GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 31, 2023

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

RE: License #: AS380306690
Investigation #: 2023A0007020
West Washington Home

Dear Ira Combs, Jr.:

Attached is the Special Investigation Report for the above referenced facility.

This facility is currently on a 1st provisional license, due to quality-of-care violations. A subsequent investigation was conducted in July of 2022 (SIR #2022A0007027), due to additional quality-of-care violations and a recommendation for revocation was submitted.

On February 13, 2023, an administrative hearing was held, the Proposal for Decision was entered on May 12, 2023, and we are currently waiting for the final decision regarding this matter. Therefore, a written corrective action plan is not required, as our recommendations for revocation remains the same.

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) 456-0308.

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 #:	AS380306690
Investigation #:	2023A0007020
Complaint Receipt Date:	06/06/2023
Investigation Initiation Date:	06/07/2023
Report Due Date:	08/05/2023
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:	West Washington Home
Facility Address:	1913 W. Washington St. Jackson, MI 49201
Facility Telephone #:	(517) 250-7937
Original Issuance Date:	08/04/2010
License Status:	1ST PROVISIONAL
Effective Date:	07/06/2022
Expiration Date:	01/05/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Allegations that residents are not getting fed due to food running out. When staff knew there would be a visit, they bought food.	No
Residents are not receiving meds as they should, sometimes not at all.	No
Staff are taking the residents money for their personal use. Residents are being exploited by the staff.	No
They are being mentally and physically abused. (The caller reported these issues to the QR. They prep the residents for conversations with outside entities so that they answer questions in a manner that's favorable for the facility).	No
Allegations of inadequate staffing. (The employees are allowed to split shifts as opposed to working full 8-hour shifts, so they don't have adequate staffing).	Yes
Additional Findings	Yes

III. METHODOLOGY

06/06/2023	Special Investigation Intake - 2023A0007020
06/07/2023	Special Investigation Initiated – Letter APS Referral
06/07/2023	APS Referral - Made.
06/08/2023	Inspection Completed On-site - Unannounced - Face to face contact with APS Worker #1, ORR Worker #1, Ms. Wenman, Home Manager, Employee #1, Employee #2, Resident A, Resident B, Resident C, Resident D, and Resident E.
06/09/2023	Contact - Telephone call received from APS Worker #1. Updated information provided.
06/13/2023	Contact - Telephone call made to Guardian A. Discussion.

06/14/2023	Contact - Document Received - Incident Report.
06/16/2023	Contact - Face to Face - APS Worker #1. Case discussion.
06/20/2023	Inspection Completed On-site - Unannounced - Face to face contact with APS Worker #1, Ms. Wenman, Home Manager, Employee #2, Resident A, Resident B, Resident C, and Resident D.
07/19/2023	Contact - Document Received - Status update from APS Worker #1.
07/19/2023	Contact - Telephone call made to ORR Worker #1. Discussion.
07/20/2023	Contact - Telephone call made to Ms. Howard, Administrative Staff. Discussion.
07/20/2023	Contact - Document Received - Copies of staff schedules.
07/20/2023	Contact - Document Received - Copies of AFC Assessment Plans.
07/21/2023	Inspection Completed On-site - Unannounced - Face to face contact with Ms. Wenman, Home Manager, Employee #4, Employee #2, Resident A, Resident B, and Resident C.
07/24/2023	Contact - Document Received - ORR Summary Report.
07/24/2023	Contact - Telephone call made to Ms. Wenman, x2 Case discussion. Interview with Employee #1.
07/31/2023	Contact - Telephone call made to Ira Combs, Licensee Designee to conduct the exit conference, no answer.
07/31/2023	Contact – Document Sent – Email to Ira Combs, Licensee Designee. I requested a returned phone call to conduct the exit conference.

ALLEGATIONS:

Allegations that residents are not getting fed due to food running out. When staff knew there would be a visit, they bought food.

