GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 23, 2025

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

RE: License #: AS300079562
Investigation #: 2025A1032008
Steamburg Road 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,

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

License #:	AS300079562
Investigation #:	2025A1032008
Complaint Receipt Date:	12/04/2024
Investigation Initiation Date:	12/05/2024
Report Due Date:	02/02/2025
Licensee Name:	Renaissance Community Homes Inc
Licensee Address:	1548 W. Maumee St. Suite C Adrian, MI 49221
Licensee Telephone #:	(734) 439-0464
Administrator:	Scott Brown
Licensee Designee:	Scott Brown
Name of Facility:	Steamburg Road Home
Facility Address:	1540 Steamburg Road Hillsdale, MI 49242
Facility Telephone #:	(517) 439-1490
Original Issuance Date:	02/11/1998
License Status:	REGULAR
Effective Date:	09/22/2024
Expiration Date:	09/21/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was assaulted by an employee, who has a criminal background.	No
Additional Findings	No

III. METHODOLOGY

12/04/2024	Special Investigation Intake 2025A1032008
12/05/2024	Special Investigation Initiated - Letter Email sent to Lenawee Community Mental Health Recipient Rights Officer Stephen Mitchell
12/05/2024	Contact - Document Received Investigative findings from Lifeways Recipient Rights Officer Ashlee Griffes
12/11/2024	Inspection Completed On-site
01/06/2025	Contact - Telephone call made Interview with Program Manager Sarah Johnson
01/13/2025	Contact - Document Received Incident Report on Resident A needing a Heimlich Maneuver, and Resident A's 2024 IPOS
01/22/2025	Contact - Document Received I received employee Donna Vanlandingham's eligibility letter
01/22/2025	Exit Conference With licensee designee Scott Brown

ALLEGATION:

Resident A was assaulted by an employee.

INVESTIGATION:

On 12/5/24, I received an email from Lenawee Community Mental Health Authority Recipient Rights Officer Stephen Mitchell. Mr. Mitchell stated that he had not conducted any recent investigations in staff abuse at the facility.

I received a copy of investigative findings from Lifeways Recipient Rights Officer Ashlee Griffes. According to the document, the agency substantiated for improper use of force. What was highlighted was that an employee repositioned Resident A in contravention of both training and Resident A's Individual Plan of Service. The document does make reference to a physical abuse allegation made by Resident A that was not substantiated.

On 12/11/24, I interviewed home manager Brenna Goodlock in the facility. Ms. Goodlock denied being in receipt of any complaint that an employee had choked a resident. She also denied observing any of her team members engaging in such proscribed behavior. Ms. Goodlock advised that there was a recent substantiated recipient rights case against employee Donna Vanlandingham. Ms. Goodlock described the complaint as Ms. Vanlandingham allegedly using too much force in repositioning Resident A. Ms. Goodlock stated that Resident A's occupational therapist observed the staff at the home and provided guidance to the effect that if Resident A needs repositioning, to ask if she needs help before applying hands on assistance.

I interviewed employee Donna Vanlandingham in the facility. Ms. Vanlandingham stated that Resident A sometimes slouches over during meals, either making it difficult to eat, or posing a choking hazard. She stated that she would alert Resident A to the fact that Resident A was slouched over and would assist Resident A by straightening posture. Ms. Vanlandingham reported that back in September 2024, she repositioned Resident A in such a manner. Shortly thereafter, Ms. Vanlandingham stated that she went on medical leave for approximately five weeks. Upon her return, she was greeted with an accusation that she had pulled Resident A's hair in retaliation for Resident A having a bowel movement accident. Ms. Vanlandingham denied doing so, and mentioned that through the recipient rights investigation, it was determined that she did not assist Resident A in the bathroom on the day in question. Ms. Vanlandingham stated that Resident A has made false allegations against her in the past.

I interviewed employee Cindy Moore in the facility. Ms. Moore stated she was working with Ms. Vanlandingham on the day in question and denied that Ms. Vanlandingham used any excessive force in repositioning Resident A during a meal. Ms. Moore stated that Resident A has made false claims against her as well, in effect distorting something like a simple touch being a forceful blow.

I interviewed Resident A in the facility. Resident A stated that she likes living at the home and reported having a case manager and an occupational therapist. Resident A stated that she was going on an outing with employee Cindy Moore, who was taking her to the post office and Walmart.

On 1/6/25, I interviewed Program Manager Sarah Johnson by telephone. Ms. Johnson stated that she was not present when employee Donna Vanlandingham repositioned Resident A. Ms. Johnson advised that Resident A has made allegations about a number of staff members that were not credible. She stated that prior to the events that ignited the current investigation, there was no stipulation in Resident A's IPOS stating that staff should not reposition her, but the new intervention requires that staff ask Resident A for permission if she needs to be changed. Ms. Johnson pointed out that recently, staff had to perform the Heimlich maneuver on Resident A because she slumped in her chair while eating a meal and choked on her food.

On 1/13/25, I reviewed Resident A's Individual Plan of Service (IPOS) prior to the recent update. The documents did not prohibit employees from repositioning Resident A's head. I also reviewed an recent incident report where Resident A required the Heimlich Maneuver to expel the food she was choking on.

On 1/22/25, I reviewed Ms. Vanlandingham's workforce background check letter, stating that she was eligible to work in the facility.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	I reviewed Resident A's IPOS and prior to October 2024, there was no language in the document prohibiting repositioning. It is apparent that Resident A's posture during mealtimes does pose a choking hazard, as evidenced by the need to utilize the Heimlich Maneuver recently. There is also documentation to suggest that Resident A is either not well oriented to her surroundings, or is not truthful, based on a mental condition. There also seems to be a dispute regarding how much force may have been used by Ms. Vanlandingham. It appears that Resident A did not require any medical treatment. There does not appear to be enough evidence to support the violation of resident mistreatment.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 1/22/25, I conducted an exit conference with licensee designee Scott Brown. I shared my findings and Mr. Brown agreed with the conclusions reached.

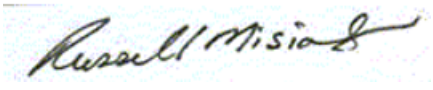
IV. RECOMMENDATION

I recommend no change to the status of this license.

1/23/25

Dwight Forde Date
Licensing Consultant

Approved By:



1/27/25

Russell B. Misiak Date
Area Manager