GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 21, 2024

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

RE: License #: AH470393393
Investigation #: 2024A1027082
Serene Gardens of Hartland

Dear Licensee:

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 authorized representative 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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH470393393
Investigation #:	2024A1027082
Complaint Receipt Date:	07/10/2024
Investigation Initiation Date:	07/16/2024
Report Due Date:	09/09/2024
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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	79
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not monitored consistently, leading to increased falls and serious injuries.	Yes
Employees shared resident information with visitors.	No
The facility experienced physical maintenance issues.	No
Additional Findings	No

III. METHODOLOGY

07/10/2024	Special Investigation Intake 2024A1027082
07/16/2024	Special Investigation Initiated - Telephone Attempted to call complainant twice; however, a response was received that the phone number was disconnected
07/16/2024	Contact - Document Sent Email sent to the complainant
07/24/2024	Contact - Telephone call received From complainant, verified information and emailed J. Rogers.
07/26/2024	Contact - Telephone call made Telephone interview conducted with complainant
07/30/2024	Contact - Document Received Email received from the complainant with additional information
08/13/2024	Inspection Completed On-site
08/15/2024	Contact - Document Received Additional documentation received from Employee #1
08/20/2024	Inspection Completed-BCAL Sub. Compliance
08/21/2024	Exit Conference Conducted by email with Daniela Popaj and Megan Rheingans

ALLEGATION:

Resident A was not monitored consistently, leading to increased falls and serious injuries.

INVESTIGATION:

On 7/10/2024, the Department received allegations by telephone with general allegations which read residents were left unattended and not checked for hours, resulting in increased falls and significant injuries.

On 7/26/2024, I conducted a telephone interview with the complainant who clarified that her concerns were specifically about Resident A. The complainant stated Resident A who lived in memory care and used a wheeled walker, had experienced three falls within one week and approximately 13 falls throughout the year. The complainant reported on 6/24/2024, Resident A fell and sustained a head injury but was not checked for hours after she returned to the facility. Additionally, there was a leak under the bathroom sink. The complainant suggested that two falls might have been related to this leak, and one fall was observed in the dining room.

On 7/30/2024, an email from the complainant included a letter detailing falls on the following dates: January 2024 (three to four times), 4/4/2024, 4/7/2024, 5/1/2024, 5/2/2024, 5/10/2024, 6/17/2024, 6/20/2024, and 6/24/2024. The letter indicated that most falls resulted in injuries, and included pictures from May 1, 2024, and May 10, 2024, showing bruising on Resident A's face.

On 8/13/2024, an on-site inspection was conducted, and staff were interviewed.

Employee #1 stated that while two-hour safety checks were performed; however, they were not documented, and chart notes were made for any unusual occurrences. Employee #1 stated incontinent care was provided if needed.

Employee #1 stated also noted that Resident A had been transferred to the hospital for a fall before the water leak occurred, and that the leak was fixed the following morning.

Employee #1 mentioned that Resident A required reminders to use her walker and had moved furniture in her room, increasing her fall risk. Although a bed alarm was implemented, Resident A removed it.

Employee #1 reported all incidents were to be documented on an incident report form. While on-site, I reviewed the facility's incident report binder. Review of incident reports for Resident A revealed there were no incident reports for April 2024, but incident reports completed for 5/7/2024, 6/4/2024, 6/20/2024, 7/8/2024, and 7/13/2024, with those dated 5/7/2024, 6/4/2024, 6/20/2024, and 7/8/2024 specifically documenting falls. Report dated 6/20/2024 did not indicate a leak

under the sink but read Resident A was in slumped in her chair with an abrasion on her head and was sent to the hospital.

Administrator Megan Rheingans confirmed the leak under Resident A's bathroom sink was identified in the evening on 6/24/2024 while Resident A was at the hospital and was fixed by 9:00 AM on 6/25/2024 by a plumber.

On 8/15/2024, a telephone interview was conducted with Resident A's hospice nurse revealed she had access to charting from 6/20/2024, onward. Resident A's hospice nurse reported the agency was notified of Resident A's falls on 6/20/2024, 6/24/2024 and 7/8/2024, with the fall on 6/24/2024 resulting in Resident A receiving two staples in her head. The hospice nurse reported Resident A has declined with an unsteady gait and shuffling; however, continues to want to maintain independence and will sometimes become agitated when staff try to assist her. Resident A's hospice nurse stated Resident A does not like clutter, so she removed her bed alarm.

Resident A's face sheet read in part she moved into the facility on 10/28/2021 and Relative A1 was her primary contact.

Resident A's service plan updated on 4/8/2024 and signed by Relative A1 read in part Resident A required standby assistance for transfers, always needed her walker, reminders to lock her walker, and to only wear flat shoes. The plan read in part staff were to assist her to and from the dining room. The plan read in part she was a fall risk requiring routine safety checks and had confusion due to her dementia.

Resident A's chart notes for the past six months did not provide relevant information beyond what was recorded, and generally noted increased confusion at night.

Review of the multi-disciplinary team policy and procedure read in part supervisors were to complete incidents reports on the same shift that they occurred and turn them in before the end of the shift to their resident care director/wellness coordinator.

