GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 17, 2024

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

RE: License #: AS460390397
Investigation #: 2024A1032028
Main Street Home 1

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 #:	AS460390397
Investigation #:	2024A1032028
Complaint Receipt Date:	02/16/2024
Investigation Initiation Date:	02/20/2024
Report Due Date:	03/17/2024
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:	Main Street Home 1
Facility Address:	451 S. Main Street, Adrian, MI 49221
Facility Telephone #:	(517) 263-4917
Original Issuance Date:	12/21/2017
License Status:	REGULAR
Effective Date:	06/21/2022
Expiration Date:	06/20/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

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

III. METHODOLOGY

02/16/2024	Special Investigation Intake 2024A1032028
02/20/2024	Special Investigation Initiated - Telephone
02/21/2024	Inspection Completed On-site
02/23/2024	Contact - Face to Face Interview with Resident A and employee Tammy Bowe
03/28/2024	Contact - Telephone call made Interview with Guardian A1
04/03/2024	Contact - Document Received Resident A's assessment plan and Individual Plan of Service
04/08/2024	Exit Conference

ALLEGATION:

Resident A was improperly discharged.

INVESTIGATION:

On 2/20/24, I interviewed the referral source, who verified the accuracy of the complaint information.

On 2/22/24, I interviewed Home Manager Katherine Yops in the home. Ms. Yops stated that Resident A was at a hospital in Coldwater MI after it had been determined that she was a danger to herself in the home. She reported that Resident A was an elopement risk and had stripped naked on a staff's vehicle, prompting a police response. Ms. Yops stated that Guardian A1 had been advised that Resident A needed a higher level of care, to which Guardian A1 agreed, prompting a discharge process that Guardian A1 initiated. Ms. Yops stated that the decision was reversed after a meeting between Community Mental Health and Pathlight management.

On 2/23/24, I interviewed Resident A in the home. Resident A advised me that she had recently returned to the home and that she had a new supply of medications. She quickly terminated the interview.

I interviewed employee Tammy Bowe in the home. Ms. Bowe stated that Resident A was typically quiet and reserved in the home but that her behaviors can be extreme and difficult to manage. She stated that Resident A does not seem to respond well to de-escalation. Ms. Bowe stated that part of the plan is to rely on law enforcement.

On 3/28/24, I interviewed Guardian A1 via telephone. Guardian A1 stated that she did initiate a discharge process based on advice from the home, that Resident A was not in the appropriate setting. She expressed that she is new to being a guardian and did not understand that there was a process whereby a more suitable setting needed to be found, rather than discharge with no back up plan. Guardian A1 stated that Resident A was re-admitted to a psychiatric hospital and there is a plan to seek more appropriate placement, where the elopement risk and extreme behaviors could be better managed without law enforcement intervention.

On 4/3/24, I reviewed Resident A's assessment plan and Individual Plan of Service to gain an understanding of Resident A's needs.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; emergency discharge;**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant**

	not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information: **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.**
ANALYSIS:	Resident A was not discharged from the home and maintains a residence there as of the completion of this report. While there seems to have been some miscommunication between Guardian A1 and the home, no actual discharge occurred. Resident A was on a leave of absence to a hospital and efforts continue to secure more appropriate placement.
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

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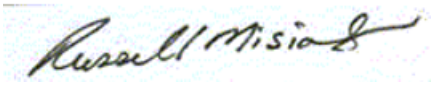
Dwight Forde Date
Licensing Consultant

Approved By:



4/17/24

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Russell B. Misiak Date
Area Manager