GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 12, 2024

Daniela Popaj
Serene Gardens of Grand Blanc
1481 E. Hill Road
Grand Blanc, MI 48439

RE: License #: AH250385140
Investigation #: 2024A0585082
Serene Gardens of Grand Blanc

Dear Daniela 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 #:	AH250385140
Investigation #:	2024A0585082
Complaint Receipt Date:	09/10/2024
Investigation Initiation Date:	09/11/2024
Report Due Date:	11/10/2024
Licensee Name:	1481 E. Hill, 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 Grand Blanc
Facility Address:	1481 E. Hill Road Grand Blanc, MI 48439
Facility Telephone #:	(810) 603-7029
Original Issuance Date:	01/26/2018
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	79
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents are talked down to and harassed.	No
Residents were left in bed during a tornado. Visitors were not notified about COVID in the building.	No
Residents are not being taken to the bathroom, residents are left on the toilet for over an hour on several occasions and residents' bandages are not being changed, and Employee #3 falsely documented that showers were given to Resident A.	No
Resident A's medication is not given or given late.	Yes
The menu does not match the food being served, the food is not appropriate and is not a balanced diet.	No
Additional Findings	No

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

The allegations of resident sliding out of the chair, staff not doing an assessment, the wound not being treated properly, resident put to bed early and call button stopped working was already investigated under 2024A0585040.

III. METHODOLOGY

09/10/2024	Special Investigation Intake 2024A0585082
09/11/2024	Special Investigation Initiated - Telephone Contacted complainant to discuss allegations.
09/11/2024	APS Referral Emailed referral to Adult Protective Service (APS).
09/13/2024	Inspection Completed On-site Completed with observation, interview and record review.
09/13/2024	Inspection Completed – BCAL Sub. Compliance

11/13/2024	Exit Conference. Conducted via email to Daniela Popaj.

ALLEGATION:

Residents are talked down to and harassed.

INVESTIGATION:

On 9/11/2024, the department received this complaint through the BCAL online complaint system. The complaint alleged that residents are being talked down to and harassed by the staff. The complaint alleged that Employee #3 is rude to the residents and talks down to them.

On 9/13/2024, an onsite was completed at the facility. I interviewed Employee #1 who stated that she has no report of residents being talked down to or harassed. She said that residents will tell if they have a problem with anybody.

I interviewed Employee #2 and Employee #4 who stated that they never harassed residents or be rude to them. They both said that do not know of anyone that has harassed any of the residents.

During the onsite, I interviewed Resident B at the facility. Resident B stated that staff are nice to her, and they talk nice to her. Resident B stated that she is not fearful of any staff.

During the onsite, I interviewed Resident C at the facility. Resident C stated that she doesn't have any problem with staff. She said that staff treat her good and she is not fearful of staff. She said staff are not rude to her.

During the onsite, I observed several residents throughout the facility. There were no issues noted and residents seemed happy. I observed staff attending to the needs of the residents.

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: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	There is no evidence to support this claim of residents being talked down and harassed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident were left in bed during a tornado. Visitors were not notified about COVID in the building.

INVESTIGATION:

The complaint alleged that on 8/28/2024, tornado sirens went off and residents were left in their beds and no safety precautions were taken. The complaint alleged that the residents were scared and was not informed of what was happening. The

complaint alleged that on 3/7/2024, Resident A was diagnosed with COVID, along with other residents and there were no COVID notices on the entry door notifying guests about positive cases.

Employee #1 stated that there is a disaster plan in place to keep the residents' safe. She said that residents that are physically able are put in the hallways, all doors are closed to the suite. She said some residents refuse to leave their rooms and we try to keep them safe the best they can. Employee #1 stated that all staff have cell phones and walkie talkies to communicate throughout. Employee #1 stated they follow protocol whenever there is a positive COVID case. She stated that they alert family, notify doctor and they follow isolation protocol. She said that personal protection equipment (PPE) is also placed outside the residents' room. She said that there were no COVID in the building at this time.

Employee #2 stated that there is a policy in place for emergencies. Employee #2 stated that if residents are able to move, they take them to the hallway. She said that if they are not able to move, then they keep them safely in their rooms and check on them throughout the time. She said that there is notification posted whenever there is COVID in the building.

