GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 16, 2022

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

RE: License #: AS380016315
Investigation #: 2022A0007032
Brown Street Home

Dear Mr. Combs, Jr.:

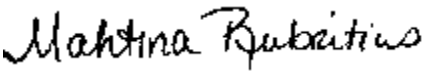
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- How continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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

Enclosures

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

I. IDENTIFYING INFORMATION

License #:	AS380016315
Investigation #:	2022A0007032
Complaint Receipt Date:	08/11/2022
Investigation Initiation Date:	08/11/2022
Report Due Date:	10/10/2022
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:	Brown Street Home
Facility Address:	1203 Brown Street Jackson, MI 49203-2732
Facility Telephone #:	(517) 250-7930
Original Issuance Date:	03/24/1995
License Status:	REGULAR
Effective Date:	05/24/2022
Expiration Date:	05/23/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Allegations that on August 5, 2022, Resident A was observed with a mark on her face. Allegations that Home Manager #1, hit her.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/11/2022	Special Investigation Intake - 2022A0007032
08/11/2022	Special Investigation Initiated - On Site - Unannounced - Face to face contact with Employee #3, Employee #6, Resident A, Resident B, Resident C, Resident D, and Resident E.
08/16/2022	Contact - Telephone call made to APS Worker #1. Discussion.
08/25/2022	Inspection Completed On-Site - Unannounced - Face to face contact with staff, Resident A, and other residents. Resident files reviewed see SIR # 2022A0007026 for additional information.
09/12/2022	Contact - Telephone call received from APS Worker #1. Discussion.
09/13/2022	Contact - Face to Face contact with APS Worker #1. Discussion.
09/21/2022	Contact - Telephone call made to Employee #5 (QI Manager), Interview.
09/21/2022	Contact - Telephone call received from ORR Officer #1. Discussion.
09/26/2022	Contact - Face to Face contact with APS Worker #1. Discussion.
09/26/2022	Contact - Document Received - Copy of Police Report 497-19686-22.
09/28/2022	Contact - Telephone call made to Jackson County Guardian A. Discussion.
10/07/2022	Contact - Document Received - Photo of Resident A.

10/13/2022	Inspection Completed On-Site - Unannounced - Face to face contact with Home Manager #2, Resident A, Resident B, Resident C, Resident D, and Resident E.
10/18/2022	Contact - Telephone call made to Employee #1 Message left. I requested a returned phone call.
10/18/2022	Contact - Telephone call received from Employee #1. Interview.
10/19/2022	Contact - Telephone call made to Employee #1. She was busy and would call back shortly.
10/19/2022	Contact - Telephone call received from Employee #1. Employee left a message.
10/20/2022	Contact - Telephone call made to Employee #1. She is unavailable and will call back later.
10/20/2022	Contact - Telephone call made to Compliance Officer #1.
10/20/2022	Contact - Telephone call received from Employee #1. Follow up Interview.
10/21/2022	Contact - Telephone call made - Interview with Ms. Howard, Administrative Staff.
10/25/2022	Contact - Telephone call made - Interview with Ms. Howard, Administrative Staff.
10/25/2022	Contact - Telephone call made - Interview with Employee #6.
10/26/2022	Contact - Telephone call made - Interview with Employee #1.
10/27/2022	Contact - Telephone call made to APS Worker #1. Copy of Report Requested.
10/27/2022	Contact - Telephone call made to ORR Officer #1.
10/27/2022	Contact - Document Sent email to ORR Officer #1. Copy of Report Requested.
10/27/2022	Contact - Document Received - Copy of Report from ORR. I was unable to review the document as submitted.

10/27/2022	Contact - Telephone call made to ORR Officer #1. Regarding the report.
10/27/2022	Contact - Document Sent - Email to ORR Officer #1. The report has not been received.
11/03/2022	Contact - Document Sent - Email to ORR Officer #1. I requested a status update regarding the report.
11/03/2022	Contact - Document Received - Email from ORR Officer #1. The report has been resent.
11/03/2022	Contact - Document Received - Copy of ORR Report.
11/03/2022	Contact - Document Received - Information from APS. Copy of report.
11/7/2022	Contact – Telephone call made to Mr. Combs, Licensee Designee, to conduct the exit conference. No answer.
11/07/2022	Contact - Document Sent - Email to Mr. Combs, Licensee Designee. I requested a returned phone call to conduct the exit conference.

