GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 7, 2026

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

RE: License #: AH820238949
Investigation #: 2026A1035042
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,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820238949
Investigation #:	2026A1035042
Complaint Receipt Date:	05/27/2026
Investigation Initiation Date:	06/03/2026
Report Due Date:	07/26/2026
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	76
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A care needs are not being met.	Yes
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

05/27/2026	Special Investigation Intake 2026A1035042
05/27/2026	APS Referral
06/03/2026	Special Investigation Initiated - Letter
06/16/2026	Contact - Face to Face
06/17/2026	Contact - Telephone call made Phone interview with Family A

ALLEGATION:

Resident A care needs are not being met.

INVESTIGATION:

On May 27, 2026, the Department received a complaint forwarded from Adult Protective Services (APS) which alleged Resident A was not receiving care in accordance with his service plan.

APS did not open an investigation pertaining to the allegations.

On June 17, 2026, an onsite investigation was conducted. While onsite, I interviewed Staff Person (SP)1 who states Resident A does not have a diagnosis of dementia. The facility physician manages Resident A's care needs. Resident A was sent to the hospital on May 10, 2026, and is expected to return to the facility in approximately 5 days. Resident A is currently at a physical rehabilitation center.

On June 16, 2026, a phone interview was conducted with Family A. Family A states they feel the facility did not provide the care that was promised prior to being admitted on April 18, 2024. Family A voiced concerns Resident A was not allowed to walk and the facility “did not take good care of him.” Family A continues to allege the assigned physician overmedicated Resident A resulting in decreased mobility. Family A stated Resident A had an “anxiety attach” at approximately 4:00 a.m. Resident A contacted Family A stating the facility would not send him to the hospital until the morning “nurse” arrived and assessed him. Resident A was sent to the hospital later that morning. Resident A is currently at a subacute rehabilitation center and has gained enough strength to start walking with a walker. Family A states Resident A will return to Brownstown Forest View related to not having another choice of placement and Resident A’s request to remain at the facility with Resident B.

Through record review of the month of May 2026, Resident A “Documentation Survey Report” indicates Resident A should receive two showers a week with 1 person assistance. No showers had been documented as being given for the month of May. Minimal to no charting completed during the month of May related to activities of daily living inclusive of, but not limited to “bladder documentation, bowel documentation, call light in reach, and fresh water to be given.” Resident A’s service plan states he requires 1 person assistance with dressing, showering, and safety checks every two hours.” Resident A’s service plan does not indicate extra services related to wound care, PT or OT.

Through record review of Resident A’s medication administration record for May 2026, Resident A did not receive scheduled doses of:

- Furosemide 20mg - 5/1 and 5/8
- Levothyroxine 50mcg - 5/1 and 5/8

Multiple medications were charted as administered after Resident A being sent to hospital on May 21, 2026, and not being in the facility on the date:

- Clopidogrel Bisulfate 75mg - 5/22, and 5/24
- Duloxetine HCL 30mg - 5/22 and 5/24
- Finasteride 5mg - 5/22
- Losartan 25mg - 5/22 and 5/24 with documented blood pressures
- Ropinirole HCL 0.25mg - 5/22
- Vitamin B - 5/22
- Buprenorphine HCL-Naloxone HCL - 5/22 and 5/24 with pain level charted as 6
- Gabapentin 400mg - 5/22
- Hydroxyzine HCL 50mg - 5/22 and 5/24
- Oyster Calcium/ D3 - 5/22 and 5/24

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:	Resident A did not receive care in accordance with his service plan, activities of daily living plan, and medication administration record. Multiple accounts of medication being administered during Resident A's leave of absence (LOA). Two accounts of medication being administered with documented blood pressures and pain level charted during Resident A's LOA. The facility does not have monitoring in place to ensure policies, procedures, and practices are followed by staff providing care and medication administration.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Disciplinary action is recommended.

06/25/2026

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Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

07/07/2026

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