GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 2, 2024

Lawrence Ragnone
Serene Gardens of Blanc LLC
4137 E Cook Rd
Grand Blanc, MI 48439

RE: License #: AL250409285
Investigation #: 2024A0779009
Serene Meadows of Grand Blanc II

Dear Lawrence Ragnone:

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. 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 responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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) 643-7960.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

This report contains quoted profanity

I. IDENTIFYING INFORMATION

License #:	AL250409285
Investigation #:	2024A0779009
Complaint Receipt Date:	11/13/2023
Investigation Initiation Date:	11/13/2023
Report Due Date:	01/12/2024
Licensee Name:	Serene Gardens of Blanc LLC
Licensee Address:	4137 E Cook Rd., Grand Blanc, MI 48439
Licensee Telephone #:	(810) 254-4500
Administrator:	Kelly Jackson
Licensee Designee:	Lawrence Ragnone
Name of Facility:	Serene Meadows of Grand Blanc II
Facility Address:	4137 E Cook Rd grand Blanc, MI 48439
Facility Telephone #:	(810) 254-4500
Original Issuance Date:	03/18/2022
License **Status:**	REGULAR
Effective Date:	09/18/2022
Expiration Date:	09/17/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 10/14/23, Resident A was verbally abused by a staff person.	Yes
Staff are not changing Resident A's briefs frequently enough or cleaning her correctly, so Resident A has bedsores.	No
Staff are not providing Resident A with proper medications.	No

III. METHODOLOGY

11/13/2023	Special Investigation Intake 2024A0779009
11/13/2023	Special Investigation Initiated - Telephone Spoke to licensee designee, Larry Ragnone.
11/13/2023	APS Referral Complaint was referred to APS centralized intake.
11/16/2023	Inspection Completed On-site
12/06/2023	Contact - Telephone call made. Spoke to social worker @ PACE.
12/06/2023	Contact - Telephone call made. Spoke to administrator, Kelly Jackson.
01/02/2024	Exit Conference Held with licensee designee, Larry Ragnone.

ALLEGATION:

On 10/14/23, Resident A was verbally abused by a staff person.

INVESTIGATION:

As part of the intake process for this investigation, an audio recording was provided and listened too. The audio recording is said to have taken place inside Resident A's bedroom and attached bathroom on 10/14/23. It has been confirmed that the two voices heard on the recording were Resident A and staff person, Christine Curtis. Staff Curtis is clearly struggling to help Resident A and is quite frustrated. The following are a few of the statements that Staff Curtis made directly to Resident A:

- "You're almost killing both of us because you won't listen."
- "You are pissing me off lady."
- "You make me want to quit my job."
- "Stand your fucking ass up."

The "F" word was used 1-2 more times by Staff Curtis, but the entire statements could not be clearly heard. Staff Curtis could be heard telling Resident A on several occasions to "grab the bar" in a loud and aggressive tone.

On 11/13/23, a phone conversation took place with licensee designee, Lawrence Ragnone, who stated that he was aware of the allegations and of the audio recording. He confirmed that the staff voice that can be heard on the recording was Staff Curtis. Licensee Ragnone stated that Resident A and her family could be quite difficult to help at times; therefore, this was Resident A's third AFC placement. He stated that Resident A receives services from Program of All-Inclusive Care for the Elderly (PACE), who actively involved in her care. Licensee Ragnone reported that they have recently met with Resident A's family and PACE and it was decided that the family will move Resident A back home with them. He stated that Resident A will stay at this home until needed renovations could be made to a family member's home.

On 11/16/23, an on-site inspection was conducted. Due to her advanced stage dementia, Resident A was not able to be interviewed. Resident A was viewed to be clean and well-groomed.

On 11/16/23, staff person, Christine Curtis, acknowledged that she was aware of an audio recording that was recorded while she worked with Resident A during the morning of 10/14/23. Staff Curtis stated that she had gotten Resident A out of bed for the day and had Resident A in the bathroom trying to clean her up and change her. Staff Curtis reported that at that time, Resident A was still a 1-person assist, but that Resident A was not being cooperative with her at all. Staff Curtis admits to being frustrated with Resident A and making several inappropriate comments towards Resident A, including using the "F" word. She stated that she has been working with the elderly for several years now and that this was the first time she has acted inappropriately.

