



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 25, 2025

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

RE: License #: AH630396381
Investigation #: 2026A1027007
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated by the home for the aged authorized representative.

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 877-458-2757.

Sincerely,

A handwritten signature in cursive script that reads "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 #:	2026A1027007
Complaint Receipt Date:	10/30/2025
Investigation Initiation Date:	11/03/2025
Report Due Date:	12/29/2025
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	58
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A lacked care consistent with her service plan.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/30/2025	Special Investigation Intake 2026A1027007
11/03/2025	Special Investigation Initiated - Letter Email sent to Megan Rheingans and Employee #1 requesting documentation
11/03/2025	Contact - Document Received Email received with requested documentation
11/04/2025	Contact - Telephone call made Conducted with Absolute Hospice staff
11/04/2025	Contact - Document Sent Email sent to Absolute Hospice requesting documentation
11/04/2025	Contact - Document Received Email received with requested hospice documentation
11/04/2025	Inspection Completed-BCAL Sub. Compliance
11/25/2025	Exit Conference Conducted by email with Megan Rheingans and Employee #1

ALLEGATION:

Resident A lacked care consistent with her service plan.

INVESTIGATION:

On October 30, 2025, the Department received a complaint alleging two incidents of neglect of Resident A prior to her death.

It was alleged that on September 2, 2025, at approximately 6:00 a.m., Resident A sustained a fall from her wheelchair. The facility's incident report did not document how Resident A, who required staff assistance for all transfers and mobility, was

able to get out of bed, transfer into her wheelchair, and move down the hallway where the fall occurred. The complainant alleged that a staff member may have assisted Resident A out of her room and left her unattended in the hallway, where she was later found with head and facial injuries. The report written by staff was vague and lacked sufficient detail, and that the facility failed to notify Relative A1 of the incident.

It was also alleged that on October 10, 2025, Resident A was found on the floor during routine room checks and sustained a shoulder injury. The facility notified Relative A1 of this incident. When Relative A1 and the hospice aide entered Resident A's room, they observed that the bedside floor mat was missing, the chair alarm was placed on the bed, and there were old blood stains on the bed linens. The complainant alleged that the facility's written documentation was again vague and that fall prevention equipment was not utilized appropriately.

Resident A passed away five days after the October 10, 2025, incident.

Resident A's face sheet indicated that she moved into the home on March 16, 2022, and was discharged on October 15, 2025. The face sheet documented that she resided in the memory care unit and was receiving hospice services through Absolute Hospice. It also identified Relative A1 as her durable power of attorney.

Resident A's service plan dated June 4, 2024, was consistent with the information documented on the face sheet and noted that she was at risk for falls. The plan indicated that Resident A required extensive assistance with activities of daily living, including dressing, grooming, ambulating, and toileting. It further documented that she utilized a wheelchair for mobility. The plan specified the use of safety devices, including a bed alarm, chair alarm, and fall mat placed next to the bed. Staff were instructed to ensure that the chair alarm was activated when the resident was in her wheelchair, recliner, or bed; to place the fall mat next to the bed at bedtime; to use the bolster at the end of the mattress; and to ensure the bed alarm was turned on.

Incident report dated 9/2/2025 at 6:00 AM read staff heard Resident A's chair alarm going off and immediately went to the resident and observed the resident on the floor. The report read Resident A cut her head and was bleeding but was assessed for further injuries, and range of motion which were at baseline. Staff contacted the hospice agency, notified of her injuries, and they stated they would assess the resident. Hospice reported they would notify Relative A1.

Incident report dated 10/10/2025 at 4:26 AM read Resident A was observed on the floor while conducting checks, vitals were taken, and resident was assessed. The report read that two staff assisted Resident A back to bed and contacted her hospice agency, as well as Relative A1. The report read she was complaining of shoulder pain, in which hospice reported to utilize pain medications. The report read Resident A was putting her legs over the bed throughout the night, and staff kept getting her back into bed and each time ensured the bed alarm was under her. The report read Relative A1 and Absolute Hospice were notified on 10/10/2025 at 4:45 AM. The report read another staff member assisted Resident A into bed with another staff member and witnessed the bed alarm working properly.

I reviewed the home's Accident/Incident Policy, which was found to be consistent with the incident reports completed by the facility.

I also reviewed Absolute Hospice notes dated September 2, 2025, and October 10, 2025.

The hospice incident report dated September 2, 2025, indicated that a nurse visit occurred, during which a dressing was applied to a hematoma with active bleeding. The nurse assessed other areas and determined that no additional dressings were needed. A concussion assessment was completed and was negative. The nurse provided education to staff, instructing that the dressing could be removed and left open to air once bleeding had stopped; staff verbalized understanding of these instructions. The nurse notes dated September 2, 2025, at 7:10 a.m. were consistent with the hospice incident report, documenting that the injury was a hematoma above the right eye, with additional abrasions (rug burns) noted on the upper cheek and below the right eyebrow. The note also reflected that care coordination occurred with Relative A1 and facility staff.

The hospice incident report dated October 10, 2025, documented that hospice received a call reporting that Resident A had rolled off her bed and complained of shoulder pain. At the time of the report, Resident A was sleeping, and no signs of pain were observed by staff. The on-call nurse instructed staff to allow Resident A to continue sleeping, and to contact hospice for further evaluation if pain was observed upon awakening. The nurse notes dated October 10, 2025, at 11:30 a.m. indicated that the nurse spoke with Employee #1, who reported Resident A had been found on the floor with safety devices in place; however, the bed alarm had not activated. The note stated that Relative A1 was present during the visit and that Resident A was observed sitting upright in a Broda chair in the common area watching television.

The nurse assessed Resident A and noted pain when her left arm was elevated, but no additional injuries were observed. Staff were instructed to administer prescribed pain medication. Relative A1 declined an X-ray of the left shoulder. The note further indicated that Resident A's room had been rearranged for safety. Upon observation, the bolster was located under the bed, and the chair alarm pad was being used on the bed in place of a bed alarm. The bed alarm was subsequently replaced with the appropriate alarm pad. No fall mat was observed in the room; the nurse noted that a fall mat had been ordered on August 5, 2025, and a new one was reordered at that time.

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:	<p>Although the Department does not have the authority to substantiate the cause of Resident A's death, documentation confirmed that the home completed the required incident reports and notified Resident A's hospice agency regarding both falls. Hospice records further verified that Relative A1 was notified by hospice staff following the incident on September 2, 2025.</p> <p>However, a review of facility records and hospice nurse observations determined that Resident A's fall prevention interventions were not implemented in accordance with her written service plan. The service plan dated June 4, 2024, required the use of a bed alarm, chair alarm, and fall mat placed next to the bed. During the hospice nurse's observation on October 10, 2025, the fall mat was not in place or observed in the room, and the chair alarm pad was being used on the bed in lieu of a bed alarm, contrary to the requirements of the service plan.</p> <p>Based on the findings, a violation is substantiated for failure to provide care consistent with Resident A's written service plan.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

Resident A's face sheet indicated that she moved into the home on March 16, 2022, and her most recent service plan was dated June 4, 2024.

APPLICABLE RULE	
R 325.1922	Admission and retention of residents.
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Resident A's service plan had not been updated at least annually; therefore, a rule violation was established.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Jessica Rogers

11/05/2025

Jessica Rogers
Licensing Staff

Date

Approved By:

Andrea Moore

11/25/2025

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

Date