GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 29, 2025

Surindar Jolly
Brownstown Forest View Assisted Living
19341 Allen Rd.
Brownstown, MI 48183

RE: License #: AH820238949
Investigation #: 2025A0784044
Brownstown Forest View Assisted Living

Dear Surindar Jolly:

Attached is the Special Investigation Report for the above-mentioned 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 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.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

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

I. IDENTIFYING INFORMATION

License #:	AH820238949
Investigation #:	2025A0784044
Complaint Receipt Date:	04/07/2025
Investigation Initiation Date:	04/07/2025
Report Due Date:	06/06/2025
Licensee Name:	Brownstown Assisted Living Center LLC
Licensee Address:	19335 Allen Road Brownstown, MI 48183
Licensee Telephone #:	(734) 658-4308
Administrator/Authorized Representative:	Surindar Jolly
Name of Facility:	Brownstown Forest View Assisted Living
Facility Address:	19341 Allen Rd. Brownstown, MI 48183
Facility Telephone #:	(734) 675-2700
Original Issuance Date:	08/14/2002
License Status:	REGULAR
Effective Date:	12/17/2023
Expiration Date:	07/31/2024
Capacity:	76
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Inadequate care and supervision for Resident A	Yes
Additional Findings	No

III. METHODOLOGY

04/07/2025	Special Investigation Intake 2025A0784044
04/07/2025	Special Investigation Initiated - Telephone Attempted with complainant
04/07/2025	Contact - Telephone call received Interview with complainant
04/08/2025	Inspection Completed On-site
04/08/2025	Contact - Telephone call made Attempted with staff 5. Message left requesting a return call.
04/08/2025	Exit Conference Conducted with staff 2

ALLEGATION:

Inadequate care and supervision for Resident A

INVESTIGATION:

On 4/07/2025, the department received this complaint.

According to the complaint, on 3/23/2025, at approximately 9:30am, Resident A was observed sitting in a recliner in her room with a blanket covering her. Underneath the blanket, Resident A was wearing only a cardigan and a brief observed to be soaked with urine. Resident A was not wearing a shirt, pants or socks. Resident A had put on the cardigan and put a blanket over herself because she was cold. Resident A is self-ambulatory but does need assistance from Staff with dressing and brief changes. Staff working that morning reported Resident A must have been put in bed by staff 1 the night before with no clothes on. Resident A was very sick from COVID

and lethargic and it is unknown how Resident A ended up in her chair as it would have been difficult for her to do so on her own due to her condition at that time.

On 4/07/2025, I interviewed complainant by telephone. Complainant stated the incident noted in the complaint was on the morning of 3/23/2025. Complainant stated that on that morning, at approximately 9:45am, two staff working at the facility were called to Resident A's room by Relative A to see the condition Resident A was in. Complainant stated both staff reported being upset and unaware of Resident A's condition. Complainant stated these staff reported staff 1 was working the night before and must have put her in bed with no clothes on. Complainant could not provide the names of the staff spoken to. Complainant stated concerns about Resident A's care have been reported to staff 2, the facility supervisor, and that staff 2 did not take them seriously. Complainant stated Resident A was moved from the facility on 3/25/2025.

I reviewed a picture provided by complainant which complainant stated was a picture of Resident A on the morning of 3/23/2025. Complainant stated the picture was taken after the blanket covering Resident A was removed to show what she was wearing at the time. The picture had a date stamp of 3/23/2024 and a time stamp of 10:07am. The picture was consistent with complainants' statements regarding what Resident A was wearing. The condition of Resident A's brief was indistinguishable.

On 4/08/2025, I interviewed staff 2, a supervisor, at the facility. Staff 2 confirmed she had received a complaint regarding Resident A being found in the manner described by complainant on the morning of 3/23/2025. Staff 2 stated she intended to look into the matter further but has been unable to complete an investigation. Staff 2 stated she is aware that staff 1 had assisted Resident A to bed on the evening of 4/22/2025. Staff 2 stated she has been unable to confirm if staff 2 put Resident A to bed as described by complainant. Staff 2 stated staff 1 was asked about the allegation and that staff 1 denied putting Resident A to bed with no clothes on. Staff 2 stated staff 3, 4 and 5 were all working the morning of 3/23/2025. Staff 2 stated Resident A did require assistance with transferring and getting dressed. Staff 2 stated Resident A was physically capable of getting up but often did not have the strength or stability to transfer herself. Staff 2 stated Resident A was able to ambulate with a walker. Staff 2 stated staff 3 was scheduled to work on the second floor that morning. Staff 2 stated staff 3 may have been late for work so she could not be certain if the second floor was without supervision for a period of time. Staff 2 stated that when someone is scheduled to work on the second floor, they are not supposed to leave that floor unless they are relieved by another staff.

On 4/08/2025, I interviewed staff 1 by telephone while at the facility. Staff 1 stated he was familiar with Resident A. Staff 1 stated he heard that other staff alleged he put Resident A in bed on the evening of 3/22/2025 in just underwear. Staff 1 denied putting Resident A to bed this way and stated he put her in bed with pajamas on as he normally did. Staff 1 stated he worked third shift that night, so he was working until the next morning. Staff 1 stated the third shift ends at 6:30am. Staff 1 stated he

left work after 6:30am on 3/23/2025. Staff 1 stated he was working with staff 6 also who he stated checked on Resident A at approximately 5am that morning as Resident A often would get up early. Staff 1 stated staff 6 reported Resident A was still in bed, dressed and dry and did not want to get up at that time. Staff 1 stated he checked on Resident A again around approximately 6:10am and that Resident A was still in bed, dressed and dry and did not want to get up yet. Staff 1 stated he would not leave Resident A in the condition described in the complaint. Staff 1 stated staff 3 was scheduled to work the morning shift on the second floor on 3/23/2025.

