GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Daniela Popaj
Serene Gardens of Clarkston
5850 White Lake Rd
Clarkston, MI 48346

August 26, 2024

RE: License #: AH630396381
Investigation #: 2024A1022070
Serene Gardens of Clarkston

Dear Daniela Popaj:

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 authorized representative and a date.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630396381
Investigation #:	2024A1022070
Complaint Receipt Date:	07/22/2024
Investigation Initiation Date:	08/02/2024
Report Due Date:	09/21/2024
Licensee Name:	Clarkston Comfort Care, LLC
Licensee Address:	4180 Tittabawassee Rd Saginaw, MI 48604
Licensee Telephone #:	(989) 607-0001
Administrator:	Jessica Butler
Authorized Representative:	Daniela Popaj
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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	58
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) does not receive her medications as ordered by the licensed health care professional.	Yes
The ROC has behaviors that are not being adequately addressed.	No
Additional Findings	Yes

III. METHODOLOGY

07/22/2024	Special Investigation Intake 2024A1022070
08/02/2024	Special Investigation Initiated - On Site
08/02/2024	Inspection Completed On-site
08/08/2024	Contact - Document Received Email exchange with authorized representative.
08/26/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) does not receive her medications as ordered by the licensed health care professional.

INVESTIGATION:

On 07/22/2024, the Bureau of Community and Health Systems (BCHS) received an anonymous complaint that in part read, “The resident came to the facility with no clearly marked medications. The family provided a pre-filled pill box for us to use.

We do not know if we are giving the correct medications, so some staff have not been giving her medications."

On 08/02/2024, at the time of the onsite visit, I interviewed the administrator and the wellness director. According to the administrator, the ROC no longer lived in the facility. She had moved into the facility for a 1-week respite care stay on 07/18/2024 and went home with her family on 07/25/2024.

According to the wellness director, at the time she moved into the facility, the ROC's family did give her a 7-day pill organizer that the family had filled with the ROC's medication along with a medication list from the ROC's physician. Because the ROC was in the facility for only 7-day respite stay, her medications were not filled by the facility pharmacy service but were supplied directly by her family. The wellness director submitted the medication list to their pharmacy service, who entered the medications into the facility's electronic medication administration system. The wellness director went on to say that she would not accept the ROC's medications stored a pill organizer without identification of each medication and informed the ROC's family that they would have to bring in the medication containers clearly labeled with the prescription information, including the name of the medication, the prescriber's name, the ROC's name, the proper dosage and directions for administration. According to the wellness director, until the son brought the ROC's medication in their respective properly labeled containers, the son would be responsible for administering the ROC's medication.

Review of the ROC's medication administration record (MAR) for 07/18/2024 through 07/25/2024 revealed the majority of medications circled, signifying that they were not given, with the reason not giver as "Med (medication) not in facility." For example, the ROC was to receive Synthroid, (LevoTHYROXine) 50 micrograms once daily before breakfast. The MAR indicated that the ROC was administered the medication as ordered on 07/20 and 07/22/2024, refused on 07/21/2024, and "med not in facility" on 07/19, 07/21, 07/23, 07/24, and 07/25/2024. On 08/08/2024, via an email exchange with the authorized representative (AR), the AR was asked to explain this documentation. According to the AR, "The med techs were directed to sign and circle stating they did not give the medications, as it was communicated to the son to administer them until we had what we needed… our staff documented that the medication was not in the facility because we were not in possession of the pills at this time." The wellness director documented in an informal note dated 07/19/2024, "Son (of the ROC) agreed to administer meds," but there was no other explanation for the medications that were documented on the MAR as not administered.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Because the ROC's family was administering the medication without supporting documentation in the MAR, it could not be established that the medications were administered according to the ROC's licensed health care professional's order.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The ROC has behaviors that are not being adequately addressed.

INVESTIGATION:

According to the written complaint, "They (the facility) had her (the ROC) in assisted living, but she was so confused they moved her to memory care. She is peeing in trash cans…"

According to the wellness director, the ROC was not assessed prior to her move-in date of 07/18/2024. As far as staff could tell from her first day, she was appropriate for the general assisted living unit. She socialized with other residents and requested assistance with toilet use. However, as nightfall came, the ROC began to display symptoms of "sundowning," for example, wandering and confusion. On 07/19/2024, the ROC was moved into the memory care unit. On 07/20/2024, at 12:15 am, the ROC was found on the floor in her room and complained of having head and right arm pain. The ROC was sent to the local emergency room (ER), where she was diagnosed with an "acute urinary tract infection." The ROC was prescribed an antibiotic, but it was not administered while the ROC was still living in the facility. According to the wellness director, the ROC's family did not retrieve the medication from the pharmacy and deliver it to the facility.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following:

	(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.
ANALYSIS:	There was no evidence that the ROC had unmanageable behaviors.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

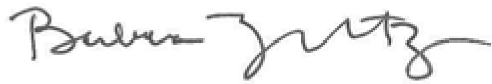
According to the AR, the ROC's family member agreed to administer medication to the ROC, but the ROC's service plan identified that the "Facility will assist resident in taking all routine and PRN (as needed) medications, according to doctors' orders."

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) A service plan must identify prescribed medication to be self-administered or managed by the home.
ANALYSIS:	The service plan indicated that medications were to be managed by the family, but the facility was relying on the family to administer the ROC's medications to her.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 08/26/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

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



08/26/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

08/21/2024

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