GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 20, 2025

Sarah LeBarre
Brookdale Senior Living Communities, Inc.
105 Westwood Place
Brentwood, TN 37027

RE: License #: AL230079864
Investigation #: 2025A1024052
Brookdale Delta AL

Dear Sarah LeBarre:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On October 16, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
269-350-6286

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL230079864
Investigation #:	2025A1024052
Complaint Receipt Date:	08/29/2025
Investigation Initiation Date:	08/29/2025
Report Due Date:	10/28/2025
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	105 Westwood Place Brentwood, TN 37027
Licensee Telephone #:	(615) 221-2250
Administrator:	Sarah LeBarre
Licensee Designee:	Sarah LeBarre
Name of Facility:	Brookdale Delta AL
Facility Address:	7323 Delta Commerce Lansing, MI 48917
Facility Telephone #:	(517) 327-5566
Original Issuance Date:	03/17/1998
License Status:	REGULAR
Effective Date:	07/03/2025
Expiration Date:	07/02/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Staff member, Chad Fender, has been stealing resident medications out of the facility.	Yes

III. METHODOLOGY

08/29/2025	Special Investigation Intake 2025A1024052
08/29/2025	Special Investigation Initiated – Telephone with direct care staff member Erica Peek, Teressa Coreus, and licensee designee Sarah Lebarre
08/30/2025	APS Referral not warranted
09/04/2025	Contact - Document Received-*Medication Cart Audit Review, AFC Licensing Division Accident/Incident Report*
09/15/2025	Contact - Telephone call made with director of operations, Brian Welch from Guardian Pharmacy
09/15/2025	Contact - Telephone call made with Jennifer Smith, Brookdale Director of Clinical Services
09/22/2025	Inspection Completed On-site with direct care staff members Samantha Idar
09/29/2025	Contact - Telephone call made with Dina Young from the Bureau of Professional Licensing
10/16/2025	Exit Conference with licensee designee Sarah Lebarre and previous licensee designee Chris Milowe
10/16/2025	Inspection Completed-BCAL Sub. Compliance
10/16/2025	Corrective Action Plan Requested and Due on 10/26/2025
10/16/2025	Corrective Action Plan Received
10/16/2025	Corrective Action Plan Approved

ALLEGATION: Staff member, Chad Fender, has been stealing resident medications out of the facility.

INVESTIGATION:

On 8/29/2025, I received a telephone call from the licensee with the allegation that staff member Chad Fender has been stealing resident medications out of the facility.

On 8/29/2025, I conducted interviews with direct care staff members Erica Peek and Teressa Coreus who both stated that they have not seen any issues with medications and have not knowledge of anyone stealing medications. These two staff members also both stated that they work regularly with Chad Fender who conducts medication counts and handles all the medication orders for residents.

Sarah Lebarre stated on 8/06/2025, Guardian Pharmacy did a routine audit of the medication cart and notified her with concerns because direct care staff member Chad Fender, who is a nurse, refused to open the narcotic lock box on the med cart during their audit. Sara Lebarre stated that Guardian Pharmacy came back to the facility a second time and found major discrepancies with the medication records and medications therefore due to those findings from their audit, Chad Fender was suspended for falsifying documentation based on finding orders that had been stopped/changed without a physician's approval. Sarah Lebarre stated subsequently to these findings, an internal investigation was conducted, and this investigation also resulted in discrepancies found therefore, Chad Fender was terminated from employment on 8/13/2025. Sarah Lebarre stated based on the narcotic log record, it appeared that Chad Fender would sign his name, then add another staff 'signature', and write transferred on pages, followed by '0' for the count. Sarah Lebarre stated during their investigation Chad Fender was interviewed, and he could not give clarification on what he meant by "transfer" and stated that he noted "0" on the narcotic logs because he would destroy the medications with no witness present which is not aligned with their narcotic protocol. Sarah Lebarre stated that it appeared that Chad Fender, who started working in the facility in March 2025 stole narcotic medications from Residents A, B, C, and D.

I reviewed the *Medication Cart Audit Review* written by Sarah Westerbrink from Guardian Pharmacy. According to this review there were 12 discrepancies for Resident A's Fentanyl patch that was ordered in March 2025.There were 304 discrepancies for Resident B's Oxycodone (Percocet) medication and this document stated that this order was active from 3/3/25 and discontinued on 4/28/25 on the medication chart however the pharmacy received a new script on 4/30/2025 from the provider with no hint of a discharge order. There were also 170 discrepancies with Resident C's Oxycodone (Percocet) medication as this order was entered incorrectly and not consistent with the actual physician script. This document also stated that there was no script for this medication in the electronic medication administration record (eMAR) nor was it dispensed from the pharmacy.

I also reviewed the facility's *AFC Licensing Division Accident/Incident Report* dated 8/11/2025 which stated that a 3rd party pharmacy, Guardian Pharmacy, brought to the attention of Brookdale Delta's district team their concerns of unauthorized changes to medication orders followed by discrepancies of narcotic counts within. Brookdale's district team suspended Chad Fender, the health and wellness director, on 8/11/2025 based on an internal audit that was also conducted. Upon completion of the internal audit and investigation, Chad Fender was terminated on 8/13/2025. This report documented that a police report was made, and the security code was changed to the building and medication cart was rekeyed. All families involved were also notified of this incident.

