



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 17, 2026

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

RE: License #: AL590407945
Investigation #: 2026A1029028
New Haven Assisted Living

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 licensee designee 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. 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 (231) 922-5309.

Sincerely,

A handwritten signature in black ink that reads "Jennifer Browning".

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

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

I. IDENTIFYING INFORMATION

License #:	AL590407945
Investigation #:	2026A1029028
Complaint Receipt Date:	02/26/2026
Investigation Initiation Date:	02/26/2026
Report Due Date:	04/27/2026
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
Facility Address:	231 4th Street, Lakeview, MI 48850
Facility Telephone #:	(989) 287-6084
Original Issuance Date:	03/30/2022
License Status:	REGULAR
Effective Date:	09/30/2024
Expiration Date:	09/29/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was able to walk outside unsupervised from New Haven Assisted Living. Direct care staff members were not aware he had left the building because the door alarm was not on.	Yes
Direct care staff members refuse to provide care to Resident B.	No

III. METHODOLOGY

02/26/2026	Special Investigation Intake 2026A1029028
02/26/2026	Special Investigation Initiated – Email to complainant
03/10/2026	Inspection Completed On-site-Face to face with Briendon Stevens, Resident A, Resident B
03/11/2026	APS Referral made to Centralized Intake.
03/11/2026	Contact - Document Received from licensee designee Joshua Parcher
03/12/2026	Contact - Telephone call received from Optimal Care Hospice RN. Trista Johnson
03/23/2026	Contact - Document Received- APS assignment letter stating Leslie Brugel was assigned to investigate the concerns.
04/09/2026	Contact – Telephone call to APS Leslie Brugel (Left message), Maleea Neely
04/14/2026	Contact – Telephone call to APS Leslie Brugel
04/15/2026	Contact – Telephone call made to licensee designee Joshua Parcher
04/16/2026	Contact – Telephone call to Guardian A1, Ashley Smith
04/17/2026	Exit conference with licensee designee Joshua Parcher

ALLEGATION: Resident A was able to walk outside unsupervised from New Haven Assisted Living. Direct care staff members were not aware he had left the building because the door alarm was not on.

INVESTIGATION:

On 02/26/2026 a complaint was received via Bureau of Community and Health Systems online complaint system alleging that Resident A wandered away from New Haven Assisted Living and direct care staff members were not aware he left the facility. According to the allegations, Resident A eloped from the facility on at least two occasions without any direct care staff being aware that Resident A left. The complaint stated on both occasions Resident A was not properly dressed for the weather conditions when he eloped from the facility. According to the complaint allegations, Resident A is diagnosed with dementia and should not be unsupervised while outside of the facility.

On 03/10/2026 I completed an unannounced on-site investigation at New Haven Assisted Living and interviewed direct care staff member, whose role is home manager, Briendon Stevens. Ms. Stevens stated there have been issues with Resident A trying to elope lately. Ms. Stevens stated Resident A does not have unsupervised community access. Ms. Stevens stated when Resident A is out in the community, he is always with relatives or direct care staff members. Ms. Stevens stated all facility doors are equipped with alarms in case someone tries to leave and these are always on. Ms. Stevens stated there are three direct care staff members working at a time and there are nineteen residents currently residing in the facility. Ms. Stevens stated when this incident occurred she was working with Ms. Neely and one of the Hospice RN's from Optimal Hospice (did not recall name) came in and said Resident A was outside the building. Ms. Stevens stated when they went outside they found Resident A next door in between the large parking lot and the AFC. Ms. Stevens stated she does not know how long Resident A was outside of the building.

I attempted to interview Resident A however due to his diagnosis of dementia, he did not remember leaving the facility. Resident A stated he did not have time to leave the facility because he moved in the day before, however, according to his *Resident ID Form* he moved into New Haven Assisted Living on 05/22/2022. I interviewed Resident B and he was unaware of anyone leaving the building at any time unsupervised.

During the on-site investigation I reviewed Resident A's resident record which included the following documents:

1. *Assessment Plan for AFC Residents* which included documentation that, "staff will assist when out in the community due to dementia." Under Alert to Surroundings, the documented stated: "Staff will assist and remind resident of location and environment due to dementia."
2. *Health Care Appraisal* stating Resident A had "cerebral atherosclerosis, was confused, and was susceptible to hyper/ hypothermia. At risk for falls."

