GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 13, 2026

Joshua Parcher
New Haven Assisted Living INC
943 Virginia St. SE
Grand Rapids, MI 49506

RE: License #: AL410418067
Investigation #: 2026A0470001
New Haven Assisted Living Of Comstock

Dear Mr. Parcher:

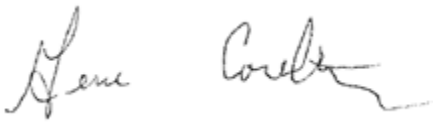
Attached is the Special Investigation Report for the above-mentioned facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 party responsible and a date.

If you desire technical assistance in addressing these issues, please 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Gene Coulter, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410418067
Investigation #:	2026A0470001
Complaint Receipt Date:	05/27/2026
Investigation Initiation Date:	05/27/2026
Report Due Date:	07/26/2026
Licensee Name:	New Haven Assisted Living INC
Licensee Address:	943 Virginia St. SE Grand Rapids, MI 49506
Licensee Telephone #:	(616) 307-7719
Administrator:	Joshua Parcher
Licensee Designee:	Joshua Parcher
Name of Facility:	New Haven Assisted Living Of Comstock
Facility Address:	155 7 Mile Rd Comstock Park, MI 49321
Facility Telephone #:	(616) 784-1262
Original Issuance Date:	10/14/2025
License Status:	REGULAR
Effective Date:	04/14/2026
Expiration Date:	04/13/2028
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL/AGED/ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 5/22/2026 Resident A fell hurting his arm. There are concerns staff failed to protect Resident A from falling.	No
Additional Findings	Yes

III. METHODOLOGY

05/27/2026	Special Investigation Intake 2026A0470001
05/27/2026	Special Investigation Initiated - Telephone spoke with Tamara Raak,
05/27/2026	APS Referral APS denied referral
05/27/2026	APS Referral
06/03/2026	Inspection Completed On-site
06/03/2026	Contact - Document Received
6/09/2026	Contact- telephone call made, Avis Brooks
07/13/2026	Exit Conference call made to licensee, Joshua Parcher

ALLEGATION: On **5/22/2026 Resident A fell hurting his arm. There are concerns staff failed to protect Resident A from falling.**

INVESTIGATION: On 5/22/2026 I received a complaint from Adult Protective Services that Resident A did not have appropriate staff to aid and assist in his care and wellbeing.

On 5/23/26 I contacted Resident A's daughter/guardian, Tamara Raak, regarding the allegation. Ms. Raak stated that Resident A's care needs were met by the staff and she does not have any concerns regarding his care needs being addressed at the home.

On 6/3/26, I and consultant Toya Zylstra, met with the home manager, Tracee Thomas to discuss the allegation. Ms. Thomas informed us that Resident A did fall and injure his left arm. Ms. Thomas stated the staff addressed the arm wounds by cleaning and applying bandages. Ms. Thomas stated Resident A had pain in his chest and arm the following day. Resident A's daughter/guardian, Tamara Raak was called and informed that Resident A was in pain. Ms. Thomas stated Ms. Raak did not want Resident A getting additional medical assistance, but they called Resident

A's primary care physician, and he directed Resident A be taken to the hospital for observation. Resident A was taken to Butterworth hospital and discharged back to the home the next day. Ms. Thomas stated there was no diagnosis when Resident A returned from hospital. She provided me with Resident A's assessment plan and incident reports dated 5/20/26, 5/22/26 and 5/25/26.

On 6/3/26, I and Ms. Zylstra interviewed first shift staff, Angelina Juczynski. Ms. Juczynski informed us that she was not present when Resident A fell but she is familiar with Resident A and noticed Resident A's left hand was swollen and heard Resident A fell. Ms. Juczynski stated she is not familiar with Resident A's assessment plan and did not know Resident A had a diagnosis of dementia.

On 6/3/26, I and Ms. Zylstra interviewed first shift staff, Natalie Trader. Ms. Trader stated she has worked with Resident A on a regular basis and is aware he has fallen in the recent past and his left hand was swollen. Ms. Trader stated she was not present when Resident A fell. Natalie was asked if she is aware of Resident A's care needs and if she is familiar with Resident A's assessment plan and diagnosis. Ms. Trader stated she does not know Resident A's had been diagnosed with dementia and is not aware of Resident A's assessment plan needs.

On 6/9/26, I spoke with staff, Avis Brooks, regarding resident A's medical condition. Ms. Brooks informed me that she was on shift when Resident A had a medical situation. Ms. Brooks stated that she heard Resident A yelling out in pain and went to check on him. She stated upon checking on Resident A, he continued to yell and stated both of his arms were hurting. Ms. Brooks stated she motioned for a coworker, Samantha, to assist her with Resident A. Ms. Brooks stated they took Resident A's vitals and called his primary care physician and his family, who did not answer, probably being that it was 4am. Ms. Brooks stated Resident A's primary care physician told them to have EMS check him out, so they did. Ms. Brooks stated Resident A was transported to a medical facility and his family called back and were informed of his medical situation.

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:	The complainant reported Resident A did not have proper staff to aid and assist with his medical care needs. Based on my investigative findings, Resident A fell on 5/22/2026, and staff acted appropriately in their response. They called Resident A's primary care physician and EMS. Therefore, a violation is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Resident A's assessment plan was not updated to reflect his level of care.

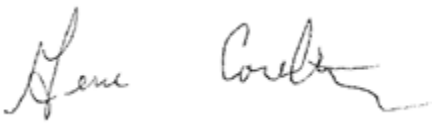
INVESTIGATION: On 6/3/2026 I interviewed the direct care staffers Angelina Juczynski and Natalie Trader regarding Resident A's assessment plan. The assessment plan did not accurately reflect Residents A's needs. For example, the plan did not reveal Resident A required assistance putting on and taking off clothing, nor did it reflect Resident A needing assistance ambulating. The licensee acknowledged he would update the assessment plan to accurately reflect Resident A's needs and a revised copy of the updated assessment plan for Resident A, was forwarded to me on 6/4/2026.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include the following: **(a) The amount of personal care, supervision, and protection required by the residents that is available at the facility.**
ANALYSIS:	Resident A's assessment plan was not updated when I reviewed the assessment plan on 6/3/2026. Therefore, a violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/13/2026 I conducted an exit conference with Joshua Parcher to inform him of the above-cited violation and to confirm compliance due to the assessment plan having been updated to reflect Resident A's current medical status.

IV. RECOMMENDATION

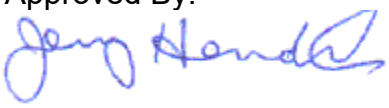
Upon receipt of an acceptable corrective action plan (CAP), I recommend that the licensing status remains unchanged.



07/13/2026

Gene Coulter Date
Licensing Consultant

Approved By:



07/13/2026

Jerry Hendrick Date
Area Manager