GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 27, 2025

Daniela Popaj
Serene Gardens of Clarkston
5850 White Lake Rd
Clarkston, MI 48346

RE: License #: AH630396381
Investigation #: 2025A1019026

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.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630396381
Investigation #:	2025A1019026
Complaint Receipt Date:	01/15/2025
Investigation Initiation Date:	01/15/2025
Report Due Date:	03/14/2025
Licensee Name:	Clarkston Comfort Care, LLC
Licensee Address:	4180 Tittabawassee Rd Saginaw, MI 48604
Licensee Telephone #:	(989) 607-0001
Administrator:	Megan Rheingans
Authorized Representative:	Daniela Popaj
Name of Facility:	Serene Gardens of Clarkston
Facility Address:	5850 White Lake Rd Clarkston, MI 48346
Facility Telephone #:	(248) 418-4503
Original Issuance Date:	10/21/2021
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	58
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Timely care was not provided to Resident A following a fall.	Yes
There is a lack of heat in resident rooms and other areas are too warm.	No
Additional Findings	No

III. METHODOLOGY

01/15/2025	Special Investigation Intake 2025A1019026
01/15/2025	Special Investigation Initiated - Letter Emailed licensee AR requesting resident census.
01/15/2025	APS Referral
01/15/2025	Inspection Completed On-site
01/15/2025	Inspection Completed-BCAL Sub. Compliance

The complainant identified some concerns that were previously investigated under special investigation report (SIR) 2025A1035003; this report is only addressing new allegations. Additionally, the complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. 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.

ALLEGATION:

Timely care was not provided to Resident A following a fall.

INVESTIGATION:

On 1/15/25, the department received a complaint alleged that on 12/14/24, Resident A had a fall, and staff did not provide timely care to her.

On 1/15/25, I conducted an onsite inspection. I interviewed administrator Megan Rheingans and Employee 1 at the facility. Employee 1 reported that she just began working at the facility the week prior and was not employed with the licensee at the time of the incident but is aware that the incident occurred. Employee 1 reported that staff provided varying accounts of what occurred and that Employee 2 (who was directly involved) is no longer employed at the facility. Employee 1 reported that Resident A is totally alert and orientated and can accurately recall the events that occurred. The administrator reported that she did not observe the incident but was told by the former administrator that she observed on surveillance camera Employee 2 escorting Residents A and B to the dining room, and both residents were in their wheelchairs and being pushed by Employee 2 simultaneously. The administrator reported that she was informed that Resident A slid out of her wheelchair and onto the floor. The administrator reported that camera footage is only maintained for five days so they no longer have the recording of the fall. The administrator reported that she never watched the video surveillance and relied on staffs' attestations to determine what occurred. The administrator and Employee 1 both acknowledged that escorting two wheelchairs at the same time was not best practice and not what staff are trained to do.

While onsite, Employee 1 provided progress note documentation indicating that medical treatment was sought for Resident A on 1/2/25 [Is this date correct, 19 days after the incident, if it occurred on 12/14/2024]. The progress notes authored by Employee 2 read "*Emailed PCP about getting an xray out to xray residents knee."* and *"Mobile xray came today and took xray of residents knee*." Employee 1 and the administrator could not provide explanation as to why there was a delay in Resident A receiving medical treatment.

While onsite, Employee 1 provided me with an incident report for the fall. Employee 2 documented the following: *"Resident was being assisted down to dining room for lunch with another resident. Resident slid out of wheelchair and landed on floor. Only visible injury was bruise on left knee but staff is unsure if that was there before the incident. Resident was given ice pack and daughter was contacted*." The incident report included a witness statement from Employee 3 that read "*Resident was holding on to hoyer strap and when staff stopped resident slid out of chair and on to the floor. Resident stated she was okay and only visible injury was bruise on left knee."*

While onsite, Employee 1 provided me with progress note documentation for the fall. Employee 2 documented the following*: "Resident had a fall today while staff was wheeling resident to lunch. Resident grabbed another residents hoyer sling strap and pulled herself out of her wheelchair. Two staff members assisted resident back into wheelchair. Staff applied ice to residents left knee. Contacted POA but no answer. Resident stated she was okay and she refused to be sent out."*

While onsite, I interviewed Employee 3. Employee 3 reported that she was in the hallway at the med cart when Employee 2 was escorting Residents A and B to the dining room. Employee 2 reported that Resident A was holding onto the back of Resident B's wheelchair via a strap that the resident was sitting on from her hoyer lift and Employee 2 was pulling both wheelchairs at the same time. Employee 3 reported that she did not witness the fall, but heard Resident A scream, saw her on the floor and assisted her back into her wheelchair with the help of Employee 2. Employee 3 reported that Resident A complained of knee pain and that she was given an ice pack.

