GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 30, 2023

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

RE: License #: AH820238949
Investigation #: 2023A1019075
Brownstown Forest View Assisted Living

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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) 284-9730.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820238949
Investigation #:	2023A1019075
Complaint Receipt Date:	09/13/2023
Investigation Initiation Date:	09/14/2023
Report Due Date:	11/13/2023
Licensee Name:	Brownstown Assisted Living Center LLC
Licensee Address:	19335 Allen Road Brownstown, MI 48183
Licensee Telephone #:	(734) 658-4308
Administrator and 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:	12/17/2022
Expiration Date:	12/16/2023
Capacity:	76
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's personal care needs are not being met.	Yes
Resident A's room is dirty.	No
Additional Findings	Yes

III. METHODOLOGY

09/13/2023	Special Investigation Intake 2023A1019075
09/14/2023	Special Investigation Initiated - Letter Emailed APS worker for additional information and status update.
10/04/2023	Inspection Completed On-site
10/04/2023	Contact - Document Sent Emailed administrator for additional information and documentation that staff were unable to provide during onsite visit.
10/06/2023	Contact- Document Received Requested documentation has been submitted.
10/06/2023	Inspection Completed BCAL Sub. Compliance

ALLEGATION:

Resident A's personal care needs are not being met.

INVESTIGATION:

On 9/13/23, the department received a complaint alleging that Resident A is not being bathed. The complaint read that it is unknown how long it has been since he was bathed and also alleged that he is not being shaved. The complaint was forwarded to the department from Adult Protective Services (APS). APS did not share the initial referral source's contact information so additional information could not be obtained.

On 10/4/23, I conducted an onsite inspection. I interviewed Employees 1, 2 and 3 at the facility. All employees attested that Resident A is difficult to provide care to, can be physically and verbally combative and often refuses to be bathed or toileted. Employee 1 stated that Resident A is scheduled to receive two showers a week (Wednesday and Friday are his scheduled days). Employee 1 stated that staff are to complete shower sheet documentation which shows if a shower was given or if the resident refused.

While onsite, I obtained shower sheet documentation for the previous four weeks. Resident A showered on the following dates during the timeframe reviewed: 9/27/23 (was not shaved) and 9/13/20 (was shaved). Staff documented that Resident A refused bathing activities on the following dates: 9/20/23 and 9/6/23. Resident A was scheduled to receive a shower on 10/4/23, however he was in the hospital on that date.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	The facility did not ensure that Resident A was bathed weekly, according to administrative rule requirement, or twice weekly, as the identified frequency by staff and shower schedule, as evidenced by shower sheet documentation completed by staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's room is dirty.

INVESTIGATION:

The complaint alleged that Resident A's room is not being cleaned and that it smells strongly or urine. Employees 2 and 3 reported that Resident A allows housekeeping to clean his room and does not refuse that service. Per the facility's housekeeping schedule and Resident A's service plan, he is to receive "light housekeeping" daily consisting of emptying the trash, making the bed, overall tidying up of the room and wiping down surfaces and receives one weekly "deep" clean.

While onsite, I observed Resident A's room and bathroom. The room was neat and orderly, items all appeared in place, there was no urine smell present and the bathroom including toilet, sink and shower were all clean.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Direct observation confirmed that Resident A's room was clean and free of odor.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Employees 1, 2 and 3 reported that Resident A is physically and verbally abusive to other residents and staff. Employees 1, 2 and 3 reported that he regularly refuses care, medications and is combative when staff attempt to complete personal care tasks. A review of Resident A's progress notes corroborates staff's attestations. Examples of these behaviors include but are not limited to the following:

- *8/31/23: Resident was removed from dining room during lunch after being warned 3x about calling both staff and residents "fat bitch" and threatening to hit them, also telling residents and staff "fuck you".*

- *7/24/23: Resident was trying to force 11 to get out of bed and remove her pajamas, 11 verbally declined many times, Resident was asked to leave 11s apartment to which he declined and started screaming and cursing at staff, resident 229 [Resident A] hit supervisor in stomach…*

- *7/18/23: Resident is agitated, states he is going to break a window.*

- *6/25/23: Resident attempted to sexually touch aide butt while giving care, resident started screaming at lunch aide… he started screaming at me hope you get fucked in the ass you are lying ass bitch.*

- *5/31/23: Resident refused blood sugar check and insulin says "Fuck the doctor"*

- *4/30/23: Resident was being sexually aggressive towards resident aide, attempted to physical [sic] touch aide improperly.*

- *4/15/23: Resident was verbally abusive to staff, stated he would shoot Employee 4, called Employee 4 a cock sucker, states that Employee 4 is not permitted to look in his direction.*

- *4/1/23: Resident ran into resident in apt 115 with his wheelchair on accident, 115 then looked at him without saying anything. He [Resident A] proceeded to tell her he would slap her in the face, staff asked him to stop cursing, again he called another resident (226) an ugly ass mother fucker and a bitch.*

- *3/19/23: Resident sexually grabbed a staff member on her buttocks, rubbing his hands on her thighs, resident state to aide he gets stiff every time he looks at her.*

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(8) A home shall not retain a resident if the resident has harmed himself or herself or others, or has demonstrated behaviors that pose a risk of serious harm to himself or herself or others, unless the home has the capacity to manage the resident's behavior.
ANALYSIS:	The licensee has placed residents and staff at risk of harm due to Resident A's repeated verbal and physical attacks and sexually inappropriate behavior.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident A's service plan was reviewed. The plan lacked pertinent detail regarding many personal care related tasks. For example, under bathing/showering, the plan reads "*Requires (SPECIFY what assistance) by ('1' number) of care team members with (SPECIFY bathing/showering) (SPECIFY FREQ) and as necessary."* The plan does not indicate what type of assistance the resident needs, the number of staff needed to provide assistance or the frequency of the task to be completed. Staff interviewed attested that Resident A has two assigned shower days per week, but the service plan is absent of that detail. Additional examples of this include but are not limited to the following:

• *LAUNDRY: (SPECIFY: Bed linens, clothing, or BOTH) is performed by (SPECIFY) and is usually picked up on (SPECIFY DAYS). Have laundry ready by (DAY, TIME) and placed (SPECIFY LOCATION) ready to be picked up.*

• *EATING: Is able to: (SPECIFY).*

• *BED MOBILITY: Uses (SPECIFY assistive device) to maximize independence with turning and repositioning in bed.*

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.
For Reference R 325.1901	**(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.**
ANALYSIS:	Resident A's service plan is missing important detail related to his personal care needs and the amount of assistance he requires.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon approval of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

10/09/2023

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

10/30/2023

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