GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 23, 2022

Daniel McNeill
PO Box 68
Fenton, MI 48430

RE: License #: AF250404622
Investigation #: 2022A0576016
Serenity Gardens

Dear Mr. McNeill:

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:

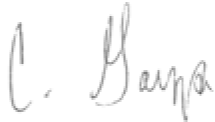
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance 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.

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.

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) 284-9730.

Sincerely,



Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF250404622
Investigation #:	2022A0576016
Complaint Receipt Date:	12/27/2021
Investigation Initiation Date:	12/28/2021
Report Due Date:	02/25/2022
Licensee Name:	Daniel McNeill
Licensee Address:	110 Lansing St. Gaines, MI 48436
Licensee Telephone #:	(810) 931-8466
Name of Facility:	Serenity Gardens
Facility Address:	110 Lansing St. Gaines, MI 48436
Facility Telephone #:	(810) 931-8644
Original Issuance Date:	08/27/2020
License Status:	REGULAR
Effective Date:	02/27/2021
Expiration Date:	02/26/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A went missing from the facility due to neglect from the owner and staff improperly monitoring their residents.	Yes
Upon staff discovering Resident A left the home, they did not commence a search for Resident A or contact law enforcement until hours later.	No
Additional Findings	Yes

III. METHODOLOGY

12/27/2021	Special Investigation Intake 2022A0576016
12/28/2021	Special Investigation Initiated - Telephone Interviewed Complainant
12/28/2021	APS Referral Made referral to Adult Protective Services (APS)
01/14/2022	Contact - Face to Face Unsuccessful On-Site contact
02/17/2022	Inspection Completed On-site Interviewed Staff, Roseanna Gibson, Resident A, Resident B, and Licensee, Dan McNeil
02/17/2022	Contact - Telephone call made Interviewed Liz Hering, Resident A's guardian office
02/22/2022	Exit Conference Exit Conference conducted with Licensee, Dan McNeil

ALLEGATION:

- Resident A went missing from the facility due to neglect from the owner and staff improperly monitoring their residents.
- Upon staff discovering Resident A left the home, they did not commence a search for Resident A or contact law enforcement until hours later.

INVESTIGATION:

On December 28, 2022, I interviewed the Complainant who advised Resident A is not supposed to leave the AFC home without supervision. Resident A is physically disabled and possibly some mental health issues due to past drug use. Resident A was found 2 miles away from the home by the owner, Dan McNeil and Mr. McNeil did not notify anyone right away. The Complainant was not sure how long Resident A was out of the home, and he is currently back at the facility.

On January 14, 2022, I attempted an unannounced on-site inspection at Serenity Gardens. I knocked on the door several times however no one answered the door. On February 17, 2022, I made an unannounced on-site inspection at the home and interviewed Staff, Roseanna Gibson, Resident A, Resident C, and Licensee, Dan McNeil. Regarding the allegation, Ms. Gibson reported Resident A took off and wanted to get to his son's home. Ms. Gibson reported she tried to redirect him, and she believed Resident A and another resident were going to the store. After 20 minutes she called the store and the store owner said there was only one resident there but not Resident A. Ms. Gibson immediately called the Licensee, Dan McNeil who directed her to call the guardian and police. According to Ms. Gibson, Mr. McNeil and the police were looking for Resident A and he made it to his son's home in Flint. She is not sure how Resident A made it from the facility to the son's home given it is about 20 miles away. Resident A left the home at approximately 10:25am and she called 911 20 minutes later at 10:45am. Resident A was able to go to the store without staff supervision and the residents often go together. The store is not far from the home and just around the corner. According to Ms. Gibson, Resident A often attempts to get to his son's home however the son's home is not an appropriate place for Resident A. Resident A is 54 years old and has past issues with drugs and alcohol. Resident A has resided at the facility since September 2021.

