GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 7, 2026

Anthony Parker
New Hope Assisted Living, LLC
702 E. Remus Road
Mt. Pleasant, MI 48858

RE: License #: AM370304806
Investigation #: 2026A0622043
New Hope Assisted Living, LLC

Dear Mr. Parker:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

Amanda Blasius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM370304806
Investigation #:	2026A0622043
Complaint Receipt Date:	05/18/2026
Investigation Initiation Date:	05/19/2026
Report Due Date:	07/17/2026
Licensee Name:	New Hope Assisted Living, LLC
Licensee Address:	702 E. Remus Road Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 621-2677
Administrator:	Anthony Parker
Licensee Designee:	Anthony Parker
Name of Facility:	New Hope Assisted Living, LLC
Facility Address:	702 E. Remus Road Mt. Pleasant, MI 48858
Facility Telephone #:	(989) 779-1477
Original Issuance Date:	04/03/2012
License Status:	REGULAR
Effective Date:	09/24/2024
Expiration Date:	09/23/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
A visitor reported concerns about poor hygiene conditions within resident bedroom.	No
Residents are not receiving their medications on time. Resident A did not receive her medications for three days and staff refused to pass the medications when visitor questioned them.	Yes
Direct care worker Abe Homan has been very snippy towards a female resident.	No
Additional Findings	Yes

III. METHODOLOGY

05/18/2026	Special Investigation Intake 2026A0622043
05/19/2026	Special Investigation Initiated – email contact with licensing consultant, Jennifer Browning.
06/11/2026	Inspection Completed On-site
06/23/2026	Contact - Document Received
06/29/2026	Contact - Telephone call made to direct care workers, Lauralyn Bellinger and Chris Tigner
06/30/2026	Contact - Document Received
07/01/2026	Inspection Completed-BCAL Sub. Compliance
07/01/2026	Contact- Telephone call made to Guardian A1, B1 and C1.
07/02/2026	Contact- Phone call to Hometown Pharmacy
07/06/2026	Exit conference with licensee designee Anthony Parker.
07/07/2026	APS referral made.

ALLEGATION: A visitor reported concerns about poor hygiene conditions within resident bedroom.

INVESTIGATION:

On 5/18/2026, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, no one has cleaned this resident's bedroom in a month, and Complainant found dirty briefs and feces on the toilet. The complaint alleged that the resident was a female. The complainant came through as anonymous, with no name or contact information provided for Complainant or the resident involved.

On 5/19/2026, I interviewed the assigned licensing consultant and obtained information regarding the facility that pertained to the current allegations.

On 06/11/2026, I completed an unannounced onsite investigation. During the unannounced onsite investigation, I viewed all five female resident bedrooms and bathrooms. During my unannounced onsite inspection, I observed all bedrooms and bathrooms to be clean. No soiled briefs were observed nor were there feces on any toilet.

On 06/11/2026, I interviewed licensee designee Anthony Parker in person. I requested information for female residents who frequently have a male relative visit often. Mr. Parker provided guardian contact for two of the residents. Mr. Parker reported that he has not had any family members contact him regarding concerns regarding the cleanliness of the home.

On 07/01/2026, I interviewed Guardian A1 via phone. He reported that he has not observed any concerns regarding soiled briefs or unsanitary bathrooms.

On 07/01/2026, I interviewed Guardian B1 via phone. He reported that he has not observed any concerns regarding soiled briefs or unsanitary bathrooms.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based upon my unannounced onsite investigation completed on 6/11/2026, I observed all female resident bathrooms and bedrooms and found all five to be well maintained and clean. No soiled briefs were observed during my inspection, and no concerns were provided from two guardians that were interviewed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Residents are not receiving their medications on time. Resident A did not receive her medications for three days and staff refused to pass the medications when visitor questioned them.

