GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 19, 2023

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

RE: License #: AS810255078
Investigation #: 2023A0122008
Clark Road Home

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 #:	AS810255078
Investigation #:	2023A0122008
Complaint Receipt Date:	12/14/2022
Investigation Initiation Date:	12/14/2022
Report Due Date:	02/12/2023
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:	Clark Road Home
Facility Address:	510 W. Clark Road Ypsilanti, MI 48197
Facility Telephone #:	(734) 961-7822
Original Issuance Date:	05/15/2003
License Status:	REGULAR
Effective Date:	09/18/2022
Expiration Date:	09/17/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
There is only one staff member on the premises providing personal care to 5 residents.	No
Resident A’s clothes are missing.	Yes
Guardian A was locked out of the facility.	No
The facility shower bed and Trixie lift are broken. The shower bed is used to transport trash out of the facility.	No
There is mold in the facility bathrooms and in Resident A’s closet.	No
Client has numerous unexplained bruises and cuts over past months.	No
Cough Assist machine ($14,000.00) missing and must be returned, or client will be charged.	No

III. METHODOLOGY

12/14/2022	Special Investigation Intake 2023A0122008 Recipient Rights Referral via letter dated 11/23/2022
12/14/2022	Special Investigation Initiated - Letter Email sent to Relative A. Requested date that Guardian was locked out of facility. Requested date one staff member observed on premises. Requested list of Resident A's missing clothes with proof of purchase.
12/15/2022	Inspection Completed On-site Observed 3 staff members on premises. Observed Resident A's closet and room. Observed facility bathrooms. Observed facility shower bed and Hoyer lifts. Pictures taken of facility bathrooms and Hoyer lifts.
12/15/2022	Contact - Face to Face Completed interview with Shana Jackson, Home Manager.
12/15/2022	Contact - Telephone call made

	APS Referral made.
12/16/2022	Contact – Document received Requested information received from Guardian A and Relative A's representative.
12/16/2022	Onsite Inspection Observed Resident A receiving personal care from Ernest Washington, staff member.
12/16/2022	Contact – Telephone call made and received Tom Karm, Supports Coordinator
12/21/2022	Onsite Inspection Observed Resident A and assessed his under garments. Completed interview with Ernest Washington, Staff Member.
12/22/2022	Contact – document received Email received from Madeline Schork, UofM Hospital Social Worker.
12/27/2022	Contact – telephone calls made Guardian B, C, and D.
12/28/2022	Contact – document received Staff schedules of the Clark Road Home.
01/04/2023	Exit Conference Discussed findings with Scott Brown, Licensee Designee.

ALLEGATION: There is only one staff member on the premises providing personal care to 5 residents.

INVESTIGATION: On 12/15/2022, I observed 3 staff members in the adult foster care facility providing care to 5 residents. I observed 5 residents sitting in the living room, clean, neat, and appropriately dressed. All were in their assigned wheelchairs. One was playing with a toy piano and the others were watching television or smiling/looking as a response to staff speaking to them.

On 12/16/2022, I observed 2 staff members in the premises providing care to 5 residents. I observed 4 residents sitting in the living room listening to music streamed/playing from the television. The volume of the music was on a soft level, the residents could hear from the living room, however, if you were in another area

of the facility, it was difficult to hear. I observed the residents to be calm, relaxed, showing no signs of distress. One resident played with his toy piano.

On 12/16/2022, a statement from Guardian A and Relative A's representative was received documenting the following: on 11/07/2022, Relative A arrived at the facility and staff member, Ernest Washington, was alone caring for four residents. Erica Newsome arrived around 30 minutes later…she bought in food for her and Ernest. She claimed to have taken the house van to fill up the gas tank.

On 12/16/2022, I completed an interview with Tom Karm, Supports Coordinator affiliated with Washtenaw County Community Mental Health. Mr. Karm reported that he visits with Resident A at the facility monthly. Mr. Karm stated he has observed staff members provide care and services to Resident A appropriately as needed. Mr. Karm stated he has observed no issues of abuse and/or neglect. He has no concerns with the care being provided by staff members currently.

On 12/19/2022, I completed an interview with Laveda Smith, Adult Protective Services Worker. Ms. Smith reported that she had completed an unannounced inspection and observed Resident A at the facility. Ms. Smith did not observe any issues of abuse and/or neglect while she was in the facility. She reported that that she has observed at least 2 staff members present whenever she has visited the facility.