On February 17, 2022, I interviewed Resident A who reported he has lived at his home since September 2021 and does not like his home because he cannot do what he wants. Regarding the allegations, Resident A hitchhiked to his son's home. It was cold outside when Resident A left his home. Resident A did not tell anyone he was leaving and he "snuck out". Resident A reported he "wants to get out" and live with his son.

On February 17, 2022, I interviewed Resident B who reported he has lived at this home for one year. Regarding the allegations, Resident B reported Resident A took off and hitchhiked to his son's home. Resident A snuck out of the home and staff called the police. According to Resident B, it was not dark when Resident A left the home, and the police were called right away when Resident A left the home.

On February 17, 2022, I interviewed Licensee, Dan McNeil who denied the allegation that he did not immediately search for Resident A or call law enforcement. Mr. McNeil advised Resident A went missing at 10:30am and he and a trooper from the Michigan State Police were looking for him in the neighborhood by 11am. They searched the neighborhood in a "grid" fashion and all the way to the highway and Resident A could

not be found. The trooper said Resident A got a ride and told Mr. McNeil to call back after 24 hours if he were still missing. Mr. McNeil reported Resident A has a fascination with his son and the trooper called the son who was on his way to work. Mr. McNeil discussed instances where Resident A has made previous attempts to leave the facility and he believes Resident A was attempting to get to his son's home. Mr. McNeil called the Michigan State Police back at 11pm and they advised him to call Flint Police who went to the son's home in Flint. Flint Police saw walker tracks in the snow however no one answered the door. A few hours later, Resident A's son contacted Mr. McNeil and reported Resident A was at his home. Mr. McNeil went and picked up Resident A from the son's home. Mr. McNeil advised he contacted the guardian immediately when Resident A left the home and when he returned. Mr. McNeil does not know how Resident A left the home as he was not there however Resident A is not allowed to leave the home without staff supervision due to being a flight risk, this according to the guardian.

On February 17, 2022, I reviewed an AFC Licensing Division Incident / Accident Report (IR). The IR documented that on December 23, 2021, at 10:30am Resident A "walked off". The police were called and they along with Licensee, Dan McNeil searched the area. Mr. McNeil and the police called Resident A's son and the guardian was also contacted. Corrective measures include "keep direct eyes on him 24 hours per day."

On February 17, 2022, I reviewed Resident A's AFC Resident Assessment Plan. I reviewed if Resident A "moves independently in community" however this question was not answered. Based on the interview with the Licensee, Dan McNeil, Resident A required supervision when out of the home and was a risk of leaving without absence. The Assessment Plan also indicated Resident A does not utilize the stairs, has mobility issues, and uses a walker.

On February 18, 2022, I interviewed Liz Hering, Case Manager from Resident A's guardian's office regarding the allegations. Ms. Hering reported that when Resident A left his home, the home notified Guardian A's office right away. Staff were directed to contact the police, which was done, and the police could not locate Resident A. Ms. Hering denied any concerns regarding the facility or their care/supervision of Resident A. Resident A is doing well at the home however does not want to live there.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until a resident assessment plan is made and it is determined that the resident is suitable pursuant to the following provisions:

	(a) The amount of personal care, supervision, and protection required by the resident is available in the home.
ANALYSIS:	It was alleged that Resident A went missing from the facility due to neglect and improper supervision of residents by staff. Upon conclusion of investigative interviews, there is a preponderance of evidence to conclude a rule violation. Resident A reported he snuck out of his home and hitchhiked to his son's home. Resident B corroborated Resident A's account in that the resident snuck out of the home. Staff, Roseanna Gibson reported she was aware Resident A left the facility and thought he was going to the corner store. Licensee, Dan McNeil advised that, per the guardian, Resident A is not allowed access to the community without staff supervision given he is a flight risk. It was also reported that Resident A has a history of attempting to leave the facility without staff supervision. There is a preponderance of evidence to conclude that the amount of supervision and protection required by Resident A was not available in the home given he was able to access the community without staff supervision, placing himself in harm's way.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1417	**Absence without notice.**
	Absence without notice. **(1) If a resident is absent without notice, the licensee or responsible person shall do both of the following:** **(a) Make a reasonable attempt to contact the resident's next of kin, designated representative, and responsible agency.** **(b) Contact the local police authority.** **(2) A licensee shall make a reasonable attempt to pursue other steps in locating the resident.** **(3) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.**

