GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 23, 2024

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

RE: License #: AS380379197
Investigation #: 2024A0007006
Northland Home

Dear Scott Brown:

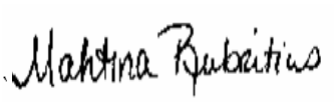
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (313) 456-0380.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604
(517) 763-0211 (Fax)

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380379197
Investigation #:	2024A0007006
Complaint Receipt Date:	11/28/2023
Investigation Initiation Date:	11/30/2023
Report Due Date:	01/27/2024
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:	Northland Home
Facility Address:	347 Ballmers Avenue Jackson, MI 49201
Facility Telephone #:	(517) 782-2122
Original Issuance Date:	11/17/2015
License Status:	REGULAR
Effective Date:	05/17/2022
Expiration Date:	05/16/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's arm was fractured while staff were trying to change her brief. There is a concern that the staff stories are inconsistent as to how the fracture occurred.	Yes

III. METHODOLOGY

11/28/2023	Special Investigation Intake - 2024A0007006
11/29/2023	Contact - Telephone call received from APS Worker #1. Case discussion.
11/30/2023	Special Investigation Initiated - On Site
11/30/2023	Inspection Completed On-site - Unannounced - Face to face contact with Home Manager #1, two staff and three residents. Resident A was at school.
11/30/2023	Contact - Face to Face contact with APS Worker #1.
12/20/2023	Contact - Face to Face contact with APS Worker #1.
01/03/2024	Contact - Face to Face contact with APS Worker #1, case discussion. He needs to interview two staff.
01/09/2024	Contact - Telephone call received from ORR. A copy of the report will be sent.
01/11/2024	Contact - Telephone call made to Home Manager #1.
01/11/2024	Inspection Completed On-site - Face to face contact with Home Manager #1, Resident A, Employee #2, Employee #3, along with other staff and residents.
01/16/2024	Contact - Document Sent - Email to ORR. The report has not been received.
01/17/2024	Contact - Document Received - Copy of report from ORR.
01/17/2024	Contact - Telephone call made - Employee #1. No answer. Message left.
01/17/2024	Contact - Telephone call received to from Employee #1. Interview.

01/17/2024	Contact - Telephone call made Home Manager #1. Status update provided.
01/17/2024	Contact - Face to Face contact with APS Worker #1.
01/19/2024	Exit Conference conducted with Scott Brown, Licensee Designee.

ALLEGATIONS:

Resident A's arm was fractured while staff were trying to change her brief. There is a concern that the staff stories are inconsistent as to how the fracture occurred.

INVESTIGATION:

On November 29, 2023, I spoke with APS Worker #1. He stated that ORR Worker #1 is also investigating the case. He stated that there was a concern regarding the stories of what happened being inconsistent. Employee #1 who was involved was new to the home.

He observed the x-rays and Resident A has a big break to the bone in her arm. In addition, there were multiple stages to the breaks. It appears to be a spiral fracture. Resident A may have osteoporosis. Resident A is scheduled to have a bone density test completed in February of 2024.

On November 30, 2023, I conducted an unannounced on-site investigation and made face to face contact with Home Manager #1 (HM #1), two staff and three residents. HM #1 informed me that Resident A was at school.

While at the home, I interviewed HM #1 regarding the injury to Resident A's arm. HM #1 was cooperative with the investigation. She stated that they were not sure what happened. HM #1 stated that Resident A has been diagnosed with Rett's Syndrome, and her condition causes her to not have control over her arms and legs. Resident A often flails her arms and legs. When they change her adult brief, it takes two staff to assist and complete the task. This is so she can be distracted and not reach down and put her hands in the feces. The staff stand side by side and one staff assists with waving Resident A's hands from left to right and the other staff will change the brief.

HM #1 was not in the facility when the incident occurred, but the staff contacted her and Medical Coordinator #1, and told them about the situation.

According to HM #1 Resident A will rub her face raw; therefore, she is prescribed "No, No" padded braces (elbow extension splints) for her arms. Employee #1 was assisting with Resident A's arms and Employee #2 was changing the brief. Staff were rolling and changing Resident A, and they rolled her over to her back. Employee #2 heard a pop, and she asked Employee #1 if she heard it. Employee #1 stated that she did not hear the pop. Staff noticed that Resident A was not moving her left arm, and they removed the "No, No" padded brace. Employee #2 said that Resident A's arm did not look right and that is when she called HM #1 and Medical Coordinator #1. Medical Coordinator #1 came into the home and observed Resident A's arm, she agreed that her arm did not look right and recommended that Resident A be taken to the emergency room.

