



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 31, 2025

Megan Rheingans
Serene Gardens of Clarkston
5850 White Lake Rd
Clarkston, MI 48346

RE: License #: AH630396381
Investigation #: 2025A0585065
Serene Gardens of Clarkston

Dear Ms. Rheingans:

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) 335-5985.

Sincerely,

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 #:	AH630396381
Investigation #:	2025A0585065
Complaint Receipt Date:	07/02/2025
Investigation Initiation Date:	07/03/2025
Report Due Date:	09/01/2025
Licensee Name:	Clarkston Comfort Care, LLC
Licensee Address:	4180 Tittabawassee Rd Saginaw, MI 48604
Licensee Telephone #:	(989) 607-0001
Authorized Representative/ Administrator:	Megan Rheingans
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	58
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's toenails are overgrown.	No
Additional Findings	Yes

III. METHODOLOGY

07/02/2025	Special Investigation Intake 2025A0585065
07/03/2025	Special Investigation Initiated - Telephone I made a referral to Adult Protective Services (APS).
07/11/2025	Inspection Completed On-site Completed with observation, interview and record review.
07/11/2025	Inspection Completed-BCAL Sub. Compliance
07/31/2025	Exit Conference Conducted via email to authorized representative Megan Rheingans.

ALLEGATION:

Resident A's toenails are overgrown.

INVESTIGATION:

On 06/29/2025, the licensing department received a complaint via BCHS online complaint. The complaint alleged that Resident A's toenails are long, and staff are not attending to them.

On 07/11/2025, I spoke to the complainant by telephone. The complainant stated that this complaint has been resolved, and Resident A has his nails cut now. She said, the facility now has the podiatrist coming every other month.

On 07/11/2025, an onsite visit was completed. The administrator was not there during this time. I spoke to Employee #1 who stated that the podiatric comes to cut the nails of the residents.

During the onsite visit, I spoke to Employee #2 who stated that the podiatric come every 2 – 3 months and as needed. Employee #2 stated that staff are not allowed to cut the nails of the residents and only the podiatric could do that.

During the onsite visit, I spoke to the director Jessica Sherbino by telephone. She stated, a podiatric come to the facility every 2 ½ months to care for the nail needs of the residents. She stated that caregivers are not allowed to cut the residents' nails.

APPLICABLE RULE	
R 325.1933	Personal care of residents.
	(1) A home shall provide a resident with necessary assistance with personal care such as, but not limited to, care of the skin, mouth and teeth, hands and feet, and the shampooing and grooming of the hair as specified in the resident's service plan.
ANALYSIS:	<p>The complaint alleged Resident A toenails were overgrown.</p> <p>Based on an interview with the complainant, this complaint has been resolved and there is a podiatrist to care for the residents' nails.</p> <p>Therefore, this complaint could not be substantiated.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite visit, the administrator was not there at that time. Upon arrival, I asked for the person in charge of the facility. The receptionist at the front desk said that she didn't know who was in charge, but she would get a caregiver. I spoke to Employee #1 who stated there was no lead on duty. She said normally there is a supervisor on every shift, but they didn't have one today. She said that if an emergency arises, they will call the director.

The complaint stated that no one seems to be in charge these days at the facility and there is no follow-up.

The director stated she is on call, and she had just left the building. She said there is no supervisor on duty today, but they normally have one.

Employee #2 and Employee #3 stated there is not supervisor on duty today.

APPLICABLE RULE	
R 325.1931	Employees; general provisions.
	(3) The home shall designate 1 person on each shift to be supervisor of resident care during that shift. The supervisor of resident care shall be fully dressed, awake, and on the premises when on duty.
ANALYSIS:	There was not a supervisor on shift during the onsite visit and no one seemed to know who was in charge. Therefore, the facility did not comply with this rule.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 325.1931	Employees; general provisions.
	(4) The supervisor of resident care on each shift shall do all of the following: (a) Assure that residents are treated with kindness and respect. (b) Protect residents from accidents and injuries. (c) Be responsible for safety of residents in case of emergency.
ANALYSIS:	There was no supervisor to assure that residents are treated with kindness and respect, or to protect residents from accidents and injuries and be responsible for the safety of residents in case of emergency. Therefore, the facility did not comply with this rule.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Brender d. Howard

07/31/2025

Brender Howard
Licensing Staff

Date

Approved By:

Andrea L. Moore

07/31/2025

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

Date