GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 8, 2022

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

RE: License #: AS380011360
Investigation #: 2022A0007026
Napoleon Rd 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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 (313) 456-0380.

Sincerely,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380011360
Investigation #:	2022A0007026
Complaint Receipt Date:	06/29/2022
Investigation Initiation Date:	06/29/2022
Report Due Date:	08/28/2022
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:	Napoleon Rd Home
Facility Address:	7722 Napoleon Road Jackson, MI 49201
Facility Telephone #:	(517) 250-7927
Original Issuance Date:	05/04/1992
License Status:	REGULAR
Effective Date:	09/23/2020
Expiration Date:	09/22/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Complaint alleges facility neglects to provide proper care.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/29/2022	Special Investigation Intake - 2022A0007026
06/29/2022	Special Investigation Initiated - Letter
06/29/2022	APS Referral Made.
06/29/2022	Inspection Completed On-site - Unannounced - Face to face contact with Ms. Hall, Home Manager, Employee #1, APS Worker #1, Resident A, Resident B, Resident C, Resident D, Resident E and Resident F.
06/29/2022	Contact - Telephone call made to Ms. Howard, Administrative Staff.
06/30/2022	Referral - Recipient Rights - Made.
06/30/2022	Contact - Telephone call received from Ms. Griffes, Office of Recipient Rights.
07/22/2022	Contact - Telephone call received from APS Worker #1. Discussion.
08/10/2022	Contact - Telephone call made from Ms. Howard, Administrative Staff.
08/25/2022	Inspection Completed On-site - Unannounced - Face to face contact with Employee #2 and residents.
08/25/2022	Inspection Completed On-site - Unannounced - Brown Street AFC Home - AS380016315

08/25/2022	Contact - Telephone call made - Ms. Hall, Interview.
08/25/2022	Contact - Telephone call made Mr. Tripp, Interview.
08/25/2022	Contact - Telephone call made Mr. Combs, Licensee Designee. I left a message regarding the exit conference.
08/25/2022	Exit Conference conducted with Mr. Combs, Licensee Designee.

ALLEGATIONS:

Complaint alleges facility neglects to provide proper care.

INVESTIGATION:

As a part of this investigation, I reviewed documentation, and the additional information was noted:

> Medical Staff #1 arrived at the home around 2:00 p.m. to provide wound care to Resident A. Resident A was found lying on his side, covered in crumbs, and without proper bedding or clothing on. Resident A stated he had been left on his left side all night and was not turned once. In addition, that he was not changed or given any food or drink, since a cookie he was given before bed. Resident A's mouth was very dry, to the point it was showing in Resident A's voice. The only article of clothing Resident A was wearing was a soiled brief. Resident A stated he had not been washed, had his teeth brushed, nor did he have his medications for the day yet. Medical Staff #1 has educated the home manager of this AFC home multiple times that Resident A requires turning every 2-hours, even through the night. Medical Staff #1 has also educated the manager twice on proper care and maintenance of the suprapubic catheter. Medical Staff #1 often finds the bag on floor which it should not be. When Medical Staff #1 announced these findings to the home manager, she becomes very defensive and yells.

On June 29, 2022, I conducted an unannounced on-site investigation and made face to face contact with Ms. Hall, Home Manager, Employee #1, APS Worker #1, Resident A, Resident B, Resident C, Resident D, Resident E and Resident F. When I arrived at the facility, things appeared to be in disarray. There was a mattress in the front yard by the garbage. There were items strewn about on the front porch. In the home, there were multiple boxes and items stacked in the activity room. There were papers, pencils and other items strewn about on the floor in the dining room. There were clothes, shoes, and other items on the ground in the back yard of the facility. I spoke with the home manager, Ms. Hall and inquired why the facility was in this condition. She informed me that they had just returned from the hotel as the well

water had to be treated after the recent environmental health inspection. She stated that Resident F had just dumped his basket of papers etc. on the floor. Once this was brought to her attention, Ms. Hall picked up the items strewn about in the facility. While at the facility, I reviewed Resident A's file. It was noted that he is his own guardian. His mother, Family Member A, is a support person. He is diagnosed with Cerebral Palsy, Mental Impairments and has limited use of his arms and legs.

I also observed a baby monitor located outside of the staff office. There was also a baby monitor located in Resident A's room. The monitor was disconnected during the interview with Resident A.

APS Worker #1 and I interviewed Resident A in his bedroom. Resident A informed us that he wanted to go to another home, within the corporation. He expressed concern as he did not want to go to a home that was worse than where he was currently residing. He stated that his mother, Family Member #1 got into an argument with Ms. Rodriguez, Administrative Staff. Resident A stated that his mother was concerned and wanted him to be taken better care of. Resident A stated that he did not like living in this home and things have changed since Home Manager A left the home. He stated that his mother was mad that Home Manager A and Staff A were no longer working in the home.