On 12/21/2022, I completed an onsite inspection. Two staff members were present, Ernest Washington and Adriana Roberts. I observed 4 residents sitting quietly in the living room, two receiving their lunch via tube feeding and two being fed with the assistance of staff members. The residents appeared to be comfortable showing no signs of discomfort or distress.

On 12/27/2022, I completed an interview with Guardian B. Guardian B reported that Resident B "seems to be cared for and well-groomed." She stated the times that she has observed Resident B she doesn't have any concerns for his care. Guardian B reported she does have concerns regarding the décor of the facility and that it was not decorated to reflect the Christmas Holiday season.

On 12/27/2022, I completed an interview with Guardian C. Guardian C stated she had no concerns with the care Resident C receives from staff members of the Clark Road Home adult foster care facility. Guardian C stated she has observed staff members at different times during different events, i.e., providing care, music therapy (listening to music), Just Us zoom meetings and reports they interact appropriately with all residents taking into account the different needs of the residents.

On 12/28/2022, I reviewed staff schedules for the dates of 10/28/2022 – 12/22/22. Staff schedules document there are at least two staff members are assigned to provide personal care to the residents every day.

On 01/04/2023, I completed an exit conference with Scott Brown, Licensee Designee. Mr. Brown was in agreement with my findings and had nothing further to add.

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 plan.
ANALYSIS:	On 12/15/2022, 12/16/2022, and 12/22/2022, I completed onsite inspections at the Clark Road Home adult foster care facility. Each time I observed at least two staff members present providing care to the residents of the facility. On 12/16/2022, a statement from Guardian A and Relative A stated on 11/07/2022 there was only one staff present providing care to four residents. On 12/16/2022, Tom Karm, Supports Coordinator reported no concerns with care being provided to Resident A by the staff members of Clark Road Home adult foster care facility. On 12/19/2022, Laveda Smith, Adult Protective Services Worker, reported that she has observed at least two staff members present whenever she has visited the facility. On 12/27/2022, Guardians B and C reported no concerns with care being provided by the staff members of the Clark Road Home adult foster care facility to the residents that live there. On 12/28/2022, Staff schedules documented at least two staff members assigned to provide personal care to the residents. Based upon my investigation there is no evidence to support the allegation there is only one staff member on the premises providing personal care to 5 residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A's clothes are missing.

INVESTIGATION: On 12/15/2022, I observed Resident A's closet. His clothes were hung neatly or folded in their proper place. I observed other personal items stored in his closet as well. Pictures were taken to document Resident A's clothing and the condition of his closet.

On 12/16/2022, a statement from Guardian A and Relative A's representative was received documenting the following: Guardian A recently purchased brand new white undershirts and they have only been able to locate one item in his belongings. He is also missing two U of M sweatpants. Guardian A would have to get with her accountant to see if she can obtain receipts for these items.

On 12/21/2022, I observed that Resident A had one white undershirt in his possession, neatly folded in his bedroom. I observed several pairs U of M sweatpants belonging to Resident A. I completed an interview with Ernest Washington. Mr. Washington confirmed that some of Resident A's undershirts are missing, stating they may be placed in another resident's room. Mr. Washington stated he did not believe any of Resident A's sweatpants were missing.

On 01/04/2023, I completed an exit conference with Scott Brown, Licensee Designee. Mr. Brown was in agreement with my findings and had nothing further to add.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(j) The right of reasonable access to and use of his or her personal clothing and belongings.**

ANALYSIS:	On 12/16/2022, Guardian A and Relative A reported recently purchasing new white undershirts for Resident A and he is missing two U of M sweatpants. On 12/21/2022, I observed that Resident A had one white undershirt and several U of M sweatpants in his bedroom. On 12/21/2022, Ernest Washington confirmed that Resident A is missing undershirts but unable to confirm that his U of M sweatpants are missing. Based upon my investigation there is evidence to support the allegation that some of Resident A's undershirts are missing therefore he does not have access to that item of personal clothing.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Guardian A was locked out of the facility.