Resident B and Resident C stated that they have been taken out of their rooms when the sirens come on.

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: **(a) Assume full legal responsibility for the overall conduct and operation of the home.**
ANALYSIS	There is no evidence to support this claim.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not being taken to the bathroom, residents are left on toilet for over an hour on several occasions and residents' bandages are not being changed, and Employee #3 falsely documented that showers were given to Resident A.

INVESTIGATION:

The complaint alleged that on 2/27/2024, Resident A was on the toilet for an hour by Employee #4 and forgot about her. The complaint alleged that on 4/1/2024, Resident A was taken to the bathroom by Employee #4 and she did not return to take Resident A from the toilet. The complaint alleged that on 4/4/2024, Employee #2 left Resident A on the toilet for 30 minutes and they did not help her off the toilet. The complaint alleged that on 2/15/2024, no shower was given by Employee #3, but it was documented that it was given.

Employee #1 stated that Resident A likes her privacy and tell the staff to leave. She said the staff would leave and go back after a few minutes to check on Resident A. She said that residents are not left on the toilets for long periods. She said that residents' bandages are being changed. Employee #1 stated that Employee #4 no longer works at the facility. She said that all residents' needs are being met. She said that Resident A got her showers when she was at the facility. Employee #1 stated that Resident A sometimes refuse showers and tell staff that her granddaughter was going to shower her. She said that Resident A was not on hospice and showers are completed by facility staff when she allows them to.

On 9/13/2024, I spoke to Employee #2 by telephone. She said that residents are being taken to the bathroom. She said that she didn't know of any residents being left on the toilet for an hour. She said that Resident A likes her privacy and would tell them to leave her. She said that she does not have any knowledge about Employee #4 leaving Resident A on the toilet, but she does know that Resident A likes her privacy and would yell at you if you didn't leave. Her statement was consistent with Employee #1 in regard to Resident A refusing showers and only wanted her family to do them. She said that they change residents' bandages as needed or as ordered.

Employee #3 stated that she only documented when she did Resident A's showers. She stated that she would never put it down as completed if she had not completed it. She said that Resident A refuse showers sometimes and don't want them to shower her.

The facility chart note reads:

2/15/2024 - "ADL: Resident was showered but she declined washing her hair today. Staff assisted her with oral care after shower also. No concerns to report at this time." Signed by Employee #3.

2/16/2024 - "*Resident received her shower this morning after breakfast. No concerns with skin and no new physical changes to report. Lotion was applied to body, hair was washed, barrier cream was applied to bottom. Glasses and pendant were put back on after shower was completed. Resident requested to put back on the same clothes, a clean brief was also put on. Signed by Employee #1*

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	There is no evidence to support this claim.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's medication is not given or given late.

INVESTIGATION:

The complaint alleged that on 2/24/2024, facility ran out of Resident A's medication, and they had to call the doctor to write prescription to pick up since it was the weekend, and the pharmacy could not fill it on the weekend. The complaint alleged that the prescription ran out again because they did not get it filled. The complaint alleged that on 3/10/2024, the nurse informed POA that they ran out of Lisinopril blood pressure medication and asked POA to bring more up there to the facility. The complaint alleged that on 3/14/2024, the caregiver called and told her that Resident A ran out of medication again. The complaint alleged that on 4/17/2024, Employee #5 asked her to tell the pharmacy not to fill Resident A's pain patch prescription because she had too many of them as they are not using them daily as prescribed. The complaint alleged that on 4/20/2024, Resident A was out of Aspirin 81 mg.

Employee #1 stated that all medication is given as prescribed. She stated that Resident A's POA signed up for the new pharmacy at the last minute and they were not able to get the medication in time. Employee #1 stated that she got Resident A's POA to bring it from home until the pharmacist start filling it. She stated that they put their own medication on the cart. She said that she keeps it until locked up until it is needed to restock the cart. She said the pharmacy deliver the medication and they restock their own cart. She said that aspirin was considered over the counter and Resident A's POA didn't want them to call the pharmacy for it. She said the POA said that they were going to provide the aspirin.

Resident A's chart notes read:

On 2/24/2024, Per management staff was told to allow granddaughter to pass missing meds. Granddaughter brought them in from previous facility the medications passed was her Toprol, aspirin, iron and Colace. Management is working on the other medications arriving asap.