During the interview, Resident A also explained that he has multiple wounds on his hips from his wheelchair. Resident A informed us that there has been an issue with the manufacture, and it is taking forever for him to be fitted for a new wheelchair. Resident A stated that he has a visiting nurse, who provides care on a regular basis. I inquired if he is turned every two hours, and he replied "sometimes." Resident A stated that his care depends on who the worker is on shift that day. Resident A reported that his catheter bag is sometimes taken care of properly. I inquired if the staff regularly brush his teeth. He stated that staff do not remember to brush his teeth in the morning. He reported that his teeth had not been brushed that day. He reported to be provided meals regularly. Resident A was prescribed an antibiotic to treat his urinary tract infection. He stated he gets medications regularly, morning and night. He did not confirm that staff were not administering his medications as prescribed. Resident A reported that he was concerned that he might be diabetic. Resident A also recalled that one staff told him (Resident A) to stop bossing him around. Resident A stated, "I say, please get me a drink." He stated that he is often thirsty. Resident A has spoken with Family Member A about this, and he will need a blood test to determine if he is diabetic. During the interview, his lips appeared to be dry. He stated that he was thirsty at that time. We informed staff that he needed something to drink and Chapstick for his lips.

After interviewing Resident A, we attempted to interview Ms. Hall, Home Manager, however, it was clear that she was overwhelmed. She reported that she had been the manager since September, and she was still learning the job. She expressed concern as six staff had recently quit. She also stated that it was stressful caring for

the residents in the hotel as they were not used to that setting. Ms. Hall reported to work long hours, that she was exhausted, and it appeared that she was about to cry.

After leaving the facility, I called and spoke to Ms. Howard, Administrative Staff. I informed her of the conditions of the facility, and we also discussed my concerns as related to the investigation and resident care not being provided.

On June 30, 2022, I spoke with Ms. Griffes, Office of Recipient Rights. She informed me that Resident A wants to move to Brown Street Home. In the meantime, the administrative staff would be stopping by to ensure that Resident A is being cared for until he is relocated. Ms. Griffes also informed me that on June 1st, 2022, ORR also conducted an investigation and substantiated allegations that Resident A was not being turned; and as a result, he had bedsores (on his ankles). They also received information that Mr. Tripp, Direct Care Staff, refused to turn Resident A and called him a "crybaby."

On July 22, 2022, I spoke with APS Worker #1. He informed me that he would be substantiating the case. He will be visiting Resident A at the Brown Street home and informing him of this information and that the case would be closed.

On August 10, 2022, Ms. Howard contacted me and informed that things had been challenging, including staffing issues. She also informed me of the names of the facility staff who had passed away due to COVID-19. She informed me that Mr. Combs helped to pay for the funeral services of both staff members who passed away.

On August 25, 2022, I conducted an unannounced on-site investigation at the facility. I made face to face contact with Employee #2 and the residents. Resident A no longer resides in this home as he relocated. The home appeared to be calm and was appropriate. The baby monitor and mattress had been removed. I requested to review Resident A's files. Employee #2 made a few phone calls and then searched the garage. She returned with tub of files and documents. She searched for the requested documents but was unable to locate them. There was one outdated document located in the box.

I then went to the Brown Street Home; the next facility Resident A was moved to. Resident A no longer resides in that facility. I reviewed Resident A's file, but it did not contain any previous case history, as related to care provided during June and July of 2022.

On August 25, 2022, I spoke with Ms. Hall. She informed me that she still works for the corporation but in a different home. I inquired about the bedsores and Ms. Hall stated that had been an ongoing problem, prior to her assignment to the home. She stated they provided Resident A with the care he required. Ms. Hall stated he was turned every two hours and his teeth were brushed twice a day, after medications were passed. I inquired about the interaction with Medical Staff #1, and if she had

brought it to her attention about the care Resident A was receiving. Ms. Hall stated that she (Medical Staff #1) did once, and Ms. Hall showed her the data. Ms. Hall stated that she also tried to explain to Medical Staff #1 that they do reposition Resident A every two hours, and they only thing they had to prove that they were turning him was the documentation. Ms. Hall confirmed that there was one incident in which she had conflict with Medical Staff #1. Ms. Hall stated when they had to take the residents to the hotel so the water could be flushed, she left her phone in the car. She was attending to the residents while the other staff was unloading the van. Medical Staff #1 was supposed to be there to visit Resident A, but they were at the hotel. Medical Staff #1 was calling Ms. Hall but her phone was in the car. According to Ms. Hall, once Medical Staff #1 located them, she came to the hotel, and she was "rude." Medical Staff #1 questioned Ms. Hall as to why she did not have her phone and told her she was unprofessional. Ms. Hall stated that she said she was sorry but was so overwhelmed with trying to care for the residents at the hotel.

Regarding Mr. Tripp calling Resident A "crybaby," Ms. Hall stated that it was around June 25, 2022, when she heard about the allegations. After returning from the community with his mom, Family Member A, Resident A told Family Member A about the name calling. Ms. Hall stated that once it was brought to their attention, they spoke with Mr. Tripp, Direct Care Staff. Ms. Hall explained that sometimes Resident A will whine, when he thinks no one is paying attention to him. Mr. Tripp told them that Resident A was whining, and he went to see about him. When he entered the room, Resident A made a comment about no one wanting to come back to his room because he whines like a cry baby. Ms. Hall reported that Mr. Tripp did not say anything back or comment about what Resident A said. Ms. Hall stated that Mr. Tripp is quiet around her but that she had never heard him call any residents names.

