GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 17, 2024

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

RE: License #: AS470093665
Investigation #: 2025A1029006
Golf Club Road Home

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 licensee designee 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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY.

I. IDENTIFYING INFORMATION

License #:	AS470093665
Investigation #:	2025A1029006
Complaint Receipt Date:	11/12/2024
Investigation Initiation Date:	11/12/2024
Report Due Date:	01/11/2025
Licensee Name:	Renaissance Community Homes Inc
Licensee Address:	1548 W. Maume St. Suite C, Adrian, MI 49221
Licensee Telephone #:	(734) 439-0464
Administrator:	Scott Brown
Licensee Designee:	Scott Brown
Name of Facility:	Golf Club Road Home
Facility Address:	2367 Golf Club Road, Howell, MI 48843
Facility Telephone #:	(517) 545-9921
Original Issuance Date:	09/01/2000
License Status:	REGULAR
Effective Date:	06/19/2024
Expiration Date:	06/18/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On November 9, 2024, during a behavioral episode Resident A was yelling at direct care staff member Ms. Smith who responded by speaking to Resident A in a disrespectful manner.	Yes
Ms. Smith restrained Resident A by holding Resident A down on the floor with her elbow on Resident A's neck.	No

III. METHODOLOGY

11/12/2024	Special Investigation Intake 2025A1029006
11/12/2024	Special Investigation Initiated – Telephone to direct care staff member Michael Blandford
11/12/2024	Contact - Document Sent to ORR Jody Marsh and Molly Myska
11/13/2024	Contact - Document Received – email from Molly Myska ORR
12/04/2024	Inspection Completed On-site – face to face with direct care staff members Michael Blandford, Angie Byard, Christina Warren, Resident A
12/04/2024	Contact - Telephone call made to direct care staff member Heidi Durand, Christina Warren, APS Justin Brown, Left messages.
12/05/2024	APS Referral - APS is already involved. Justin Brown is the assigned APS worker.
12/05/2024	Contact - Document Sent -FOIA request sent for EMS and LE reports
12/05/2024	Contact - Document Sent to APS Justin Brown
12/06/2024	Contact - Document Received from Michael Blandford
12/10/2024	Contact - Document Sent to APS Justin Brown
12/13/2024	Contact – Telephone call to licensee designee Scott Brown, direct care staff members Desirae Smith and Heidi Durand
12/13/2024	Exit conference with licensee designee Scott Brown.

ALLEGATION:

On November 9, 2024, during a behavioral episode Resident A was yelling at direct care staff member Ms. Smith who responded by speaking to Resident A in a disrespectful manner.

Ms. Smith restrained Resident A by holding Resident A down on the floor with her elbow on Resident A's neck.

INVESTIGATION:

On November 12, 2024, a complaint was received via Bureau of Community and Health Systems online complaints system with allegations Resident A was spoken to in a disrespectful tone by direct care staff member Desirae Smith while she physically restrained Resident A during a behavioral episode. Livingston County Office of Recipient Rights (ORR) advisor Molly Myska and Adult Protective Services (APS) specialist Justin Brown will also be investigating the concerns.

On November 12, 2024, I contacted direct care staff member whose current role is home manager, Michael Blandford. Mr. Blandford stated the direct care staff members involved with the incident were Heidi Durand, Christina Warren, and Desiree Smith. Mr. Blandford stated Ms. Smith is the one who allegedly used her elbow to hold Resident A down and Ms. Durand witnessed the incident. Mr. Blandford stated this has not occurred before. Mr. Blandford stated Ms. Smith is loud at times but he does not believe she would never put her hands on someone like that. Mr. Blandford stated he does not have concerns and they completed an *AFC Incident / Accident Report*. Mr. Blandford stated Ms. Smith is suspended pending the outcome of the investigation.

On December 4, 2024 I completed an unannounced onsite investigation at Golf Club Road Home and interviewed direct care staff member whose role is home manager, Mr. Blandford and direct care staff member Angie Byard. Ms. Byard stated she was not present for this incident with Resident A and she has not observed concerns with any of Ms. Smith's previous interactions with Resident A.