On 03/11/2026 I received an email from licensee designee Joshua Parcher. Mr. Parcher sent over the hourly checks for Resident A to confirm that direct care staff members observed Resident A on 2/17/2026 throughout the day. Mr. Parcher stated he has had issues with the Wi-Fi door alarms and he is going to order different battery powered door alarms. Mr. Parcher included the following account of the timeframe when Resident A was found:

"[Resident A] ate lunch around 12:30 PM. He was still in the common area at 1 pm. The incident occurred between 1 PM and 1:30 PM. The Optimal Care Hospice Nurse entered the building stating [Resident A] was outside. Staff went outside and located him in the next door parking lot walking away from New Haven of Lakeview. I'm not sure where the gas station idea originated, other than from the Hospice Nurse's statement, based on what I heard from New Haven Staff. [Resident A] also did not have his walker with him. It was located near the East Side Door Exit. Which is near his room 3".

Mr. Parcher also emailed me the *Door Alarm Hourly Check Off* which will be implemented to check all four doors every hour to make sure the door alarms are on at all times. On this form, direct care staff members will document whether the door is armed or disarmed when they check it. I also reviewed the *Door Alarm Policy* that Mr. Parcher will review with direct care staff members and have them sign this document showing their understanding.

I reviewed the *Resident Check Sheet Hourly* for 02/17/2026 showing that Resident A was observed each hour of the day. According to the *AFC Incident / Accident Report* this incident occurred around 1:30 PM. According to the *Resident Check Sheet Hourly* Resident A was observed at 1 PM and 2 PM in the common room of the facility.

On 03/12/2026 I received a call from Optimal Care Hospice RN Trista Johnson. RN Johnson stated she had seen Resident A at New Haven Assisted Living before providing services to him so she thought he was a resident when she drove by and saw him outside on the sidewalk while driving to the facility. RN Johnson stated when she observed him he was in the parking lot of a party store however she was unable to say how far he was from the facility or the name of the party store stating she was not familiar with Lakeview. RN Johnson stated she did see him in motion and thought he may be a resident so she pulled into New Haven Assisted Living and told Ms. Stevens there was a resident who was walking near a store. RN Johnson stated she does not know how long he was outside for. RN Johnson stated he did have a jacket on but sometimes he will have his coat on inside the building too. RN Johnson stated when she went into the front door of the facility the alarm did go off and the alarms were very loud so she knows they do use them periodically.

On 04/09/2026 I interviewed direct care staff member Maleea Neely. Ms. Neely stated she was working during the incident on 02/17/2026 and she stated right after lunch Hospice nurse RN Johnson came in and stated Resident A was down by a gas station. Ms. Neely stated she was already checking for him right before lunch because they had

to do their two hour checks. Ms. Neely stated she realized the middle door by his bedroom and the back kitchen did not have the alarm on at the time but the rest of the alarms were working. Ms. Neely stated she quickly went over to Ms. Stevens and they went outside and saw that Resident A was already by the corner heading their way. Ms. Neely stated he did not have any injuries to him but when they brought him inside they did take his vitals which were normal and gave him his walker. Ms. Neely stated RN Johnson stated that he was found by a gas station but she does not know the name of this store now but that it used to be called the Next Door Store. Ms. Neely stated when she went outside he was on the same road as the facility and he was near the large parking lot next door. Ms. Neely stated Resident A previously eloped from the facility but she was not working during the previous instances. Ms. Neely stated that since she's been working there he's been outside alone 3-5 times.

Ms. Neely stated she did not know why the door alarm was not alarmed but it was turned off during third shift and the day shift should have checked it. Ms. Neely stated the other door alarms were working correctly when this occurred. Ms. Neely stated this is the last time this occurred and she does not believe that he's been out of the building since this incident. Ms. Neely stated Resident A does not have unsupervised community access as Resident A is required to be with direct care staff members or family at all times. Ms. Neely stated they are constantly checking the door alarms and they are more on top of it than they were before since this incident occurred.

I reviewed Google Map images for Lakeview and although there is no party store near the facility, in order to walk to Lincoln Avenue which is the main street going downtown Lakeview, MI, Resident A would have had to walk for approximately 350 feet to get to the corner. On that road, there is a community center, Griffith Market, Tavern, Main Street Pizza, and various stores. Ms. Neely stated it was called the Next Door Store which is on Lincoln Avenue and is .3 miles from the facility.

