GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 28, 2026

Marcia Curtiss
Bridgeway Park Lansing
7235 Delta Commerce Dr.
Lansing, MI 48917

RE: License #: AH230236932
Investigation #: 2026A1010010
Bridgeway Park Lansing

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 (877) 458-2757.

Sincerely,
Lauren Wohlfert

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 #:	2026A1010010
Complaint Receipt Date:	11/24/2025
Investigation Initiation Date:	11/25/2025
Report Due Date:	01/24/2025
LicenseeName:	Bridgeway Park Senior Living LLC
Licensee Address:	Suite 115 21800 Haggerty Rd Northville, MI 48167
Licensee Telephone #:	(517) 886-5200
Administrator:	Zachary Fisher
Authorized Representative:	Marcia Curtiss
Name of Facility:	Bridgeway Park Lansing
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	38
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A fell the first week she moved into the facility and was on the floor for two hours.	Yes

III. METHODOLOGY

11/24/2025	Special Investigation Intake 2026A1010010
11/25/2025	Special Investigation Initiated - Letter Emailed assigned Ingham Co APS worker Penny Howard
11/25/2025	Contact - Document Received Email received from Ms. Howard
12/04/2025	Inspection Completed On-site
12/04/2025	Contact - Document Received Received resident service plan, incident report, and staff note
01/28/2026	Exit Conference

ALLEGATION:

Resident A fell the first week she moved into the facility and was on the floor for two hours.

INVESTIGATION:

On 11/24/2025, the Bureau received the complaint from Adult Protective Services (APS). The allegations read, "[Resident A] was moved into the Memory Care facility on 11/12/25. [Relative A1] had a camera installed in her room. [Relative A1] reported that [Resident A] had a fall the first week [Resident A] was there and lay on the floor for 2 hours."

On 11/25/2025, I emailed Ingham County APS worker Penny Howard for additional information. Ms. Howard reported the complaint was not assigned for APS investigation.

On 12/04/2025, I interviewed Staff Person 1 (SP1) at the facility. SP1 stated Resident A fell during third shift on 11/14/2025. SP1 reported staff are trained to "check on residents" every two hours. SP1 denied knowledge regarding staff not checking on Resident A every two hours when the incident occurred. SP1 explained third shift staff found Resident A on the floor in her room. SP1 said Resident A was

not injured during the incident. SP1 said Resident A's fall was not witnessed, therefore it was unknown how long Resident A was on the floor in her room.

SP1 provided me with a copy of Resident A's incident report dated 11/14/2025 for my review. The *Described what happened* section of the report read, "Resident was found directly in front of her rocking chair laying on the floor. There is no sign of physical injury. Vitals was [sic] checked." The *What does resident say happened* section of the report read, "Resident mention [sic] she was trying to get up." The report read the incident occurred at 3:20 am and Resident A did not require any first aid.

SP1 reported Resident A was unable to make her needs known. SP1 stated after Resident A fell, Relative A1 requested that Resident A be checked on every half hour. SP1 said staff accommodated this request and began checking on Resident A every half hour.

SP1 provided me with Resident A's staff *Charting Notes* for my review. A note dated 11/14/2025 at 4:26 AM read, "Resident had a fall. Family contacted." SP1 provided me with a copy of Resident A's service plan for my review. The *Fall Risk* section of Resident A's plan read, "Limited supervision. Unsteady Gait." The *Ambulation/TRANSFER* section of the plan read, "Independent. Appliances Walker."

On 12/04/2025, I was unable to interview or observe Resident A. SP1 reported Resident A was moved out of the facility on 11/24/2025. SP1 said Resident A only resided in the facility for a couple of weeks before Resident A's responsible persons moved her out.

APPLICABLE RULE	
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 interview with SP1 revealed that after Resident A fell on 11/14/2025, staff began to check on Resident A every half hour per Relative A1's request. Review of Resident A's service plan revealed it was not updated to reflect this change in Resident A's supervision. Review of Resident A's service plan revealed there was a lack of detail regarding Resident A's care needs. As a result, the facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with the facility's licensee authorized representative on 01/28/2026.

IV. RECOMMENDATION

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

01/06/2026

Lauren Wohlfert Date
Licensing Staff

Approved By:

01/28/2026

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