INVESTIGATION:

As a part of this investigation, I reviewed the complaint, and the following information was noted:

The residents aren't getting adequate meals because the food runs out often, so the complainant has called DHHS to report the food shortage. When the staff was alerted to the visit, they purchased groceries. The residents don't receive their medication as directed, and sometimes not at all. The employees are allowed to split shifts as opposed to working full 8-hour shifts, so they don't have adequate staffing. Residents are being exploited by the staff. The staff takes their money from the residents for their personal use, they're being mentally, and physically abused. These issues were reported to the QR. They prep the residents for conversations with outside entities, so that they answer questions in a manner that's favorable for the facility.

On June 8, 2023, an unannounced on-site investigation was conducted at the facility. This investigation was coordinated with APS Worker #1 and ORR Worker #1. While at the facility, I made face to face contact with Ms. Wenman, Home Manager, Employee #1, Employee #2, Resident A, Resident C, Resident D, and Resident E. Resident B was on an outing and returned later during the on-site visit.

According to Ms. Wenman, they have no issues with getting food. She shops once a week or every other week. Staff will run to the store during the week if they run out of pop or other small items. Ms. Wenman reported to fix a hot breakfast that day, which included eggs, toast, and corned beef hash. On Friday's the residents like to have pizza for dinner. Ms. Wenman informed us that Resident A and Resident C do not have teeth, so she must be mindful of the foods served.

Ms. Wenman reported that they have no issue with running out of money, and some of the residents receive food stamps. Three residents receive $244.00 each month in food stamps, and Resident D's mother buys things in bulk for the facility. Resident D does not qualify for food stamps due to his income. While at the facility, there was plenty of food observed in the refrigerator, cabinets, freezers, and other storage areas of the home.

APS Worker #1, ORR Worker #1, and I interviewed Employee #1. Employee #1 reported to be employed as a direct care worker for almost five years. Regarding the food, she reported that they always have food. Ms. Wenman shops for the food. Employee #1 informed us that the residents are provided with home cooked meals and snacks.

On June 9, 2023, I spoke with APS Worker #1. She informed me that Guardian A is the guardian for Resident A and Resident B. Guardian A completed a visit to the home and when she arrived, Employee #1 was on the computer by the door, and not facing the residents. Resident A requires 1:1 staff supervision; however, Employee #1 was the only staff there. According to APS Worker #1, Resident B told Guardian

A that he had chicken nuggets and tater tots for dinner, and that he ate the BBQ sauce, so he didn't get hungry.

In addition, while Guardian A was at the facility, Resident A informed her that he purchased some dolls from a garage sale. Resident A told Guardian A that he was going to give the dolls to Ms. Wenmans' children when they visited the home. Resident A is a registered sex offender.

On June 16, 2023, I made face to face contact with APS Worker #1. APS Worker #1 reported to conduct another on-site investigation at the home, and she interviewed the residents about the meals provided. Resident A reported that the food could be better and Resident C reported that he would like more food. APS Worker #1 also interviewed Ms. Wenman, who reported that her children are not in the facility. The residents interviewed also confirmed this information.

On June 20, 2023, APS Worker #1 and I conducted an unannounced on-site investigation to observe the mealtime; however, when we arrived, Ms. Wenman informed us that they were getting ready to go out in the community and have lunch. Ms. Wenman reported that they try to take the residents out twice a week for meals. While in the facility, we observed plenty of food in the home.

APS Worker #1 and I interviewed Employee #2. She reported to work for CCH for almost a year. Employee #2 works mainly first and second shifts. She informed us that they do not run out of food in the home.

On July 19, 2023, I spoke with ORR Worker #1. ORR Worker #1 informed me that she would provide a copy of her report. In addition, that the allegations for this investigation were not substantiated.

As a part of this investigation, I reviewed the report authored by ORR Worker #1. She interviewed Resident A, Resident B, Resident C, Resident D and Resident E. Overall, the residents reported that there was food in the home, and they get enough food to eat. ORR #1 also consulted with a nurse who reviewed the weight records for the residents. There were no concerns noted when comparing to the old weight records. As a part of the investigation, ORR Worker #1 also reviewed the receipts for groceries purchased and documented that between April 20, 2023, and May 30, 2023, facility staff spent approximately $2,121.76 on food. ORR Worker #1 also provided me with copies of the receipts for groceries purchased.

