GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 21, 2019

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

RE: License #: AS380016315
Investigation #: 2019A0007030
Brown Street Home

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) 456-0380.

Sincerely,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
301 E. Louis Glick Hwy
Jackson, MI 49201
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380016315
Investigation #:	2019A0007030
Complaint Receipt Date:	09/20/2019
Investigation Initiation Date:	09/24/2019
Report Due Date:	11/19/2019
Licensee Name:	Christ Centered Homes, Inc.
Licensee Address:	327 West Monroe Street Jackson, MI 49202
Licensee Telephone #:	(517) 788-9231
Administrator:	Ira Combs, Jr.
Licensee Designee:	Ira Combs, Jr.
Name of Facility:	Brown Street Home
Facility Address:	1203 Brown Street Jackson, MI 49203-2732
Facility Telephone #:	(517) 990-9058
Original Issuance Date:	03/24/1995
License **Status:**	REGULAR
Effective Date:	11/15/2018
Expiration Date:	11/14/2020
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Allegations that Ms. Norris, direct care staff, was sitting in her car during work hours; she was asked to return to the facility. Once in the facility, Ms. Norris was upset and accusing someone of drugging her coffee. Ms. Norris yelled at Resident A and Resident B. Ms. Norris got into one of the resident's faces and yelled at them. A resident tried to go after her. The other staff tried to remove the residents from the situation. Ms. Norris has been removed from the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/20/2019	Special Investigation Intake - 2019A0007030
09/24/2019	Special Investigation Initiated – Letter
09/24/2019	APS Referral made.
09/30/2019	Inspection Completed On-site- Unannounced - face to face contact with Employee #1, Direct Care Staff, Resident A, Resident B, other staff and residents.
09/30/2019	Contact - Telephone call made to Ms. Howard, Administrative Staff.
09/30/2019	Contact - Document Received- Contact information for Ms. Norris.
10/03/2019	Contact - Document Received - APS will not be investigating the allegations.
11/18/2019	Inspection Completed On-site - Christ Centered Homes Main Office- I reviewed the employee records for Ms. Norris.
11/18/2019	Inspection Completed On-site- Face to Face contact with Home Manager #1, Employee #1 and one resident.
11/18/2019	Contact - Telephone call made- Interview with Ms. Norris.
11/18/2019	Contact - Telephone call made Ms. Howard, no answer.

11/18/2019	Contact - Telephone call made- Ms. Wilson, Administrative Staff. Discussion.
11/18/2019	Contact - Document Sent- Email to Mr. Combs, requesting a phone call to conduct the exit conference.
11/19/2019	Exit Conference with Mr. Combs.

ALLEGATIONS:

Allegations that Ms. Norris, direct care staff, was sitting in her car during work hours; she was asked to return to the facility. Once in the facility, Ms. Norris was upset and accusing someone of drugging her coffee. Ms. Norris yelled at Resident A and Resident B. Ms. Norris got into one of the resident's faces and yelled at them. A resident tried to go after her. The other staff tried to remove the residents from the situation. Ms. Norris has been removed from the home.

INVESTIGATION:

On September 30, 2019, I conducted an unannounced on-site investigation and made face to face contact with Employee #1, Direct Care Staff, Resident A, Resident B, other staff and residents. I interviewed Employee #1, who informed me that on the day in question (9/17/2019), the home manager (HM #1), told Ms. Norris that she could not sit in her car. According to Employee #1, Ms. Norris sat in her car a few hours, every day, that she (Ms. Norris) worked.

On September 17, 2019, Employee #1 worked alone, the majority of that morning, assisting the residents with daily living activities, passing medications, and preparing the meals. Employee #1 stated that she went out to the car to tell Ms. Norris to come back into the facility to do her job, as HM #1 had already told her that she could not sit in her car when she was supposed to be working in the home.

