GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 20, 2023

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

RE: License #: AS810243198
Investigation #: 2023A0122029
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 Bouldin

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 #:	2023A0122029
Complaint Receipt Date:	05/26/2023
Investigation Initiation Date:	05/26/2023
Report Due Date:	07/25/2023
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 05/24/2023, Resident C was taken out of his bed by Resident A, dragged to Resident A's bedroom and suffered injury.	Yes

III. METHODOLOGY

05/26/2023	Special Investigation Intake 2023A0122029
05/26/2023	Special Investigation Initiated - Telephone Completed telephone interview with Scott Brown, Licensee Designee.
05/30/2023	Inspection Completed On-site Received requested documents.
05/30/2023	Exit Conference Discussed my findings with Scott Brown, Licensee Designee.
05/30/2023	Contact – Telephone calls made. Completed interview with Guardian A. Completed interviews with staff members, Deon Rodgers and Erica Newsome.
05/30/2023	APS Referral Email sent to Renita Young, Adult Protective Services Worker.
06/01/2023	Contact – Telephone call received. Jeremey Campernal, APS Worker. Discussed case and findings.
06/01/2023	Contact – Document sent. Email to Jeremey Campernal, APS Worker. Case Summation and rule violation.
06/01/2023	Contact – Document Sent Recipient Rights Referral.

ALLEGATION: On 05/24/2023, Resident C was taken out of his bed by Resident A, dragged to Resident A's bedroom and suffered injury.

INVESTIGATION: On 05/26/2023, I completed an interview with Scott Brown, Licensee Designee. Mr. Brown stated the following was reported to him: Resident A pulled Resident C out of his bed and dragged him to her bedroom. By doing so, Resident C's Gastrointestinal (GI) tube was pulled out, he broke a vertebrae, and received stitches to his face.

Per Mr. Brown, Resident A displayed this behavior prior with a female resident, Resident B, Resident A was deemed no longer compatible with the other residents in the home and is moving from the facility as of 05/26/2023.

On 05/30/2023, I completed an interview with Deon Rodgers, staff member. Mr. Rodgers confirmed that he was on duty on 05/24/2023 and observed the incident involving Resident A and C with his co-worker, Erica Newsome. Mr. Rodgers reported the following: upon his arrival Resident A had knocked Resident B out of her chair attempting to take Resident B into their bedroom. Please note Resident A displayed this same behavior towards Resident B in an incident in April 2023, which was investigated, and rule violation found (SIR #2023A0122022).

Mr. Rodgers stated that he attempted to redirect Resident A's behavior by taking her for a walk. When they arrived back to the facility, they both observed staff members loading Resident B into the facility van. Mr. Rodgers reported that Resident A attempted to pull Resident B out of the van and get into the van with her. Per Mr. Rodgers he attempted to redirect Resident A's behavior by taking her into the facility. Once there, he observed Resident A pacing, as though Resident A was looking for Resident B.

At this point Mr. Rodgers stated that Resident A left the living area and went down the hallway. Per Mr. Rodgers, he began providing care to another resident while his co-worker Ms. Newsome observed. He stated Resident A came back into the living area, grabbed Ms. Newsome, and lead Ms. Newsome down the hallway. Ms. Newsome followed Resident A into her bedroom and then he heard Ms. Newsome call his name for assistance. Mr. Rodgers stated he went into Resident A's bedroom, observed Resident C on the floor with a bloody nose.

Mr. Rodgers stated that as he and Ms. Newsome were lifting Resident C to move him back into his bedroom, Resident A followed them and began physically assaulting and attacking them. According to Mr. Rodgers, he and Ms. Newsome were able to get Resident C back into his bedroom and place him in bed. Ms. Newsome then firmly placed her hands on Resident A's shoulders, backing her out of Resident C's bedroom, and into the hallway. Mr. Rodgers stated once Resident A was out of Resident C's bedroom he locked the door, leaving him and Resident C alone in Resident C's bedroom. Once Mr. Rodgers was alone in the bedroom with Resident C, he contacted emergency personnel by calling 911 and his home

manager. Mr. Rodgers stayed with Resident C until emergency personnel arrived and transported Resident C to the hospital. Ms. Newsome observed Resident A return to her bedroom without further incident. Ms. Newsome checked on the other residents and provided care to them as needed.