On July 19, 2023, APS Worker #1 provided me an update regarding her investigation. APS Worker #1 interviewed residents, staff, and guardians. She informed me that the complaint was unsubstantiated for neglect. There was no evidence found regarding the lack of food; and documents for resident's funds and shopping receipts were also reviewed, with no concerns noted. Food supplies were checked at home visits and were adequate.

On July 21, 2023, I conducted an unannounced on-site investigation and made face to face contact with Ms. Wenman, Home Manager, Employee #4, Resident A, Resident B, and Resident C. Resident D was in his room and Resident E was out in the community. Employee #2 later returned to the facility, after dropping Resident E off at the day program. Ms. Wenman reported that Resident C was having a rough day.

While at the facility, I observed an adequate amount of food in the home. While checking the refrigerator, I observed Resident C's medications in the refrigerator. The medications were not maintained in a lock box.

During the on-site investigation, I first interviewed Resident B. He reported to get enough to eat. He also reported not liking some of the food provided, including any fruit that grows on a vine and chicken alfredo.

During the interview with Resident C, he provided a list of the foods he enjoyed eating and stated that he would like more servings of those foods. He reported that he would like more food at each meal.

Resident D was not interviewed, as there were concerns that he may go into behaviors.

Resident E was not home at the time of the on-site investigation.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	Adequate amounts of food were observed during all the unannounced on-site investigations. The residents were interviewed and reported to get enough food to eat. The receipts for groceries purchased were provided and it was documented that between April 20, 2023, and May 30, 2023, facility staff spent approximately $2,121.76 on food. On July 21, 2023, Resident C reported that he would like more food at each meal. APS Worker #1 and ORR Worker #1 also conducted investigations and did not substantiate the allegations of neglect. Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that the residents are not provided with three regular, nutritious meals, and snacks, each day.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

Residents are not receiving meds as they should, sometimes not at all.

INVESTIGATION:

While at the facility on June 8, 2023, I randomly selected and reviewed the resident medications and medication logs. There were no other deficiencies noted, except for Resident C's file. The medication log was missing the staff initial for the 8:00 a.m. medication pass.

On June 8, 2023, we interviewed Employee #1. She reported to pass medications to the residents. She was not aware of the residents not receiving their medications as prescribed and she has not forgotten to pass their medications.

During my conversation with APS Worker #1 on June 16, 2023, she stated that the residents interviewed all reported that they get their medications.

Regarding medications, Employee #2 reported that she has not observed the residents not getting their medications as prescribed.

On July 19, 2023, APS Worker #1 provided me an update regarding her investigation. She informed me that the complaint was unsubstantiated for neglect. No evidence was found regarding medication mismanagement.

On July 21, 2023, during the interviews, Resident A and Resident B, reported to receive their medications daily. Resident C reported that he received his medications on a regular basis, but then stated that he had not received his morning medications that day.

After the interviews I spoke with Ms. Wenman, who reported that Resident C was having a challenging day, and that he had received his medications.

I reviewed the medication logs and medications for Resident A, Resident C and Resident E. No deficiencies were noted.

I interviewed Employee #4. She reported to be a direct care staff member who has worked for CCH for the last five to six years. She stated that things were going well in the home, things were very routine, and she did not have any concerns. She reported to administer medications. She informed that the medications were administered as prescribed, and she was not aware of the residents not being given their medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	While at the facility on June 8, 2023, I randomly selected and reviewed the resident medications and medication logs. There were no other deficiencies noted, except for Resident C's file (please see additional findings). Employee #1. She reported that she was not aware of the residents not receiving their medications as prescribed and she has not forgotten to pass their medications. Employee #2 reported that she has not observed the residents not getting their medications as prescribed. Employee #4 informed me that the medications were administered as prescribed, and she was not aware of the residents not being given their medications. During my conversation with APS Worker #1 on June 16, 2023, she stated that the residents interviewed all reported that they get their medications. On July 21, 2023, I reviewed the medication logs and medications for Resident A, Resident C and Resident E. No deficiencies were noted. Based on the information gathered during this investigation and provided above, there is not a preponderance of the evidence to support the allegations that the residents' medications were not administered as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

Staff are taking the residents money for their personal use. Residents are being exploited by the staff.

