GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 2, 2022

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

RE: License #: AS380015543
Investigation #: 2022A0007008
Renaissance III

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 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 (313) 456-0380.

Sincerely,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosures

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS SEXUALLY EXPLICIT INFORMATION

I. IDENTIFYING INFORMATION

License #:	AS380015543
Investigation #:	2022A0007008
Complaint Receipt Date:	11/23/2021
Investigation Initiation Date:	11/24/2021
Report Due Date:	01/22/2022
Licensee Name:	Renaissance Community Homes Inc
Licensee Address:	Suite C 1548 W. Maume St. Adrian, MI 49221
Licensee Telephone #:	(734) 439-0464
Administrator:	Larry Holleman
Licensee Designee:	Scott Brown
Name of Facility:	Renaissance III
Facility Address:	1600 Munith Road Jackson, MI 49201
Facility Telephone #:	(517) 764-6040
Original Issuance Date:	08/16/1995
License Status:	REGULAR
Effective Date:	01/22/2021
Expiration Date:	01/21/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Employee #1 has been supplying marijuana and alcohol to residents. Employee #1 made a false allegation that residents fled the car on her.	Yes
Employee #1 has also been stealing food and supplies from the home.	No
Employee #1 is assisting residents to write false complaints of sexual harassment against a staff in hopes of getting them fired.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/23/2021	Special Investigation Intake - 2022A0007008
11/24/2021	Special Investigation Initiated – Telephone call made to Guardian A, Jackson County Guardian.
11/24/2021	Referral - Recipient Rights
12/17/2021	Contact - Telephone call received - Discussion with Resident A's guardian, Guardian A, Staff A, and Case Manager A.
01/18/2022	Inspection Completed On-site - Unannounced - Face to face contact with Employee #2, Resident A, Resident B, Resident C, Resident D, Home Manager #1, and Employee #1.
01/19/2022	Contact - Telephone call made to the facility. I spoke with Employee #2, Resident B, and Resident C.
01/19/2022	Contact - Telephone call received to from Home Manager #1.
01/19/2022	Contact - Document Received - Notes, Complaints, and Disciplinary Actions.
01/21/2022	APS Referral Made.

01/21/2022	Exit Conference conducted with Mr. Brown, Licensee Designee.

ALLEGATIONS:

Employee #1 has been supplying marijuana and alcohol to residents.
Employee #1 made a false allegation that residents fled the car on her.

INVESTIGATION:

As a part of this investigation, I reviewed the complaint and noted the following additional information:

An employee by the name of [Employee #1] has been supplying marijuana and alcohol to the residents of the Ren 3 building of the Renaissance Community Homes. She [Employee #1] has been seen stealing food and supplies from the home. She [Employee #1] was seen on camera taking two residents to the Stone Depot dispensary in Jackson, MI. She [Employee #1] then proceeded to lie to her employers about the incident stating the residents fled the car on her. After these incidents were reported, she [Employee #1] started training and aiding her residents to write false complaints of sexual harassment against another employee in hopes of getting them fired.

It should be noted that there was a pending special investigation at this home when this subsequent complaint was received. Please see SIR# 2022A0007006 for additional information.

According to the complaint, Employee #1 has been supplying marijuana and alcohol to the residents of the Ren 3 building of the Renaissance Community Homes. She [Employee #1] was seen on camera taking two residents to the Stone Depot dispensary in Jackson, MI. Employee #1 then proceeded to lie to her employers about the incident stating the residents fled the car on her.

On December 17, 2021, I spoke with Resident A's guardian, Guardian A, Staff A, and Case Manager A. Resident A has a history of alcohol abuse and his doctor has provided a written statement about the imminent risks involved. There is a concern about the interactions between the prescribed medications and the alcohol. In addition, Resident A was recently prescribed a medication to treat problem drinking, as it creates an unpleasant reaction to the alcohol, if he drinks while taking the medication. On December 14, 2021, Resident A had an appointment with his psychiatrist, and he had already been drinking prior to the meeting. There is a new resident in the home from another county and there is a possibility that he (Resident A) is getting the alcohol from him. Resident A is now getting whisky from the resident. There was recently an emergency meeting and Office of Recipient Rights

(ORR) was there. It was determined that the facility staff cannot take the Resident's to purchase marijuana but if they go to the Jackson Crossing, the residents can walk over to the dispensary on their own. ORR informed them that it was okay for residents to walk down the street and smoke marijuana, just not at the facility because the home is federally funded. Guardian A and her staff do not want Resident A to have access to drugs or alcohol, and they are concerned about the imminent health risks.