That afternoon, Ms. Riley arrived to work at 2:30 p.m. then Ms. Norris “snapped.” Ms. Norris was saying to Ms. Riley that Employee #1 got on her last nerves and that she (Employee #1) drugged her by putting something in her coffee. Employee #1 denied putting anything in Ms. Norris’ coffee, and stated that if Ms. Norris saw her (Employee #1) put something in her coffee, then why would she drink it? According to Employee #1, Ms. Norris argued with the residents and tried to fight Resident A and Resident B; Resident A was trying to elope, and Resident B went after Ms. Norris with her cane. Then she (Ms. Norris) started recording the incident, further upsetting the residents. Management was contacted and Ms. Norris was escorted off the property by Ms. Wilson, Administrative Staff.

Employee #1 expressed some concerns regarding Ms. Norris, as she has observed her randomly spinning and twirling in the living room of the facility. On her first day of work, Ms. Norris demanded coffee be made, and stated she could not work without coffee. Employee #1 also observed Ms. Norris prepare sandwiches for the residents, which had "chunks" of mayo. According to Employee #1, there was enough mayo on one sandwich that it could have be used for all five sandwiches.

I interviewed Resident A, who had resided in the home for 4 years. Resident A described Ms. Norris as having "really strange eyes." Regarding the incident, Resident A stated that Ms. Norris would just sit in her car the whole (2nd) shift. Resident A recalled that Ms. Norris was aggravating him and the other resident, Resident B. Ms. Norris was yelling and got into his face. This made him feel scared. According to Resident A, Ms. Norris was "getting out of control." He also recalled that Resident B wanted to fight Ms. Norris. Resident A stated that his mom picked him up from the home, and he was able to calm down.

I interviewed Resident B, who has not resided in the home for very long. Resident B stated that Ms. Norris started going off on the staff, and "I told her to go for a walk." Resident B recommended that Ms. Norris go for a walk to cool down. The situation did not de-escalate so Resident B grabbed Ms. Norris by the shirt. Resident B stood up to demonstrate what she did during the incident. Resident B stated that she said to Ms. Norris "I don't know what your problem is." According to Resident B, Ms. Norris then got on her phone and started taking pictures. Then Ms. Riley pulled up and said "[Resident B], leave her alone." According to Resident B, Employee #1 didn't know what was going on and why Ms. Norris was acting this way. Resident B informed me that Ms. Norris has sat in her car on several occasions, when she was supposed to be working. Resident B stated, "I don't know if she's on drugs or what." Resident B also stated, "you mess with my staff, then you messing with me."

On September 30, 2019, I spoke with Ms. Howard, Administrative staff, regarding Ms. Norris and her employee records. Ms. Howard informed me that Ms. Norris works at the unlicensed facilities, but that a record clearance had been completed. In addition, that Ms. Norris had been removed from the licensed homes and Office of Recipient Rights had been to the home to conduct an investigation regarding this matter.

During the course of this investigation, I reviewed the incident reports authored by Employee #1. It was documented that on September 17, 2019, the day started pretty good but the other staff, Ms. Norris, kept going out to her car, sitting, and talking on the phone. At 9:00 a.m. the home manager observed this behavior and told Ms. Norris she was not allowed to sit in her car. In addition, that she needed to be on the floor, to supervise the residents. Employee #1 went out to the car, again, asking her to come into the home and complete her job duties. Ms. Norris returned to the facility and stated that she didn't work well with others and that she was going to sit outside. Around 2:30 p.m., when the 1:1 staff (Ms. Riley) showed up, Ms. Norris started going off. Ms. Norris was saying that Employee #1 drugged her and that she put

something in her coffee. A couple of the residents were able to observe what was going on, as Employee #1 and Ms. Riley attempted to calm Ms. Norris down. Ms. Norris grew more, and more upset and started yelling at the residents. She got into the face of one of the residents, stated that she wasn't the one. Resident B then tried to go after her, Employee #1 and Ms. Riley. It was also noted that Employee #1 tried to remove the residents from the situation, utilizing gentle approach, and they contacted management.

Employee #1 also documented that she verbally prompted and encouraged the residents to walk away from the situation. Ms. Norris then started recording Employee #1, her vehicle, and the residents that were outside. Management was contacted and Ms. Norris was asked to leave. Ms. Norris was removed from the home.