ALLEGATIONS:

Allegations that on August 5, 2022, Resident A was observed with a mark on her face. Allegations that Home Manager #1, hit her.

INVESTIGATION:

As a part of this investigation, I reviewed the incident report authored by Employee #1. Employee #1 documented that on August 5, 2022, at 7:45 a.m., after morning medication pass, Resident A asked for a cigarette. Employee #1 saw Resident A's face while sitting next to Home Manager #1. Home Manager #1 stated that Resident A must have scratched herself, and Employee #1 assumed that it was true. Employee #1 documented that the mark was "thin and fresh." The next day, Resident A told her that Home Manager #1 hit her. Resident A requested an aspirin.

Employee #2 documented that on August 5, 2022, during 3rd shift, Resident A came out to check the time, as usual. Employee #2 noticed that her eye was bruised. Employee #2 asked her what happened and Resident A informed that Home Manager #1 hit her. Employee #2 documented that she didn't know what to say.

Employee #2 asked Resident A if she was okay, and she said it hurt. Resident A was given an aspirin and she went back to sleep.

I reviewed an incident report authored by Employee #5 and the following was noted: Employee #5 documented that on August 6, 2022, at 9:25 a.m., Home Manager #1 called her to inform that Employee #1 was not at the home and that Employee #4 was asleep in the home, while residents were present. Employee #5 remained on the phone with Home Manager #1, while she was in the home, and assisted Resident B with getting ready to leave on a family outing. Home Manager #1 remained in the home until Employee #1 returned. This information was reported to QI and Cooperate Compliance.

Employee #3 documented that on August 7, 2022, at 6:30 a.m., she was standing at the medication cart when Resident A walked by, going to the kitchen. As Resident A was leaving the kitchen, Employee #3 stopped Resident A, to get a closer look, as she noticed a mark on her face by her eye. Employee #3 noticed a bruise in the corner of Resident A's right eye and by her nose. When asked what happened, Resident A stated that someone hit her in the eye. When asked who, Resident A stated that she could not say because they would be mad at her. Employee #3 told Resident A not to worry about that, and again asked who hit her. Resident A then informed that Home Manager #1 hit her yesterday.

Home Manager #1 documented that on August 7, 2022, she received a text message at 6:42 a.m., and was asked if she hit Resident A in the face. Home Manager #1 replied "no." Home Manager #1 was informed that Resident A had a bruise on her face, and she said Home Manager #1 caused it. A picture of the bruise was sent to Home Manager #1. She reported that it looked very fresh. Home Manager #1 told the staff member to write a report documenting what Resident A stated. Home Manager #1 documented that the last day she worked was August 5, 2022, before this incident. It was also noted on the incident report that Resident A was seen at Medical Center #1 on August 8, 2022, for an eye injury.

Employee #4 documented that on August 7, 2022, at 2:00 p.m., when she arrived for her shift, she was completing rounds, and she noticed that Resident A had a bruise on her right eye. She asked Resident A what happened and Resident A said that Home Manager #1 hit her. Resident A also stated that she did not know why Home Manager #1 didn't like her. Employee #4 followed-up, restating the question, and Resident A again stated that Home Manager #1 hit her. Employee #4 asked Resident A that if she reported the incident, would she tell them the same thing and Resident A said "yes." The information was reported. ORR was also contacted and began an investigation.

The medical records reflected that Resident A was seen at Medical Center A on August 8, 2022, with complaints that someone hit her in the face two days ago. Resident A also complained of right eye bruising and nasal pain.

On August 11, 2022, I conducted an unannounced on-site investigation and made face to face contact with Employee #3, Employee #6, Resident A, Resident B, Resident C, Resident D, and Resident E.

I interviewed Resident A. Resident A informed me that she was hit in the forehead, jaw, and nose by Home Manager #1. She stated that she "did not know what's the matter with [Home Manager #1]." When asked if she had any injuries from being hit, Resident A pointed to her right eye. I did not observe any injuries on Resident A's face.

