GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 23, 2022

Scott Brown
Renaissance Community Homes Inc
P.O. Box 749
Adrian, MI 49221

RE: License #: AS810243198
Investigation #: 2022A0122028
South Lawn House

Dear Mr. Brown:

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) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS810243198
Investigation #:	2022A0122028
Complaint Receipt Date:	05/20/2022
Investigation Initiation Date:	05/23/2022
Report Due Date:	07/19/2022
Licensee Name:	Renaissance Community Homes Inc.
Licensee Address:	Suite C 1548 W. Maume St. Adrian, MI 49221
Licensee Telephone #:	(734) 439-0464
Administrator:	Scott Brown
Licensee Designee:	Scott Brown
Name of Facility:	South Lawn House
Facility Address:	2735 South Lawn Ypsilanti, MI 48197
Facility Telephone #:	(734) 572-0783
Original Issuance Date:	11/26/2001
License **Status:**	REGULAR
Effective Date:	06/18/2020
Expiration Date:	06/17/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Residents of the South Lawn House adult foster care facility did not receive their evening medications on 05/18/2022.	Yes
There was no documentation for the missed medications on 05/18/2022.	No
Additional Findings	Yes

III. METHODOLOGY

05/20/2022	Special Investigation Intake 2022A0122028 APS Referral
05/23/2022	Special Investigation Initiated - Telephone Completed interviews with Jenise Boykin, District Manager, and staff members 1 and 2.
05/23/2022	Contact - Telephone call made Left voice messages for Staff 2 and 3. Requesting return phone call.
05/23/2022	Contact - Document Received Received information from Jenise Boykin.
06/02/2022	Contact – Telephone call received Scott Brown, Licensee Designee
06/02/2022	Exit Conference Discussed findings with Scott Brown
06/13/2022	ORR Referral

ALLEGATION: Residents of the South Lawn House adult foster care facility did not receive their evening medications on 05/18/2022.

INVESTIGATION: On 05/23/2022, I completed an interview with Staff 1. Staff 1 reported that she arrived to work on 05/19/2022 and observed that the evening medications of all residents for 05/18/2022 were in their pharmacy containers and

had not been dispensed by the previous assigned staff members. Staff 1 stated she contacted administrative staff members Jenise Boykin, District Manager, Alanda, Area Manager, and Christy, Operations Manager. Ms. Boykin directed Staff 1 to administer the missed medication to the residents, however, Staff 1 stated she did not feel comfortable completing that directive. Staff 1 stated Ms. Boykin arrived at the facility, stated she would pass the missed medication, and directed Ms. Boykin to leave the property.

On 05/23/2022, Staff 2 reported that worked on 05/18/2022 and reported to Ms. Boykin that her medication certification expired in January 2022, and she did not feel comfortable administering medication. Staff 2 confirmed she did not administer evening medication to the residents on 05/18/2022.

On 05/23/2022, I completed an interview with Jenise Boykin. Ms. Boykin confirmed that the residents did not receive their evening medication on 05/18/2022. Ms. Boykin further explained that due to a scheduling issue there was no employee who had a current medication certification on site to pass medication on the evening of 05/18/2022. Ms. Boykin stated that an incident report was completed to document the missed medications of the residents and she made reference of the missed medications on each resident's medication administration sheet.

On 05/23/2022 and 05/26/2022 Ms. Boykin submitted Medication Administration Records for all the residents (Residents A- F) dated May 2022. The records document that all residents (Residents A-F) did not receive their evening medications as prescribed on the evening of 05/18/2022; there is no staff initial to verify medication was administered and it states "medication was missed" on all forms.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	On 05/23/2022, Staff 1, 2, and Jenise Boykin reported none of the residents received their prescribed medication on the evening of 05/18/2022. Medication Administration Records dated May 2022 document that all residents (Residents A-F) did not receive their prescribed medication on the evening of 05/18/2022. Based upon my investigation I find that the prescription medication of all residents (Residents A-F) was not given as prescribed by their physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: There was no documentation for the missed medications on 05/18/2022.

INVESTIGATION: On 05/23/2022 and 05/26/2022 Ms. Boykin submitted Medication Administration Records for all the residents (Residents A- F) dated May 2022. The records document that all residents (Residents A-F) did not receive their evening medications as prescribed on the evening of 05/18/2022; there is no staff initial to verify medication was administered and it stated “medication was missed” on all forms.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

ANALYSIS:	Resident Medication Administration Records were submitted on 05/23/2022 and 05/26/2022. The records documented that all residents (Residents A-F) did not receive their evening medications as prescribed on 05/18/2022 as there was no staff initial to verify medication was administered and it stated "medication was missed" on all forms. Based upon my investigation there is evidence to support that individual medication logs were completed appropriately on the evening of 05/18/2022. There was no staff initial placed on the records the evening of 05/18/2022 indicating that medication was not administered at that time. In addition, there was a statement on the back of each form stating that all medication was missed during the evening medication pass.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 06/02/2022, Scott Brown reported there was insufficient staffing on the midnight shift on 05/28/2022 and during the day shift on 5/29/2022. There was only one staff on duty at the Southlawn Home, District Manager Jenise Boykin. Mr. Brown further reported that Ms. Boykin was given the directive to contact Operations Manager, Kristy Gottschalk if she was unable to cover shifts on 05/28/2022 and 05/29/2022. Ms. Boykin did not contact Kristy to say the home was understaffed. When this was discovered on Sunday night, Jenise quit her position without notice. Per Mr. Brown, there is a need to have at least 2 staff members during all shifts to address resident needs.

Mr. Brown further reported that he and Ms. Gottschalk formulated a staff schedule to cover all shifts to include processes that will address staff call-ins so that staff are always available to residents to address their needs.

On 06/02/2022, I reviewed Assessment Plans for all residents, Residents A-F. The information reviewed documented that four residents need assistance from staff members with walking/ambulation. Of the four residents that require assistance with walking/ambulation two of them require total assistance from staff members to move as they both use wheelchairs.

On 06/02/2022, I completed an exit conference with Scott Brown, Licensee Designee. Mr. Brown was in agreement with my findings and stated he would submit a corrective action plan to address rule violations found.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plans.
ANALYSIS:	On 06/02/2022, Scott Brown, Licensee Designee reported insufficient staff on duty for the dates of 05/28/2022 midnight shift and during the day shift on 5/29/2022. Mr. Brown stated due to the resident needs there should be at least 2 staff members present during all shifts. Reviewed resident Assessment Plans documented four residents require assistance from staff members with walking/ambulation. Of the four residents that require assistance with walking/ambulation two of them require total assistance from staff members to move as they both use wheelchairs. Based upon my investigation there is evidence to support insufficient direct care staff on duty on 05/28/2022 midnight shift and during the day shift on 05/29/2022. During those dates and times there was only one staff present. Per Mr. Brown and Resident Assessment Plans, residents require there to be at least 2 staff members present in the facility providing care.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan I recommend no change to the status of the license.

Vanita C. Bouldin — Date: 06/13/2022
Licensing Consultant

Approved By:

Ardra Hunter — Date: 06/23/2022
Area Manager