On November 18, 2019, I conducted an unannounced on-site investigation at the main office. I reviewed the employee file for Ms. Norris, and it contained all of the required trainings and record clearances. Ms. Norris completed the CMH Lifeways Recipient Rights 30-day orientation. In the orientation documents, it was noted that "Consumer Neglect" is leaving a resident unsupervised (based on their Individual Plan of Service) or leaving shift before the replacement staff arrives. It was also noted that Ms. Norris acknowledged, by signing the documents, that she had read the information regarding recipient rights; and that she would contact supervision or ORR if she had any questions. Copies of these documents are in the licensing file.

On November 18, 2019, I conducted an unannounced on-site investigation, and made face to face contact with Home Manager #1, Employee #1 and one resident. I had some follow up questions for Employee #1. I inquired if any of the residents required 1:1 supervision, while Ms. Norris was sitting in the car, and Employee #1 stated that she could not recall.

I then spoke with Home Manager #1 who stated that she spoke with Ms. Norris about sitting in the car, as Resident C required stand-by and assist, when ambulating. She explained to Ms. Norris that if Employee #1 was busy in the kitchen and Resident C attempted to get up and walk around, Ms. Norris would need to be there to assist him. While at the facility, I reviewed Resident C's file, along with the Individual Plan of Service, and regarding the ambulation guidelines, it was noted that Resident C has a history of falls in the home and in the community. Resident C "utilizes a 4 WW for mobility and should be provided with SBA [stand by assist] from staff within the home…" It was also noted that "SBA means staff are walking within arms-length of [Resident C]." A photo of this document was taken for the licensing file. Ms. Norris also signed the work rules, which requires staff to be at their designated work areas on time, and they are to remain in their work area until their scheduled quitting time; unless given permission by management. In addition, the staff shall not leave the place of employment before the relief staff has arrived.

On November 18, 2019, I interviewed Ms. Norris. At the beginning of the interview, Ms. Norris put me on hold, two separate times. I inquired if she had time to complete the interview and she informed she did. Ms. Norris explained that she is still employed for the company and confirmed that she worked at a different home. She stated that she only worked at the Brown Street home for about two-weeks, as she picked up some extra shifts. Ms. Norris explained that she has a family to take care of. Ms. Norris stated that her father recommended this home to her. I attempted to introduce the topic and Ms. Norris kept returning to the fact that she only worked at the home for about two weeks. I stated that our division has 60-days to conduct the investigation (so it may seem like a while ago). I also explained that I had already interviewed the other staff and the residents; and I needed to hear her side of the story. Ms. Norris stated that I should talk to her father. I explained that it would not be necessary to interview her father, unless he was there to witness the incident.

Ms. Norris described Employee #1 as the “Black older lady,” and said that she [Employee #1] was trying to make her (Ms. Norris) look bad. When asked if HM #1 spoke to her (Ms. Norris) about her sitting in the car, while she was supposed to be working, a clear and consistent answer was not given. Ms. Norris stated that she didn’t smoke and that she was in her car taking a break. All in all, Ms. Norris adamantly denied accusing Employee #1 of putting something in her coffee. She also denied yelling at Resident A or B, and she denied that the resident went after her. Ms. Norris did admit to taking out her phone to record the situation. She explained that Employee #1 “was acting ridiculous.” She explained that in this day in age, with all the issues going on with law enforcement, having a recorded situation helps to tell the story. I expressed concern that Ms. Norris was only providing part of the story and asked her to explain what happened, leading up to her getting out her phone to record. Ms. Norris did not provide any information other than Employee #1 was following her around the house, and Ms. Norris was just trying to ignore her. Once management was contacted, Ms. Norris stated that Ms. Howard just asked her to leave, and that she could keep her job at the other (unlicensed) home. Ms. Norris also stated that the girls at the Brown Street Home didn’t like her, she saw this as a problem, and she left. Ms. Norris explained that she was just trying to keep her job.

