GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 18, 2024

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

RE: License #: AS460306622
Investigation #: 2024A1032049
Sunrise 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 #:	AS460306622
Investigation #:	2024A1032049
Complaint Receipt Date:	09/19/2024
Investigation Initiation Date:	10/01/2024
Report Due Date:	11/18/2024
Licensee Name:	Renaissance Community Homes Inc
Licensee Address:	Suite C 1548 W. Maumee St. Adrian, MI 49221
Licensee Telephone #:	(734) 439-0464
Administrator:	Scott Brown
Licensee Designee:	Scott Brown
Name of Facility:	Sunrise Home
Facility Address:	530 Sunrise Dr. Hudson, MI 49247
Facility Telephone #:	(517) 448-3007
Original Issuance Date:	05/10/2010
License Status:	REGULAR
Effective Date:	11/10/2022
Expiration Date:	11/09/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A male employee observed Resident A while nude.	No
The home manager hit Resident A in the chest.	No
Resident A has had meals withheld.	No
Additional Findings	No

III. METHODOLOGY

09/19/2024	Special Investigation Intake 2024A1032049
10/01/2024	Special Investigation Initiated - On Site
10/01/2024	APS Referral APS referral not needed
10/01/2024	Contact - Document Received APS findings
10/17/2024	Exit Conference

ALLEGATION:

A male employee observed Resident A while nude.

INVESTIGATION:

On 10/1/24, I interviewed employee Larry Grundy in the facility. Mr. Grundy denied that he invaded Resident A's privacy by looking at her while she was nude. He stated that Resident A was on a precautionary watch of every five minutes because

she refused to return a tablet charger. He stated that there was another female employee on shift who stood in the doorway while he remained off to the right side of the room. Ms. Sloan reported that Resident A is court ordered to be in the home and is on an assisted outpatient treatment order.

I reviewed Resident A's Assessment Plan. The document reflected a history of self-injurious behavior and that five-minute checks were to be employed when Resident A does engage in self-harm. Resident A does not have community access without staff, per the assessment plan.

I attempted to interview Resident A in the facility. Due to a medical condition, this was somewhat challenging. Resident A reported that a male employee had seen her nude.

I reviewed investigative findings from a related Adult Protective Services investigation, which concluded that there was no preponderance of evidence to support Resident A's claim of being viewed nude by Mr. Grundy.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on interviews, there is insufficient evidence to establish a violation of dignity and respect. While Larry Grundy denied observing Resident A in the nude, there are no administrative rules preventing Mr. Grundy from doing five-minute checks on Resident A when she was exhibiting behavior that required this intervention.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The home manager hit Resident A in the chest.

INVESTIGATION:

On 10/1/24, Ms. Sloan denied every striking Resident A in the chest. She stated that employees are not allowed to use force against a resident.

I interviewed employee Cory Smith in the facility. Ms. Smith denied observing Ms. Sloan strike Resident A in the chest. Ms. Smith offered praise for Ms. Sloan, whom she attributed to improving conditions at the facility.

I reviewed investigative findings from a related Adult Protective Services investigation, which concluded that there was no preponderance of evidence to support Resident A's claim that Michelle Sloan struck her. The report referenced multiple trips to the hospital for self-injurious behavior and an opinion by a recipients rights officer that Resident A is trying to get moved from the facility to a location of her own choosing.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	There is insufficient evidence, based on interviews, to establish that Michelle Sloan struck Resident A in the chest.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A has had meals withheld.

INVESTIGATION:

On 10/1/24, I interviewed Home Manager Michelle Sloan in the facility. Ms. Sloan denied that the facility was withholding food from Resident A. She stated that Resident A has access to her own snacks that I observed in an unlocked cupboard. She advised that Resident A also has snacks in the refrigerator. Ms. Sloan allowed me to review a food log document that the facility had created to track Resident A's

meals. The document reflected a pattern of breakfast refusal, but consumption of lunch and dinner.

I attempted to interview Resident A in the facility. Resident A reported that she had cereal for breakfast on the morning of September 30th, despite the log saying that she refused.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	I observed Resident A's food log, which reflected Resident A's refusal or acceptance of meals. Resident A also has access to snacks.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

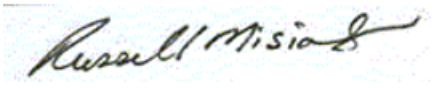
IV. RECOMMENDATION

I recommend no change to the status of this license.

10/18/24

Dwight Forde Date
Licensing Consultant

Approved By:



10/21/24

Russell B. Misiak Date
Area Manager