GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 3, 2022

Birdie Goynes
Renaissance Gardens at Fox Run
41215 Fox Run Rd.
Novi, MI 48377

RE: License #: AH630306479
Investigation #: 2022A1019039

Dear Ms. Goynes:

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 authorized representative and a date.

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) 284-9730.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630306479
Investigation #:	2022A1019039
Complaint Receipt Date:	03/29/2022
Investigation Initiation Date:	03/29/2022
Report Due Date:	05/28/2022
Licensee Name:	Fox Run Village, Inc.
Licensee Address:	41000 W. 13 Mile Rd. Novi, MI 48377
Licensee Telephone #:	(248) 668-8688
Administrator and Authorized Representative:	Birdie Goynes
Name of Facility:	Renaissance Gardens at Fox Run
Facility Address:	41215 Fox Run Rd. Novi, MI 48377
Facility Telephone #:	(248) 668-8720
Original Issuance Date:	02/24/2010
License Status:	REGULAR
Effective Date:	12/13/2021
Expiration Date:	12/12/2022
Capacity:	200
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents' rights were violated by staff.	Yes
Additional Findings	No

III. METHODOLOGY

03/29/2022	Special Investigation Intake 2022A1019039
03/29/2022	Special Investigation Initiated - Letter Notified APS of the allegations via email referral template.
03/29/2022	APS Referral
03/31/2022	Contact - Document Received Email received form APS worker H. Stickel providing notification that she is assigned to the investigation.
04/18/2022	Inspection Completed On-site
04/18/2022	Inspection Completed-BCAL Sub. Compliance
05/03/2022	Exit Conference

ALLEGATION:

Residents' rights were violated by staff.

INVESTIGATION:

During March 2022, administrator and authorized representative Birdie Goynes submitted four separate incident reports outlining alleged verbal and physical abuse of residents by facility staff. On 3/14/22, it was reported that Employee A told Resident A to “shut up”. That same day, it was reported that Employee A kicked Resident B. On 3/20/22, it was reported that Employee B had a verbal altercation with Resident C. It was also reported that on 3/24/22, Employee B had a physical altercation with Resident D.

On 4/18/22, I conducted an onsite inspection. Ms. Goynes was not present at the time of my visit, Employees C and D were interviewed in her absence. Employees C and D reported that internal investigations were conducted regarding each circumstance. Employees C and D stated that the allegations against Employee B which involved Residents C and D were not substantiated and it is believed that the issues stemmed from “personality conflicts among staff”. Employees C and D did state that there were witnesses alleging to have seen Employee A kick Resident B and stated that Employee A admitted to telling Resident A to shut up.

While onsite, I obtained documentation (human resources interview transcripts) from the facility’s internal investigations in the abovementioned matters. Employee E interviewed Employee F, as it was alleged that she heard Employee A tell Resident A to shut up and that she observed Employee A kicking Resident B. In the interview transcript, Employee F stated to Employee E that she observed Employee A telling Resident A and other residents to “shut up” and that she also directly observed Employee A kicking Resident A. Employee F stated:

> *It started with when I was coming around the corner down the hallways and [Employee A] was sitting on the bench and I saw her kick [Resident B]. I see her take her foot and swing it at [Resident B] and [Resident B] said, why did you kick me. [Employee A] said why did you kick me. [Resident B] said I am sorry I kicked you. [Resident B] then said ow ow why did you kick me. [Employee A] responded why did you kick me. Then that is when she started arguing with the residents…*

Employee E interviewed Employee G. Employee G reported that she didn’t see Employee A kick Resident B, but stated that she heard the resident state that she was kicked. The transcript read “[Resident B] said it. [Employee A] said, because you kicked me first. {Resident B] was really upset and they started going back and forth saying things to each other. I was in the nursing station and [Employee A] was on the bench. My back was to them so I didn’t see I just heard.”

Employee E interviewed Employee H. Employee H stated that she did not see Resident B being kicked, but heard a conversation between Employee A and Resident B where Resident B stated “ow, why did you kick me” to Employee A.

Interview transcripts with Employees F and G read that in addition to being told to shut up by Employee A, they observed that Resident A was forcefully pushed into her room and Employee A slammed her door during the same encounter. Employee H's statement corroborated that Employee A slammed Resident A's door but she did not see Resident A being pushed into her room by Employee A.

In interview transcripts with Employee E, Employee A denied kicking Resident B. Employee A reported that Resident B kept telling people she was kicked but that it never happened. The transcripts read that Employee A admitted to telling Resident A to "shut up".

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference MCL 333.20201	**(2)(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	Interviews and attestations from multiple staff and Employee A herself confirmed that Resident A was spoken to in a disrespectful manner and at least one employee witnessed Employee A physically kicking Resident B. This undignified

	treatment is inconsistent with the provision of appropriate supervised personal care.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/3/22, I shared the findings of this report with authorized representative Birdie Goynes.

IV. RECOMMENDATION

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

05/02/2022

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

05/02/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section