



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 11, 2026

Jennifer Herald
Glastonbury Drive Opco LLC
Suite 200
7297 Nemco Way
Brighton, MI 48116

RE: License #: AL190414603
Investigation #: 2026A1033032
Grace Haven Assisted Living - Specialized Care

Dear Ms. Herald:

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 feel free to 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. 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,

A handwritten signature in cursive script that reads "Jana Lipps". The signature is written in a dark ink and is positioned below the word "Sincerely,".

Jana Lipps, 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 #:	AL190414603
Investigation #:	2026A1033032
Complaint Receipt Date:	04/28/2026
Investigation Initiation Date:	04/28/2026
Report Due Date:	06/27/2026
Licensee Name:	Glastonbury Drive Opco LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
Administrator:	Dennis Lambert
Licensee Designee:	Jennifer Herald
Name of Facility:	Grace Haven Assisted Living - Specialized Care
Facility Address:	1507 Glastonbury Drive St. Johns, MI 48879
Facility Telephone #:	(989) 224-1650
Original Issuance Date:	07/09/2024
License Status:	REGULAR
Effective Date:	01/09/2025
Expiration Date:	01/08/2027
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not administered prescribed medications for multiple weeks.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/28/2026	Special Investigation Intake 2026A1033032
04/28/2026	Special Investigation Initiated - Telephone Interview conducted with Complainant, via telephone.
04/28/2026	Contact – Telephone call made Interview conducted with Relative A1, via telephone.
04/30/2026	Inspection Completed On-site Interview conducted with Wellness Director, Jordan Biddinger, and Executive Director, DJ Lambert. Review of resident MARs completed. Review of Resident A's daily chart notes completed.
04/30/2026	Contact - Document Sent Email correspondence sent to licensee designee, Jennifer Herald.
04/30/2026	Inspection Completed-BCAL Sub. Compliance
04/30/2026	APS Referral No current suspicion of abuse, neglect, exploitation.
04/30/2026	Exit Conference Conducted via email with licensee designee, Jennifer Hereald.
05/07/2026	Contact – Telephone call made Attempt to interview direct care staff, Carissa Brown, via telephone. Voicemail message left, awaiting returned call.
05/07/2026	Contact – Telephone call made Attempt to interview direct care staff, Brooke Wright, via telephone. Voicemail message left, awaiting response.

ALLEGATION: Resident A was not administered prescribed medications for multiple weeks.

INVESTIGATION:

On 4/28/26 I received an online complaint regarding the Grace Haven Assisted Living - Specialized Care, adult foster care facility (the facility). The complaint alleged that Resident A did not receive her prescribed medications from 4/14/26 through 4/26/26. The complaint noted that direct care staff did not contact Resident A's physician or family members regarding the medications not being available for administration at the facility.

On 4/28/26 I interviewed Complainant via telephone regarding the allegation. Complainant reported that Resident A was admitted to the facility in February 2026. Complainant reported that they were made aware of the fact that Resident A had not received her prescribed medications from 4/14/26 through 4/26/26. They reported that Relative A1 had further information regarding these allegations.

On 4/28/26 I interviewed Relative A1, via telephone. Relative A1 reported that Resident A has resided at the facility since February 2026. She reported on 4/20/26 Resident A made a telephone call to Relative A1 and noted that she was not feeling well. Relative A1 reported that she spoke with a direct care staff member on this date (name not recalled), who confirmed Resident A had not been feeling well. Relative A1 reported that she made a visit to Resident A at the facility on 4/20/26 around 7am. She reported she took Resident A's blood pressure, and it was high. Relative A1 reported that she encouraged Resident A to take her medication and eat her breakfast to see if this helped. She reported that she then left the facility and did not hear further. Relative A1 reported that she received another telephone call from Resident A on 4/26/26 stating she was not feeling well again. Relative A1 reported that she had previously been to the facility to visit Resident A on this date, and she decided to return to the facility. She reported that she took Resident A's blood pressure on this date and it was high, again. Relative A1 reported that she spoke with direct care staff, Carissa Brown, and asked if Resident A had received her medications that day. Relative A1 reported that Ms. Brown looked at the *Medication Administration Record* (MAR) for Resident A and noted that Resident A had not received her medications in several days. She reported that there were notations on the MAR stating, "Awaiting arrival from pharmacy". Relative A1 reported that Ms. Brown checked the medication cart for Resident A's medications and could not find them. She reported that there are two licensed adult foster care facilities on this campus and Ms. Brown then looked in the other facility's medication cart and Resident A's medications were located. Relative A1 reported that Resident A was then restarted on her medications that evening.

