designee Maryann Lavender. Maryann Lavender acknowledged that Resident A was a fall risk but denied that Resident A needed any physical assistance with walking from direct care staff other than observation for safety. Maryann Lavender reported Resident A arrived at this facility with two gait belts and used them for a short while but no longer needed them.

Maryann Lavender reported that Resident A only had one fall since being admitted to this facility and reported this incident was when Resident A was unsteady while

walking and slipping on his bare feet. Maryann Lavender reported Resident A was examined at urgent care. Maryann Lavender reported the allegations of falling may be related to the observations of direct care staff, who would often find Resident A on the floor and on his knees, as this was how Resident A engaged in inappropriate sexual acts and solicited others to engage in inappropriate sexual acts

On 01/02/2026, I reviewed the *AFC Licensing Division Incident / Accident Report* for Resident A, dated 07/12/2025. The *AFC Licensing Division Incident / Accident Report* completed by direct care staff Imaria Walker documented that Resident A was confused and demonstrated unstable walking and was suspected of having a urinary tract infection. The *AFC Licensing Division Incident / Accident Report* documented that Resident A was taken to Urgent Care.

On 11/07/2025, I reviewed the *After Care Summary* for Resident A from Bronson Hospital, dated 07/12/2025. The *After Care Summary* for Resident A documented that Resident A was examined after a fall. The *After Care Summary* for Resident A documented that Resident A was diagnosed with a fall and closed head injury. The *After Care Summary* for Resident A documented that Resident A completed lab work and a CT scan and chest x-ray and was discharged with no follow up appointments.

On 11/07/2025, I reviewed the *Care Flow Sheet* for Resident A, dated 06/26/2025 and provided by the U.S. Department of Veteran's Affairs. The *Care Flow Sheet* for Resident A documented that Resident A only needs partial assistance from staff when ambulating and only when getting in and out of bed or a chair.

On 11/07/2025, I reviewed the *AFC Health Care Appraisal* for Resident A, dated 07/07/2025. The *AFC Health Care Appraisal* for Resident A documented that Resident A is diagnosed with neurocognitive disorder, prediabetes, pulmonary embolism, onychomycosis of toenails, seborrheic dermatitis, oropharyngeal dysphagia, catatonia, and hyperlipidemia. The *AFC Health Care Appraisal* for Resident A documented that Resident A is fully ambulatory.

On 11/20/2025, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 11/17/2025. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A requires staff support in the community and intermittent help with walking. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A ambulates but requires observation.

On 12/30/2025, Maryann Lavender acknowledged the difference in the *Assessment Plan for AFC Residents* for Resident A dated 11/17/2025 and the *Care Flow Sheet* for Resident A completed by the U.S. Department of Veteran's Affairs on 06/26/2025. Maryann Lavender reported the level of assistance Resident A required varied depending on his dementia or his frequency of urinary tract infections. Maryann Lavender reported that Resident A would sometimes be confused when being prompted for using the bathroom or going to the kitchen table for meals.

Maryann Lavender reported that direct care staff would provide verbal prompting and if necessary, a one-arm assist when directing Resident A to certain areas. Maryann Lavender reported Resident A's need for this type of assistance was inconsistent, and when there was a concern for Resident A's stability or potential for a urinary tract infection, Resident A would be taken to the U.S. Department of Veteran's Affairs urgent care. Maryann Lavender reported there are other times when Resident A is stable in his walking and behavior. Maryann Lavender reported for these reasons, she was working with Resident A's U.S. Department of Veteran's Affairs case worker to obtain a placement with a higher level of care.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.</b>
<b>ANALYSIS:</b>	Based upon my investigation, which consisted of interviews with direct care staff Jennifer Lavender, and licensee designee Maryann Lavender, as well as observations made during an unannounced investigation on-site, there was not enough evidence to substantiate the allegations that Resident A is not kept protected and safe by being provided with intermittent help with walking as indicated in his <i>Assessment Plan for AFC Residents</i> .
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: Resident A has difficulties eating and is not provided with a pureed diet.**

**INVESTIGATION:**

On 11/07/2025, Complainant alleged that Resident A has issues eating, and his meals are supposed to be pureed to prevent choking issues. Complainant alleged Resident A's meals are not pureed in the facility.

On 11/17/2025, Complainant reported that Resident A has very little teeth, but direct care staff at this facility continue to provide Resident A with meats that are hard for Resident A to chew.

On 11/07/2025, I completed an unannounced investigation on-site at this facility and interviewed direct care staff Jennifer Lavender regarding the allegation. Jennifer Lavender denied that Resident A has any kind of special diet, or special dietary requirements in the preparation of his food, such as mechanically soft food as ordered by a physician. Jennifer Lavender reported Resident A does not have the healthiest teeth and has some rotten teeth, but this does not interfere with Resident

A consuming his meals. Jennifer Lavender reported that direct care staff sit with Resident A at meal times and monitor him for any difficulties with consuming his food. Jennifer Lavender reported Resident A has been observed leaving the dining room and laying down in his bed with a mouthful of food. Jennifer Lavender reported for these reasons direct care staff prompt Resident A to swallow his food before leaving the kitchen area. Jennifer Lavender acknowledged that Resident A had an incident two or three weeks ago where he choked on his food, and direct care observed Resident A excitedly eating food prior to this occurrence of choking and described the incident as Resident A “hacking” his food. Jennifer Lavender reported Resident A began having more difficulties with solid foods two or three weeks ago.

