



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
ACTING DIRECTOR

November 27, 2023

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

RE: License #: AS810015656  
Investigation #: 2024A0575004  
North Territorial 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.
- 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. 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,

A handwritten signature in blue ink that reads "Jeffrey J. Bozsik".

Jeffrey J. Bozsik, Licensing Consultant  
Bureau of Community and Health Systems  
(734) 417-4277

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS810015656
<b>Investigation #:</b>	2024A0575004
<b>Complaint Receipt Date:</b>	11/14/2023
<b>Investigation Initiation Date:</b>	11/14/2023
<b>Report Due Date:</b>	12/14/2023
<b>Licensee Name:</b>	Renaissance Community Homes Inc
<b>Licensee Address:</b>	1548 W. Maumee St., Ste. C Adrian, MI 49221
<b>Licensee Telephone #:</b>	(151) 740-3769
<b>Administrator:</b>	Scott Brown, Designee
<b>Licensee Designee:</b>	Scott Brown, Designee
<b>Name of Facility:</b>	North Territorial House
<b>Facility Address:</b>	10865 N Territorial Dexter, MI 48130
<b>Facility Telephone #:</b>	(734) 426-3167
<b>Original Issuance Date:</b>	12/16/1993
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	12/14/2021
<b>Expiration Date:</b>	12/13/2023
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A was mistreated by direct care staff.	Yes

**III. METHODOLOGY**

11/14/2023	Special Investigation Intake-2024A0575004
11/14/2023	Special Investigation Initiated - Telephone
11/14/2023	Contact - Telephone call made-interviews with direct care staff (a) Laura Kendrick, and (b) Sherry Griffith
11/14/2023	APS Referral
11/14/2023	Referral - Recipient Rights
11/16/2023	Inspection Completed On-site-(1) interview with Resident A, review of Resident A's AFC Assessment plan and possible behavior plan; (2) interviews with (a) Fabian Acosta-home manager; (b) Jennifer Baloki-district manager; (c) Christy Gottchalk-operations manager
11/16/2023	Inspection Completed-BCAL Sub. Compliance
11/16/2023	Exit Conference-with Scott Brown, licensee designee

**ALLEGATION:**

**Resident A was mistreated by direct care staff.**

**INVESTIGATION:**

APS and ORR referrals were made/received.

On 11/16/2023, Resident A interviewed, but he had no recollection of the incident. He uses a walker to assist in mobility.

On 11/14/2023, I interviewed direct care staffs Laura Kendrick and Sherry Griffith.

Both staffs stated that Resident A was upset about having to go to the bathroom and then to bed. That's where their versions of the incident diverge. Staff Laura Kendrick stated that she was trying to get Resident A to sit down. She stated staff Sherry Griffith was holding Resident A upright by holding onto his gait belt. Staff Laura Kendrick stated that when staff Sherry Griffith let go of Resident A's gait belt, he fell down on his butt. She stated he was not injured.

Staff Sherry Griffith stated that staff Laura Kendrick was loud and angry with Resident A about going to bed and using the bathroom. Staff Sherry Griffith stated she was holding Resident A's gait belt to keep him from falling while staff Laura Kendrick was in a tug of war with Resident A and his walker. Staff Sherry Griffith stated that staff Laura Kendrick basically pulled Resident A down on the floor. She stated Resident A was not injured.

On 11/16/2023, I reviewed Resident A's AFC assessment and treatment plan with Fabian Acosta, the home manager, Jennifer Baloki, the district manager, and Christy Gottchalk, the operations manager. Resident A does not have a behavior plan and his treatment plan makes no mention of his aggressive behavior. Home manager, Fabian Acosta stated that Resident A's aggressive behavior is infrequent and does not warrant a formal behavior plan. I reviewed Resident A's AFC assessment plan dated 11/13/2023. It does state that Resident A does not control his aggressive behavior, but there is nothing documented as to how staff are supposed to intervene/address the incident.

On 11/16/2023, I conducted an exit conference with the home manager, district manager, operations manager, and the licensee designee.

<b>APPLICABLE RULE</b>	
<b>R 400.14308</b>	<b>Resident behavior interventions prohibitions.</b>
	<b>(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.</b>

<b>ANALYSIS:</b>	Since Resident A's AFC assessment plan notes he can exhibit aggressive behavior but fails to document how staff are supposed to intervene, and Laura Kendricks and Sherry Griffith's inconsistent statements about the incident resulting in Resident A being pulled/falling to the floor, then the licensee permitted the direct care staff to mistreat Resident A by omitting any direction and therefore putting Resident A's safety at risk.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Contingent upon receipt of an acceptable plan of correction; I recommend no changes in the status of the license.

---

Jeffrey J. Bozsik  
Licensing Consultant

Date: 11/21/2023

Approved By:

---

Ardra Hunter  
Area Manager

Date: 11/27/2023