GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 7, 2021

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

RE: License #: AS460015679
Investigation #: 2021A0575031
Oakwood Home

Dear Mr. 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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9720.

Sincerely,

Jeffrey J. Bozsik, Licensing Consultant
Bureau of Community and Health Systems
(734) 417-4277

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

I. IDENTIFYING INFORMATION

License #:	AS460015679
Investigation #:	2021A0575031
Complaint Receipt Date:	08/27/2021
Investigation Initiation Date:	08/27/2021
Report Due Date:	09/26/2021
Licensee Name:	Renaissance Community Homes Inc
Licensee Address:	1548 W. Maumee St., Suite C Adrian, MI 49221
Licensee Telephone #:	(734) 439-0464
Administrator:	Scott Brown
Licensee Designee:	Scott Brown
Name of Facility:	Oakwood Home
Facility Address:	2650 Oakwood Road Adrian, MI 49221
Facility Telephone #:	(517) 263-1868
Original Issuance Date:	01/01/1994
License Status:	REGULAR
Effective Date:	12/05/2020
Expiration Date:	12/04/2022
Capacity:	6
Program Type:	PH; DD

II. ALLEGATION(S)

	Violation Established?
Staff mistreated Resident A.	No

III. METHODOLOGY

08/27/2021	Special Investigation Intake 2021A0575031
08/27/2021	Special Investigation Initiated - Telephone
08/28/2021	Contact - Telephone call made-(a) Athena Meza -home manager; (b) direct care staff: (1) Sarah Torres; (2) Loretta Baughey; (3) Tina Putten
08/31/2021	Inspection Completed On-site
08/31/2021	Exit Conference with Scott Brown, licensee designee
09/02/2021	Inspection Completed-BCAL Full Compliance
09/02/2021	Contact- Telephone calls made and received-Tina Putten

ALLEGATION: Staff mistreated Resident A

INVESTIGATION: Resident A was not interviewed due to her cognitive impairment, and she is non-verbal.

I interviewed home manager Athena Meza on 8/27/21 and she stated direct care staff Tina Putten was suspended pending the outcome of investigations from Recipient Rights, Adult Protective Services, and AFC licensing.

I interviewed direct care staff Sarah Torres on 8/28/21 and she stated she heard coworker Tina Putten swearing at Resident A because Resident A was making loud noises and she witnessed Tina Putten push Resident A into her bedroom and told her to stay in her room. Additionally, she stated she witnessed Tina Putten push Resident A onto a recliner three times.

Since Tina Putten is suspended and unavailable for an in-person interview, I attempted to call her numerous times on 8/28/21, 8/29/21 and on 8/31/21, but I got no answer, and I couldn't leave a message for her to call me back.

On 9/2/21, I was able to contact Tina Putten, and she denied swearing at Resident A, although she admitted to swearing out of frustration with something unrelated to Resident A. She stated she did not push Resident A into a recliner, but that Resident A backed into the recliner and fell into the chair.

I interviewed direct care staff Loretta Baughey on 8/28/21 and she stated she did not hear Tina Putten swearing at Resident A and did not witness her push Resident A into a recliner.

I conducted an exit conference with Scott Brown, licensee designee, who stated he would wait for the various agency investigations to decide on Tina Putten's employment, but she remained suspended for now.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

~~ANALYSIS~~:	Direct care staff Sarah Torres stated she heard Tina Putten swearing at Resident A. Ms. Torres stated she also observed Ms. Putten push Resident A into her bedroom and onto a recliner. Tina Putten denied swearing at Resident A, although she admitted to swearing out of frustration with something unrelated to Resident A. She also denied pushing Resident A into a recliner. Direct care staff Loretta Baughey stated she did not hear Ms. Putten swear at Resident A and did not observe Ms. Putten push Resident A. Resident A could not be interviewed because she is non-verbal. The preponderance of credible evidence is that Tina Putten did not mistreat Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend no changes to the status of the license.

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Jeffrey J. Bozsik
Licensing Consultant

Date: 09/07/2021

Approved By:

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Jerry Hendrick
Area Manager

Date: 09/07/2021