On August 25, 2022, I interviewed Mr. Tripp, Direct Care Staff. He stated that he spoke with Lifeways a few weeks ago regarding these same allegations. He stated that he was not sure where it came from, but he did not call Resident A "crybaby." Mr. Tripp stated he was helping Resident D and he heard Resident A crying. He went into his room and asked why he was crying, and Resident A said something about his catheter. Mr. Tripp stated he had on gloves, due to assisting Resident D, and he could not use the same gloves. He told Resident A that Employee #3 would be right back. Mr. Tripp stated he never called Resident A "crybaby."

I inquired if he refused to turn Resident A. Mr. Tripp stated that Ms. Hall was verbally told by the doctor that Resident A could not lay on his right side because the wound would not heal. Mr. Tripp stated that he told Resident A he could not lay on that side, but he did not refuse to turn him. Regarding ADLs, Mr. Tripp stated that he would bathe Resident A, and that his teeth were brushed each morning when he woke up. He stated he could not confirm if Resident A's teeth were brushed at night after meds because he typically did not work that shift.

On August 25, 2022, I conducted the exit conference with Mr. Combs. We discussed the findings and my recommendations. He agreed to submit a written corrective action plan to address the established violations.

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:	Resident A reported concerns regarding the treatment he was receiving in the home. I inquired if he is turned every two hours, and he replied “sometimes.” Resident A stated that his care depends on who the worker is on shift that day. Resident A reported that his catheter bag is sometimes taken care of properly. I inquired if the staff regularly brushed his teeth. He stated that staff do not remember to brush his teeth in the morning. He reported that his teeth had not been brushed that day. During the interview, Resident A’s lips appeared to be dry. He stated that he was thirsty at that time. The staff reported that Resident A’s teeth are brushed; however, there was no documentation provided to support this information. Resident A receives treatment for wound care. The staff report to turn Resident A as required. However, there was no documentation or data sheets provided to support this information. According to Ms. Griffes from ORR, a case was recently substantiated due to Resident A not being turned and having bedsores. APS Worker #1 substantiated the allegations of neglect. Based on the information gathered during this investigation and provided above, it is concluded that there is a preponderance of the evidence to support the allegations that Resident A has not received proper care; and he was not treated with dignity and his personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On June 29, 2022, when I arrived at the facility, things appeared to be in disarray. There was a mattress in the front yard by the garbage. There were items strewn about on the front porch. In the home, there were multiple boxes and items stacked in the activity room. There were papers, pencils and other items strewn about on the

floor in the dining room. There were clothes, shoes, and other items on the ground in the back yard of the facility. I spoke with the home manager, Ms. Hall and inquired why the facility was in this condition. She informed me that they had just returned from the hotel as the well water had to be treated after the recent environmental health inspection. She stated that Resident F had just dumped his basket of papers etc. on the floor. Once this was brought to her attention, Ms. Hall picked up the items strewn about in the facility.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	According to Ms. Hall, they had just returned to the facility and were in the process of settling and returning to the home. Excluding the multiple boxes and items stacked in the activity room, other conditions of the facility were observed to be in disarray. Based on the information gathered during this investigation and provided above, it is concluded that there is a preponderance of the evidence to support the allegations that the housekeeping standards did not present in a comfortable and orderly manner.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On June 29, 2022, I observed a baby monitor located outside of the staff office. There was also a baby monitor located in Resident A's room. To ensure that Resident A could speak freely, and ensure privacy, the monitor was disconnected during the interview with Resident A.

It should be noted that video and audio recording or monitoring devices are only allowed in the common areas of the home, with posted notification to all occupants. In addition, documentation of written approval shall be contained within the resident record.

During the on-site inspection, I did not observe any posted notification of the monitoring device.

On August 25, 2022, during the on-site investigation, I noted that the baby monitor had been removed.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	On June 29, 2022, I observed a baby monitor located outside of the staff office. There was also a baby monitor located in Resident A's room. Based on the information gathered during this investigation and provided above, it is concluded that there is a preponderance of the evidence to support the allegations that Resident A was not treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On August 25, 2022, I requested to review Resident A's files. Employee #2 made a few phone calls and then searched the garage. She returned with tub of files and documents. She searched for the requested documents but was unable to locate them. There was one outdated document located in the box.

I then went to the Brown Street Home; the next facility Resident A was moved to. Resident A no longer resides in that facility. I reviewed Resident A's file, but it did not contain any previous case history, as related to care provided during June and July of 2022.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from a home.
ANALYSIS:	The resident records for Resident A were not kept on file, and available for review, for two years after the date of his discharged from the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, I recommend that the status of the license remains unchanged.

Mahtina Rubritius 08/25/2022

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Mahtina Rubritius Date
Licensing Consultant

Approved By:

A. Hunter 09/08/2022

_____

Ardra Hunter Date
Area Manager