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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 28, 2022

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

RE: License #: AS380016315
Investigation #: 2023A0007001
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 #:	AS380016315
Investigation #:	2023A0007001
Complaint Receipt Date:	09/28/2022
Investigation Initiation Date:	10/03/2022
Report Due Date:	11/27/2022
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:	Brown Street Home
Facility Address:	1203 Brown Street Jackson, MI 49203-2732
Facility Telephone #:	(517) 250-7930
Original Issuance Date:	03/24/1995
License Status:	REGULAR
Effective Date:	05/24/2022
Expiration Date:	05/23/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 9/27/2022, Resident A was taken to a medical appointment. The staff did not bring the data sheets which included information regarding the diabetic charting, blood pressure readings and bowel movements. The staff reported that they did not bring the data sheets because the new home manager (name unknown) said it was a HIPPA violation.	No
Additional Findings	Yes

III. METHODOLOGY

09/28/2022	Special Investigation Intake - 2023A0007001
10/03/2022	Special Investigation Initiated – Letter - Email to ORR
10/03/2022	Referral - Recipient Rights
10/13/2022	Inspection Completed On-site - Unannounced - Face to face contact with Home Manager #1, Resident A, Resident B, Resident C, Resident D and Resident E.
10/20/2022	Contact - Telephone call received from Jackson County Guardian A (Guardian A). Discussion.
10/25/2022	Contact - Telephone call received - Subsequent Allegations Received- Please see SIR#2023A0007005 for additional information.
10/27/2022	Contact - Telephone call made to ORR Officer #1. Case discussion.
11/09/2022	Contact - Telephone call received from ORR Officer #1. Case discussion.
11/21/2022	Contact - Telephone call made - Nurse A. Interview.
11/22/2022	Inspection Completed On-site - Unannounced - Face to face contact with Home Manager #2, Administrative Staff #1, Resident C, Resident D, Resident E, Resident F and Resident G.

11/22/2022	Contact - Telephone call made - Interview with Employee #2.
11/22/2022	Contact - Telephone call made to Medical Center A x 4. No answer, unable to leave a message.
11/23/2022	Contact - Telephone call made to Mr. Combs, Licensee Designee, no answer.
11/23/2022	Contact – Document Sent – Email to Mr. Combs, I requested a returned phone call to conduct the exit conference.

ALLEGATIONS:

On 9/27/2022, Resident A was taken to a medical appointment. The staff did not bring the data sheets which included information regarding the diabetic charting, blood pressure readings and bowel movements. The staff reported that they did not bring the data sheets because the new home manager (name unknown) said it was a HIPPA violation.

INVESTIGATION:

On October 13, 2022, I conducted an unannounced on-site investigation and made face to face contact with Home Manager #1, Resident A, Resident B, Resident C, Resident D, and Resident E.

I interviewed Home Manager #1 and discussed the protocols when residents are taken to their medical appointments. According to Home Manager #1, the paperwork they take includes information regarding blood pressure, bowel movements, and diabetic readings. The after-care summary is placed in the file once they return from the medical visit. I inquired about staff saying it was a HIPPA violation to take the medical information that was tracked to the medical appointments, and Home Manager #1 stated that she was not aware of staff saying it was a HIPPA violation. Home Manager #1 also stated that Manager #1 and Manager #2 were saying that staff could not take the full medical book, which contained medical information on all the residents in the home to a resident's medical appointment. To address these issues, staff are now required to go to the office and make a copy of the information that is to be taken to the doctor appointment, leaving the full medical book at the facility.

On October 20, 2022, I spoke with Jackson County Guardian A (Guardian A), and we discussed the care the residents were receiving in the home. Guardian A stated that she was considering moving Resident A and Resident B to another home. She

stated that staff took Resident A to his medical appointment and staff still did not have the documentation regarding the blood sugars. Staff tried to cancel the appointment, but they were instructed that they needed to follow-through with the appointment. In addition, Resident B's walker was broken; however, Guardian A was not informed (in a timely manner) that the brakes on the walker were not working. Guardian A had a new walker stored for him, and if she had been informed, this matter could have been quickly addressed. According to Guardian A, the manager stated that she was never told that Resident B's walker was broken; however, there was a staff member there who stated she (the manager) was aware because she (staff member/name unknown) told her. Resident B also requires staff assistance when standing. Staff are to utilize the gate belt to assist with transitioning. Resident B was walking around without a gate belt.

On October 27, 2022, I spoke with ORR Officer #1. She stated that Medical Center A staff were upset with the facility staff because they did not bring some documentation to the appointment; however, the information had been submitted to the EMR tracking system. These allegations were not investigated by ORR.

On November 9, 2022, I spoke with ORR Officer #1. We discussed the investigation. She stated that the staff at Medical Center A were upset with the home. On or about October 25, 2022, the home did not know that Resident B had a follow-up appointment; however, the after-care summary did not give a follow-up date, nor did it instruct staff of what documents to bring to the appointment. ORR Officer #1 talked with Home Manager #1 about how to address this issue.

On November 21, 2022, I interviewed Nurse A. Nurse A stated that she was new to the home, beginning in September. During her visit, she made face to face contact with Resident A and Resident B. She stated that Resident B was in his room, which is just outside the dining room. When he came out of his room, he did not have on shoes or socks that gripped; he was wearing plain socks. She informed the staff of her concern. When Resident B attempted to sit in the chair, she locked the walker brakes. After taking his vitals, she held the walker, so he could stand up and go to the living room. Resident B was not wearing his gate belt.