On 05/30/2023, I completed an interview with Erica Newsome who reported the same as Mr. Rodgers. Ms. Newsome described Resident A's physically assaultive behavior as "charging into us like a linebacker" or "slamming us again" as they were trying to return Resident C to his bedroom.

On 05/30/2023, I completed an interview with Guardian C. Guardian C confirmed that she had been informed of the incident involving Resident C by her paralegal, Denise Harrison. On 05/30/2023, Ms. Harrison reported that she had been informed that Resident C was being transported to the hospital due to injury caused by another resident. Guardian C stated prior to this incident she had a minor concern regarding Resident C's GI tube needing to be replaced frequently, however, that issue is being followed by his physician and hospital personnel.

On 06/01/2023, I reviewed Incident Report dated 05/24/2023 documenting the incident involving Resident A and Resident C. The report states that Resident C was taken to St. Joseph Hospital and was diagnosed with a "fractured lower vertebrae and received 4 stiches to the nose."

On 06/01/2023, I reviewed Resident C's After Visit Summary from St. Joseph Hospital dated 05/24/23 – 05/30/23. Resident C was treated for "Assault" and discharged with recommendations of following-up with his primary care physician (appointment scheduled for 06/13/23), updated list of prescribed medications, and instructions to resume GI tube fees and activity as tolerated.

Resident C's Written Assessment dated 06/02/2022 documents that he is unable to bear weight and he uses a wheelchair and receives total assistance from staff members with walking/mobility. His Individual Plan of Service dated 07/01/2022 documents that he is nonverbal, diagnosed with cerebral palsy, and unable to reposition himself.

On 06/01/2023, I reviewed 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.

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 05/24/2023, Resident C was taken out of his bed by Resident A, dragged to Resident A's bedroom and suffered injury. On this date Resident A also knocked Resident B out of her chair attempting to take Resident B into their shared bedroom. On 05/30/2023, staff member Deon Rodgers stated that he observed Resident A knocked Resident B out of her chair attempting to take Resident B into their shared bedroom. On 05/30/2023, staff members Deon Rodgers and Erica Newson, confirmed that while they were attending to another resident, Resident A took Resident C out of his bed, dragged him to her bedroom, and Resident C suffered injury. On 05/24/2023, Deon Rodgers observed that Resident A was upset, he observed Resident A attempting to enter the facility van trying to grab Resident B. He observed Resident A pacing while inside of the facility as if she were looking for Resident B. On 05/24/2023, staff members Deon Rodgers and Erica Newson, failed to check on Resident A when she went down the facility hallway out of their line of sight while agitated. On 05/24/2023, Resident A was able to remove Resident C from his bedroom and drag him into her bedroom without any intervention from staff members, Deon Rodgers and Erica Newson, as they had no knowledge of what she was doing. On 05/24/2023, Resident C suffered injury from Resident A without any intervention from staff members, Deon Rodgers and Erica Newson. Resident C's After Visit Summary dated 05/24/2023 – 05/30/2023 documents that Resident C received medical treatment for assault. Resident C's Individual Plan of Service dated 07/01/2022 documents that he is nonverbal, diagnosed with cerebral palsy, and unable to reposition himself. His Written Assessment dated 06/02/2022 documents that he receives total assistance from staff members with walking/mobility. Resident A's Behavior Plan dated 02/09/2023 documents that she uses her body weight to intimidate staff and peers. The

	Plan documents that Resident A's aggression towards staff and peers has increased. On 04/20/2023, Resident A participated in a similar incident and displayed the same behaviors towards Resident B. In Special Investigation Report 2023A0122022, it was documented that "Resident A targeted Resident B by attempting to climb over the counter to get to Resident B to take Resident B to their shared bedroom. Resident A engaged in this behavior for hours…" Resident A has displayed the same behavior, making attempts to drag Resident B from one area of the facility into her bedroom, during an incident in April 2023. The incident was investigated, and a rule violation found. Based upon my investigation of the incident on 05/24/2023, I find that Resident C's protection and safety were not attended to, as staff members, Deon Rodgers and Erica Newson, knew Resident A was upset but did nothing to prevent Resident A from taking Resident C out of his bedroom, dragging Resident C to her bedroom and in doing so, Resident C suffered injury.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2023A0122022 dated 05/11/2023 and CAP dated 05/24/2023.**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend change in the status of the license to 1st Provisional License.

Vanita C. Bouldin — Date: 06/16/2023
Licensing Consultant

Approved By:

Ardra Hunter — Date: 06/20/2023
Area Manager