



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 25, 2026

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

RE: License #: AL410418067  
Investigation #: 2026A0469002  
New Haven Assisted Living Of Comstock 2

Dear Mr. Parcher:

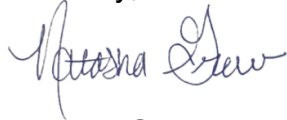
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,

A handwritten signature in blue ink that reads "Natasha Grew". The signature is written in a cursive style with a large initial 'N' and 'G'.

Natasha Grew, 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**

<b>License #:</b>	AL410418067
<b>Investigation #:</b>	2026A0469002
<b>Complaint Receipt Date:</b>	03/13/2026
<b>Investigation Initiation Date:</b>	03/16/2026
<b>Report Due Date:</b>	05/12/2026
<b>Licensee Name:</b>	New Haven Assisted Living INC
<b>Licensee Address:</b>	943 Virginia St. SE Grand Rapids, MI 49506
<b>Licensee Telephone #:</b>	(616) 307-7719
<b>Administrator:</b>	Joshua Parcher
<b>Licensee Designee:</b>	Joshua Parcher
<b>Name of Facility:</b>	New Haven Assisted Living Of Comstock 2
<b>Facility Address:</b>	155 7 Mile Rd Comstock Park, MI 49321
<b>Facility Telephone #:</b>	(616) 784-1262
<b>Original Issuance Date:</b>	10/14/2025
<b>License Status:</b>	TEMPORARY
<b>Effective Date:</b>	10/14/2025
<b>Expiration Date:</b>	04/13/2026
<b>Capacity:</b>	20
<b>Program Type:</b>	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL ALZHEIMERS, AGED



## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A's medication Oxycodone went missing from the medication cart on 03/07/2026.	Yes

## III. METHODOLOGY

03/13/2026	Special Investigation Intake 2026A0469002
03/16/2026	Special Investigation Initiated - Telephone Kent County Sheriff's Department Deputy Danielle Pedroza
03/16/2026	APS Referral APS acknowledged the allegations and did not investigate the concerns.
03/19/2026	Inspection Completed On-site
03/20/2026	Contact - Telephone call made Night Shift Supervisor Samantha Hahnenberg
03/20/2026	Contact - Telephone call made Staff Annaleese Juarez
03/20/2026	Contact - Telephone call made Faith Hospice Triage Nurse Kim Vanputten
03/25/2026	Exit Conference Licensee Designee Joshua Parcher

**ALLEGATION: Resident A's medication Oxycodone went missing from the medication cart on 03/07/2026.**

**INVESTIGATION:** On 03/13/2026, I received a complaint from the BCHC online complaint system. The complaint alleged that a full sleeve of Oxycodone, containing 30 pills, was missing from the medication cart. The card and rubber band were still present in the cart, but the sleeve of Oxycodone was gone. Samantha (Shift Supervisor) was advised of the missing medications and called police. Annaleese, Amaria, and Jessenia were the overnight staff working when the medications went missing.

On 03/16/2026, I received additional information related to this complaint from a referral from Adult Protective Services (APS) that Resident A's medication was

stolen by an employee on 03/07/2026. APS screened out this complaint and did not assign it for investigation.

On 03/16/2026, I interviewed Kent County Sheriff Deputy Danielle Pedroza via telephone. I asked if Deputy Pedroza responded to an incident at New Haven Assisted Living of Comstock regarding Resident A's missing medication. Deputy Pedroza confirmed she responded to a call at this facility about Resident A's medication, which was Oxycodone. Deputy Pedroza stated the whole sleeve of Oxycodone was missing, and what was left was a count sheet that listed the prescription for Oxycodone on it for Resident A. Deputy Pedroza stated she spoke with shift supervisor Samantha Hahnenberg, licensee designee Joshua Parcher, and the night shift staff who worked the shift when the medication was discovered missing. Deputy Pedroza stated the staff were Annaleese Juarez, Amaria Longmire, and Jessenia Gonzalez-Bowen. Deputy Pedroza stated there were no confessions of who took the medication, and a couple searches of resident rooms had been completed and the medication had not been located. Deputy Pedroza stated that the only consistent story she got was that Ms. Juarez was training Ms. Longmire and Ms. Gonzalez-Bowen. Ms. Juarez and Ms. Longmire each had a set of keys to the medication cart. Deputy Pedroza stated that Ms. Gonzalez Bowen reported to her that Ms. Juarez left keys in a medication cart.

