GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 26, 2024

Daniel McNeill
PO Box 68
Fenton, MI 48430

RE: License #: AF250404622
Investigation #: 2025A0580002
Serenity Gardens

Dear Dan 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.
- 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) 643-7960.

Sincerely,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF250404622
Investigation #:	2025A0580002
Complaint Receipt Date:	10/01/2024
Investigation Initiation Date:	10/03/2024
Report Due Date:	11/30/2024
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 #:	(989) 271-6073
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?
Resident A eloped from the home. Resident B is intimidating and scaring citizens in the community.	No
Home accepted Resident A without any insurance information.	No
Additional Findings	Yes

III. METHODOLOGY

10/01/2024	Special Investigation Intake 2025A0580002
10/03/2024	Special Investigation Initiated - On Site Unannounced onsite.
10/07/2024	APS Referral Referral shared with APS.
10/07/2024	Comment Intake #202773 was received.
11/19/2024	Inspection Completed On-site Unannounced onsite.
11/19/2024	Contact - Face to Face Interview with Residents B-E.
11/22/2024	Contact - Telephone call made Call to Drake Dawson, CNS Healthcare
11/25/2024	Contact - Telephone call made Call to Resident A.
11/25/2024	Exit Conference Exit with licensee Dan McNeill.

ALLEGATION:

Resident A eloped from the home. Resident B is intimidating and scaring citizens in the community.

INVESTIGATION:

On 10/01/2024, I received a complaint via BCHS online complaint system.

On 10/03/2024, I conducted an unannounced onsite inspection at Serenity Gardens AFC. Contact was made with Home Manager (HM) Julie Davis, who stated that Resident A left to go for a walk, next thing she knows, Resident A was being brought back by the police. Resident A stated that Resident A did not want to be here at the home, so the police took Resident A with them. When she called the police station, she was told that Resident A had walked away. HM Davis began calling the hospitals as well as informing Resident A's case manager what was happening. Somehow Resident A ended up at Hurley Hospital. Hurley Hospital returned Resident A to the home. Staff Davis stated that Resident A does not have any supervision restrictions and is able to move about the community independently. Resident A attends dialysis 3 days a week and is currently at his dialysis appointment.

On 10/03/2024, Residents in the home were observed in the living room area of the home watching television, and/or utilizing personal tablets. They were adequately dressed and groomed. No concerns were noted. They appeared to be receiving proper care.

On 10/03/2024, while onsite, I reviewed the AFC Assessment plan for Resident A. The assessment plan indicates that Resident A does not require supervision while in the community. The incident report reviewed indicates that on 09/29/2024, at 1pm, the police showed up with Resident A, saying he was brought to the station by someone in town. Resident A stated that he did not want to be here so police took Resident A to the station. Resident A walked away from the police station. Resident A was later found at Hurley Hospital and was transported back to the AFC. Staff informed Resident A's case manager, Tanya Wade at CNS HealthCare of Oakland County, who informed her to make a missing person's report and to keep her updated. As a corrective measure, staff will remind Resident A not to wander off.

On 10/07/2024, I made a complaint to Adult Protective Services (APS). APS was informed of the allegations in this investigation.

On 11/19/2024, I conducted a follow-up unannounced onsite inspection at Serenity Gardens. Contact was made with HM Davis, who stated that Resident A had not had any additional incidents or complaints since the original allegations. Resident A is currently away at dialysis.

Regarding Resident B, HM Davis stated that the local store owner came to the AFC to inform Resident B that he is no longer allowed in the store. Resident B knows he is not allowed; however, Resident B continues to do so. Staff Davis stated that the case manager for Resident B has been made aware. The case manager will speak with Resident B

On 11/29/2024, while onsite, I interviewed Resident B regarding the allegations. Resident B began talking incoherently; however, Resident B denied messing with anyone in the neighborhood and denied that Resident B steals from the store adding that he does not go up there anymore.

On 11/29/2024, Resident C stated that he does not go into town much and when Resident C does, Resident C does so with staff. Resident C identified Resident B as the resident who bothers others while in the community.

On 11/29/2024, Resident D stated Resident D goes into town and does not have any problems. Resident D identified Resident B as the resident who is aggressive and belligerent while in the community. Resident D stated that Resident B also steals from the store.

On 11/29/2024, Resident E stated that every once in a while, Resident E goes to the store in town. Resident E stated that he can go to the store with no problem.

The assessment plans reviewed for Residents B-E indicates that each resident can go out in the community without supervision.

On 11/22/2024, I spoke with Drake Dawson, Case Manager Supervisor at CNS of Oakland County. Supervisor Dawson stated that he is aware of the events surrounding Resident A leaving the home when Resident A was initially placed, adding that since then Resident A has not had any known issues with eloping. Resident A is allowed unsupervised access to the community.

Supervisor Dawson further stated that he is 100% aware of the incidents surrounding Resident B and allegations that Resident B continues to cause trouble in the community. As a resolve, Supervisor Dawson will be submitting an expedited request for additional supervision for Resident B while in the community, which should be effective next week.

