RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

April 19, 2017

Ira Combs, Jr
Christ Centered Homes, Inc.
327 West Monroe Street
Jackson, MI 49202

RE: License #: AS380381916
Investigation #: 2017A0122017
Adams Street AFC

Dear Mr. Combs, Jr:

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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 (313) 456-0360.

Sincerely,

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 #:** | AS380381916 |
| | |
| **Investigation #:** | 2017A0122017 |
| | |
| **Complaint Receipt Date:** | 03/03/2017 |
| | |
| **Investigation Initiation Date:** | 03/09/2017 |
| | |
| **Report Due Date:** | 05/02/2017 |
| | |
| **Licensee Name:** | Christ Centered Homes, Inc. |
| | |
| **Licensee Address:** | 327 West Monroe Street<br>Jackson, MI 49202 |
| | |
| **Licensee Telephone #:** | (517) 788-9231 |
| | |
| **Administrator:** | Ira Combs, Jr |
| | |
| **Licensee Designee:** | Ira Combs, Jr |
| | |
| **Name of Facility:** | Adams Street AFC |
| | |
| **Facility Address:** | 606 Adams Street<br>Jackson, MI 49202 |
| | |
| **Facility Telephone #:** | (517) 784-2142 |
| | |
| **Original Issuance Date:** | 08/19/2016 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 02/19/2017 |
| | |
| **Expiration Date:** | 02/18/2019 |
| | |
| **Capacity:** | 2 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Trisha Milligan-Shell, direct care worker, slapped Resident A on the arm. | No |
| Trisha Milligan-Shell, direct care worker, yelled and cursed at Resident A. | No |
| Trisha Milligan-Shell, direct care worker, called another staff person a name in the presence of Resident A. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 03/03/2017 | Special Investigation Intake<br>2017A0122017 |
| 03/09/2017 | Special Investigation Initiated - On Site<br>Completed interviews with Resident A and direct care worker, Trisha Shell |
| 03/10/2017 | Contact - Telephone call made<br>Completed interview with Jason Obits, case manager. |
| 03/14/2017 | Contact – Telephone call made<br>Completed interview with Doris Gossett, home manager |
| 03/16/2017 | Contact – Telephone call made<br>Michelle Corwin, direct care worker. Non-working telephone number, unable to complete an interview with Ms. Corwin. Per Ms. Gossett, Ms. Corwin is no longer employed by the company. |
| 03/27/2017 | Exit Conference<br>Discussed findings with Ira Combs, Jr. |

**ALLEGATION: Trisha Milligan-Shell, direct care worker, slapped Resident A on the arm.**

**INVESTIGATION:** On 03/09/2017, I completed an interview with Resident A. Resident A reported on the day of the incident her and Trisha Shell, direct care worker, were sitting next to each other. Ms. Snell had a can of pop located on the side of her. Resident A stated she had a blanket wrapped around her and she got up to move. Resident A states as she was moving she dragged her blanket along with her and it was getting close to Ms. Shell's pop. Resident A reported Ms. Shell flung/used her hand to prevent the blanket from knocking over her can. Per Resident A, as Ms. Shell flung her hand it came into contact with Resident A's arm.

Resident A reported that the incident was an accident and she wasn't hurt in anyway, but stated she was angry over another incident that involved another staff member so she reported the incident to her case manager. Resident A stated Ms. Shell provides good care and she would never intentionally hurt her.

On 03/09/2017, I completed an interview with Trisha Milligan-Shell. Ms. Shell stated that on the day of the incident, she and Resident A were sitting next to each other in chairs. According to Ms. Shell, Resident A was wrapped in a blanket, got up to move to another location, and dragged the blanket along with her. Ms. Shell stated as Resident A was dragging the blanket it got close to her beverage, almost knocking it over, so she reached out with her hand to move the blanket out of the way. Ms. Shell reported her hand made contact with Resident A's arm as she moved the blanket out of the way. Ms. Shell stated she apologized to Resident A and that was the end of the incident.

Ms. Shell denied using physical force with Resident A. Ms. Shell stated the incident was an accident and that she has never hit Resident A or Resident B, who also resides in the facility.

On 03/10/2017, I completed an interview with Jason Obits, case manager of Resident A. Mr. Orbits confirmed that Resident A reported the incident to him, stating that it happened over a month ago. Mr. Orbits stated initially Resident A reported the incident wasn't an accident, stating that Ms. Shell "slapped her on the arm." However, when Resident A demonstrated what happened he observed it to be a light, playful tap.

Mr. Obits stated he felt that Resident A made the complaint as she was upset with Ms. Shell over an incident that involved another direct care staff worker. Mr. Obits reported he has no concerns with Resident A's safety or supervision while she is placed at the Adams Street AFC home. Mr. Obits stated he doesn't feel as if the staff members are physically abusive when interacting or providing care to the residents.

On 03/09/2017, Resident B was asleep and unable to participate in an interview. I contacted Resident B on 03/09/2017 and 03/10/2017 via telephone in an effort to complete an interview with her. I left messages for Resident B to contact me on each day. As of 03/14/2017, I have received no contact from Resident B.

