



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 22, 2026

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

RE: License #: AS460069264
Investigation #: 2026A1032028
Marvin Drive 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in cursive script, appearing to read "Dwight Forde".

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 #:	AS460069264
Investigation #:	2026A1032028
Complaint Receipt Date:	04/03/2026
Investigation Initiation Date:	04/06/2026
Report Due Date:	06/02/2026
Licensee Name:	Christ Centered Homes, Inc.
Licensee Address:	327 West Monroe Street, Jackson, MI 49202
Licensee Telephone #:	(517) 499-6404
Administrator:	Ira Combs, Jr., Designee
Licensee Designee:	Ira Combs, Jr., Designee
Name of Facility:	Marvin Drive Home
Facility Address:	3376 Marvin Drive Adrian, MI 49221
Facility Telephone #:	(517) 499-6404
Original Issuance Date:	05/13/1996
License Status:	REGULAR
Effective Date:	04/29/2025
Expiration Date:	04/28/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
The facility negligently exposed Resident A to a potentially harmful situation.	No

III. METHODOLOGY

04/03/2026	Special Investigation Intake 2026A1032028
04/06/2026	Special Investigation Initiated - On Site
05/22/2026	Exit Conference
04/07/2028	Contact - Telephone call made

ALLEGATION:

The facility negligently exposed Resident A to a potentially harmful situation.

INVESTIGATION:

On 4/6/26, I interviewed Home Manager Adriana Garcia in the facility. Ms. Garcia stated that Resident A's behavioral specialist rescinded an earlier plan restricting her community access. Ms. Garcia stated that Resident A also had internet access and had been conversing with men on the internet, the latest being a gentleman from Pennsylvania who showed up on 4/2/26 and left with her. Ms. Garcia stated that as a protective measure, staff took copies of this person's identification. She advised that Resident A returned to the facility on 4/3/26 after police arrested the gentleman for outstanding warrants. Ms. Garcia mentioned that Resident A was now lodged at a behavioral unit at a hospital after becoming assaultive and unmanageable over the weekend, since her restrictions were re-imposed. Furthermore, the facility had issued a 30-day discharge notice due to the escalating behaviors. Ms. Garcia stated that they had opposed the plan to remove Resident A's restrictions; she reported that they had stayed in contact with Resident A's governing mental health agency regarding the matter.

I reviewed Resident A's behavior treatment plan from March 2026, where it was documented that when Resident A left the facility, she had to sign out. I reviewed the

current plan, signed on April 3, 2026, restricting Resident A’s community and internet access.

On 4/7/26, I interviewed Lenawee Community Mental Health Authority supervisor Jearald Dudley by telephone. Mr. Dudley opined that the facility did and did not follow protocol; he stated that while they did take steps to gather information to maintain surveillance on Resident A, the police should have been contacted when the gentleman showed up. He acknowledged that while the gentleman did not commit any crime at the facility or against Resident A that would have warranted a police call, it was still the right thing to do to ensure Resident A’s safety. He stated that an app on Resident A’s phone allowed the facility to keep track of her and that the gentleman did in fact take her to their planned destination.

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	Resident A’s community access had been reinstated. The facility had expressed its discomfort with that decision to Resident A’s responsible community mental health agency. The facility took steps to ensure that they were aware of Resident A’s whereabouts and followed the documented behavior plan. Therefore, there is insufficient evidence to establish a violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 5/22/26, I conducted an exit conference with licensee designee Bishop Ira Combs, where I shared my findings.

IV. RECOMMENDATION

I recommend no change to the status of this license.

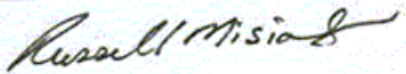


5/22/26

Dwight Forde
Licensing Consultant

Date

Approved By:



5/27/26

Russell B. Misiak
Area Manager

Date