GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 13, 2022

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

RE: License #: AS380306690
Investigation #: 2022A0007019
West Washington 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.

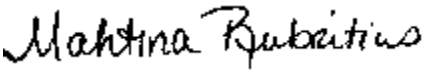
If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even

if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY AND SEXUALLY EXPLICIT CONTENT

I. IDENTIFYING INFORMATION

License #:	AS380306690
Investigation #:	2022A0007019
Complaint Receipt Date:	04/06/2022
Investigation Initiation Date:	04/07/2022
Report Due Date:	06/05/2022
Licensee Name:	Christ Centered Homes, Inc.
Licensee Address:	327 West Monroe Street Jackson, MI 49202
Licensee Telephone #:	(517) 499-6404
Administrator:	Ira Combs, Jr.
Licensee Designee:	Ira Combs, Jr.
Name of Facility:	West Washington Home
Facility Address:	1913 W. Washington St. Jackson, MI 49201
Facility Telephone #:	(517) 250-7937
Original Issuance Date:	08/04/2010
License Status:	REGULAR
Effective Date:	03/28/2021
Expiration Date:	03/27/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On April 3, 2022, Ms. Hazlett and Mr. Ganton, Direct Care Staff, were sitting in the car smoking, leaving the residents unattended inside the home. Resident A performed oral sex on Resident B. The residents were in the home for 30-45 minutes without staff supervision. Staff have been removed from the schedule pending the investigation. Resident A requires 1:1 staff supervision and is a registered sex offender.	Yes
On May 1, 2022, Resident B eloped from the facility, while staff were asleep.	Yes

III. METHODOLOGY

04/06/2022	Special Investigation Intake - 2022A0007019
04/07/2022	Special Investigation Initiated - Letter
04/07/2022	APS Referral made.
04/07/2022	Contact - Telephone call made to Home Manager #1. Interview.
04/07/2022	Contact - Telephone call made to Guardian B, no answer.
04/07/2022	Contact - Telephone call made to Ms. Howard, Administrative Staff, no answer.
04/07/2022	Contact - Telephone call received from Ms. Howard, Administrative Staff, case discussion.
04/07/2022	Contact - Telephone call received from Mr. Thomas, Compliance Officer.
04/13/2022	Contact - Telephone call received from Guardian B.
04/14/2022	Contact - Document Sent - Email to APS Worker #1.

04/14/2022	Inspection Completed On-site - Unannounced - Face to face contact with Home Manager #1 and Employee #1.
04/18/2022	Contact - Telephone call received from APS Worker #1. Case update.
04/26/2022	Inspection Completed On-site - Unannounced - Face to face contact with APS Worker #1, Resident A, Resident B, and Staff.
05/03/2022	Contact - Document Received - Incident Report regarding Resident B eloping from the facility.
05/06/2022	Contact - Telephone call made to Ms. Howard, Administrative Staff. Case discussion.
05/09/2022	Contact - Document Received - Email from Home Manager #1, Contact information for Employee #2.
06/01/2022	Inspection Completed On-site - Unannounced - Face to face contact with Home Manager #1, Resident A, Resident B and Employee #1.
06/01/2022	Contact - Telephone call made to Employee #2. Message left.
06/01/2022	Contact - Telephone call made to Ms. Howard, Administrative Staff.
06/01/2022	Contact - Telephone call made to Administrative Officer Worker #1.
06/01/2022	Contact - Telephone call made - Interview with Employee #3.
06/01/2022	Contact - Telephone call received - Missed call from Employee #2.
06/02/2022	Contact - Telephone call made to Employee #2, no answer.
06/02/2022	Contact - Telephone call made to Administrative Officer Worker #1. Contact information for Ms. Hazlett and Mr. Ganton provided.
06/02/2022	Contact - Telephone call made to Ms. Hazlett, number not accepting calls.
06/02/2022	Contact - Telephone call made to Mr. Ganton, Interview.
06/02/2022	Contact - Telephone call made to Employee #1, no answer.

