GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 5, 2023

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

RE: License #: AS810255078
Investigation #: 2023A0122007
Clark Road Home

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 (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 #:	AS810255078
Investigation #:	2023A0122007
Complaint Receipt Date:	12/14/2022
Investigation Initiation Date:	12/14/2022
Report Due Date:	02/12/2023
Licensee Name:	Renaissance Community Homes Inc.
Licensee Address:	Suite C 1548 W. Maume St. Adrian, MI 49221
Licensee Telephone #:	(734) 439-0464
Administrator:	Scott Brown
Licensee Designee:	Scott Brown
Name of Facility:	Clark Road Home
Facility Address:	510 W. Clark Road Ypsilanti, MI 48197
Facility Telephone #:	(734) 961-7822
Original Issuance Date:	05/15/2003
License Status:	REGULAR
Effective Date:	09/18/2022
Expiration Date:	09/17/2024
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Home Manager's, Shana Jackson, daughter was at the facility.	Yes
Staff members are not administering Resident A's medication as prescribed.	Yes
Resident A's facility record has other residents' information in it and pages are missing out of it.	No
Inoperable cars are parked in the facility parking lot.	No

III. METHODOLOGY

12/14/2022	Special Investigation Intake 2023A0122007 Recipient Rights Referral via letter dated 11/23/2022
12/14/2022	Special Investigation Initiated - Letter Email sent to Relative A. Requesting information.
12/15/2022	Inspection Completed On-site Reviewed Resident A's records. Received Incident reports. Observed facility parking lot and property.
12/15/2022	Contact - Face to Face Completed interview with Shana Jackson, Home Manager. Requested staff to pick up trash observed inf the front yard.
12/15/2022	Contact - Telephone call made APS referral made.
12/16/2022	Contact – Document sent to Scott Brown, Licensee Designee Email sent to Scott Brown
12/16/2022	Onsite inspection completed

	Contact – Telephone call made. Completed interview with Tom Karm, Supports Coordinator affiliated with Washtenaw County Community Mental Health
12/19/2022	Contact – Telephone call received Madeline Schork, UofM Hospital Social Worker and Laveda Hoskins, Adult Protective Services Worker.
12/21/2022	Contact – Onsite Inspection Resident A observed. Reviewed Resident A's medication file, medications, and medication administration records. Completed interview with Adriana Roberts, staff member.
12/22/2022	Contact – Document received Email from Madeline Schork, UofM Hospital Social Worker.
12/27/2022	Contact – Telephone call made Guardian B, C, and D. Completed interviews with Guardian B and C.
12/27/2022	Contact – Telephone call made Adriana Roberts, Staff Member.
12/28/2022	Onsite Inspection Reviewed Resident A's medication administration records. Completed interview with Suzie McRoberts, Nurse affiliated with Washtenaw County Community Mental Health, and Adriana Roberts.
01/03/2023	Contact – Telephone call made Completed interview with Shana Pitts, Home Manager.
01/04/2023	Exit Conference Discussed findings with Scott Brown, Licensee Designee.

ALLEGATION: Home Manager's, Shana Jackson, daughter was at the facility.

INVESTIGATION: On 12/16/2022, a statement from Guardian A and Relative A's representative was received documenting the following: On 10/18/2022 and 10/27/2022 Relative A observed Home Manager's, Shana Jackson, daughter in the facility. Per Relative A, Ms. Jackson stated she was "off the clock" on 10/18/2022 therefore, it was ok for her daughter to be at the home at that time. On 10/27/2022 at approximately 5:00 p.m., Relative A observed the minor child in the facility and

bought Relative A a bottle filled with pills. She had come from the home managers office. Relative A directed the child to give the bottle to Ms. Jackson.

On 01/03/2023, I completed an interview with Shana Jackson. Ms. Jackson confirmed that her daughter was at the facility on 10/18/2022 and 10/27/2022. Ms. Jackson further reported that she was not scheduled to work but had to follow-up with clerical job duties that had not been completed during her scheduled shift. Ms. Jackson stated that her daughter had obtained a bottle of pills belonging to her and had them in her possession while in the facility. Ms. Jackson stated she took the bottle of pills from her daughter, completed her assigned tasks, and left the facility without further incident.

