



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

June 03, 2026

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

RE: License #: AL700382076  
Investigation #: 2026A0467030  
Serenity Homes – North

Dear Mrs. Bailey:

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:

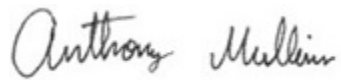
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (616) 356-0100.

Sincerely,

A handwritten signature in cursive script that reads "Anthony Mullins".

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**

<b>License #:</b>	AL700382076
<b>Investigation #:</b>	2026A0467030
<b>Complaint Receipt Date:</b>	04/08/2026
<b>Investigation Initiation Date:</b>	04/08/2026
<b>Report Due Date:</b>	06/07/2026
<b>Licensee Name:</b>	Serenity Homes - North, L.L.C.
<b>Licensee Address:</b>	747 Tamarack Ave NW Grand Rapids, MI 49504
<b>Licensee Telephone #:</b>	(419) 494-4008
<b>Administrator:</b>	Morgan Bailey
<b>Licensee Designee:</b>	Morgan Bailey
<b>Name of Facility:</b>	Serenity Homes - North
<b>Facility Address:</b>	830 Hayes Street Marne, MI 49435
<b>Facility Telephone #:</b>	(616) 677-6015
<b>Original Issuance Date:</b>	06/02/2016
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/26/2024
<b>Expiration Date:</b>	09/25/2026
<b>Capacity:</b>	20
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

## II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B’s case management team at Network 180 is not notified consistently when medications and labs are refused.	Yes
Additional Findings	Yes

## III. METHODOLOGY

04/08/2026	Special Investigation Intake 2026A0467030
04/08/2026	Special Investigation Initiated - Telephone Spoke to complainant via phone
04/08/2026	APS Referral – complaint received from Ottawa County APS
04/08/2026	Contact - Document Received Received an email from Ashton Byrne with Kent County Recipient Rights.
04/14/2026	Inspection Completed On-site
05/06/2026	Contact – document received from Ashton Byrne from Kent County Recipient Rights
06/03/2026	Exit conference with licensee designee, Morgan Bailey and Chief Operations Officer, Jess Engstrom.

**ALLEGATION: Resident A and Resident B’s case management team at Network 180 is not notified consistently when medications and labs are refused.**

**INVESTIGATION:** On 4/8/26, I received a complaint alleging that the case management team for Resident A and Resident B through Network 180 is not being notified when either resident refuses medications or required labs.

That same day, I spoke with the complainant via phone and he confirmed the allegations. He reported that both residents are prescribed Clozapine, which requires frequent lab monitoring. According to the complainant, both residents have missed or arrived late to their lab appointments after being told by staff that transportation would be provided. He emphasized that the residents have the right to

refuse medications and labs. However, their case management team must be notified in real time so they can consult with the prescribing physician and make adjustments as needed. The complainant shared that the AFC staff's lack of communication has resulted in Resident A and Resident B's Clozapine levels becoming essentially non-existent. He further reported that Resident B has been admitted to Southridge Behavioral Health for inpatient psychiatric care for the past two weeks, during which it was discovered that her Clozapine levels were nearly absent. These concerns were raised because historically, neither resident refuses their medication.

On 4/8/26, Recipient Rights Officer Ashton Byrne and I agreed to complete a joint investigation at the home on 4/14/26.

On 4/14/26, Mrs. Bryne from Recipient Rights and I conducted an unannounced onsite investigation at the home. Upon arrival, entry was made into the home and AFC staff member Kimberly Gillman agreed to discuss case allegations. Ms. Gillman explained that she is responsible for transporting residents to their medical appointments, including lab draws. Staff member Kayla Bailey typically accompanies her, but Ms. Gillman is the only one who drives.

Ms. Gillman reported that she transported Resident A to Trinity Health last Tuesday (4/7/26) for her lab work. She believed she had taken Resident B for labs the previous month but could not recall the exact date. She stated she had no knowledge of either resident failing to have labs completed on time, except in February 2026 when both residents refused to go.

Ms. Gillman also described one instance when she took Resident B alone because Resident A went shopping with a friend without notifying staff she was leaving. She noted that she was able to take Resident A later that same day for her labs once she returned home. Ms. Gillman said she is usually notified by Network 180 only a few days before labs are due, which makes scheduling difficult. She believes that scheduling lab appointments in advance through 180 would improve consistency. I encouraged Ms. Gillman to connect with staff at Network 180 to discuss ways to streamline communication and scheduling.

When asked about communicating with Network 180 regarding residents refusing meds and lab draws, Ms. Gillman explained that she does not administer medications because she is not trained to do so. She stated that she has not had to notify Network 180 about residents refusing lab draws because she is generally able to persuade them to complete the labs the following day. Ms. Gillman also reported that she completes incident reports only when instructed to do so by her colleagues. Mrs. Bryne informed her that incident reports should have been completed when Resident A and Resident B previously refused their lab draws. From a licensing

standpoint, these instances should have also prompted notification to the residents' case management team.

Mrs. Bryne and I then spoke with staff member Carmen Ash regarding the allegations. Ms. Ash confirmed that both Resident A and Resident B are prescribed Clozapine, which requires consistent lab draws. She stated that transportation for lab appointments is handled by Ms. Gillman and Kayla Bailey. Ms. Ash described both residents as "difficult," noting that they frequently refuse labs. She added that staff sometimes attempt to offer incentives to encourage compliance, though this not always effective. Ms. Ash was unsure whether incident reports were being completed in these situations and denied any knowledge of herself or other staff communicating with Network 180 when either resident refuse labs.