On 11/07/2025, I reviewed the *Discharge Instructions* for Resident A, dated 07/07/2025 and provided by the U.S. Department of Veterans Affairs. The *Discharge Instructions* for Resident A documented that Resident A was discharged from the U.S. Department of Veterans Affairs to this facility with no dietary instructions or restrictions.

On 11/20/2025, I completed an unannounced investigation on-site and observed Resident A while Resident A ate lunch. I observed Resident A consuming a sandwich on loaf bread that had been cut in half. I observed Resident A consume this meal with no observable difficulties.

On 11/20/2025, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 11/17/2025. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A should be observed while eating, and that his food should be cut into “small bites”

<b>APPLICABLE RULE</b>	
<b>R 400.663</b>	<b>Nutrition; adoption by reference.</b>
	<b>(5) A resident who has a prescribed diet by an appropriately licensed health care professional shall be provided that diet.</b>
<b>ANALYSIS:</b>	Based upon my investigation, which consisted of interviews with direct care staff Jennifer Lavender, as well as observations made during an unannounced investigation on-site, there was not enough evidence to substantiate the allegations that Resident A is not provided with a diet prescribed by an appropriately licensed health care professional.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: Resident A is not regularly bathing.**

**INVESTIGATION:**

On 11/07/2025, Complainant alleged that direct care staff during first and third shift are not making sure that Resident A is properly bathed.

On 11/07/2025, I interviewed direct care staff Gloria Jackson regarding the allegation. Gloria Jackson denied the allegation and reported that she ensures Resident A is properly bathed every day she works and provides assistance as necessary. Gloria Jackson reported that she works every Monday, Thursday, Friday, Saturday and Sunday.

On 11/07/2025, I interviewed direct care staff Shaclaire Lewis regarding the allegations. Shaclaire Lewis acknowledged that Resident A is compliant with daily bathing.

While at the facility, I observed Resident A to be neatly dressed and clean with no observable concerns for hygiene.

<b>APPLICABLE RULE</b>	
<b>R 400.677</b>	<b>Resident hygiene, clothing.</b>
	<b>(1) A licensee shall offer a resident appropriate opportunity, access to, and instructions for the following daily:</b> <b>(a) Bathing or showering, or both.</b> <b>(b) Shaving.</b> <b>(c) Oral care.</b> <b>(d) Grooming.</b> <b>(e) Peri-care.</b>
<b>ANALYSIS:</b>	Based upon my investigation, which consisted of interviews with direct care staff Shaclaire Lewis and direct care staff Gloria Jackson, and licensee designee Maryann Lavender, as well as observations made during an unannounced investigation on-site, there was not enough evidence to substantiate the allegation that Resident A is not being provided with the appropriate opportunity or access to daily bathing.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: Resident A has rotting teeth and toenails and has not had an appointment with a dentist or podiatrist.**

**INVESTIGATION:**

On 11/07/2025, Complainant alleged Resident A's toenails are black and green, and also brittle and thick. Complainant also alleged Resident A's teeth appear to be rotting. Complainant reported Resident A has not had any dental appointments since moving to this facility.

On 11/07/2025, I interviewed licensee designee Maryann Lavender regarding the allegation. Maryann Lavender reported that prior to receiving services from the U.S. Department of Veterans Affairs, Resident A was homeless. Maryann Lavender clarified that all Resident A's medical, dental or podiatry appointments are coordinated through the U.S. Department of Veterans Affairs. Maryann Lavender reported that Resident A arrived at this facility with missing or damaged teeth and thick and discolored toenails. Maryann Lavender reported that Resident A is currently not "service connected" for his benefits such as dental and podiatry services from the U.S. Department of Veterans Affairs, and in addition to this process, she has been informed these services are "backlogged" and if Resident A needed immediate care for any dental or podiatry needs, the closest U.S. Department of Veterans Affairs center that provided these services was available in Detroit.

On 11/07/2025, I reviewed the *AFC Health Care Appraisal* for Resident A, dated 07/07/2025. The AFC Health Care Appraisal for Resident A documented that Resident A is diagnosed with onychomycosis of toenails, or the thickening and discoloring of toenails.

On 11/20/2025, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 11/17/2025. The *Assessment Plan for AFC Residents* documented that Resident A "requires assistance" with personal hygiene and grooming of teeth and nails.

<b>APPLICABLE RULE</b>	
<b>R 400.671</b>	<b>Resident care.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Based upon my investigation, which consisted of interviews with licensee designee Maryann Lavender, as well as observations made during an unannounced investigation on-site, there was not enough evidence to substantiate the allegation that Resident A is not being provided with the appropriate personal care as specified in Resident A's <i>Assessment Plan for AFC Residents</i> .
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: Direct care staff are not ensuring that Resident A is taking his medication.**

**INVESTIGATION:**

On 11/17/2025, Complainant alleged that direct care staff at this facility are not ensuring that Resident A is swallowing his pills when he receives his medications. No additional details were provided.

