GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 21, 2021

Birdie Goynes
Renaissance Gardens at Fox Run
41215 Fox Run Rd.
Novi, MI 48377

RE: License #: AH630306479
Investigation #: 2021A1019039

Dear Ms. Goynes:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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 authorized representative and a date.

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 (248) 975-5053.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630306479
Investigation #:	2021A1019039
Complaint Receipt Date:	07/07/2021
Investigation Initiation Date:	07/07/2021
Report Due Date:	09/06/2021
Licensee Name:	Fox Run Village, Inc.
Licensee Address:	41000 W. 13 Mile Rd. Novi, MI 48377
Licensee Telephone #:	(248) 668-8688
Administrator and Authorized Representative:	Birdie Goynes
Name of Facility:	Renaissance Gardens at Fox Run
Facility Address:	41215 Fox Run Rd. Novi, MI 48377
Facility Telephone #:	(248) 668-8720
Original Issuance Date:	02/24/2010
License Status:	REGULAR
Effective Date:	12/13/2020
Expiration Date:	12/12/2021
Capacity:	88
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Numerous physical altercations involving Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/07/2021	Special Investigation Intake 2021A1019039
07/07/2021	Comment Multiple incident reports received recently for unprovoked physical altercations.
07/07/2021	Special Investigation Initiated - Letter Emailed admin/AR requesting service plan
07/19/2021	APS Referral
07/19/2021	Inspection Completed BCAL Sub. Compliance
07/21/2021	Exit Conference

ALLEGATION:

Numerous physical altercations involving Resident A.

INVESTIGATION:

Licensing staff received multiple incident reports outlining physical altercations with Resident A on 6/15/21, 6/24/21 and 7/3/21. On 6/15/21, facility staff documented that at 2:00pm:

> MK [staff member] heard Resident B screaming from down the hall and arrived to observe Resident A hitting Resident B's left leg with the bedroom door. Residents were separated and assessed for injury. No injury noted to Resident A. Resident A stated, "someone walked into my room and we were talking."

> Resident A had no recollection of any physical altercation and was last noted sleeping in bed before the incident. Staff were assisting other residents with ADL care at the time of incident. Resident A has a history of physical actions and expressions. Resident A is also seeing mental health for antipsychotic medication management and psychotherapy.

The corrective measures for the incident read “Velcro stop sign installed on entryway apartment door to redirect other residents' away from apartment. Apartment lock requested on 6-15-21 and installed on 6-16-21.”

On 6/15/21, facility staff documented that at 6:00pm:

Care staff NS heard Resident C yell, "don't hit me on my head again". Care staff went to observe the situation and noted Resident A walking away from Resident C with rolled papers in her hand. Resident C stated, "that girl hit me on my head with a newspaper." No injuries noted. Care staff was assisting another resident with medication administration at the time of the incident. Resident A has a history of physical and verbal actions and expressions. Resident was last observed laying in her bed sleep 30 minutes before the incident.

The corrective measures for the incident read:

> MCM to provide 1:1 companionship for remainder of afternoon shift for safety purposes on 6-15-21. Husband to provide 1:1 companionship on day shift on 6-16-21. Actively pursuing companion to engage resident as tolerated on regular basis to provide socialization. Resident will undergo medical work up to obtain urine collection and bloodwork to rule out medical issues.

On 6/17/21, licensing staff had a phone call with facility administrator and authorized representative Birdie Goynes. The phone call addressed the department’s concerns over the aforementioned unprovoked physical altercations involving Resident A. Licensing staff advised Ms. Goynes to evaluate the resident’s disposition as it relates to the facility’s discharge policy, taking into consideration safety of all other residents at the facility. Ms. Goynes did not feel that Resident A should be discharged and wanted more time to seek other alternatives. Licensing staff reviewed the home for the aged administrative rules pertaining to discharge with Ms. Goynes and discussed expectations for discharge if outbursts continued to occur, to which Ms. Goynes verbalized understanding.

