



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
ACTING DIRECTOR

November 20, 2023

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

RE: License #: AS460306622  
Investigation #: 2024A1032001  
Sunrise Home

Dear Scott Brown:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

A handwritten signature in black ink, appearing to read "Dwight Forde".

Dwight Forde, Licensing Consultant  
Bureau of Community and Health Systems  
Unit 13, 7th Floor  
350 Ottawa, N.W.  
Grand Rapids, MI 49503

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS460306622
<b>Investigation #:</b>	2024A1032001
<b>Complaint Receipt Date:</b>	10/03/2023
<b>Investigation Initiation Date:</b>	10/06/2023
<b>Report Due Date:</b>	12/02/2023
<b>Licensee Name:</b>	Renaissance Community Homes Inc
<b>Licensee Address:</b>	Suite C 1548 W. Maume St. Adrian, MI 49221
<b>Licensee Telephone #:</b>	(151) 740-3769
<b>Licensee Designee:</b>	Scott Brown
<b>Name of Facility:</b>	Sunrise Home
<b>Facility Address:</b>	530 Sunrise Dr. Hudson, MI 49247
<b>Facility Telephone #:</b>	(517) 448-3007
<b>Original Issuance Date:</b>	05/10/2010
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	11/10/2022
<b>Expiration Date:</b>	11/09/2024
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
The home was not supporting Resident A's medical needs.	No
Additional Findings	No

**III. METHODOLOGY**

10/03/2023	Special Investigation Intake 2024A1032001
10/06/2023	Special Investigation Initiated - On Site
10/11/2023	Contact - Document Received
10/18/2023	Exit Conference

**ALLEGATION:**

**The home was not supporting Resident A's medical needs.**

**INVESTIGATION:**

On 10/6/23, I interviewed home manager Michelle Sloan via telephone. Ms. Sloan advised that in the past, Resident A has been resistant to things such as following a proper diet or participating in self-care. She stated that he would often soil his adult diaper and not inform staff. She stated that he resists getting out of his wheelchair, to air out his wounds. Ms. Sloan stated that the home has provided transportation to his various appointments, but that some of his providers do not appreciate that if Resident A refuses care, that there is very little the home can do other than offer encouragement.

I interviewed staff member Courtney Olrich in the home. Ms. Olrich stated that Resident A has improved his diet and has been following a chart where he reduces the number of snacks he eats and pops he drinks, to better manage his weight. I reviewed documents in the home detailing after visit summaries from Resident A's various doctor's visits, including a visit from Elara Care dated 10/5/23 and a visit to Henry Ford Health in Jackson, where he was seen by a Dr. Roger Bloomer for wound care follow-up.

I interviewed Resident A in the home. Resident A expressed that he is satisfied with the care he receives in the home.

On 10/11/23, I interviewed Adult Protective Services Specialist Jason Harris via telephone. Mr. Harris stated that he has closed his investigation into neglect allegations and determined that Resident A was at fault for self-neglect.

On 11/17/23, I interviewed staff member Larry Grundy via telephone. Mr. Grundy described documenting Resident A's medication refusals on an Incident Report form, which is then transmitted to his Lenawee Community Health Authority case manager Sheila Sears. Mr. Grundy advised that Resident A was now being tended to at a nursing home, because he required intravenous medications.

I interviewed Lenawee Community Health Authority case manager Sheila Sears via telephone. Ms. Sears confirmed that she receives incident reports (IRs) from the home regarding Resident A's medication and care refusals. She reported that both she and the home manager provide updates to Resident A's primary care physician. Ms. Sears discussed Resident A's current status as a patient in a nursing home, as well as doctor approval for daily nursing care once he is discharged from the nursing home.

<b>APPLICABLE RULE</b>	
<b>R 400.14310</b>	<b>Resident health care.</b>
	<p><b>(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following:</b></p> <p><b>(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.</b></p>
<b>ANALYSIS:</b>	Based on interviews with the staff members, the resident, and Resident A's case manager, there is insufficient evidence to establish a violation. Resident A from time to time refuses to cooperate with facets of his medical care, and the home takes appropriate action to encourage compliance and notify members of his team.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

On 10/18/23, I conducted an exit conference with licensee designee Scott Brown. I shared my findings, and Mr. Scott agreed with the conclusions reached.

**IV. RECOMMENDATION**

I recommend no change in the status of the license.



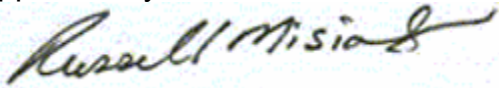
11/20/23

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Dwight Forde  
Licensing Consultant

Date

Approved By:



11/20/23

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Russell B. Misiak  
Area Manager

Date