GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 9, 2021

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

RE: License #: AS380016315
Investigation #: 2022A0122002
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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (517) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380016315
Investigation #:	2022A0122002
Complaint Receipt Date:	10/19/2021
Investigation Initiation Date:	10/20/2021
Report Due Date:	12/18/2021
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) 990-9058
Original Issuance Date:	03/24/1995
License Status:	REGULAR
Effective Date:	11/15/2020
Expiration Date:	11/14/2022
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff members failed to notify Resident A's guardian of his illness.	No
Staff members failed to follow physician orders regarding Resident A's lab requests.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/19/2021	Special Investigation Intake 2022A0122002
10/20/2021	Special Investigation Initiated - Telephone Completed an interview with Guardian A.
10/21/2021	Inspection Completed On-site Completed interview with Staff 2. Reviewed Resident A's file. Received copies of requested information.
10/21/2021	Contact - Telephone call made Completed interview with Staff 1. Contacted Staff 3. Left voice message requesting return phone call.
10/22/2021	Contact – Telephone call made Completed interview with Nichole Hardman, Home Manager. Completed interview with Shella Worden, Case Manager.
10/22/2021	Contact – Telephone call made Completed interview with Guardian A regarding Resident B.
10/26/2021	Contact – Telephone call made APS and ORR referrals made.
10/26/2021	Contact – Telephone call made Completed interviews with Donna Hoffman, RN, Integro.

10/26/2021	Contact – Telephone call made Completed interview with Kyaria Arrington.
10/26/2021	Exit Conference Discussed findings with Ira Combs, Licensee Designee.
10/27/2021	Contact – Document received Guardian A submitted information via email.

ALLEGATION: Staff members failed to notify Resident A's guardian of his illness.

INVESTIGATION: On 10/20/2021, I completed an interview with Guardian A. Guardian A reported that Resident A was admitted to the hospital on 10/09/2021 and died on 10/16/2021. On 10/11/2021, during a telephone conference Guardian A received information that Resident A received a flu shot on 10/05/2021 and it was reported after the shot he wasn't feeling well, he wasn't eating, nor having proper urination. Guardian A stated Resident A's health declined prior to his hospital admission and she wasn't notified.

On 10/21/2021, I completed interviews with Staff 1 and Staff 2. Staff 1 stated she began noticing changes in Resident A's eating habits the week of 09/26/2021. Staff 2 noticed the same changes as Staff 1, but she also noticed changes in his facial movements, "He was holding his mouth differently." Both Staff 1 and 2 stated these concerns were reported to Nicole Hardman, home manager, and they were directed to monitor Resident A and take his vitals.

On 10/21/2021, I contacted Staff 3, however, she was unavailable. I left a voice message requesting a return phone call. As of 10/28/2021, Staff 3 has not contacted me; therefore, I did not complete an interview with her.

On 10/21/2021, I reviewed Resident A's file. Staff Note dated 10/08/2021 completed by Staff 2 during 1st shift, 6:00 a.m. – 2:00 p.m., documented that she began observing a difference with his physical condition, she wrote Resident A is "looking a little sick at end of shift." During the 2nd shift, 2:00 p.m. – 10:00 p.m., on 10/08/2021 Staff Note completed by Staff 3 documented that Resident A "appears to not be feeling well." Staff 3 documented that Resident A threw up after 8:00 p.m. meds." Both notes document that staff were giving him water and taking his vitals every two hours.

Staff note dated 10/09/2021 completed by Staff 3 during 3rd shift, 10:00 p.m. – 6:00 a.m., documents that Resident A "fell tonight around 5:00 a.m. He's dry heaving and vomiting water when given fluids every 2 hours with vitals taken…he's stumbling when he walks and breathing heavy. He's very tired, not himself." Staff 2

documented on Staff Note dated 10/09/2021 during 1st shift the following, “at the beginning of shift Resident A looking sick, vitals (they were low), called case manager and got him up and to the hospital.” Resident A was admitted to the hospital on 10/09/2021.