INVESTIGATION:

Regarding resident funds and money, Ms. Wenman reported that the staff don't have access to the cash and the money is not kept in the facility. When residents are going into the community to buy things, the receipts are brought back, which is then submitted to the main office for record keeping.

During the interview with Employee #1, she reported that she was not aware of any issues regarding the residents' money being taken. However, she did think that the residents should have more money.

During the conversation with APS Worker #1 (on 6/9/23), she informed me that Guardian A stated that the residents don't get their money until the end of the month. Ms. Howard will release the money, but the manager will hold the money until the very end of the month.

During the interview with Employee #2, she informed that after residents spend their money in the community, receipts are returned to the main office. She denied seeing staff take money from the residents.

On July 21, 2023, I interviewed Resident B and Resident A (separately). They did not confirm that staff were taking money from the residents.

Resident C stated that a staff member said he (Resident C) owed him (staff) money for a pop, which cost $2,000. Resident C stated that he wrote him a check for $2,000 dollars. I asked to see the check book and Resident C stated that he just writes the checks on lined paper.

After the interviews, I followed up with Ms. Wenman, and she stated that Resident C makes statements like this all the time. He has written on paper, what he refers to as checks, and asked that she cash them. She has explained to him that this is not a good idea (to try to cash them). She reported that he has his markers and papers, and he likes to draw.

Regarding staff taking money from the residents, Ms. Wenman stated that she is the one who takes them out to buy things. Other staff usually do not carry out this duty, as it's much easier to keep track of what's going on. I inquired if she waits until the end of the month to spend the money, and she stated she will request money for their outings, when they take place. After they spend their money, the receipts are returned to the main office. She also stated that Resident E will receive cash, but he takes the money directly to his day program and pays for snacks.

I interviewed Employee #4. She reported that she was not aware of any staff taking money from the residents. She stated that Ms. Wenman is the only person that handles the resident funds. She also confirmed that Resident C has made comments about writing (imaginary) checks to people.

As a part of this investigation, I reviewed the Resident Funds Part II forms and receipts for each of the residents for the months of April and May. No deficiencies were noted with exception of the licensee accepting more than $200 dollars for safe keeping.

In April of 2023, the licensee maintained $309.89 of resident funds for Resident B.

In May of 2023, the licensee maintained $369.89 of resident funds for Resident B.

In May of 2023, it was documented that the licensee maintained $386.31 for Resident C.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Employee #1, Employee #2, and Employee #4 were not aware of staff were taking money from the residents. Resident B and Resident A did not confirm that staff were taking money from the residents. Ms. Wenman stated that she is the one who takes them out to buy things, as it was easier to keep track of the money this way. Once the money is spent, the receipts are maintained, and returned to the main office for accounting purposes. Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that staff are taking money from the residents or exploiting them.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

They are being mentally and physically abused. (The caller reported these issues to the QR. They prep the residents for conversations with outside entities so that they answer questions in a manner that's favorable for the facility).

INVESTIGATION:

On June 8, 2023, Employee #1 reported that she has not seen the residents being mistreated or abused.

During the interview with Employee #2 she denied having concerns about how the residents were treated by staff.

On July 19, 2023, APS Worker #1 provided me an update regarding her investigation. APS Worker #1 interviewed residents, staff, and guardians. She informed me that the complaint was unsubstantiated for physical abuse.

On July 21, 2023, I interviewed Resident B. When questioned, he did not provide any information to confirm that he was being mentally or physically abused.

Resident A reported to be treated well by the staff.

When asked how he was treated by staff, Resident C replied, “Not good.” When asked what he meant by “not good” Resident C stated that staff joke with him about owing them money, but he already wrote them a check. Resident C did not provide any additional information about how he was treated.

Ms. Wenman stated that she has a pretty good group of staff members right now, and she has not had any complaints since the issue with Mark Austin, who is no longer employed with the company.

Employee #4 informed me that she has not seen or witnessed staff mentally or physically abusing the residents.