06/03/2022	Contact - Telephone call made - Interview with Employee #2.
06/03/2022	Contact - Telephone call made to Mr. Combs, Licensee Designee. Message left regarding the exit conference.
06/03/2022	Contact – Document Sent – Email to Mr. Combs, Licensee Designee regarding the exit conference.
06/03/2022	Contact – Voicemail message from Mr. Combs.
06/07/2022	Exit Conference conducted with Mr. Combs, Licensee Designee.

ALLEGATIONS:

On April 3, 2022, Ms. Hazlett and Mr. Ganton, Direct Care Staff, were sitting in the car smoking, leaving the residents unattended inside the home. Resident A performed oral sex on Resident B. The residents were in the home for 30-45 minutes without staff supervision. Staff have been removed from the schedule pending the investigation.

Resident A requires 1:1 staff supervision and is a registered sex offender.

INVESTIGATION:

On April 7, 2022, I interviewed Home Manager #1. She stated that the incident occurred on Sunday, April 3, 2022. The incident was discovered as yesterday, Resident A and Resident B were in the company vehicle bickering. Direct Care Worker #1 asked what was going on. Resident A then reported that Resident B gave him oral sex. Once the residents returned to the home, they were asked what happened. It was reported that Resident A went into Resident B's room and said he was "horny." Resident B then went to see if there were any staff around. Ms. Hazlett, and Mr. Ganton, Direct Care Staff, were out in the car smoking. Resident B went into Resident A's room and asked "'if he could suck his d-i-c-k.'" According to Home Manager #1, both Resident A and Resident B stated they were in the home for 35-40 minutes. Then Mr. Ganton returned into the home and asked what he was doing, and Resident B stated he was talking to Resident A. Home Manager #1 stated that she contacted Office of Recipient Rights, who will be investigating, and an incident report was written. I informed her that APS also needed to be contacted.

According to Home Manager #1, Resident B requires 1:1 supervision, as he is a registered sex-offender. Home Manager #1 stated that Ms. Hazlett has been employed for at least three years and she knows better; that the residents must be supervised. Home Manager #1 stated that "the staff just have to do their jobs." Home Manager #1 informed that both staff have been removed from the schedule. I

requested that she send me their contact information. She also informed me that Resident A is his own guardian and Jackson County Guardian (Guardian B), is the guardian for Resident B.

On April 7, 2022, I spoke with Ms. Howard, Administrative Staff. She informed me that they will be conducting an in-service with all staff. In addition, they are planning a Team Meeting for Resident B. They want to discuss the dangers of his behaviors. Regarding the supervision level, Ms. Howard informed me that Resident A requires 1:1 supervision, not eyes on if he is in his room. Checks are to be completed every 15-minutes.

On April 7, 2022, I spoke with Mr. Thomas, Compliance Officer. He stated that those two staff have been removed from the schedule and an in-service will be conducted to address code of ethics and the 1:1 staff supervision eyes on vision requirements.

On April 13, 2022, I spoke with Guardian B. She informed me that the supervision level for Resident B is “eyes on” during all waking hours. She agreed to provide a copy of his Behavior Treatment Plan.

On April 14, 2022, I conducted an unannounced on-site investigation and made face to face contact with Home Manager #1 and Employee #1. The residents were not in the home, as they were out in the community. Employee #1 reported that Adult Protective Services had been to the home to investigate.

On April 18, 2022, I spoke with APS Worker #1, and he provided an update regarding his investigation. Resident B requires 1:1 staff supervision. The residents were left alone in the facility. Resident A was interviewed, and he admitted that Resident B performed oral sex on him. Resident A really did not want to talk about the situation. Resident A reported that he feels safe in the home and that he is staying away from Resident B.

On April 26, 2022, APS Worker #1 and I conducted an unannounced on-site investigation and made face to face contact with Resident A, Resident B, and staff.

