GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 31, 2025

Megan Rheingans
Serene Gardens of Clarkston
5850 White Lake Rd
Clarkston, MI 48346

RE: License #: AH630396381
Investigation #: 2025A0784059
Serene Gardens of Clarkston

Dear Megan Rheingans:

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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Aaron L Clum

Sincerely,

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

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

I. IDENTIFYING INFORMATION

License #:	AH630396381
Investigation #:	2025A0784059
Complaint Receipt Date:	06/16/2025
Investigation Initiation Date:	06/16/2025
Report Due Date:	08/15/2025
Licensee Name:	Clarkston Comfort Care, LLC
Licensee Address:	4180 Tittabawassee Rd Saginaw, MI 48604
Licensee Telephone #:	(989) 607-0001
Administrator/Authorized Representative:	Megan Rheingans
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	58
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff do not adequately toilet residents.	No
Additional Findings	Yes

III. METHODOLOGY

06/16/2025	Special Investigation Intake 2025A0784059
06/16/2025	Special Investigation Initiated - Telephone Interview with witness 1
06/17/2025	Inspection Completed On-site
06/17/2025	Exit Conference Conducted with staff 2

ALLEGATION:

Staff do not adequately toilet residents

INVESTIGATION:

On 6/16/2025, the department received this complaint from adult protective services (APS). Witness 1 was named as a contact for this complaint.

According to the complaint, staff double brief residents.

On 6/16/2025, I interviewed witness 1 by telephone. Witness 1 was unable to provide a specific date but stated this has happened on third shift. Witness 1 stated the belief that staff are double briefing, so they do not have to change these residents through the night and that they are left until the morning for first shift staff to clean up. Witness 1 stated this happens mostly in memory care (MC). Witness 1 named staff 1 as a witness who would confirm this. Witness 1 named Residents, A, B, C, D and E as residents who have been double briefed and left soaking all night.

On 6/17/2025, I interviewed staff 1 at the facility. Staff 1 stated she regularly works the first shift in MC. Staff 1 reported she assists residents out of bed and conducts brief changes in the morning and is not aware of any residents that have been double briefed or left in soaking briefs all night. Staff 1 stated that if this was the

case, she would report this to supervision as it could be harmful to residents and make it more difficult to provide morning care.

On 6/17/2025, I observed Resident A sitting on a recliner in her room. Resident A appeared well groomed and comfortable. Resident A was non-responsive to an attempted interview.

On 6/17/2025, I observed Resident B in the common area of the MC. At that time, staff were transferring Resident B to her wheelchair per Resident B's request to be taken to the bathroom. Resident B appeared calm and well groomed.

On 6/17/2025, I observed Resident C sleeping in her bed. Resident C appeared comfortable and well groomed.

On 6/17/2025, I interviewed Resident D in her room at the facility. Resident D was pleasant and appeared well groomed. Resident D stated staff were very responsive to her needs and that she had no complaints regarding her care at the facility.

On 6/17/2025, I observed Resident E sleeping in her bed. Resident E appeared comfortable and well groomed.

On 6/17/2025, I interviewed staff 2 at the facility. Staff 2 stated she is unaware of any issues with staff double briefing or leaving residents in soaked briefs. Staff 2 stated the department did have a finding on this matter several months ago and that the issue has been addressed since.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	The complaint alleged third shift staff have double briefed residents and left them in soaking briefs all night. Based on the findings, there is insufficient evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 6/17/2025, I interviewed Resident F at the facility. Resident F stated that on 6/15/2025, the toilets in the facility were backed up for several hours. Resident F stated staff did not have enough bed pans or any other back up plan to assist residents in using the bathroom. Resident F stated that when she asked about using the bathroom a staff member, whose name she was unable to recall, told her to go in her brief and that staff would change her later.

When interviewed, staff 2 stated that on 6/15/2025, the septic system at the facility backed up and the toilets were not usable for several hours until she was able to get a plumber to the facility to fix it. Staff 2 stated the facility only had one bed pan available to use for residents. Staff 2 stated the facility did not have a written emergency plan for this specific type of emergency. Staff 2 stated she was not aware of staff telling residents to just go to the bathroom in their briefs, which she stated would not be an acceptable suggestion from staff.

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.**
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
R 325.1981	**Disaster plans.** **(1) A home shall have a written plan and procedure to be followed in case of fire, explosion, loss of heat, loss of power, loss of water, or other emergency.**
ANALYSIS:	Based on the findings, the facility is not in compliance with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

7/24/2025

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Aaron Clum Date
Licensing Staff

Approved By:

07/31/2025

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