On 11/16/23, administrator, Kelly Jackson, stated that they were first made aware of the audio recording on 10/16/23. Admin Jackson stated that Resident A has a son that is her POA and has a daughter that visits her almost daily. She stated that the daughter has been verbally aggressive and abusive toward staff and that they have had staff quit

employment there because of it. Admin Jackson reported that the daughter came to the home and confronted staff about the audio recording. She stated that the daughter was shouting out insults, calling staff names and was slamming doors. Admin Jackson confirmed that she had heard the recording and that Staff Curtis had acted quite inappropriately. Admin Jackson stated that, since this incident took place, Resident A has been changed to a 2-person assist or 1-person with a mechanical lift to make all transfers and changings easier for everyone involved.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(ii) Verbal abuse.**
ANALYSIS:	It was confirmed that there was an audio recording that recorded interactions between Resident A and staff person, Christine Curtis, on the morning of 10/14/23. The recording was listened too and several inappropriate statements were made by Staff Curtis toward Resident A, including using the "F" word. Staff Curtis admits to being frustrated at the time and making several inappropriate statements during her interactions with Resident A. There was sufficient evidence found to prove that Resident A was verbally abused by staff person, Christine Curtis, on 10/14/23.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff are not changing Resident A's briefs frequently enough or cleaning her correctly, so Resident A has bedsores.

INVESTIGATION:

Resident A's *Assessment Plan for AFC Residents was* reviewed*.* The plans stated that Resident A is unable to walk or stand or her own and utilizes a wheelchair. It confirms that Resident A requires total care from staff. This home has provided a physician order to confirm the change of being able to utilize a mechanical lift for all transfers.

On 11/16/23, administrator, Kelly Jackson, stated that Resident A has end stage dementia and is wheelchair and bed bound. She stated that staff are rotating Resident A from bed to wheelchair every 2 hours during waking hours and repositioning her every 2 hours while sleeping. Admin Jackson reported that Resident A may have a small red mark (pressure mark) on her bottom, but that Resident A has never had any bedsores or open wounds during her stay at this home. Admin Jackson stated that they were only changing Resident A's brief when it was wet, but they recently started changing the briefs at every 2-hour interval.

On 11/16/23, three staff persons were interviewed separately, but all reported the same information. They all confirmed that Resident A is rotating between her bed and wheelchair every 2-hours during the day and evening and that her brief is changed each time. They stated that Resident A is not combative with staff but does not help or assist staff with her care at all. All three staff reported that Resident A has never had any skin breakdown or sores. They stated that cream is applied if a red mark appears. The staff stated that Resident A used to help with her care, but recent declines has led to staff having to use a mechanical lift.

During the on-site inspection on 11/16/23, the transferring and changing of Resident A was observed. Resident A offered no assistance to staff at all and a mechanical lift was utilized. Resident A's brief was observed to be wet, but she had no visible skin breakdown.

On 12/6/23, a phone conversation took place with PACE social worker (SW) Denise Grimes. She confirmed that Resident A received all her medical care through the PACE program and that someone from PACE saw Resident A frequently. SW Grimes stated that PACE is not aware of Resident A ever having bed sores or skin breakdown during her stay at this home. She reported that someone from PACE would visit with Resident A at this home 2-4 times monthly and they have never found any concerns regarding Resident A's hygiene. SW Grimes stated that a PACE nurse was at the home last on 11/19/23 and it was determined that Resident A should be sent to the hospital, where she passed away on 11/20/23. SW Grimes stated that PACE has no issues or concerns regarding the care Resident A was provided at this home.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A suffered from end stage dementia and was wheelchair and bed bound. Staff at this home all reported that Resident A was rotated between her bed and her wheelchair

	every 2-hours during day and evening hours. Resident A's brief was also changed at those times. Staff all deny that Resident A
	has ever had bedsores or skin breakdown while at this home. Resident A was seen to be clean and well-groomed on 11/16/23. Resident A received all medical services through PACE, which saw Resident A several times each month. PACE is not aware of Resident A ever having bedsores. There was lack of sufficient evidence to prove that Resident A was being provided adequate supervision, protection, and personal care at this home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff are not providing Resident A with proper medications.

INVESTIGATION:

On 11/16/23, Admin Jackson, stated that she is not aware of there ever being any issues related to Resident A's medications. Admin Jackson stated that PACE physicians provided all medications/scripts for Resident A. Admin Jackson stated that Resident A had one medication/pill that had to be crushed and placed in applesauce and all her other medications/pills were small, but still placed in applesauce.

During the on-site inspection on 11/16/23, Resident A's physician orders, medications, and medication administration record (MAR) were reviewed. All medications matched what physician orders this home had for Resident A. The MAR indicated that Resident A had received all medications as written by a physician.

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.**

ANALYSIS:	Resident A's medications and physician orders were reviewed. All medications that Resident A received at this home had a corresponding physician order and the medications appeared to be passed via physician orders. There was no evidence found to prove that the Resident A was not being properly provided needed/prescribed medications.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 1/2/2024, an exit conference was held with licensee designee, Lawrence Ragnone. Lawrence Ragnone was informed that a written corrective action plan is required.

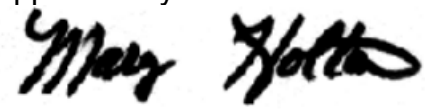
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

1/2/2024

Christopher Holvey Date
Licensing Consultant

Approved By:



1/2/2024

Mary E. Holton Date
Area Manager