GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2026 AMENDED REPORT

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

RE: License #: AS810243198
Investigation #: 2026A0122015
South Lawn House

Dear Scott Brown:

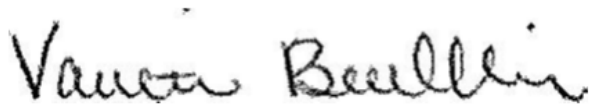
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9720.

Sincerely,



Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS810243198
Investigation #:	2026A0122015
Complaint Receipt Date:	02/09/2026
Investigation Initiation Date:	02/09/2026
Report Due Date:	03/11/2026
Licensee Name:	Renaissance Community Homes Inc.
Licensee Address:	4224 W. Maumee St Adrian, MI 49221
Licensee Telephone #:	(734) 439-0464
Administrator:	Scott Brown
Licensee Designee:	Scott Brown
Name of Facility:	South Lawn House
Facility Address:	2735 South Lawn Ypsilanti, MI 48197
Facility Telephone #:	(734) 879-0626
Original Issuance Date:	11/26/2001
License Status:	REGULAR
Effective Date:	01/03/2026
Expiration Date:	01/02/2028
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 02/07/2026, Resident A did not receive lunch.	Yes
On 02/07/2026, staff member, Rianna Thomas, did not provide personal care to Residents A and B.	Yes

III. METHODOLOGY

02/09/2026	Special Investigation Intake 2026A0122015
02/09/2026	APS Referral Recipient Rights Referral
02/09/2026	Special Investigation Initiated - Telephone Rita Sharma, APS worker. Unavailable, left voice message requesting return phone call.
02/10/2026	Inspection Completed On-site Completed interviews with home manager, Michelle McCree and staff member, LaKeeda Abdulah. Reviewed Resident A and B's file. Observed Resident B. Resident A not present.
02/12/2026	Contact – telephone calls made Completed interviews with staff members, Rianna Thomas and Makayla Taylor.
02/18/2026	Exit Conference Discussed findings with licensee designee, Scott Brown.
02/23/2026	Contact – telephone call made Completed interview with supports coordinator for both Residents A and B, Carolyn Filman.

ALLEGATION: On 02/07/2026, Resident A did not receive lunch.

INVESTIGATION: On 02/10/2026, I conducted an interview with home manager, Michelle McCree. Ms. McCree stated on 02/07/2026, she received the following report from staff member, Makayla Taylor, Resident A had not received lunch. Ms.

McCree stated that staff member, Lakeeda Abdulah, was assigned to provide care to Resident A, which included feeding him meals. Ms. McCree confirmed that Resident A did not receive lunch on 02/07/2026 as she had conducted an internal investigation, she also reported the incident to the office of recipient rights.

On 02/10/2026, Resident A was not present at the facility. Per Ms. McCree he was sent out to receive medical treatment for low oxygen level that was observed by staff earlier in the day. I reviewed Resident A's file and found that he is diagnosed with a cognitive disability and non-verbal, therefore, he is unable to participate in an interview.

On 02/10/2026, I conducted an interview with staff member, Lakeeda Abdulah. Ms. Abdulah confirmed that she was assigned to provide care to Resident A, which included feeding him meals. Ms. Abdulah stated she fed lunch to Resident A but did not remember the time of that meal.

On 02/12/2026, I conducted an interview with staff member, Rianna Thomas, who confirmed that she worked with Ms. Abdulah on 02/07/2026. Ms. Thomas confirmed that Resident A did not receive lunch on 02/07/2026 due to miscommunication between herself and Ms. Abdulah.

On 02/18/2026, I conducted an exit conference with licensee designee, Scott Brown, and discussed my findings with him. Mr. Brown stated he understood my findings and would submit a corrective action plan to address rule violations found.

On 02/23/2025, I conducted an interview with supports coordinator for Resident A, Carolyn Filman. Ms. Filman confirmed that she received a report of the allegation that Resident A did not receive lunch on 02/07/2026. Ms. Filman stated she felt the incident had been handled appropriately and she had no concerns with the personal care Residents A and B have received from the staff members of South Lawn adult foster care.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(3) Not more than 14 hours must elapse between the evening and morning meal.

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with facility home manager, Michelle McCree, and staff members, Lakeeda Abdulah and Rianna Thomas, and supports coordinator, Carolyn Filman there is enough evidence to substantiate the allegation that on 02/07/2026 Resident A did not receive lunch. Therefore, more than 14 hours elapsed between the evening and morning meal for Resident A on 02/07/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 02/07/2026, staff member, Rianna Thomas, did not provide personal care to Residents A and B.

INVESTIGATION: On 02/10/20206, I observed Resident B in his bedroom, laying on his bed. Resident A smiled when I entered the room, I observed him to be properly dressed, showing no signs of discomfort or distress. Resident B was unable to participate in an interview due to his limited cognitive abilities, he is nonverbal. Resident A was not present in the facility, as he was transported to the hospital to receive medical care due to low oxygen level observed earlier in the day. Resident A is nonverbal and therefore unable to participate in an interview.