On 10/22/2021, I completed an interview with Nicole Hardman, Home Manager. Ms. Hardman reported that during the timeframe of 10/08/2021 and 10/09/2021 Resident A was complaining of headaches and stomach pain to which she gave him Tylenol and Pepto-Bismol.

Ms. Hardman reported that she contacted Guardian A on 10/09/2021, however, she was not available, so she spoke with a representative from Guardian A’s office, Kyaria Arrington. Ms. Hardman stated she cannot provide cell phone records to verify that she contacted Guardian A as this information has been erased from her phone. Staff Note dated 10/08/2021 has a handwritten notation “Guardian Office.” This notation is written in a different handwriting style than that of Staff 1 who completed the note. It is unknown if this notation is a reference indicating that Guardian A’s office was contacted on 10/08/2021.

On 10/26/2021, I completed an interview with Kyaria Arrington. Ms. Arrington denied receiving a phone call from Ms. Hardman on 10/09/2021. Ms. Arrington stated she did not speak with Ms. Hardman nor was there a voice message received from her on 10/08/2021 or 10/09/2021.

On 10/22/2021, an email was received from Guardian A. It states, “Nicole paged at 6:30 a.m. on 10/09/2021 that she is sending Resident A to ER for being sick and he was admitted on 10/09/2021 as well.”

On 10/26/2021, I completed an exit conference with Ira Combs, Licensee Designee. My findings were discussed with Mr. Combs. Mr. Combs stated that upon review of the approved report he would submit a response to my recommendation and a corrective action plan.

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: **(b) Any accident or illness that requires hospitalization.**

ANALYSIS:	On 10/20/2021, Guardian A reported Resident A was admitted in the hospital on 10/09/2021, however, she was not notified of Resident A's illness/hospitalization until 10/11/2021. On 10/21/2021, both Staff 1 and 2 stated they observed Resident A's illness on 09/26/2021 and 10/03/2021 respectively. Staff notes dated 10/08/2021 and 10/09/2021 document Resident A was ill, he was observed "looking sick, appears not to be feeling well," and vomited. On 10/22/2021, Nicole Hardman, Home Manager, stated that Resident A was admitted to the hospital on 10/09/2021 and she contacted a representative from Guardian A's office on the same date. Staff Note dated 10/08/2021, has the notation "Guardian Office" written in different handwriting than that of Staff 1 who completed the note. On 10/26/2021, Kyaria Arrington, Guardian A's representative, reported that she received no contact from Ms. Hardman on 10/08/2021 or 10/08/2021. An email received from Guardian A documents that Nicole paged Guardian A on 10/09/2021 to notify her of Resident A's illness and hospitalization. Based upon my investigation, I find that the licensee did make a reasonable attempt to contact the resident's designated representative by telephone to report Resident A's illness/hospitalization. Resident A was admitted to the hospital on 10/09/2021, Guardian A was sent a page by Nicole Hardman informing her of Resident A's hospital admission on 10/09/2021.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Staff members failed to follow physician orders regarding Resident A's lab requests.

INVESTIGATION: On 10/21/2021, I completed an interview with Staff 2. She reported that she had discussed a February 2021 appointment with Nicole Hardman to which Ms. Hardman stated to Staff 2, "you took him to this appointment." Per Staff 2, she has no recollection of what the nature of this appointment was for nor

whether she took Resident A. Staff 2 stated there is no documentation that Resident A completed/attended an appointment in February 2021.

On 10/21/2021, I reviewed the Resident Appointment Calendar. I reviewed the month of February 2021, Resident A had an appointment listed for 02/09/2021 at Lifeways Clinic for 2:30 p.m., 02/16/2021 at PCP (Primary Care Physician) at 2:00 p.m., and 09/26/2021. All staff attend Resident A in-service at 11:00 a.m.

