GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 11, 2023

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

RE: License #: AS810243198
Investigation #: 2023A0122022
South Lawn House

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 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 #:	AS810243198
Investigation #:	2023A0122022
Complaint Receipt Date:	04/18/2023
Investigation Initiation Date:	04/18/2023
Report Due Date:	06/17/2023
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:	South Lawn House
Facility Address:	2735 South Lawn Ypsilanti, MI 48197
Facility Telephone #:	(734) 572-0783
Original Issuance Date:	11/26/2001
License **Status:**	REGULAR
Effective Date:	06/18/2022
Expiration Date:	06/17/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 04/17/2023, Bruising was observed on Resident A by school personnel.	No
Additional Findings	Yes

III. METHODOLOGY

04/18/2023	Special Investigation Intake 2023A0122022
04/18/2023	Special Investigation Initiated - Telephone Completed interview with Complainant 1.
04/18/2023	APS Referral APS Denied intake and referred to BCHS - Adult Foster Care Licensing Dept.
04/18/2023	Contact – Telephone Call made. Scott Brown, Licensee Designee. Requested an appointment to have Resident A be medically assessed by her primary care physician.
04/20/2023	Contact – Document received. Medical information from Resident A's physician visit received.
04/21/2023	Onsite Inspection Observed Resident A. Completed interview with Jennifer Baloki, District Manager, and Scott Brown, Licensee Designee. Exit Conference Discussed findings with Scott Brown, Licensee Designee.
04/25/2023	Contact – Telephone calls made. Completed interviews with staff members, Michelle McCree and Billy Mclkey. Residents A and B's Case Manager, Tom Karm. Left voice message for Guardian A.
04/26/2023	Exit Conference Discussed findings with Scott Brown, Licensee Designee. Left voice message for Guardian A.

ALLEGATION: On 04/17/2023, Bruising was observed on Resident A by school personnel.

INVESTIGATION: On 04/18/2023, Complainant 1 reported that on 04/17/2023 she observed Resident A with a scratch on her left cheek, a bruise on the top of her left thigh, a bruise on her left knee, and several small fingerlike bruises on the inside of both of her thighs. Complainant 1 stated that her co-worker observed the bruising on Resident A and agreed that they were suspicious in nature.

On 04/21/2023, I reviewed Resident A's After Visit Summary dated 04/20/2023. Resident A was medically assessed for bruises. The summary stated that problems and diagnosis acknowledged or addressed were "need for hepatitis C screening test and routine screening for STI (sexually transmitted infection)" both issues were initially diagnosed in 2010. There were no issues of abuse and/or neglect listed on the summary by Resident A's physician.

Resident A's Consultation Report dated 04/20/2023 documented that Resident A was medically assessed for "bruises on legs from behavior on 04/16/2023." Her physician wrote, "healing bruises on legs, superficial abrasion on cheek. Recommend observation for routine healing, continue care as usual." There were no issues of abuse and/or neglect listed on the report by Resident A's physician.

Resident A's Assessment Plan and Individual Plan of Service both dated 09/16/2022 documents that she participates in self-injurious behaviors. She hits and bites herself.

Resident A's Behavior Plan dated 02/09/2023 documents that when staff try to redirect Resident A's self-injurious behaviors, she "uses her body weight to intimidate staff and peers." The plan states that her aggression towards staff and peers have increased. She has been displaying yelling, grabbing at/hitting staff and roommate, Resident B.

On 04/18/2023, Incident Reports were submitted and reviewed documenting on 04/16/2023 Resident A was attempting to get in the kitchen by standing on chairs, a desk, and climbing over the counter. She also attempted to grab Resident B. Staff members separated the residents and monitored Resident A to keep everyone involved safe. It was documented after her episode Resident A had a scratch on her left cheek and bruising on her legs. A separate incident report was completed documenting that school personnel observed the same wounds.

On 04/21/2023, I observed Resident A in the facility. She walked around briefly showing no signs of distress or discomfort. Eventually Resident A went into her bedroom, laid down, and watched television with her roommate, Resident B, in the room as well.

