GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 21, 2025

Marianne Love
Brookdale Senior Living Communities, Inc.
105 Westwood Place
Brentwood, TN 37027

RE: License #: AL130077500
Investigation #: 2025A1032031
Brookdale Battle Creek AL (MI)

Dear Marianne Love:

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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL130077500
Investigation #:	2025A1032031
Complaint Receipt Date:	05/05/2025
Investigation Initiation Date:	05/07/2025
Report Due Date:	07/04/2025
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	105 Westwood Place Brentwood, TN 37027
Licensee Telephone #:	(615) 221-2250
Administrator:	Marianne Love
Licensee Designee:	Marianne Love
Name of Facility:	Brookdale Battle Creek AL (MI)
Facility Address:	191 Lois Drive, Battle Creek, MI 49015
Facility Telephone #:	(269) 979-7781
Original Issuance Date:	11/03/1997
License Status:	REGULAR
Effective Date:	07/28/2024
Expiration Date:	07/27/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Recommendations were not followed for Resident A's falls and wound care.	No
Additional Findings	No

III. METHODOLOGY

05/05/2025	Special Investigation Intake 2025A1032031
05/07/2025	Special Investigation Initiated - On Site
05/08/2025	Contact - Document Received
05/08/2025	Exit Conference

ALLEGATION:

Recommendations were not followed for Resident A's falls and wound care.

INVESTIGATION:

I received this complaint as an Adult Protective Services screen-out.

On 5/7/25, in Interviewed nurse director Jenna Brunner at the facility. Ms. Brunner stated that Resident was transferred from another facility on May 2nd 2025 and was sent to the hospital on May 3rd. She advised that Resident A had since passed away as he had been diagnosed with stage four kidney disease. He was also receiving hospice care. She stated that when he arrived, the facility had to get a physician's order for Ativan because Resident A was extremely dysregulated, making it difficult for the Elara Caring nurse to apply his bandages.

Ms. Brunner stated that Resident A had removed his clothing and bandages during the night and was found on the floor. When checks were made, Ms. Brunner was

notified and instructed the staff to call an ambulance to have Resident A transferred to a hospital

Ms. Brunner reported that Resident A did not have a history of falls at the facility, as he had been there one day; she mentioned that a concave mattress was ordered to prevent Resident A from rolling out of bed, but it had not arrived.

On 5/9/25, I reviewed an incident report from the facility, detailing Resident A's condition when staff checked on him. A 911 call was made per the document.
An email chain was also received where Ms. Brunner requested a concave mattress as a fall precaution.

Resident A's assessment plan outlined bathing twice a week with wound care, to be administered by Elara Caring.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.** **(b) Special diets.** **(c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate.** **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	I reviewed Resident A's assessment plan and the incident report on the day he was transferred to the hospital. There were fall precautions in place as well as an outline for wound care. The facility notified Emergency Medical Services appropriately. There is no indication that Resident A's course of treatment was not followed by the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 5/8/25, I conducted an exit conference with licensee designee Marianne Love. I shared my findings and Ms. Love agreed with the conclusions reached.

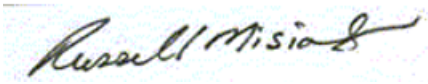
IV. RECOMMENDATION

I recommend no change to the status of this license.

5/21/25

Dwight Forde — Date
Licensing Consultant

Approved By:



6/11/25

Russell B. Misiak — Date
Area Manager