GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 20, 2024

Daniel McNeill
PO Box 68
Fenton, MI 48430

RE: License #: AF250404622
Investigation #: 2024A0871011
Serenity Gardens

Dear Mr. McNeill:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

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 #:	AF250404622
Investigation #:	2024A0871011
Complaint Receipt Date:	04/04/2024
Investigation Initiation Date:	04/05/2024
Report Due Date:	06/03/2024
Licensee Name:	Daniel McNeill
Licensee Address:	110 Lansing St. Gaines, MI 48436
Licensee Telephone #:	(810) 931-8466
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Serenity Gardens
Facility Address:	110 Lansing St. Gaines, MI 48436
Facility Telephone #:	(810) 931-8644
Original Issuance Date:	08/27/2020
License **Status:**	REGULAR
Effective Date:	02/27/2023
Expiration Date:	02/26/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On March 27, 2024, Resident A was wandering through the town, threatening the citizens and requires business owners to close early.	No
Additional Findings	Yes

III. METHODOLOGY

04/04/2024	Special Investigation Intake 2024A0871011
04/05/2024	Special Investigation Initiated - Telephone Call to the complainant.
04/10/2024	Inspection Completed On-site Interviewed Home Manager Julie Davis
05/09/2024	Contact - Telephone call received Telephone call from Licensing Consultant Sabrina McGowan
05/13/2024	Inspection Completed On-site Interviewed Residents B-C
05/16/2024	Contact - Telephone call made Telephone call to Family Member 1
05/20/2024	APS Referral Through Central Intake to Genesee County MDHHS
05/20/2024	Contact - Telephone call made Telephone call to Staff Alex Basher
05/20/2024	Exit Conference Telephone exit conference with Licensee Daniel McNeill

ALLEGATION:
On March 27, 2024, Resident A was wandering through the town, threatening the citizens and requires business owners to close early.

INVESTIGATION:
On April 8, 2024, Licensing Consultant Sabrina McGowan contacted Complainant 1 and was advised that Resident A "has been standing in the middle of the street smoking, refusing to move for cars." Resident A continued to threaten staff at a local bar, causing them to close at 8:30. Licensing Consultant McGowan also indicated Resident A is his own guardian and had no community restrictions.

On April 10, 2024, I conducted an unannounced onsite investigation and interviewed Home Manager Julie Davis. Manager Davis was aware of the situation but was not working the evening of March 27, 2024. On that evening, Manager Davis received a text from second shift staff Alex Basher indicating that Resident A left and did not come back and was missing his meds. Manager Davis received the text at about 8:30 pm on March 27, 2024. Manager Davis reported that Resident A likes to drink a lot of water to wash the medications out of his system and will go to the local bar to drink water or soda. Manager Davis reported the bar will not serve him anymore. Manager Davis indicated Resident A is on water restrictions and "that is why he leaves the house." Manager Davis indicated she received another text at 9:49 pm and Staff Basher told her that Licensee Daniel McNeill said to call the police. Manager Davis indicated Resident A is on water restrictions and "that is why he leaves the house." Manager Davis stated that Resident A's case manager was told to file a petition to have a guardian for Resident A. Manager Davis indicated Resident A is at a psychiatric unit at a Pontiac hospital and will not be returning to the facility.

Manager Davis gave me a copy of Resident A's *Assessment Plan for AFC Residents.* It indicates in the section 'Moves Independently in the Community' is marked 'yes'. It was signed and dated on August 10, 2023, by Resident A and Licensee Daniel McNeill.

On May 13, 2024, I conducted another unannounced onsite investigation and interviewed Manager Davis. Manager Davis stated Resident A returned to the facility on March 28, 2024, and went to the hospital on March 29, 2024. Manager Davis indicated that Resident A's Family Member 1 was at the facility the day before Resident A went to the hospital on March 29, 2024. Manager Davis stated Resident A was swearing at her and told her "fuck you" and to "get out of here." Manager Davis stated Resident A was given a 30-day discharge notice in January but has not been placed elsewhere. Manager Davis said Resident A will not be returning to the facility. I observed a copy of the 30-day discharge notice, and it was dated for January 7, 2024. Manager Davis stated Resident A, Family Member 1, and the case manager were all provided a copy of the notice.