We interviewed Resident B. He stated, “I was kind of horny, and I kept thinking about [Resident A].” Resident B stated, “I asked can I suck your dick? And he said ‘”yes.’” Resident B stated that Resident A gave his consent. Resident B stated that he gave Resident A “a BJ.” Resident B stated that he got tired and walked out of Resident A’s room. Resident B stated that he told Resident A “don’t tell.” Resident B stated, “I’m not gonna get into trouble because I got consent.” Resident B stated that he did not rape Resident A, and “we were both horny.” Resident B reported that Ms. Hazlett and Mr. Ganton were on duty (3rd shift) when this occurred, and they got fired. Resident B stated that staff talked to him about this and “I’m not going to do it again.” Resident B stated that he made a poor choice as he put himself at risk, due to Resident A having Hepatitis.

Resident A was interviewed. Resident A stated that Resident B asked, "'if he could go down on me.'" Resident A reported that Resident B paid him a little bit of change for this; it was about .35 to .40 cents. There was oral sex for about 10 to 15 minutes, and Resident A stated, "He ain't gonna make me bust." Resident A stated that the staff did not know what happened. Resident A did not confirm that Resident B said to not say anything. Resident A informed that he eventually told staff what happened.

On June 2, 2022, I interviewed Mr. Ganton. He voiced multiple concerns regarding issues in the facility. Mr. Ganton reported that he has not worked in the facility since approximately the end of February or March of 2022. I inquired about him smoking in the car with Ms. Hazlett, leaving the residents unattended. Mr. Ganton stated that never happened. He recalled that Resident B was acting out that day and Ms. Hazlett was the 1:1 staff supervision. Ms. Hazlett had taken Resident B with her to pick up medications etc. that day. He stated that once Ms. Hazlett returned, she was in the home until the end of her shift. He adamantly denied that he and Ms. Hazlett were ever in the car smoking together, leaving the residents unattended. He stated that he was written up and told to leave work but really did not learn the reason why until ORR told him what happened. He thought there was an issue with him splitting a work shift and him leaving at 4:00 a.m. Mr. Ganton stated he was told (by ORR) that there was an assault that occurred. Mr. Ganton stated that he went on a smoke break, but it was with permission from Ms. Hazlett. He stated that he let her sleep a couple of hours and when she got up from her nap, around 7:30 p.m. - 8:00p.m., he asked if he could go out to his car for a smoke break. Mr. Ganton reported to sit on the couch next to Ms. Hazlett while she napped. Mr. Ganton stated he never heard anything about an assault happening, prior to the notification from ORR.

As a part of this investigation, I received and reviewed the report completed by APS Worker #1. The allegations were substantiated against the home for neglect.

A search completed on the Michigan Sex Offender Registry reflected that Resident B is a registered sex-offender.

A review of the *AFC Assessment Plan* reflected that regarding supervision, staff would refer to the Behavioral Treatment Plan (BTP).

A review of the Behavioral Treatment Plan for Resident B reflects that he requires "eyes on" supervision.

On June 7, 2022, I conducted the exit conference with Mr. Combs, Licensee Designee. We discussed the investigation, my findings, and recommendations. He stated that he talked with staff when they first learned of the incident, and the staff were removed from the schedule. An in-service was provided to the staff in the home regarding the importance following the Individual Plan of Service. He informed me that the staff should have been supervising the residents, including Resident A being provided with the 1:1 supervision, as required. He stated that they have been

working and getting rid of bad staff. Mr. Combs expects staff to supervise the residents appropriately. He informed me that he would be promptly addressing the matter, in addition to providing a written corrective action plan. He does not anticipate submitting an objection to the provisional license.