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 reported that she has not seen the residents being mistreated or abused. Employee #2 denied having concerns about how the residents were treated by staff. On July 19, 2023, APS Worker #1 informed me that she did not substantiate the allegations of physical abuse. Resident B did not provide any information to confirm that he was being mentally or physically abused. Resident A reported to be treated well by the staff. When asked how he was treated by staff, Resident C replied, “Not good.” When asked what he meant by “not good” Resident C stated that staff joke with him about owing them money, but he already wrote them a check. Resident C did not provide any additional information about how he was treated. Based on the information gathered during this investigation and provided above, it’s concluded that there is not a preponderance of the evidence to support the allegations that the residents are not being treated with dignity and their personal needs, including protection and safety were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

Allegations of inadequate staffing. (The employees are allowed to split shifts as opposed to working full 8-hour shifts, so they don’t have adequate staffing).

INVESTIGATION:

On June 8, 2023, Ms. Wenman informed that the facility currently employes seven staff. One longtime staff was recently relieved of his duties, due to issues with a criminal background check. Ms. Wenman did not know the details but found the information to be surprising. Ms. Wenman reported that there are two staff on each shift. Ms. Wenman reported to work 16-hour shifts. She reported that staff can work eight or 16-hour shifts. She confirmed that they are short staffed, (as they have borrowed staff from other homes), but the shifts are covered.

During my conversation with APS Worker #1 on June 16, 2023, she stated that the residents interviewed all reported that there are two staff on duty.

On June 20, 2023, APS Worker #1 and I interviewed Employee #2. She reported to work for CCH for almost a year. Employee #2 works mainly first and second shifts. Regarding staffing, staff are supposed to contact a manager if there is only one staff on duty as they do not work alone in the home.

On July 20, 2023, I spoke to Ms. Howard, Administrative Staff, and requested copies of the staff schedules. I also inquired about the staff schedule, and she informed that it changed after a licensing visit. During the middle of June, Lifeways changed their contract. The new staff schedule is three staff on 1st and 2nd shifts (8:00 a.m. 4:00 p.m. & 4:00 p.m. to 12:00 a.m.), and two staff on 3rd shift (12:00 a.m. to 8:00 a.m.). Ms. Howard informed me that Resident A requires 1:1 staff supervision in the home and in the community. Resident B and Resident D require 1:1 supervision while in the community. I inquired about split shifts and Ms. Howard informed that the staff do work them. She stated that there is a critical staff shortage and they've done everything they can to hire more staff, without success. Ms. Howard also provided me with copies of the AFC Assessment Plans for the residents.

On July 21, 2023, Ms. Wenman informed me that after the incident involving Resident D going to jail, the staffing pattern changed. There was some confusion as to what was being reported, as Resident D had never been assigned as having 1:1 supervision. According to Ms. Wenman, this was an error on case management's part. Lifeways contacted them and informed that the new staffing pattern would be 3, 3, 2 (three staff on 1st), three staff on 2nd, and two staff on 3rd shift.

On July 24, 2023, I spoke with Ms. Wenman as I had some additional questions regarding the staff schedules. Ms. Wenman reported to complete work for the home, even though she may not be listed on the schedule sometimes. She explained that it's easier to get work done in the home when she's not assigned to supervise the residents. I inquired about the specific date as to when they went from two staff on each shift to three (on 1st and 2nd and 2 on 3rd), and she stated she believed it was June 16, 2023, that they were notified about the changes.

I also inquired about split shifts, and Ms. Wenman stated that she usually does not do split shifts in this home. She has one staff that sometimes needs to leave at 2:00 p.m. instead of working until 4:00 p.m. Since the change, she will now have to bring in an additional person to cover the two hours, so there are three staff on duty. Previously, this was not an issue as they still had enough staff even if the staff member left, as they were only required to have two staff on shift.

As a part of this investigation, I reviewed the staff schedules from June 4, 2023 to July 8, 2023 and the following was noted:

- During the week of June 4, 2023 to June 10, 2023 & June 11, 2023 to June 17, 2023, a minimum of two staff were scheduled for each shift (there were usually 3 staff assigned during 1st shift). There were three staff scheduled for 2nd shift on June 17, 2023.

- During the week of June 18, 2023 to June 24, 2023, it was noted that on June 18, 2023 there were only two staff on 2nd shift. On June 20, 2023 there were only two staff on 1st shift. On June 23, 2023 there were only two staff on 2nd shift between the hours of 4:00 p.m. and 6:00 p.m.

