



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 15, 2026

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

RE: License #: AS630416760
Investigation #: 2026A0991018
Turning Point

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 (248) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "Kristen Donnay".

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630416760
Investigation #:	2026A0991018
Complaint Receipt Date:	04/10/2026
Investigation Initiation Date:	04/13/2026
Report Due Date:	06/09/2026
Licensee Name:	Renaissance Community Homes Inc
Licensee Address:	4224 W. Maumee St Adrian, MI 49221
Licensee Telephone #:	(734) 439-0464
Administrator:	Keisha Duvall
Licensee Designee:	Scott Brown
Name of Facility:	Turning Point
Facility Address:	29545 Rutherland Southfield, MI 48076
Facility Telephone #:	(734) 483-9636
Original Issuance Date:	01/12/2024
License Status:	REGULAR
Effective Date:	07/12/2024
Expiration Date:	07/11/2026
Capacity:	6
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the home with a woman to seek drugs and sex and has since missed his medications, increasing his risk of erratic and potentially violent behavior.	Yes

III. METHODOLOGY

04/10/2026	Special Investigation Intake 2026A0991018
04/10/2026	APS Referral Received from Adult Protective Services (APS)
04/10/2026	Referral - Recipient Rights Referred to Office of Recipient Rights (ORR) by APS- assigned to Greg Szopo
04/13/2026	Special Investigation Initiated - Telephone Contacted Adult Protective Services (APS) worker, Gene Evans
04/16/2026	Inspection Completed On-site Unannounced onsite inspection- interviewed home managers and Resident A
04/16/2026	Contact - Document Received Incident report, assessment plan, individual plan of service
05/05/2026	Contact - Telephone call made To APS worker, Gene Evans
05/08/2026	Contact - Document Sent Requested police report
05/11/2026	Contact - Telephone call made To case manager at Easter Seals
05/11/2026	Contact - Document Received Copy of police report
05/13/2026	Contact - Telephone call made To administrator, Keisha Duvall

05/13/2026	Contact - Document Received Copy of incident report
05/13/2026	Contact - Telephone call made Left message for ORR worker, Greg Szopo
05/13/2026	Contact - Telephone call made Left message for licensee designee re: exit conference
05/13/2026	Contact - Telephone call received From administrator, Keisha Duvall
05/13/2026	Exit Conference Via telephone with licensee designee, Scott Brown

ALLEGATION:

Resident A eloped from the home with a woman to seek drugs and sex and has since missed his medications, increasing his risk of erratic and potentially violent behavior.

INVESTIGATION:

On 04/10/26, I received a complaint from Adult Protective Services (APS), alleging that Resident A eloped from Turning Point with a female, stating that he wanted to go get high and have sex. The complaint noted that Resident A has not had his medications since leaving the AFC home. When Resident A does not have his medications, he acts erratic and can be violent. I initiated my investigation on 04/13/26 by contacting the assigned APS worker, Gene Evans. Mr. Evans stated that Resident A moved to a room and board placement in Madison Heights, because it was cheaper than the licensed AFC. Mr. Evans met with Resident A at the new placement, and Resident A denied that he moved to live with his girlfriend and use drugs in this new placement.

On 04/16/26, I conducted an unannounced onsite inspection at Turning Point. I interviewed the home managers, Suronda Hall and Charmaine Wright. Ms. Hall and Ms. Wright stated that Resident A eloped from the home on 04/07/26 to be with his girlfriend. It was an unauthorized leave of absence (LOA). Resident A tried to change his address, because he wanted to go have sex and do drugs. On 04/06/26, Resident A told staff that he was planning to leave the home. The home managers stated that they contacted Resident A's case manager through Easter Seals to inform her of his plan to leave. Resident A started packing his belongings and stated that he had made arrangements to move out. Ms. Hall and Ms. Wright stated that they tried to talk to Resident A and told him to wait and to speak with his case manager. Resident A did not

listen and left the home with people they did not know. He did not sign out or indicate where he was going. A white Mercedes truck picked him up. Ms. Hall and Ms. Wright stated that they contacted the Southfield Police Department non-emergency number and reported that Resident A had left the home without authorization. Ms. Hall and Ms. Wright stated that they received a phone call from the woman with whom Resident A was staying, and she was asking for his medications. The Easter Seals case manager advised them not to release Resident A's medications. They stated that Resident A is his own guardian and he feels that he can do whatever he wants to do. He has a history of drug use and had a stroke from Fentanyl, which led to him being placed in an AFC. Resident A wants to be out on his own, using drugs and panhandling. He wants free reign to come and go when he wants. They stated that Resident A returned to the home on Tuesday, 04/14/26. He was scheduled to get an injection at Easter Seals that day, which he missed. Staff took him for his injection on 04/15/26, and they worked with Easter Seals to get him back on his medications. Resident A was gone from the home for one week. He was staying at a room and board located in Madison Heights during that time. Resident A has stated that he plans to leave the home again. They stated that Resident A has community access, and he can leave the home when he wants as long as he signs out and tells staff where he is going. Resident A did not sign out when he left the home on 04/07/26.

On 04/16/26, I interviewed Resident A. Resident A stated that he left Turning Point last week, and he did not sign out. He moved to a home in Madison Heights. He stated that it is similar to a group home, but it does not have 24-hour staff. He stated that they help him with what he needs, and it is very luxurious. Resident A stated that he recently got a new case manager through Easter Seals. He stated that his old case manager knew that he wanted to move and told him to just give the address of where he was moving to. Resident A stated that he can go out in the community without staff supervision. He just needs to sign out and write where he is going in the book, as well as the time he leaves and the time he returns. He stated that he needs to be back by 8:00pm, because that is medication time. He gets medications at 8:00am and 8:00pm. Resident A stated that when he left last week, he told staff, but he did not sign out. He stated that he plans to leave again in about two weeks, but he is figuring things out right now. He stated that his new case manager wants to talk to him again.

