GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 6, 2022

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

RE: License #: AS380381916
Investigation #: 2022A0007033
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 was required. On September 16, 2022, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved 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

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

I. IDENTIFYING INFORMATION

License #:	AS380381916
Investigation #:	2022A0007033
Complaint Receipt Date:	09/08/2022
Investigation Initiation Date:	09/08/2022
Report Due Date:	10/08/2022
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:	Adams Street AFC
Facility Address:	606 Adams Street Jackson, MI 49202
Facility Telephone #:	(517) 784-2142
Original Issuance Date:	08/19/2016
License Status:	REGULAR
Effective Date:	02/19/2021
Expiration Date:	02/18/2023
Capacity:	2
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff (name unknown) pulls Resident A's hair if she wakes up wet in the morning or if she is not listening or moving quickly enough. There are no other details known. Resident A has thought of suicide before and does not have a plan.	Yes

III. METHODOLOGY

09/08/2022	Special Investigation Intake - 2022A0007033
09/08/2022	Special Investigation Initiated – Letter - Email to ORR
09/08/2022	Referral - Recipient Rights Made.
09/08/2022	APS Referral Received.
09/13/2022	Contact - Face to Face contact with APS Worker #1. Discussion.
09/13/2022	Inspection Completed On-site - Unannounced - Face to face contact with APS Worker #1, Resident B, Employee #2 and Employee #1.
09/13/2022	Contact - Face to Face contact with Ms. Howard, Administrative Staff.
09/13/2022	Inspection Completed On-site - Unannounced - Face to face contact with APS Worker #1, Employee #1, Employee #2, Resident B, and Individual #1.
09/14/2022	Contact - Face to Face with APS Worker #1. Discussion.
09/16/2022	Contact - Document Received - Request to close license.
10/03/2022	Contact - Telephone call made to Guardian B. Discussion.
10/05/2022	Exit Conference conducted with Mr. Combs, Licensee Designee.

ALLEGATIONS:

Staff (name unknown) pulls Resident A's hair if she wakes up wet in the morning or if she is not listening or moving quickly enough. There are no other details known. Resident A has thought of suicide before and does not have a plan.

INVESTIGATION:

As a part of this investigation, I reviewed the complaint and it was noted that Resident A is 68-years-of age, and she has been diagnosed with schizophrenia. It was also noted that the unknown staff member may be Employee #1 or Employee #2.

On September 13, 2022, I made face to face contact with APS Worker #1. He informed me that Resident A demonstrated how her hair was being pulled by staff. Resident B has also been reporting to her guardian (Guardian B), about her hair being pulled. Resident B reported to keep her hair short so that staff won't grab her by the hair. In addition, it was reported that Employee #1 was withholding Resident B's money until the end of the month. He also informed the Resident A has incontinence and is made to wear underwear instead of being allowed to wear briefs.

On September 13, 2022, APS Worker #1 and I went to the facility, and made face to face contact with Employee #2 and Resident B. Resident A was not in the home at that time, as she recently had surgery and was rehabilitating at another location.

When we arrived at the home Employee #2 and Resident B were in the home. The home smelled strongly of cigarette smoke. We interviewed Resident B outside on the back porch. When asked how she was treated by staff, Resident B informed us that they "yell at me and hit me; push me down on the couch." Resident B stated that the phone, which is provided by [Mr. Combs] does not work, and she could not call anyone. Resident B stated they needed a phone to call for help. Resident B informed us that Resident A is mistreated too and that Employee #1 pulls her hair. When asked why, she stated that Resident A will pee or poop her pants, and "she can't help it." When asked why she (Resident B) keeps her hair short, she stated that it grows back curly. She also reported that she goes for walks and the squirls in the trees pee in her hair. As we were interviewing Resident B, there was a knock on the door from the inside of the house. Employee #1 opened the door, introduced herself, and stated she was there to answer any of our questions. We informed her that we would talk with her after our interview with Resident B. Resident B then stated "did she hear us? I hope not, she'll pull my hair." Resident B informed us that she was scared. She started to cry stating that she might get hit again. Resident B stated that "they yell at me all the time; they hit [Resident A]."

During the interview, Resident B asked if she could move. She reported that she wanted to move “because they’re mean.” She stated that the staff tell her to hurry up. Resident B stated that they would not let her go to church with her sister. Resident B stated that her sister, Relative B, lives close by and works at Walmart. Resident B stated that her sister was crying because she (Resident B) could not go to church with her. Resident B stated that she couldn’t go to therapy one time because the company van did not have gas.

Regarding her money, Resident B stated that she gave Employee #2 $5.00. When asked why, Resident B stated that Employee #2 said she owed her money. Resident B reported that she received $25.00 yesterday. She gets $25.00 each month. She reported that she had never given staff money before.

While at the facility, I requested to see copies of the *Resident Funds Part II* form. Staff contacted Home Manager #1, who reported that the funds were kept at a different office, and Ms. Howard, Administrative Staff maintained those documents and funds.

Prior to leaving the facility, APS Worker #1 and I interviewed Employee #1. She appeared to be anxious and wanted her side of the story to be told. She provided information and her concerns regarding other staff members, and her interactions with Resident B’s guardian. Employee #1 reported that Guardian B called Ms. Howard, Administrative Staff, and said she (Employee #1) was being rude. In addition, that Guardian B said Employee #1 was being mean to Resident B.