- There was adequate staffing for the weeks of June 25, 2023 to July 1, 2023 & July 2, 2023 to July 8, 2023.

On July 24, 2023, I spoke with Ms. Wenman and inquired about the staff schedules for June 18, 20, & 23. She reported that on June 18, 2023, Employee #1 called off and the new staff member did not return. On June 20, 2023, Employee #4 did not show up for work; therefore, there were only two staff on duty from 8:00 a.m. to 2:00 p.m. On June 23, 2023, between the hours of 4:00 p.m. and 6:00 p.m. there were only two staff on duty, as she had no one to cover while completing payroll responsibilities.

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:	Prior to June 16, 2023, the staffing pattern included two staff on each shift. After this date, the staffing pattern was increased to 3, 3, 2 (three staff on 1st), three staff on 2nd, and two staff on 3rd shift. On June 18, 2023, there were only two staff on 2nd shift. On June 20, 2023, there were only two staff on 1st shift. On June 23, 2023, there were only two staff on 2nd shift between the hours of 4:00 p.m. and 6:00 p.m. Ms. Wenman reported that on June 18, 2023, Employee #1 called off and the new staff member did not return. On June 20, 2023, Employee #4 did not show up for work; therefore, there were only two staff on duty from 8:00 a.m. to 2:00 p.m. On June 23, 2023, between the hours of 4:00 p.m. and 6:00 p.m. there were only two staff on duty, as she had no one to cover while completing payroll responsibilities. Ms. Howard stated that there is a critical staff shortage and they've done everything they can to hire more staff, without success. 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 there was not sufficient direct care staff on duty, at all times, for the supervision, personal care, and protection of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the investigation, it was reported that there was an altercation between Resident A and Resident D. There was a concern that Resident A requires 1:1 supervision but there was only one staff member on duty.

On June 8, 2023, Employee #1 reported that Resident A is the only resident who requires 1:1 supervision in the home.

On June 13, 2023, I interviewed Guardian A. She informed me that on June 8, 2023, there was a physical altercation between Resident A and Resident D. Resident D also pulled Resident A's hair out. Resident A called 911 and they responded to the home. Resident D was taken to jail. When CCH staff reported this information to Guardian A's worker (Staff A), Staff A requested that Ms. Wenman take Resident A to the walk-in clinic to be seen. However, Ms. Wenman stated that the EMTs already looked over Resident A and he was fine. Ms. Wenman was informed that she still needed to take Resident A to the walk-in clinic. Resident A was taken to the walk-in clinic on Friday, and it was discovered that he had human bites on his hands. Resident A was prescribed an antibiotic for treatment. Guardian A recalled that when she completed the walk-through on Thursday, June 8, 2023, Resident A kept blocking her when she attempted to go into the kitchen to observe the food. Resident A reported to her that he was doing that because Resident D was not nice (Resident D's room is located by the kitchen). Guardian A stated that Employee #1 was the only staff on duty when she completed the walk-through of the home, and that Employee #1 was back on 1st shift the following day, as she was the one who took Resident A to the walk-in clinic.

On June 14, 2023, I received a copy of the incident report authored by Employee #1 and the following was noted: On June 8, 2023, at 8:04 p.m. Resident D came out of his room to use the restroom and attacked another consumer (Resident A) because there was something on the television that he did not like. Resident D pulled Resident A's hair out and bit his finger. The other residents contacted 911, and Resident D was arrested. Resident D was released from jail and returned to the home on Friday, June 9, 2023, at 4:00 p.m.

On June 16, 2023, during the conversation with APS Worker #1, she reported to make face to face contact with Resident A, and she observed a scab on his hand from the altercation with Resident D. The residents were watching the news and Resident D became upset. He punched the wall and then lunged at Resident A. Resident D also bit Resident A's finger and ripped out his hair. Employee #1 and Employee #3 broke up the fight between the residents.