On 2/26/2024, Administrator: Reordered several of resident's medications that were marked as unavailable.

On 3/14/2024, Resident bedtime medication was passed through as unavailable, but Administrator came and dropped them off and resident was able to receive them.

A review of Resident A's medication administrator record (MAR) for February – April 2024 shows in part, the following:

According to Resident A's February MAR, these medications were marked as not available from February 2, 2024 – February 26 according to Resident A's MAR: Lisinopril, Metoprol Tartrate 25 mg, Pantoprazole sodium 40 mg, Atorvastatin Calcium 40 mg, Ferrous Sulfate 325 mg tabs, Calcium 500+D, Cholecalciferol 25 mcg (1000 UT) caps, diclofenac sodium, docusate sodium 100 mg caps, Lidocaine patch.

22-Mar-2024 9:50 AM hydrocortisone acetate 25mg re supp - physically unable to take - medication unavailable.

1-Mar-2024 7:47 am hydrocortisone acetate 25mg re supp med unavailable
4-Mar-2024 7:34 am hydrocortisone acetate 25mg re supp med unavailable
6-Mar-2024 10:50 am hydrocortisone acetate 25mg re supp medication is unavailable
9-Mar-2024 10:36 am procto-med hc 2.5% to cream - medication unavailable
11-Mar-2024 9:22 AM hydrocortisone acetate 25mg re supp - med unavailable
13-Mar-2024 9:07 am hydrocortisone acetate 25mg re supp - medications are unavailable
13-mar-2024 9:07 am ldr lidocaine patch 4% to patch - medications are unavailable
13-Mar-2024 9:07 am procto-med hc 2.5% to cream - medications are unavailable
13-mar-2024 7:47 pm atorvastatin calcium 40mg po tab - medications have been reordered.
14-mar-2024 7:18 pm atorvastatin calcium 40mg po tab medication is unavailable, reordered 3/13 (yesterday)
14-mar-2024 7:18 pm ferosul (m) 325mg po tab - unavailable, reordered 3/13 (yesterday)
14-mar-2024 7:18 pm metoprolol tartrate 25mg po tab - medication is unavailable, reordered 3/13 (yesterday)
17-mar-2024 9:46 am aspirin 81 mg - physically unable to take - med not here
18-apr-2024 7:17 pm latanoprost 0.005 % - unavailable
20-apr-2024 7:18 am aspirin 81 mg - med unavailable
21-apr-2024 7:13 am aspirin 81 mg - med unavailable

22-apr-2024 7:06 am aspirin 81 mg - med unavailable. family was notified a few days ago.
22-mar-2024 9:50 am hydrocortisone acetate 25mg re supp - medication unavailable

For the month of April, it was marked on the MAR that on several days (3-6, 9, 11-14, 16-20, 25, 29-30) Resident A refused to have the pain patch put on her.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	Based on the review of Resident A's medication administration record, Resident A did not receive her medications as prescribed. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The menu does not match the food being served, the food is not appropriate and is not a balanced diet.

INVESTIGATION:

The complaint alleged that the menu is never given out ahead of time and often get printed until halfway through the week. The complaint alleged that the menu does not match the food being served and it is not an appropriate or balanced diet. The complaint alleged that the residents are not given condiments. The complaint alleged that residents are not given proper utensils to eat and must share it since they are not given to all residents.

Employee #1 stated that everyone can't have a knife and staff cut it up for them. She stated that they have plenty of silverware available for the residents to use. She said that residents are given three meals a day. She said the menu are placed out weekly and they go by what's on the menu. She said that Resident A often requested different food than what's on the menu. She said that they give condiments to residents if they ask for it.
Employee #2 and Employee #3 statements were consistent to Employee #1 regarding the menu, the condiments and the silverware.

During the onsite, I observed residents eating in the dining room. Staff were in the dining room assisting residents. There were no issues noted. Food was served as printed on the posted menu.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(2) A home shall work with residents when feasible to accommodate individual preferences.
ANALYSIS:	The facility reasonably complied with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

11/12/2024

Brender Howard Date
Licensing Staff

Approved By:

11/12/2024

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