On 11/25/2024, I conducted a telephone interview with Resident A who stated that Resident A is doing ok in the home, adding that Resident A was afraid and in a confused state of mind when Resident A wandered off from the home. Resident A stated that Resident A made a mistake, the incident was a long time ago, and Resident A promises Resident A will not try leaving again. Resident A stated that he may go for a walk, however, Resident A doesn’t go to the store unless Resident A has some money. Resident A denied bothering people while out in the community.

On 11/25/2024, I spoke with licensee McNeill who stated that it is his understanding that on the day in question, Resident A left the home stating that he was going for a walk and was brought back to the home by the police. HM Davis reached out to the police department; they indicated that Resident A had walked off. Staff Davis began calling around to the local hospitals looking for Resident A and was initially told no, Resident A was not at Hurley Hospital, however, shortly thereafter Hurley Hospital contacted the AFC, indicating that Resident A was there and trying to obtain his medical information. Resident A was brought back from Hurley the same day.

Licensee McNeill stated that Resident B does not require any supervision and is not allowed in the local store. While Licensee McNeill has addressed Resident B's behavior concerns with Supervisor Dawson, he does believe that some of the complaints being made are frivolous, because oftentimes, the residents are on their own property. Licensee McNeill was informed that if he is not receiving the support needed from the placing agency, a 30-day discharge notice for Resident B may be required.

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:	It was alleged that Resident A eloped from the home and Resident B is intimidating and scaring citizens in the community. HM Julie Davis stated that Resident A stated that he did not want to be here at the home, so the police took him with them. Resident A eloped from the police station and A ended up at Hurley Hospital. Resident A's case manager was contacted and a missing person's report was filed. Resident A stated that he made a mistake, the incident was a long time ago, and he promises he won't try leaving again. Resident A stated that he may go for a walk, however, he doesn't go to the store unless he has some money. Resident A denied bothering people while out in the community. The incident report dated 09/29/2024 stated the police showed up with Resident A, saying he was brought to the station by someone in town. Resident A stated that he did not want to be

	here so police took him to the station. Resident A walked away from the police station. Resident A was later found at Hurley Hospital and was transported back to the AFC. The AFC Assessment plan for Resident A indicates that he does not require supervision while in the community. Drake Dawson, Case Manager Supervisor at CNS of Oakland County, stated that he is aware of the events surrounding Resident A leaving the home when he was initially placed, adding that since then Resident A has not had any known issues with eloping. Resident A is allowed unsupervised access to the community. Supervisor Dawson adds that he aware of the incidents surrounding Resident B and allegations that he continues to cause trouble in the community. As a resolve, he will be submitting an expedited request for additional supervision for Resident B while in the community. Resident B began denied messing with anyone in the neighborhood and denied that he steals from the store adding that he does not go up there anymore. The assessment plan for Residents B indicates that he can go out in the community without supervision. Licensee McNeill stated that Resident B does not require any supervision is not allowed in the local store. While he has addressed Resident B's behavior concerns with Supervisor Dawson, he does believe that some of the complaints being made are frivolous because residents are on their own property. Based on the interviews conducted and the documents reviewed, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Home accepted Resident A without any insurance information.

INVESTIGATION:

On 10/03/2024, I conducted an unannounced onsite inspection at Serenity Gardens AFC. Contact was made with the home manager Julie Davis who stated that Resident A

did not come to the home with a lot of information, however, she denies the allegations that she did not have his insurance information. Resident A was placed in the home on 09/19/2024 upon being released from psychiatric care.

On 10/03/2024, while onsite, I reviewed the Resident file belonging to Resident A. Resident A was placed in the home on 09/20/2024. The file contained a completed face sheet, with Medicaid listed as the health insurance as well as the Medicaid number. The September 2024 Medication Log for Resident A lists his medications, which he began receiving on 09/20/2024. The Health Care Appraisal on file was completed on 09/27/2024.

APPLICABLE RULE	
R 400.1422	**Resident records.**
	(1) A licensee shall complete and maintain a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication.** **(iv) Instructions for emergency care.**
ANALYSIS:	It was alleged that the home accepted Resident A without any insurance information. The resident file reviewed contained a completed face sheet, with Medicaid listed as the health insurance as well as the Medicaid number. The September 2024 Medication Log for Resident A lists his medications, which he began receiving on 09/20/2024. The Health Care Appraisal on file was completed on 09/27/2024. Based on the document reviewed in the resident file, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/03/2024, while onsite I observed medication for the residents evening medication in medication cups, prepared for passing. Staff Davis was informed that this is a licensing rule violation due to medication being required to remain in the original pharmacy supplied and pharmacy-labeled container.

On 11/25/2024, I conducted an exit conference with licensee, Dan McNeill. Mr. McNeill stated that he understands the reason for the violation and will ensure that medication remains in the original container per the licensing rule.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(5) Prescription medication shall be kept in the original pharmacy supplied and pharmacy-labeled container, stored in a locked cabinet or drawer, refrigerated if required, and labeled for the specific resident.
ANALYSIS:	Based on my observation of the medication for resident prepared in medication cups prior to being administered, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.

Sabrina McGowan November 26, 2024

Sabrina McGowan Date
Licensing Consultant

Approved By:

Mary Holton November 26, 2024

Mary E. Holton Date
Area Manager