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 #: 2026A1035043
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 #:	2026A1035043
Complaint Receipt Date:	06/02/2026
Investigation Initiation Date:	06/03/2026
Report Due Date:	08/02/2026
Licensee Name:	Brownstown Assisted Living Center LLC
Licensee Address:	19335 Allen Road Brownstown, MI 48183
Licensee Telephone #:	(734) 658-4308
Administrator/ 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 facility has a disorganized program. Resident A did not receive care in accordance with their service plan.	Yes
Residents are not receiving care in accordance with their service plans. Facility is understaffed and not able to meet the needs of the Residents within the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/02/2026	Special Investigation Intake 2026A1035043
06/02/2026	APS Referral
06/03/2026	Special Investigation Initiated - Letter
06/17/2026	Contact - Face to Face

ALLEGATION:

The facility has a disorganized program. Resident A did not receive care in accordance with their service plan.

INVESTIGATION:

On June 2, 2026, the Department received a complaint forwarded from Adult Protective Services (APS) which made allegations Residents are not receiving care in accordance with their service plan. The facility has no oversight ensuring residents are receiving quality of care. Management staff are overheard “cussing out a resident.”

On June 16, 2026, an onsite investigation was conducted. While onsite, I interviewed Staff Person (SP)1 who states Resident A was sent to the hospital related to shortness of breath. Resident A had expired at the hospital. SP1 states all residents receive care in accordance with their service plans. SP1 states SP2 develops and manages resident service plans. SP1 states she has never witnessed staff members being verbally aggressive with residents.

While onsite I interviewed SP2 who states she has newly taken the position that oversees service plans, documentation, and staff compliance with policy and procedures. SP2 states it has been difficult to gain compliance.

Through record review, Resident A was sent to the hospital on May 30, 2026, at approximately 07:33 a.m. for respiratory distress. Record review of Resident A's electronic medical record revealed:

- Resident A's service plans states showers are scheduled twice a week on Tuesdays and Fridays. Showers had not been documented within the electronic medical record for the month of May. Three shower sheets provided for the month of May show on 5/6/26 shower completed on midnight shift, 5/14/26 bed bath given on midnight shift, and 5/22/26 bed bath given on midnight shift.

- "Documentation Survey Report" requires documentation on: "call lights in reach every shift" had been documented seven times for the month of May. "Hourly check and change" had been documented 26 times for the month of May. "Hourly safety checks" documented 24 times for the May.

- Resident A's care plan was initiated April 2022 and last updated April 2024.

- Resident A medication had not been administered on afternoon shift in May of 2026 on the following dates 1, 3, 10, 11, 16, 17, 19, and 29.

On June 17, 2026, a phone interview was conducted with Family A. Family A states, Resident A was sent to the hospital related to shortness of breath and was diagnosed with pneumonia. Resident A had gone into cardiac arrest while at the hospital. The hospital staff revived Resident A stating they had been unaware of Resident A's "Do Not Resuscitate (DNR) status. Family A states there had been several times Resident A was observed soiled and unkept. Resident A was observed unkept when Family A arrived at the hospital and nails observed long and dirty.

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 had not received care in accordance with their service plan. Facility is not maintaining an organized program monitoring staff documentation and quality of care.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are not receiving care in accordance with their service plans. Facility is understaffed and not able to meet the needs of the Residents within the home.

INVESTIGATION:

On June 2, 2026, the Department received a complaint forwarded from Adult Protective Services (APS) which made allegations that residents are not receiving care in accordance with their service plan. The facility is understaff therefore not meeting the needs of the residents.

While onsite, I interviewed SP1 who states care is provided in accordance with each resident's service plan. The facility staffs one med tech and three caregivers per day and afternoon shift, one med tech and two caregivers per midnight shift for an average census of 28 residents. SP1 states the facility will mandate to meet "state" minimum staffing requirements. SP1 states assignments had been stopped each staff member is assigned to a floor and is responsible to assist on the opposite floor.

While onsite, I interviewed SP2 who states the facility attempts to overstaff but staff members continue to call off and employees are not held accountable. SP2 states there are several staff members who continuously come in late or call off. SP2 states there are 4 residents that require two-person assistance. SP2 states, staff are trained to follow each resident's service plan and document care within the electronic medical record. SP2 states there has been increased confusion and accountability since the assigned sets have been eliminated. "No one takes accountability and are confused on who they should be taking care of and charting on."

While onsite, I interviewed SP3 who states midnight med techs will stay over until day shift med tech arrives when running late. SP3 states Residents are not receiving care in accordance with their service plan. SP3 states the management team does not hold staff members accountable and continues to bring back staff that have been fired.

While onsite, I interview SP4 who states the facility is always understaffed. SP4 states there are only 3 persons on duty each day on the days shift. SP4 states they

count the clinical coordinator as a staff member working but little help is offered. SP4 states new management took away assignments and has everyone assigned to a floor. SP4 states this is confusing and no is held accountable for assigned people.