On 03/27/2017, I completed an exit conference with Ira Combs and discussed my findings with him. Mr. Combs was in agreement with my findings.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14308** | **Resident behavior interventions prohibitions.** |
| | (2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:<br>(b) Use any form of physical force other than physical restraint as defined in these rules. |
| **ANALYSIS:** | Allegations were made that direct care worker, Trisha Milligan-Shell, slapped Resident A on the arm with physical force.<br><br>On 03/09/2017, both Resident A and Trisha Shell reported that the incident was an accident. Both reported that Ms. Shell hit Resident A's arm while trying to prevent a beverage from being knocked over. Both confirmed that Resident A received no injury during the incident.<br><br>On 03/10/2017, case manager, Jason Obits, reported that as Resident A demonstrated the incident, he observed it be a light, playful tap. Mr. Obits confirmed that Resident A made the complaint as she was upset over a different issue. Mr. Obits is not concerned that direct care staff works used physical force when interacting with the residents of the Adams Street adult foster care group home.<br><br>There is no evidence to support allegations that direct care worker, Trisha Milligan-Shell, used physical force with Resident A during this incident. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ALLEGATION:**

- **Trisha Milligan-Shell, direct care worker, yelled and cursed at Resident A.**
- **Trisha Milligan-Shell, direct care worker, called another staff person a name in the presence of Resident A.**

**INVESTIGATION:** On 03/09/2017, Resident A reported that a few weeks ago she overheard Ms. Shell using profanity while having a private phone conversation outside of the facility. Resident A reported there was an argument between staff members, Trisha Shell and Michelle Corwin, about her day program.

Resident A stated Ms. Shell went outside to speak with the home manager on her personal cell phone about the incident while she and Ms. Corwin went to the back porch. Resident A stated she sat on the back porch but then went to the front of the house and opened the door. Once she opened the door she heard Ms. Shell talking on the phone to her home manager and overheard the use of profanity during that conversation.

Resident A reported that Ms. Shell never yelled or used profanity towards her. She never heard Ms. Shell use profanity in the facility or towards Resident B.

On 03/09/2017, I completed an interview with Trisha Shell. Ms. Shell reported the same as Resident A regarding the incident. Ms. Shell stated that she and direct care worker, Ms. Corwin, had an argument regarding the residents attending their day program. Ms. Shell acknowledged that both Resident A and B were present during her argument with Ms. Corwin. Ms. Shell stated at one point Ms. Corwin and Resident A went to the back porch. Ms. Shell stated she went outside to contact the home manager, Doris Gossett.

Ms. Shell stated as she was speaking to Ms. Gossett Resident A and Ms. Corwin came around to the front of the facility. Ms. Shell admitted that she did use profanity during her conversation with Ms. Gossett and Resident A overheard her. Ms. Shell reported that she did not yell or use profanity towards Resident A or B, but did confirm that Resident A overheard her use of profanity.

On 03/14/2017, I completed an interview with Doris Gossett. Ms. Gossett confirmed what was reported by both Resident A and Trisha Shell. Ms. Gossett confirmed that Ms. Shell was using profanity during their conversation, however Ms. Shell reported that she was away from the clients outside of the facility. Ms. Gossett stated she gave verbal redirection to Ms. Shell informing her that she was inappropriate in her use of profanity and by arguing with Ms. Corwin in front of the client. Ms. Gossett reported that Ms. Shell received disciplinary action for this incident.

On 03/09/2017, Resident B was asleep and unable to participate in an interview. I contacted Resident B on 03/09/2017 and 03/10/2017 via telephone in an effort to complete an interview with her. I left messages for Resident B to contact me on each day. As of 03/14/2017 I have received no contact from Resident B.

On 03/16/2017, I attempted to complete a phone interview with direct care worker, Michelle Corwin. The telephone number for Ms. Corwin is not in working order, therefore I was unable to complete an interview with her.

On 03/27/2017, I completed an exit conference with Ira Combs, Licensee Designee. I discussed my findings with Mr. Combs. Mr. Combs was in agreement with my findings and stated he would submit a corrective action plan to address the rule violation.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14308** | **Resident behavior interventions prohibitions.** |
| | (2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:<br>(f) Subject a resident to any of the following:<br>(i) Mental or emotional cruelty.<br>(ii) Verbal abuse.<br>(iii) Derogatory remarks about the resident or members of his or her family.<br>(iv) Threats. |
| **ANALYSIS:** | Allegations were made that direct care worker, Trisha Milligan-Shell, yelled and cursed at Resident A. It was stated that Ms. Shell called another direct care worker a name in the presence of Resident A.<br><br>On 03/09/2017, both Trisha Shell and Resident A denied that Ms. Shell yelled and cursed at Resident A.<br><br>On 03/09/2017, Both Resident A and Trisha Shell confirmed that Resident A heard Ms. Shell call another direct care worker, Michelle Corwin, a name in the presence of Resident A.<br><br>On 03/14/2017, Doris Gossett, home manager, confirmed that Ms. Shell called Ms. Corwin a name during a telephone conversation. Ms. Gossett confirmed that both Trisha Shell and Michelle Corwin were working at the Adams Street adult foster care home during this incident providing care for Residents A and B.<br><br>Trisha Shell and Michelle Corwin, direct care workers, were arguing in front of Residents A and B regarding the resident's day program. On 03/09/2017 both Ms. Shell and Resident A confirmed that the argument between Ms. Shell and Ms. Corwin was overheard by the both Residents A and B. |
| **CONCLUSION:** | VIOLATION ESTABLISHED |

## IV. RECOMMENDATION

Contingent upon receipt and approval of an acceptable corrective action plan, I recommend no change in the status of the license.

Vanita C. Bouldin — Date: 03/27/2017
Licensing Consultant

Approved By:

Ardra Hunter — Date: 04/19/2017
Area Manager