



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 31, 2025

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

RE: License #: AM460269628
Investigation #: 2025A1032047
Mohawk 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in black ink, appearing to read "Dwight Forde".

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 #:	AM460269628
Investigation #:	2025A1032047
Complaint Receipt Date:	09/04/2025
Investigation Initiation Date:	09/05/2025
Report Due Date:	11/03/2025
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:	Mohawk Home
Facility Address:	4015 Mohawk Tr., Adrian, MI 49221
Facility Telephone #:	(517) 263-7735
Original Issuance Date:	09/30/2005
License Status:	REGULAR
Effective Date:	04/15/2024
Expiration Date:	04/14/2026
Capacity:	8
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
An employee left Resident A unattended and soiled in the bathroom.	No
Additional Findings	No

III. METHODOLOGY

09/04/2025	Special Investigation Intake 2025A1032047
09/05/2025	Special Investigation Initiated - On Site
09/13/2025	Contact - Document Received
10/31/2025	Contact - Document Received Email from Lenawee Recipient Rights Officer Stephen Mitchell
10/31/2025	Exit Conference

ALLEGATION:

An employee left Resident A unattended and soiled in the bathroom.

INVESTIGATION:

On 9/5/25, I interviewed employee Lilith Craft in the facility. Ms. Craft denied leaving Resident A in soiled briefs or in the bathroom for extended periods of time. Ms. Craft reported that back in June 2025, there was a day when she had to be focused on Resident A's care because other shift partners were engaged in other activities. She stated that she has let him sit on the toilet for 10 minutes at most. She advised that on the day in question, Resident A had urinated on the floor and she had to clean things up. She stated that Resident A will often remove his clothing so she re-directs

him to the bathroom to get dressed. According to Ms. Craft, Resident A also receives two showers a day to help with sensory issues.

I interviewed home manager Jody Ejarque in the facility. Ms. Ejarque denied directly observing Ms. Craft interacting with Resident A in any inappropriate manner.

I observed Resident A but was unable to interview him because he is non-verbal.

Ms. Craft reported that on 9/1/25, assistant manager Sidney was disrespectful toward a resident. She described an interaction between Sidney and Resident B where she claimed Resident B was always blocking the way. Ms. Craft stated that another employee named CiCi had choked Resident A with a clothing protector.

I interviewed Resident B in the facility. Resident B stated that Sidney did not want him having his chair in a certain position and had asked him to reposition the chair.

On 9/13/25, I reviewed an incident report that referenced an employee tying a garment around Resident A's neck. I was advised that the incident was not substantiated by recipient rights due to there being a lack of credible evidence.

On 10/31/25, I received correspondence from Lenawee County Recipient Rights officer Stephen Mitchell, confirming that there was no substantiation of abuse arising from the incident report referenced on 9/13/25. Mr. Mitchell's report indicated that using Velcro to secure the garment protector was more appropriate than tying the apparel.

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:	During the course of the investigation, Ms. Craft denied leaving Resident A unattended and soiled. The home manager did not confirm the allegation nor did anyone from the organization come forward with any information. Resident B did not appear to feel disrespected by the assistant manager and Ms. Craft's report of an incident where a garment protector was improperly applied did not rise to the level of abuse.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 10/31/25, 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.

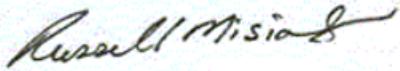


10/31/25

Dwight Forde
Licensing Consultant

Date

Approved By:



11/4/25

Russell B. Misiak
Area Manager

Date