On January 18, 2022, I conducted an unannounced on-site investigation and made face to face contact with Employee #2, Resident A, Resident B, Resident C, Resident D, Home Manager #1, and Employee #1.

Due to the current health pandemic, a brief on-site investigation was completed. Interviews were conducted in the garage of the facility. I also followed up and conducted telephone interviews on this same day, and on January 19, 2022.

I interviewed Employee #2 and inquired about the residents being supplied with marijuana and alcohol. She informed me that a direct care staff, Employee #3, drove Resident B to the store. Resident B then walked over to the dispensary. As far as she knows, Home Manager #1 did address this issue with Employee #3. In addition, that when residents would go out into the community with CI staff (facility direct care staff), Resident A would go to the store and purchase alcohol. According to Employee #2, there have been some changes and staff are no longer allowed to take the residents to stores that sell alcohol. I inquired if there have been any new incidents since the changes and Employee #2 informed there was an issue last night. Resident B had been out on a visit with relatives. When he returned, Resident B gave Resident A a shot of alcohol. Resident A consumed the alcohol; however, it really did not affect him. It should be noted that Resident A is prescribed a medication to treat problem drinking, as it creates an unpleasant reaction to the alcohol. According to Employee #2, Resident A's face turns bright red, but it does not make him sick.

I then interviewed Resident A. During the interview he did not confirm that staff were providing or had provided marijuana to the residents. He did confirm that staff had taken him to get alcohol in the past but that is no longer occurring. Resident A also informed me that Resident B gave him a shot of alcohol for his birthday.

Resident C did not confirm that staff were supplying marijuana to the residents.

During the on-site investigation, Home Manager #1 informed me that staff had taken Resident B to into the community, close to a dispensary. It was reported that Resident B bailed and ran to the dispensary. Marijuana is not allowed in the company van, so Resident B walked around, smoking the marijuana until it was gone. He then returned to the van and was returned to the facility. Staff received a verbal warning for this incident.

During the follow-up interview, Home Manager #1 informed me that there were two staff (Employee #1 and Employee #3) involved in incidents with residents being taken to the marijuana dispensary. Resident B was taken directly to the dispensary by Employee #1. Resident B was admitted into the home in October of 2021, and this incident occurred during the first month that he resided in the home. According to Home Manager #1, disciplinary action was taken to address this incident. In addition, Employee #1 no longer takes Resident B into the community.

Home Manager #1 also informed me that there may be some conflict between Employee #1 and Employee #4. They no longer work on the same shifts and only see each other during shift change.

On January 18, 2022, I interviewed Employee #1. She was cooperative with the interview. I inquired about her taking Resident B to the dispensary, and she informed me that she wasn't clear about this issue, as he has rights, and he also had a marijuana card. She described this situation as a gray area. I inquired if she contacted supervision to clear up her confusion and she stated she did not. Employee #1 stated that it was a bad decision, and it won't happen again. Employee #1 also informed me that Resident A is the only resident that she has taken to purchase beer. During the interview, Employee #1 informed me that there are a lot of rumors going around, many of which are not true. She stated there was gossip in the home. She tries to keep to herself and do her job; letting the rumors go. She stated, "I hear things that are not true. I let go and pray about it."

On January 18, 2022, I interviewed Employee #4. He informed me that Employee #1 and Employee #3 took residents to the dispensary, but they tried to say that they went to the gas station and the residents took off. Employee #4 stated that Employee #3 would take Resident C to his AA meetings, and they would return to the facility later. It appeared to him that it was much later than it should have been. In addition, that Resident C has been to Employee #3's apartment. Employee #4 stated that Resident C is not going to say that he's been to the apartment, but they made a quick stop by the apartment.

On January 18, 2022, I interviewed Employee #3. She informed me that she heard a rumor about staff getting marijuana for residents, but she did not know anything about staff providing them with alcohol. She denied running personal errands with the residents in the van. She informed me that the allegations of taking any residents to her home was not true. Employee #3 stated that there are a lot of rumors going around, that are not true.

On January 19, 2022, I interviewed Resident B. He told me that he did give Resident A a shot of alcohol for his birthday. Resident B stated this was the first time he had given Resident A alcohol. Resident B informed me that he was not going to provide alcohol to Resident A anymore.

On January 19, 2022, I interviewed Resident C. He confirmed that Employee #3 has taken him to AA meetings. He did not confirm that she runs personal errands while out in the community or that he has ever been taken to her apartment.

As a part of this investigation, I reviewed the disciplinary action forms and noted that a staff member was reprimanded for not following the employee policies and instructions. It was also noted that the staff member was not to supply or acquire marijuana for the residents.