Per Ms. Jackson, the bottle of pills did not belong to any resident of the facility as most of their medication are received in bubble packet form.

On 01/04/2023, I completed an exit conference with Scott Brown, Licensee Designee. Mr. Brown stated he understood my findings and would submit a corrective action plan to address the rule violation.

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:	On 10/18/2022 and 10/27/2022, Shana Jackson confirmed that her daughter was in the facility while she completed clerical job duties. Based upon my investigation I find there is evidence to support the allegation that Shana Jackson's daughter was in the facility therefore, the resident's protection and safety were not attended to. The residents of this facility are medically fragile and therefore, having unsupervised minor children within the facility can place them at risk medically.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff members are not administering Resident A's medication as prescribed.

INVESTIGATION: On 12/15/2022, I completed an onsite inspection. Shana Jackson reported that Resident A had missed the medication, Diazepam 2mg, it was not administered by Adriana Roberts as prescribed.

Resident A is prescribed Diazepam 2mg tables two times daily. On 12/07/2022 an incident report documented, "while counting controlled substance medication I noticed Resident A's 9:00 a.m. Diazepam 2mg was signed by Adriana Roberts but not given. On 12/15/2022 an incident report documented, "while counting controlled substance medications I noticed Resident A's 9:00 p.m. Diazepam 2mg was signed by Adriana Roberts but was not given."

On 12/27/2022, I completed an interview with Adriana Roberts. Ms. Roberts confirmed that she did not administer Resident A's Diazepam 2mg on 12/07/2022 and 12/15/2022. Ms. Roberts stated she is uncertain how she missed giving Resident A's medication on those dates but again acknowledged that it happened.

On 12/21/2022, I completed an onsite inspection. I reviewed Resident A's medical file, medications, and medication administration records dated December 2022. Resident A's medications were accounted for. Resident A's medication records documented that Resident A received all medication as prescribed, however, per Ms. Jackson and Ms. Roberts he did not receive the medication, Diazepam 2mg, as prescribed. The actual medication on hand and his controlled substance sheet did not reflect that the medication was given as prescribed.

On 12/22/2022, I received an email from Madeline Schork. Ms. Schork stated that she had spoken with Resident A's primary care physician, Dr. Ledesai and reported the following: She told me when she has seen Resident A in the clinic she has seen no "red flags" for concern of abuse or neglect. She reports he is fragile medically, but she has seen no bed sores or unexplained bruises and appears to be well taken care of.

On 12/28/2022, I reviewed Resident A's medication administration records dated October 2022 and November 2022. October 2022 medication administration records documented on 10/01/2022 through 10/03/2022, Diazapam 2mg 1 tablet 2 times per day was not given to Resident A as the medication was not available. Per Adriana Roberts, the pharmacy representative did not deliver that medication for Resident A. Ms. Roberts stated phone calls to the pharmacy were made until the medication was delivered.

Also, November 2022 medication administration records documented there was no staff initial on 11/17/2022 to verify that Baclofen 10mg was administered to Resident A.

On 12/28/2022, Suzie McRoberts, Nurse affiliated with Washtenaw County Community Mental Health was present to review all resident files, including prescriptions and medications present at the facility. Ms. McRoberts completes this

review for all residents monthly. Ms. McRoberts reported that Resident A's review disclosed that the medication, Chlorhexidine Gluconate 0.12% twice per day has a current prescription but is not listed on the medication sheet. Also, the medication Biotene dry mouth liquid twice per day is listed on his medication sheet, but the medication is not present in the facility nor is there a prescription from his physician for him to receive the medication. Ms. McRoberts will have staff members follow up with Resident A's physician to determine if this medication should be listed on his medication administration record.

Ms. McRoberts stated the community pharmacy used for resident medication needs has made several mistakes with fulfilling resident medications and what medications are listed on their medication administration records which is why she completes monthly reviews to make certain all resident medications are in order.

