

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA DIRECTOR

July 18, 2024

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

> RE: License #: AS810416758 Investigation #: 2024A0116036

Saxon House

Dear Mr. 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,

Pandrea Robinson, Licensing Consultant Bureau of Community and Health Systems Cadillac Pl. Ste 9-100 3026 W. Grand Blvd Detroit, MI 48202 (313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS810416758
Investigation #:	2024A0116036
Complaint Receipt Date:	07/03/2024
Investigation Initiation Date:	07/05/2024
mvootigation initiation bato.	0170072021
Report Due Date:	09/01/2024
Licensee Name:	Renaissance Community Homes Inc
Liberiote Name.	Tremaissance Cerminarity Fromes inc
Licensee Address:	Suite C
	1548 W. Maume St.
	Adrian, MI 49221
Licensee Telephone #:	(734) 483-9363
	0 " "
Administrator:	Scott Brown
Licensee Designee:	Scott Brown
Name of Facility:	Saxon House
Facility Address:	1812 Saxon
-	Ann Arbor, MI 48103
Facility Telephone #:	(734) 483-9363
Tuenty Telephone #.	(104) 400-0000
Original Issuance Date:	11/02/2023
Liconeo Statue:	REGULAR
License Status:	NEGOLAN
Effective Date:	05/02/2024
Evaluation Date:	05/04/2026
Expiration Date:	05/01/2026
Capacity:	6
_	
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

Violation Established?

Resident A reported that staff, Tonya Gillespie, hit her a month ago and she does not feel safe with her. Resident A also has burns inside her mouth from being fed food that was too hot.	Yes

III. METHODOLOGY

07/03/2024	Special Investigation Intake 2024A0116036
07/05/2024	APS Referral Made.
07/05/2024	Special Investigation Initiated - Telephone Interviewed Co-Guardian A1.
07/09/2024	Referral - Recipient Rights Made.
07/11/2024	Inspection Completed On-site Interviewed Residents A-D, and home manager, Gretta Alexander.
07/11/2024	Contact - Document Received Photographs of the burn on Resident A's lip.
07/11/2024	Inspection Completed-BCAL Sub. Compliance
07/12/2024	Contact - Telephone call made Interviewed licensee designee, Scott Brown, and requested training records and background clearance for staff, Tonya Gillespie.
07/12/2024	Contact - Document Received Staff, Tonya Gillespie's, training, and background clearance.
07/17/2024	Contact - Telephone call made Left a message for staff, Tonya Gillespie, requesting a return call.
07/17/2024	Exit Conference With licensee designee, Scott Brown.

ALLEGATION:

Resident A reported that staff, Tonya Gillespie hit her a month ago and she does not feel safe with her. Resident A also has burns inside her mouth from being fed food that was too hot.

INVESTIGATION:

On 07/05/24, I interviewed Co-Guardian A1, and she reported that she was shocked to hear about Resident A being hit by staff and being fed food that was too hot, resulting in burns to her lip and mouth. Co-Guardian A1 reported that Resident A has limited feeling in a portion of her mouth, due to a surgery she had some years ago. Co-Guadian A1 reported that all the staff are aware of that and should be taking extra precautions to ensure the temperature of the food is safe prior to feeding Resident A. Co-Guardian A1 reported that she has been in touch with Resident A and the home manager, Gretta Alexander, and reported that to her knowledge, staff, Tonya Gillespie, is suspended pending completion of all of the pending investigations. Co-Guardian A1 reported that Resident has lived in the facility for over 25 years, and she has not had any concerns regarding the care the staff have provided prior to this incident.

On 07/11/24, I conducted an unscheduled on-site inspection and interviewed home manager, Gretta Alexander, and Residents A-D. Ms. Alexander reported that on 07/01/24, she was at the facility completing paperwork, when staff, Travis Moody, observed a blister on Resident A's lower right lip area and asked her to look at it. Ms. Alexander reported that after observing the burn she asked Resident A what happened, and reported that Resident A told her that staff, Tonya Gillespie, fed her hot grits and pancakes even after she told her the grits were too hot. Ms. Alexander reported that she called emergency medical services, and they transported Resident A to the hospital for evaluation and treatment. Ms. Alexander reported that while in the hospital, it was discovered that the grits also burned the inside of Resident A's mouth. Ms. Alexander reported that the burns did not require any treatment and the discharge orders did not require them to do anything additional for Resident A. The discharge instructions documented that the burns would heal on their own.