Relative A1 reported that she was upset by Resident A not receiving her medication for what appeared to be at least a two-week period. She reported that she made telephone calls to the facility Administration, Dennis Lambert, and Wellness Director, Jordan Biddinger, to address this concern. Relative A1 reported that she received a returned

call from Ms. Biddinger on 4/26/26. She reported that Ms. Biddinger blamed the confusion and lack of medication in the facility on the pharmacy. Relative A1 reported that Ms. Biddinger implied that several residents had issues with receiving their medications from the pharmacy this month. Relative A1 reported that Ms. Brown stated that the direct care staff responsible for ordering and managing the availability of medications had their employment terminated and this may have impacted Resident A's medications being available on-site.

On 4/30/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Biddinger regarding the allegation. Ms. Biddinger reported that last week Relative A1 had made a telephone call to her to report that Resident A was missing her Losartan, Atorvastatin, and Aspirin, from the medication cart. Ms. Biddinger reported that direct care staff, Deb Straub, did call the Corso Care Pharmacy to request refills on these medications and was told that it was too early to refill these medications. Ms. Biddinger reported that the pharmacy delivered the new months "cycle fill" of medications for Resident A on 4/25/26 and direct care staff were able to take from this supply and begin administering Resident A's medications again. Ms. Biddinger reported that she was not certain why there was an issue with receiving Resident A's medications but believed this was a pharmacy error. She reported that she sent an email to licensee designee, Jennifer Herald, and Regional Wellness Director, Crystal Smith, on 4/26/26 to explain that there had been an issue with receiving Resident A's medications during the month of April 2026. Ms. Biddinger reported that on 4/27/26 Ms. Smith emailed Corso Care Pharmacy pharmacist, Hassan Ali, directly to question the missing medications. She reported that they received a response that the medications had been sent to the facility and there should have been enough medication on-site to administer to Resident A for the month of April 2026. Ms. Biddinger reported that a direct care staff/care coordinator had been terminated by the facility multiple months prior to this incident and it was this individual's responsibility to manage resident medications. She reported that since this individual is no longer employed, Ms. Straub has been filling in with this task. Ms. Biddinger reported that it was an oversight of each direct care staff member who signed Resident A's MAR during the month of April stating there were no medications available for Resident A. She reported that these direct care staff members should have informed the pharmacy, licensee designee, and/or the Administrator regarding this issue instead of continuing to document that medications were not available for administration and not following up on why this was occurring. Ms. Biddinger reported that these direct care staff members are all receiving written disciplinary actions regarding this issue.

On 4/30/26 during the on-site inspection, I reviewed Resident A's MAR for the month of April 2026, with Ms. Biddinger. The following information was identified:

- Resident A is prescribed the following routine medications:
 - Aspirin Low Chw 81 MG, Chew and swallow 1 tablet by mouth every day
 - Atorvastatin Tab 20 MG, Take 1 tablet by mouth every night at bedtime
 - Levothyroxine Tab 25 MCG, Take 1 tablet by mouth every day
 - Losartan POT Tab 50MG, Take 1 tablet by mouth every day
 - Trazodone Tab 50MG, Take 1 tablet by mouth every night at bedtime