I reviewed Resident A's resident record which included the following documentation:

1. Resident A's *Individual Plan of Service* from Livingston County CMH which included the following documentation:

> *"In the past year [Resident A] has had some behavioral and self-care concerns including poor boundaries, aggression, self-injurious behaviors, picking at her skin and refusing to participate in hygiene however those improved since moving to Golf Club Road Home. Staff will treat her with dignity and respect. Staff will prompt or redirect as needed. Staff will monitor Resident A for safety and call 911 in case there is an emergency they cannot handle."*

2. Resident A's *Positive Behavioral Support Plan* written by Jonathan Kwok LMSW included documentation she had the following concerning behaviors: Aggressive behaviors, property destruction, and toileting and hygiene related behaviors.
3. I reviewed Resident A's *Assessment Plan for AFC Residents* which stated she does not move independently in the community and under the section titled self-injurious behavior, Resident A's *Assessment Plan for AFC Residents* documented the following: "[Resident A] has rage moments during shower time and random behaviors."
4. Specialized Residential Progress Notes from November 9, 2024 stating the following account of the incident:

> *"[Resident A] was on her iPad and started asking about her baby stroller she wanted to talk to her sister she escalated and attacked staff members. LOA to hospital around 6:30-7 PM. Kaylin brought her home and I gave [Resident A] her meds and she went to toilet as needed."*

5. The direct care staff members all completed a "Reacting to Extreme behaviors Written Test" after the incident and signed by direct care staff members on November 15, 2024.

I received an email on December 10, 2024 with the following documentation:

1. Verification Ms. Smith has completed all required AFC trainings.
2. "Disciplinary Documentation" from December 27, 2023 where she had a rights violation – Abuse Class III and received a written reprimand because Ms. Smith asked a resident, "Why are you acting like an asshole?"
3. "Disciplinary Documentation" from December 27, 2023 where she had a rights violation for dignity and respect because on December 4, 2003 she reported that "I lost my temper and yelled at a consumer that enough is enough."
4. Letter from Michigan Workforce Background Check showing Ms. Smith is eligible to work in an AFC setting.

There were two *AFC Incident / Accident Reports* completed for this incident. I reviewed both *AFC Incident / Accident Reports* which included the following account of the incidents. The first one was a detailed account matching the description in Ms. Smith's interview about the incident. The second one was written by Ms. Durand and included the following details regarding Ms. Smith's interactions with Resident A.

"As soon as they (EMS) left [Resident A] came out of her room and started attacking Desirea while she was on the couch Desirea started yelling at her to stop and that she knows what's going to happen almost as if she was trying to reason with her. Then eventually after 5 minutes of Desirea just kept letting her punch her I tried to pull [Resident A] away and Desirea yelled at me to stop and continue to just sit on the couch while she was being punched. She threatened [Resident A] and said if she punched her one more time she was going to beat the shit out of her. [Resident A] then punched her again and Desirea got off the couch got on top of her and was holding her down by the

neck with her elbow and yelled that she would never be able to see her grandson again and that she'll never see a real baby again."

On December 4, 2024, I interviewed Resident A however she was unable to give details about the incident. Resident A responded to "yes / no" questions and used her tablet to communicate. Resident A kept pointing to the hospital picture on her tablet and saying, "yes." Resident A was unable to give an account of what happened but stated she liked living at Golf Club Road Home. When asked if there was an incident with Ms. Smith, she nodded yes and pointed to the floor. I asked if Ms. Smith hurt her and she said, "yes" but was nodding her head indicating "no." I asked her if she was hurt anywhere and she denied being hurt. Resident A stated she feels safe where she lives.

On December 4, 2024, I interviewed direct care staff member Christina Warren. Ms. Warren stated Resident A was upset that night because she wanted to call her sister but she could not locate the number. Ms. Warren stated she could tell by the look in Resident A's eyes that she was getting more upset and then she threw her food against the wall. Ms. Warren stated she has never observed behaviors like this in the past from Resident A. Ms. Warren stated she was standing near the dining room and Resident A came up behind her and punched her. Ms. Warren stated Ms. Durand called 911 and she texted Ms. Smith to see if she had Resident A's sister's phone number because she worked with her previously. Ms. Warren stated she informed Ms. Smith what was occurring and she came over to the home and informed her they should not have contacted law enforcement. Ms. Warren stated when Ms. Smith arrived she went outside to sit with the residents Ms. Smith had brought in her car but she was able to watch through the window what was occurring and she saw Resident A hitting Ms. Smith. Ms. Warren stated she could not make out the specifics of what was occurring but knew they were near the floor and she could see Resident A's hands moving while she was hitting her. Ms. Warren stated there have been no recent concerns with Ms. Smith however in summer 2024 she threw a cup of water in Resident A's face and told her she needed to cool down. Ms. Warren stated she was outside so she did not hear what she was saying to Resident A during the incident but eventually Ms. Smith came outside and told EMS to "just take her" to the hospital.