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:	Resident A has a history of alcohol abuse, and his doctor has provided a written statement about the imminent risks involved. Guardian A and her staff do not want Resident A to have access to drugs or alcohol, and they are concerned about the imminent health risks. Resident A confirmed that staff had taken him to get alcohol in the past but that is no longer occurring. Employee #1 informed me that Resident A is the only resident that she has taken to purchase beer. I asked Employee #1 about her (Employee #1) taking Resident B to the dispensary, and she informed me that she wasn't clear about this issue, as he has rights, and he also had a marijuana card. Employee #1 stated that it was a bad decision, and it won't happen again. Employee #2 informed me that a direct care staff, Employee #3, drove Resident B to the store. Resident B then walked over to the dispensary. Employee #4 informed me that Employee #1 and Employee #3 took residents to the dispensary, but they tried to say that they went to the gas station and the residents took off. Home Manager #1 informed me that staff had taken Resident B to into the community, close to a dispensary. It was reported that Resident B bailed and ran to the dispensary. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence that the residents of this home were not treated with dignity and respect and their personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

Employee #1 has also been stealing food and supplies from the home.

INVESTIGATION:

During the interview with Employee #2, she informed me that she has heard rumors about staff stealing, but she has not personally observed anything. She noted that there is enough food in the main refrigerator for a couple of days. The extra food is maintained in a refrigerator in the garage, which is now locked.

Resident A reported that the food was good at the home and that he gets enough to eat. He was not aware of any incidents regarding food being stolen or missing.

Resident C stated that he is getting enough food to eat and that he has gained weight. He did not have any concerns about food being stolen.

Home Manager #1 informed me that he was not aware of food being stolen. He did describe that the menu would call for a certain type of meat, but it would not be available when it was time to prepare the meal. Home Manager #1 suggested that staff might be substituting the meals, which is why the products were not there. I informed Home Manager #1 that if staff are substituting meals, then staff should be documenting that information on the menus. Home Manager #1 mentioned that there was an issue with the paper plates. I informed him that the residents were to use regular dishes (not disposable). He informed me that the staff mainly utilized the paper products.

During my interview with Employee #1, she stated that she has never stolen anything and never seen anything being taken from the home.

During my interview with Employee #4 he informed that he has observed Employee #1 put raw steaks into her purse. In addition, that Employee #1 took some paper plates out of the cabinet.

During my interview with Employee #3, she informed me that she has heard rumors about staff stealing. Employee #3 stated that will go to cook food or go to get supplies and they're gone, and they have not used them. Employee #3 stated that she has not personally observed anyone taking anything.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or

	borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	The residents report to get enough food to eat and they are not aware of any missing items. While some staff report that they have observed food and supplies to be missing, even though they have not used them, there is not a 51% preponderance of the evidence to support the allegations that a specific employee (Employee #1) is stealing from the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

Employee #1 is assisting residents to write false complaints of sexual harassment against a staff in hopes of getting them fired.

INVESTIGATION:

Regarding these allegations, Employee #2 informed me that Employee #1 said that Employee #4 had a keychain that was shaped like a penis. Employee #1 was coaching Resident D to say that Employee #4 was swinging the keychain in his face. I inquired if Resident D could tell me what happened and Employee #2 informed that me that he (Resident D) will just repeat what you say. Employee #2 stated that Employee #1 did write a complaint regarding this matter, but she was not aware of the results.

While at the facility, I made face to face contact with Resident D at the door of the facility. I spoke with Resident D. Based on his diagnosis and cognitive abilities, I did not interview Resident D.

Home Manager #1 informed me that Employee #4 did bring in a plug-in incense, that was inappropriate into the facility. Employee #1 wrote up a complaint. Home Manager #1 spoke to Employee #5, who was also present, about what happened; he confirmed that it was inappropriate to bring in the keychain.

During the course of this investigation, Home Manager #1 informed me that there may be some conflict between Employee #1 and Employee #4. They no longer work

on the same shifts and only see each other during shift change. He also agreed to send me a copy of the written statements and disciplinary actions.

According to Employee #1, Employee #4 brought in an imitation penis. Employee #5 was also at work and observed the incident. According to Employee #1, Employee #4 took the imitation penis and put it where his penis would be. Employee #4 also made statements and said, “suck it old lady” to her. Employee #1 stated that Employee #4 then went to Resident D, who was sitting in the living room and started wiggling his hand, really fast, in front of Resident D’s face. Resident D got angry.

According to Employee #1, at one point, Employee #4 was antagonizing Resident D, saying “why you so mad?” Employee #1 stated that it was not a pleasant experience and after this happened, the lies about her started.