On 04/14/2026 I interviewed APS Ms. Brugel. Ms. Brugel stated she does have an open APS case with Resident A regarding this incident. Ms. Brugel stated she completed an on-site investigation and interviews when the complaint was received on 03/12/2026 and when she arrived at the facility, the door alarms didn't go off because she checked this before completing interviews. Ms. Brugel stated she also reopened it from the inside and it didn't go off leaving either. Ms. Brugel stated there are four doors and on two of the doors they have a lock higher up on the doors and they were alarmed but Mr. Parcher was waiting on locks that he had purchased for the other two doors. Ms. Brugel stated they still had an alarm on them but they didn't have them set to go off. Ms. Brugel stated she went back to New Haven Assisted Living on 04/02/2026 and the entrance door alarm did go off when she walked in and she was informed they have new locks and alarms on all of the doors now. Ms. Brugel stated the direct care staff members and Ms. Stevens also told her that Resident A was found in the large parking lot right next door to the building once they were notified that he was gone. Ms. Brugel stated she didn't know how long he was out of the building. Ms. Brugel stated she was also informed third shift did not lock the door after they used it because he went out the door by his bedroom. Ms. Brugel stated that she would be substantiating because the

door alarms were off allowing Resident A to elope from the facility unsupervised and undetected.

On 04/15/2026 I interviewed licensee designee Joshua Parcher. Mr. Parcher stated Resident A went out the side door and went around the front around the parking lot so they think he was out for about 3-5 minutes long. Mr. Parcher stated he completed an internal investigation and he stated the RN who came stated he was by the party store and he does not think that he would have been able to make that trip without his walker. He stated the closest store is about a ½ mile to 1 mile away. Mr. Parcher stated Resident A has not eloped from the facility since this incident. Mr. Parcher stated there was something wrong with the Wi-Fi alarms and since he stopped using these alarms they have been working consistently. Mr. Parcher stated Resident A still wants to go outside when its nice weather and he has been an elopement risk since he opened this facility. Mr. Parcher also stated Resident A has been on and off hospice care a few times since his admission. Mr. Parcher stated there is no way to find Resident A an alternative placement because of his financial situation so he's been working with him. Mr. Parcher stated there were more behaviors last year with Resident A trying to leave the facility unsupervised so for a while Resident A had 1:1 staffing but over time his health declined, he was on hospice, and the exit seeking behavior stopped. Mr. Parcher stated now that Resident A's health has improved again, he plans to assess if Resident A needs more supervision. Mr. Parcher stated he has never had an issue with the third shift direct care staff members turning the alarms off but sometimes it will beep showing it's not alarmed when it's supposed to be. Mr. Parcher stated Montcalm Care Network is pushing them to not have alarms at all on the doors because the alarms are intrusive and too loud. Mr. Parcher stated he is trying the best he can to work with Resident A because he has been there for so long. Mr. Parcher stated when he tries to leave, he's never gone toward the lake but he will go toward the main road. He stated since he has been there he has tried to leave approximately 3-5 times and they will continue to address these concerns with Guardian A1.

On 04/16/2026 I interviewed Guardian A1. Guardian A1 stated Resident A has eloped from the facility a few times in the last three years since he has resided there. Guardian A1 stated he spoke with Ms. Brugel from APS and she stated Resident A went down to the store but he stated Resident A has a hard time walking and it would be extremely hard for Resident A to go that far. Guardian A1 stated he has never been harmed when he left the facility and it's happened about 3-4 times since he has moved in. Guardian A1 stated there have been a couple times that an alarm activated when he arrived for visits but he thinks that they are normally turned off and he hasn't heard them when he visits with Resident A. Guardian A1 stated that he has not been there in a couple weeks so he does not know if the alarm has been turned back on or if there are new alarms. Guardian A1 stated there are a lot of younger direct care staff members who do not seem to be trained to handle dementia behaviors and at times when the behavior increases, he is more likely to try and leave.

On 04/16/2026 I interviewed direct care staff member Ashley Smith. Ms. Smith stated she was working when Resident A eloped and a hospice nurse reported that she saw

Resident A at the gas station. Ms. Smith did not observe Resident A elope from the facility because it was after lunch and she was cleaning the rooms. Ms. Smith stated when Ms. Stevens and Ms. Neely came outside they saw that he was in the parking lot next door to the facility and they went out right away to bring him in. Ms. Smith stated she checked the door alarms and learned the side door was not alarmed, which was the one that was right next to Resident A's resident bedroom and likely the door he exited. Ms. Smith stated Resident A had previously eloped from the facility because in the last three years since he moved in, this has occurred about 3-4 times. Ms. Smith stated sometimes she will see him go out and she will walk with him to make sure he's okay and he will agree to go back to the facility. Ms. Smith stated the door alarms are supposed to be set at all times and all four doors are alarmed. Ms. Smith stated she knows that she saw Resident A around 12:30 PM because he was in the dining room eating lunch and then after lunch that she started to clean rooms so she did not know that he eloped from the facility. Ms. Smith stated after this incident, the alarms are always set and each morning she goes through each door to make sure they are always on. Ms. Smith stated since the incident in February Resident A hasn't eloped from the facility. Ms. Smith stated there is a party store a couple blocks away and that's the closest one, however he can barely walk to the bathroom on his own so she does not think that he got that far, especially because he did not have his walker with him at the time.

