GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 21, 2026

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

RE: License #:	AL410413568
Investigation #:	2026A0356056
	New Haven Assisted Living of Cedar Springs

Dear Mr. Parcher:

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 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,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410413568
Investigation #:	2026A0356056
Complaint Receipt Date:	08/31/2026
Investigation Initiation Date:	09/02/2026
Report Due Date:	10/30/2026
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 Cedar Springs
Facility Address:	270 West Street Cedar Springs, MI 49319
Facility Telephone #:	(989) 287-6084
Original Issuance Date:	05/09/2023
License Status:	REGULAR
Effective Date:	11/09/2025
Expiration Date:	11/08/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility and was without staff supervision.	Yes

III. METHODOLOGY

08/31/2026	Special Investigation Intake 2026A0356056
09/02/2026	Special Investigation Initiated - Telephone Ricky Kurnat, Kent County sheriff office.
09/17/2026	Inspection Completed On-site
09/17/2026	Contact - Face to Face Toni King, Winifred John, Connie McVicker, Resident A.
09/17/2026	Contact - Document Received IR (incident report)-facility document, assessment plan.
09/17/2026	APS Referral open investigation.
09/22/2026	Contact - Telephone call made Emily Graves, Kent County APS.
10/20/2026	Contact-Document Sent Senia Eckelbarger, Kent County APS.
10/20/2026	Contact-Telephone call made Relative #1
10/21/2026	Exit conference-Joshua Parcher, Licensee Designee.

ALLEGATION: Resident A eloped from the facility and was without staff supervision.

INVESTIGATION: On 08/31/2026, I received a complaint from LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint system from the Michigan Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing. The complaint documented the following information written on 08/15/2026, *'On 08/14/2026, Deputy Pechtel and Deputy Kurnat, Kent County Sheriff's Deputies, were sent to a runaway*

dementia/Alzheimer's complaint. Cassidy from New Haven Estates, an assisted living home at 270 West St. NE, called 911 to make a report. Cassidy advised that (Resident A) had ran away from the facility. Cassidy reported that (Resident A) is 77 years old, is on medication and is unable to make sound decisions. New Haven staff was out searching for (Resident A). Deputy Pechtel contacted the complainants and witnesses at New Haven Estates. Deputy Pechtel sent a photograph of (Resident A) and advised that the subject intended to walk to Grand Rapids, though staff doubted he knew how to get there. (Resident A) reportedly did not have a phone or currency on him. I checked the White Pine Trail, Library, Meijer and several other areas within walking distance. I (Deputy Kurnat) entered Wesco and observed (Resident A) standing at the register appearing confused. (Resident A) stated that he was trying to make it to his father's funeral in Grand Rapids but was frustrated that someone gave him bad directions. I had (Resident A) sit in the back of my patrol vehicle. I asked him what month it was and he said January. I asked him his date of birth, and he could not tell me. I asked him who the president was and he did not know. I made contact with (Resident A's) son and power of attorney, (Relative #1) explained that (Resident A's) father passed away over twenty years ago. (Relative #1) said that (Resident A) suffers from dementia and Alzheimer's, (Relative #1) was informed that his father would be transferred by ambulance to the hospital. Rockford ambulance arrived on scene. Staff from New Haven Estates also arrived. Staff explained (Resident A's) medical issues and that he has been cognitively declining for a couple of weeks. (Resident A) was transported to the hospital by Rockford Ambulance staff.'

On 09/17/2026, I conducted an unannounced inspection at the facility and interviewed home manager, Toni King. Ms. King stated they has not experienced any issues with Resident A attempting to leave the facility prior to this incident on 08/14/2026. Ms. King stated Resident A's cognition declined recently dramatically and "it came out of nowhere." Ms. King stated the week prior to the elopement Resident A was saying he had to help his brother, that his brother turned into Godzilla and he was smashing Grand Rapids and had to help his twin sister stop him. Ms. King stated Resident A does not have a twin sister. Ms. King stated in addition, Resident A stated he needed to get to Grand Rapids to his parents' funeral, but his parents have been deceased for many years. Ms. King stated staff were able to redirect Resident A easily.

Ms. King acknowledged the events on 08/14/2026, documented in the allegations occurred. Resident A was in the back yard and eloped from the facility. Staff called 911 and the police found Resident A at the Wesco gas station unattended by staff. Ms. King stated he had never disappeared before. Ms. King stated before this happened, Resident A could go in the backyard that has a fence around it without staff and staff would "keep tabs on him." Ms. King stated on 08/14/2026, Resident A was in the yard and when staff, Winnie John went to the backyard to check on him and he was gone. Staff Kassie Vogel immediately called 911. The following weekend, on Saturday 08/22/2026 staff were with Resident A in the yard and could not get Resident A to go back into the facility. Resident A hit staff and left the yard

but staff followed him and called 911 and they were able to get him back into the facility. Ms. King stated they have alarms on doors now and staff visually check on Resident A every 15 minutes to ensure safety (I heard the alarms on the doors). In addition, Ms. King stated an evaluation was completed through Optimal Behavioral Health and Resident A has been prescribed Haloperidol which is helping.