On 04/25/2023, I completed interviews with staff members, Michelle McCree, and Billy Mulkey. Both confirmed that they were worked on 04/16/2023 and observed the incident involving Resident A. Ms. McCree and Mr. Mulkey stated that Resident A was

constantly trying to get into the kitchen to where Resident B was located, attempting to obtain Resident B and place her in their bedroom.

Ms. McCree stated she was on one side of the counter preventing Resident A from entering the kitchen by positioning her body in front of Resident A so that she could not gain access by walking through or climbing on the counter. Ms. McCree stated she also attempted to redirect Resident A by offering her different activities as part of her behavior plan, but she would not be deterred. Ms. McCree stated Resident A displayed this behavior for an hour.

Mr. Mulkey stated he was in the kitchen with Resident B and described Resident A's behavior as trying to get to Resident B at any cost. Mr. Mulkey stated the few times that Resident A got into the kitchen he placed his hands on her shoulders so that she would not touch Resident B.

Both Ms. McCree and Mr. Mulkey stated they were present providing during the entirety of Resident A's behaviors. Both believed Resident A obtained bruising on her legs during this behavior incident of attempting to climb over the kitchen counter.

On 04/21/2023 and 04/26/2023, exit conferences were completed with Scott Brown, Licensee Designee where my findings were discussed with him. Mr. Brown stated he understood my findings and would submit a corrective action plan to address rule violations found.

On 04/25/2023 and 04/26/2023, I left voice messages for Guardian A requesting a return phone call. As of 05/05/2023 I have not received contact from Guardian A.

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 04/16/2023, an incident report was completed documenting that Resident A displayed physically aggressive behaviors described as standing on chairs, a desk, and climbing over the counter. She also attempted to grab Resident B. On 04/25/2023, direct care staff members, Michelle McCree and Billy Mulkey confirmed they observed Resident A displaying physically aggressive behaviors. Resident A's Consultation Report dated 04/20/2023 documented that Resident A was medically assessed for "bruises on legs from behavior on 04/16/2023." Her physician wrote, "healing bruises on legs, superficial abrasion on cheek. Recommend observation for routine healing, continue care as usual." There were no issues of abuse and/or neglect listed on the report by Resident A's physician. Based upon my investigation I find that Resident A's personal needs, including protection and safety, were attended to on 04/16/2023. Direct care staff were present while Resident A was displaying behaviors and redirected her to the best of their abilities.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 04/21/2023, Jennifer Baloki, District Manager, submitted an incident report documenting behaviors displayed by Resident A on 04/20/23.

The incident report documented on 04/20/23, Resident A targeted Resident B by attempting to "climb over the counter to get to Resident B" to take her into their shared bedroom. Resident A engaged in this behavior for a few hours. Staff members were present and kept the residents separated, sometimes locking Resident B in a separate bedroom while Resident A attempted to gain access. During this incident staff members attempted to redirect Resident A by following the suggestions of her behavior plan to no avail.

Ms. Baloki stated that Resident A has been displaying this behavior for at least a few months. Staff members have been unable to identify what triggered this behavior change in Resident A. Per Ms. Baloki, it has been observed that when Resident A wants to go into her room to lay down, she goes after Resident B and attempts to take her into the bedroom as well. Resident A attempts to take Resident B out of her wheelchair, place her in her bed independently. Once Resident B is placed in

her bed, Resident A will lay down. If Resident B does not accompany Resident A into the bedroom, then Resident A goes into behaviors and will go after Resident B until they are both in the bedroom.

Ms. Baloki stated a team meeting has been held with Resident A's case manager, psychologist, etc. to discuss/address her behavior changes. Ms. Baloki reported that medication changes have been made but have not addressed Resident A's behaviors. Resident A's psychologist has been informed that her current behavior plan is not working as the recommendations do not divert her behaviors. The team has recommended replacement for Resident A however, until that time they are complying with Resident A's request to have Resident B accompany her into the shared bedroom when she wishes.