APPLICABLE RULE	
R 400.671	Resident care.
	(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.

ANALYSIS:	Resident A was able to elope the building unsupervised because the door alarm to the side door near Resident A's bedroom was turned off at the time of his departure. Although it is unclear how long he was out of the facility, RN Johnson stated that she observed him to be near a store and Ms. Stevens and Ms. Neely both stated he was found in the parking lot near the building. Based on the interviews with Mr. Parcher, Ms. Neely, Ms. Smith, Guardian A1, and Ms. Stevens there is evidence that he has been found outside unsupervised on more than one occasion, which is a great risk due to the nearby lake and traffic that could put him in danger. Consequently, Resident A's supervision needs were not provided in accordance with his assessment plan.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Direct care staff members refuse to provide care to Resident B.

INVESTIGATION:

On 02/26/2026 a complaint was received via Bureau of Community and Health Systems online complaint system alleging that direct care staff members have refused to provide personal care to Resident B. According to the allegations, they are refusing to provide care to two residents because they are on the sex offender registry and because the resident "doesn't need help he can do everything himself" but he does need more assistance than they are giving. There were no details in the allegations about what personal care the two residents were not receiving or who was refusing to provide care to them.

On 02/26/2026 I emailed Complainant to see if there was additional information, however there were no additional details including which resident was not being provided care or which direct care staff members were not providing care as required.

On 03/10/2026 I completed an unannounced on-site investigation at New Haven Assisted Living and interviewed direct care staff member, whose role is home manager, Ms. Stevens. Ms. Stevens stated there are two residents who are on the sex offender registry however she has never had concerns regarding them not receiving care due to this or any other reason. Ms. Stevens stated that Resident B requires 1:1 supervision and needs assistance with getting his legs up into his bed. Ms. Stevens stated direct care staff use a sliding board to complete this task. Ms. Stevens stated Resident B could be interviewed but Resident C has a lot of confusion and would not understand enough to complete an interview. I did observe Resident C who was sitting at the table and appeared to be in good spirits.

I interviewed Resident B who stated he has resided there for two years and that sometimes "he needs a lot of help." Resident B stated he has a catheter but he can

change this himself. Resident B stated sometimes he “feels like the direct care staff members don’t want to help him”. When I asked Resident B why he feels that way, he stated “I don’t want to get into it”. Resident B was unable to give examples of when he wasn’t cared for.

During the on-site investigation I reviewed the following documents regarding Resident B:

1. *Assessment Plan for AFC Residents* which stated Resident B requires assistance with all areas of self-care such as toileting, bathing, grooming, dressing, hygiene, and walking / mobility.
2. *Health Care Appraisal* which stated he had the diagnosis of GERD, BPH, Anoxic brain damage, falls, and sarcopenia.

On 04/09/2026 I interviewed direct care staff member Ms. Neely. Ms. Neely stated she knew that there were two residents on the sex offender registry. Ms. Neely stated she does not believe there was a time when they didn’t receive care or heard any of the direct care staff members refuse to provide care to either resident for any reason.

On 04/14/2026 I interviewed APS Ms. Brugel. Ms. Brugel stated there were no concerns of any residents not receiving appropriate care.

On 04/15/2026 I interviewed licensee designee Joshua Parcher. Mr. Parcher stated there are two residents who are on the Sex Offender Registry and in the past Resident B has made the younger direct care staff members uncomfortable because he will stare at them and make them feel uncomfortable. Mr. Parcher stated there are certain tasks that he is able to do and they encourage him to do these on his own, however, no direct care staff refused to provide care for him. Mr. Parcher stated Guardian B1 wants him to become more independent and do mores tasks on their own so they do encourage this. Mr. Parcher stated Resident C is also on the sex offender registry and sometimes he will be aggressive due to his mental illness and dementia but he’s not sexually inappropriate with the direct care staff members and this hasn’t been a concern. Mr. Parcher stated he has no concerns the direct care staff members are not providing care to Resident C.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: (p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.

ANALYSIS:	There is no indication Resident B or Resident C was not provided necessary personal care while residing at New Haven Assisted Living. Based on the interviews with licensee designee Mr. Parcher, Ms. Neely, and Ms. Stevens there was no indication any of the direct care staff members stated they would not provide care for any of the residents or evidence that residents were not provided care as required. Resident B stated has resided there for two years and could not give examples of when he was not provided with personal care.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning

Jennifer Browning
Licensing Consultant

4/17/2026

Date

Approved By:

Dawn Timm

04/17/2026

Dawn N. Timm
Area Manager

Date