It was somewhat difficult to follow what Resident A was describing. I asked what happened. Resident A did not know what happened leading up to her being hit. Resident A said she was in her room and that her roommate, Resident C, said she saw her (Resident A) fall. I asked what happened after she was hit, and Resident A stated, "I fell on the floor."

Resident A confirmed that she went for medical treatment, but she was not sure if it was to have her eye examined. Resident A reported that she did not like it living in this home (no other details were provided).

I then interviewed Resident C, who shared a room with Resident A. Resident C reported that no one in their room has been hit. She stated that she has not seen any staff hit residents. Resident C reported to see the mark on the right side of Resident A's face, but Resident A didn't tell her what happened. Resident C stated that Resident A's face was bruised. Resident C stated that she did not see Resident A fall. Resident C reported that things are fine in the home and that she feels safe in the home.

On August 16, 2022, I interviewed APS Worker #1. He made face to face contact with Resident A and observed faint discoloration around her eye. In addition, that above her eyebrow it looked like dry skin. There was a little mark in the corner of her right eye. During his interview with Resident A, she could not give him specifics as to what occurred. He will interview the roommate as well. He will be returning to the home to complete follow-up interviews.

On September 12, 2022, I spoke with APS Worker #1. He reported that Resident A appeared to be happy. She told the same story, that she had an injury to her eye. He also spoke with ORR Officer #1 regarding the investigation. He has concerns about Home Manager #1. The police are investigating, and this case will be sent to the prosecutor. Charges will be pressed.

On September 21, 2022, I interviewed Employee #5, who also has the role of QI Manager. She informed me that Resident A was doing well. She also stated that she has known Home Manager #1 for a very long time and it's not in her character (to hit a resident). Employee #5 #1 stated that this was retaliation. Employee #5 stated that Home Manager #1 stopped by the facility on Saturday, August 6, 2022, to drop off a

schedule. When she arrived, she discovered that the residents were awake by themselves. Employee #1 was gone, and Employee #4 was asleep. Home Manager #1 sent her (Employee #5) a picture of Employee #4 sleeping. Employee #5 stated it was good that she (Home Manager #1) “did a pop-up,” because she was able to assist Resident B with getting ready to leave, as her family member had arrived.

On September 21, 2022, I received a phone call from ORR Officer #1. She informed me that Resident A was examined at Medical Center A. A CT scan was also completed, which was negative. Two doctors observed Resident A and had concerns. The police are also investigating, they interviewed Resident A and she told the police she was assaulted. The incident occurred earlier in the week and staff kept saying it Saturday, because Home Manager #1 was in the home dropping off the schedule. Staff also brought up the concern that this may have been reported in retaliation. During her investigation, she (ORR Officer #1) also interviewed other staff who reported that Home Manager #1 was kind of pushy and aggressive. ORR Officer #1 reported that she substantiated the allegations.

As a part of this investigation, I reviewed the incident report 497-19686-22 authored by Officer #1. It was noted that Resident A has been diagnosed with schizophrenia. On August 10, 2022, Officer #1 interviewed Resident A and she advised that Home Manager #1 assaulted her. Resident A could not tell him why it happened, and he was unable to understand her when she spoke about the events leading up to the assault. He documented that Resident A had slight bruising on her right eye. No other injuries were seen or mentioned.

Officer #1 interviewed Home Manager #1. She advised that she wasn’t at the residence the evening of the alleged assault. She denied ever putting her hands on Resident A. Home Manager advised she thinks one of her co-workers was upset with her because she caught her sleeping and advised management staff of the situation and that is where the alleged assault was coming from. He also interviewed Employee #3 (witness), Employee #5 and Employee #6 (other subjects).

Employee #3 reported that while conducting her normal duties, she observed a bruise on Resident A. She informed management of the injury and Resident A was taken to Medical Center A for any unseen injury. An internal report was also completed.

Note: According to the AFC Incident Report, Employee #3 documented that she noticed the injury on August 7, 2022.

Employee #6 was interviewed by Officer #1 and advised that he worked a double (2 p.m. to 6:00 a.m.) the day before (on August 6, 2022) Employee #3 discovered the injury. He did not observe Resident A to have injuries during that time and none when she went to sleep. He advised that Home Manager #1 was not at the home during his shift.

