GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 4, 2023

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

RE: License #: AS300016311
Investigation #: 2023A1032057
Westwood Home

Dear Ira Combs, Jr.:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS300016311 |
| | |
| **Investigation #:** | 2023A1032057 |
| | |
| **Complaint Receipt Date:** | 09/14/2023 |
| | |
| **Investigation Initiation Date:** | 09/15/2023 |
| | |
| **Report Due Date:** | 11/13/2023 |
| | |
| **Licensee Name:** | Christ Centered Homes, Inc. |
| | |
| **Licensee Address:** | 327 West Monroe Street<br>Jackson, MI 49202 |
| | |
| **Licensee Telephone #:** | (517) 499-6404 |
| | |
| **Licensee Designee:** | Ira Combs, Jr. |
| | |
| **Name of Facility:** | Westwood Home |
| | |
| **Facility Address:** | 115 Westwood<br>Hillsdale, MI 49242 |
| | |
| **Facility Telephone #:** | (517) 439-1914 |
| | |
| **Original Issuance Date:** | 09/26/1995 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/25/2022 |
| | |
| **Expiration Date:** | 08/24/2024 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| The home did not adequately attend to Resident A's bruising. | No |
| No incident report was written regarding the bruising. | No |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 09/14/2023 | Special Investigation Intake<br>2023A1032057 |
| 09/15/2023 | Special Investigation Initiated - Letter |
| 09/18/2023 | Inspection Completed On-site |
| 09/29/2023 | Contact - Document Received |
| 10/03/2023 | Contact - Telephone call made<br>Interview with Alicia Williams, Quality Control Coordinator |
| 10/04/2023 | Exit Conference |
| 10/04/2023 | Contact - Telephone call made<br>Interview with Alicia Williams, Quality Control Coordinator |

**ALLEGATION:**

**The home did not adequately attend to Resident A's bruising.**

**INVESTIGATION:**

On 9/18/23, I interviewed employee Payton Brown in the home. Ms. Brown stated that Resident A was not struck by an employee. Ms. Brown stated that she was unaware of how Resident A sustained bruising around his left eye. She stated that she thought he had burst a blood vessel around his eye but was advised that a burst vessel would have resulted in discoloration in his actual eye. She advised that Resident A was being moved because of the investigation into his bruising. She advised that Resident A does press his thumb into his eyes quite often.

I attempted to interview Resident A, but he was visibly agitated initially. I observed faint bluish coloring around his left eye.

I interviewed Resident B in the home. Resident B denied ever being struck by an employee., nor did she observe anyone strike Resident A. Resident B stated that she has been in the home for about two years and expressed satisfaction with the quality of care.

On 9/29/23, I communicated with Adult Protective Services specialist Jessica Bradley, via email. Ms. Bradley reported that Hillsdale Police had been contacted and that the outcome of that investigation was that no physical abuse had occurred. Ms. Bradley stated that Resident A was no longer being moved and that a meeting had occurred between the home and Resident A's guardian, to improve communication for Resident A's continuing care.

On 10/3/23, I interviewed Quality Control Coordinator for Christ Centered Homes, Alicia Williams, via telephone. Ms. Williams stated that a meeting had been held between the home and the guardian, to resolve any communication issues surrounding Resident A's doctor appointments. Ms. Williams stated that Resident A's doctors' appointments require prior authorization from the guardian, and there were instances in the past where he missed appointments because the authorization was not obtained. Ms. Williams stated that one solution was to send all appointments through the corporate office, so that the home has a second tier of support in documenting efforts to schedule appointments and request authorization.

| **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 interviews with staff members and residents, there does not seem to be a pattern of undignified treatment of residents, such as physical aggression or omission of duty regarding their care. |

| | |
|---|---|
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**No incident report was written regarding the bruising.**

**INVESTIGATION:**

On 9/18/23, Ms. Brown advised that Resident A often rubs his eyes, causing bruising, and that there was no suspicion on staff members' part that anyone had struck Resident A. I observed Resident A pinching and rubbing his eyes with his thumbs. Ms. Brown advised that this was typical behavior for Resident A.

I reviewed a doctor's visit note dated 9/13/23. The note was authored by a nurse practitioner Bridget, stating: "Diagnoses and all orders for this visit: Urinary tract infection without hematuria, site unspecified Comments: Continue Kelfex until gone. Ecchymosis of left eye, initial encounter Comments: Easy bruising noted, no c/o pain." This note was consistent with information provided to me by Adult Protective Services.

On 10/4/23, I interviewed Alicia Williams, via telephone. Ms. Williams stated that at the time, no incident report was generated because the staff members reasonably assumed that the bruising was made by Resident A, who rubs his eyes frequently. The staff members have now been directed to write incident reports if Resident A has any bruising around the eye.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14311** | **Investigation and reporting of incidents, accidents, illnesses, absences, and death.** |
| | **(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:**<br><br>**(c) Incidents that involve any of the following:**<br>**(i) Displays of serious hostility.**<br>**(ii) Hospitalization.**<br>**(iii) Attempts at self-inflicted harm or harm to others.** |

| | |
|---|---|
| | **(iv) Instances of destruction to property.** |
| **ANALYSIS:** | Based on interviews with staff members, my observations of Resident A's behavior of rubbing his eyes, it appears that the staff members believed that the bruising around Resident A's eyes did not require outside medical attention; nor was the bruising considered to be the result of self-injurious behavior given their established insight into Resident A's behavior. A follow-up doctor's appointment revealed easy bruising without pain. There is insufficient evidence to establish that the home violated the intent of the rule requiring an incident report. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

On 10/4/23, I conducted an exit conference with Tony Thomas, Compliance Officer for Christ Centered Homes, as licensee designee Bishop Ira Combs was not available. I shared my findings with Mr. Thomas, and he agreed with the conclusions reached.

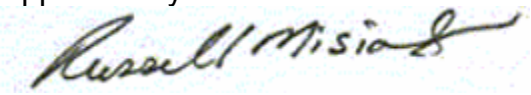
## IV. RECOMMENDATION

I recommend no change to the status of this license.

10/4/23

Dwight Forde — Date
Licensing Consultant

Approved By:



10/5/23

Russell B. Misiak — Date
Area Manager