Regarding medications, Ms. Ash reported that Resident A and Resident B often refuse their medications. She stated that when this occurs, she and other staff document the refusal on the MAR. According to Ms. Ash, staff are required to complete an incident report each time a resident refuses medication, and staff may receive disciplinary action if they fail to comply with this policy. When asked how often the residents' case management team, including the prescribing physician is notified when a medication is refused, Ms. Ash stated that they are informed "when they come in," referring to the case management team coming onsite to visit their clients. She acknowledged that staff are not consistently notifying the case management team when the residents refuse medications and she was not aware of this requirement under AFC licensing rules.

Resident A and Resident B were interviewed during the onsite investigation. Both residents stated that they never refuse their medications and take them as prescribed. They also reported that they do not refuse lab draws. Resident B confirmed that she had recently been admitted to Southridge Behavioral Health but did not know the specifics for her admission. The residents did not have any further information to add.

On 06/03/2026, I conducted an exit conference with licensee designee, Morgan Bailey and Chief Operations Officer, Jess Engstrom. They were informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of this report.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: (g) Contact the appropriately licensed health care professional when a resident refuses a prescribed medication or procedure. A licensee, administrator, or staff</b>

	<b>shall document and follow the instructions given by the licensed health professional. Documented instructions may include procedures to follow when a resident refuses medication or procedures in the future.</b>
<b>ANALYSIS:</b>	AFC staff member Ms. Ash acknowledged that staff are only updating Resident A and Resident B's case management team/doctor of refused meds and labs when they come onsite to visit the residents. She also acknowledged that she is unfamiliar with this AFC licensing rule and therefore, not following it. Based on the information provided, there is a preponderance of evidence to support this applicable licensing rule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDING:**

**INVESTIGATION:** While investigating the allegation listed above, I requested to review Resident A and Resident B's Medication Administration Records (MARS) for February and March 2026.

Resident A's February 2026 MAR indicated that she missed one or more doses of the following medications: Clozapine 25mg, Clozapine 100mg, Glipizide 5mg, Levothyroxine Sodium 137mcg, Omeprazole Dr 20MG, Simvastatin 40mg, Duloxetine Hydrochloride 60mg, Gabapentin 800mg, Lisinopril 2.5mg, Lorazepam 1mg, magnesium oxide, meloxicam 15mg, Metformin 500mg multivitamin Myrbetriq 50mg, Senna Plus 50mg, Solifenacin Succinate 10mg, and Vitamin D3.

Resident A's March 2026 MAR indicated that she missed one or more of the same medications listed in February. The only medication that was given a reason for why it was missed was Glipizide 5mg, which was "out of medication" and "waiting on refill," neither of which are appropriate reasons for a resident to miss a medication.

Resident B's February 2026 MAR indicated that she missed one or more doses of the following medications: Pantoprazole Sodium 40mg, Clozapine 200mg, Fludrocortisone Acetate 0.1MG, Vitamin B12, Oxcarbazepine 600mg, Aripiprazole 5mg, Fluvoxamine Maleate 100mg, Gabapentin 300mg, Glycopyrrolate 2mg, Hydroxyzine Hydrochloride 25mg, Melatonin 3mg, Midodrine Hydrochloride 5mg, Oxcarbazepine 150mg, Trazadone 100mg, and Vitamin D3. There was no explanation provided on the MAR as to why these medication passes were missed.

Resident B's March 2026 MAR indicated that she missed one or more of the same medications listed in February. The only medications that were given a reason for why it was missed were Oxcarbazepine 600mg which was "not in blister pack or med cart" and Fludrocortisone Acetate 0.1mg which was the resident "kept going

back to sleep,” neither of which are appropriate reasons for a resident to miss a medication.

It should be noted that both Resident A and Resident B have the same medications listed on their MAR’s multiple times, not only making it difficult to follow, but also easy for a staff to make a medication error.

On 5/6/26, I received an email from Mrs. Byrne of Kent County Recipient Rights. The email included lab results for Resident A and Resident B. Resident A’s labs showed that her clozapine levels were within normal range on 02/19/26. On 3/27/26, her Clozapine levels were at 29 when they should have been between 200-700 ng/mL, making her March 2026 clozapine levels nearly non-existent. This is a clear indication that Resident A was not taking her medication as prescribed.

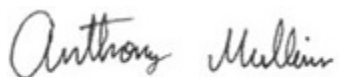
Resident B’s labs showed that her clozapine levels were within normal range on 01/30/26. On 03/28/26, her clozapine levels were at 17 when they should have been between 350-600 ng/mL. This is also a clear indication that Resident B was not taking her medication as prescribed.

On 06/03/2026, I conducted an exit conference with licensee designee, Morgan Bailey and Chief Operations Officer (COO), Jess Engstrom. They were informed of the investigative findings and made aware that a corrective action plan is due within 15 days of receipt of this report. Due to this being a repeat violation, I also informed them that a provisional license is being recommended and that they must state in writing whether they accept the provisional license. If they contest the recommendation, an administrative hearing will be scheduled.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.</b>
ANALYSIS:	Reviewing Resident A and Resident B’s Mars clearly indicates that they are not receiving their medications as prescribed. Therefore, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	<b>VIOLATION ESTABLISHED (Repeat violation from SIR #2026A0467015 dated 2/24/26)</b>

#### IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, issuance of a provisional license is recommended for the above-cited quality-of-care violation. R. 400.675 (1) is a repeat violation from SIR #2026A0467015 dated 2/24/26.



06/01/2026

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Anthony Mullins  
Licensing Consultant

Date

Approved By:



For

06/03/2026

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Jerry Hendrick  
Area Manager

Date