GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 7, 2026

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

RE: License #: AH820238949
Investigation #: 2026A0628025
Brownstown Forest View Assisted Living

Dear Licensee:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against the license is recommended.

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,

Rebekah Looney, Licensing Staff
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 #:	AH820238949
Investigation #:	2026A0628025
Complaint Receipt Date:	02/02/2026
Investigation Initiation Date:	02/03/2026
Report Due Date:	04/01/2026
Licensee Name:	Brownstown Assisted Living Center LLC
Licensee Address:	19335 Allen Road Brownstown, MI 48183
Licensee Telephone #:	(734) 658-4308
Administrator:	Donna Surerus
Authorized Representative:	Surinder 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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	76
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The home failed to keep Resident A safe.	Yes
Additional Findings	No

III. METHODOLOGY

02/02/2026	Special Investigation Intake 2026A0628025
02/03/2026	Special Investigation Initiated - On Site

ALLEGATION: The home failed to keep Resident A safe.

INVESTIGATION:

On 02/02/2026, the department received a complaint that alleged Resident A left the home and was found deceased outside the home during the overnight hours of 01/31/2026 to 02/01/2026.

On 02/03/2026, while onsite, I interviewed the administrator. The administrator reported that Resident A had left the home during the timeframe noted and was deceased. The administrator reported that the last time someone reported seeing Resident A in the home was around 10:30pm on 01/31/2026 and Resident A was in her room. Additionally, the administrator reported that there was a camera in the room of Resident A (provided by the family) with a cordless monitor for staff to monitor Resident A. The administrator reported that the monitor sits at the nursing station, but when staff are passing medications, they will, at times, take it with them on the medication cart. Additionally, Resident A is to be checked on every two hours. The administrator reported that she was made aware of the incident at 8:57am on 02/01/2026, when she received a text message from Employee #3. Text messages provided by the administrator show Employee #3 sent a text message at 8:03am on 02/01/2026 notifying her that a staff member had called off and other information regarding the timing of the medication pass and narcotic medication discrepancies. Employee #3 noted that, “Everything else is fine.” The text message received at 8:47am, from Employee #3 stated that Resident A was deceased and she needed immediate help as she had no access to POC, indicating she could not get records information regarding Resident A.
The administrator reported that there were three employees working on the evening of 01/31/2026 and that three employees were scheduled to work 02/01/2026 from 6:30a-2:30p. The administrator reported that the leaving shift should be rounding

with the oncoming shift and they have been informed they will be paid for the additional ½ hour that this might take beyond their scheduled shift.

While onsite, I interviewed Employee #1 who reported that Resident A often walks to the front door of the home and talks about going home. Employee #1 reported that Resident A is easily redirected. She reported that she hadn't witnessed Resident A actually trying to open the door or leave the home. She reported that the alarm that goes off when the front door is opened without using a code is very loud and can be heard throughout the building, with the exception of perhaps the kitchen. Employee #1 also reported that the shift that is leaving should be giving report to the oncoming shift. She reported that they should do rounds together. Employee #1 reported that Resident A ate her meals in the dining room and that breakfast is from 8:00am-9:00am.

While onsite, I interviewed Employee #2 who reported that she clocked in at 6:30am. She reported that she clocked in via written log since she does not have a code to punch in via the timeclock. Employee #2 reported that Employee #4 and Employee #5 were pretty much out the door when she arrived. She reported that Employee #6 was reviewing medication technician stuff with Employee #3 and was onsite until about 7:30am. Employee #2 reported that she started working upstairs, getting residents up and downstairs for breakfast. After that, she started getting up residents on the first floor for breakfast. Sometime during that time, Employee #3 alerted her to what was going on and asked her to cover the back half of the first floor. Employee #3 said she would cover the front half of the first floor and talk to the police. Employee #2 reported that there were no assigned "sets" and everyone just worked together to cover all the needs of the residents in the building. Additionally, she reported that she did not have access to POC to chart care of residents.

While onsite, I interviewed Employee #3 who reported she was running a little late on the morning of 02/01/2026. She reported she passed medications upstairs first. She stated she did room checks while she was passing medications. She reported she got to the room of Resident A around 7:30am and noticed she was not in her room. Employee #3 reported that she then looked throughout the building for Resident A.
Employee #3 reported that Employee #6 did not complete the medication count with her and was eating in the dining room. She reported that no information was relayed to her about any significant issues on the midnight shift. Additionally, Employee #3 reported that the front door was ajar when she arrived to work and she did not need to use her key fob to access the door and unlock it to enter the building.

