GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 1, 2026

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

RE: License #: AL700382076
Investigation #: 2026A0467039
Serenity Homes - North

Dear Mrs. Turner:

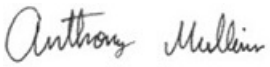
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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,



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

License #:	AL700382076
Investigation #:	2026A0467039
Complaint Receipt Date:	06/01/2026
Investigation Initiation Date:	06/05/2026
Report Due Date:	07/31/2026
Licensee Name:	Serenity Homes - North, L.L.C.
Licensee Address:	747 Tamarack Ave NW Grand Rapids, MI 49504
Licensee Telephone #:	(419) 494-4008
Administrator:	Morgan Turner
Licensee Designee:	Morgan Turner
Name of Facility:	Serenity Homes - North
Facility Address:	830 Hayes Street Marne, MI 49435
Facility Telephone #:	(616) 677-6015
Original Issuance Date:	06/02/2016
License Status:	1ST PROVISIONAL
Effective Date:	06/18/2026
Expiration Date:	12/17/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is not receiving his medications as prescribed.	Yes

III. METHODOLOGY

06/01/2026	Special Investigation Intake 2026A0467039
06/01/2026	APS Referral Complaint received from Ottawa County APS
06/05/2026	Special Investigation Initiated - On Site
06/08/2026	Contact – telephone call made to AFC staff member Rashida Brown
07/01/2026	Contact – email received from AFC staff member Kayla Bailey
07/01/2026	Contact – telephone call received from AFC staff member Kayla Bailey
07/01/2026	Exit conference with licensee designee Morgan Turner and chief operations officer Jess Engstrom

ALLEGATION: Resident A is not receiving his medications as prescribed.

INVESTIGATION: On 06/01/26, I received a complaint from Ottawa County Adult Protective Services (APS) alleging that Resident A was not receiving his medications as prescribed. The complaint stated his nebulizer treatment was not provided on 05/28/26 and that he was receiving more oxygen than order.

On 06/05/26, I conducted an unannounced onsite investigation at the facility. Upon arrival, I spoke with staff member Kimberly Doctor regarding the allegation. Ms. Doctor confirmed that Resident A is prescribed a nebulizer and stated that she attempted to administer it “sometime this week.” However, she reported the machine could not be used because a part was missing. According to Ms. Doctor, the missing part was later found under Resident A’s bed, and to her knowledge, all other prescribed doses were administered. She denied any knowledge of staff failing to provide the nebulizer as ordered but noted Resident A has refused it “a few times.”

Regarding Resident A’s oxygen, Ms. Doctor confirmed that his oxygen level had recently been set to 10 liters via nasal cannula, despite his prescribed range being 2 to 5 liters. A setting of 10 liters indicates that he was receiving more than twice the ordered amount. Ms. Doctor stated that Resident A is currently receiving Hospice services through Elara Caring and she is unsure whether hospice was notified of the

oxygen increase. She also does not know how or why the setting was changed to 10 liters. Ms. Doctor reported that Resident A did not require hospitalization and that facility staff are responsible for adjusting his oxygen levels. Ms. Doctor also confirmed that Resident A recently had dried blood in his oxygen tubes.

I then spoke with home manager Kayla Bailey, who confirmed that Resident A is prescribed a nebulizer “around the clock.” She explained that her 3rd shift employee, Lisa VanWyk is still learning the Medication Administration Record (MAR) system and was unsure how to proceed when Resident A was asleep. As a result, Ms. VanWyk did not administer the nebulizer because she did not want to wake him. Ms. Bailey stated that aside from this incident, she believes Resident A has received his nebulizer treatments as prescribed.

Ms. Bailey confirmed that she signed his oxygen safety agreement on 05/29/26 with Elara Caring Hospice, which is when he began receiving oxygen in the facility. She stated that according to the Hospice nurse, Resident A is prescribed 2 to 5 liters via nasal cannula for an Sp02 below 88 and as needed for comfort. Ms. Bailey showed proof of a text message conversation from the hospice nurse to verify this information. She also reported that on 06/01/26, when Resident A’s oxygen was set to 10 liters, he was not wearing his nasal cannula.

Ms. Bailey explained that on 06/01/26 at 4:22am, staff member Zachary Pickett sent a text message to the staff group chat showing a picture of Resident A’s oxygen tubing with dried blood inside. Later that morning, staff member Rashida Brown noticed that Resident A’s oxygen concentrator was set to 10 liters, although it was not connected to him. Before placing the nasal cannula back on Resident A, Ms. Brown reduced the oxygen setting to 2 liters, consistent with the prescribed range. Ms. Bailey stated she does not know who increased the oxygen to 10 liters, only that it occurred sometime between 05/29/26 and when Ms. Brown discovered it on 06/01/26. Following the incident, Ms. Bailey held a staff meeting to reinforce that employees must verify oxygen settings prior to administering it to Resident A. She stated that Hospice was not notified because staff had already corrected the issue, including cleaning the oxygen tubing.

