GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 13, 2025

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

RE: License #: AL700382076
Investigation #: 2025A0467022
Serenity Homes - North

Dear Mr. Gerdeman:

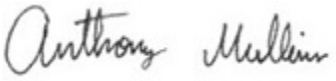
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0183.

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 #:	2025A0467022
Complaint Receipt Date:	02/07/2025
Investigation Initiation Date:	02/11/2025
Report Due Date:	04/08/2025
Licensee Name:	Serenity Homes - North, L.L.C.
Licensee Address:	747 Tamarack Ave NW Grand Rapids, MI 49504
Licensee Telephone #:	(419) 494-4008
Administrator:	Steven Gerdeman
Licensee Designee:	Steven Gerdeman
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:	REGULAR
Effective Date:	09/26/2024
Expiration Date:	09/25/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B are not getting their labs drawn as ordered by their physician.	Yes
Additional Finding	Yes

III. METHODOLOGY

02/07/2025	Special Investigation Intake 2025A0467022
02/11/2025	Special Investigation Initiated - On Site
02/11/2025	APS Referral Not necessary based on allegations
02/12/2025	Exit conference with licensee designee, Steve Gerdeman

ALLEGATION: Resident A and Resident B are not getting their labs drawn as ordered by their physician.

INVESTIGATION: On 2/10/25, I received a complaint from LARA-BCHS online complaint system. The complaint alleged that Resident A and Resident B are both prescribed Clozapine, which requires lab draw every 29-30 days as ordered by their physician. The complaint alleged that Resident A and Resident B's labs were late "several times" despite staff being informed to address this. Delayed labs increase the chances of the pharmacy not filling the medications for the residents.

On 2/11/25, I made an unannounced onsite investigation at the facility. Upon arrival, I spoke to manager, Briendon Stevens and she agreed to discuss the allegations in her office. Mrs. Stevens confirmed that both Resident A and Resident B are prescribed Clozapine and are required to have labs drawn approximately once a month per the standby order by their physician. Mrs. Stevens did not have a copy of the order on file as she stated that Trinity Health lab on 3-Mile Rd has it on file for the residents. Mrs. Stevens stated that Resident A and Resident B have had this order in place since she has worked at the facility, which has been since August 2023. However, only as of the last few months has Serenity Homes – North staff taken over this task from Network 180. Mrs. Stevens confirmed that there have been a "couple of times" when Resident A and Resident B's labs were drawn late. Mrs. Stevens stated that Resident A did not want to go one time and Resident B has refused to go a few times. Mrs. Stevens also shared that there was a time that she was sick and unable to transport the residents to the lab and she notified Network 180 about this matter.

In addition to the reasons listed about, Mrs. Stevens stated that an employee was recently terminated due to their attendance, which has caused issues for transporting the residents to have their labs drawn. Mrs. Stevens stated that a new employee has been hired and she does not foresee residents missing lab draws as an ongoing issue. Mrs. Stevens reported that the residents are now caught up with their required lab draws as Resident A's labs were drawn yesterday and Resident B's labs were drawn this past Friday (2/7/25). Despite the allegations stating that residents have gone more than two weeks without getting their labs drawn, Mrs. Stevens was adamant that at most, residents were late to have their labs drawn by one week.

While onsite, introductions were made with Resident A and she agreed to discuss the allegations. I attempted to speak with her privately. However, Resident A gave consent to be interviewed in the living room. Resident A confirmed her DOB and stated that she has lived at the facility for approximately one year and things are going well for her. Resident A confirmed that she has to get labs drawn monthly or bi-monthly, which she had done yesterday when staff transported her to the appointment. Resident A denied refusing to have her labs drawn at any time. Prior to concluding the interview, Resident A expressed concerns for some of the residents in the home choosing to be "miserable" despite not having to be. Resident A was encouraged to continue to share her concerns with staff and her team at Network 180 like she has done recently.

Introductions were made with Resident B and she was offered to be interviewed privately. However, Resident B gave consent to be interviewed in the dining room. Resident B confirmed her DOB and stated that she has lived in the home for approximately three years. Resident B stated that things are going well for her at the home and she confirmed that she has monthly lab draws for her clozapine medication. Resident B confirmed that she was recently taken to the lab by AFC home manager, Mrs. Stevens and she denied refusing to have her labs drawn at any point.

On 02/12/25, I conducted an exit conference with licensee designee, Steve Gerdeman. He was informed of the investigative findings and agreed to complete a Corrective Action Plan within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.** **(b) Special diets.**

	(c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate. **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	AFC home manager Mrs. Stevens confirmed that Resident A and Resident B's physician has ordered them to have monthly lab draws due to their prescribed Clozapine medication. Mrs. Stevens confirmed that lab draws have been late on a few occasions for different reasons. Therefore, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: While addressing the allegation listed above, I requested to review Resident A and Resident B's MARs for the month of January and February to ensure that they're receiving their clozapine medication as prescribed. Resident A's MAR was not initialed on 2/1/25 through 2/9/25 for the following medications: Vitamin D3, Vitamin B12, Protonix, Fludrocortisone Acetate, Cymbalta, Midodrine HCL, Neurontin, Trileptal, Abilify, Clozaril, Luvox, Melatonin, Desyrel, Robinul Forte, and Atarax. Resident B's Mar was not initialed on 2/1/25 through 2/9/25 for the following medications: Vitamin D3, Vesicare, Zestril, Prilosec, Myrbetriq, Mobic, Ativan, Cymbalta, Multivitamins, Synthroid, Tylenol, Mag-OX, Neurontin, Glucophage, Glucotrol, Zocor, Melatonin, Desyrel, Clozaril, Ozempic, Silvadene, and Motrin.

Mrs. Stevens stated that there was a spill in the office and the water from the mop bucket ruined the Mars. Mrs. Stevens stated that she just recently obtained additional Mars for the residents, which is why the have yet to be initialed. Mrs. Stevens was adamant that residents are receiving their medications as prescribed, and she showed me their medication packs from the pharmacy to confirm the meds are being passed as scheduled. Mrs. Stevens appeared to be honest and transparent regarding this matter. It should be noted that both Resident A and Resident B confirmed that they receive their medications daily as scheduled.

On 02/12/25, I conducted an exit conference with licensee designee, Steve Gerdeman. He was informed of the investigative findings and agreed to complete a Corrective Action Plan within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.15312	**Resident medications.**

	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Mrs. Stevens confirmed that Resident A and Resident B's MARs were not completed for several days in February due to a spill. Regardless, this is a licensing requirement and there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Anthony Mullins

02/12/2025

Anthony Mullins — Date
Licensing Consultant

Approved By:

Jerry Hendrick

02/13/2025

Jerry Hendrick — Date
Area Manager