



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

December 4, 2025

Sarah LeBarre  
Brookdale Senior Living Communities, Inc.  
105 Westwood Place  
Brentwood, TN 37027

RE: License #: AL130077500  
Investigation #: 2026A1032003  
Brookdale Battle Creek AL (MI)

Dear Sarah LeBarre:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (616) 356-0100.

Sincerely,

A handwritten signature in cursive script, appearing to read "Dwight Forde".

Dwight Forde, Licensing Consultant  
Bureau of Community and Health Systems  
350 Ottawa, N.W. Unit 13, 7th Floor  
Grand Rapids, MI 49503

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AL130077500
<b>Investigation #:</b>	2026A1032003
<b>Complaint Receipt Date:</b>	10/03/2025
<b>Investigation Initiation Date:</b>	11/10/2025
<b>Report Due Date:</b>	12/02/2025
<b>Licensee Name:</b>	Brookdale Senior Living Communities, Inc.
<b>Licensee Address:</b>	105 Westwood Place Brentwood, TN 37027
<b>Licensee Telephone #:</b>	(615) 221-2250
<b>Administrator:</b>	Sarah LeBarre
<b>Licensee Designee:</b>	Sarah LeBarre
<b>Name of Facility:</b>	Brookdale Battle Creek AL (MI)
<b>Facility Address:</b>	191 Lois Drive, Battle Creek, MI 49015
<b>Facility Telephone #:</b>	(269) 979-7781
<b>Original Issuance Date:</b>	11/03/1997
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	07/28/2024
<b>Expiration Date:</b>	07/27/2026
<b>Capacity:</b>	20
<b>Program Type:</b>	PHYSICALLY HANDICAPPED AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
The facility does not practice proper kitchen sanitation.	No
Resident health care concerns are ignored.	No
Additional Findings	No

**III. METHODOLOGY**

10/03/2025	Special Investigation Intake 2026A1032003
11/10/2025	Special Investigation Initiated - On Site
11/13/2025	Contact - Telephone call made Interview with administrator Jenna Brunner
12/04/2025	Exit Conference

**ALLEGATION:**

**The facility does not practice proper kitchen sanitation.**

**INVESTIGATION:**

On 11/10/25, I interviewed licensee designee Larry Ragnone in the facility. Mr. Ragnone stated that the dishwashers were being replaced because a new company had taken over the contract to repair them. He pointed out as we spoke, that a technician was on site to remove the old dishwasher and replace it with the new one. While on site I observed a technician taking steps to disconnect the dishwasher. Mr. Ragnone stated that the memory care facility in the adjacent building already had the dishwasher installed.

<b>APPLICABLE RULE</b>	
<b>R 400.665</b>	<b>Food service.</b>
	<b>(8) Kitchen appliances must be properly installed and maintained according to the manufacturer's instructions.</b>
<b>ANALYSIS:</b>	During my onsite inspection, I observed a technician preparing to install a new dishwasher. The sister facility already had one installed. The licensee designee's explanation was credible. Therefore there is insufficient evidence to establish a violation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**Resident health care concerns are ignored.**

**INVESTIGATION:**

Mr. Ragnone denied being aware of any gaps in care with regard to medications. He advised that if there were any medication incident reports, they would be generated by the medical technicians then sent to the administrator Jenna Brunner for review and corrective action.

I interviewed medical technician Katie Brown in the facility. Ms. Brown denied being aware of any MIRs. She stated that if there were any medication errors, they would be recorded on an incident report form and sent to the nursing director and administrator Jenna Brunna.

I interviewed Resident A in the facility. Resident A stated that generally speaking, she receives good care at the facility.

During my onsite inspection I observed residents participating in craft activities and I interacted with family visiting a resident; the family provided a positive report.

On 11/12/25, I interviewed administrator Jenna Brunner by telephone. Ms. Brunner denied receiving any MIRs from the medication technicians at the facility. She advised that there have been issues where family members will change pharmacies for residents, making it problematic refilling prescriptions. However, she reported that there have been no issues with refills at this time.

<b>APPLICABLE RULE</b>	
<b>R 400.689</b>	<b>Resident health care.</b>
	<b>(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.</b>
<b>ANALYSIS:</b>	Inadequate information was provided regarding resident care concerns. During my onsite inspection I interacted with family members, residents and interviewed employees regarding problems with medication administration. The positive feedback provided hindered my ability to establish a violation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

On 12/4/25, I conducted an exit conference with administrator Jenna Brunner, where I shared my findings.

#### **IV. RECOMMENDATION**

I recommend no change to the status of this license



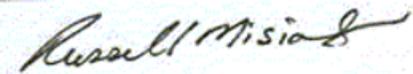
12/4/25

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Dwight Forde  
Licensing Consultant

Date

Approved By:



02/5/26

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Russell B. Misiak  
Area Manager

Date