On May 13, 2024, I interviewed Resident B and Resident C. Resident B stated he is receiving good care and has no complaints about the facility. I asked Resident B about when Resident A was living there, and he stated that Resident A "threatened to kill me"

the day before he went to the hospital. Resident A also said he “was going to get people to kill me.”

Resident C stated he likes living in the facility and gets good food. I asked Resident C about Resident A and he indicated “he was controlling” but he was not too afraid of him. Resident C stated Resident A always tried to get him into trouble and things are better because he is gone.

On May 16, 2024, I telephoned Family Member 1. Family Member 1 indicated whenever she visited Resident A, he appeared clean and happy. Family Member 1 stated because of his mental illness, she did not know what was going through his mind. Resident A told Family Member 1 that he had not been showering. Family Member 1 said the other residents in the facility appeared clean and happy as well and she had no concerns about the care Resident A received while living in the facility.

On May 20, 2024, I interviewed Staff Alex Basher via telephone. Staff Basher indicated when he arrived to work about 7:00 pm on March 27, 2024, Resident A had already left the facility and was advised he had been gone for a while. Staff Basher said Resident A was always there to get his meds at 8:00 pm and he was not there. Staff Basher sent a text to Manager Davis and then a text to Licensee McNeill. Staff Basher indicated Licensee McNeill asked if the other residents were sleeping, and they were sleeping. Licensee McNeill told Staff Basher to walk through town to see if he could find Resident A. Staff Basher left the facility and walked through town but could not find Resident A. Staff Basher observed an ambulance that was parked and talked to the ambulance staff to inquire if they saw Resident A. They did not and told Staff Basher told them to notify him if they saw Resident A. Staff Basher returned to the facility and called the police, and a State Trooper came to the facility. Staff Basher received a phone call from Resident A about 2 am and he wanted a ride home from the hospital. Staff Basher advised he could not leave the facility and Resident A would have to wait until morning for a ride. Staff Basher found out that the ambulance that was parked prior to the ambulance staff he talked to took Resident A to the hospital. Resident A approached the prior ambulance and complained of stomach problems and was taken to the hospital. I asked Staff Basher who was at the facility when he left and he said no one, “because everybody was asleep.”

On May 20, 2024, I received a copy of an *AFC Licensing Division – Incident/Accident Report* that was signed and dated by Licensee Daniel McNeill on March 27, 2024. The date of the incident indicates March 27, 2024. What happens indicates “[Resident A had been gone at bar downtown since 5p (per other staff). [Resident A] not had dinner or meds. At 10p searched downtown and was nowhere. Called 911, MSP came, took report and searched but did not find. At 2a, [Resident A] called from hospital and wants a ride home.” Action taken indicates “told [Resident A] no vehicle available to pick him up. The only authorized vehicle is gone and only personal vehicle here and no extra staff available. He is going to take bus in am.” Corrective measures indicate “Advised [Resident A] he needs to alert staff of his need to go to hospital and his location.”

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until a resident assessment plan is made and it is determined that the resident is suitable pursuant to the following provisions: **(a) The amount of personal care, supervision, and protection required by the resident is available in the home.**
ANALYSIS:	Resident A does not have a guardian and can move independently in the community as indicated in the *Assessment Plan for AFC Residents.* Resident A left the facility and failed to inform staff his whereabouts. The appropriate steps were taken to find Resident A. There is insufficient evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On May 20, 2024, I asked Staff Basher who was at the facility when he left and he said no one, “because everybody was asleep.”

APPLICABLE RULE	
R400.1410	**Resident protection.**
	A licensee or responsible person shall always be on the premises when a resident is in the home.
ANALYSIS:	Staff Alex Basher left the facility to look for Resident A and there was no staff at the facility. I confirm violation of this rule.
CONSLUSION:	**VIOLATION ESTABLISHED**

On 5/20/2024, and exit conference was conducted with licensee Daniel McNeill. Licensee McNeill was informed of the findings of this investigation.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care family home remain unchanged (capacity 1-6).

05/20/2024

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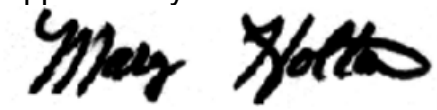
Kathryn A. Huber Date
Licensing Consultant

Approved By:



05/20/2024

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Mary E. Holton Date
Area Manager