Once at the hospital, several x-rays were taken, and it was discovered that her humerus had a fracture. Resident A's left arm was put into a splint, and it was wrapped in an ace bandage. They followed up with medical personnel, and Dr. #1 reviewed the x-rays. According to HM #1, Dr. #1 said it was possible that Resident A hit her arm on the bedrails, or it could have been injured the day before when they rolled her. HM #1 stated that the brace has a metal piece on it and inquired if that could have been jammed into the arm during repositioning, and the Dr. #1 said it was possible. There were many ways that this break could have occurred. According to HM #1, Dr. #1 thinks the injury will heal with no problem. HM #1 stated that she was going to follow up with OT and make sure they are doing what is best for Resident A. They might remove the "No, No" pads during brief changes.

HM #1 stated that Employee #1 is getting additional training, including how to use the Hoyer Lift. Employee #1 was new to this home but not new to the company. Employee #1 had been trained on how to change Resident A.

HM #1 agreed to send me the IPOS, AFC Assessment Plan, Occupational Therapy Report, and the Incident Report. These reports were received and reviewed as part of this investigation. It was noted that Resident A is a female in her twenties, who has been diagnosed with Rett's Syndrome. Resident A requires total assistance for all bathing, toileting, dressing, and she is fed through a GI tube. She is unable to communicate her basic wants and needs; however, family and staff that are familiar with her may pick up on her non-verbal communication through facial expressions etc.

Regarding toileting, it was noted in the AFC Assessment Plan that Resident A benefits from staff assistance, she wears briefs, and she needed to be changed every two hours.

I also reviewed the Residential Care/ Personal Care Plan for Resident A. It was noted that Resident A "is incontinent and wears briefs. She is completely dependent of staff to change and toilet her. You will utilize dignity and respect while providing toileting needs. All urinary and bowel/brief changes will be done with dignity and respect."

On November 30, 2023, I made face to face contact with APS Worker #1. I observed a picture of Resident A's broken arm. He stated that he observed Resident A in the home.

On December 20, 2023, I made face to face contact with APS Worker #1. He stated that he saw Resident A at school, and they said she was doing well. APS Worker #1 reported that he still needed to interview the staff.

During this investigation, I reviewed the report authored by ORR Worker #1 and the following was noted:

> The Emergency Department Summary dated November 23, 2023, was reviewed. The chief complaint was an injury to the left arm. It was noted that Resident A, a 25-year-old, nonverbal female, with Rett Syndrome and scoliosis, presented to the ER with concerns for a left arm injury. The facility staff reported that when they were changing Resident A, they heard a pop in her left arm. In addition, the story was somewhat unclear, and it was unknown what position Resident A's arm was in when they were changing her, and the pop was felt. The x-rays showed an obvious displaced midshaft oblique fracture.
>
> ORR Worker #1 also interviewed Dr. #2. He reported "a spiral fracture of the humerus occurs due to a twisting motion/force applied to the upper arm. If [Resident A] was properly maneuvered during changing of her adult brief, this should be a nearly impossible outcome seeing as the humerus (upper arm bone) should not be enduring any twisting movement with such a procedure. Dr. #2 reported the report from staff also provides a dearth of information regarding the patient's positioning/movement during the changing of her brief. Dr. #2 reported no spontaneous fracture would occur unless some underlying pathology of the bone (such as osteosarcoma bone cancer) exists mid-shaft, which was not identified on the x-ray. Dr. #2 reported that the incident involving Resident A was avoidable."

ORR Worker #1 interviewed Employee #1 and Employee #2, Guardian A, medical personnel, and other involved individuals. The allegations were supported by a preponderance of the evidence for a violation of Neglect, Class 1 against Employee #1, and Employee #2.

On January 11, 2024, I conducted an on-site investigation and made face to face contact with HM #1, Resident A, Employee #2, Employee #3, along with other staff and residents.

Resident A was not interviewed due to her diagnoses. I observed Resident A in her wheelchair, in the den, watching television. She appeared to be doing well.