On 03/19/2026 I completed an onsite inspection and spoke with Licensee Designee Joshua Parcher. I asked Mr. Parcher about the incident when Resident A's Oxycodone medication went missing. Mr. Parcher confirmed that on 03/07/2026, Resident A's Oxycodone was missing when the morning shift did the narcotic count. He stated the entire package of Oxycodone was missing which had contained 30 pills, and the narcotic count sheet and rubber band were left in the medication cart. Mr. Parcher explained that there were three staff on third shift from 03/06/2026 to 03/07/2026. Staff for this shift were Annaleese Juarez, Amaria Longmire, and Jessenia Gonzalez-Bowen.

Mr. Parcher stated he completed an internal investigation for the missing medications, law enforcement was contacted on 03/07/2026, and an incident report (IR) was completed. I asked Mr. Parcher what had been reported to him and when he was notified. Mr. Parcher stated he was notified about Resident A's missing medication after the narcotic count was completed at the start of the morning shift on 03/07/2026. Mr. Parcher and the night shift supervisor Samantha Hahnenberg went to the facility on 03/07/2026 to assist with following their protocol for the missing medication.

Mr. Parcher stated that there were no confessions from any of the staff working third shift on 03/06/2026 to 03/07/2026. Mr. Parcher stated that Ms. Juarez was in charge of the keys for the medication carts as she was training the two other staff that night. Mr. Parcher stated there had been a medication delivery from the pharmacy on 03/06/2026 which he was told Ms. Juarez gave the medication cart keys to Ms. Gonzalez-Bowen to put the medications in. I asked Mr. Parcher if Resident A's

Oxycodone was in that delivery. Mr. Parcher denied it was, and that Resident A's Oxycodone prescription had been in the medication cart already from a prior delivery in February 2026. Mr. Parcher stated he was also told that there had been two resident falls that night, and that was the only time Ms. Juarez reported not having keys on her as she set them on the table while she assisted the residents. Mr. Parcher stated that Ms. Gonzalez-Bowen reported Ms. Juarez had left her keys in the medication cart and Ms. Gonzalez-Bowen had found them there.

I asked Mr. Parcher if Resident A has missed any doses or shown a need for her Oxycodone or if she did not receive it. Mr. Parcher stated that Resident A has not taken this PRN in "a while", as Resident A has not shown a need for it and does not like to take narcotic medications if she does not have to.

I asked Mr. Parcher if Resident A's Oxycodone had been replaced. Mr. Parcher stated that he contacted Faith Hospice on 03/07/2026 regarding Resident A's Oxycodone prescription to get it refilled that day. He was informed that hospice had discontinued the prescription for Oxycodone on an earlier date in February, and it was not filled again. I asked to see the written documentation for the discontinued order. Mr. Parcher stated that hospice has not provided the written order for discontinuing this PRN and they are still asking for it. He continued to state that he has had difficulty working with Faith Hospice trying to give verbal orders for medication changes. He stated he has been telling hospice that he needs the written orders before he can implement the changes.

While onsite, I reviewed the IR and Resident A's medication administration record (MAR). Resident A is on other medications, and the MAR showed Resident A receiving those medications. Resident A's MAR had Oxycodone listed as a PRN as they have not received the order to discontinue it. When the MAR was reviewed for the PRN Oxycodone, no doses had been given to Resident A in February 2026 or thus far in March 2026.

I asked Mr. Parcher what has occurred since this incident to address this incident. He stated that he has had his house managers at all of New Haven Assisted Living facilities, including New Haven Assisted Living of Comstock 2, review education for "Med Cart Protocol" and to specifically address narcotic counts and medication cart key responsibilities. Mr. Parcher stated that Ms. Gonzalez-Bowen was terminated from employment following this incident. Mr. Parcher stated that Ms. Juarez was given disciplinary action in the form of "written counseling". He continued to state that Ms. Juarez has been employed with New Haven for "almost a year", and primarily works in another one of their facilities, and he has not had any issues with her handling medications prior to this incident. Mr. Parcher reported that Ms. Longmire has been terminated from employment as he was having other performance difficulties with her not related to the missing medication incident.