INVESTIGATION: On 12/16/2022, a statement from Guardian A and Relative A's representative was received documenting the following: On 11/01/2022 and 11/07/2022 both Guardian A and Relative A were locked out of the facility. On 11/01/2022, both "arrived early and were in the car waiting. Staff member, Adriana Roberts, pulled in while they were in the car, she was the last person in the home after seeing them in the driveway. The door was locked while Guardian A and Relative A were waiting for the dog to do her business, both heard the facility door being locked. They had to knock/ring the doorbell to be let in.

On 11/07/2022, at approximately 3:00 -4:00 p.m., when Guardian A and Relative A arrived at the home there were no cars in the driveway, Relative A tried the door, and it was locked. She knocked and staff member, Ernest Washington came to the door and let them in.

On 12/15/2022 and 12/16/2022, upon my arrival to the facility to complete my onsite inspections I found the facility door locked. I rang the doorbell and knocked to announce my arrival. I was allowed entry by a staff member. This has always been the procedure of this adult foster care facility and many others that I monitor. The doors of the adult foster care facilities are locked for safety and staff members allow entry.

On occasion I have had to wait for as long as 5 minutes until I am allowed entry into the Clark Road Home adult foster care facility as staff members have been attending to the needs of the residents. I have not observed any unusual activity from staff

members during those times where entry was delayed nor have, I observed unusual activity or behaviors from the residents. This is a home that provides care to several medically fragile individuals so delayed entry can be expected from visitors.

On 12/27/2022, I completed an interview with Adriana Roberts. Ms. Roberts reported that she vaguely remembered the incident on 11/01/2022. She reported that she arrived at the facility and entered first. She heard a knock on the door and allowed Guardian A and Relative A into the facility. Ms. Roberts confirmed that the door is always locked.

On 01/04/2023, I completed an exit conference with Scott Brown, Licensee Designee. Mr. Brown was in agreement with my findings and had nothing further to add.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(k) The right to have contact with relatives and friends and receive visitors in the home at a reasonable time. Exceptions shall be covered in the resident's assessment plan. Special consideration shall be given to visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.**

ANALYSIS:	On 12/16/2022, Guardian A and Relative A reported that on 11/01/2022 and 11/07/2022 the facility door was locked when they attempted to gain entry. A staff member had to let them in when they knock and/or rang the doorbell. On 12/15/2022 and 12/16/2022, I observed that the facility door was locked, and a staff member had to let me into the facility. On 12/27/2022, Adriana Roberts, confirmed that the facility door is always locked. Based upon my investigation there is no evidence to support the allegation that Guardian A was locked out of the facility. On 11/01/2022 and 11/07/2022, the facility door was locked but Guardian A was allowed entry by staff members.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility shower bed and Trixie lift are broken. The shower bed is used to transport trash out of the facility.

INVESTIGATION: On 12/15/2022, 12/16/22 and 12/21/22, I observed the facility shower bed stored in the facility bathroom. Per Shana Jackson, the Trixie lift has not been used to transfer resident for years. There are two Hoyer lifts used to transfer residents. I observed two Hoyer lifts in the facility. All assistive devices, shower bed and Hoyer lifts, were clean and placed properly in the facility. Pictures were taken to document the condition of the assistive devices.

On 01/04/2023, I completed an exit conference with Scott Brown, Licensee Designee. Mr. Brown was in agreement with my findings and had nothing further to add.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(1) An assistive device shall only be used to promote the enhanced mobility, physical comfort, and well-being of a resident.

ANALYSIS:	On 12/15/2022, 12/16/2022, and 12/21/2022, I observed that the shower bed and Hoyer lifts were clean and appropriately placed in the facility. On 12/15/2022, Shana Jackson reported the Trixie lift is not used to transfer the residents. Based upon my investigation I find no evidence to support the allegation that the shower bed and Trixie lift are broken; nor that the shower bed is used to transport trash out of the facility. During my onsite inspections I observed the assistive devices to be clean and appropriately placed. Therefore, the assistive devices are used to promote the enhanced mobility, physical comfort, and well-being of a resident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: There is mold in the facility bathrooms and in Resident A's closet.

INVESTIGATION: On 12/15/2022, I observed no mold in the facility bathrooms nor any mold in Resident A's closet. I observed the bathrooms and the closet to be clean and neat. Pictures were taken to document the condition of the facility bathrooms and Resident A's closet.

