GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 28, 2025

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

RE: License #: AM460269628
Investigation #: 2025A1032042
Mohawk Home

Dear Scott 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.
- Specific time frames as to when the correction will be completed.
- How continuing compliance will be maintained.
- The signature of the responsible party and a date.

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 (616) 356-0100.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
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 #:	AM460269628
Investigation #:	2025A1032042
Complaint Receipt Date:	07/22/2025
Investigation Initiation Date:	07/23/2025
Report Due Date:	09/20/2025
Licensee Name:	Renaissance Community Homes Inc
LicenseeAddress:	1548 W. Maumee St. Suite C Adrian, MI 49221
Licensee Telephone #:	(734) 439-0464
Administrator:	Scott Brown
Licensee Designee:	Scott Brown
Name of Facility:	Mohawk Home
Facility Address:	4015 Mohawk Tr., Adrian, MI 49221
Facility Telephone #:	(517) 263-7735
Original Issuance Date:	09/30/2005
License Status:	REGULAR
Effective Date:	04/15/2024
Expiration Date:	04/14/2026
Capacity:	8
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
The facility allowed Resident A to be assaulted and restricts his movements.	No
Resident A is fed meals in the bathroom.	Yes
Additional Findings	No

III. METHODOLOGY

07/22/2025	Special Investigation Intake 2025A1032042
07/23/2025	Special Investigation Initiated - On Site
07/28/2025	Contact - Document Received I received a copy of Resident A's health care appraisal
07/29/2025	Contact - Document Received Interview with LCMHA Supervisor Jearald Dudley
07/31/2025	Contact - Document Received Email from Recipient Rights officer Stephen Mitchell
08/28/2025	Exit Conference With COO Kristy Gottschalk
08/28/2025	Corrective Action Plan Requested and Due on 09/11/2025

ALLEGATION:

The facility allowed Resident A to be assaulted and restricts his movements.

INVESTIGATION:

I received this complaint as an APS screen-out

On 7/23/25, I interviewed employee Holly Johnson in the facility. Ms. Johnson stated that on July 19th, 2025, she observed former employee Kayla Roach push resident A to the ground, then kick him to his room. She later observed Ms. Roach drag Resident A to his room after he spilled some orange juice in the dining room area. She advised that management and the police were notified of Ms. Roach's conduct, resulting in her no longer working at the facility. Ms. Johnson stated that Ms. Roach was using profanity toward Resident A.

I interviewed employee Dawn Schuch in the facility. Ms. Schuch stated that because Resident A will sometimes disrobe, a plan was put in place where his shorts are put on backwards and tied, so that he cannot easily strip down. She denied that he is barricaded in his room. Ms. Schuch stated that Resident A had been at the facility for close to 30 years and that giving him time and space was effective in managing some of his extreme behaviors.

During my onsite inspection, Resident A's room was not barricaded and I observed employees assisting him to the bathroom.

I was unable to interview Resident A due to a cognitive issue.

On 7/31/25, I received an email from Lenawee County Recipient Rights officer Stephen Mitchell, stating that he was in receipt of information that an employee had used excessive force against Resident A.

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:	Interviews conducted revealed that the employee in question was immediately terminated and police were notified, thus ensuring Resident A's safety. While Resident A was mistreated by this individual, the licensee took steps to correct the problem.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is fed meals in the bathroom.

INVESTIGATION:

On 7/23/25, Ms. Schuch stated that Resident A has difficulty controlling his bowels and the staff feed him a piece of fruit while he is having a bowel movement. She stated that this typically happens at breakfast. She mentioned that he is rarely fed a whole meal, such as cereal, but it has happened. Ms. Schuch stated that because Resident A will sometimes disrobe, a plan was put in place where his shorts are put on backwards and tied, so that he cannot easily strip down. She was unaware of these measures being documented as special interventions. Ms. Schuch denied that any other resident is feed in the lavatory.

I interviewed Resident B in the facility. Resident B stated that the residents are served meals in the dining room.

I reviewed Resident A's assessment plan and individual plan of service (IPOS) and neither form documented special interventions such as Ms. Schuch had discussed.

On 7/28/25, I received and reviewed Resident A's health care appraisal. The document did not specify any conditions that would warrant an intervention having Resident A consume food or meals in the bathroom, such as bowel issues.

On 7/29/25, I interviewed Lenawee County Mental Health Authority Supervisor Jearald Dudley by telephone. Mr. Dudley stated that he was unaware of any special provision allowing the home to provide Resident A with food while he went to the bathroom

APPLICABLE RULE	
R 400.14402	**Food service.**
	(2) All food shall be protected from contamination while being stored, prepared, or served and during transportation to a facility.
ANALYSIS:	There was no supporting documentation in Resident A's health care appraisal, individual plan of service or assessment plan that would require him to receive partial or full meals in the bathroom, in contravention of the rule protecting meals from contamination.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/27/25, I conducted an exit conference with Chief Operations Officer Kristy Gottschalk. I shared my findings with Ms. Gottschauk, who agreed to furnish the department with a corrective action plan.

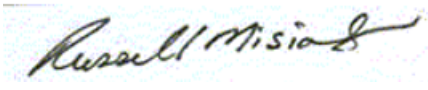
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.

8/28/25

Dwight Forde Date
Licensing Consultant

Approved By:



9/11/25

Russell B. Misiak Date
Area Manager