Employee #4 stated that he had an incense/air freshener, which was in the shape of a penis. The incense/air freshener was about two to three inches in length. The incense/air freshener was designed to be attached to the car vent. Employee #4 stated that he took the incense/ air freshener into the facility to show his co-worker, Employee #5; asking if this was something his girlfriend should have in her car. Employee #1 asked to see it and she smelled it. Employee #4 stated that he was playing with the incense/air freshener. Employee #4 stated that the home has “old men”, and they were laughing. He then took it back to the car. Employee #4 stated that it was nothing sexual but that he should not have done that. Employee #4 also stated that Employee #1 was mad at him.

As a part of this investigation, I reviewed the notes, complaint forms, and disciplinary actions regarding this matter.

There was documentation of a written complaint, which was completed on the behalf of Resident D, which in relevant part, noted the following: Employee #4 “had a fake rubber penis and was flapping it in front of my face taunting me. I got so upset I wanted to hit him. I feel like this was sexual harassment.”

It was noted that Home Manager #1 spoke to Employee #5 regarding the incident that occurred on November 16, 2021. Home Manager #1 documented that Employee #5 told him that Employee #4 did bring in a keychain sized automobile incense, which was shaped like a penis. He wanted to show him the incense and ask if this was something his (Employee #4’s) girlfriend should have in her car. Employee #1 came into the area and asked to check it out. Employee #4 told Employee #1 to smell it, which she did, and she made jokes. According, Employee #5’s reporting, Employee #4 never said “suck it.” Employee #5 reported that no residents were in the immediate area. Employee #5 added that he overheard one resident complaining saying he did not understand why Employee #1 was encouraging and trying to get residents to write complaints on certain staff.

According to the records, the staff member was reprimanded for bringing the inappropriate keychain into the facility.

On January 21, 2022, I conducted the exit conference with Mr. Brown, Licensee Designee. We discussed the investigation and my recommendations. He agreed to submit a written corrective action plan to address the established violations.

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:	While there are some inconsistencies in what the staff reported, what is clear and consistent is that Employee #4 brought an inappropriate keychain into the home of the residents. This action caused disruption in the home. The staff report that there are issues with gossiping and rumors going around. Home Manager #1 reported to adjust the staff scheduling to address the conflict between Employee #1 and Employee #4. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that in this environment, the residents of the home were not being treated with dignity and their personal needs, including protection and safety, were not attended to at all times, in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

According to Employee #2, Resident B gave Resident A a shot of alcohol. Resident A consumed the alcohol.

Resident A also informed me that Resident B gave him a shot of alcohol for his birthday.

During the interview with Resident B, he told me that he did give Resident A a shot of alcohol for his birthday. Resident B stated this was the first time he had given Resident A alcohol. Resident B informed me that he was not going to provide alcohol to Resident A anymore.

Home Manager #1 informed me that Resident B was on a community visit with his parents, and he purchased alcohol. Resident B gave Resident A a shot of alcohol for his birthday. Home Manager #1 reported that they're actively addressing the issue with Resident B providing alcohol or marijuana to any of the residents. According to Home Manager #1, the case managers have been contacted and the assessment plans will be updated to reflect the changes. In addition, Resident B has been notified of the facility rules and regulations, and failure to follow the rules will jeopardize the placement. Resident B is his own guardian, and he has signed the documents.

It should be noted that in the previous investigation (SIR #2022A0007006), Resident B supplied Resident A with marijuana, and those allegations were substantiated.

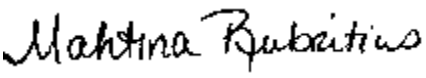
During the exit conference with Mr. Brown, he expressed concerns as he has received inconsistent guidance. His corporation has received push back from ORR, as he has tried to establish guidelines to address some of these issues. Mr. Brown was clear that these situations could not continue in this licensed setting, which receives federal funding. In addition, that there are other supported living settings that may be more appropriate for some individuals. Mr. Brown agreed to submit a written corrective action plan.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**

ANALYSIS:	Based on this information, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A received alcohol from another resident (Resident B) and consumed it; thus, the amount of personal care, supervision, and protection that is required by Resident A was not provided by the facility staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

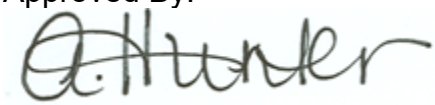
Contingent upon a very detailed written corrective action plan, I recommend the status of the license remains unchanged.



01/26/2022

Mahtina Rubritius — Date
Licensing Consultant

Approved By:



02/02/2022

Ardra Hunter — Date
Area Manager