Prior to concluding my onsite investigation, Ms. Bailey provided copies of Resident A’s MAR for May and June 2026. I reviewed the MARS and confirmed that in May he missed at least one to two doses of the following medications: 2 doses of the following medications: Carbidopa Anhydr/Levodop 25MG, Melatonin 5mg, Stool softner 50mg, trazadone 50mg, and albuterol nebulizer 0.083. Through June 5th, 2026, Resident A had missed at least one dose of Senna Plus 8.6-50mg and albuterol. The MAR did not contain any documentation related to his oxygen.

On 06/08/26, I spoke with staff member Rashida Brown regarding the allegation. Ms. Brown could not recall the exact date, but she stated she observed Resident A’s oxygen set to 10 liters when she entered his room. She first administered Resident A’s nebulizer as prescribed, then confirmed that his oxygen tubing was not

connected. As she attempted to plug in the oxygen concentrator, she noticed the setting at 10 liters and immediately reduced it to 2 liters before applying it to Resident A. Ms. Brown reported that she notified her manager Ms. Bailey immediately. She stated she does not know who increased the oxygen to 10 liters and suggested it is possible that Resident A adjusted it himself while trying to disconnect it. Ms. Brown denied seeing any blood in the oxygen tubing during this incident and noted that Resident A's presentation appeared "normal," with no signs of distress.

On 06/25/26, I spoke with Janae Porter, Hospice nurse from Elara Caring. Ms. Porter stated that she began weekly visits with Resident A in April, and as of this week, her nursing visits have increased to twice per week. She reported positive working relationships with staff at Serenity Homes – North AFC, noting that they follow instructions, seek clarification when needed, and request medication refills promptly. Ms. Porter confirmed that Resident A's original oxygen order was 2 to 5 liters as needed to maintain an oxygen saturation above 88. That order was discontinued today. The new order is "3 liters nasal cannula continuous at baseline," with staff being able to titrate up to 10 liters via nasal cannula as needed to "rescue him." Ms. Porter was not aware of any blood found in Resident A's tubing, but she stated that Ms. Bailey requested new tubing for him on 06/05/26.

On 06/25/26, I also spoke to Rachel Caron, social worker through Elara Caring Hospice. Ms. Caron confirmed that Resident A signed-on to hospice on 04/16/26 and that she has been visiting him monthly. We discussed Resident A's end-of-life care, including the hospice physician's plan to prescribe one 8 oz beer per day per Resident A's request. Ms. Caron stated that staff will be responsible for tracking this. She reported no concerns regarding the care Resident A has received at the home.

On 07/01/26, I received an email and text message from Ms. Bailey containing an updated MAR that included Resident A's oxygen listed on it. The MAR indicated that Resident A had been ordered three liters scheduled and four to ten liters as needed to maintain an oxygen saturation above 90 perfect. She also provided a document that showed Resident A's oxygen saturation and his machine flow rate from 06/07/26 through 06/25/26 when he was ordered between 2 to 5 liters. However, Resident A began receiving oxygen on 05/29/26 and there is no documentation to confirm how much oxygen he received from 05/29/26 through 06/06/26.

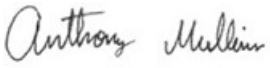
On 07/01/26, I received a call from staff member Kayla Bailey. Ms. Bailey reported that she was at the home with Hospice nurse Ms. Porter and that Resident A had been pronounced deceased at 12:17pm. Ms. Bailey stated she would be contacting all necessary parties. It should be noted that Resident A's death was expected.

On 07/01/26, I conducted an exit conference with licensee designee Morgan Turner and chief operations officer Jess Engstrom. They were informed of the investigative findings and agreed to complete a Corrective Action Plan within 15 days of receiving this report.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Resident A's MAR confirmed that he did not receive his albuterol and other prescribed medications as ordered. The MAR also showed that staff were not properly documenting the amount of oxygen administered to Resident A. Based on the information obtained, there is a preponderance of evidence to support this applicable licensing rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

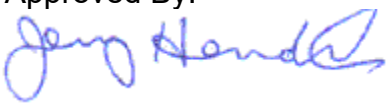
The rule violation cited in this report occurred prior to the receipt of a Corrective Action Plan in response to SIR #2026A0467030, which resulted in a recommendation and issuance of a Provisional License. Therefore, upon receipt of an acceptable corrective action plan, I recommend that the license remain on its current provisional status, which is valid through 12/17/2026.



07/01/2026

Anthony Mullins Date
Licensing Consultant

Approved By:



07/01/2026

Jerry Hendrick Date
Area Manager