GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Daniela Popaj
Serene Gardens of Rochester Hills AL
910 S. Boulevard
Rochester Hills, MI 48307

May 23, 2024

RE: License #: AH630385331
Investigation #: 2024A1022034
Serene Gardens of Rochester Hills AL

Dear Daniela Popaj:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 authorized representative and a date.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630385331
Investigation #:	2024A1022034
Complaint Receipt Date:	04/05/2024
Investigation Initiation Date:	04/16/2024
Report Due Date:	06/05/2024
Licensee Name:	Serene Gardens of Rochester Hills LLC
Licensee Address:	Ste. 104 9463 Holly Road Grand Blanc, MI 48439
Licensee Telephone #:	(810) 241-4084
Administrator:	Margo Kendzier
Authorized Representative/	Daniela Popaj
Name of Facility:	Serene Gardens of Rochester Hills AL
Facility Address:	910 S. Boulevard Rochester Hills, MI 48307
Facility Telephone #:	(248) 270-4040
Original Issuance Date:	06/26/2018
License **Status:**	REGULAR
Effective Date:	12/26/2023
Expiration Date:	07/31/2024
Capacity:	38
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Residents do not receive appropriate incontinence care.	No
There are bars on residents' beds.	Yes
The facility is not kept clean.	No

III. METHODOLOGY

04/05/2024	Special Investigation Intake 2024A1022034
04/16/2024	Special Investigation Initiated - On Site
04/16/2024	Inspection Completed On-site
05/09/2024	Contact Email exchange with authorized representative.
05/23/2024	Exit Conference

ALLEGATION:

Residents do not receive appropriate incontinence care.

INVESTIGATION:

On 04/05/2024, the Bureau of Community and Health Systems (BCHS) received an anonymous referral from Adult Protective Services (APS) that in part read, "They (facility staff) are leaving people (residents) in the room wet for multiple hours and feces on the bed when they are changed and on the linen the linen is not properly being changed."

The referral was marked, "Denied," signifying that APS had determined they would not be investigating the allegations.

On 04/16/2024, at the time of the onsite visit, I interviewed the interim administrator and the lead supervisor. When asked about incontinence care, the lead supervisor stated that any resident who needed assistance with toilet use was checked every two hours and either assisted to the toilet or changed as needed.

At the time of the onsite visit, I made observations of Resident A, Resident B, and Resident C. Both Resident A and Resident B were provided incontinence care just before I walked into their respective rooms. Caregiver #1 was preparing to provide Resident C with incontinence care as I got to her room. When caregiver #1 checked Resident C's incontinence brief, it was clean and dry.

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:	Residents received appropriate incontinence care and assistance with toilet use.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There are bars on residents' beds.

INVESTIGATION:

According to the referral, "they were trying to hide … that they had bars on the bed …"

At the time of the onsite visit, Resident A was observed lying in her bed. Resident A was awake and able to reliably answer questions. Resident A's bed was noted to be a "hospital" bed that was equipped with ½ bilateral bed rails. Resident A stated that she was unable to transfer on her own and that the caregivers used a mechanical lift to help her out of bed and to transfer. When asked about the side rails, Resident A stated that she did use them from time to time to help her position herself on her side. Review of Resident A's service plan revealed no mention of the use of bed rails or assist bars. The facility provided a letter dated 04/30/2024, after the date of the onsite visit, from a physician acknowledging that Resident A "uses guardrails on her bed for ease of mobility…" The letter was not an order for the use of assist bars or side rails.

At the time of the onsite visit, Resident B was observed lying in her bed. Resident B was also awake but was unsure on how to respond to some questions. Resident B's bed was also noted to be a "hospital" bed that was equipped with ½ bilateral bed rails. When asked about the rails, Resident B also acknowledged that she could use them to position herself on her side, but that she wished she could lower the rails below the edge of her mattress. Resident B was further observed to use the side rails to pull herself up in her bed. Review of Resident B's service plan also revealed no mention of the use of bed rails or assist bars. The facility provided a physician's order dated 04/24/2024, also after the date of the onsite visit, for the use of bilateral bed rails.

When asked about the use of bed rails or assist bars, the interim administrator stated that the facility had procedures in place to ensure that assist bars or side rails could be safely used by residents, including ongoing assessments of the potential for entrapment caused by the bed rails and that she would provide the written procedures to me. On 05/09/2024, via an email exchange, the authorized representative (AR) informed me that the interim administrator had left her position. AR provided the facility's assessment process that was outlined in the following Bed Rail Clinical Guidance:

1. Evaluate all residents for safety need regarding the use of bed rails on admission and reassessment, (by) identifying potential medical needs/safety hazards.
2. Implement and monitor effectiveness of least restrictive care plan interventions.
3. Work to mitigate environmental factors to reduce risk of injury.
4. Educate resident/legal representative on the benefits and risks of bed rail use.
5. Develop (a) care plan that outlines the medical factors necessitating bed rails.
6. Implement and monitor resident response to bed rails if indicated and when ordered by the physician.
7. Assess bed, mattress, and bed rails for safety precautions against entrapment risks.
8. Initiate (an) ongoing monitoring plan.
9. Document effectiveness, quality improvement reporting, and rationale for continued need on an ongoing basis.

When the AR was asked to provide the documentation showing that both Resident A and Resident B had been evaluated using their process, the AR responded, "At this time we are not able to locate the forms referenced."

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(2) 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:	The facility did not follow its own Bed Rail Clinical Guidance. There was no safety assessment with an ongoing monitoring plan, no physician order and no guidance to staff in the service plan for either Resident A or Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is not kept clean.

INVESTIGATION:

According to the referral, “The residents are being served food and it doesn't get immediately picked up and it stays in their room for at least two hours. The bathrooms are filthy, toilets are disgusting.”

At the time of the onsite visit, I made observations in 8 resident bedrooms. All of the bathrooms, including the toilets, appeared to be clean. There were no observations of soiled dishes from previous meals.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	The facility’s interior, including resident rooms, was clean.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 05/23/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

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

05/23/2024

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Barbara Zabitz Date
Licensing Staff

Approved By:

05/16/2024

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