ANALYSIS:	It was alleged that Resident A went missing from the facility due to neglect by staff and, upon Resident A leaving the home, a search or law enforcement notification was not completed immediately. Upon conclusion of investigative interviews, there is not a preponderance of evidence to conclude a rule violation. Resident A was interviewed and advised he “snuck” out of his home and hitchhiked to his son’s home. Upon realizing Resident A had left the home, staff immediately contacted Resident A’s guardian, the licensee, and law enforcement. The Licensee, Dan McNeil and a Trooper from the Michigan State Police conducted a thorough search for Resident A however he could not be located. The Trooper concluded Resident A obtained a ride from someone, which was accurate per Resident A’s account. The following day, Resident A’s son contacted Mr. McNeil to advise Resident A was at his home. Mr. McNeil immediately picked up Resident A from his son’s home. Resident A does not want to live at the AFC home and attempts to leave the facility. Upon Resident A leaving the home, staff contacted Resident A’s son, guardian, and law enforcement; a search was conducted for Resident A; and an IR was forwarded to Resident A’s guardian all in accordance with licensing rules.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On February 17, 2022, I interviewed Licensee, Dan McNeil who advised Resident A moved into the home in September 2021. Resident A had been in the hospital for an extended time prior to moving into the facility. The hospital contacted him for placement of Resident A, and hospital personnel were supposed to come to the home to assist with completing an assessment plan for Resident A, however this did not occur.

On February 17, 2022, I reviewed Resident A’s AFC Resident Assessment Plan. I reviewed if Resident A “moves independently in community” however this question was not answered. The Assessment Plan was not signed by Resident A or his guardian.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians instructions; health care appraisal.**
	(3) In situations where a resident is referred for admission, the resident assessment plan shall be conducted in conjunction with the resident or the resident's designated representative, the responsible agency, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A moved into the facility in September 2021. The resident assessment plan was not signed by Resident A or designated representative. Additionally, the assessment plan was missing vital information pertaining to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On February 17, 2022, I interviewed Resident A at his home. Resident A was viewed using a walker and advised his bedroom is on the 2nd floor of the home. Resident A was asked if he has trouble navigating the stairs given he has to use a walker and Resident A stated he has fallen going up the stairs before.

On February 17, 2022, I interviewed Licensee, Dan McNeil. Mr. McNeil confirmed Resident A's bedroom is on the 2nd floor of the home.

On February 17, 2022, I reviewed Resident A's AFC Resident Assessment Plan. The Assessment Plan Indicated Resident A does not utilize the stairs, has mobility issues, and uses a walker.

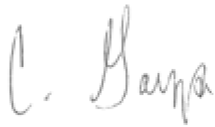
APPLICABLE RULE	
R 400.1431	**Bedrooms generally.**
	(7) A resident having impaired mobility, as determined by a licensed physician, shall not sleep in or be assigned a bedroom located above the street floor in a single-family residence.

ANALYSIS:	Resident A's AFC Assessment Plan indicates Resident A does not use stairs, requires the use of a walker, and has mobility issues. Resident A's bedroom is on the 2nd floor of the home, which is in violation of licensing rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

On February 22, 2022, I conducted an Exit Conference with Licensee, Dan McNeil. I advised Mr. McNeil I would be requesting a corrective action plan for the cited rule violations. Mr. McNeil was not in agreement with being cited for rule 407(2)(a). Consultation was provided and it was explained that there must be adequate staffing to ensure resident safety at all times.

IV. RECOMMENDATION

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



2/22/2022

Christina Garza Date
Licensing Consultant

Approved By:

02/23/2022

Mary E Holton Date
Area Manager