On 09/17/2026, I observed Resident A in his room at the facility. Resident A cannot provide information pertinent to this investigation due to cognitive decline.

On 09/17/2026, I interviewed DCW Winifred "Winnie" John at the facility. Ms. John stated on 08/14/2026, Resident A kept talking about going to Grand Rapids. He was pacing back and forth, put his coat on, and went outside to the backyard. Ms. John stated she knocked on the kitchen window that looks out over the backyard because Resident A had gone toward the gate. Ms. John stated she told Resident A that he could not go out the gate. He came back and sat down in the pavilion which is in the middle of the back yard. Ms. John stated this was at 11:00a.m. on 08/14/2026, and after that, DCW Kassidy "Kassie" Vogel said she did not see Resident A when she checked on him so Ms. John stated she "ran down the road" looking for Resident A and Ms. Vogel called the police. Ms. John stated Resident A had never done this before. Ms. John stated the facility is now equipped with alarms on the doors so they know if/when Resident A exits the facility.

On 09/17/2026, I interviewed DCW (direct care worker) Connie McVicker at the facility. Ms. McVicker stated she was with Resident A on the second incident that occurred on 08/22/2026. Ms. McVicker stated she was outside with Resident A. He went for the gate to leave the yard, she attempted to redirect him, he hit her and went out the gate. Ms. McVicker stated she followed him and was able to get Resident A back to the facility and they have not had an incident since.

On 09/17/2026, I received and reviewed the IR (Incident Report) dated 08/14/2026, 11:10 a.m. written by Kassidy Vogel and named Winnie John as another person involved/witness. The IR documented the following information, '*Around 10-10:30a.m., (Resident A) asked to go outside, we walked him to the gazebo where he spent about an hour talking to (another resident). I checked on him when (Resident B) came inside and he was out there with (Resident C) and about 5-10 minutes later (Resident D) goes outside and we notice (Resident A) is not out there and gate is open. Winnie checks outside, even goes around the block while I searched inside. I call her, she hasn't found him yet and he's not inside. So, she calls Toni while I call 911. When I hung up, Winnie came back inside so I drove my car around for about 30-40 minutes even went to Wesco, I didn't see him while driving towards Meijer, I got a call from Sheriff and he said they believe they found him at Wesco. So, I turn around and head back to Wesco and it was him, sitting in the back of their car, they asked him questions that he did not know, he didn't know his name either. They took him to Corwell Health Blodgett Hospital and are thinking of doing a psych evaluation due to him forgetting things and wandering off.'*

On 09/17/2026, I received and reviewed the assessment plan for AFC residents for Resident A, dated 02/10/2026. The assessment plan documented that Resident A is 'not able to move independently in the community' and describes Resident A's needs as, 'staff will assist as needed due to cognition.' The assessment plan documented that Resident A is not 'alert to surroundings' and describes Resident A's needs as, 'staff will monitor/assist as needed due to cognition.'

On 10/20/2026, I interviewed Relative #1 via telephone and Relative #1 stated he was aware of the incidents that occurred in August 2026 and that Resident A is not cognizant and cannot be in the community on his own, unattended without staff supervision. Relative #1 stated there have been no further incidents of Resident A eloping from the facility since the 08/14/2026 and 08/22/2026 incidents.

On 10/21/2026, I conducted an exit conference with Joshua Parcher, Licensee Designee via telephone. Mr. Parcher stated the incident on 08/14/2026 was the first time Resident A ever eloped from the facility. Prior to that, Resident A always sat in the yard with other residents and never left the grounds. Mr. Parcher stated since this incident occurred, they have implemented door alarms, increased supervision of Resident A, and added Haloperidol to his medications as safety measures. Mr. Parcher stated he understood the information, analysis, and conclusion of this applicable rule.

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 complaint was reported that Resident A had left the facility on 08/14/2026, unattended by staff and was discovered later at a gas station. Resident A was confused and unable to answer the officer's questions. Resident A's assessment plan documented that Resident A could not be independent in the community without supervision. Based on my investigative findings, Resident A left the facility on 08/14/2026 and was unaccounted for a period of time, causing staff to call 911 for police assistance to find him. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

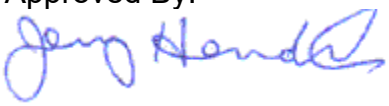
Upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.



10/21/2026

Elizabeth Elliott — Date
Licensing Consultant

Approved By:



10/21/2026

Jerry Hendrick — Date
Area Manager