Review of the facility's fall protocol read in part staff were to contact the physician, administrator, resident's family, as well as monitor the resident's condition.

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.
For Reference: R 325.1924	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	Review of Resident A's records indicated she was at risk for falls and had a history of falls, aligning with the complainant's information. Staff interviews revealed two-hour checks were conducted and increased after hospitalization. Interviews with staff revealed that incident reports were required for all incidents. However, a review of these reports showed discrepancies between the hospice records and the complainant's notes, specifically for the fall with injury on 6/24/2024. Although Resident A's falls could not be attributed to a lack of monitoring, the facility did not adhere to their incident reporting policy and lacked an organized program to ensure all reports were completed for Resident A's falls. Thus, a violation was substantiated for this allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Employees shared resident information with visitors.

INVESTIGATION:

On 7/10/2024, the Department received allegations by telephone alleging employees disclosed details about other residents to visitors.

On 7/26/2024, I conducted a telephone interview with the complainant reported that staff had mentioned another resident's diagnosis of schizophrenia and an incident of sexual assault.

On 8/13/2024, an on-site inspection was conducted, and staff were interviewed. Employee #1 confirmed that staff received HIPAA training upon hire and annually, including through a toolkit and quiz provided during orientation. Employee #1 also noted that there were no residents with schizophrenia or a history of sexual abuse and mentioned in-services planned for today that focused on HIPAA and other topics.

On 8/15/2024, I interviewed Resident A's hospice nurse by phone. The nurse denied witnessing staff discuss resident information with visitors and noted that memory care families frequently shared information among themselves.

I reviewed the facility's training toolkit which read consistent with statements from Employee #1.

On 8/15/2024, Employee #1 confirmed via email that she conducted the scheduled in-services, which included HIPAA training. The email also included sign-in sheets dated 8/13/2024 and 8/14/2024.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(c) A patient or resident is entitled to confidential treatment of personal and medical records, and may refuse their release to a person outside the health facility or agency except as required because of a transfer to another health care facility, as required by law or third party payment contract, or as permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.**

ANALYSIS:	Review of the facility's training program demonstrated education on resident privacy. Given the evidence from the training program and interviews, there was insufficient support that staff violated HIPPA regulations; therefore, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility experienced physical maintenance issues.

INVESTIGATION:

On 7/10/2024, the Department received allegations by telephone regarding plumbing issues.

On 7/26/2024, I conducted a telephone interview with the complainant who reported Resident A's sink had a leak which was covered with a plastic bag until a plumber could be arranged. The complainant also mentioned septic tank issues and claimed that Employee #2 had turned off the septic alarm. As a result, they were unable to do the dishes due to the septic backup.

On 8/13/2024, an on-site inspection was conducted, and staff were interviewed.

Employee #1 reported that housekeeping identified the water leak in Resident A's room and notified maintenance, which required a plumber. The leak was repaired by the following morning.

Additionally, Employee #1 noted that an alarm for the sewage system outside near the dumpster had sounded. The township was contacted, and an electrical issue was identified by the township staff. The problem was temporarily fixed that day and fully resolved the next day, though the facility had to monitor water usage overnight.

Administrator Megan Rheingans' statements were consistent with those of Employee #1.

During the site visit, Ms. Rheingans contacted Employee #3, who explained that the plumber had to go through a wall to access the leaking pipe, and the maintenance person covered the area afterward for future access.

Ms. Rheingans stated Daniela Popaj was on duty the day there were sewage pipe issues. While on-site, Ms. Rheingans spoke with Daniela Popaj, who

confirmed that on 6/28/2024, the City of Hartford accidentally cut a sewage line. The line was temporarily repaired that day and permanently fixed the next day.

During this time, water usage was temporarily stopped, and the septic tank was pumped. Various parties, including the City of Hartford, a plumber, a septic company, and an electrician, assisted with the issue.

While on-site, I observed sewage alarm was functioning properly and Resident A's bathroom sink was not leaking.

A review of text messages between Relative A1 and Employee #2 showed that Resident A's sink was repaired on 6/25/2024 at 7:48 AM, with a Home Depot receipt dated the same day.

Review of the facility's invoices for services related to the sewage issue revealed an invoice for Hartland Septic Service dated 6/28/2024, plumber receipt dated 6/29/2024, Metcalf Electrical invoice dated 7/1/2024. Additionally, text correspondence between Ms. Popaj and Employee #2 revealed confirmed that the septic pump's electrical power was temporarily restored on 6/28/2024 and permanently fixed on 6/29/2024 after the electrician obtained necessary parts.

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 did not have documentation for Resident A's fall on 6/24/2024; therefore, the cause could not be confirmed. However, the sink was repaired promptly once the issue was identified. Additionally, the sewage problem identified on 6/28/2024, which involved multiple contractors including the City of Hartford, was temporarily addressed on 6/28/2024 and fully resolved by 6/29/2024. As a result, these allegations were not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

08/20/2024

Jessica Rogers Date
Licensing Staff

Approved By:

08/20/2024

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