



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 #: AS460067721
Investigation #: 2025A1032041
Main St Home II

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. 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,

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

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 #:	AS460067721
Investigation #:	2025A1032041
Complaint Receipt Date:	07/18/2025
Investigation Initiation Date:	07/21/2025
Report Due Date:	09/16/2025
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:	Main St Home II
Facility Address:	453 S Main Street, Adrian, MI 49221
Facility Telephone #:	(517) 264-1221
Original Issuance Date:	12/21/1995
License Status:	REGULAR
Effective Date:	06/21/2024
Expiration Date:	06/20/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was physically grabbed and bruised by an employee who had previously sent her inappropriate messages on Facebook.	No
Additional Findings	No

III. METHODOLOGY

07/18/2025	Special Investigation Intake 2025A1032041
07/21/2025	Special Investigation Initiated - On Site
07/21/2025	Contact - Document Received Incident reports reviewed
07/22/2025	Contact - Document Received Resident A's assessment plan
07/30/2025	Contact - Document Received I received and reviewed Resident A's behavior treatment plan
08/26/2025	Contact - Telephone call made Interview with employee Matthew Miller
08/27/2025	Exit Conference With COO Kristy Gottschaulk
08/26/2025	Contact - Telephone call made Message to APS specialist Samantha Garcia sharing my findings

ALLEGATION:

Resident A was physically grabbed and bruised by an employee who had previously sent her inappropriate messages on Facebook.

INVESTIGATION:

On 7/21/25, I interviewed home manager Katherine Yops in the facility. Ms. Yops stated that there seemed to be discrepancies between Resident A's report and the incident authored by employee Matthew Miller. Ms. Yops advised that Resident A had been the subject of several incidents recently. She acknowledged that there was light bruising around Resident A's arms, but stated that Resident A has engaged in self-injurious behavior. She advised that Mr. Miller works at a different facility at this time.

I interviewed Resident A in the facility. Resident A stated that on the day in question, she was 'high', tried to leave the facility, and Mr. Miller dragged her back into the home, where he sat her on the couch in the living room. Resident A also claimed that Mr. Miller gave her dating advice several months ago, where he suggested she send naked pictures of himself. Resident A did not furnish any messages exchanged between them.

I reviewed an incident report authored by employee Matthew Miller. The report indicates attempts by staff to prevent Resident A from harming herself with objects around the facility. The report mentions Resident A speaking incomprehensibly. According to the report, Resident A ran to the door to leave but was guided back to the living room.

On 7/22/25, I reviewed Resident A's assessment plan. The plan reflects limited community access.

On 7/30/25, I reviewed a behavior treatment plan, dated 3/21/25, detailing limited community access and outlining Resident A's self-harm tendencies. The document specified an intervention for when Resident A twists other's words to "intentionally create drama" in the facility, where a second staff is to witness the claim and write an incident report.

On 8/25/25, I interviewed employee Matthew Miller by telephone. Mr. Miller discussed events that were consistent with the incident report that he authored, including a request from an on-call worker to come in to assist with Resident A's behaviors.

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:	The incident report written did not reflect any use of force. The assessment plan detailed limited community access. There were no other witnesses. There are also no records of messages exchanged between Mr. Miller and Resident A. Therefore, there is insufficient evidence to establish a violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 8/27/25, I conducted an exit conference with Chief Operations Officer Kristy Gottschaulk by telephone. I shared my findings and Ms. Gottschaulk agreed with the conclusions reached.

IV. RECOMMENDATION

I recommend no change to the status of this license.

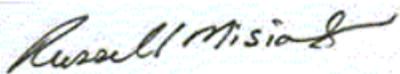


8/28/25

Dwight Forde
Licensing Consultant

Date

Approved By:



9/11/25

Russell B. Misiak
Area Manager

Date