Employee #1 recalled that Resident A tried to hit her in the back with a shovel, she has thrown coffee on her and called her the “N word.” Employee #1 stated that we were provided with false information, and that staff are not mean to her. Employee #1 also stated that Resident B threw a coffee mug at Resident A, and she (Resident B) tries to bully her (Resident A). Employee #1 stated that one of the residents said they were going to get them fired, as they would believe her before staff.

Regarding Resident A, Employee #1 confirmed that she had issues with incontinence. She stated they had Resident A’s sister purchase her underwear. Employee #1 stated that if she (Resident A) wears underwear, she will go to the restroom; however, if she is wearing a brief, she won’t go to the restroom (she will use the brief instead).

APS Worker #1 and I left the home and met with Ms. Howard, Administrative Staff, to review the *Resident Funds Part II* forms. Regarding the checks being held, Ms. Howard informed that the checks arrive around the 3rd or the 5th and they a disbursed around the 12th of the month.

Regarding Resident B, Ms. Howard stated that Resident B was starting to get forgetful. In addition, that Guardian B now wanted Resident B to sign out her money.

This is when it was determined that staff did not track Resident B's spending money and maintain receipts, as the money was given directly to Resident B.

The *Resident Funds Part II* form reflected that Resident B was given $25.00 in cash on September 12, 2022.

APS Worker #1 and I returned to the home to inquire about how much money Resident B had on hand. When we arrived, Resident B was outside walking on the sidewalk. The staff were standing outside smoking and talking to an individual (Individual #1) parked in front of the home.

Resident B again reported to give Employee #2 $5.00 dollars. Resident B counted her money, and only had $11.00 left. Resident B also reported that staff took her to buy a shake and cookies.

While at the facility, we interviewed Employee #2. She stated that Resident B wanted to give her $5.00 because she (Resident B) broke a can of hair spray that belonged to Employee #2. Employee #2 stated that she did not take any money from Resident B. Employee #2 stated that they took Resident B to get some chicken and tea yesterday, which totaled $3.00 even.

Employee #2 denied being mean to Resident B.

On September 14, 2022, I made face to face contact with APS Worker #1. He stated that during a follow up interview with Employee #1, she informed that Employee #2 made Resident A stand on the wall for two hours for peeing her pants. In addition, that Employee #2 was telling Resident A that she could not wear briefs (and that she had to wear underwear instead). Employee #1 stated that Employee #2 told Resident A that she better not tell, or she would get into more trouble. APS Worker #1 has interviewed Resident A and Resident B, and they both report being mistreated by staff. He has been in contact with the guardians regarding these concerns.

It should be noted that on September 16, 2022, I received a written request from the licensee, requesting to withdraw and close the facility license. The facility is on a regular license and there had not been any discussions with the licensee regarding disciplinary action. Based on the request to close the license, the investigation was concluded. The request to close the license will be utilized as the written corrective action plan and the facility will be closed.

On October 5, 2022, I conducted the exit conference with Mr. Combs, Licensee Designee. I informed him of my findings and recommendations. He stated that the staff were immediately fired and removed from the home once the allegations were brought to their attention. Resident A did not want to return to the home from the hospital. An investigation was conducted by APS. ORR staff were also investigating and informed them not to ask any questions of staff; therefore, to assure resident

safety, the staff were removed. Mr. Combs stated that the request to close the facility was not an intent to get around the situation of having bad employees. They are in the process of re-evaluating their homes with lower capacities, as they're not required to be licensed. These homes will operate as independent living settings with CMH oversight. Mr. Combs agreed with the recommendations as presented.

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:	APS Worker #1 informed me that Resident A demonstrated how her hair was being pulled by staff. Resident B has also been reporting to her guardian (Guardian B), about her hair being pulled. Resident B informed us (APS Worker #1 and I) that they (staff) "yell at me and hit me; push me down on the couch." Resident B informed us (APS Worker #1 and I) that Resident A is mistreated too, and that Employee #1 pulls her hair. When asked why, she stated that Resident A will pee or poop her pants, and "she can't help it." Employee #1 and Employee #2 deny being mean to the residents. APS Worker #1 stated that during the interview with Employee #1 she informed that Employee #2 made Resident A stand on the wall for two hours for peeing her pants. In addition, that Employee #2 was telling Resident A that she could not wear briefs (and that she had to wear underwear instead). Employee #1 stated that Employee #2 told Resident A that she better not tell, or she would get into more trouble. 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 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.

ANALYSIS:	The *Resident Funds Part II* form reflected that Resident B was given $25.00 in cash on September 12, 2022. Resident B reported to give Employee #2 $5.00 (on 9/12/22). She also reported that staff took her to get a shake and cookies. She had $11.00 left. Employee #2 denied taking any money from Resident B. Employee #2 also reported that Resident B was taken to the store, and she purchased chicken and tea, totaling $3.00 even. Without receipts or other witnesses, there is not a way to determine if Resident B gave Employee #2 $5.00. Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that Resident B gave Employee #2 $5.00.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

The licensee has requested that the license be closed; therefore, the written request will serve as the acceptable written corrective plan, and the license will be closed.

Mahtina Rubritius 10/05/2022

Mahtina Rubritius Date
Licensing Consultant

Approved By:

A. Hunter 10/06/2022

Ardra Hunter Date
Area Manager