On 04/21/2023, I observed Resident A in the facility. She walked around briefly showing no signs of distress or discomfort. Eventually Resident A went into her bedroom, laid down, and watched television with her roommate, Resident B, in the room as well.

Per Ms. Baloki, when both residents are in the bedroom staff members perform 15 minute interval checks to make certain both residents are doing well. They have discussed this issue with case manager, Tom Karm, of Washtenaw County Community Mental Health. Mr. Karm is working with Ms. Baloki and Scott Brown, Licensee Designee, to obtain additional funding for staff supervision/coverage and replacement search.

Resident B's Individual Plan of Service Meeting Report dated 10/18/2021 documents that she is diagnosed with the following: Profound Intellectual Disability, osteoporosis, seizure disorder, cerebral palsy, spastic quadriplegia, scoliosis, etc. It also states that Resident B is to participate in socialization, community outings, neighborhood walks, exercise, for at least 30 minutes per day. Regarding community outings, it has been determined that she experience them 8 times per month – 90 minutes each outing.

Resident B's Assessment Plan dated 05/25/2022 states that requires staff/total assistance while moving in the community, communicating (non-verbal), and walking/mobility. The plan documents that Resident B uses a wheelchair for mobility.

On 04/21/2023 and 04/26/2023, exit conferences were completed with Scott Brown, Licensee Designee where my findings were discussed with him. Mr. Brown stated he understood my findings and would submit a corrective action plan to address rule violations found.

On 04/25/2023, I completed an interview with Tom Karm, Case Manager for both Resident A and B. Mr. Karm confirmed that he has been made aware of Resident A's behavior towards Resident B. He stated that placement options are being researched for Resident A. Per Mr. Karm, Resident B has been placed on a hospice

program and a hospice placement may be considered for her. Mr. Karm reported that a meeting is being held involving his supervisor to discuss additional placement options for both residents.

On 04/27/2023, I reviewed an incident report dated 02/10/2023, which documents Resident A push past direct care staff member, Breanna Thomas, grab Resident B out of her wheelchair and drop her. Resident B was medically assessed by hospital personnel and returned to the facility the same day.

On 04/25/2023 and 04/26/2023, I left voice messages for Guardian A requesting a return phone call. As of 05/05/2023 I have not received contact from Guardian A.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(p) The right of access to his or her room at his or her own discretion.
ANALYSIS:	On 04/21/2023, Jennifer Baloki, District Manager, reported that to control Resident A's behaviors they are complying with Resident A's request to have Resident B accompany her into the shared bedroom when she wishes. Resident B is non-verbal but based upon her Individual Plan of Service she is to participate in socialization, community outings, neighborhood walks, exercise, for at least 30 minutes per day. Regarding community outings, it has been determined that she experience them 8 times per month – 90 minutes each outing. Based upon my investigation I find enough evidence to support that Resident B does not have access to her room at her own discretion as staff members are allowing Resident A to request Resident B accompany Resident A into their shared bedroom without Resident B's consent.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 04/17/2023 and 04/20/2023 incident reports documented that Resident A displayed physically aggressive behaviors towards Resident B. Resident A attempted to grab Resident B. Staff members, Michelle McCree, and Billy Mulkey, observed on 04/17/2023, Resident A's attempting to get in the kitchen where Resident B was located by standing on chairs, a desk, and climbing over the counter. Mr. Mulkey described Resident A's behavior as trying to get to Resident B at any cost. On 02/10/2023, an incident report documented that Resident A pushed past direct care staff member, Breanna Thomas, grab Resident B out of her wheelchair and drop her. Based upon my investigation Resident B's protection and safety are not attended to as Resident A displays aggressive behaviors towards her, attempting to grab her. On 02/10/2023, Resident A grabbed Resident B out of her wheelchair and dropped her.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Vanita C. Bouldin
Licensing Consultant

Date: 05/05/2023

Approved By:

Ardra Hunter
Area Manager

Date: 05/11/2023