HM #1 provided me with an update regarding Resident A's progress. She also reported that Resident A was doing well and showing very few signs of pain. OT Worker #1 completed an in-service with the staff about how to change Resident A.

HM #1 informed me that they now have pads on her bedrails, so if Resident A is flailing her arms there will be protection.

HM #1 also informed me that Employee #1 no longer works for the company (no call, no show).

While at the home, I interviewed Employee #2. Employee #2 reported that Resident A had a BM, and she was laying on the bed to be changed. Employee #1 was standing by the top of the bed and Employee #2 was standing by the end of the bed. The straps were undone, and Resident A was rolled towards the wall. According to Employee #2, Resident A rolls better to her right. The old brief was removed and placed in the trash. Resident A's hands were moving "wildly." Employee #1 tried to keep Resident A from putting her hands in the way. Employee #2 stated that her back was to Employee #1, and as she was cleaning Resident A her feet were also going. Resident A was all clean and they were ready to roll her back but before they rolled her, Employee #2 stated she heard a pop. Employee #2 stated that her glove was covered with poop and she turned and asked Employee #1 "what was that?" Employee #1 said, "what was what? I didn't hear anything."

According to Employee #2, when they rolled Resident A back over "her arm didn't go with her body; and it flopped." I inquired if Resident A appeared to be in any pain, and Employee #2 informed me Resident A had already been crying, even while watching television earlier. Employee #2 stated that Resident A didn't scream or display any facial expressions communicating that she was hurt. They stopped and didn't finish rolling her, as something was not right with her arm. That is when they called for the shift supervisor (Employee #3). Employee #2 and Employee #3 moved Resident A to her wheelchair, utilizing a sheet to lift her.

Employee #2 stated that when she turned around Employee #1 was "balling," and she stated she didn't know what was wrong.

Employee #2 stated that Employee #1 worked for the company for five years. She questioned why she would quit unless she was guilty of something.

Employee #2 stated that she really feels bad about the situation because she didn't know what happened.

I interviewed Employee #3, who reported to work for the company for four years and was a supervisor. Employee #3 was assisting another resident when Employee #2 came out of Resident A's room and asked her to come and look at something. Resident A was in the bed. Employee #2 told Employee #3 to look at Resident A's arm. Employee #3 observed Resident A's arm and reported that it looked broken.

Employee #3 then contacted HM #1 and Medical Coordinator #1. Employee #3 stated that Employee #1 started to cry when she (Employee #3) said that her arm was broken. Employee #1 stated that she did not know what happened and didn't do anything wrong. Employee #3 reported that she did not think that any of the staff would intentionally harm Resident A. In addition, that she had no previous concerns regarding how Employee #1 interacted with Resident A.

On January 17, 2023, I interviewed Employee #1. Employee #1 explained that they were changing Resident A's adult brief. She was standing at the head of the bed and Employee #2 was standing at the foot of the bed. Employee #1 stated they (she and Employee #2) were standing very close to each other. Employee #2 was changing Resident A. Employee #1 reported that she was "guiding" Resident A's hands. She stated that she was not gripping Resident A's arms, and she was just moving with her. I inquired how Resident A was moving her arms and hands. Employee #1 informed me that Resident A was moving her arms towards her feet and then towards her head, one at a time. I inquired if she was moving from left to right and she stated she could not because she was wearing the "No, No's." Resident A was moving her arms back and forth. Employee #2 then said, "Did you hear that?" Employee #1 stated, "No, I didn't hear it." Employee #2 stated that she thought she heard a light pop. Employee #1 stated she absolutely did not hear anything. They checked Resident A's arm and they thought she should be moving it more. That is when they called the lead person (Employee #3), who then contacted the Medical Coordinator #1. Medical Coordinator #1 assessed the situation and determined that Resident A needed to be taken to the emergency room.

Employee #1 confirmed that she received additional trainings after this incident occurred. She stated that she was not able to work with Resident A again until she received multiple trainings from HM #1.

During the interview, Employee #1 stated that it was horrible and that she felt bad. Her voice was shaking during the conversation. Employee #1 stated, "All I wanted to know was that she was okay." Employee #1 stated that she loved the residents and cared about them. Employee #1 stated, "They need us." I asked her what she thought happened and she stated that she didn't know but maybe the "No, No's" were out of place. However, she also stated she wasn't 100% sure, if they were out of place, as this was only the third time working with Resident A.