INVESTIGATION:
On 5/18/2026, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, direct care worker Abe Homan was supposed to pass Resident A's medication at 4pm and completely forgot. The complaint stated that when Complainant questioned DCW Homan, he "blew him off." On 6/7/2026, additional complaints were received through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, Resident A and Resident C are not receiving their medications properly. The complaint stated that Resident A had not received her medications for three days, staff were aware and refused to pass the medications. According to the compliant, Complainant attempted to address the concerns with the manager, Abbey Parker, but she "blew him off." Complainant also stated that he overheard direct care workers talking about the narcotics count being off. On 6/8/2026, additional complaints were received through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, direct care workers Abe Homan and Chris Tigner refuse to pass medications to residents or are late passing the medications. The complaint stated that direct care worker Chris Tigner makes the staff leaving pass Resident C's medication early, so she does not have to deal with his behaviors. On 6/9/2026, additional complaints were received through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, direct care workers, Abe Homan and Chris Tigner have not been passing medications to Resident A's for three days. The complaint stated Resident A went without her blood pressure pill for three days. According to Complainant, he visited at 6pm and observed direct care worker Makalya Snider pass medications at 6pm, which is two hours early according to Complainant. Complainant also observed direct care worker Chris Tigner tell another staff member to give Resident C Haldol so he does not have to deal with his behaviors. No names or contact information was provided for Complainant.

On 05/19/2026, I interviewed the assigned licensing consultant to obtain further information regarding the home. I also viewed the workforce background clearance system to confirm that the alleged direct care workers are presently employed at New Hope Assisted Living.

On 06/11/2026, I completed an unannounced onsite investigation to New Hope Assisted Living. During the unannounced onsite investigation, I interviewed direct care workers and viewed medication administration records for residents.

On 06/11/2026, I interviewed direct care worker (DCW) Abe Homan in person. He stated that medications may be administered later than usual if he is helping shower

a resident or helping another resident. DCW Homan stated that if he is going to pass medications later than expected, he lets residents know. DCW Homan stated that no family members or visitors have approached him regarding administering medications to the residents. DCW Homan stated that medications are not passed early.

On 06/11/2026, I interviewed DCW Abbey Parker in person. She stated that one of the newer residents struggled to understand that she could not keep her medications in her bedroom and also could not take them when she wanted throughout the day as they are scheduled and administered by direct care workers. DCW Abbey Parker reported that she is not the manager over medications and her co-worker Lauralyn Bellinger oversees the medications. DCW Parker reported that if a resident refuses the medication or the medication is not available the box should be circled with notes provided on the back of the medication administration record. DCW Parker stated that the boxes on the medication administration record should not be blank. She described DCW Chris Tigner as a new employee who often asks many questions and follows the rules. DCW Parker stated that DCW Homan tends to be more passive and may not encourage residents to take their medications through additional conversations. DCW Parker stated that she has not observed the narcotic count to be off and that two DCWs sign off on the narcotic count each shift. During the unannounced onsite investigation, I viewed the narcotic count log and confirmed it was being completed each shift.

On 06/29/2026, I left a voicemail for direct care worker Makalya Snider. No response has been received.

On 06/29/2026, I interviewed DCW Chris Tigner. He reported that he has worked at the home for about 3 months and works second shift. He stated that he works with another employee until about 8pm and then works independently with residents. DCW Tigner stated that sometimes he passes medication late, as there is one resident, Resident C who tends to wander and roam the hallway. He also stated that Resident C has had a lot of falls recently, therefore when he is working alone medications could be passed after 9pm if he is tending to Resident C. DCW Tigner stated that if a resident refuses a medication, he knows that he needs to circle the date and put an explanation on the back. DCW Tigner denied having a direct care worker pass Resident C's medication early.

On 06/11/2026, I viewed Resident A's, Resident B's, Resident C's and Resident D's medication administration record.

According to Resident A's medication administration record (MAR) the following was found:

- Oxybutynin Cl Er 5mg: take one tablet by mouth every day. According to the MAR Resident A had not received this medication from June 1st-11th. The MAR had a circle on the following dates: 6/2, 6/4, 6/5, 6/6, 6/7. There was no documentation on the MAR explaining what the circle meant.

