



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 29, 2026

Megan Rheingans
Serene Gardens of Grand Blanc
1481 E. Hill Road
Grand Blanc, MI 48439

RE: License #: AH250385140
Investigation #: 2026A0585015
Serene Gardens of Grand Blanc

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 responsible party 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 (517) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "Brender Howard".

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250385140
Investigation #:	2026A0585015
Complaint Receipt Date:	12/11/2025
Investigation Initiation Date:	12/12/2025
Report Due Date:	02/10/2026
Licensee Name:	1481 E. Hill, LLC
Licensee Address:	3520 Davenport Avenue Saginaw, MI 48602
Licensee Telephone #:	(989) 892-0658
Administrator:	Kelly Jackson
Authorized Representative:	Megan Rheingans
Name of Facility:	Serene Gardens of Grand Blanc
Facility Address:	1481 E. Hill Road Grand Blanc, MI 48439
Facility Telephone #:	(810) 603-7029
Original Issuance Date:	01/26/2018
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	79
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell and was left on the floor for 20 to 40 minutes with no call pendant available.	Yes
Resident A did not get his medication.	Yes
Additional Findings	No

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

Showers were investigated under 2025A0784083.

III. METHODOLOGY

12/11/2025	Special Investigation Intake 2026A0585015
12/12/2025	Special Investigation Initiated - Telephone Contacted the Attorney General Office regarding allegations submitted by their office for additional information.
12/17/2025	Inspection Completed On-site Completed with interview and record review.
12/17/2025	Inspection Completed-BCAL Sub. Compliance
12/18/2025	Contact - Telephone call made Contacted the physical therapist who was listed as the witness to the allegations.
01/30/2026	Exit Conference Conducted via email to authorized representative Megan Rheingans.

ALLEGATION:

Resident A fell and was left on the floor for 20 to 40 minutes.

INVESTIGATION:

On 12/08/2025, the licensing department received a complaint via BCHS online complaint. The complaint alleged that Resident A fell in his room on 09/22/25 somewhere around 10:30/11:00, although the exact time is not known, was left on the floor for 20-40 minutes without a functioning medical alert device or staff response, received no immediate medical care or family notification, and was later hospitalized with significant injuries and dangerously low blood sugar, prompting concerns of severe neglect, poor communication, and inadequate care at the facility.

On 12/17/2025, an onsite was completed at the facility. I interviewed the administrator Kelly Jackson at the facility. The administrator stated that Resident A refused help a lot of times from staff. She said Resident A was found in his room next to the bed where he had fallen. She said that he did not call for help. She said that staff would do hourly safety checks because Resident A didn't have a pendant when he first came to the facility. Ms. Jackson stated that a family member was at the facility and stated that he was going to call the POA at the time Resident A had the fall.

On 12/17/2025, I interviewed Employee #1 at the facility. Employee #1's statement was consistent with the administrator. Employee #1 stated Resident A fell while attempting to change his own brief. She said that Resident A never called staff for assistance. She said that POA was called after incident, but they first had to check to make sure the resident was okay. Employee #1 said there were issues with getting the call pendant, but the staff would do hourly rounds to ensure their safety.

On 12/18/2025, I interviewed Witness #1 who stated that on 09/15/2025 she recommended that facility provides Resident A with a call pendant and on 09/22/2025 Resident A received his call pendant after a fall. Witness #1 said Resident A's room was further away from down the hallway, but she did observe staff come in to check on him when she was there at the facility. She said there are pull cords in the room.

Resident A's service plan read, admitted to the facility on 08/06/2025, history of falls, needs extensive toileting assistance, resident should be checked every two hours and brief changed as needed, safety assistance around the clock, able to use call system.

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>The complaint alleged that Resident A fell in his room on 09/22/2025 somewhere around 10:30/11:00, although the exact time is not known, was left on the floor for 20-40 minutes without a functioning medical alert device or staff response, received no immediate medical care or family notification, and was later hospitalized with significant injuries and dangerously low blood sugar, prompting concerns of severe neglect, poor communication, and inadequate care at the facility.</p> <p>The resident had a fall; however it is no evidence to show how long he was on the floor. Resident A's room was equipped with pull cords. Resident A had refusals for calling for help and was monitored by staff. However, a call pendant was not available for Resident A at the time he fell.</p> <p>Although a family member was present at the time of Resident A's fall, the facility did not contact the POA.</p> <p>This claim was substantiated.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident A did not get his medication.

INVESTIGATION:

The complaint alleged Resident A was out of medication for days and he wasn't doing well.

The administrator stated that Resident A was out of his probiotic due to waiting for a doctor's order, the omeprazole was reordered, and Resident A had been out of for three days. She said the family was ordering Resident A's medication but after they switched to using the facility chosen pharmacy, the pharmacy was delayed refilling it.

Employee #1 said the family did not want to use the pharmacy that the facility uses. She said their pharmacy has automatic refill. She said once the resident is down to five pills, they call the pharmacy to get it refilled. Employee #1 stated that the family was ordering Resident A's medication.

Resident A's service plan read, "staff assists with routine medication and PRN medications as directed. Resident is independent taking and managing medication. Regular cycle fill for routine medication and family takes care of delivering all meds."

Resident A's medication administration record (MAR) shows,

Medication	Missed Dosage
Actazolamide	9/6-9/10
Aspirin	9/6-9/10
Cetirizine	9/6-9/10
Daily Probotic	9/10
Divalproex	9/6-9/10
Flurosemide	9/6-9/10
Metformin	9/7-9/10
Metroprolol	9/5, 9/10, 9/13, 9/14
Omeprazole	9/6-9/10
Potassium	9/6-9/10
Sertraline	9/6-9/10
Tamsulosin	9/9
Vitamin D	9/6-9/10

APPLICABLE RULE	
R 325.1932	Resident medications.
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	The complaint alleged Resident A did not get his medication. The MAR showed that Resident A had missed medication on several days. There was some disconnect in ordering Resident A's medication, causing Resident A to go without medication. Therefore, this claim is substantiated.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent on the receipt of an acceptable corrective action plan, I recommend no change in the status of this license.

Brender d. Howard

01/29/2026

Brender Howard
Licensing Staff

Date

Approved By:

Andrea L. Moore

01/29/2026

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

Date