Resident A was given a business card with an incident number and advised her how to seek charges. The disposition of the case is closed.

On October 7, 2022, I interviewed Home Manager #1. She informed me that she no longer works for CCH as there was a rights violation substantiated against her. Home Manager #1 stated there was no incident and no problem with Resident A. She informed that she worked on Friday, August 5, 2022, on first shift from 6:00 a.m. to 2:00 p.m. There were no incidents or problems during that shift. On Saturday, August 6, 2022, she went to the home to drop off the schedule. At first, she was going to drop the schedule off as when she pulled up, Resident B was outside. Resident B asked for assistance with her hearing aids, and Resident B reported that neither staff, (Employee #1 and Employee #4) knew how to help her. When Home Manager #1 entered the home, she observed that Employee #1 was gone, and Employee #4 was asleep in the chair. A photo was taken. Home Manager #1 then assisted Resident B with her hearing aids and told her to go outside so that her family would not see Employee #4 sleeping. Resident B forgot her cigarettes, so Home Manager #1 got them for her. She then went outside and spoke to Resident B's family, then they left. Employee #1 pulled up. Home Manager #1 expressed concern as Employee #1 left the home and Employee #4 was sleeping, while the residents were awake. Employee #1 expressed concern as it seems to be a problem when she works with Employee #4, so she told Home Manager #1 to go in and wake her up. When they entered the home, Employee #1 went to the left so that she would not be visible to Employee #4. Home Manager #1 called Employee #4's name four times before she finally woke up. Employee #4 was speaking incoherently as she was awakened. She then stood up, walked into the kitchen, turned around came and sat down, back in the chair. Once Home Manager #1 left the home, a photo (of staff sleeping on the job) was sent to Corporate Compliance Officer #1. This information was sent to him that morning. At 2:30 p.m., Home Manager #1 received a call from Employee #4. Employee #4 says that Corporate Compliance Officer #1 called the home (at the beginning of 2nd shift) and asked who worked 1st shift because he got a picture of them sleeping on the job. Home Manager #1 did not say anything about the photo being sent. Home Manager #1 stated that Corporate Compliance Officer #1 was speaking to Employee #4, who was working a double shift that day (and she was the staff member who was sleeping, during 1st shift).

Note: A review of the staff schedules documented that Employee #4 worked a double shift on August 6, 2022.

Home Manager #1 stated that by Sunday morning, August 7, 2022, she received a text message saying that Resident A had a mark, and that Home Manager #1 did it. Home Manager #1 stated that she knew she didn't cause the mark and told the staff to document what Resident A reported. Home Manager #1 stated that at no time did she hit Resident A, and she did not know where she got the injury. A picture of the injury was sent to her, and the injury looked fresh. It looked like a scratch. Home Manager #1 later sent me the picture for the file. During the interview, I informed Home Manager #1 that I reviewed the incident report, which documented that

Employee #1 asked Home Manager #1 about the scratch. She confirmed that Employee #1 did ask her, but she did not know how Resident A got the scratch because she didn't see what happened. She could not recall which day Employee #1 asked her about the scratch, but believed it could have been on Saturday, August 6, 2022.

Home Manager #1 stated that on Sunday, (August 7, 2022), during second shift, Recipient Rights was contacted.

Home Manager #1 stated that no one wrote up an incident report all weekend, and the incident reports were not written until after Resident A went to the doctor for her eye to be examined. They asked Resident A what happened, and Resident A said that [Home Manager #1] did it. Home Manager #1 stated that the staff had all weekend long to coach Resident A.

On October 13, 2022, I conducted an unannounced on-site investigation and made face to face contact with Home Manager #2, Resident A, Resident B, Resident C, Resident D, and Resident E.

I interviewed Resident B. She confirmed that the staff did not know how to help with her hearing aids, so she asked for assistance from Home Manager #1. Resident B did not confirm that staff were sleeping while on shift. Resident B reported that staff treat her well. She also stated that she really liked the new home manager (Home Manager #2).

I interviewed Resident C. She did not confirm that staff have been observed sleeping while on duty.

On October 18, 2022, I spoke with Employee #1. The information she reported was consistent with what she documented on the incident report. In addition, Employee #1 stated that Resident A also told everyone that Home Manager #1 pushed her down and punched her in the eye. Employee #1 stated that she did not know why there was an investigation, because Resident A "is in her right mind."