On December 5, 2024, I reviewed the Livingston County Sheriff's Office report for case number 24-05761 written by investigator BR Hulse. During this investigation, Ms. Smith explained that she could not have taken Resident A down to the floor because she has issues with her knee and is unable to get up from a seated position with ease, however, during the interview she was able to get up several times without issue. The summary of the report stated, "*Based on the conflicting statements, lack of any evidence of injury and the victim being primarily non-verbal, it is unclear what if any assaults occurred. The consistent statements of witnesses are that Desirae was unprofessional and used excessive force on a vulnerable adult."*

On December 10, 2024, I contacted Livingston County APS specialist, Justin Brown. Mr. J. Brown stated Ms. Smith was placed on administrative leave pending the investigation. Mr. J.

Brown stated he is going to substantiate the concerns because there were inconsistencies in the interviews and what Ms. Smith was telling him conflicts with what Ms. Durand and Ms. Warren stated who were witnesses to the assault. Mr. J. Brown stated during the interview Ms. Smith told him and law enforcement that she did not get on the ground with Resident A because she had bad knees, however both Ms. Durand and Ms. Warren told him she was on the ground. Mr. J. Brown stated he was informed by law enforcement there would be no charges filed by the prosecutor's office. Mr. J. Brown stated Ms. Durand and Ms. Warren both stated Ms. Smith stated she was going to "going to beat the shit out of her [Resident A]".

On December 13, 2024, I contacted licensee designee Scott Brown. Mr. S. Brown stated he has not had concerns regarding Ms. Smith in the past regarding physical assault however there have been Rights investigations because of her demeanor toward residents and absenteeism. Mr. S. Brown stated he did not agree with Ms. Smith driving there from another home because that is against policy but he knows she does have history with Resident A. Mr. S. Brown stated the direct care staff member should have waited for a call back from on call instead of reaching out to Ms. Smith. Mr. S. Brown stated Ms. Smith should not have been cussing and yelling at Resident A because this is also against protocol. Mr. S. Brown stated this was the first time they had an outburst this way from Resident A but law enforcement was aware of her from her previous placements.

On December 13, 2024, I interviewed direct care staff member Desirae Smith. Ms. Smith stated she was working at another licensed facility when Ms. Warren called her crying from Golf Road Home saying Resident A just beat her up. Ms. Smith stated Ms. Warren asked her if she thought she could get her to take her PRN medication so Ms. Smith stated she put two of the residents from the other facility in the car and drove to Gulf Road Home. Ms. Smith stated she did contact Mr. Blandford on the way to let him know. Ms. Smith stated Resident A hit her two different times when she was in another licensed facility however typically she can get her calmed down and she's never had to call 911 in the past. Ms. Smith stated when she arrived law enforcement and EMS were already there and she asked Ms. Warren to go outside and stand by the car with the other residents. Ms. Smith stated Resident A was sitting on the loveseat and she sat down next with her, she took her medication and she thought Resident A was starting to relax and calm down. Ms. Smith stated the officer asked if everything was alright and EMS and law enforcement left. Ms. Smith stated as soon as they walked out the door, Resident A back handed her and lowered herself to the ground and started hitting her in the face. Ms. Smith stated every time she started to stand, Resident A hit her again. Ms. Smith stated Ms. Durand came over and grabbed Resident A by the shoulders and Ms. Smith stated she told her they could not restrain Resident A so Ms. Durand walked away and she did not see her again. Ms. Smith stated she was yelling and cussing at Resident A which she knows she should not have been but she was so upset. Ms. Smith stated while she was being hit, she told Resident A she was going to press charges on her, told her what jail was like, and how she could not have her baby dolls there because she would be in a cell with nothing. Ms. Smith stated she was hoping that if she would explain what a jail cell was then it would calm her down. Ms. Smith

