GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 22, 2025

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

RE: License #: AH630396381
Investigation #: 2025A1027063
Serene Gardens of Clarkston

Dear Licensee:

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.

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.
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 877-458-2757.

Sincerely,
Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630396381
Investigation #:	2025A1027063
Complaint Receipt Date:	06/23/2025
Investigation Initiation Date:	06/25/2025
Report Due Date:	08/23/2025
Licensee Name:	Clarkston Comfort Care, LLC
Licensee Address:	4180 Tittabawassee Rd Saginaw, MI 48604
Licensee Telephone #:	(989) 607-0001
Authorized Representative/ Administrator:	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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	58
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A and other residents were abused.	No
Additional Findings	Yes

The complaint alleged via telephone interview that residents were not receiving enough food, toilet issues, and medication training which were investigated in Special Investigation Report 2025A0784059 and 2025A0784061.

III. METHODOLOGY

06/23/2025	Special Investigation Intake 2025A1027063
06/25/2025	Special Investigation Initiated - Letter Email sent to the administrator and authorized representative requesting documentation
06/26/2025	Contact - Document Received Email received with the requested documentation
07/01/2025	Contact - Telephone call made Telephone interview conducted with Resident A
07/02/2025	Inspection Completed On-site
07/02/2025	Inspection Completed-BCAL Sub. Compliance
07/22/2025	Exit Conference Conducted with Megan Rheingans

ALLEGATION:

Resident A and other residents were abused.

INVESTIGATION:

On 6/23/2025, the Department received an online complaint alleging that Resident A had been abused and had also witnessed abuse of other residents.

On 7/1/2025, I conducted a telephone interview with Resident A. She reported that Employee #1 pulled her out of bed by her arm and that staff had been mean to her. She stated Employee #1 was later terminated. Resident A also described Employee

#2 as "rude" and reported that both Employees #2 and #3 refused to assist her in readjusting her brief, leaving her uncomfortable. She also reported witnessing staff yelling at other residents but declined to identify the individuals involved.

On 7/2/2025, I conducted an on-site inspection and interviewed staff.

The Authorized Representative and Administrator, Megan Rheingans, along with Employee #4, confirmed that Resident A had reported being mistreated by Employee #1, who was subsequently terminated. Employee #4 reported that, in response to the incident involving Employee #1, additional skills training was conducted on 5/13/2025, for staff on transferring residents from bed to wheelchair using a transfer belt, as well as assisting with ambulation using a transfer belt.

Employee #4 also confirmed Resident A reported Employees #2 and #3 failed to assist with readjusting her brief. Employees #2 and #3 received a written disciplinary action, and Employee #3 no longer worked at the facility.

The Administrator stated that she met with Resident A on 7/1/2025, and Resident A reiterated her concerns regarding Employees #1, #2, and #3, which had been addressed by the home.

While on-site, additional residents were interviewed.

- Resident B described the care as “pretty good” and said there was a “good nucleus of people.” However, he recalled an incident, possibly involving Employee #5, where he felt someone had pulled him out of bed or possibly, he fell out of bed. He noted that Employee #5 no longer worked at the facility.
- Resident C reported that staff were neither physically nor verbally abusive. She described most staff as kind, respectful, and courteous.
- Resident D stated that staff were helpful and responded to her pendant promptly.
- Relative D1 shared that the staff were “wonderful”, and he had no complaints.

In response to Resident B’s interview, Employee #4 stated that Employee #5 resigned due to a conflict of interest. She was unaware of any incidents involving Resident B being pulled from bed and noted that Resident B had not had any falls.

While on-site, I observed five staff members interacting positively with residents, and residents were smiling completing an activity with staff.

While on-site, I reviewed employee files.

Employee #1 was hired on 7/29/2024 and terminated on 4/10/2025. She completed training on resident rights and incident reporting on her hire date, as well as the medication passer competency on 8/29/2024. However, her file lacked documentation of caregiver training and competency, which included training related to resident transfers.

Employee #2 was hired on 3/19/2025 and remains employed. She completed the required training on resident rights and incident reporting on 3/14/2025, caregiver competency on 4/11/2025, and an additional training on transfers on 5/13/2025. A disciplinary action form dated 5/1/2025, read that Resident A was left in a vulnerable state, uncomfortable in her brief, and that care was refused. The corrective action plan included potential suspension or termination.

Employee #3 was hired on 6/6/2024 and terminated on 5/30/2025. Her file included completed caregiver training and competency, incident reporting, resident rights and responsibilities, and medication passer competency. A disciplinary action form dated 5/1/2025, noted the same incident with Resident A and listed next steps as suspension up to termination.

Employee #5 was hired on 6/10/2024 and resigned on 6/12/2025. His file contained completed training on resident rights, the disciplinary policy, caregiver competency checklist and medications passer competency, as well as the additional training on transfers on 5/13/2025. There were no disciplinary actions related to abuse.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(*l*) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician, by a physician's**

	assistant with whom the physician has a practice agreement, or by an advanced practice registered nurse, for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician, physician's assistant, or advanced practice registered nurse who authorized the restraint. In case of a chemical restraint, the physician, or the advanced practice registered nurse who authorized the restraint, shall be consulted within 24 hours after the commencement of the chemical restraint.
ANALYSIS:	Staff statements corroborated Resident A's account of abuse by Employee #1, who was terminated as a result. Employees #2 and #3 were disciplined in response to their failure to provide appropriate care, and Employee #3 no longer works at the home. There was no evidence found to substantiate allegations against Employee #5. Given that the facility took appropriate corrective action, including termination and disciplinary measures, the allegation of abuse is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

A review of Employee #1's file revealed she had not completed the home's caregiver checklist and competency verification for personal care tasks, including training on resident transfers. Employee #3's file included a caregiver task checklist; however, the sections requiring training staff to sign and date verification of competency were left blank. Additionally, Employees #1, #2, #3, and #5 lacked documented training in dementia care, despite some having worked in the memory care unit.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the

	residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
For Reference: 333.20178	**Nursing home, home for the aged, or county medical care facility; description of services to patients or residents with Alzheimer's disease; contents; "represents to the public" defined.**
	Sec. 20178. (1) Beginning not more than 90 days after the effective date of the amendatory act that added this section, a health facility or agency that is a nursing home, home for the aged, or county medical care facility that represents to the public that it provides inpatient care or services or residential care or services, or both, to persons with Alzheimer's disease or a related condition shall provide to each prospective patient, resident, or surrogate decision maker a written description of the services provided by the health facility or agency to patients or residents with Alzheimer's disease or a related condition. A written description shall include, but not be limited to, all of the following: **(d) Staff training and continuing education practices.**
ANALYSIS:	A review of employee files revealed missing, incomplete, or insufficient training, including a lack of dementia-specific training for staff working in the memory care unit. As a result, a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

07/08/2025

Jessica Rogers Date
Licensing Staff

Approved By:

07/21/2025

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