On 03/19/2026, I received documentation of a signed order that Resident A's Oxycodone PRN was discontinued.

On 03/20/2026 I interviewed night shift supervisor Ms. Hahnenberg via telephone. I asked Ms. Hahnenberg about Resident A's missing Oxycodone on 03/07/2026, and what occurred regarding that. Ms. Hahnenberg stated that she was contacted by Ms. Gonzalez-Bowen the morning of 03/07/2026 and was told that medications were missing. Ms. Hahnenberg asked if Ms. Gonzalez-Bowen was still at the facility, to which she reported she was not. Ms. Hahnenberg stated she informed Ms. Gonzalez-Bowen of their protocol that staff do not leave the facility if there are medications missing until law enforcement has been contacted and responds along with management. Ms. Hahnenberg stated she asked Ms. Gonzalez-Bowen to return to the facility. Ms. Hahnenberg stated that Ms. Gonzalez-Bowen told her she could not return to the facility that morning.

Ms. Hahnenberg stated she was coming from another facility that morning and when she arrived at New Haven Assisted Living of Comstock 2, Ms. Juarez was present. Ms. Hahnenberg stated that after she arrived, she contacted law enforcement to report the missing medication. Ms. Hahnenberg stated that Ms. Juarez allowed her personal belongings and car to be searched and the medication was not found. Ms. Hahnenberg stated that there were two newer residents, and they also agreed to have their rooms searched for the missing medication and it was not located. I asked Ms. Hahnenberg if the medication was replaced. Ms. Hahnenberg reported that Mr. Parcher called on 03/07/2026 to have the medication replaced.

I asked Ms. Hahnenberg if Resident A had missed any doses of her Oxycodone. Ms. Hahnenberg reported that Resident A's Oxycodone was a PRN which Resident A does not typically take. Ms. Hahnenberg stated Resident A does not like to take narcotic medications. I asked Ms. Hahnenberg if there was a medication delivery on 03/06/2026 and if Resident A's Oxycodone was in that delivery. Ms. Hahnenberg confirmed there was a delivery on 03/06/2026, however Resident A's Oxycodone was not in that delivery. Resident A's Oxycodone is a PRN and it had been in the medication cart since mid-February 2026 with a full 30-day supply as Resident A had not been given any of the Oxycodone prior to the incident occurring.

I asked Ms. Hahnenberg if Ms. Juarez, Ms. Gonzalez-Bowen, and Ms. Longmire were trained in medication management. She confirmed that Ms. Juarez had fully been trained in medication management as she typically works at another one of their facilities and was training the other two staff. She stated Ms. Gonzalez-Bowen was only a couple days through her training and not trained in medication management yet. She stated Ms. Longmire was at the end of her training, where she was to do observations of medication passes. Ms. Hahnenberg stated that Ms. Juarez should have held on to both sets of keys for the medication carts and then observed Ms. Longmire when doing medication passes. Ms. Hahnenberg was told that Ms. Longmire had a set of keys to one of the medication carts while Ms. Juarez had the keys to the other one.

I asked Ms. Hahnenberg if anything has been implemented following this incident with staff training. Ms. Hahnenberg stated that Ms. Juarez did receive discipline with

a "write up" and is no longer training new staff. Ms. Hahnenberg stated that Mr. Parcher has asked all the site supervisors for all shifts for their best employees so that he can create a group of staff who he specifically trains to train new staff for more consistency. Ms. Hahnenberg stated that even though this incident occurred at New Haven of Comstock 2, all facilities are having training about medication protocols and what to do when a narcotic cart is off, as well as key holder responsibilities for medication carts.

On 03/20/2026 I interviewed Ms. Juarez via telephone. I asked Ms. Juarez to tell me about Resident A's missing medication on 03/07/2026. Ms. Juarez stated she was working with Ms. Gonzalez-Bowen and Ms. Longmire for night shift on 03/06/2026 to 03/07/2026. Ms. Juarez stated she was aware she was training Ms. Gonzalez-Bowen, but not aware that Ms. Longmire was not done with training. Ms. Juarez stated there are two medication carts and two sets of keys. She held on to one set of keys and Ms. Longmire held the other set of keys as she thought Ms. Longmire was fully trained to have them.

