GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 9, 2024

Lawrence Ragnone
1839 S. Almont Ave. LLC
780 Sycamore Dr.
Owosso, MI 48867

RE: License #: AL440411397
Investigation #: 2024A0569039
Serene Gardens of Imlay City II

Dear Lawrence Ragnone:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL440411397
Investigation #:	2024A0569039
Complaint Receipt Date:	05/17/2024
Investigation Initiation Date:	05/20/2024
Report Due Date:	07/16/2024
Licensee Name:	1839 S. Almont Ave. LLC
Licensee Address:	780 Sycamore Dr. Owosso, MI 48867
Licensee Telephone #:	(810) 241-4084
Administrator:	Amada Kipke
Licensee Designee:	Lawrence Ragnone
Name of Facility:	Serene Gardens of Imlay City II
Facility Address:	1839 S. Almont Imlay City, MI 48444
Facility Telephone #:	(989) 721-7131
Original Issuance Date:	03/01/2022
License Status:	REGULAR
Effective Date:	09/01/2022
Expiration Date:	08/31/2024
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
• **Resident A was given another resident's medications on 5/13/24.**	Yes

III. METHODOLOGY

05/17/2024	Special Investigation Intake 2024A0569039
05/20/2024	APS Referral complaint to APS.
05/20/2024	Special Investigation Initiated - Letter Email to ORR.
07/02/2024	Inspection Completed On-site
07/02/2024	Contact - Telephone call made Contact with Guardian.
07/02/2024	Inspection Completed-BCAL Sub-compliance
07/09/2024	Exit Conference Exit conference with Amanda Kipke, facility manager and Lawrence Ragnone.

ALLEGATION:

Resident A was given another resident's medications on 5/13/24.

INVESTIGATION:

This complaint was received via the on-line complaint portal. The complainant reported that on 5/13/24, Resident A was accidentally administered another resident's medication. The complainant reported that the incident was reported to Amanda Kipke, administrator, but there was no follow up with Resident A's physician.

An unannounced inspection of this facility was conducted on 7/2/24. Resident A was observed to be appropriately dressed and groomed with no visible injuries. Resident A was not aware that she had been given incorrect medication on 5/13/24. Resident A's file contains an incident report (IR) dated 5/13/24. The IR documents that staff administered Resident A another resident's medication. The IR documents that the error was immediately reported to Amanda Kipke and Resident A's physician was contacted for instructions. The IR documents that the corrective measures were to remove the staff person from administering medications and the staff received a "write up". Resident A's file contains documentation from her physician confirming that staff contacted the physician on 5/13/24 to report the medication error. The document confirms that Resident A was given a blood thinner that she normally does not take. The physician order documents that staff were to monitor Resident A for any adverse reactions, and if a reaction is noted, to seek immediate medical attention. Resident A's medication administrator record (MAR) was reviewed. Resident A's MAR documents that she was given her prescribed medications on 5/13/24 and the medication error is also noted.

Amanda Kipke, administrator, stated on 7/2/24 that Resident A was given a dose of a blood thinner that was not prescribed to her on 5/13/24. Amanda Kipke stated that the staff person who was administering medications became distracted and accidentally gave Resident A the medication. Amanda Kipke stated that the mistake was reported to her immediately, so she called Resident A's physician to report the error. Amanda Kipke stated that she was instructed to take Resident A's vitals and monitor her for three days to determine if Resident A suffered any side effects. Amanda Kipke stated that Resident A did not have any negative side effects from taking the blood thinner.

Resident A's guardian (Guardian) stated on 7/2/25 that she was notified of the medication error. Guardian stated that Amanda Kipke did follow up immediately with Resident A's physician and Resident A did not have any side effects from the error. Guardian stated that she does not have any concerns regarding Resident A's care at this facility.

An exit conference was conducted with Amanda Kipke, administrator, and Lawrence Ragnone, licensee designee on 7/9/24. Amanda Kipke stated that the staff person involved has received a written disciplinary action, was taken off of medication

administration, and will receive a re-training in medication administration. A corrective action plan was requested and will be submitted.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	The complainant reported that Resident A was given a medication not prescribed to her in error on 5/13/24 and that there was no follow up with Resident A's physician. Resident A's file contains physician orders documenting that Amanda Kipke immediately contacted Resident A's physician and followed the orders given. Amanda Kipke stated that she did follow up with Resident A's physician and that Resident A did not experience any negative side effects. Guardian stated that she did not have any concerns regarding Resident A's care. Based on the documentation reviewed and statements given, it is determined that there is a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

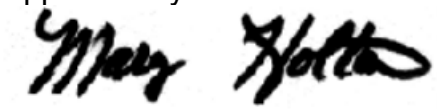
IV. RECOMMENDATION

I recommend that the status of this license remain unchanged and this investigation be closed with the receipt of an acceptable corrective action plan.

7/9/24

Kent W Gieselman Date
Licensing Consultant

Approved By:



7/9/24

Mary E. Holton Date
Area Manager