I received and reviewed a copy of Resident A's assessment plan dated 01/14/26. The box is checked "yes" that Resident A moves independently in the community; however, there is a comment that states Resident A "needs assist and redirecting for safety reasons with mobility."

I received and reviewed a copy of Resident A's individual plan of service (IPOS) effective 01/22/26. The IPOS notes that Turning Point will provide 24-hour supervision and monitoring for health and safety. The IPOS indicates that home staff will provide 1:3

staffing during awake and community hours. When asked for clarification regarding Resident A's supervision in the community, the home managers, Suronda Hall and Charmaine Wright, stated that they were told by the Easter Seals case manager that they could not stop Resident A from going into the community. They stated that he does not require supervision in the community, and he can leave the home as long as he signs out.

On 05/11/26, I interviewed Resident A's Easter Seals case manager, Lakeisha Timmons, via telephone. Ms. Timmons stated that she recently inherited Resident A's case after his previous case manager left, so she was not that familiar with his plan of service. She stated that she believed Resident A has community access and there are no restrictions. When asked about the 1:3 staff supervision in the community that is specified in his IPOS, she stated that staff do take him where he needs to go and accompany him to his appointments. She was unable to clarify if Resident A can sign in and out to go into the community unsupervised. Ms. Timmons stated that Resident A was trying to move into another home, because he wanted to have sex and do drugs. He was having a good time and partying when he was going to the other home. She stated that the provider at the other home did not care about his well-being and only wanted his money. Ms. Timmons stated that Turning Point contacted her and the police when Resident A eloped from the home. She did not feel that staff at Turning Point could have done anything to prevent Resident A from leaving the home, as it is his behavior. Resident A has returned to Turning Point, and Ms. Timmons had a conversation with Resident A letting him know that he needs to stay there.

I received and reviewed an incident report dated 04/07/26. The incident report notes that on 04/06/26, Resident A and an unknown woman contacted Pathlight Community Services administrative offices to notify them that he was moving and wanted a refund on his rent because he was going to be moving into her home. Resident A was reminded that he should go through his treatment team at Easter Seals and make better choices due to him stating that he wanted to have sex and do drugs when he moves out. Resident A was persistent that he was still going to move, and after a month he planned to move to another home after this one he had chosen. Staff tried to encourage him to wait and plan this potential move with his treatment team. On 04/07/26, a younger female came to the home and picked up Resident A and his personal belongings. She stated he was moving and asked if the home had any money for him. Resident A moved out and took all of his clothes and his TV. A young girl picked him up in an SUV and they drove off. The incident report notes that Resident A's responsible agency was contacted at 8:00am on 04/08/26 and law enforcement was contacted at 9:30am on 04/08/26.

On 05/13/26, I contacted the licensee designee, Scott Brown, to conduct an exit conference. Mr. Brown was not available, so I left a message and requested a return

phone call. On 05/13/26, I received a phone call from the administrator, Keisha Duvall, and reviewed the findings of the investigation with her. Ms. Duvall stated that they did know Resident A's whereabouts when he left the home on 04/07/26, as he was going to a room and board in Madison Heights, because he wanted to be with his girlfriend and do drugs. She stated that they did not contact the police immediately because Resident A is his own guardian and is able to make his own living arrangements. She stated that they contacted the police the following day because they did not feel it was safe for Resident A at the home in Madison Heights. Resident A was sleeping in the basement, and he requires the use of a walker. Ms. Duvall stated that Resident A does not have a behavior plan in place with any restrictions regarding his community access. She stated that she would contact Resident A's case manager to revise his IPOS to reflect that he has community access.

On 05/13/26, I received a return phone call from the licensee designee, Scott Brown. I conducted an exit conference and reviewed my findings with Mr. Brown and the program director. The program director reiterated that Resident A had been talking about his plan to leave the home all week prior to leaving on 04/08/26. She stated that Resident A's case manager was notified when he left the home. She stated that the 1:3 ratio referenced in Resident A's IPOS refers to the staffing pattern of the home, but it does not mean that he requires supervision in the community. The licensee designee stated that he would speak to the case manager to have the IPOS updated to more accurately reflect Resident A's supervision needs in the community and how to respond when he leaves the home without authorization.


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 on the information gathered through my investigation, there is sufficient information to conclude that Resident A was not provided with supervision as specified in his assessment plan. Resident A's individual plan of service (IPOS) notes that home staff will provide 1:3 staffing during awake and community hours. The home managers, Suronda Hall and Charmaine Wright, stated that Resident A does not require supervision in the community, and he is able to leave the home unsupervised if he signs himself in and out. This contradicts the 1:3 staffing

	requirement outlined in Resident A's IPOS. Resident A's assessment plan also provides contradictory information regarding his supervision needs in the community, as it states he can move independently in the community, but then notes that he needs assistance and redirecting for safety reasons with mobility.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.693	Incident notification, incident records.
	(2) If an elopement occurs, facility staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the initiation of the search, staff shall contact law enforcement.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not contact law enforcement within 30 minutes after Resident A eloped from the home on 04/07/26. Resident A left the home at 6:00pm on 04/07/26 after being picked up by an unknown female. He did not sign out when leaving the home. The incident report notes that Resident A's Easter Seals case manager and law enforcement were not contacted until the following morning on 04/08/26, after Resident A had been gone from the home for more than 14 hours.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



05/13/2026

Kristen Donnay
Licensing Consultant

Date

Approved By:



For

05/15/2026

Denise Y. Nunn
Area Manager

Date