On 02/05/2026, I interviewed Employee #4 via telephone. Employee #4 reported that there were no assigned sets on the night in question. The employees took turns answering every other call light. Employee #4 reported that Employee #6 had a friend with her at work for about three hours. He thought she was present from

about 11:00pm until 2:00am but wasn't positive about the time frame. This friend was not an employee at the home. Employee #4 reported that the friend followed Employee #6 around the entire time she was on the premises. He reported that Resident A fell around 11:15 and he asked Employee #6 if she needed help with Resident A after she fell. He reported that Employee #6 stated she didn't need assistance and that she was going to call Resident A's daughter about the fall and then assist Resident A back to bed. Employee #4 reported that, at times, Resident A will be up all night and other times she will sleep through the night. He reported not being around the nurses station all night. Additionally, he reported seeing the monitor for Resident A at the nurse's station, but was unsure if it was plugged in. When questioned about Resident A being checked on every two hours, he reported he didn't think she was a resident that required a check every two hours.
Employee #4 reported that Employee #6 doesn't have a key fob to access the door, so she asked to use his. He reported he let her use it so he wouldn't have to keep letting her in when she and her friend went outside. He reported that Employee #6 told him at some point that she "was blowed" because they were not smoking cigarettes. At some point during the night Employee #6 returned the key fob to Employee #4, but he was not sure of what time that occurred. Employee #4 denied hearing the door alarm go off at any point during his shift. Additionally, he reported that the alarm has gone off in the past and everyone checked the whole building for all the residents.
Employee #4 reported that he clocked out between 6:30am-7:00am on 02/01/2026. He reported that morning shift is in charge of getting Resident A up for breakfast. He reported that when he left there had been no mention of Resident A missing from the home.

On 02/05/2026, I interviewed Employee #5 via telephone. Employee #5 reported that there were no assigned sets on the night in question and employees took turns responding to every other call light. Employee #5 reported that Employee #6 had a friend with her at work on the evening of 01/31/2026. That friend was not employed by the home. Employee #5 reported that the friend of Employee #6 was with her from the start of the shift and believed she left sometime after 1:00am. Employee #5 reports that they went outside several times to smoke and they used Employee #4 's key fob because Employee #6 doesn't have a key fob.
Employee #5 reported that she was informed by Employee #4 that Resident A did have a fall that night, but she was unsure what time. She reported that Employee #4 offered to help Employee #6 with Resident A, but Employee #6 stated she didn't need help and she was putting Resident A to bed. Employee #5 reported that sometimes Resident A is up wandering all night and sometimes she sleeps all night. She assumed Resident A was sleeping. Employee #5 originally reported seeing the monitor for Resident A at the nurse's station. She reported that monitor wasn't plugged in and she wasn't even sure if there was a cord to plug in the monitor. She then reported that she wasn't sure if the monitor was at the nurse's station at all. Employee #5 reported that she does not have access to POC for charting, so she wrote down all of the resident's she completed "check and change" care for on a piece of paper.

Employee #5 reported that she did not hear the door alarm go off at all throughout the course of her shift. She reported that she clocked out 7:34am on 02/01/2026 and there had been no mention of Resident A missing.

On 02/05/2026, I attempted to interview Employee #6 via telephone. Employee #6 did not answer, and her voicemail box was full so I was unable to leave a message. On 02/10/2026, I spoke with a detective from the Brownstown Police Department who asked that I not attempt to contact Employee #6 again until after they have had a chance to speak with her.

Review of Resident A's service plan does state that she is to be checked on every two hours. Review of the home's policies and procedures reveal that upon determination that a resident cannot be accounted for, the entire premises, inside and outside, are to be searched.

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 home did not provide protection and safety to Resident A and the home did not follow the service plan of Resident A resulting in Resident A leaving the building and expiring outside in the elements on the night of 01/31/2026. Therefore, this allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1)(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for residents.

ANALYSIS:	Through review of documents and interviews with staff it is evident that the home does not have an organized program to provide protection, supervision and supervised personal care for the residents. Not all staff have access to clock in via a time clock. Not all staff have access to complete electronic charting for resident care. Staff are sharing key fobs for door access. The home's outside camera feeds are accessed on the telephone of an employee who no longer works at the home. Nobody followed the service plan for Resident A and nobody looked for Resident A when they didn't find her in her room on the morning of 02/01/2026. The lack of an organized program played a role in Resident A leaving the home on the night of 01/31/2026 and expiring outside in the elements. Therefore, this allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Disciplinary action is recommended.

Rebekah Looney
Licensing Staff

Date

Approved By:

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

07/07/2026

Date