Resident A's Health Care Appraisal dated 11/10/2020, states "patient has difficulty following direction to complete full assessment." It also documents that he was diagnosed with Seizure Disorder, Intellectual Functioning Disability, and Epileptic Spasms. Noted on his form was Care/Risk Scores…"6 diabetes risk, no significant changes."

On 10/22/2021, Nicole Hardman reported that Resident A missed completing laboratory work in February 2021. She also reported that this appointment was not rescheduled.

On 10/22/2021, I completed an interview with Shella Worden, Case Manager for Resident A. Ms. Worden reported that she had no knowledge, nor had she received any reports that Resident A missed medical or laboratory appointments.

On 10/26/2021, I completed an interview with Donna Hoffman, RN for Integro. Ms. Hoffman reported that Resident A did not receive nursing services, therefore, there is no documentation in her department that he missed appointments.

On 10/27/2021, Guardian A submitted the following information: Resident A completed an appointment on 02/09/2021 with Center for Family Health (CFFH) Lifeways Clinic to which he received a medical assessment for constipation and referral of laboratory work. Both items were completed with a referral to follow-up return in 6 months to include laboratory work. Guardian A stated she received a report that Resident A missed his 6 month (August 2021) follow-up appointment, and it was rescheduled for 10/12/2021.

On 10/26/2021, I completed an exit conference with Ira Combs, Licensee Designee. My findings were discussed with Mr. Combs. Mr. Combs stated that upon review of the approved report he would submit a response to my recommendation and a corrective action plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as

	prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Staff members failed to follow physician orders regarding Resident A's lab requests. The Resident Appointment Calendar documented that Resident A had an appointment listed for 02/09/2021 at CFFH Lifeways Clinic for 2:30 p.m. On 10/22/2021, Nicole Hardman, Home Manager, reported that Resident A missed completing laboratory work in February 2021. Ms. Hardman reported that she did not reschedule the appointment. On 10/27/2021, Guardian A submitted information that Resident A completed his medical appointment and laboratory work on February 9, 2021, at CFFH Lifeways Clinic, however missed his 6 month follow-up appointment in August 2021. Based upon my investigation there is evidence to support staff members failed to follow physician orders regarding Resident A's laboratory request. Guardian A submitted paperwork that Resident A completed his laboratory work on February 9, 2021, however, Home Manager, Nicole Hardman had no knowledge that he did so and reported that he missed completing laboratory work on February 9, 2021. Per paperwork submitted by Guardian A, Resident A was scheduled for follow-up laboratory work in August 2021. Nicole Hardman had no knowledge of Resident A's appointment in August 2021; therefore, Resident A missed that appointment. Resident A's individual special medical procedure was not completed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 10/21/2021, I completed an interview with Staff 1. She reported the following: She began noticing a change with Resident A the week of September 26, 2021. Staff 1 stated she first notice that he wasn't eating as he "normally does," in that he wasn't finishing all his meals and he was not requesting a second helping. She reported this concern to Home Manager, Nichole Hardman.

On 10/08/2021, Staff 1 stated she worked the following hours: 6:00 a.m. – 2:00 p.m. and 10:00 p.m. – 6:00 a.m., on 10/09/2021 she worked the following hours: 6:00 a.m. – 2:00 p.m. On 10/08/2021, Staff 1 again noticed a difference with Resident A's eating in that he did not finish all his meals. Staff 1 also observed on 10/08/2021 at approximately 2:00 p.m., Resident A sitting on the couch and "he didn't look good." She further described that his "eyes were rolling in the back of his head, like he was fighting sleep." Staff 1 reported this to Ms. Hardman and was directed to monitor him and take his vitals, to which she complied.

Per Staff 1, Resident A's vitals were taken at approximately 2:00 p.m. on 10/08/2021 by Ms. Hardman. Staff 1 stated Ms. Hardman directed staff members to take Resident A's vitals every two hours and report them to her. Staff 1 states she received a report from Staff 3 that Resident A threw up sometime during the shift of 2:00 p.m. -10:00 p.m. on 10/08/2021 and staff members were directed to continue to monitor him and take his vitals.