On 02/10/2026, I conducted an interview with home manager, Michelle McCree. Ms. McCree stated on 02/07/2026, she received the following report from staff member, Makayla Taylor, she observed both Resident A and Resident B in wet/soiled briefs as if they had not been changed for an extended period of time. Ms. Taylor reported that Resident A's bed sheets were wet as well.

Ms. McCree stated she could not confirm the statement of Ms. Taylor; however, she assessed both Resident A and B's skin on 02/09/2026 and found no skin breakdowns. Ms. McCree reported the incident to office of recipient rights.

On 02/10/2026, I conducted an interview with staff member, Lakeeda Abdulah. Ms. Abdulah confirmed that she was assigned to provide care both to Residents A and B. Ms. Abdulah reported that she changed both residents' briefs. Ms. Abdulah reported that she completed her assigned job tasks to the best of her abilities and had no explanation as to why a report was received stating both residents' briefs were wet on 02/07/2026.

On 02/12/2026, I conducted an interview with staff member, Rianna Thomas, who confirmed that she worked with Ms. Abdulah on 02/07/2026. Ms. Thomas stated she observed Ms. Abdulah use the Hoyer lift to move Resident A from the living room to his bedroom on 02/07/2026 and assumed she changed his brief at that time. However, when staff member, Makayla Taylor arrived at 4:00 p.m. and showed

pictures to document that both Resident A and B's briefs were soiled and wet, she could give no explanation for what they both observed. Ms. Thomas stated the condition she observed both Resident A and B's briefs appeared that they had not been changed for an extended amount of time on 02/07/2026.

On 02/12/2026, I reviewed both files of Residents A and B. Resident A's Assessment Plan dated 08/26/2025 documents that staff are to provide "supervision on toilet and wears brief with changes/checks every 2 hours. Resident B's Assessment Plan dated 04/27/2025 documents that staff are to give full assistance with toileting. According to both assessment plans Residents A and B receive full assistance from staff with bathing, grooming, dressing, and personal hygiene tasks.

On 02/18/2026, I conducted an exit conference with licensee designee, Scott Brown, and discussed my findings with him. Mr. Brown stated he understood my findings and would submit a corrective action plan to address rule violations found.

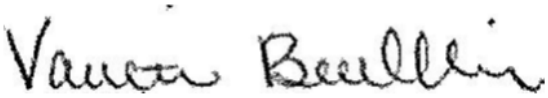
On 02/23/2025, I conducted an interview with supports coordinator for both Resident A and B, Carolyn Filman. Ms. Filman confirmed that she knew of the allegation that on 02/07/2026, staff member, Rianna Thomas, did not provide personal care to Residents A and B. Ms. Filman stated she felt the incident had been handled appropriately and she had no concerns with the personal care Residents A and B have received from the staff members of South Lawn adult foster care.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with facility home manager, Michelle McCree, and staff members, Lakeeda Abdulah, Rianna Thomas, and Makayla Taylor, and supports coordinator, Carolyn Filman and a review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that on 02/07/2026 staff member, Rianna Thomas did not provide personal care to Residents A and B. Therefore, the licensee did not provide personal care to Residents A and B as specified in their assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend no change in the license status.



Vanita C. Bouldin Date: 02/23/2026
Licensing Consultant

Approved By:

Ardra Hunter Date: 02/24/2026
Area Manager

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

I. IDENTIFYING INFORMATION

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Investigation #:	2026A0122015
Complaint Receipt Date:	02/09/2026
Investigation Initiation Date:	02/09/2026
Report Due Date:	03/11/2026
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Licensee Address:	4224 W. Maumee St Adrian, MI 49221
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Licensee Designee:	Scott Brown
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Facility Telephone #:	(734) 879-0626
Original Issuance Date:	11/26/2001
License Status:	REGULAR
Effective Date:	01/03/2026
Expiration Date:	01/02/2028

Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

I. PURPOSE: To correct errors documented on the initial special investigation reported dated 02/24/2026. On 03/04/2026, I reviewed the special investigation report 2026A0122015 dated 02/24/2026 and discovered two errors. In the first allegation, the wrong rule was cited in the initial report, 400.663 (3), finding rule substantiation more than 14 hours elapsing between the evening and morning meal. The correct cited rule should have been rule 400.633 (1).

The second error was found in the second allegation. I found that the staff members' names were listed incorrectly. Staff member, Rianna Thomas, should not have been named in the allegation. Staff member, LaKeeda Abdulah should have been listed in the allegation involving Residents A and B on 02/07/2026.

II. METHODOLOGY

03/04/2026	Contact – telephone call received Completed an interview with licensee designee, Scott Brown.
03/04/2026	Contact – document received Reviewed special investigation report 2026A0122015.
03/04/2026	Exit Conference Discussed findings with licensee designee, Scott Brown.