Ms. Norris then offered for me to review the video and I attempted to make arrangements; explaining that I could stop by her home to review the video or she could stop by the state office building. Ms. Norris then asked if she could email me a copy. I informed that she could; however, by the end of the conversation, Ms. Norris stated that she was not sure if she would send the information, as she didn’t know if it would matter. I explained that I would be continuing the investigation regardless, and the video would just document was going on at the time of the incident; but the decision was up to her. I inquired if Ms. Wilson or anyone else had reviewed the video and she informed they had not. Ms. Norris stated that she could keep or delete the video.

I inquired if she had spoken to ORR and Ms. Norris stated she might have, but ultimately, did not confirm this information. Ms. Norris did not send the video of the incident.

On November 18, 2019, I interviewed Ms. Wilson, Administrative staff. She was not sure who called Ms. Howard, but they were in the office together when Ms. Howard received the call regarding the incident. According to Ms. Wilson, Ms. Howard turned around in her chair and asked Ms. Wilson to go over to the Brown Street Home, which was not far away, and have Ms. Norris leave shift and replace her with another staff; as the residents didn't want her in the home. When Ms. Wilson arrived at the home, Resident A and Resident B were upset, because Ms. Norris was recording them. Ms. Norris was asked to leave the home because the residents did not want her there. According to Ms. Wilson, Ms. Norris left without an issue. Ms. Wilson then had to calm Resident A and Resident B down, as they were upset.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered during this investigation and provided above, it's concluded that there is preponderance of the evidence to support the allegations that Resident A and Resident B were not treated with dignity and their personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On September 17, 2019, Employee #1 reported that she worked alone, the majority of that morning, assisting the residents with daily living activities, passing medications, and preparing the meals. Employee #1 stated that she went out to the car to tell Ms. Norris to come back into the facility to do her job, as HM #1 had already told her that she could not sit in her car when she was supposed to be working in the home.

On November 18, 2019, I conducted an unannounced on-site investigation at the main office. I reviewed the employee file for Ms. Norris, and it contained all of the required trainings and record clearances. Ms. Norris completed the CMH Lifeways Recipient Rights 30-day orientation. In the orientation documents, it was noted that "Consumer Neglect" is leaving a resident unsupervised (based on their Individual Plan of Service) or leaving shift before the replacement staff arrives. It was also noted that Ms. Norris acknowledged, by signing the documents, that she had read the information regarding recipient rights; and that she would contact supervision or ORR if she had any questions. Copies of these documents are contained within the licensing file.

During the interview with HM #1, she stated that she spoke with Ms. Norris about sitting in the car, as Resident C required stand-by and assist, when ambulating. She explained to Ms. Norris that if Employee #1 was busy in the kitchen and Resident C attempted to get up and walk around, Ms. Norris would need to be there to assist him. While at the facility, I reviewed Resident C's file along with the Individual Plan of Services; and regarding the ambulation guidelines, it was noted that Resident C has a history of falls in the home and in the community. Resident C "utilizes a 4 WW for mobility and should be provided with SBA [stand by assist] from staff within the home…" It was also noted that "SBA means staff are walking within arms-length of [Resident C]."

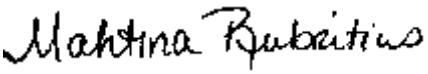
On November 19, 2019, Mr. Combs contacted me, and the exit conference was conducted. We discussed the investigation and findings. Mr. Combs stated that Ms. Norris was no longer working in the Brown Street home. Mr. Combs agreed to submit a written corrective action plan.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**

ANALYSIS:	Based on the information gathered during this investigation and provided above, it's concluded that the kinds of services, skills, and physical accommodations that Resident C required were not available, as Ms. Norris was sitting in her car, instead of in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of a detailed written corrective action plan, I recommend no change in the license status.

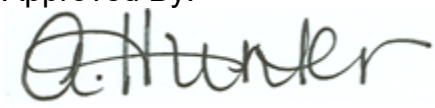


11/18/2019

_____

Mahtina Rubritius — Date
Licensing Consultant

Approved By:



11/21/2019

_____

Ardra Hunter — Date
Area Manager