Staff 1 stated at approximately 5:30 a.m. on 10/09/2021 she heard a loud noise. She went into Resident A's room and observed that his shelf was broken, and bed was pushed back from its normal position. Staff 1 assumed that Resident A had fallen. She along with Staff 3 assisted Resident A up and took his vitals which were reported to Ms. Hardman. Staff 1 was directed to take Resident A to the emergency room to which she complied on 10/09/2021.

Staff 1 reported she was concerned about Resident A's health before she was directed to take him to receive medical treatment.

On 10/21/2021, I contacted Staff 3, however, she was unavailable. I left a voice message requesting a return phone call. As of 10/28/2021, Staff 3 has not contacted me; therefore, I did not complete an interview with her.

On 10/22/2021, I completed an interview with Nicole Hardman. She reported that she began receiving messages from staff members that Resident A wasn't feeling well on 10/06/2021. She observed the same on 10/07/2021 and 10/08/2021. Per Ms. Hardman, Resident A threw up on 10/08/2021. Ms. Hardman stated she reported Resident A's physical issues to a nurse without identifying him so that she could receive guidance. She was told to monitor his vitals to which she and staff complied and was given direction to take him to the hospital on 10/09/2021.

Resident A received medical treatment from Henry Ford Health System. His Emergency Department Note dated 10/09/2021 states the following: “Pt. presents to ED with complaints of weakness, nausea, and vomiting since lunch yesterday” (10/08/2021). “Pt’s caretaker states that he has not been eating or drinking well since Tuesday” (10/05/2021). “Patient brought in by a care provider from the care home who tells me for the last several days he has been becoming gradually more confused and decreased oral intake with associated nausea vomiting, belly pain and confusion. They have noted some elevated blood sugars but not intervened because he has no prior history or treatment of diabetes they were not allowed to intervene. Blood sugar in triage is over 600 and he is noted to be hypotensive with Kussmal breathing.

The Emergency Department Note diagnosed him with AKI (acute kidney injury), Cardiac arrest, and Diabetic acidosis on 10/09/2021. The Physical Exam section states that Resident A “Appears significantly ill…”

Resident A’s Lifeways Death Report dated 10/18/2021 documents that he died on 10/16/2021. “He was in the ICU (Intensive Care Unit) treated for Acute Ketosis and Diabetic Shock, he was on ventilator and sedated.”

On 10/26/2021, I completed an exit conference with Ira Combs, Licensee Designee. My findings were discussed with Mr. Combs. Mr. Combs stated that upon review of the approved report he would submit a response to my recommendation and a corrective action plan.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident’s physical condition or adjustment, a group home shall obtain needed care immediately.

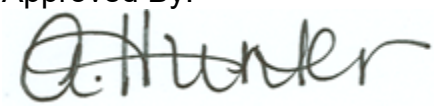
ANALYSIS:	Resident A did not receive immediate care when his physical condition changed suddenly. Staff notes dated 10/08/2021 and 10/09/2021 documented that Resident A physical health was declining. On 10/08/2021 it was documented that Resident A vomited and 10/09/2021 he fell. Staff 1 reported instead of seeking immediate medical care for Resident A his vital signs were taken, reported to Ms. Hardman, and staff members transported Resident A to the emergency room. Based upon my investigation there is evidence to support that Resident A did not receive immediate care when his physical condition changed suddenly. Staff members observed Resident A vomit on 10/08/2021 and fall on 10/09/2021 instead of calling 911 they took vitals, reported them to Ms. Hardman, and transported him to the emergency room.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend the status of the license be changed to a six-month provisional license.

Vanita C. Bouldin — Date: 11/09/2021
Licensing Consultant

Approved By:



Ardra Hunter — Date: 11/09/2021
Area Manager