



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

February 24, 2026

Morgan Bailey  
Serenity Homes - North, L.L.C.  
747 Tamarack Ave NW  
Grand Rapids, MI 49504

RE: License #: AL700382076  
Investigation #: 2026A0467015  
Serenity Homes - North

Dear Ms. Bailey:

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 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 (616) 356-0100.

Sincerely,

A handwritten signature in cursive script that reads "Anthony Mullins".

Anthony Mullins, Licensing Consultant  
Bureau of Community and Health Systems  
Unit 13, 7th Floor  
350 Ottawa, N.W.  
Grand Rapids, MI 49503

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AL700382076
<b>Investigation #:</b>	2026A0467015
<b>Complaint Receipt Date:</b>	02/13/2026
<b>Investigation Initiation Date:</b>	02/13/2026
<b>Report Due Date:</b>	04/14/2026
<b>Licensee Name:</b>	Serenity Homes - North, L.L.C.
<b>Licensee Address:</b>	747 Tamarack Ave NW Grand Rapids, MI 49504
<b>Licensee Telephone #:</b>	(419) 494-4008
<b>Administrator:</b>	Morgan Bailey
<b>Licensee Designee:</b>	Morgan Bailey
<b>Name of Facility:</b>	Serenity Homes - North
<b>Facility Address:</b>	830 Hayes Street Marne, MI 49435
<b>Facility Telephone #:</b>	(616) 677-6015
<b>Original Issuance Date:</b>	06/02/2016
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/26/2024
<b>Expiration Date:</b>	09/25/2026
<b>Capacity:</b>	20
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A did not receive his medications as prescribed around Thanksgiving 2025. There are concerns that he missed his scheduled medications on other days as well.	Yes
Additional Findings	Yes

**III. METHODOLOGY**

02/13/2026	Special Investigation Intake 2026A0467015
02/13/2026	Special Investigation Initiated - Letter Email sent to complainant
02/13/2026	APS Referral Ottawa County APS worker Emily Fewless is assigned
02/17/2026	Inspection Completed On-site
02/24/2026	Exit conference completed with licensee designee, Morgan Bailey

**ALLEGATION: Resident A did not receive his medications as prescribed around Thanksgiving 2025. There are concerns that he missed his scheduled medications on other days as well.**

**INVESTIGATION:** On 2/13/26, I received a complaint through LARA-BCHS online system. The complaint alleged that around Thanksgiving 2025, Resident A did not receive his prescribed medication for more than four days due to a communication issue with the pharmacy. According to the complaint, this lapse reportedly resulted in increased symptoms of tardive dyskinesia, which is described as involuntary movements. The complaint also expressed concern about additional missed medications following Thanksgiving.

On 2/17/26, I conducted an unannounced onsite investigation at the facility. Upon arrival, introductions were made with home manager, Kayla Bailey and direct care worker Kimmy Doctor. During the interview, Ms. Bailey confirmed that there had been an issue with Resident A missing medications around Thanksgiving. She explained that staff at Long Term Care (LTC) Pharmacy attempted to deliver the medication order early to ensure delivery prior to the holiday. However, despite this, the medications were delivered late due to a snowstorm. As a result, Resident A did not receive his prescribed medication for what Ms. Bailey described as “a couple of days.” She was unable to provide an exact number of days but estimated it to be approximately two days.

Ms. Bailey stated that she did not personally observe any additional symptoms of tardive dyskinesia for Resident A during this time period. However, she acknowledged that missing doses of Austedo XR, the medication prescribed to treat tardive dyskinesia, could have contributed to an increase in symptoms.

During the same timeframe listed above, Resident A was on an approved leave of absence with his mother from 11/26/25 and returned to the home on 11/30/25. According to Ms. Bailey, Resident A’s mother was expected to return him to receive additional medication prior to running out. However, she did not return him as planned, which also contributed to a lapse in medication.

While interviewing Ms. Bailey, I requested Resident A’s medication administration records (MARs) from November 2025 through present. A review of the November 2025 MAR showed that Resident A did not receive several prescribed medications on 11/21/25, including Cardura, Toprol XL, Thera M Plus and Neurontin.

Further review of Resident A’s MARs confirmed additional missed doses in subsequent months. The January 2026 MAR indicated that Resident A missed one or more doses of multiple medications, including Doxazosin, Finasteride, Gabapentin, Metoprolol, Quetiapine, Atorvastatin, Vitamin D, Thera M Plus, Austedo XR, and Breztri Aerosphere inhaler. The February 2026 MAR reflected similar patterns, with missed doses of the same medications except for the inhaler.

On 02/24/26, I conducted an exit conference with licensee designee, Morgan Bailey. She was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of this report.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.</b>
<b>ANALYSIS:</b>	Resident A’s MARs from November 2025 through February 2026 indicated that he did not receive multiple doses of medications. Some of the explanations given were “out of stock”, “out of medication”, “not in med cart” and “other”. Therefore, there is a preponderance of evidence to support this applicable licensing rule violation.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDING:**

**INVESTIGATION:** While investigating the allegation listed above, I reviewed Resident A's MARs from November 2025 through February 2026. In doing so, I observed that Resident A's MAR was not initialed by the staff members responsible for passing the medications. The days of the missed staff initials varied, but the medications included the following: Doxazosin Mesylate 1MG, Finasteride 5MG, Gabapentin 300MG, Metoprolol Succinate ER 50MG, Quetiapine Fumarate ER 40MG, Atorvastatin Calcium 40MG, Vitamin D, Thera M Plus, Austedo XR, and Breztri Aerosphere.

On 02/24/26, I conducted an exit conference with licensee designee, Morgan Bailey. She was informed of the investigative findings and agreed to complete a corrective

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<p><b>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</b></p> <ul style="list-style-type: none"> <li><b>(a) Be trained in the proper handling and administration of medication.</b></li> <li><b>(b) Complete an individual medication log that contains all of the following:</b> <ul style="list-style-type: none"> <li><b>(i) Medication name.</b></li> <li><b>(ii) Dosage.</b></li> <li><b>(iii) Label instructions for use.</b></li> <li><b>(iv) Time to be administered.</b></li> <li><b>(v) Initials of the individual who administered the medication at the time given.</b></li> <li><b>(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.</b></li> </ul> </li> </ul>
<b>ANALYSIS:</b>	Resident A's MAR was not initialed on several days from November 2025 through present as required per licensing rules. This also makes it difficult to confirm if the medications were ever received. Based on the information provided, there is a preponderance of evidence to support this applicable licensing rule violation.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.

Anthony Mullins

02/24/2026

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Anthony Mullins  
Licensing Consultant

Date

Approved By:

Jerry Hendrick

02/24/2026

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Jerry Hendrick  
Area Manager

Date