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:	Resident B is a Registered Sex Offender. Resident B requires “eyes on” supervision and 15-minute bed checks when he is in his room. Mr. Ganton recalled that Resident B was acting out that day and Ms. Hazlett was the 1:1 supervision. Mr. Ganton admits to going outside for a smoke break but denied that he and Ms. Hazlett were in the car smoking together, leaving the residents unattended. Mr. Ganton stated that he let her (Ms. Hazlett) sleep a couple of hours and when she got up from her nap, around 7:30 p.m. - 8:00p.m., he asked if he could go out to his car for a smoke break. Mr. Ganton reported to sit on the couch next to Ms. Hazlett while she napped. Resident A and Resident B both reported that Resident B performed oral sex on Resident A. Based on the information gathered during this investigation and provided above, it’s concluded that there is a 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**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Resident B stated that he gave Resident A “a BJ.” Resident B stated that he got tired and walked out of Resident A’s room. Mr. Ganton stated that he let her (Ms. Hazlett) sleep a couple of hours and when she got up from her nap, around 7:30 p.m. - 8:00p.m., he asked if he could go out to his car for a smoke break. Mr. Ganton reported to sit on the couch next to Ms. Hazlett while she napped. Whether the staff were in the living room or outside the home smoking, the residents were not being appropriately supervised, including following the “eyes on” supervision requirement for Resident B, as Resident B went into Resident A’s bedroom and performed a sexual act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

On May 1, 2022, Resident B eloped from the facility, while staff were asleep.

INVESTIGATION:

On May 3, 2022, an incident report was received, and the following was noted:

> On May 1, 2022, Home Manager #1 woke up to text messages from staff (Employee #2), documenting that when she arrived for her shift at 12:20 a.m. one staff was sleeping on the couch and the other staff was gone. While completing bed checks, she noticed that Resident B was gone. She drove around looking for Resident B without success. Home Manager #1 arrived at the facility that morning, completing notifications then going to look for Resident B. He was located sitting underneath a tree on Biddle Street and Greenwood Street. He was brought back to the facility and checked for injuries, there were none. The guardian, 911, and Ms. Howard were contacted regarding this incident. The corrective measures included the staff being in-serviced regarding making

appropriate contact to administrative staff (calling not texting) and following staffing schedules and protocols.

On May 6, 2022, I spoke with Ms. Howard, Administrative Staff. I inquired about the name of the individual who was sleeping on the job. She informed me that Employee #2 arrived at the facility and Employee #3 was sleeping. Ms. Howard informed me that Mr. Thomas, Compliance Officer, would be meeting with Employee #3. In addition, that they would be removing or terminating employees with poor work performance. They are no longer tolerating employees who are problematic. I discussed my concerns regarding the lack of supervision and issues with this home. On June 1, 2022, I conducted an unannounced on-site inspection and made face to face contact with Home Manager #1, Resident A, Resident B and Employee #1.

I interviewed Resident B. He stated that staff were in the facility when he left. One was in the restroom and the other in the laundry room. He stated that he snuck out of the facility. Once he left, he went to the gas station, returned pop bottles, and purchased cigarettes and pop. He then went over to Greenwood Street. He stated that a worker saw him and told him to get into their car. They returned him to the facility.

According to Home Manager #1, Employee #3, was sleeping when Employee #2 arrived for her shift. She did her rounds and noticed that Resident B was missing. She woke up Employee #3 and then went looking for Resident B. It was pouring rain that evening. Employee #2 returned to the facility around 3:00 a.m., unable to locate Resident B. Home Manager #1 arrived at the facility around 7:30 a.m. and she went looking for Resident B. She observed him sitting underneath a tree on Greenwood Street, smoking a cigarette. She assisted Resident B in returning to the facility. Resident B reported that he met a female, and they went to someone's house. They were kicked out as the occupant said they could not stay there. The female left him on the curb and that is where he was observed, sitting under the tree.

According to Home Manager #1, Employee #3, has been removed from the schedule.

On June 1, 2022, Ms. Howard, Administrative Staff, reported that Employee #3 was removed from the schedule. On this same day, I spoke to Administrative Officer Worker #1, and she informed that Employee #3 is not working for their organization.

