



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 18, 2023

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

RE: License #: AM460269628
Investigation #: 2023A1032033
Mohawk Home

Dear Mr. Brown:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (616) 356-0183.

Sincerely,

A handwritten signature in black ink, appearing to read "Dwight Forde".

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM460269628
Investigation #:	2023A1032033
Complaint Receipt Date:	03/08/2023
Investigation Initiation Date:	03/08/2023
Report Due Date:	05/07/2023
Licensee Name:	Renaissance Community Homes Inc
Licensee Address:	1548 W. Maumee St. Suite C Adrian, MI 49221
Licensee Telephone #:	(734) 439-0464
Licensee Designee/Administrator:	Scott Brown
Name of Facility:	Mohawk Home
Facility Address:	4015 Mohawk Tr. Adrian, MI 49221
Facility Telephone #:	(517) 263-7735
Original Issuance Date:	09/30/2005
License Status:	REGULAR
Effective Date:	04/15/2022
Expiration Date:	04/14/2024
Capacity:	8
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly discharged.	No
Additional Findings	No

III. METHODOLOGY

03/08/2023	Special Investigation Intake 2023A1032033
03/08/2023	Special Investigation Initiated - Telephone
03/09/2023	Inspection Completed On-site
04/10/2023	Contact - Telephone call made Interview with complainant
04/11/2023	Exit Conference With licensee designee Scott Brown

ALLEGATION:

Resident A was improperly discharged.

INVESTIGATION:

On 3/8/23, I received a screened-out complaint from adult protective services.

On 3/8/23, I interviewed Renaissance Community Homes District Manager Greg Pfeiffer via telephone. Mr. Pfeiffer stated that Resident A returned to the home after being discharged from Hickman Hospital and confirmed that Resident A had been served an emergency discharge notice for sexually assaulting another resident and assaulting an employee. Mr. Pfeiffer reported that the home was exploring environment management options to prevent Resident A from further sexually

assaulting Resident B. Mr. Pfeiffer stated that the home and Community Mental Health in Lenawee County were actively exploring further housing options for Resident A.

I received a copy of the incident report (IR) and the discharge notice.

On 3/9/23, I interviewed assistant home manager Robin Renner in the home. She advised me that she was the employee who was assaulted by Resident A. Ms. Renner stated that Resident A has been at the home for approximately one year. She stated that she was unaware of any previous sexual behavioral concerns about Resident A, but that he has displayed physical aggression in the past. Ms. Renner reported that staff have struggled to manage Resident A's behaviors such as elopement and making messes in the home.

I reviewed Resident A's Individual Plan of Service, Behavioral Treatment Plan and resident assessment plan. The assessment plan indicates that Resident A controls sexual behavior. The plan makes reference to the Behavioral Treatment Plan should he fail to control his assaultive behavior.

I observed Resident A sitting at a table. He was engaged in an activity on his electronic tablet and nodded his head when I asked to see his room. He did not provide any further information.

I observed Resident B sitting on a chair in the living room, watching television. Resident B is non-verbal and was unable to provide any information.

On 4/10/23, I interviewed the complainant, who verified the accuracy of the complaint information.

APPLICABLE RULE	
R 400.14302	Resident admission and discharge policy
	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: (c) Substantial risk, or an occurrence, of serious physical assault.

ANALYSIS:	Resident A returned to the home after being discharged from the hospital. Resident A was issued a discharge notice by the home after engaging in assaultive behavior against another resident and an employee. This explanation for the discharge was provided in writing to all relevant parties. The home is reportedly seeking other housing options for Resident A. The home has issued a discharge notice consistent with this rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 4/11/23, I called Licensee designee Scott Brown, to conduct an exit conference. I shared my findings and Mr. Brown agreed with the conclusions reached.

IV. RECOMMENDATION

I recommend no change to the status of this license.

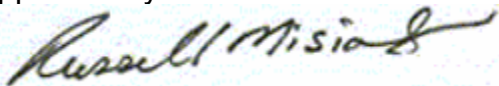


4/18/23

Dwight Forde
Licensing Consultant

Date

Approved By:



4/20/23

Russell B. Misiak
Area Manager

Date