On November 22, 2022, I conducted an unannounced on-site investigation, and made face to face contact with Home Manager #2, Administrative Staff #1, Resident C, Resident D, Resident E, Resident F and Resident G. Resident A and Resident B no longer reside in the home.

Home Manager #2 reported to be new to the home this month, and he could not provide any information regarding the paperwork for appointments, the broken walker, or the use of gate belts, as he was still in training.

While at the home, I reviewed the files for Resident A and Resident B.

Resident A's file documented his diagnoses. Resident A is also diagnosed with Type 2 diabetes. According to his plan, he requires a gate belt, walker, and requires stand by assistance with ambulation.

Resident B's file documented that he was diagnosed with essential hypertension, spastic quadriplegic cerebral palsy. Per his Health Care Appraisal, he utilized a walker. I also reviewed the Nursing Assessment for Resident B. It was noted that he utilized a walker and gate belt. The gate belt was to be utilized at all times.

I also interviewed Administrative Staff #1. She stated that when Resident B was in the home, he did not like to keep the gate belt on all the time. She stated that understandably the gate belt would get uncomfortable. Administrative Staff #1 was not aware of Resident B's walker being broken, but after the fact, she did hear that Guardian A was upset because she had to bring a walker to the home.

During the interview with Administrative Staff #1, while addressing the allegations for both investigations (SIR #2023A0007001 & SIR #2023A0007005), she informed me that I was on a "witch hunt." She recalled that a staff member from another home, within their corporation, took a resident to Medical Center A for an appointment. It took an hour to get to the appointment. Then, they sat for approximately two hours waiting to see the doctor, and the resident was having many behaviors. As a result, the employee complained to Medical Center A's upper management and other officials, as there was no reason for residents to wait that long. According to Administrative Staff #1, the employee caused "a big stink." There is a concern that the medical center is coming after the corporation.

On November 22, 2022, I interviewed Employee #2. He informed that when he takes residents to the doctor, the manager prints off whatever they need, and it's given to the medical staff. He did not confirm that it would be a HIPPA violation to give the information to the doctor.

On November 22, 2022, I called Medical Center A four times, and no one answered the phone. There was not an option to leave a message.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	Home Manager #1 stated that she was not aware of staff saying it was a HIPPA violation to provide the data sheets. Home Manager #1 also stated that Manager #1 and Manager #2 were saying that staff could not take the full medical book, which contained medical information on all the residents in the home to a resident's medical appointment. ORR Officer #1 stated that Medical Center A staff were upset with the facility staff because they did not bring some documentation to the appointment; however, the information had been submitted to the EMR tracking system. Employee #2 did not confirm that it would be a HIPPA violation to give the information to the doctor. Based on the information gathered during this investigation and provided above, it's concluded that there is not a 51% preponderance of the evidence to support the allegations that the staff are not following the instructions or recommendations of the physician.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

According to Guardian A, Resident B's walker was broken; however, Guardian A was not informed timely that the brakes on the walker were not working. Guardian A had a new walker stored for him, and if she had been informed, this matter could have been quickly addressed. In addition, Guardian A stated the manager stated that she was never told that Resident B's walker was broken; however, there was a staff member there who stated she (the manager) was aware because she (staff member/name unknown) told her.

Administrative Staff #1 was not aware of Resident B's walker being broken, but after the fact, she did hear that Guardian A was upset because she had to bring a walker to the home.

According to Guardian A, Resident B also requires staff assistance when standing. Staff are to utilize the gate belt to assist with transitioning. Resident B was walking around without a gate-belt.

According to Nurse A, Resident B was not wearing his gate belt when she observed him in the home in September.

Administrative Staff #1. She stated that when Resident B was in the home, he did not like to keep the gate belt on all the time, as she imagined it could be uncomfortable.

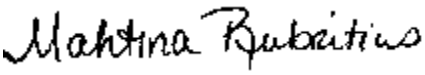
I reviewed the Nursing Assessment for Resident B. It was noted that he utilized a walker and gate belt. The gate belt was to be utilized at all times.

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:	According to Guardian A, Resident B's walker was broken, and she was not informed that the brakes were not working. In addition, Guardian A stated the manager stated that she was never told that Resident B's walker was broken; however, there was a staff member there who stated she (the manager) was aware because she (staff member/name unknown) told her. Administrative Staff #1 was not aware of Resident B's walker being broken, but after the fact, she did hear that Guardian A was upset because she had to bring a walker to the home. According to Guardian A, Resident B also requires staff assistance when standing. Staff are to utilize the gate belt to assist with transitioning. Resident B was walking around without a gate-belt. According to Nurse A, Resident B was not wearing his gate belt when she observed him in the home in September. Administrative Staff #1. She stated that when Resident B was in the home, he did not like to keep the gate belt on all the time. I also reviewed the Nursing Assessment for Resident B. It was noted that he utilized a walker and gate belt. The gate belt was to be utilized at all times. 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 B's personal needs, including protection and safety, were not attended to at all times, in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, I recommend that the status of the license remains unchanged.



11/23/2022

Mahtina Rubritius — Date
Licensing Consultant

Approved By:

11/28/2022

Ardra Hunter — Date
Area Manager