Employee #1 also explained why she no longer worked for the home; she voiced her concerns. She informed me that she quit her job, and she stated she won't work in this home.

On January 17, 2024, I spoke with HM #1. She informed me that on the morning of Friday, January 12, 2024, Resident A sounded a little congested and a message was sent to Guardian A regarding the matter. They did not hear back, and Resident A went to school. The school called and informed that Resident A threw up, but they would keep her since it was a half-day of school. The school personnel then called

back again stating that Resident A was projectile vomiting and she needed to be picked up. They picked her up from school, got her cleaned up, took her vitals and her heart rate seemed high. It was determined that they would seek medical treatment. Resident A's sodium and potassium were low, she had pneumonia and was septic. Resident A's cast was also removed, and a wound was discovered. HM #1 also voiced concerns that her diagnosis with Rett's Syndrome might also be a factor in her health condition. Resident A remains in the hospital. HM #1 stated that Resident A was seen at the doctor the day before, and he could not believe how well she was doing. HM #1 agreed to keep me updated regarding Resident A's condition.

On January 17, 2024, I made face to face contact with APS Worker #1. He stated that he made face to face contact with Resident A and her family members at the hospital. He stated that Resident A's mother informed him that her (Resident A's) condition could be because of Rett Syndrome. APS Worker #1 also informed me that Resident A's cast was removed. It appeared that Resident A's arm may have been swollen and once the swelling went down, she was able to move her arm more, causing the irritation to the skin.

On January 19, 2024, I conducted the exit conference with Scott Brown, Licensee Designee. We discussed the investigation, findings, and my recommendations. I also provided technical assistance regarding how staff referred to the elbow extension splints, as "No, No's" may appear to others as restrictive. I recommended that staff refer to the assistive devices by the proper names. Scott Brown agreed to assess the situation and submit a written corrective action plan to address the established violation. He also agreed to have the staff utilize the appropriate names for the assistive devices.

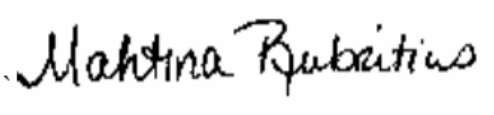
APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Employee #1 and Employee #2 were interviewed and there were some inconsistencies in what they reported. What is consistent is that during the brief change, Employee #1 was assisting with Resident A's arms, while Employee #2 was changing the brief. Additionally, that Employee #1 asked Employee #2 if she heard a pop, and Employee #2 stated she did not. Both staff agreed that Resident A's arm did not look right, requested assistance, and medical treatment was sought. Where Resident A's arms were positioned, and how the specific injury to Resident A's arm occurred, was unclear. It was documented in the Emergency Department Summary that the facility staff reported that when they were changing Resident A, they heard a pop in her left arm. In addition, the story was somewhat unclear, and it was unknown what position Resident A's arm was in when they were changing her, and the pop was felt. The x-rays showed an obvious displaced midshaft oblique fracture. ORR Worker #1 interviewed Dr. #2. He reported "a spiral fracture of the humerus occurs due to a twisting motion/force applied to the upper arm. If [Resident A] was properly maneuvered during changing of her adult brief, this should be a nearly impossible outcome seeing as the humerus (upper arm bone) should not be enduring any twisting movement with such a procedure. Dr. #2 reported the report from staff also provides a dearth of information regarding the patient's positioning/movement during the changing of her brief. Dr. #2 reported no spontaneous fracture would occur unless some underlying pathology of the bone (such as osteosarcoma bone cancer) exists mid-shaft, which was not identified on the X-ray. Dr. #2 reported that the incident involving Resident A was avoidable." The Residential Care/ Personal Care Plan for Resident A documented that Resident A "is incontinent and wears briefs. She is completely dependent of staff to change and toilet her. You will utilize dignity and respect while providing toileting needs. All urinary and bowel/brief changes will be done with dignity and respect." Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A was not provided with the supervision, protection, and personal care, as

	defined in the act, and as specified in Resident A's written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.



1/19/2024

Mahtina Rubritius — Date
Licensing Consultant

Approved By:

1/23/2024

Ardra Hunter — Date
Area Manager