- Vitamin D3 Tab 25MCG, Take 1 tablet by mouth every day
- I observed the following about Resident A's routine medications:
 - Aspirin 81MG was marked as not administered on the following dates, 4/1/26-4/26/26.
 - Atorvastatin 20MG was marked as not administered on the following days, 4/1/26-4/25/26.
 - Levothyroxine 25MCG was marked as being administered every day.
 - Losartan 50MG was marked as not administered on the following days, 4/15/26-4/26/26.
 - Trazodone 50MG was marked as not administered on the following days, 4/16/26-4/25/26.
 - Vitamin D3 was marked as being administered every day.
- Each of the dates these medications were not administered there was a note on the MAR which read, "Awaiting Med Arrival from Pharmacy", except on 4/18/26 Ms. Straub entered a note for the Losartan and the Aspirin which read, "Family to bring in".
- During the on-site investigation I asked Ms. Biddinger and Ms. Straub about the note on 4/18/26 regarding "Family to bring in". Both Ms. Straub and Ms. Biddinger reported that this note was entered in error as all Resident A's medications are to be delivered from the Corso Care Pharmacy.

On 4/30/26, during the unannounced on-site investigation I reviewed the document, *Charting Notes for [Resident A]* for the dates, 2/27/26-4/30/26. I observed the following information:

- 4/21/26, Ms. Straub entered a note stating, "I called [Resident A's] Dr. so he could send scripts for her meds to Corso care pharmacy".
- 4/26/26, direct care staff, Brooke Wright, documented, "[Resident A] was down in AL socializing with other residents, she came back to Mc and her family was visiting and came to us and said her emotions are all over the place, daughter realized we were out of her meds and was really upset, so staff was searching and contacting management and we found her meds."

During the on-site investigation on 4/30/26 I reviewed all MARs for the month of April 2026 for the current residents at the facility. Resident A's MAR was the only MAR which documented a routine issue with missing medications.

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 the interviews conducted and documentation reviewed during this investigation it can be determined that there is substantial evidence to identify that Resident A did not receive her routinely prescribed medications as ordered during the month of April 2026. Upon reviewing the April MAR for Resident A, I identified that Resident A did not receive her Aspirin from 4/1/26-4/26/26, her Atorvastatin from 4/1/26-4/25/26, Losartan from 4/15/26-4/26/26, Trazadone from 4/16/26-4/25/26. Ms. Biddinger reported that after conducting an internal audit it has been identified that multiple direct care staff members continued to document "Awaiting Med Arrival From Pharmacy" on Resident A's MAR and did not consult facility administration to determine why Resident A's medications were not available on-site. Ms. Biddinger reported that Ms. Straub did contact the physician for refill orders on 4/21/26, but there were no other notes indicating anyone had contacted the pharmacy, the physician, or the family to identify why Resident A's medications were not available on-site for administration. Resident A went anywhere from 10-26 days without physician prescribed medications during the month of April. Ms. Biddinger reported that once the issue was identified, a corrective action plan was enacted in efforts to prevent any future issues of this nature. However, the fact remains that Resident A was not administered her required routine medications for weeks. Therefore, a violation has been established.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 4/30/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Biddinger. Ms. Biddinger had Administrator, Dennis Lambert, on a conference call during parts of this interview. I requested to review the *Resident Register* for the facility. The *Resident Register* listed 21 residents currently under care. I inquired about this number and the names on the document were reviewed for accuracy. Ms. Biddinger agreed that all 21 individuals are current residents at the facility. It was discussed that this facility is only licensed to provide care to 20 residents at any given time. Mr. Lambert reported that there are two licensed adult foster care facilities on this campus which both have a 20-resident capacity. He reported that both licensed facilities were at or above capacity. Mr. Lambert reported that an individual from the other licensed adult foster care facility was planning a scheduled move out date today. He reported that Resident A had planned to move into the other facility the week of 5/4/26 and then the capacity at both facilities would be 20 residents.

On 4/30/26 I sent email correspondence to licensee designee, Jennifer Herald, explaining the facility currently being over capacity and the need to address this issue.

APPLICABLE RULE	
R 400.613	Licensed capacity, occupants.
	(1) The number of residents and number of resident beds must not be greater than the capacity authorized on the license.
ANALYSIS:	At the time of the on-site inspection on 4/30/26 the facility was over capacity by one resident. Therefore, a violation has been established.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the current status of the license recommended at this time.

Jana Lipps 5/7/26

 Jana Lipps Date
 Licensing Consultant

Approved By:

Dawn Timm 05/08/2026

 Dawn N. Timm Date
 Area Manager