GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 20, 2023

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

RE: License #: AS470238879
Investigation #: 2023A0466059
Oak Grove Home

Dear Mr. Brown:

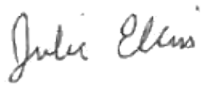
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9727.

Sincerely,



Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS470238879
Investigation #:	2023A0466059
Complaint Receipt Date:	08/24/2023
Investigation Initiation Date:	08/24/2023
Report Due Date:	10/23/2023
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:	Oak Grove Home
Facility Address:	3485 Oak Grove Rd. Howell, MI 48855
Facility Telephone #:	(517) 295-4444
Original Issuance Date:	12/13/2001
License Status:	REGULAR
Effective Date:	09/25/2021
Expiration Date:	09/24/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION:

	Violation Established?
On 08/23/2023, Resident A was left unsupervised in the facility between 5pm-8:06pm.	Yes

III. METHODOLOGY

08/24/2023	Special Investigation Intake- 2023A0466059.
08/24/2023	Referral - Recipient Rights- Jody Marsh assigned.
08/24/2023	Special Investigation Initiated – Telephone call to DCW/house manager Michael Blandford interviewed.
08/24/2023	Inspection Completed- On-site on 8/23/2023 the date the allegation occurred.
09/13/2023	Contact - Document Sent email to Michael Blandford.
9/13/2023	Contact- Telephone call made to DCW Desirae Smith, interviewed.
9/13/2023	Contact- Telephone call made to Devion Nelson, message left.
09/15/2023	Contact- Telephone call received from Devion Nelson, interviewed.
09/15/2023	APS Referral.
9/20/2023	Exit Conference with Scott Brown.

ALLEGATION: On 08/23/2023, Resident A was left unsupervised in the facility between 5pm-8:06pm.

INVESTIGATION:
On 08/24/2023, Complainant reported that on 8/23/2023 between 5pm and 8:06 pm Resident A was left at the facility without any supervision from a direct care worker (DCW). Complainant reported Resident A goes to program and was out of the facility from about noon until 5pm. Complainant reported a DCW was at the facility with Resident A until he was picked up at noon to attend program. Complainant reported that when the bus dropped Resident A off on 08/23/2023 at approximately 5pm, Resident A was able to enter the facility as the door was left unlocked. Complainant reported that about 8:06pm on 8/23/2023, DCW Devion Nelson contacted house

manager/DCW Michael Blandford to report that he forgot to report to work today. Complaint reported DCW Blandford immediately contacted DCW Desirae Smith who lives close to the facility. Complainant reported DCW Smith was scheduled to work at 10pm on 08/23/2023 but she was able to start her shift early at 8:06 pm. Complainant reported Resident A was found in his bedroom by DCW Smith watching his iPad unharmed.

On 08/23/2023, I conducted a renewal on-site inspection and observed Resident A who was the only resident currently living in the facility. I reviewed Resident A's record. DCW Blandford reported another resident is moving into the facility in mid-September. DCW Blanford reported residents are slowly being moved into the facility after the completion of major renovations.

On 08/24/2023, I interviewed DCW Blanford whose role is house manager. DCW Blandford reported that on 8/23/2023 between 5pm and 8:06 pm Resident A was left at the facility without any supervision from a DCW. DCW Blandford reported that about 8:06pm on 8/23/2023, DCW Nelson contacted him to report that he forgot to report to work today. DCW Blandford reported that he has been at the facility earlier Resident A goes to program and was out of the facility from about noon until 5pm. DCW Blandford reported immediately contacting DCW Desirae Smith who lives close to the facility. DCW Michael Blandford reported that DCW Smith was scheduled to work at 10pm on 08/23/2023 but that she was able to start her shift early and arrived at the facility by 8:06pm. DCW Blandford reported DCW Smith found Resident A in his bedroom watching his iPad unharmed.

On 09/06/2023, I interviewed Jody Marsh from the office of recipient rights (ORR) who reported DCW Blandford told her Resident A was left home alone with no direct care worker providing supervision from approximately 5pm until 8:06pm after DCW Nelson forgot to report to work. ORR Marsh stated Resident A was not harmed but was observed on his iPad in his bedroom once direct care staff arrived at the facility.

On 09/13/2023, I interviewed DCW Smith who reported she was scheduled to work on 08/23/2023 from 10pm-6am but received a telephone call asking her to go immediately to the facility as Resident A was without direct care staff supervision. DCW Smith reported the facility door was unlocked so she was able to get into the facility. DCW Smith reported she found Resident A sitting on his bed watching his iPad. DCW Smith reported Resident A had a glass a juice in his room with him and she found a bowl in the sink that had ranch and chipotle sauce in it. DCW Smith reported Resident A was hungry, so she made him dinner. DCW Smith reported Resident A is not very verbal however he can give yes and no responses. DCW Smith was not sure if Resident A realized he was unsupervised. DCW Smith reported that although Resident A had been left unsupervised, he was unharmed. DCW Smith did not see any marks or bruises on him nor was he reporting that he was in any pain. DCW Smith reported Resident A was happily watching his iPad and that he spends a lot of time every day watching his iPad especially when he comes home from program.

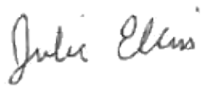
On 09/15/2023, I interviewed DCW Nelson who admitted that he did not report to work on 08/23/2023 as scheduled. DCW Nelson reported he works two different jobs and that he got his schedules mixed up and that he did not realize until 7:45pm on 8/23/2023 that he was supposed to be at work that evening. DCW Nelson reported that since there was just one resident living at the facility, he called DCW Blandford to report that he did not show up for work. DCW Nelson reported this is the first time this has ever happened. DCW Nelson reported he was taken off the schedule at the facility due to this incident.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Complainant, DCW Blandford, ORR Marsh, DCW Smith and DCW Nelson all admitted that Resident A was without a direct care worker on 08/23/2023 for at least 3 hours because DCW Nelson did not report to work.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/20/2023 I conducted an exit conference with licensee designee Scott Brown who understood the findings of the investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in license status.



09/20/2023

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Julie Elkins Date
Licensing Consultant

Approved By:

09/20/2023

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Dawn N. Timm Date
Area Manager