While onsite, I interviewed Resident A. Resident A reported that on 12/14/24, Employee 2 came to take her to lunch. Resident A reported that Employee 2 told her to hold onto the back of Resident B's wheelchair and began pulling both. Resident A reported that Resident B's wheelchair began getting too far in front of her, and instead of letting go of it, she tried to keep holding on and it eventually pulled her forward and onto the floor. Resident A reported that her knee instantly began to hurt and developed swelling and bruising. Resident A reported that staff gave her an ice pack but denied that anyone offered her medical attention. Resident A reported that she eventually had x-rays taken that were negative for a fracture, but that the doctor advised she could have a meniscus tear that would require and MRI for diagnosis. At the time of my inspection, Resident A was wearing a pain patch on her left knee. Resident A reported that there was still bruising and swelling present which couldn't be seen due to the patch. Resident A answered all questions appropriately upon interview and I found her to be a credible and reliable historian.

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:	Staff attestations reveal that Residents A and B were both escorted in their wheelchairs at the same time by Employee 2 on 12/14/24. This improper transfer and escorting technique contributed to Resident A falling and sustaining injury. Staff didn't complete adequate follow up on the incident, as evidenced by management failing to investigate the inconsistent staff statements provided in the incident report and progress note documentation and the administrator's failure to review the camera footage. Resident A denies being offered medical treatment timely (aside from being given an ice pack) and she was not medically evaluated until 19 days after the incident occurred on 1/2/25.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There is a lack of heat in resident rooms and other areas are too warm.

INVESTIGATION:

On 1/15/25, the department received a complaint that read **"***Most of the residents don't have heat in the rooms and the heat is stuck in the hallways and won't go down it's stuck on 90 in some areas*". Due to the anonymous nature of the complaint, additional information could not be obtained.

Employee 1 reported that to her knowledge, on 1/13/25 the heat began to malfunction in the 300 hallway and affected five resident rooms. Employee 1 reported that maintenance staff immediately contacted an HVAC repair company to come out. Employee 1 reported that as of 1/14/25 all repairs have been made.

The administrator/AR reported that on 1/9/25, she was informed by the activities director that there were heating issues in the building. The administrator/AR reported that she contacted Employee 4, who has oversight of maintenance department for the licensee. The administrator/AR reported that Employee 4 contacted Property Monkey Heating and Cooling who completed a service call the same day.

Employee 4 was not present during my onsite but submitted a timeline of events that read:

1/9/25

- *Megan Rheingans notified about heating issues in resident rooms.*
- *Megan Rheingans notified [Employee 2].*
- *[Employee 2] contacted Property Monkey to address the issue.*

- *Property Monkey assessed the rooms and was able to fix some of the affected rooms. For the final rooms it was determined an additional part was needed.*

1/9/25-1/14/25

- *Temperatures in affected rooms were monitored hourly.*
- *Doors to rooms were left open to allow heat circulation.*
- *Hallway temperatures were raised to help maintain comfort for residents.*

1/14/25

- *Property Monkey returned to complete repairs and resolve the final heating concerns.*

During my onsite, I toured the entire facility, observing thermostat temperatures in all common areas and affected resident rooms. The temperatures were all observed to be at a safe and comfortable level, mostly between 72-78 degrees Fahrenheit. I did not observe any area of the facility to be any warmer than 78 degrees and no thermostats were set to 90 degrees as the complaint alleges.

In follow up correspondence with the licensee, I was provided documentation from Property Monkey Heating and Cooling demonstrating the service call on 1/9/25 and subsequent repairs completed on 1/14/25.

APPLICABLE RULE	
R 325.1973	**Heating.**
	(1) A home shall provide a safe heating system that is designed and maintained to provide a temperature of at least 72 degrees Fahrenheit measured at a level of 3 feet above the floor in rooms used by residents. **(2) A resident's own room or rooms in the home shall be maintained at a comfortable temperature.**
ANALYSIS:	While there was a malfunction to the facility's HVAC system, it was an unforeseen incident and facility staff responded timely and appropriately to rectify the situation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

01/21/2025

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

01/24/2025

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