



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 24, 2025

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

RE: License #: AH630396381
Investigation #: 2025A0784086
Serene Gardens of Clarkston

Dear Megan Rheingans :

Attached is the Special Investigation Report for the above-mentioned 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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "Aaron Clum".

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

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

I. IDENTIFYING INFORMATION

License #:	AH630396381
Investigation #:	2025A0784086
Complaint Receipt Date:	09/19/2025
Investigation Initiation Date:	09/19/2025
Report Due Date:	11/18/2025
Licensee Name:	Clarkston Comfort Care, LLC
Licensee Address:	4180 Tittabawassee Rd Saginaw, MI 48604
Licensee Telephone #:	(989) 607-0001
Administrator/ Authorized Representative:	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?
Inadequate supervision	Yes
Additional Findings	No

III. METHODOLOGY

09/19/2025	Special Investigation Intake 2025A0784086
09/19/2025	Special Investigation Initiated - Telephone Interview with complainant
09/19/2025	Contact - Telephone call made Interview with administrator Megan Rheingans
09/19/2025	Contact - Document Sent Email sent to administrator with request for investigative documentation/information
09/22/2025	Contact - Document Received Email received from administrator with requested documents
11/24/2025	Exit - Email Report sent

ALLEGATION:

Inadequate supervision

INVESTIGATION:

On 9/19/2025, the department received this complaint.

According to the complaint, Resident A was brought a cup of hot tea that was spilled on his lap resulting in second degree burns on his legs and groin. Resident A has since passed away.

On 9/19/2025, I interviewed complainant by telephone. Complainant stated the incident happened on 7/18/2024. Complainant stated Resident A was brought a cup of a tea to his room which was placed next to him on a table while he was in bed.

Complainant state Resident A attempted to drink the tea and spilled it on himself causing the burns due to the tea being so hot. Complainant stated Resident A did not require assistance to drink from a cup but felt he should not have been given tea so hot it caused second degree burns. Complainant stated the staff member who placed the tea next to Resident A admitted setting it there. Complainant could not recall the staff members name.

On 09/19/2025, I interviewed administrator Megan Rheingans by telephone. Administrator stated she was not serving as the administrator at the time of the incident. Administrator stated the staff member involved, staff 1, no longer works with the community and that Resident A passed away a few weeks after the incident. Administrator stated she would provide any documentation regarding the incident.

I reviewed the facilitates incident report, provided by administrator, pertaining to Resident A and the incident in question. The report indicated an incident date of 7/18/2024 at 5:30pm. Under a section titled *What happened:* the report read "Residents pendent was going off and when staff walked in residents meal tray was tipped over on residents lap. Resident had hot tea that was spilled on thighs. Staff put resident in bed and cleaned resident up. Staff called hospice and followed directions per hospice. Staff was told by hospice to apply burn cream to affected area:. Under a section titled *Determined cause,* the report read "Resident stated he hit his meal tray causing it to tip over onto his lap which made the hot tea tip over on to lap as well. Resident has burns from the tea on thighs and genital area. Hospice burn cream to apply on burns".

I reviewed hospice *Visit Notes* for Resident A, provided by administrator. Notes dated 7/18/2025 read, in part, "On call notification received stating that the patient has suffered significant burns after spilling hot tea on his lap. On call RNCM contacted facility and spoke with med tech. Writer (on call RN) was informed that the facility applied burn cream to the patients burns on his thighs and that the burns "were blistering but aren't bad". Upon arrival the patient was found lying in his bed with 2nd degree burns on his bilateral top and inner thighs. The patient states that he is very uncomfortable as he "now can't sit on his butt" due to positionings of his burns. "burn cream " noted to be burn spray with lidocaine OCT. Facility staff report that the patient requested to have hot tea and that caregivers were "doing what he asked". Staff stated that they provided dinner to the patient shortly before RNCM received notification from on-call services and that a med passer noticed the patient call light was on and went in to find him "covered in Jell-o, his dinner and his pants were all wet". Caregivers state that he did not immediately verbalized his pain or the burns and that they were unaware until 2-3 minutes of being with patient. Caregiving staff stated that they immediately transferred the patient to his bed to attempt to complete an assessment and wound care. Writer provided extensive education regarding appropriate temperatures for liquids when feeding patients. Writer informed caregiving staff that the patient is not physically capable of handling a cup without a lid and should not have fluids that are boiling/scalding under any circumstances. Caregiving staff verbalized understanding. The patient stated that he

did ask for hot tea, but “didn’t ask for boiling water” and remarked that he “didn't know why the staff wouldn't open the top to cool it off”.

APPLICABLE RULE	
R 325.1931	Employees; general provisions.
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	The complaint alleged Resident A suffered second degree burns on his legs and groin due to staff inappropriately leaving scolding hot tea on a tray by his bed. Based on the findings, the allegation is supported.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L. Clum

11/12/2025

Aaron Clum
Licensing Staff

Date

Approved By:

Andrea L. Moore

11/24/2025

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

Date