According to Resident B's medication administration record (MAR) the following was found:

- Benadryl 25mg at bedtime: Time listed on MAR was 8pm. According to the MAR, Resident B was not provided this medication for the entire month of May. No documentation on the MAR stated that this medication was a PRN, that Resident B refused the medication or that it was not available within the facility.

According to Resident C's medication administration record (MAR) the following was found:

- Sennoside/Docusate 8.6 50mg tablet take two tablets by mouth twice a day daily for constipation. The MAR documented to hold this medication on 5/14/26. The MAR also documented that staff attempted to give this medication at 8pm on 5/18-5/21, 5/24 and 5/31 but instead of staff initials circles were documented on the MAR with no explanation. According to the MAR, Resident C was administered this medication at 8pm on 5/22, 5/23, 5/26, 5/27 and 5/30.

On 07/01/2026, I interviewed Guardian A1, Guardian B1 and Guardian C1. None of the guardians reported any concerns about medication administration or how direct care workers care for residents.

On 07/02/2026, I called Hometown Pharmacy to obtain additional information regarding Resident A's Oxybutynin Cl Er 5mg. The pharmacy reported that this medication was a transfer medication from Walgreens Pharmacy and was transferred over on 4/23/26. They reported that the medication was never filled, as it was not requested to be filled by New Hope Assisted Living. According to the pharmacist, they were not informed to remove it from Resident A's medication administration record until 6/12/2026.

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:	Based upon review of the medication administration record, it was found that Resident A's Oxybutynin Cl Er 5mg was not administered for 11 days as it was not ordered and delivered from the pharmacy. New Hope Assisted Living did not contact the pharmacy until 6/12/2026 to request that this medication be discontinued. Resident B's medication, Benadryl 25mg at bedtime, was not administered for the month of May 2026. No documentation was available on the MAR explaining why this was not administered. Resident C's Sennoside/Docusate 8.6 50mg tablet medication was held on the MAR starting on 5/14/26, but according to the MAR, direct care workers administered the medication on 5/22, 5/23, 5/26, 5/27 and 5/30 at 8pm. A violation was established as direct care workers were not providing medication as ordered and prescribed according to the medication administration records.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care worker Abe Homan has been very snippy towards a female resident.

INVESTIGATION:
On 5/18/2026, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, DCW Abe Homan has been snippy towards residents, No additional information, resident names or complainants name or contact information was received.

On 06/11/2026, I interviewed DCW Abe Homan in person. He denied being "snippy" toward any resident. He stated that he has worked there for 5.5 years and mainly works second shift. DCW Homan stated that he has not had any resident family members approach him about how he treats residents.

On 06/11/2026, I interviewed DCW Abbey Parker and she identified her role as a manager. She stated that she has not observed any concerns regarding DCW Homan being rude or disrespectful towards residents.

On 07/01/2026, I interviewed Guardian A1 via phone. He stated that he visits Resident A often and has not observed any concerns regarding any DCW being rude or disrespectful towards residents. He explained that his mother, Resident A, just moved from independent living and was used to making her own choices and not having to follow rules, therefore she might be the one being rude towards staff members.

On 07/01/2026, I interviewed Guardian B1 via phone and he reported that he visits Resident B at least twice a week. He stated that he has not observed any concerns

regarding DCWs being rude or disrespectful towards residents. He explained that Resident B would probably have mentioned something if there were concerns.

On 07/01/2026, I interviewed Guardian C1 via phone. She reported that she visits weekly and she has not observed any staff members to be rude or disrespectful towards residents.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	DCW Abe Homan denied being disrespectful towards any residents. Three guardians were interviewed and none had concerns regarding direct care workers being disrespectful towards residents. There was no evidence to support that direct care worker, Abe Homan was being "snippy" towards any resident, therefore a violation was not established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 06/11/2026, I completed an unannounced onsite investigation to New Hope Assisted Living. Upon investigation, I viewed four residents' medication administration records.