On June 20, 2023, APS Worker #1 and I conducted an unannounced on-site investigation. When speaking to Ms. Wenman about the altercation, she informed us that Employee #1 and Employee #3 were the staff members on shift when Resident D went into behaviors. Ms. Wenman also informed us that Employee #3 was not longer employed as he quit yesterday.

On July 19, 2023, I spoke to ORR Worker #1. She stated that Resident A requires 1:1 staff supervision in the home. When Resident D attacked Resident A, Employee #1 was outside smoking and Employee #3 was in the bathroom. When she interviewed the staff, neither one could tell her who was assigned as the 1:1 staff for Resident A. ORR Worker #1 substantiated these allegations and is waiting for a written corrective action plan from the licensee.

As a part of this investigation, I reviewed the AFC Assessment Plan for Resident A. It was documented that staff were to supervise him at all times and follow his behavior treatment plan.

On July 21, 2023, I spoke to Ms. Wenman and inquired about his level of supervision and behavior treatment plan. She informed me that when Resident A is in his bedroom, staff are to conduct 15-minute checks. If he is outside smoking, staff are with him.

I interviewed Resident A regarding the altercation between he and Resident D. Resident A stated they were in the living room watching television and the news came on about the wildfires. Resident D came out if his room and hearing the news upset him. Resident A stated that Resident D punched the wall “then he attacked me.” Resident A stated that Resident D clamped down and bit his finger. Resident A showed me the bite marks on his finger, in which the skin appeared to be yellow and brown. His fingernail was also bruised and was deep purple and red. I inquired where the staff were when the incident occurred and Resident A stated that Employee #3 was in the bathroom, and Employee #1 was outside. He stated that the staff broke up the fight. Resident A stated that this is not the first time that Resident D has attacked him and that he wanted to attend the sentencing hearing for Resident D.

Resident D was not interviewed due to concerns that he may go into behaviors.

As a part of this investigation, I reviewed the ORR Summary Report authored by ORR Worker #1. The complaint alleged that West Washington home only had one staff member on duty, during 2nd shift, and Resident A requires 1:1 staffing. While the facility was understaffed, Resident A was attacked by another resident.

ORR Worker #1 reviewed Resident A’s Behavior Treatment Plan, dated August 22, 2022, and noted that Resident requires Dedicated Staffing- arm’s length – 1:1 “Eyes on” supervision. Resident A requires this level of supervision in both the home and the community due to behaviors that occurred in a previous placement and involvement with the legal system due to these behaviors. It was also noted that staff are to have “eyes on supervision with [Resident A] in the home and community during waking hours ([Resident A] needs to be within seeing and hearing distance at all times during waking hours) and sleeping hours 15-minute checks.”

ORR Worker #1 documented that she interviewed the residents and staff. Employee #3 reported to ORR Worker #1 that when he came out of the bathroom, he heard yelling and screaming and saw [Resident D] on top of [Resident A]. Resident D was pulling Resident A’s hair. Once Employee #3 got Resident D off Resident A, Resident D started throwing a chair and a hand sanitizer bottle. Employee #3 reported to get Resident D to go into his bedroom and talk with him until the police arrived and spoke with him. Employee #3 reported that he was not Resident A’s 1:1 staff.

ORR Worker #1 documented that she interviewed Employee #1. She reported to be by the front door smoking a cigarette, and when she stepped inside, she heard yelling. Employee #1 observed Resident D on top of Resident A, and he had Resident A's fingers in his mouth, biting them. Resident D also pulled Resident A's hair out. This caused a bald spot. Employee #1 observed Employee #3 prying Resident A's fingers out of Resident D's mouth, and Employee #1 helped get Resident D off Resident A. Once Resident D went to his room, and she spoke with Resident A, he wanted to contact the police. Employee #1 reported that she was not assigned as Resident A's 1:1, as staff just watch him.

ORR Worker #1 substantiated the allegations of Neglect Class III and recommended that CCH clearly assigns staff when there is a resident in the home that requires 1:1 staffing.

I reviewed the staff schedule for the home on June 8, 2023, and noted that both Employee #1 and Employee #3 were on the schedule for the 4:00 p.m. shift to 12:00 a.m. shift.