I attempted to follow-up with Employee #1 a few times to finish the interview; however, she reported to have other obligations and requested to talk later.

On October 20, 2022, I interviewed Compliance Officer #1. He informed me that regarding the assault, Lifeways substantiated the case and Home Manager #1 has been terminated.

During the interview, I inquired if he received information regarding staff sleeping on the job. He stated that on Saturday morning (August 6, 2022), he received a picture of a staff member sleeping. There was no additional information provided at that time (name of staff, facility etc..). He stated that it was not until after he called the number back that he was informed who the picture was from and the situation. He

also requested that an incident report be completed, and staff were instructed to contact ORR. He did not receive an incident report regarding this matter. Compliance Officer #1 also stated that Ms. Howard, Administrative Staff, was the QI individual, who would have handled personnel issues. In addition, since Employee #1 left shift, she was moved to a different home and the staff (Employee #1 and Employee #4) have been separated. There have not been any issues since the separation.

On October 20, 2022, I conducted a follow-up interview with Employee #1. She stated that she did not know why I needed to know details and investigate the case, as Resident A already told everyone what happened. I asked her to tell me what happened prior to her discovering the scratch on Resident A's face. Employee #1 stated that Home Manager #1 hollered at Resident A everyday to get her shoes on or to fix her clothes. Employee #1 stated that while she was passing medications, Home Manager #1 was in the back with Resident A and was "back there hollering at her." When Resident A asked for a cigarette, Employee #1 noticed the scratch on her face. Employee #1 said she asked Home Manager #1 how she (Resident A) got the scratch on her face and Home Manager #1 replied that she probably scratched herself. Employee #1 stated that at first, she did think that maybe Resident A scratched herself. However, the next day, Resident A told her that Home Manager #1 hit her in the face and knocked her down. Employee #1 stated that Resident A had bruises on her arms as well.

On October 25, 2022, I spoke with Ms. Howard, Administrative Staff. I inquired how she was notified regarding the allegations. Ms. Howard stated that she was notified via incident report from staff. This started on Saturday, August 6, 2022, when Compliance Officer #1 received a call regarding staff sleeping on the job. Home Manager #1 stayed in the home with the residents until they were able to wake up the staff person. Compliance Officer #1 then called back to the facility and inquired about who was sleeping on the job. He was talking to the staff (Employee #4) who had been asleep. Employee #4 then called Home Manager #1 and said that Resident A said that she (Home Manager #1) hit her. Home Manager #1 instructed staff to complete an incident report, documenting what Resident A stated. On Monday, August 8, 2022, Ms. Howard received a call from ORR, and they informed that Home Manager #1 had to be removed from the schedule pending the investigation.

According to Ms. Howard, Resident A's roommate (Resident C) told staff that Resident A fell, and that Resident A should tell the truth about what happened. Ms. Howard also stated that Resident A shuffles her feet when she walks. In addition, that Resident A is always rubbing her eyes.

On October 25, 2022, I interviewed Employee #6. He confirmed that he did not observe Resident A to have injuries (during the time in question) and none when she went to sleep. Employee #6 stated that when he heard that someone had hit Resident A, he sat her down and asked her who hit her. She informed that she did

not want to tell because she would get into trouble. Employee #6 explained that she would not get into trouble. Resident A then said that Home Manager #1 hit her. He asked why and Resident A said nothing. He again tried to gather information about what happened.

Employee #6 reported that during the interview with law enforcement, Resident A stated that Home Manager #1 picked her up and dropped her on the floor. Employee #6 informed Officer #1 that Resident A did not mention any of that information when he inquired about what happened.

Employee #6 informed that he wasn't sure what happened but based on the events, in his opinion, this may have been a set up (against Home Manager #1).

On October 26, 2022, I contacted Employee #1 with follow-up questions. I inquired about what transpired leading up to Resident A reporting to be hit, and she stated that people started asking her (Resident A) what happened. That's when Resident A reported to be knocked down, grabbed, and hit in the eye. Employee #1 stated she saw a mark that morning, and the next day it was worse and swollen. Employee #1 stated that Home Manager #1 was mean to Resident A, and she would always yell at her to fix her clothes.

