GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 17, 2023

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

RE: License #: AS460015676
Investigation #: 2023A1032003
Westhaven AFC

Dear Mr. 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
350 Ottawa, N.W. Unit 13, 7th Floor
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 #:	AS460015676
Investigation #:	2023A1032003
Complaint Receipt Date:	10/18/2022
Investigation Initiation Date:	10/18/2022
Report Due Date:	11/17/2022
Licensee Name:	Christ Centered Homes, Inc.
Licensee Address:	327 West Monroe Street Jackson, MI 49202
Licensee Telephone #:	(517) 499-6404
Licensee Designee:	Ira Combs, Jr.
Name of Facility:	Westhaven AFC
Facility Address:	1501 Westhaven Drive Tecumseh, MI 49286
Facility Telephone #:	(517) 423-4279
Original Issuance Date:	12/06/1993
License Status:	REGULAR
Effective Date:	02/24/2021
Expiration Date:	02/23/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Employees did not properly respond to Resident A's medical emergency.	No
Additional Findings	No

III. METHODOLOGY

10/18/2022	Special Investigation Intake 2023A1032003
10/18/2022	Special Investigation Initiated - Letter Email sent to ORR.
10/20/2022	Inspection Completed On-site
10/20/2022	Contact - Face to Face
12/01/2022	Contact - Telephone call made
12/07/2022	Contact - Document Received
01/09/2023	Contact - Telephone call received ORR report
01/13/2023	Exit Conference

ALLEGATION:

Employees did not properly supervise Resident A, resulting in a medical emergency.

INVESTIGATION:

On 10/18/22, I emailed Office of Recipient Rights (ORR) specialist Stephen Mitchell. Mr. Mitchell confirmed that ORR was also investigating a complaint involving improper supervision of a resident.

On 10/20/22, I interviewed Employee #1 and Employee #2 in the backyard of the home. Employee #1 stated that they checked on Resident A around 8am. She stated that on the weekends they are more relaxed with their schedules and tend not to get all the residents up. She stated that around 930, they checked on Resident A and observed her on the floor. They assisted Resident A to her bed and asked what happened. Employee #1 stated that Resident A reported to them that she did not alert staff because she did not wish to get in trouble. Employee #1 stated that they assured Resident A that she would not be in trouble for calling for assistance. Employee #1 detailed staff actions at that point, stating that they called 911 and alerted responsible parties as well. Employee #2 stated that he tried to call Guardian A while he was at the hospital with Resident A. Employee #1 stated that the staff members were all trained by the home manager on how to arrange Resident A in bed, with pillows placed on either side.

I interviewed Employee #3 in the home. Employee #3 stated that there was an approximate two-hour gap between the initial check on Resident A and the discovery that she had fallen. Employee #3 denied hearing Resident A call out for help. She reported that staff members were in the house and that initially there were four employees on shift. Employee #3 stated that when they discovered that Resident A had fallen, they assisted her up and contacted emergency services.

On 12/1/22, I interviewed Resident A via telephone. Resident A stated that on the day in question, she rolled out of bed. Resident A stated that the employees did not get her after she fell. She stated that the employees would place pillows on either side of her to prevent her from rolling. She mentioned that she was on the edge of the bed when she fell.

I interviewed Guardian A via telephone. Guardian A stated that fifteen-minute checks were also mandated per Resident A ‘s assessment plan and Individual Plan of Service. Guardian A stated that she trained the home manager, who in turn trained the employees, on the proper placement of pillows, so as to avoid falling out of the bed.

On 12/7/22, I received a copy of Resident A’s assessment plan and Individual Plan of Service. Upon review, there was no documented requirement for fifteen-minute checks.

On 1/9/23, I received a copy of Lenawee County Office of Recipient Rights Officer (ORR) Stephen Mitchell’s report. The report reflected compliance with special certification requirements.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	I interviewed Employees #1, 2 and 3. It was explained that the program on the weekends starts later than the weekdays. The employees reported that when Resident A had been discovered, they made calls for emergency medical attention. I reviewed Resident A's assessment plan and Individual Plan of Service. Neither document referenced a required fifteen-minute check.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 1/13/23, I attempted to conduct an exit conference with licensee designee, Bishop Ira Combs, to share my findings. Bishop combs was not available at the time that I called. He later called and left a voicemail, agreeing with the findings.

IV. RECOMMENDATION

I recommend no change to the status of this license.

1/16/23

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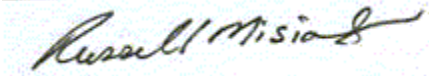
Dwight Forde Date
Licensing Consultant

Approved By:



1/26/23

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Russell B. Misiak Date
Area Manager