GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 21, 2026

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

RE: License #: AS300016270
Investigation #: 2026A1032045
West 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) 356-0100.

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 #:	AS300016270
Investigation #:	2026A1032045
Complaint Receipt Date:	07/27/2026
Investigation Initiation Date:	07/28/2026
Report Due Date:	09/25/2026
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 Home
Facility Address:	430 N West Street, Hillsdale, MI 49242
Facility Telephone #:	(517) 439-5690
Original Issuance Date:	12/06/1994
License Status:	REGULAR
Effective Date:	08/31/2024
Expiration Date:	08/30/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's health was compromised due to medical neglect.	No

III. METHODOLOGY

07/27/2026	Special Investigation Intake 2026A1032045
07/28/2026	Special Investigation Initiated - Telephone Interview with CCH QI Cheryl Howard
08/05/2026	Inspection Completed On-site Interview with Home Manager Cody Lonczkowski, meeting with Resident A and review of Resident A's discharge paperwork from Toledo Hospital
08/07/2026	Contact - Telephone call made Call to complainant #2
08/17/2026	Inspection Completed On-site Review of Resident A's MAR, Health Care Appraisal
08/18/2026	Contact - Telephone call made Voicemail left for Guardian A1 to make contact
08/21/2026	Exit Conference

ALLEGATION:

Resident A's health was compromised due to medical neglect.

INVESTIGATION:

On 7/28/26, I interviewed Christ Centered Homes Quality Inspector Cheryl Howard by telephone. Ms. Howard stated that on 7/20/26, Resident A was sent to the Hillsdale Hospital ER then transferred to Toledo Hospital, where he was ultimately discharged. Ms. Howard stated that Resident A's guardian had a former facility employee complete the actual discharge before handing Resident A over to the home manager Cody Lonczkowski. She reported that the hospital sent a prescription

for anti-seizure medication to Genoa Pharmacy in Jackson instead of Walgreens in Hillsdale, which was not communicated to Mr. Lonczkowski. As such, Mr. Lonczkowski was unable to pick up the medication. Subsequently, on 7/21/26, the facility received the medication, but Resident A had taken ill and was once again sent to the hospital.

On 8/5/26, I interviewed Home Manager Cody Lonczkowski in the facility. Mr. Lonczkowski discussed Resident A not receiving prescribed anti-seizure medication after Resident A was discharged from Toledo Hospital. He provided a timeline as follows: Resident A was sent to Flower hospital for a seizure, and upon discharge, Depakote was prescribed. He retrieved Resident A from a relative of the former home manager, who had been with Resident A at the hospital at Guardian A1's request. Mr. Lonczkowski stated that the former home manager called in a prescription to Walgreens on Resident A's behalf, but a prescription had also been sent to the facility's preferred pharmacy, Genoa. Due to the hour, the prescription was not filled on the day Resident A was discharged. The next day, Resident A suffered another seizure and was taken to Hillsdale Hospital where he was then transferred back to Toledo hospital. Resident A returned to the facility that day whereupon he received his nighttime dose of Depakote, since it had arrived that day.

I observed Resident A eating cereal. I was unable to interview him due to a neurocognitive delay.

I observed Resident A's discharge paperwork from the initial hospitalization. I noted that the instructions were to obtain the medication from the hospital pharmacy.

On 8/7/26, I called complainant #2 however I was unable to leave a message.

On 8/17/26, I reviewed Resident A's Medication Administration Record (MAR). There did not appear to be any errors. The new anti-seizure medication was logged in on and administered the evening of the second hospitaliztion.

During an onsite inspection I observed meal service and med-pass, where home manager Cody Lonczkowski gave Resident A his noon medication, watched him take it, then log an entry into the MAR. The process appeared to be in line with the administrative rule governing resident medications.

On 8/18/26, I left a voicemail for Guardian A1. At the time that this report was completed, Guardian A1 had not returned my call.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Resident A was not picked up from the hospital by staff, but at a separate location. The person to whom he was discharged did not pick up the medication from the hospital. A prescription was called in to the pharmacy that the facility uses and the medication was delivered the day after Resident A returned, which also happened to be the day that he had a second seizure. The MAR showed that Resident A received the dose of the anti-seizure medication on that same evening. Due to the time frame involved according to Mr. Lonczkowski, he would not have been able to obtain the medication until the following day. At the time of this report, neither the second complainant nor Guaridan A1 had returned my calls to confirm or deny Mr. Lonczkowski's versions of events. Given that the medication was received the day after Resident A returned from the first hospital visit, it seems reasonable to conclude that the facility followed instructions to address Resident A's health, by obtaining the medication in a fairly timely manner. These factors lead me to conclude that there is insufficient evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 8/21/26, I shared my findings with licensee designee Bishop Ira Combs during an exit conference.

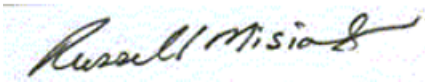
IV. RECOMMENDATION

I recommend that the status of this license remains unchanged.

8/21/26

Dwight Forde — Date
Licensing Consultant

Approved By:



8/25/26

Russell B. Misiak — Date
Area Manager