



STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

GRETCHEN WHITMER  
GOVERNOR

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 #: 2026A0467031  
Serenity Homes - North

Dear Ms. 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:

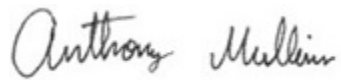
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance 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. 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 (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>	2026A0467031
<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)

	<b>Violation Established?</b>
Resident A was not receiving her Invega medication as prescribed.	Yes
Additional Findings	Yes

## III. METHODOLOGY

04/08/2026	Special Investigation Intake 2026A0467031
04/08/2026	Special Investigation Initiated - Telephone Spoke to complainant via phone
04/14/2026	Inspection Completed On-site
04/15/2026	A second unannounced inspection was completed On-site
04/15/2026	Contact – document received via email from Chief Operations Officer, Jess Engstrom.
05/12/2026	Contact – document received via email from Chief Operations Officer, Jess Engstrom
06/03/2026	Exit conference with licensee designee, Morgan Bailey and Chief Operations Officer, Jess Engstrom

**ALLEGATION:** Resident A was not receiving her Invega medication as prescribed.

**INVESTIGATION:** On 4/8/26, I received an online complaint alleging that Resident A went without her oral Invega medication for approximately two weeks in January 2026.

On the same day, I spoke to the complainant via phone and he confirmed the allegations. He explained that Resident A had been taken off her Invega injection in December 2025 after the physician determined it was appropriate to transition her to the oral form. However, Resident A reportedly went about two weeks without receiving the oral medication in January 2026. Her case management team was not made aware of this issue until 01/23/26 during an onsite visit. During the visit, the

case manager learned that the oral Invega prescription had been sent to the wrong pharmacy, and the problem was corrected immediately.

There is concern that the missed doses could have been prevented with proper communication from AFC staff. Additionally, because Resident A went more than two weeks without the medication, there is concern that she may have concluded she no longer needed it without first consulting her physician.

On 4/14/26, I conducted an unannounced onsite investigation at the facility. Upon arrival, I briefly spoke with AFC staff member Kimberly Gillman regarding the allegations. Ms. Gillman shared that she does not administer medications to residents because she is not trained to do so; therefore, she did not have relevant information, and the interview concluded.

I then spoke with AFC staff member Carmen Ash regarding the allegations. Ms. Ash denied having any knowledge that Resident A went more than 14 days without her oral Invega medication in January 2026. However, she stated that Resident A often refuses her medications and needs encouragement to take them. Ms. Ash reported that staff sometimes attempt to offer incentives to prompt Resident A to take her medication, though this is not always effective. She also stated that she was unsure whether other staff were completing incident reports when Resident A refused her medications, despite the requirement to do so. Ms. Ash further acknowledged that it is possible that she forgot to complete an incident report at times because “it gets confusing.”

Before concluding my interview with Ms. Ash, she provided copies of Resident A’s MAR’s from January through April as requested. The MAR’s were reviewed and the findings are summarized below:

The January 2026 MAR shows that Resident A’s Paliperidone ER 6MG Tab (Invega) was either out of stock or marked as refused beginning on 01/25/26. It should be noted that the prescription was not sent to the correct pharmacy until 01/23/26, which accounts for Resident A not receiving the medication for the majority of January. Resident A is also prescribed Desyrel 100mg (Trazadone) and the MAR indicates that most doses in January were missed due to the medication being listed as “out of stock” or “none in the med cart,” which is not an appropriate justification for missed doses.

The February 2026 MAR shows that Resident A missed one or more doses of both Desyrel 100mg (Trazadone) and Paliperidone ER 6mg (Invega). On 02/02/26, Resident A did not receive her Trazodone due to it being “out of stock,” which again

is not an acceptable reason for missed medication. On 02/04/26, there is no explanation documented for the missed doses of either medication.

The MARs for March and April 2026 are coded appropriately with no noted issues through the current date.

After reviewing the MARs, I interviewed Resident A in the staff's office at her request. Resident A stated that she has lived at Serenity Homes – North AFC since October 2025. She stated that she had previously been receiving an Invega injection, but this was discontinued because it caused pain in her hip. She has since been switched to the oral form of Invega.

Resident A reported that staff administer her medications as prescribed. She adamantly denied refusing any of her medications since moving into the home. She also denied being aware of any instances in which she did not receive a medication because it was out of stock, despite the MAR documenting otherwise. Resident A stated that her needs are being met, and she expressed no concern regarding staff or the care she receives in the home.

On 06/03/26, I conducted an exit conference with licensee designee, Morgan Bailey and Chief Operations Officer, 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>
<b>ANALYSIS:</b>	Resident A's MAR's confirmed that she did not receive her Invega medication as prescribed in January and February 2026. She also did not receive her Trazadone medication as prescribed in those same months. Therefore, there is a preponderance of evidence to support this applicable rule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED (Repeat violation from SIR #2026A0467015 dated 2/24/26 and SIR #2026A0467030 dated 6/3/26.</b>

**ADDITIONAL FINDING:**

**INVESTIGATION:** Due to the facility’s history of roof leaks and water damage dating back to 2024, I conducted an unannounced onsite visit on 4/15/26 following a storm the previous day. Upon arrival, I spoke with staff member Charlena Pickett and asked whether any leaks had occurred as a result of the storm. Ms. Pickett confirmed that the only active leak was located in the boiler room.

Ms. Pickett provided access to the boiler room, where I observed four empty totes placed on the floor to collect water dripping from the ceiling. The ceiling was visibly wet and showed signs of damage requiring repair. Ms. Pickett reported that roofing contractors had been at the home a few days prior, but she was unsure what the plan was to address the ongoing issue.

On the same day, I received an email from Chief Operations Officer (COO), Jess Engstrom. Mrs. Engstrom reported that work was already underway on the roof to ensure full leak-proof coverage. She stated that minor issues had been identified around February 2026, and she immediately contacted the roofing contractor, who conducted a full inspection to assess and address any additional concerns. A temporary patch was installed to stop the leak until warmer weather allows for permanent repairs. Mrs. Engstrom also stated that she would be signing up for a roof maintenance package, which includes full inspections twice per year and additional service as needed if any leaks are identified.

On 05/12/26, I received an email from Chief Operations Officer (COO), Jess Engstrom. Mrs. Engstrom stated that the roofing contractors through JM Roofing Solutions completed work on the roof and they have not had any issues since the repairs. Mrs. Engstrom provided copies of invoices from JM Roofing Solutions. The two invoices totaled \$3,347.88. As of receipt of this email from Mrs. Engstrom, there are no leaks or needed repairs to the roof.

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 400.647</b>	<b>Safety and maintenance of premises</b>
	<b>(4) Roofs, exterior walls, doors, skylights, and windows must be weathertight and watertight and maintained in good repair.</b>

<b>ANALYSIS:</b>	The ceiling in the boiler room was observed leaking water on 04/15/26 and is in obvious need of repair. Mrs. Engstrom provided invoices from JM Roofing Solutions totaling \$3,347.88, indicating that the issue has been rectified. The facility also has a maintenance contract with the roofing contractor to address any future issues. Based on the information provided, there is a preponderance of evidence to support this applicable licensing rule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I continue to recommend a provisional license as originally recommended in SIR #2026A0467030 on June 3, 2026.

*Anthony Mullins*

06/03/2026

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Anthony Mullins  
Licensing Consultant

Date

Approved By:

*Jay Caluverts*

For

06/03/2026

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Jerry Hendrick  
Area Manager

Date