Per Ms. McRoberts if an error is found she works closely with the staff of Clark Road Home adult foster care facility to resolve the issue. Ms. McRoberts stated she has no concerns with the care being provided by the staff members of Clark Road Home.

On 01/04/2023, I completed an exit conference with Scott Brown, Licensee Designee. Mr. Brown stated he understood my findings and would submit a corrective action plan to address the rule violation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	On 12/07/2022 and 12/15/2022, Resident A did not receive his medication, Diazepam 2mg, as prescribed. On 12/27/2022, staff member, Adriana Roberts, confirmed that she did not administer the medication, Diazepam 2mg, as prescribed. Resident A's medication administration records for October 2022 documented that he did not receive his Diazepam 2 mg during 10/01/2022 through 10/03/2022 as the medication was not in the facility due to a pharmacy delivery error. Resident A's medication administration records for November 2022 documented that staff did not initial for administration of the medication Baclofen 10 mg. Based upon my investigation I find there is evidence to support the allegation that staff members are not administering Resident A's medication as prescribed. He missed his prescribed medication on 12/07/2022 and 12/15/2022. There was no staff initial to document administration of the medication Baclofen 10 mg in November 2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's facility record has other residents' information in it and pages missing out of it.

INVESTIGATION: On 12/15/2022, I reviewed Resident A's facility record. Resident A's file is approximately 3.5 inches thick. I found that Resident A's file was complete, I did not observe any missing pages. I also observed that all the information is identified with Resident A's name on it.

On 12/21/2022, I reviewed Resident A's medication file. Paperwork held in the file belonged to Resident A.

On 01/04/2023, I completed an exit conference with Scott Brown, Licensee Designee. Mr. Brown stated he understood my findings and had nothing further to add.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.** **(c) Date of discharge and the place to which the resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.** **(h) Incident reports and accident records.** **(i) Resident funds and valuables record and resident refund agreement.** **(j) Resident grievances and complaints.**

ANALYSIS:	On 12/15/2022 and 12/21/2022 I reviewed Resident A's files. I observed paperwork held in the files belong to Resident A. Based upon my investigation I find no evidence to support the allegation that Resident A's facility record has other residents' information in it and missing pages from it. All required information was in Resident A's files.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Inoperable cars are parked in the facility parking lot.

INVESTIGATION: On 12/15/2022 and 12/16/2022, I observed vehicles in the facility parking lot. One was a black pick-up truck. Shana Jackson disclosed that the truck belonged to Staff 1, who is no longer employed by the company, and it is inoperable. I sent an email to Scott Brown to inform him that the vehicle was inoperable. Mr. Brown directed the vehicle to be removed from the property. On 12/16/2022, Scott Brown sent an email stating that the black pick-up truck was removed from the facility property.

On 12/15/2022 and 12/16/2022, I did not observe Staff 1 on the property of the Clark Road Home adult foster care facility. The truck was parked furthest away from the property. It did not obstruct the use of the facility van or other vehicles from arriving and leaving the property. Pictures of the facility property were taken to document the condition and placement of the truck and other vehicles on the property.

On 12/21/2022, I did not observe the black pick-up truck on the facility property.

On 01/04/2023, I completed an exit conference with Scott Brown, Licensee Designee. Mr. Brown stated he understood my findings and had nothing further to add.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(13) A yard area shall be kept reasonably free from all hazards, nuisances, refuse, and litter.

ANALYSIS:	On 12/15/2022 and 12/16/2022, I observed an inoperable black truck in the facility parking lot. The truck was parked furthest away from the property and did not obstruct the transportation needs of the residents. On 12/16/2022, Scott Brown, Licensee Designee, sent an email stating that the black pick-up truck was removed from the property. Based upon my investigation I find that there was an inoperable black truck in the facility parking lot, but it was parked appropriately. It did not obstruct the transportation needs of the residents. The inoperable truck did not present a hazard, nuisance, refuse, or litter the facility yard.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Vanita C. Bouldin
Licensing Consultant
Date: 01/04/2023

Approved By:

Ardra Hunter
Area Manager
Date: 01/05/2023