GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 13, 2026

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

RE: License #: AS300016311
Investigation #: 2026A1032035
Westwood Home

Dear Ira 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 7/14/26, 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

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 #:	2026A1032035
Complaint Receipt Date:	05/05/2026
Investigation Initiation Date:	05/05/2026
Report Due Date:	07/04/2026
Licensee Name:	Christ Centered Homes, Inc.
Licensee Address:	327 West Monroe Street, Jackson, MI 49202
Licensee Telephone #:	(517) 499-6404
Administrator:	Ira Combs, Jr.
Licensee Designee:	Ira Combs, Jr.
Name of Facility:	Westwood Home
Facility Address:	115 Westwood Hillsdale, MI 49242
Facility Telephone #:	(517) 439-1914
Original Issuance Date:	09/26/1995
License Status:	REGULAR
Effective Date:	08/25/2024
Expiration Date:	08/24/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's injury was not addressed in a timely manner	Yes

III. METHODOLOGY

05/05/2026	Special Investigation Intake 2026A1032035
05/05/2026	Special Investigation Initiated - Letter APS Investigation requested
05/05/2026	APS Referral No referral made
06/01/2026	Inspection Completed On-site
06/03/2026	Exit Conference
06/26/2026	Contact - Document Sent Text message to Guardian A1
07/13/2026	Corrective Action Plan Requested and Due on 07/20/2026

ALLEGATION:

Resident A's injury was not addressed in a timely manner

INVESTIGATION:

On 5/5/26, I received investigative notes from Adult Protective Services Specialist Betsy Clark. The notes referenced an event in March 2026, where Resident A's leg was injured, medical attention was not obtained in a timely fashion and the wound grew worse. Per the notes, a teacher had noticed that there was a wound which was getting progressively worse. Ultimately, Guardian A1 took Resident A to the emergency room to get treatment after five days had passed. The wound was supposedly washed daily. According to the document, the staff were re-trained and a new policy implemented where the Quality Inspector for the facility, Erica Parker, would be notified of any serious medical issues.

On 6/1/26, I interviewed Home Manager Blu Lucero in the facility. Ms. Lucero stated that Resident A received new foot pedals for his wheelchair which grazed his skin. She reported that the staff observed a scratch and applied gauze to the wound. She advised that in hindsight, this was the wrong course of treatment since it made the wound worse. She stated that the facility had to ask Guardian A1 to take Resident A to the hospital for treatment because the staff at that time were not fully confident in their ability to secure Resident A in the van and erred on the side of caution. She stated that as a result, all wound care issues will be directed to the facility's Quality Inspector, Erica Parker.

I was unable to interview Resident A due to a speech issue, but I observed the wound to be healing.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	I conducted an interview with Home Manager Blu Lucero, where she acknowledged that the course of care used by the facility may have worsened the wound. The wound was treated daily yet at the end of five days it required emergency medical treatment. Health care was not obtained until a serious infection had set in, meaning that things were allowed to deteriorate. Therefore a violation was established.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/3/26, I conducted an exit conference with licensee designee Bishop Ira Combs in person. Bishop Combs furnished me with a nurse's report stating that Resident A's wound had healed.

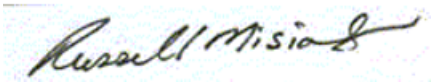
IV. RECOMMENDATION

On 7/14/26, I received an acceptable corrective action plan, therefore I recommend no change to the status of this license.

7/14/26

Dwight Forde — Date
Licensing Consultant

Approved By:



7/15/26

Russell B. Misiak — Date
Area Manager