On July 24, 2023, I interviewed Employee #1. She stated that she was standing outside with the front door open, smoking. When she came into the home, the residents were already fighting. Resident D was upset because of something on the news. She assisted with breaking them apart. I inquired who was assigned as 1:1 staff for Resident A, and Employee #1 informed me that there are no assignments, they just supervise all of the residents.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**

ANALYSIS:	Resident A is a registered sex-offender, and he requires 1:1 supervision while in the home and community. Employee #1 completed an incident report and documented the following: On June 8, 2023, at 8:04 p.m. Resident D came out of his room to use the restroom and attacked another consumer (Resident A) because there was something on the television that he did not like. Resident D pulled Resident A's hair out and bit his finger. The other residents contacted 911, and Resident D was arrested. Resident D was released from jail and returned to the home on Friday, June 9, 2023, at 4:00 p.m. Resident A stated they were in the living room watching television and the news came on about the wildfires. Resident D came out if his room and hearing the news upset him. Resident A stated that Resident D punched the wall "then he attacked me." Resident A stated that Resident D clamped down and bit his finger. Resident A sustained injuries from the incident and required medical attention. When asked where the staff were, Resident A stated that Employee #3 was in the bathroom, and Employee #1 was outside. He stated that the staff broke up the fight. ORR Worker #1 documented that she interviewed the residents and staff. Employee #3 reported to ORR Worker #1 that when he came out of the bathroom, he heard yelling and screaming and saw [Resident D] on top of [Resident A]. ORR Worker #1 documented that she interviewed Employee #1. She reported to be by the front door smoking a cigarette, and when she stepped inside, she heard yelling. Employee #1 observed Resident D on top of Resident A, and he had Resident A's fingers in his mouth, biting them. ORR Worker #1 substantiated the allegations of Neglect Class III and recommended that CCH clearly assigns staff when there is a resident in the home that requires 1:1 staffing. Employee #1 was by the front door smoking and Employee #3 was in the bathroom. While there were two staff on during the time of this incident, they were not providing the 1:1 supervision that Resident A required. 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 amount of supervision and protection that Resident A required was not available in the home on June 8, 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility on June 8, 2023, I randomly selected and reviewed the resident medications and medication logs. There were no other deficiencies noted, except for Resident C's file. The medication log was missing the staff initial for the 8:00 a.m. medication pass.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.** **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.** **(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as needed basis. The review process shall include the resident's prescribing physician, the resident or his or her designated representative, and the responsible agency.** **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the**

	resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication. **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	On June 8, 2023, the medication log was not initialed at the time of medication administration for Resident C.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On July 21, 2023, during the on-site investigation, I observed Resident C's medications in the refrigerator. The medications were not safeguarded or maintained in a lock box.

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:	Resident C's medications, which were being kept in the refrigerator, were not safeguarded.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During this investigation, I reviewed the Resident Funds Part II forms and receipts for each of the residents for the months of April and May. No deficiencies were noted with exception of the licensee accepting more than $200 dollars for safe keeping.

In April of 2023, the licensee maintained $309.89 of resident funds for Resident B.

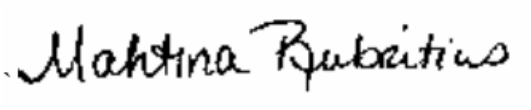
In May of 2023, the licensee maintained $369.89 of resident funds for Resident B.

In May of 2023, it was documented that the licensee maintained $386.31 for Resident C.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(6) Except for bank accounts, a licensee shall not accept resident funds of more than $200.00 for any resident of the home after receiving payment of charges owed.
ANALYSIS:	The licensee accepted over $200 for safe keeping for Resident B and Resident C.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

This facility is currently on a 1st provisional license, due to quality-of-care violations. A subsequent investigation was conducted in July of 2022 (SIR #2022A0007027), due to additional quality-of-care violations and a recommendation for revocation was submitted. On February 13, 2023, an administrative hearing was held, the Proposal for Decision was entered on May 12, 2023, and we are currently waiting for the final decision regarding this matter. It's recommended that the status of the license and recommendation for revocation remain the same.



7/24/2023

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Mahtina Rubritius — Date
Licensing Consultant

Approved By:

7/27/2023

_____

Ardra Hunter — Date
Area Manager