On 12/15/2022, Scott Brown, Licensee Designee, reported that a leak in the facility bathroom had been discovered in 2021 causing mold in the bathroom and in Resident A's closet. Mr. Brown stated the leak was repaired, the facility cleared of mold, and bathroom remodeled. Per Mr. Brown, the repair of the bathroom took some time due to delays with material and repair personnel's schedule but since repairs have completed the bathroom is functioning properly without issues.

On 01/04/2023, I completed an exit conference with Scott Brown, Licensee Designee. Mr. Brown was in agreement with my findings and had nothing further to add.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	On 12/15/2022, I observed no mold in the facility bathrooms nor in Resident A's closet. The bathrooms and closet were clean and neat. Based upon my investigation I find no evidence to support the allegation of mold in the facility bathrooms and Resident A's closet. Therefore, the Clark Road Home is constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Recliner chair has been broken repeatedly and had formula spilled all over it – needed to be replaced or repaired more than once. Guardian has paid for some replacements. Renaissance Community Homes paid for some.**
- **Feces frequently on the bed sheets and client's recliner chair.**

INVESTIGATION: Special investigations were completed on the above additional allegations received from letter dated 11/23/2022.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Special Investigation Reports 2022A0122042 and 2022A0122040 documents investigation and findings of the above allegations
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A has numerous unexplained bruises and cuts over past months.

INVESTIGATION: A special investigation was completed on the above additional allegation received from letter dated 11/23/2022.

On 12/16/2022, I completed an interview with Tom Karm, Supports Coordinator affiliated with Washtenaw County Community Mental Health. Mr. Karm reported that he visits with Resident A at the facility monthly. Mr. Karm stated he has observed staff members provide care and services to Resident A appropriately as needed. Mr. Karm stated he has observed no issues of abuse and/or neglect. He has no concerns with the care Resident A is receiving from staff members currently.

On 12/19/2022, Ms. Smith, Adult Protective Services Worker, reported that she had completed an unannounced inspection and observed Resident A at the facility. Ms. Smith did not observe any issues of abuse and/or neglect while she was in the facility. She reported that Resident A was neat, clean, and smiled as she interacted with him. Ms. Smith reported that Resident A's bedroom, closet/clothing, assistive devices were clean and neatly arranged.

On 12/22/2022, I received an email from Madeline Schork, U of M Hospital Social Worker. Ms. Schork stated she had followed up with Resident A's primary care physician, Dr. Ledesai, and reported the following: She told me when she has seen Resident A in the clinic she has seen no "red flags" for concern of abuse or neglect. She reports he is fragile medically, but she has seen no bed sores or unexplained bruises and appears to be taken care of.

On 12/27/2022, I completed an interview with Guardian B. Guardian B reported that Resident B "seems to be cared for and well-groomed." She stated the times that she has observed Resident B she doesn't have any concerns for his care. Guardian B reported she does have concerns regarding the décor of the facility and that it was not decorated to reflect the Christmas Holiday season.

On 12/27/2022, I completed an interview with Guardian C. Guardian C stated she had no concerns with the care Resident C receives from staff members of the Clark Road Home adult foster care facility. Guardian C stated she has observed staff members at different times during different events, i.e., providing care, music therapy (listening to music), Just Us zoom meetings and reports they interact appropriately with all residents taking into account the different needs of the residents.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Special Investigation Reports 2022A0122040 and 2022A0122042 documents investigation and findings of the above allegations. On 12/16/2022, 12/19/2022, 12/22/2022, and 12/27/2022, Tom Karm, Laveda Smith, Madeline Schork, Guardian B, and Guardian C reported they had not observed any issues of abuse and/or neglect with Resident A or any other resident in the Clark Road Home adult foster care facility. Mr. Karm and Ms. Smith reported they had observed staff provide care to Resident A and no concerns.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Cough Assist machine ($14,000.00) missing and must be returned, or client will be charged.

INVESTIGATION: A special investigation was completed on the additional allegation received from letter dated 11/23/2022.

On 12/15/2022, Scott Brown, Licensee Designee, reported that he has the Cough Assist Machine and is awaiting direction of where it should be returned.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Special Investigation Report 2023A0122001 documents investigation and findings of the above allegation. 12/15/2022, Scott Brown, Licensee Designee, reported he has the machine in his possession – awaiting direction of where it should be returned.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of corrective action plan I recommend no change in the status of the license.

Vanita C. Bouldin
Licensing Consultant

Date: 01/19/2023

Approved By:

Ardra Hunter
Area Manager

Date: 01/19/2023