On 9/15/2025, I conducted an interview with director of operations Brian Welch from Guardian Pharmacy who stated that their company conducted a routine medication audit at the facility in August 2025 and became suspicious due to discrepancies and lack of cooperation from Chad Fender who wouldn't allow their staff to open the lock box of the medication cart to review those medications. Brian Welch stated the second alarming issue they noticed was the fact that there were some medications that were noted as being "discontinued" or "transferred" by Chad Fender however the pharmacy was still dispensing the medications to the facility. Brian Welch stated that their team also called the medical provider regarding these "discontinued or transferred" medications and these providers stated that these specific medications were not in fact discontinued. After this verification, their team reached out to Jennifer Smith who is the facility's contact person for them and notified her of their concerns.

On 9/15/2025, I conducted an interview with Jennifer Smith who stated that she was contacted by Guardian Pharmacy after they conducted a routine audit of the facility's medication cart and became suspicious when they noticed Resident A's medication Ritalin 5mg was dispensed incorrectly therefore they asked Chad Fender to open the lock box to review additional medications but he refused to open the lock box. Jennifer Smith stated the second clue that prompted suspicion was medications that were labeled as being discontinued or transferred on the narcotic log but were still being delivered to the facility regularly however were not listed on the medication administration record (MAR). Jennifer Smith stated controlled medications must have an order each month with a current physician prescription. Jennifer Smith stated these controlled narcotic medications were ordered and delivered each month to Chad Fender but he did not add the medications to each resident's MAR as required rather he listed the medications as discontinued on the narcotic medication log. Jennifer Smith stated this usually happened approximately one week after the medications were delivered. Jennifer Smith stated she conducted an internal investigation after these concerns were brought to her by Guardian Pharmacy staff and found these same discrepancies as well as learning that Chad Fender was taking these medications out of the facility. Jennifer Smith stated resident MAR's did not indicate any suspicious activity because Chad Fender was never listed these narcotics that he was stealing on the MAR. Consequently, direct care staff members did not know residents were required to take them. Jennifer Smith stated Chad Fender oversaw all medication administrations and believed no one else had knowledge of what Chad Fender was doing with resident

medications. Jennifer Smith further stated she made a complaint to the Attorney General and has been subpoenaed to provide supporting documentation by 9/19/2025.

On 9/22/2025, I conducted an onsite investigation at the facility with direct care staff member Samantha Idar who stated that she regularly prepares and administers medications to residents and had no knowledge of anyone taking resident medications nor did she see any issues on the resident MARs that would indicate any issues with medications. Samantha Idar stated she worked regularly with Chad Fender who was responsible for direct care staff who pass resident medications and she and other staff members basically just followed his instructions. Samantha Idar stated she did not have any suspicion of wrongdoing by Chad Fender.

While at the facility, I reviewed MARs from March 2025 to August 2025 for Residents A, B, C and D and found no concerns.

I also reviewed a Subpoena dated 9/5/2025 authorized by the Ingham County Circuit Court pursuant to a petition filed by Michigan's Department of Attorney of General requesting unredacted documents that caused the investigation by Brookdale Senior Living and basis for the termination of Chad K. Fender, LPN.

On 9/29/2025, I conducted an interview with Dina Young from the Bureau of Professional Licensing who stated that she received complaint that Chad Fender was stealing medications out of the facility filed by the licensee and is awaiting documentation before assigning case to a field agent at which time this allegation will be further investigated.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

ANALYSIS:	Based on my investigation which included interviews with direct care staff members Erica Peek, Teressa Coreus, Samantha Idar, licensee designee Sarah Lebarre, Brookdale Director of Clinical Services Jennifer Smith, Brian Welch from Guardian Pharmacy, Dina Young from the Bureau of Professional Licensing, review of the *Medication Cart Audit Review,* and *AFC Licensing Division Accident/Incident Report* there is evidence that staff member Chad Fender took resident medications out of the facility. According to Brian Welch a routine medication cart audit was conducted by Guardian Pharmacy which prompted concerns due to findings that showed multiple discrepancies in resident medications. Further, when asked for explanation direct care staff member Chad Fender refused to cooperate with the request by not opening the narcotic section of the medication cart and refusing to answer questions. Sarah Lebarre and Jennifer Smith further stated after medication concerns were brought to their attention, an internal investigation was conducted which found these same discrepancies with some of the resident narcotic medications and led to the discovery that Chad Fender was taking resident medications out of the facility. According to the Medication Cart Audit Review performed by Guardian Pharmacy there were multiple discrepancies noted with some of the resident narcotics which resulted in the facility filing these concerns to the Attorney General. I reviewed a Subpoena dated 9/5/2025 authorized by the Ingham County Circuit Court pursuant to a petition filed by Michigan's Department of Attorney of General requesting unredacted documents that caused the investigation by Brookdale Senior Living and basis for the termination of Chad Fender. I reviewed facility's incident report that Chad Fender was terminated on 8/13/2025 due to this allegation. Therefore, resident prescription medications were being used by a person other than the resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/16/2025, I conducted an exit conference with licensee designee Sarah Lebarre and previous licensee designee Chris Milowe. I informed them of my findings and allowed them an opportunity to ask questions and make comments. An acceptable corrective action plan was also received and approved 10/16/2025.

IV. RECOMMENDATION

An acceptable corrective action plan was received therefore I recommend the current license status remain unchanged.

10/16/2025

Ondrea Johnson — Date
Licensing Consultant

Approved By:

10/20/2025

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Dawn N. Timm — Date
Area Manager