



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 29, 2025

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

RE: License #: AH250385140
Investigation #: 2025A0784083
Serene Gardens of Grand Blanc

Dear Megan Rheingans:

Attached is the Special Investigation Report for the above-mentioned 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.

Please review the enclosed documentation for accuracy and contact me with any questions. If 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 "Aaron L. Clum".

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250385140
Investigation #:	2025A0784083
Complaint Receipt Date:	09/08/2025
Investigation Initiation Date:	09/09/2025
Report Due Date:	11/07/2025
Licensee Name:	1481 E. Hill, LLC
Licensee Address:	3520 Davenport Avenue Saginaw, MI 48602
Licensee Telephone #:	(989) 892-0658
Administrator/AR:	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?
Inadequate supervision for Resident A	Yes
Resident C was not bathed	Yes
Additional Findings	No

III. METHODOLOGY

09/08/2025	Special Investigation Intake 2025A0784083
09/09/2025	Special Investigation Initiated - On Site
09/09/2025	Inspection Completed On-site
09/09/2025	Exit Conference Conducted with staff 1

ALLEGATION:

Inadequate supervision for Resident A

INVESTIGATION:

On 9/08/2025, the department received this online complaint. Due to the anonymous nature of the complaint, additional information could not be obtained.

According to the complaint, a resident recently eloped from the building and was eventually brought back to the facility by the police. No names, dates or times were provided with this complaint.

On 9/09/2025, I interviewed staff 1, a supervisor, at the facility. Staff 1 stated that on 8/25/2025, Resident A was able to exit the facility through a window in Resident B's room. Supervisor stated the window had a stopper on it so that it could only open partially, however the stoppers on each side of the window were not secured. Staff 1 stated Resident A is a memory care (MC) resident and that the room she exited through was in the memory care. Staff 1 stated that each stopper, one of each side of the window, if pulled in at the same time would allow the window to open all the way. Staff 1 stated this is how Resident A was able to get out through the window. Staff 1 stated staff 2 has since put a stopper on the window that cannot be

maneuvered. During the onsite, I observed the window in Resident B's room which did have a block drilled into the side of the wall about the window so it could not be opened all the way. Staff 1 stated Resident A had not been living at the facility for long. Staff 1 stated that since Resident A started living there, she was a known exit seeker, often trying to get out of the building any way she could. Staff 1 stated Resident A had been observed attempting to leave through another residents window prior to getting out on 8/25/2025. Staff 1 stated that based on the time frame Resident A was brought back to the building by police, approximately, staff reported she had been checked on approximately 15 minutes before she exited the building as staff had reportedly asked if Resident A wanted to play bingo. Staff 1 stated Resident A is receiving hospice services and that due to new medications, she has calmed down a bit. Staff 1 stated Resident A does still wander but is doing less exit seeking.

I reviewed Resident A's service plan, provided by staff 1. According to the plan Resident A was admitted to the facility on 8/20/2025. Under a section titled *Elopement History/Risk Information*, the plan read "Resident does not want to be at the facility. Will attempt to find anyway to leave the building". Under a section titled *Safety Checks*, the plan read "staff will check on the residents' whereabouts and safety regularly throughout the day, around the clock", "6 Times/Day".

I reviewed Charting Notes for Resident A, provided staff 1. Notes dated 8/24/2025 read "resident was out in the lobby with two more residents, resident was given prn today due to agitation and trying to exit bedroom window".

During the onsite, I observed Resident A in the dining area talking with another resident. Resident A appeared well groomed and calm at that time.

APPLICABLE RULE	
R 325.1921	Governing bodies, administrators, and supervisors.
	<p>(1) The owner, operator, and governing body of a home shall do all of the following:</p> <p style="padding-left: 40px;">(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.</p>

ANALYSIS:	<p>The complaint alleged Resident A was inadequately supervised when she exited the building through another resident's window on 8/25/2025. When interviewed, staff 1 confirmed Resident A was able to exit through Resident B's window on 8/25/2025. The investigation revealed that while Resident A was known to constantly exit seek and had previously attempted to exit the building through a window, she was still unsupervised for long enough that staff did not notice she was gone from the building for approximately 30 minutes. Staff 1 stated the staff reported having last checked on Resident A approximately 15 minutes before she was able to exit the building which would indicate staff was not aware of Resident A's whereabouts for approximately 45 minutes before she was brought back to the facility by police. It should also be noted that Resident A was able to exit through Resident B's window that, at the time, did not have secured window stoppers as what was on the window could be easily manipulated to fully open the window. Additionally, while Resident A is known to be a constant exit seeker who exit the building within 15 minutes of staff checking on her, Resident A's service plan defines her supervision needs as around the clock and at least 6 times a day while providing no specific times or duration for these checks. Based on the findings, the allegation is substantiated.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident C was not bathed

INVESTIGATION:

According to the complaint, Resident C was admitted to the facility on 8/06/2025. Resident C is supposed to be bathed two times a week and has not received a shower or bathing since he moved in.

When interviewed, staff 1 stated Resident A is scheduled to receive showers at least two times a week. Staff 1 stated she could not be certain what his shower schedule was or how often he had been showered since he moved to the facility. Staff 1 stated bathing is tracked on the facilities ADLs (activities of daily living) log and that when showers or baths are provided, staff initials are entered into the log to indicate this task was completed.

On 9/09/2025, I interviewed Resident C at the facility. Resident C stated he received a shower this morning for the first time since he moved into the facility. Resident C stated he feels the staff at the facility are nice but do not seem to ever offer him opportunities for bathing. Resident C stated he does need assistance with bathing as he cannot perform the task on his own. Resident C appeared clean and well-groomed at the time of the interview.

I reviewed Resident C's service plan, provided by staff 1. The service indicated Resident C required assistance from staff with bathing and preferred this task to be completed on Tuesday and Friday mornings.

I reviewed Resident A's ADLs log for August and September 2025. Under the *BATHING* section, the log did not include initials for any day between Resident A's admission date and present day.

APPLICABLE RULE	
R 325.1933	Personal care of residents.
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	The complaint alleged Resident C had not been bathed since his admission to the facility on 8/06/2025. The investigation revealed that while Resident C had been bathed the day of the onsite, interviews and documentation from the facility indicated Resident A had gone several days, perhaps since his admission, without being bathed. Based on the findings, the allegation is substantiated.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L. Clum

9/25/2025

Aaron Clum
Licensing Staff

Date

Approved By:

Andrea L. Moore

09/26/2025

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

Date