GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 12, 2024

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

RE: License #: AS460015679
Investigation #: 2024A1032031
Oakwood Home

Dear Scott 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
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 #:	AS460015679
Investigation #:	2024A1032031
Complaint Receipt Date:	03/11/2024
Investigation Initiation Date:	03/11/2024
Report Due Date:	05/10/2024
Licensee Name:	Renaissance Community Homes Inc
Licensee Address:	1548 W. Maumee St. Suite C Adrian, MI 49221
Licensee Telephone #:	(734) 439-0464
Administrator:	Scott Brown
Licensee Designee:	Scott Brown
Name of Facility:	Oakwood Home
Facility Address:	2650 Oakwood Road, Adrian, MI 49221
Facility Telephone #:	(517) 263-1868
Original Issuance Date:	01/01/1994
License Status:	REGULAR
Effective Date:	12/05/2022
Expiration Date:	12/04/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A's medical needs were neglected.	No
Additional Findings	No

III. METHODOLOGY

03/11/2024	Special Investigation Intake 2024A1032031
03/11/2024	Special Investigation Initiated - Telephone
03/14/2024	Inspection Completed On-site
04/08/2024	Exit Conference

ALLEGATION:

Resident A's medical needs were neglected.

INVESTIGATION:

On 3/11/24, I interviewed APS investigator Samantha Garcia by telephone. Ms. Garcia advised that Resident A had fallen onto a piece of furniture, and that employees noted no bruising for two days while Resident A appeared to have full use of her arm. Per her notes, the employees at the home noticed bruising on the third day and observed Resident A having difficulty using the arm.

On 3/14, 24, I interviewed Home Manger Angela Zimmerman in the home. Ms. Zimmerman stated that Resident A had provoked Resident B by invading her space, and that Resident B then ran at Resident A. Ms. Zimmerman stated that staff tried to intervene by using space to prevent Resident A from being struck by Resident B. During this episode, Resident A tripped on her own feet and collided with the edge of a table. Ms. Zimmerman stated that Resident A was checked and there did not appear to be any bruising, nor did Resident A have difficulty moving her arm. Ms.

Zimmerman reported that three days later, bruising was noticed, and it appeared that Resident A had difficulty moving her right arm. At that point, she sent Resident A out to a hospital for treatment.

I interviewed Resident A in the home. Resident A was unable to provide any information but greeted me. She often mumbled to herself. She appeared to respond to direction when employees noted that she would invade other's privacy. I observed a sling immobilizing her right arm.

I was unable to interview Resident B in the home. Resident B appeared agitated during my visit and paced the home, blurting out loudly.

I reviewed Resident A's assessment plan and Individual Plan of Service at the home. Both plans reflected the need for prompts and redirection to guide Resident A to appropriate, pro-social behaviors should she invade other's boundaries.

I reviewed Resident B's Individual Plan of Service (IPOS). I noted that there was no behavior treatment plan attached to the IPOS. I was advised that this meant that Resident B had not been assigned a specific psychological intervention through Community Mental Health to address a specific problem behavior.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Based on interviews with an employee and Adult Protective Services, it seems plausible that the extent of Resident A's injury was not apparent, but once it fully manifested, the home took appropriate action to obtain medical attention.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 4/8/24, I conducted an exit conference with licensee designee Scott Brown. I shared my findings and Mr. Brown agreed with the conclusions reached.

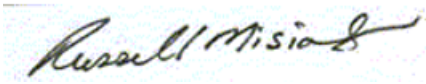
IV. RECOMMENDATION

I recommend no change to the status of this license.

4/12/24

Dwight Forde — Date
Licensing Consultant

Approved By:



4/17/24

Russell B. Misiak — Date
Area Manager