On June 1, 2022, I interviewed (previous) Employee #3. He stated that Resident B has left the facility many times, but regarding this specific situation, he and Employee #1 were working. Employee #1 had worked a double and he wanted to leave early, so it was just him (Employee #3) on shift. Employee #3 stated that Resident B snuck out of the home, through a door in Resident A's room. Employee #3 stated that when he discovered that Resident B had left the facility, he contacted Home Manager #1 and let her know. Employee #3 denied being asleep while on shift.

On June 2, 2022, I interviewed Mr. Ganton. He stated that Resident B has eloped from the facility multiple times. He confirmed that Resident B requires 1:1 staff supervision. There is a concern that when Resident B is out in the community, without staff supervision, he is getting a hold of marijuana.

Mr. Ganton stated that he was placed on an “on-call” status but has not been called back to work. He had some questions regarding bonus pay; however, I informed him that our department did not provide oversite regarding that matter. The last time he worked in the facility was approximately at the end of February or March of 2022.
On June 3, 2022, I interviewed Employee #2. She informed that there were several incidents in which Resident B left the facility. Regarding this specific incident, she arrived to work about 12:20 a.m. and the first thing she noticed when she arrived was that the exterior door to Resident A’s room was open. She walked in the door and observed Resident A sleeping in his bed. She went to Resident B’s room and noticed he was gone. She went to the living room and observed Employee #3 sleeping on the couch. Employee #2 stated that Employee #3 had just worked a double (2nd & 3rd shifts). He was the only employee in the home.

She woke Employee #3 up, stating “you know [Resident B] is not here.” Employee #3 stated to her (Employee #2) that he did not know Resident B was not there. Employee #2 then texted Home Manager #1. She went looking for him but could not locate Resident B. It was storming out that evening. Employee #2 also called the hospital, but Resident B was not there. When Home Manager #1 arrived in the morning, she went looking for Resident B and located him.

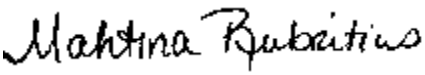
I followed up and asked about staffing. Employee #2 reported there were usually two staff on 3rd shift duty; however, Employee #1 left early. Employee #1 rides a bike to work, and he did not want to get caught in the storm. She heard he left around 10:00 p.m.

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: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**

ANALYSIS:	According to the BTP for Resident B, he is a registered sex offender and has a history of elopement from the facility. Due to safety concerns, Resident B requires “eyes on” supervision and 15-minute bed checks. On May 1, 2022, Home Manager #1 woke up to text messages from staff (Employee #2), documenting that when she arrived for her shift at 12:20 a.m. one staff was sleeping on the couch and the other staff was gone. While completing bed checks, she noticed that Resident B was gone. Employee #2 went to look for Resident B but was unable to locate him. I interviewed Resident B. He stated that staff were in the facility when he left. One was in the restroom and the other in the laundry room. He stated that he snuck out of the facility. According to (previous) Employee #3, Employee #1 had worked a double and he wanted to leave early, so it was just him (Employee #3) on shift. Employee #3 stated that Resident B snuck out of the home, through a door in Resident A’s room. Employee #3 denied being asleep while on shift. According to Employee #2, when she arrived at the facility, she observed the exterior door to Resident A’s bedroom open. She also noticed that Resident B was not in the home. Employee #2 observed Employee #3 sleeping on the couch, and she woke him up to inform that Resident B was not in the home. Employee #2 attempted to locate Resident B without success. Home Manager #1 went looking for Resident B when she arrived at work, locating him sitting underneath a tree, and assisted him back to the home. Based on this information, the amount of supervision and protection that Resident B required was not provided by the staff in the home. **This is a REPEAT VIOLATION – Please see SIR #2019A0007029**
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, a provisional license is recommended.



06/03/2022

Mahtina Rubritius — Date
Licensing Consultant

Approved By:

06/13/2022

Ardra Hunter — Date
Area Manager