On 11/20/2025, I interviewed direct care staff Gloria Jackson and direct care staff Shaclaire Lewis regarding the allegation. Gloria Jackson and Shaclaire Lewis both denied the allegation and reported that Resident A is compliant with receiving his daily medications.

While at the facility, I reviewed the medication administration records for Resident A and compared them with the available medications for Resident A in this facility. The medication administration records and available medications for Resident A documented Resident A's compliance with his daily medications.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.</b>
<b>ANALYSIS:</b>	Based upon my investigation, which consisted of interviews with direct care staff Shaclaire Lewis, and direct care staff Gloria Jackson, as well as observations made during an unannounced investigation on-site, there was no evidence that direct care staff are not ensuring that Resident A is taking his routine medications.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: Resident A is not provided with his needed briefs.**

**INVESTIGATION:**

On 11/17/2025, Complainant alleged that Resident A has been running out of incontinence briefs, and it is unknown why the U.S. Department of Veteran Affairs is not delivering Resident A's briefs. Complainant reported direct care staff have been rationing Resident A's briefs by keeping Resident A in soiled undergarments to prevent Resident A from completely running out of briefs.

On 11/20/2025, I completed an unannounced investigation on-site and interviewed direct care staff Shaclaire Lewis regarding the allegation. Shaclaire Lewis denied the allegation and reported the U.S. Department of Veterans Affairs just made a delivery of Resident A's incontinence briefs. Shaclaire Lewis reported Resident A mostly uses briefs at night and is prompted throughout the day to use the bathroom. While at the facility, Shaclaire Lewis demonstrated an appropriate supply of briefs for Resident A located in his bedroom closet.

On 11/20/2025, I interviewed licensee designee Maryann Lavender regarding this allegation. Maryann Lavender reported that all Resident A's medical supplies are delivered by the U.S. Department of Veterans Affairs, and clarified that if they are ever delayed for any reason, she has covered the expense of purchasing additional briefs for Resident A. Maryann Lavender reported for these reasons, Resident A would never go without being provided with his needed briefs.

On 11/20/2025, I reviewed the *Health Summaries* for Resident A which documented that Resident A was prescribed protective and super absorbent briefs as needed for incontinence.

On 11/20/2025, Maryann Lavender reported that due to the lack of response from U.S. Department of Veteran Affairs in coordinating care and obtaining room and board for Resident A, Resident A was receiving a 30-day notice of discharge. Maryann Lavender reported the current overdue payments for Resident A's room and board exceeded several thousand dollars.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.</b>
<b>ANALYSIS:</b>	Based upon my investigation, which consisted of interviews with direct care staff Shaclaire Lewis, and licensee designee Maryann Lavender, as well as observations made during an unannounced investigation on-site there was no evidence that Resident A was not treated with dignity and respect by being allowed to remain in soiled briefs to prevent running out of briefs.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ADDITIONAL FINDING:**

**INVESTIGATION:**

On 11/07/2025, I observed direct care staff Jennifer Lavender and direct care staff Gloria Jackson providing Resident A with assistance from the hallway to the kitchen table with the use of a gait belt.

While at the facility, I interviewed licensee designee Maryann Lavender. Maryann Lavender reported Resident A arrived at this facility with two gait belts and used them for a short while but no longer needed them. I informed Maryann Lavender that I had directly observed Resident A receiving assistance from direct care staff with the use of a gait belt. Maryann Lavender denied that a gait belt was prescribed by a physician for Resident A.

On 11/20/2025, I reviewed the allegation with licensee designee Maryann Lavender. Maryann Lavender reported that since the unannounced investigation on-site, a prescription for Resident A's use of a gait belt was obtained from the U.S. Department of Veteran's Affairs.

On 11/20/2025, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 11/17/2025. The *Assessment Plan for AFC Residents* for Resident A did not document the use of any assistive device including a gait belt.

On 11/20/2025, I reviewed a physician's order for Resident A and dated 11/13/2025. This physician's order was signed by Dr. Amanda Bennet and documented that Resident A can use a gait belt as needed for ambulatory and transfer safety.

<b>APPLICABLE RULE</b>	
<b>R 400.673</b>	<b>Use of assistive devices, therapeutic support.</b>
	<b>(2) An assistive device or therapeutic support must be authorized in writing by an appropriately licensed health care professional and the authorization must state the reason for and the term of the authorization.</b>

<b>ANALYSIS:</b>	Based upon my investigation, which consisted of interviews with direct care staff Jennifer Lavender, and direct care staff Gloria Jackson, as well as observations made during an unannounced investigation on-site, and a review of pertinent documentation, Resident A's use of a gait belt with assistance from direct care staff during an unannounced investigation on-site was not authorized at the time in writing by an appropriately licensed health care professional.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

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



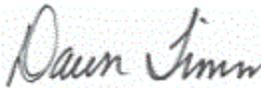
01/02/2026

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Eli DeLeon  
Licensing Consultant

Date

Approved By:



01/05/2026

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Dawn N. Timm  
Area Manager

Date