Upon reviewing Resident A's medication administration record, I found that direct care workers initials were missing on Resident A's medication administration record for May and June 2026 verifying that Resident A's medications were administered. The dates listed below were left blank with no direct care staff initials verifying medications were administered and no documentation on the MAR explaining if the resident refused the medication or if the resident was away from the home.

- Hydralazine 10 mg, take one tablet by mouth every twelve hours. Direct care worker's initials were missing from the MAR on the following dates for her 8pm administration: 5/7, 5/14, 5/15, 5/21, 6/4, 6/9.
- Cranberry extract, 1 tab daily at 9am. Direct care workers initials were missing from the MAR on 5/15/26.
- Aspirin 81mg 1 tab daily at bedtime. Direct care workers initials were missing from the MAR on 5/4, 5/15, 5/21.
- Metformin 500 mg ½ tab twice a day. Direct care workers initials were missing from the MAR on 5/29, 6/4 and 6/9.
- Diltiazem cap 120mg, take one tablet by mouth daily. Direct care workers initials were missing from the MAR on 6/2.

- Dicyclomine 10mg 1 tab daily, twice a day: The MAR stated that this medication was started on May 1st. Direct care worker's initials were missing from the MAR on 5/3 and 5/6 at 5pm and 5/5 at 9am.

Upon reviewing Resident B's medication administration record, I found that direct care workers initials were missing from Resident B's medication administration record for May and June verifying that Resident B's medications were administered. The dates listed below were left blank with no direct care staff initials verifying medications were administered and no documentation on the MAR explaining if the resident refused the medication or if the resident was away from the home.

- Betoptic .25 eye drop in each eye twice daily. Direct care workers' initials were missing from the MAR on 5/7 and 5/25.
- Acylovir 800mg take ½ tablet twice a day for cold sore prevention. Direct care workers' initials were missing from the MAR on 5/7.
- Acetaminophen 325 mg take two tables by mouth daily at lunch and bedtime: Direct care workers' initials were missing from the MAR on 5/7.
- Quetiapine Fumarate 25mg, take one tablet by mouth every evening. Direct care workers' initials were missing from the MAR on 5/7.
- Losartan Potassium 25mg tab take one tablet by mouth once nightly: Direct care workers' initials were missing from the MAR on 5/7.
- Potassium Cl Er 20 meg take one tablet by mouth daily. Direct care workers' initials were missing from the MAR on 5/7 and 5/16.
- Aspirin 81 mg tablet take one table by mouth daily: Direct care workers' initials were missing from the MAR on 5/15, 5/16 and 5/19.
- Glucosamine 1,000 mg tab, take one 1.5 tablets by mouth daily. Direct care workers' initials were missing from the MAR on 5/30.
- Vitamin B12 1,000 mg ½ tab daily. Direct care workers' initials were missing from the MAR on 5/26.
- Systane eye drops, 1 drop in each eye daily. Direct care workers' initials on the MAR were missing on the following dates: 5/5, 5/9 and 5/12.
- Benadryl 25mg at bedtime: Direct care workers' initials were missing from the MAR on 5/1-5/31.
- Probiotic 250mg twice daily. Direct care workers' initials were missing from the MAR on 5/26.

Upon reviewing Resident C's medication administration record, I found that direct care workers initials were missing on Resident C's medication administration record for May and June verifying that Resident C's medications were administered. The dates listed below were left blank with no direct care staff initials verifying medications were administered and no documentation on the MAR explaining if the resident refused the medication or if the resident was away from the home.

- Midodrine HCL 5mg take one tablet by mouth three times daily: Direct care workers' initials were missing from the MAR on 5/6, 5/8, 5/13, 5/16, 5/26(2) and 5/27.