stated she would not bring her grandson up to see her again because she was hurting her because she was afraid that she would hurt the baby. Ms. Smith stated that worked a little but then she would point to her arm where they would draw blood because she wanted to go to the hospital because she thought she was going to be admitted which she likes. Ms. Smith stated after about 20 times of getting hit in the face, she put her arm up in front of her face and moved to the side so she can get out from underneath her to get EMS attention by opening the front door and said, “you guys can come fucking take her” because they were still in the driveway. Ms. Smith stated EMS then turned around so the back was facing the house and asked if they needed her to get medical treatment because they could tell her face was sore. Ms. Smith stated Resident A went outside and put herself on the stretcher because she was happy to go to the hospital. Ms. Smith stated she used her arm to move out from underneath her but she never got down on the floor with her, wrestled with her, or hit her back. Ms. Smith stated, “Quit fucking hitting me” and she knows that she used other swear words but did not recall what she specifically said. Ms. Smith stated she did see Resident A after this incident and she did apologize to Resident A.

On December 13, 2024, I interviewed direct care staff member Heidi Durand. Ms. Durand stated she was there during the incident. Ms. Durand stated when she first started her shift, Resident A was asking for a stroller and they said she could put it on a Christmas list but she started to get more irritated and asked in a louder voice. Ms. Durand stated Resident A was pointing at her arm where an IV would go because she wanted to be sent to the hospital. Ms. Durand stated Ms. Warren texted the managers and on call but they did not answer and Resident A started getting more escalated throwing her dinner plate against the wall. Ms. Durand stated Ms. Warren started getting hit and she was able to guide Resident A away from her but then Resident A started to kick at her instead. Ms. Durand stated Resident A went to her room for a bit and they called 911 and Ms. Smith who came to the home around the same time as EMS. Ms. Smith came into the home and asked her “why the fuck did you call 911?” and kept yelling at the direct care staff members. Ms. Durand stated Ms. Smith apologized to the paramedics and police that they were called and tried to send them out of the house, but EMS did stay in the driveway. Ms. Durand stated Resident A then started to punch Ms. Smith so she tried to go over and intervene and Ms. Smith yelled at her to stop trying to move her away and continued to let Resident A punch her. Ms. Durand stated she heard Ms. Smith state to Resident A, “If you punch me one more time, I am going to beat the shit out of you” and then when she got punched again and Ms. Smith said, “you are never going to see a real baby ever again” and she got on top of Resident A and was holding her down using her forearm near her neck. Ms. Durand stated shortly after this Ms. Smith stated, “I am done, I am done, have them come back in” and they took her to the hospital. Ms. Durand stated she has observed Ms. Smith yell at another resident in the past, but not to this extent. Ms. Durand stated Resident A did not have any injuries on her from the incident.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on my review of Livingston County Sheriff's Office report for case number 24-05761 regarding the incident written by investigator BR Hulse, there were verbal assaults during this incident and Resident A was not treated with dignity and respect during this altercation. The summary of the report stated, "*Based on the conflicting statements, lack of any evidence of injury and the victim being primarily non-verbal, it is unclear what if any assaults occurred. The consistent statements of witnesses are that Desirae was unprofessional and used excessive force on a vulnerable adult."* Ms. Smith also admitted she yelled and swore at Resident A during the incident as well as threatened Resident A by describing a jail cell to her and stating she was never going to see a real baby again. Consequently, Ms. Smith did not treat Resident A with consideration and respect.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Ms. Smith stated she was trying to protect her face when she put her arm out to block Resident A while Resident A was hitting her. Ms. Smith denied putting her elbow on her, going down to the floor with Resident A, or hitting Resident A at any time in any manner. Due to the conflicting reports, there is not enough information to determine Ms. Smith used physical force toward Resident A that was not appropriate or warranted to protect Ms. Smith from Resident A's blows.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

_____12/16/2024_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

12/17/2024

_____

Dawn N. Timm
Area Manager

Date