GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 29, 2025

Mary North
Brookdale Delta MC (MI)
7235 Delta Commerce Dr.
Lansing, MI 48917

RE: License #: AH230236932
Investigation #: 2025A1010052
Brookdale Delta MC (MI)

Dear Licensee:

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 authorized representative 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) 241-1970.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH230236932
Investigation #:	2025A1010052
Complaint Receipt Date:	06/04/2025
Investigation Initiation Date:	06/05/2025
Report Due Date:	08/04/2025
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	105 Westwood Place Brentwood, TN 37027
Licensee Telephone #:	(615) 221-2250
Administrator:	Sarah LeBarre
Authorized Representative:	Mary North
Name of Facility:	Brookdale Delta MC (MI)
Facility Address:	7235 Delta Commerce Dr. Lansing, MI 48917
Facility Telephone #:	(517) 886-5200
Original Issuance Date:	07/01/1999
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	38
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 2/22/2025, Resident A fell and hit her head. The facility did not follow its protocol and did not send Resident A to the hospital for evaluation.	No
Staff did not notify Resident A's authorized representative when she fell on 2/22/2025.	Yes

III. METHODOLOGY

06/04/2025	Special Investigation Intake 2025A1010052
06/05/2025	Special Investigation Initiated - Letter Emailed complainant to gather additional information
06/05/2025	Contact - Document Received Email received from the complainant
06/12/2025	Inspection Completed On-site
06/12/2025	Contact - Document Received Received staff training documents
06/16/2025	Contact - Document Received Received resident service plan via email from the administrator
07/29/2025	Exit Conference

ALLEGATION:

On 2/22/25, Resident A fell and hit her head. The facility did not follow its protocol and did not send Resident A to the hospital for evaluation.

INVESTIGATION:

On 6/4/2025, the Bureau received the complaint. The allegations read, "Resident fall with head injury. She is on blood thinners and they failed to transport her to the ER in violation of their own fall protocol."

On 6/5/2025, I emailed the complainant to gather additional information. The complainant stated on 2/22/2025, it was reported to Resident A's family when they arrived at the facility at approximately 10:00 pm that Resident A "fell but was fine and in bed asleep." The complainant reported that the facility's administrator and head nurse were unaware of the incident and that Resident A was not sent to the hospital despite being on a blood thinner and hitting her head.

On 6/12/2025, I interviewed the administrator at the facility. The administrator reported Resident A did fall and hit her head during second shift on 2/22/2025. The administrator reported the fall was unwitnessed, however Staff Person (SP1) responded when Resident A fell out of bed. The administrator said Resident A had facial injuries and was on blood thinning medication. The administrator reported that because Resident A hit her head and was on a blood thinning medication, she should have been sent to the hospital for evaluation per the facility's policy and procedure. The administrator said this policy and procedure was not followed; Resident A was not sent to the hospital on 2/22/2025.

The administrator reported SP1 left Resident A's authorized representative a telephone voicemail after the incident on 2/22/2025. The administrator stated that in the telephone voice message, SP1 asked Resident A's authorized representative if "we should send her [Resident A] out" to the hospital for evaluation. The administrator said SP1 should not have posed this question to Resident A's authorized representative, it was not in compliance with the facility's incident policy and procedure.

The administrator said SP1 and all staff received re-education and re-training regarding the facility's resident incident policy and procedure. The administrator said the topics covered included when to send a resident to the hospital for evaluation after an incident and to ensure contact with the resident's listed authorized representative or other emergency contact(s) is made if the resident's authorized representative is not available. The administrator provided me with a copy of the staff meeting sign-in document for my review. The documents were dated 3/19/2025 and 3/20/2025. I observed the employee signatures and topics that were covered, including, "head injury policy – hospice IR – notifying families, procedure and wording."

On 6/12/2025, I interviewed SP1 at the facility. SP1's statements were consistent with the administrator. SP1 reported she contacted SP2 regarding the incident, however she "wasn't specific" with the details of the incident, including the fact that Resident A was on blood thinning medication. SP1 stated because SP2 was not aware of all of the details regarding the incident, he advised staff to keep Resident A at the facility and to monitor her frequently.

On 6/12/2025, I interviewed SP2 at the facility. SP2's statements were consistent with the administrator and SP1. SP2 stated that the following morning, Resident A was transported to the hospital because she was lethargic and not at her baseline.

On 6/12/2025, I was unable to interview Resident A as she no longer resides at the facility. The administrator stated Resident A was moved out of the facility in April 2025.

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.**
ANALYSIS:	The interview with the facility's administrator, SP1, and SP2, revealed the facility's resident incident protocol and procedure was not followed when Resident A fell and hit her head on 2/22/2025. Resident A is also on a blood thinning medication that would have required her to be sent out after she fell on 2/22/2025 per the facility's protocol. The administrator, SP1, and SP2 reported corrective action was taken after this incident when staff were re-educated and re-trained on 3/19/2025 and 3/20/2025. Because the facility took effective corrective action, the facility is in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff did not notify Resident A's authorized representative when she fell on 2/22/25.

INVESTIGATION:

On 6/4/2025, the complaint read staff knew Relative A1 was "out of the country" when Resident A fell on 2/22/2025. Staff were supposed to contact Resident A's second emergency contact person, however this contact was not made.

On 6/5/25, the complainant reported Relative A2 was "never notified of the head injury fall on 2/22. It was [Relative A1] who let him know they were trying to reach [Relative A1] but [Relative A1] didn't know why. [Relative A2] went to Brookdale at approximately 10pm and was told [Resident A] fell but was fine and in bed asleep."

On 6/12/25, The administrator stated Relative A1 was out of the country when the incident occurred on 2/22/2025. The administrator reported Relative A1 did leave

staff a note regarding this and to contact Relative A2 if any incidents occurred while she was gone. The administrator explained SP1 did not see this note and therefore called Relative A1 rather than Relative A2.

The administrator reported that because SP1 responded to the incident on 2/22/2025, she should have completed the incident report. The administrator was unable to confirm whether an incident report was completed regarding Resident A's fall and the injuries she sustained after the incident.

On 6/12/2025, SP1's statements were consistent with the administrator. SP1 was unable to recall if she wrote an incident report on 2/22/2025.

On 6/12/2025, SP2's statements were consistent with the administrator and SP1.

As of 7/2/2025, the administrator could not confirm there is an incident report in Resident A's resident record regarding her fall on 2/22/2025.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	The interviews with the administrator, SP1, and SP2 revealed an incident report regarding Resident A's fall and the injuries she sustained on 2/22/2025 is not documented in Resident A's resident record. The facility was unable to provide Resident A's incident report and therefore is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with the facility's licensee authorized representative on 7/29/25.

IV. RECOMMENDATION

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

07/03/2025

Lauren Wohlfert Date
Licensing Staff

Approved By:

07/29/2025

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