- Metformin HCL 500mg, take on tablet by mouth twice daily: Direct care workers' initials on the MAR were missing on 5/6, 5/8, 5/13, 5/16, 5/26(2) and 5/27.
- Furamate take two tablets by mouth 50mg by mouth twice daily for restlessness and agitation: Direct care workers' initials were missing from the MAR on 5/7, 5/8, 5/9, and 5/16.
- Sennoside /Docusate 8.6 50mg tablet take two tablets by mouth twice a day daily for constipation. Direct care workers' initials were missing from the MAR on 5/4 and 5/8. According to the MAR, this medication was ordered to be put on hold from 05/14 onward. Per the MAR, direct care workers administered this medication for the 8pm medication pass on 5/22, 5/23, 5/26, 5/27 and 5/30.
- Melatonin 5mg tablet, take one tablet by mouth at bedtime for insomnia. Direct care workers' initials on the MAR were missing on the following dates: 5/8, 5/9, 5/16 and 5/28.

Upon reviewing Resident D's medication administration record, I found that direct care workers initials were missing on Resident D's medication administration record for the month of June verifying that Resident D's medications were administered. The dates listed below were left blank with no direct care staff initials verifying medications were administered and no documentation on the MAR explaining if the resident refused the medication or if the resident was away from the home.

- Icosapent Ethyl 1 gram capsule, take two capsules by mouth twice a day. Direct care workers' initials were missing from the MAR on 6/4 at 8pm.
- Vitamin D3 25 Mcg, tablet take one tablet by mouth every day. Direct care workers' initials were missing from the MAR on 6/3, 6/4, 6/8 and 6/9.
- Acetaminophen 500mg caplet. Take two tablets by mouth two times daily. Direct care workers' initials were missing from the MAR on 6/3.

On 6/29/2026, I interviewed DCW Lauralyn Bellinger via phone. She identified as a home manager in charge of managing resident medications. DCW Bellinger stated that on each shift the DCW assigned to administer medication should be signing or circling each time a medication is administered. She stated that the medication record should not be blank and any notes for the refusal or medication not available should be documented on the back of the record. DCW Bellinger stated that on Mondays she usually orders medications through the pharmacy and hospice.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(b) Complete an individual medication log that contains all of the following:** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initials of the individual who administered the medication at the time given.** **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.**
ANALYSIS:	During the unannounced onsite investigation, I reviewed four resident medication administration records. All four medication administration records had multiple days left without direct care staff initials verifying the medication had been administered or an explanation on MAR why the medication was not administered. A violation was established as on the four resident administration records reviewed for May and June, a total of 102 direct care workers initials were missing during this timeframe for the four residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 6/11/2026, I completed an unannounced onsite investigation to New Hope Assisted Living. Upon review of four resident medication administration records, I found some documentation that a resident refused their medication on the back of the medication administration record.

On 6/29/2026, I interviewed direct care worker, Lauren Bellinger via phone. She identified as a home manager in charge of managing resident medications. During the interview, I asked her who she contacts if a resident refuses medication and she stated that she will write the refusal in the documentation and let their family member know. DCW Bellinger stated that she will inform the resident physician every couple of weeks if a resident is refusing medication. DCW Bellinger stated that she was unaware that she was supposed to contact a residents health care professional each time a resident refuses medication.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(g) Contact the appropriately licensed health care professional when a resident refuses a prescribed medication or procedure. A licensee, administrator, or staff shall document and follow the instructions given by the licensed health professional. Documented instructions may include procedures to follow when a resident refuses medication or procedures in the future.**
ANALYSIS:	A violation was established as no documentation was available to review verifying that direct care staff are contacting a licensed health care professional after a resident refuses prescribed medication. DCW Bellinger she oversees medications for the home and was unaware that she was supposed to contact a licensed health care professional each time a resident refuses a prescribed medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.

07/06/2026

_____

Amanda Blasius Date
Licensing Consultant

Approved By:

07/07/2026

_____

Dawn N. Timm Date
Area Manager