As a part of this investigation, I reviewed the investigative report authored by ORR Officer #1. During her investigation, it was discovered that the incident occurred during the week of August 1, 2022, not August 6, 2022. ORR Officer #1 also interviewed Dr. #1. It was noted that Dr. #1 reported that the "injury was a result of being physically hit and there is no other way that she [Resident A] could have gotten the injury." Dr. #1 reported that the injury would cause pain. The allegations were substantiated for Abuse – Class II Non-Accidental against Home Manager #1.

I also reviewed the report authored by APS Worker #1. It was noted that the allegations were substantiated; and that Home Manager #1 had been terminated, removing the risk of harm to Resident A.

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:	Employee #1 documented that on August 5, 2022, at 7:45 a.m., after morning medication pass, Resident A asked for a cigarette. Employee #1 saw Resident A's face while sitting next to Home Manager #1. Home Manager #1 stated that Resident A must have scratched herself, and Employee #1 assumed that it was true. Employee #1 documented that the mark was "thin and fresh." The next day, Resident A told her that Home Manager #1 hit her. Resident A requested an aspirin. Employee #1 stated that Home Manager #1 was mean to Resident A, and she would always yell at her to fix her clothes. Employee #2 noticed that Resident A's eye was bruised. Employee #2 asked her what happened and Resident A informed that Home Manager #1 hit her. Employee #3 noticed a bruise in the corner of Resident A's right eye and by her nose. When asked what happened, Resident A stated that someone hit her in the eye. Resident A eventually informed that Home Manager #1 hit her yesterday. Employee #4 documented that she noticed that Resident A had a bruise on her right eye. She asked Resident A what happened and Resident A said that Home Manager #1 hit her. Resident A also stated that she did not know why Home Manager #1 didn't like her. Home Manager #1 stated there was no incident and no problem with Resident A. Home Manager #1 stated that at no time did she hit Resident A, and she did not know where she got the injury. Home Manager #1 reported that the allegations were made in retaliation against her after Employee #1 and Employee #4 were caught not following protocols. Officer #1 interviewed Resident A and she advised that Home Manager #1 assaulted her. Resident A could not tell him why it happened, and he was unable to understand her when she spoke about the events leading up to the assault. He documented that Resident A had slight bruising on her right eye. No other injuries were seen or mentioned. During the interview with Resident A, she informed me that she was hit in the forehead, jaw, and nose by Home Manager #1. Resident A stated that she "did not know what's the matter with [Home Manager #1]." When asked if she had any injuries from

	being hit, Resident A pointed to her right eye. I did not observe any injuries on Resident A's face. APS Worker #1 substantiated the allegations against Home Manager #1. According to the report authored by ORR Officer #1, it was noted that Dr. #1 reported that the "injury was a result of being physically hit and there is no other way that she [Resident A] could have gotten the injury." Dr. #1 reported that the injury would cause pain. The allegations were substantiated for Abuse – Class II Non-Accidental against Home Manager #1. Home Manager #1 has been terminated from CCH. While there are some inconsistencies as to when the incident occurred and the situation leading up to the incident, what is clear is that Resident A consistently reported that she was hit by Home Manager #1. Based on the information gathered during this investigation and provided above it's concluded that there is a preponderance of the evidence to support the allegations that Resident A was not treated with dignity and her 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:

Employee #5 stated that Home Manager #1 stopped by the facility on Saturday, August 6, 2022, to drop off a schedule. When she arrived, she discovered that the residents were awake by themselves. Employee #1 was gone, and Employee #4 was asleep.

During the interview with Home Manager #1 it was reported that when she (Home Manager #1) entered the home, she observed that Employee #1 was gone, and Employee #4 was asleep in the chair. A photo was taken.

Once Employee #1 returned to the home, Home Manager #1 expressed concern as Employee #1 left the home and Employee #4 was sleeping, while the residents were awake.

While in the home, Home Manager #1 called Employee #4's name four times before she finally woke up. Employee #4 was speaking incoherently as she was awakened. She then stood up, walked into the kitchen, turned around came and sat down, back in the chair. Once she left the home, a photo (of staff sleeping on the job) was sent to Corporate Compliance Officer #1.