On 4/08/2025, I interviewed staff 3 at the facility. Staff 3 confirmed she worked on the morning of 3/23/2025 and was scheduled to work on the second floor. Staff 3 stated she came in late to work that day "around 7 or 7:30am". Staff 3 acknowledged that she was scheduled to come into work that morning at 6:30am. Staff 3 stated she had not seen Resident A yet that morning as she had been assisting staff 5 on the first floor since she arrived at work. Staff 3 stated that before she could get up to the second floor to assist Resident A, Relative A approached her asking why Resident A was sitting in her chair undressed. Staff 3 stated Resident A does not normally get assisted to bed at night without pajamas on, so she "assumed" Resident A had been put to bed without any pajamas on. Staff 3 stated she could not say for sure if this was true. Staff 3 stated Resident A had not been feeling well during that time and was not very active or mobile so she did not believe Resident A would have gotten out of bed on her own. Staff 3 stated that prior to going to the second floor as scheduled, she did not know if any other staff had been supervising on that floor.

On 4/08/2025, I interviewed staff 4 by telephone while at the facility. Staff 4 confirmed she worked on the morning of 3/23/2025. Staff 4 stated she first saw Resident A sometime between 8 and 9am as she was passing medications on the second floor. Staff 4 stated that at that time, Resident A was in her pajamas sitting in her recliner with her blanket over her and that she appeared to be doing well. Staff 4 stated she also retrieved a cup of coffee for Resident A at that time. Staff 4 stated she did not know how Resident A got to her chair. Staff 4 stated Resident A was capable of getting up. Staff 4 stated Resident A was limited as to her mobility and ability to transfer but that some days, when she was feeling good, she was able to get over to her chair next to her bed. Staff 4 stated Resident A could also get to her walker and ambulate on her own. Staff 4 stated Resident A was limited in this ability at times. Staff 4 stated she does not know how Resident A ended up in her chair in just a brief. She stated it was possible for Resident A to do it on her own. Staff 4 stated she did see staff 3 on the first floor that morning. Staff 4 stated she did not know why staff 3 was on the first floor as she was scheduled to work the second floor. Staff 4 stated their would have been no reason for staff 3 to be on the first floor as both staff 5 and 6 were working on that floor that morning. Staff 4 stated she was also available to assist if needed. Staff 4 stated that when staff are assigned to the second floor, they are not supposed to leave that floor unless relieved by another staff. Staff 4 stated "lately it is common for the second floor to be left unattended". Staff 4 stated she did not know when staff 3 arrived at work that morning.

On 4/08/2025, I interviewed staff 6 by telephone while at the facility. Staff 6 confirmed having worked on the first floor on the morning of 3/23/2025. Staff 6 also confirmed having worked the shift prior during third shift. Staff 6 stated she last checked on Resident A that morning at around approximately 7am and that at that time, she was still in bed, under her blanket and in pajamas. Staff 6 stated Resident A did not want to get out of bed at that time. Staff 6 provided statements consistent with those of staff 4 regarding Resident A's ability to get out of bed on her own. Staff 6 stated she was not aware of Resident A's condition that morning until Relative A came to the building and notified staff. Staff 6 stated staff 3 had been assisting on the first floor that morning, but she did not know when staff 3 came into work.

I reviewed the facilities daily assignment staff sheets titled *Care Team Daily Shift Assignment*, provided by staff 2, for 3/23/2025. The sheets read consistently with statements provided by staff regarding where staff had been assigned to work that morning. According to the sheets, "Day Shift" is from 6:30am to 3pm.

I reviewed staff 1 and staff 3's *Time Card*, provided by staff 2, for 3/23/2025. According to the timecard, staff 1 punched out at 7am and staff 3 punched in at 8:45am that morning.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

ANALYSIS:	The complaint alleged inadequate care was provided to Resident A when she was found on the morning of 3/23/2025 in her recliner wearing only a brief and a cardigan. While it was reported that staff 1 had put Resident A to bed the night before without any clothes on, contrary to appropriate dress for her, there is insufficient evidence to support this claim or provide clarity on how Resident A ended up how she was found by Relative A. Interviews with staff and review of daily assignment sheets revealed that staff working first shift are supposed to report to work at 6:30am. Review of the daily assignment sheets also revealed staff 3 was assigned to work first shift on the second floor the morning of 3/23/2025. While staff 3 reported she arrived to work at approximately 7am that morning, the *Timecard* records showing when staff clock into work showed staff 3 did not punch into work until 8:45am that morning. Staff 3 admitted that when she did get to work, she did not immediately report to the second floor where she was assigned and that it was not until Relative A approached her, approximately 9:45am as reported by complainant, that she was even aware of Resident A's condition. While staff 4 reported having been on the second floor for a period of time to pass medications, statements from staff and review of timecard information indicate that between approximately 7am and 9:45am, the second floor was left unsupervised for the majority of time and that during that time, Resident A, who needs assistance from staff, somehow moved from her bed to her chair and remove her clothing while staff responsible to her care were not aware until approached by family. Based on the findings, Resident A was not provided with adequate care and supervision.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

5/16/2025

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Aaron Clum Date
Licensing Staff

Approved By:

05/29/2025

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section