III. DESCRIPTION OF FINDINGS AND CONCLUSIONS: On 03/04/2026, I reviewed the special investigation report 2026A0122015 dated 02/24/2026 and discovered two errors. I found that for the first allegation, Resident A did not receive lunch, the wrong rule was cited in the initial report, 400.663 (3), finding rule substantiation more than 14 hours elapsing between the evening and morning meal. The correct cited rule should have been rule 400.633 (1).

The second error found was in the second allegation, I found that the staff members' names were listed incorrectly. The allegation read as follows, On 02/07/2026, staff member, Rianna Thomas, did not provide personal care to Residents A and B. The allegation should have stated, On 02/07/2026, staff

member, LaKeeda Abdulah, did not provide personal care to Residents A and B.

Please see the corrections listed below:

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with facility home manager, Michelle McCree, and staff members, Lakeeda Abdulah and Rianna Thomas, and supports coordinator, Carolyn Filman there is enough evidence to substantiate the allegation that on 02/07/2026 Resident A did not receive lunch. Therefore, on 02/07/2026 Resident A did not receive 3 meals.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 02/07/2026, staff member, LaKeeda Abdulah, did not provide personal care to Residents A and B.

INVESTIGATION: On 02/10/20206, I observed Resident B in his bedroom, laying on his bed. Resident B smiled when I entered the room, I observed him to be properly dressed, showing no signs of discomfort or distress. Resident B was unable to participate in an interview due to his limited cognitive abilities, he is nonverbal. Resident A was not present in the facility, as he was transported to the hospital to receive medical care due to low oxygen level observed earlier in the day. Resident A is nonverbal and therefore unable to participate in an interview.

On 02/10/2026, I conducted an interview with home manager, Michelle McCree. Ms. McCree stated on 02/07/2026, she received the following report from staff member, Makayla Taylor, she observed both Resident A and Resident B in wet/soiled briefs as if they had not been changed for an extended period of time. Ms. Taylor reported that Resident A's bed sheets were wet as well.

Ms. McCree stated she could not confirm the statement of Ms. Taylor; however, she assessed both Resident A and B's skin on 02/09/2026 and found no skin breakdowns. Ms. McCree reported the incident to office of recipient rights.

On 02/10/2026, I conducted an interview with staff member, Lakeeda Abdulah. Ms. Abdulah confirmed that she was assigned to provide care both to Residents A and

B. Ms. Abdulah reported that she changed both residents' briefs. Ms. Abdulah reported that she completed her assigned job tasks to the best of her abilities and had no explanation as to why a report was received stating both residents' briefs were wet on 02/07/2026.

On 02/12/2026, I conducted an interview with staff member, Rianna Thomas, who confirmed that she worked with Ms. Abdulah on 02/07/2026. Ms. Thomas stated she observed Ms. Abdulah use the Hoyer lift to move Resident A from the living room to his bedroom on 02/07/2026 and assumed she changed his brief at that time. However, when staff member, Makayla Taylor arrived at 4:00 p.m. and showed pictures to document that both Resident A and B's briefs were soiled and wet, she could give no explanation for what they both observed. Ms. Thomas stated the condition she observed both Resident A and B's briefs appeared that they had not been changed for an extended amount of time on 02/07/2026.

On 02/12/2026, I reviewed both files of Residents A and B. Resident A's Assessment Plan dated 08/26/2025 documents that staff are to provide "supervision on toilet and wears brief with changes/checks every 2 hours. Resident B's Assessment Plan dated 04/27/2025 documents that staff are to give full assistance with toileting. According to both assessment plans Residents A and B receive full assistance from staff with bathing, grooming, dressing, and personal hygiene tasks.

On 02/18/2026, I conducted an exit conference with licensee designee, Scott Brown, and discussed my findings with him. Mr. Brown stated he understood my findings and would submit a corrective action plan to address rule violations found.

On 02/23/2025, I conducted an interview with supports coordinator for both Resident A and B, Carolyn Filman. Ms. Filman confirmed that she knew of the allegation that on 02/07/2026, staff member, LaKeeda Abdulah, did not provide personal care to Residents A and B. Ms. Filman stated she felt the incident had been handled appropriately and she had no concerns with the personal care Residents A and B have received from the staff members of South Lawn adult foster care.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with facility home manager, Michelle McCree, and staff members, Lakeeda Abdulah, Rianna Thomas, and Makayla Taylor, and supports coordinator, Carolyn Filman and a review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that on 02/07/2026 staff member, LaKeeda Abdulah did not provide personal care to Residents A and B. Therefore, the licensee did not provide personal care to Residents A and B as specified in their assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/04/2026, I conducted an exit conference with licensee designee, Scott Brown, and discussed my findings with him, errors found in the special investigation report, and that an addendum to the special investigation report would be completed to correct errors found. Mr. Brown agreed with my findings. Mr. Brown will submit a corrective action plan to address rule violations found once he receives a corrected copy of the special investigation report.

IV. RECOMMENDATIONS:

Contingent upon receipt and approval of a corrective action plan I recommend no change in the license status.

Vanita C. Bouldin Date: 03/10/2026
Licensing Consultant

Approved By:

Ardra Hunter Date: 03/11/2026
Area Manager