On 6/24/21, facility staff documented at 7:00pm:

> Resident A entered Apt 320 and stated to staff member, “do something with these people”. Staff member observed Resident D and Resident B at Apt 316 doorway. Resident D was holding the right side of her face and stated that woman [Resident A] hit me pointing at Resident A. No redness or bruising noted. No injury noted. Resident D declined more thorough assessment continuing to

explore neighborhood independently in wheelchair. No change in condition noted.

Resident A entered Apt 320 and stated to staff member, “do something with these people”. Staff member observed Resident D and Resident B at Apt 316 doorway. Resident B observed upset. When asked by staff member if she was hurt, resident said she thinks she dreamed of being hit but could not give details. No injury noted. No change in condition noted.

The corrective measures listed for Residents B and D read “Resident encouraged socialize with other residents in common areas.” The corrective measures listed for Resident A read “Resident was seen by mental health provider on 6-25-21. Labs work ordered to evaluate Depakote level. Resident encouraged to use fabric barrier on door.”

On 6/28/21, licensing staff reached out to Ms. Goynes advising on the need for more monitoring and supervision of Resident A given the additional outbursts. At that time, licensing staff also reminded Ms. Goynes on licensing rules pertaining to discharge, including less than 30 day discharge criteria. On 6/29/21, revised corrective measures were submitted for Resident A that read “Care staff will complete 30 minute checks on resident during every shift, for 2 weeks to assess and document resident whereabouts and patterns. Family will increase visitation to 7 days a week during the timeframe where increased actions and expressions occur.”

On 7/3/21, facility staff documented at 11:50am:

Med tech TU stated that resident was sitting at the dining table with other residents. The other residents started to make fun of Resident A, and Resident E started laughing at her. Resident A took the birthday card that she was holding and hit Resident E in the left arm with the card. No injuries noted to either resident. Resident A has a history of physical actions and expressions, and is currently taking Depakote 250mg, twice a day. Resident routinely follows up with the mental health team for medication management. Resident also had labs drawn on 6-25-21. Labs showed that resident was dehydrated, therefore staff increased fluids.

The corrective measures for the incident read “Staff will encourage resident to dine and socialize with other residents during meals.”

On 7/3/21, facility staff documented at 1:33pm:

Dining staff SC reported that Resident A was sitting in the living room, and Resident F attempted to talk to her. Resident A told Resident F to get out of her face. As Resident F was backing up, Resident A lightly kicked the other resident in the right leg twice. No injuries noted to either resident. Resident A has a history of physical actions and expressions.

The corrective measures for the incident read “Staff have increased their rounding to every 30 minutes. Medications submitted to pharmacy for review to rule out interactions. MCM is pursuing 1:1 companionship for resident for time to be determined during waking hours.”

Resident A’s service plan was updated to reflect the corrective measures outlined in the incident reports.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: **R 325.1901**	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision. **(22) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following:** **(d) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.**

ANALYSIS:	Facility staff have documented incidents of physical outbursts on 6/15/21, 6/24/21 and 7/3/21 all involving Resident A. Licensing staff advised the facility to increase supervision and discussed discharge criteria on more than one occasion, however given that issues continue to arise, it is not reasonable to assume that facility staff are providing adequate monitoring and supervision of Resident A in order to sufficiently protect other residents. Based on this information, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(8) A home shall not retain a resident if the resident has harmed himself or herself or others, or has demonstrated behaviors that pose a risk of serious harm to himself or herself or others, unless the home has the capacity to manage the resident's behavior.
ANALYSIS:	Facility staff have demonstrated an inability to manage Resident A's unpredictable physical outbursts, placing other residents at risk of harm. Based on this information, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/21/21, I shared the findings of this report with authorized representative Birdie Goynes. Ms. Goynes verbalized understanding of the citations.

IV. RECOMMENDATION

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

7/21/21

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

7/21/21

Russell B. Misiak Date
Area Manager