GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 12, 2024

Daniela Popaj
Serene Gardens of Hartland
2799 Bella Vita Dr.
Hartland, MI 48353

RE: License #: AH470393393
Investigation #: 2024A0585020
Serene Gardens of Hartland

Dear Ms. Popaj:

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) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH470393393
Investigation #:	2024A0585020
Complaint Receipt Date:	01/29/2024
Investigation Initiation Date:	01/30/2024
Report Due Date:	03/28/2024
Licensee Name:	2799 Bella Vita LLC
Licensee Address:	3520 Davenport Avenue Saginaw, MI 48602
Licensee Telephone #:	(989) 892-0658
Administrator:	Megan Rheingans
Authorized Representative:	Daniela Popaj
Name of Facility:	Serene Gardens of Hartland
Facility Address:	2799 Bella Vita Dr. Hartland, MI 48353
Facility Telephone #:	(810) 746-7800
Original Issuance Date:	08/19/2020
License Status:	REGULAR
Effective Date:	02/19/2024
Expiration Date:	07/31/2024
Capacity:	79
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell and staff did not come to help her.	No
The facility stopped administering Resident A her medication.	Yes
Additional Findings	No

III. METHODOLOGY

01/29/2024	Special Investigation Intake 2024A0585020
01/30/2024	Special Investigation Initiated - Telephone Contacted complainant by telephone for additional information.
01/31/2024	Inspection Completed On-site Completed with observation, interview and record review.
02/05/2024	Contact - Document Received Additional information received from complaint unit.
03/12/2024	Exit Conference. Conducted via email.

ALLEGATION:

Resident A fell and staff did not come to help her.

INVESTIGATION:

On 1/29/2024, the department received the allegations via the BCHS Online Complaint website. The complaint alleged that Resident A fell out the bed and staff did not come to help her.

On 1/30/2024, a referral was made to Adult Protective Services (APS).

On 1/31/2024, an onsite was completed at the facility. I interviewed the administrator Megan Rheingans and Employee #1 at the facility. Employee #1 stated that Resident A had a fall, and they did an incident report. Employee #1 stated that they did a full body assessment and sent her to the hospital. Employee #1 stated that Resident A was attempting to reach for something and fell off the bed. Employee #1 stated that staff saw Resident A during rounds thirty minutes prior, and she was doing fine. She stated that Resident A did not have her pendant when she fell and was found when they made rounds again about 20-30 minutes later when they heard her yelling. She said they called 911 for lift assist. Employee #1 stated that Resident A went to the hospital, but they sent Resident A back to the facility the same night because of no injuries.

Employee #2's statement was consistent with Employee #1 regarding Resident A falling out of the bed.

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 a fall at the facility and was found during rounds on the floor. Resident was sent to the hospital and returned later on that same day with no injuries. Therefore, the facility reasonably complied with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility stopped administering Resident A her medication.

INVESTIGATION:

The complaint alleged that on 1/24/2024, the facility did not give Resident A her Oxycontin prescribed for her severe pain.

The complainant's statements were consistent with what was written in the complaint. The complainant stated that they are in the process of getting a doctor's script for the oxycontin because her doctor wouldn't do it. The complainant stated that the facility took Resident A off the oxycontin, and they did not give her anything. She stated that Resident A had a withdrawal because the facility would not give her the medication.

Ms. Rheingans stated, Resident A was an emergency admit and they had a hard time with hospital. She stated that she was not there when they brought her to the facility on . She said the daughter brought five pills from home and they told the daughter that they would need a script from the physician. She said that Resident A did not have any type of withdrawal and received her medication after the script was signed.

I interviewed Employee #1 at the facility. Employee #1 stated that they told Resident A's family member that they needed a script from the doctor. She explained that she spoke to hospital staff that they cannot take Resident A without a script, but they showed up anyway and they took her. She said that the new doctor would not write a new script until after they saw the resident. She said they had to get Resident A a physician right away. She said that Resident A's family member brought the medication that she had at home but when they got it, they realized that there were multiple pills in the bottle, and they could not give it to the resident because they didn't know what it was. Employee #1 stated that Resident A is getting all of her medication now but missed a few days because they did not have the script from the physician.

I interviewed Employee #2 who stated that Resident A was admitted to the facility on 12/21/2023. She stated that Resident A came with a 14-day supply of oxycontin. She said the doctor felt that Resident A did not need new prescription and he refused to refill it. She said Resident A's daughter had the full prescription and when they requested the medication, she only brought five pills. She said that Resident A was also signed up with the pain clinic and was supposed to sign up with hospice, but when she got to the facility, she changed her mind about signing up.

During the onsite, I interviewed Resident A at the facility. Resident A stated that she gets her medication and staff was good. She said that she does not have any issues with getting her medication now, but she did miss giving her medication one day. Resident A did not appear to be under any distress.

Employee #1 showed me a pill bottle that was brought to the facility by Resident A's family member. The pills that were in the bottle was a combination of several different pills with no label and I could not tell what they were.

A review of the medication prescribed in the cart included Oxycontin with a signature date of 1/12/2024 by the physician.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(6) A home shall require an individual who, at the time of admission, is under the care of a licensed health care professional for ongoing treatments or prescription medications that require the home's intervention or oversight, to provide a written statement from that licensed health care professional completed within the 90-day period before the individual's admission to the home. The statement shall list those treatments or medications for the purpose of developing and implementing the resident's service plan. If this statement is not available at the time of an emergency admission, then the home shall require that the statement be obtained not later than 30 days after admission.
ANALYSIS:	Resident A was admitted to the facility without her prescribed medication. The facility accepted the Resident without getting the physician orders, therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED.**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Brender L. Howard 03/12/2024

Brender Howard Date
Licensing Staff

Approved By:

Andrea L. Moore 03/12/2024

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