GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 20, 2023

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

RE: License #: AS300016311
Investigation #: 2023A1032052
Westwood Home

Dear Ira Combs, Jr.:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS300016311
Investigation #:	2023A1032052
Complaint Receipt Date:	08/10/2023
Investigation Initiation Date:	08/10/2023
Report Due Date:	10/09/2023
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:	Westwood Home
Facility Address:	115 Westwood, Hillsdale, MI 49242
Facility Telephone #:	(517) 439-1914
Original Issuance Date:	09/26/1995
License Status:	REGULAR
Effective Date:	08/25/2022
Expiration Date:	08/24/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Employees did not follow recommendations for Resident A's occupational therapy.	No
Employees did not clean Resident A's linens or wheelchair.	No
Additional Findings	No

III. METHODOLOGY

08/10/2023	Special Investigation Intake 2023A1032052
08/10/2023	Special Investigation Initiated - On Site
08/10/2023	Contact - Telephone call received Interview with Guardian A1
09/08/2023	Exit Conference With licensee designee Bishop Ira Combs

ALLEGATION:

Employees did not follow recommendations for Resident A's occupational therapy.

INVESTIGATION:

On 8/10/23, I interviewed employee Payton Brown in the home. Ms Brown stated that Resident A has a focus area in his Individual Plan of Service to address occupational therapy. Resident A is supposed to use a standing frame. Ms. Brown provided a log sheet for the month of July, where there were some entries that were notated with a 0, and some where a 6 or a 9 was added to a 0 to indicate 60 or 90

minutes. Ms. Brown explained that Resident A will often refuse, the employee will put a 0, then he would change his mind, thus creating the need to adjust the entry.

I reviewed Resident A's Individual Plan of Service, regarding occupational therapy. The document reflects a recommendation to use the standing frame, with employees encouraging it's use.

I interviewed employee Koral Mclain in the home. Ms. Mclain identified her initials on the log sheet and stated that Resident A has sometimes refused, then changed his mind.

I interviewed Guardian A1 via telephone. Guardian A1 stated that he checks in regularly on Resident A. He stated that the standing frame was something Resident A typically used in school and that it was on loan to the home during the summer months. Guardian A acknowledged that Resident A does not always comply with the recommendation that he use it.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	I reviewed Resident A's IPOS, with a focus area for occupational therapy. Based on interviews with the employees and Guardian A1, Resident A has the option to refuse use of the device.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Employees did not clean Resident A's linens or wheelchair.

INVESTIGATION:

On 8/10/23, I interviewed employee Shiayne Crapo in the home. Ms. Crapo stated denied the allegation that Resident A's room was not cleaned or sheets changed for a week. She stated that deep cleaning and laundry services are typically done on Saturdays. She provided a tour of Resident A's room, and the room appeared to be clean. The bedding appeared to be clean.

I interviewed Resident B in the home. Resident B stated that he has lived at the home for six years and expressed satisfaction with his care. He was asked how often his room is cleaned and he stated that his room is cleaned daily. He stated that the bedding is usually changed on weekends. Resident B and Resident A share rooms.

I did not interview Resident A, due to a health condition. Resident A typically communicates through a vocalizer. I observed Resident A's wheelchair, and it appeared to be clean. There was no evidence of extraneous material such as grit, old foodstuff or accumulations of dust on the wheelchair.

On 8/10/23, Guardian A1 stated that he was satisfied with the cleaning schedule and that Resident A has expressed being happy at the home.

On 8/25/23, I interviewed the complainant via telephone. The complainant clarified that the notes documenting Resident A's bedsheets being changed and wheelchair being cleaned pointed to a nine day span between checks. The complainant emphasized that Resident A does not shower regularly and sweats often, therefore his bedding and wheelchair should be cleaned weekly.

APPLICABLE RULE	
R 400.14411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillow case, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.

ANALYSIS:	Based on observations of the bedding and wheelchair, as well as interviews with employees, Resident B and Guardian A1, there is insufficient evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

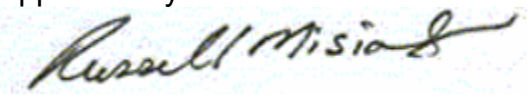
IV. RECOMMENDATION

I recommend no change to the status of this license.

9/8/23

Dwight Forde Date
Licensing Consultant

Approved By:



9/21/23

Russell B. Misiak Date
Area Manager