On October 20, 2022, I interviewed Compliance Officer #1. During the interview, I inquired if he received information regarding staff sleeping on the job. He stated that on Saturday morning (August 6, 2022), he received a picture of a staff member sleeping. There was no additional information provided at that time (name of staff, facility etc..). He stated that it was not until after he called the number back that he was informed who the picture was from and the situation. He also requested that an incident report be completed, and staff were instructed to contact ORR. He did not receive an incident report regarding this matter. Compliance Officer #1 also stated that Ms. Howard, Administrative Staff, was the QI individual, who would have handled personnel issues. In addition, since Employee #1 left shift, she was moved to a different home and the staff (Employee #1 and Employee #4) have been separated. There have not been any issues since the separation.

On October 20, 2022, I interviewed Employee #1. She stated that Home Manager #1 allowed her to run down the street all the time to handle a personal matter. Employee #1 stated that she would only be gone for a few minutes. I inquired about what Home Manager #1 stated to her when she arrived at the home on that Saturday (August 6, 2022), and she recalled that Home Manager #1 did say that Employee #4 was sleeping. Employee #1 stated that when she left, Employee #4 was not sleeping. Employee #1 stated that Employee #4 has a history of sleeping on the job and management is aware of the situation.

On October 21, 2022, I interviewed Ms. Howard, Administrative Staff. I inquired if the issue regarding Employee #4 sleeping on the job had been addressed. She stated that Compliance Officer #1 handled the situation. Midnight walk-throughs have also been conducted. Ms. Howard recalled that on one surprise visit, it took staff longer to answer the door; however, they could not prove that staff were sleeping on the job. In addition, that an in-service was completed with staff regarding staying alert while on shift.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services

	specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Home Manager #1 reported that when she (Home Manager #1) entered the home, she observed that Employee #1 was gone, and Employee #4 was asleep in the chair. A photo was taken. While in the home, Home Manager #1 called Employee #4's name four times before she finally woke up. Compliance Officer #1 confirmed that he received a photo of staff sleeping. In addition, since Employee #1 left shift, she was moved to a different home and the staff (Employee #1 and Employee #4) have been separated. There have not been any issues since the separation. Employee #1 stated that when she left, Employee #4 was not sleeping. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that the ratio of direct care staff to residents was inadequate to carry out the responsibilities, as defined in the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

As a part of this investigation, I reviewed the incident report authored by Employee #1. Employee #1 documented that on August 5, 2022, at 7:45 a.m., after morning medication pass, Resident A asked for a cigarette. Employee #1 saw Resident A's face while sitting next to Home Manager #1. Home Manager #1 stated that Resident A must have scratched herself, and Employee #1 assumed that it was true. Employee #1 documented that the mark was "thin and fresh." The next day, Resident A told her that Home Manager #1 hit her. Resident A requested an aspirin. Employee #1 signed this incident report on August 8, 2022.

Employee #2 documented that on August 5, 2022, during 3rd shift, Resident A came out to check the time, as usual. Employee #2 noticed that her eye was bruised. Employee #2 asked her what happened and Resident A informed that Home Manager #1 hit her. Employee #2 documented that she didn't know what to say. Employee #2 asked Resident A if she was okay, and she said it hurt. Resident A

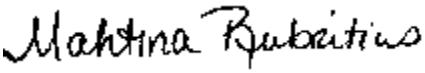
was given an aspirin and she went back to sleep. Employee #2 signed this incident report on August 5, 2022.

The incident reports were submitted to LARA on August 10, 2022.

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: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	Employee #1 completed the incident report, and it was signed on August 8, 2022. Employee #2 completed the incident report, and it was signed on August 5, 2022. The incident reports were submitted to LARA on August 10, 2022. The incident reports were not submitted within the required time frames.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

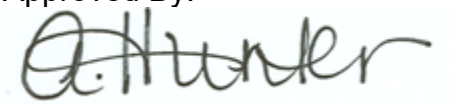
Contingent upon receipt of a very detailed written corrective action plan, I recommend that the status of the license remains unchanged.



11/09/2022

Mahtina Rubritius — Date
Licensing Consultant

Approved By:



11/16/2022

Ardra Hunter — Date
Area Manager