Through record review:

- Resident B Documentation Survey Record is minimal to nonexistent. Showers scheduled twice a week. No showers documented for the month of May. Multiple missed doses of Atorvastatin, Clopidogrel, Duloxetine. Finasteride, Furosemide, Levothyroxine, Melatonin, Gabapentin, and Oyster Calcium throughout the month of May of 2026.

- Resident C Documentation Survey Record is minimal to nonexistent. Showers scheduled twice a week. One shower was documented within the electronic medical record for the month of May 2026. Shower sheets provided that showers were completed on the following dates: 5/1/26, 5/20/26, and 5/27/26. Multiple missed doses of Carbidopa-Levodopa throughout the month of May of 2026.

- Resident D Record is minimal to nonexistent. Showers scheduled twice a week. No showers documented within the electronic medical record for the month of May. One shower was provided for the month of May. “Every 2-hour check and change” rounds and “Every 2-hour safety rounds” were documented minimally for the month of May 2026. Multiple missed doses of Buspirone, Pregabalin, Sacubitril-Valsartan, Tramadol, Acetaminophen, Hydrocodone, and Morphine throughout the month of May of 2026.

Through record review of staffing from May 24, 2026, through June 6, 2026. The facility frequently had one med tech and two caregivers on day and afternoon shift. Multiple midnight shift had call ins leaving one med tech and one caregiver for 28 residents span across two floors with four residents requiring two-person assistance.

Through record review, it was noted that staff members do not have assigned sets or tasks, they are assigned to a primary floor with the opposite floor as a secondary floor. Assignment sheet does not identify the shift supervisor.

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. **(3) The home shall designate 1 person on each shift to be supervisor of resident care during that shift. The**

	supervisor of resident care shall be fully dressed, awake, and on the premises when on duty. **(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.**
ANALYSIS:	Through record review, there is minimal to nonexistent charting related to daily care needs inclusive of but not limited to showers given, safety checks, and every two-hour rounding for checking and changing of residents. Residents are not receiving medications as ordered. Facility does not maintain staffing to meet the needs of the Residents. Facility does not assign set nor shift supervisors. Based on interview and record review allegations have been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

Residents are not receiving medications as ordered.

INVESTIGATION:

Through record review:

- Resident A's medication had not been administered on afternoons in May of 2026 on the following dates 3, 10, 11, 16, 17, 19, and 29.

- Resident B had multiple missed doses of Atorvastatin, Clopidogrel, Duloxetine. Finasteride, Furosemide, Levothyroxine, Melatonin, Gabapentin, and Oyster Calcium throughout the month of May 2026.

- Resident C had multiple missed doses of Carbidopa-Levodopa throughout the month of May 2026.

- Resident D had multiple missed doses of Buspirone, Pregabalin, Sacubitril-Valsartan, Tramadol, Acetaminophen, Hydrocodone, and Morphine within the month of May 2026.

Through direct observation, 142 Tramadol 50mg pills were observed in the medication room on the second floor and the pills were not double locked. Medication room has a keypad that can be accessed by any staff member who has the key code.

Through record review of the narcotic book found that there were multiple missed signatures observed related to narcotic counts completed at shift change.

Insulin observed in a red box within an unoccupied room 226 refrigerator. SP2 stated they were instructed to store the box in that refrigerator since the medication room refrigerator does not work.

APPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.
ANALYSIS:	Observations identified that Resident A, B, C, D are not receiving medications as ordered. There were 142 Tramadol pills not securely stored, and insulin observed stored in an unoccupied room. Narcotic books are not being maintained, with multiple missed signatures observed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

Ceiling observed cracked with peeling paint on first floor. Multiple unoccupied rooms observed unsecured and utilized as storage.

INVESTIGATION:

Through direct observation, cracks in ceiling on first floor.

Vacant rooms 100,106, 114, 125, 202, 204, 205, 207, 209, 214, 215, 217, 220, 222, 223, 224, 226, and 227 observed unlocked and being utilized as storage areas.

APPLICABLE RULE	
R 325.1964	**Interiors.**
	(12) A floor, wall, or ceiling must be covered and finished in a manner that allows maintenance of a sanitary environment.
ANALYSIS:	Ceiling is not maintained in a sanitary manor. Multiple rooms observed being used for storage and unsecure.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

Water temperature exceeds regulated temperature of 120 degrees Fahrenheit.

INVESTIGATION:

Water temperature temped in first floor staff bathroom temping 137.1 degrees, room 125 temped 125 degrees, room 206 temped 135 degrees.

APPLICABLE RULE	
R 325.1970	**Water supply systems.**
	(7) The temperature of hot water at plumbing fixtures used by residents shall be regulated to provide tempered water at a range of 105 to 120 degrees Fahrenheit.
ANALYSIS:	Water temperature exceeds 120 degrees in staff bathroom and observed resident rooms.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Disciplinary action against the license is recommended.

06/22/2026

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