I asked Ms. Juarez if there were any times that Ms. Gonzalez-Bowen had access to either medication cart. Ms. Juarez stated that as part of training, she showed Ms. Gonzalez-Bowen what she was doing when passing medications at 12am. Ms. Juarez stated the 12am medication pass was the last medication pass until 6am. Ms. Juarez stated that there had been two resident falls around the same time that evening and happened after the 12am medication pass, and that she remembered setting the keys on a table to assist the residents. Ms. Juarez stated she thought she put the keys back on her person, however around 5am Ms. Gonzalez-Bowen told her the medication keys were in the medication cart. Ms. Juarez stated she thought that was odd because she knew she did not leave them in the medication cart and had remembered putting them on the table to help the residents after they fell.

I asked Ms. Juarez how Resident A's medication was discovered missing. Ms. Juarez stated the medication was discovered missing at the end of her shift when the next shift came in and the narcotic count was completed. She stated that the facility protocol is that staff must stay at the facility while law enforcement and management are contacted. Ms. Juarez stated she was planning to give Ms. Gonzalez-Bowen a ride that day, however when the narcotic count was off and she told Ms. Gonzalez-Bowen they would need to stay, Ms. Gonzalez-Bowen asked Ms. Longmire for a ride, and they both left the facility.

I asked Ms. Juarez if Resident A had missed any doses of her Oxycodone. Ms. Juarez denied any doses being missed as it is a PRN for this resident and not scheduled. Ms. Juarez stated that Resident A does not typically take narcotic medications. I asked Ms. Juarez if Resident A received the other medications as scheduled. Ms. Juarez confirmed that Resident A had her nightly medication as scheduled.

I asked Ms. Juarez if she received training in medication management prior to this

incident. Ms. Juarez confirmed she has been fully trained and typically works at another facility with New Haven Assisted Living. Ms. Juarez stated she has not had any incidents prior to this with medication management. I asked Ms. Juarez how long she has been employed with New Haven's facilities. Ms. Juarez stated she has been employed for almost 7 months. I asked Ms. Juarez if she received any discipline for this incident. Ms. Juarez stated she received a "write up" for not keeping the keys on her and for this incident. Ms. Juarez stated that she also received an "educational" about medication management with protocol regarding narcotic counts and key holder responsibilities.

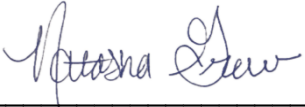
On 03/20/2026 I interviewed hospice triage nurse Kim Vanputten with Faith Hospice via telephone. I asked Ms. Vanputten if New Haven Assisted Living of Comstock Park had called to request Resident A's prescription for Oxycodone to be replaced from an incident on 03/07/2026. Ms. Vanputten reviewed records and stated that on 03/07/2026, Mr. Parcher contacted them to request that Oxycodone be re-ordered due to it being missing and that law enforcement had been contacted. Ms. Vanputten stated that Mr. Parcher was told on 03/07/2026 that a verbal order was given on 02/23/2026 that Oxycodone PRN was discontinued. Ms. Vanputten confirmed that Mr. Parcher had requested this as a written order, to which he was not provided until 03/19/2026. Ms. Vanputten stated she spoke with the nurse on 03/19/2026 who gave the verbal order previously and confirmed that facilities need a written order before they are able to discontinue or do any medication changes.

On 03/25/2026 I completed an exit conference with licensee designee Joshua Parcher. I informed him of the investigative findings and discussed the corrective action plan (CAP), which is due within 15 days of receipt of this report. Mr. Parcher agreed to send the CAP within 15 days of receipt of this report.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.</b>
<b>ANALYSIS:</b>	Mr. Parcher, Ms. Hahnenberg, and Ms. Juarez also confirmed that Resident A's Oxycodone medication was missing from the medication cart. While this medication was missing and reported to be stolen, it was not used by the person it had been prescribed. Therefore, there is sufficient evidence to support this rule violation.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



03/25/2026

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Natasha Grew  
Licensing Consultant

Date

Approved By:



03/25/2026

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Jerry Hendrick  
Area Manager

Date