



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 15, 2024

Nimmy Cherian
Serenity At Walnut Creek
14666 Elrond Dr
Sterling Heights, MI 48313

RE: License #: AS500418238
Investigation #: 2024A0604026
Serenity At Walnut Creek

Dear Ms. Cherian:

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 (248) 975-5053.

Sincerely,

A handwritten signature in cursive script that reads "Kristine Cilluffo".

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
Detroit, MI 48202
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500418238
Investigation #:	2024A0604026
Complaint Receipt Date:	09/23/2024
Investigation Initiation Date:	09/23/2024
Report Due Date:	11/22/2024
Licensee Name:	Serenity At Walnut Creek
Licensee Address:	14666 Elrond Dr Sterling Heights, MI 48313
Licensee Telephone #:	(586) 229-3889
Administrator:	Nimmy Cherian
Licensee Designee:	Nimmy Cherian
Name of Facility:	Serenity At Walnut Creek
Facility Address:	49228 Walnut Creek Dr Macomb, MI 48044
Facility Telephone #:	(586) 846-3138
Original Issuance Date:	08/28/2024
License Status:	TEMPORARY
Effective Date:	08/28/2024
Expiration Date:	02/27/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED

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II. ALLEGATION(S)

	Violation Established?
There are shifts without staff at home.	No
Residents changed to another location without proper protocols.	No
Additional Findings	Yes

III. METHODOLOGY

09/23/2024	Special Investigation Intake 2024A0604026
09/23/2024	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Staff, Demetria Griggs. No residents in care.
09/23/2024	Contact - Document Sent Email to Licensee Designee, Nimmy Cherian, requesting documents
09/23/2024	Special Investigation Initiated - On Site Completed unannounced onsite investigation. Interviewed Staff, Demetria Griggs
09/24/2024	Contact - Document Received Received email from Nimmy Cherian. Received copy of resident register, staff list and schedule.
09/25/2024	Contact - Document Sent Email to Licensee, Nimmy Cherian
11/14/2024	Exit Conference Completed exit conference by phone with licensee designee, Nimmy Cherian

ALLEGATION:

- **There are shifts without staff at home.**
- **Residents changed to another location without proper protocols.**

INVESTIGATION:

I received a licensing complaint regarding Serenity at Walnut Creek on 09/23/2024. The Complainant alleged that at two visits, they had rung the bell and waited for more than 35 minutes and had to leave. There was no staff or owner at building. There are shifts with no staff at this location. Also, they have changed patients to another location without proper protocols. It is a real safety concern for patients.

On 09/23/2024, I completed an unannounced onsite investigation. I interviewed Staff, Demetria Griggs. Ms. Griggs stated that she is a Direct Care Staff/Live in Caregiver. Ms. Griggs stated that they had one resident in care. Resident A was on hospice and passed away on Friday. They currently have no residents. Ms. Griggs stated that the home does provide 24-hour care and supervision. She stated that staff, Angie, comes to relieve her when she is off. Ms. Griggs indicated that I could walkthrough home to confirm there were no residents. I completed a walkthrough of home with Ms. Griggs and did not see any residents or evidence of occupied bedrooms.

On 09/23/2024, I received an email from licensee designee, Nimmy Cherian. Ms. Cherian indicated that they have never ran a shift with no staff on site. She stated that they did move two residents from this location to Emily Drive location (Serenity Homes At Emily Drive AS500418365) on 08/15/2024, before their license was issued. Ms. Cherian indicated that the moves were authorized by power of attorney, hospice and providers. Ms. Cherian stated that since they have received their temporary license for Walnut Creek location, they had one resident and are open for tours and have been working with placement agencies for welcoming more residents. She stated that the resident they had just passed away Friday night. Ms. Cherian stated that the caregiver took a day off on Saturday and one of their staff gave a tour of the facility this Saturday. She stated they do have potential move ins this week and early next week.

On 09/24/2024, I received copy of resident register by email from licensee designee, Nimmy Cherian. The resident register indicates that Resident A was placed in the home from 09/03/2024- 09/20/2024. Resident A passed away on McLaren Hospice. There are no other residents listed on resident register. The licensee did report prior to licensure that they were operating with up to two residents. Serenity at Walnut Creek received temporary license on 08/28/2024.

APPLICABLE RULE	
R 400.14206	Staffing requirements.
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	There is not enough information to determine that there are shifts with no staff. On 09/23/2024, I completed an unannounced onsite investigation and found live in caregiver, Demetria Griggs was present. Ms. Griggs and licensee designee, Nimmy Cherian both indicated that there are always staff present at the home. However, there are currently no residents in care. The home has had one resident since receiving temporary license on 08/28/2024. Resident A was placed in the home from 09/03/2024- 09/20/2024 and passed away on hospice.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14302	Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.
	(6) A licensee shall not change the residency of a resident from one home to another without the written approval of the resident or the resident's designated representative and responsible agency.
ANALYSIS:	There is not enough information to determine that residents have been moved to another location without following proper protocols. Serenity at Walnut Creek received temporary license on 08/28/2024. The home has only had one resident in care since becoming licensed. Resident A was placed in the home from 09/03/2024- 09/20/2024.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 09/24/2024, I received copy of September 2024 staff schedule and staff list by email from licensee designee, Nimmy Cherian. The staff schedule lists one to two caregivers per day. However, the schedule does not include any hours or shifts worked for staff.

I completed an exit conference with licensee designee, Nimmy Cherian, by phone on 11/14/2024. I informed her of the violation found and that a copy of the special investigation report would be mailed once approved. I also informed her that a corrective action plan would be requested. Ms. Cherian again stated that there have not been any shifts without staff or moves without approval.

APPLICABLE RULE	
R 400.14208	Direct care staff and employee records.
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: (c) Hours or shifts worked.
	On 09/24/2024, I received copy of September 2024 staff schedule. The schedule does not include hours or shifts worked for staff.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

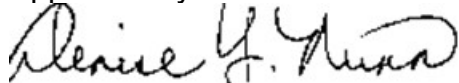


11/14/2024

Kristine Cilluffo
Licensing Consultant

Date

Approved By:



11/15/2024

Denise Y. Nunn
Area Manager

Date