Ms. Alexander reported that while in the hospital, Resident A disclosed to hospital personnel that Ms. Gillespie had hit her a month ago. Ms. Alxander reported that Resident A had not shared that with her or any of the other staff. Ms. Alexander reported that Ms. Gillespie was immediately removed from the schedule and has not worked since the morning of 07/02/24.

I interviewed Resident A, and she reported that staff, Tonya Gillespie, is mean and yells at her and the other residents. Resident A reported that about a month ago Ms. Gillespie hit her on her buttock, because she was having difficulty standing, while she was assisting her out of her wheelchair. Resident A reported Ms. Gillespie was upset, she yelled at her and then smacked her on her right buttock. Resident A

reported that this was the first time Ms. Gillespie had ever hit her. Resident A reported that Ms. Gillespie would threaten her and say, "I'm going to make you stay in bed all day, if you get the state or rights on me." Resident A reported that Ms. Gillespie also said, "If you don't get up on time, you're not going to get breakfast." Resident A reported that she never disclosed this to anyone because she didn't want anyone to get in trouble. Resident A reported that since talking with Co-Guardian A1 and home manager, Greta Alexander, she will tell someone she trusts if anyone mistreats her again.

Resident A reported that one day last week, staff, Tonya Gillespie, was feeding her breakfast, and reported that although she is visually impaired, her tastebuds are still intact. Resident A reported that Ms. Gillespie was feeding her grits and pancakes and reported that the grits were extremely hot. Resident A reported that she still has nerve endings and can feel temperature on the right side of her mouth. She reported that Ms. Gillespie continued to feed her the hot grits even after she told her that they were too hot. Resident A reported that Ms. Gillespie just kept, "Ramming the fork in my mouth." Resident A reported later that same day, staff, Travis Moody, observed a blister on the right side of her bottom lip and brought it to the attention of the home manager, Gretta Alexander. Resident A reported that she was transported to the hospital and released two days later. Resident A reported that the doctor treating her told her that she had burns inside her mouth on the right side and reported that they would heal on their own. Resident A reported that she is glad that Ms. Gillespie will not be returning to the home.

I interviewed Residents B-D separately and they all reported that staff, Tonya Gillespie, yells at them. They denied that she has ever hit them. Resident D reported that Ms. Gillespie has hurt Resident A's feelings and had made her cry.

I reviewed Resident A's discharge papers, and they documented the burn on the bottom right lip as well as burns inside Resident A's mouth. The discharge paperwork also documented that the burns do not require treatment or the need for a burn consult.

During the on-site inspection, I requested to review the training and background clearance information for staff, Tonya Gillespie. Ms. Alexander reported that Ms. Gillespie's employee file had been taken to the main office.

On 07/11/24, I received and reviewed pictures of the blister/burn on Resident A's lip.

On 07/12/24, I interviewed licensee, Scott Brown. Mr. Brown reported that he is aware of the situation at the home and reported that staff, Tonya Gillespie, was immediately removed from the schedule. Mr. Brown reported she will be terminated pending the outcome of the current investigations. Mr. Brown reported that he would have Ms. Gillespie's training and background clearance information sent over to me for review.

On 07/17/24, I conducted the exit conference with licensee designee, Scott Brown, and informed him of the findings of the investigation as well as the rule cited. Mr. Brown reported an understanding and stated that Ms. Gillespie will be terminated. Mr. Brown reported that upon receipt of the report, he would submit an acceptable corrective action plan.

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 the findings of the investigation, which included interviews of home manager, Gretta Alexander, and Residents A-D, I am able to corroborate the allegations that staff, Tonya Gillespie, hit Resident A and caused the burn/blister to her bottom right lip area and inside her mouth, by feeding her food that was too hot.	
CONCLUSION:	VIOLATION ESTABLISHED	

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

Pandrea Robinson Licensing Consultant	07/18/24 Date
Approved By:	
a. Hunder	
G. 11 W. G.	07/18/24
Ardra Hunter Area Manager	Date