



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 23, 2024

Theresa Chang
Citizens For Quality Care Co.
2348 Estates Courts
Ann Arbor, MI 48103

RE: License #: AL460070146
Investigation #: 2024A1032039
Citizens for Quality Care Morenc

Dear Theresa Chang:

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,

A handwritten signature in black ink, appearing to read "Dwight Forde".

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 #:	AL460070146
Investigation #:	2024A1032039
Complaint Receipt Date:	06/28/2024
Investigation Initiation Date:	06/28/2024
Report Due Date:	08/27/2024
Licensee Name:	Citizens For Quality Care Co.
Licensee Address:	2348 Estates Courts, Ann Arbor, MI 48103
Licensee Telephone #:	(734) 327-0818
Administrator:	Theresa Chang, Designee
Licensee Designee:	Theresa Chang, Designee
Name of Facility:	Citizens for Quality Care Morenc
Facility Address:	233 Baker Street, Morenci, MI 49256
Facility Telephone #:	(517) 458-2344
Original Issuance Date:	06/21/1996
License Status:	REGULAR
Effective Date:	04/21/2024
Expiration Date:	04/20/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is not receiving proper follow-up care in the facility.	No
An employee sold gummies to Resident B.	No
Additional Findings	No

III. METHODOLOGY

06/28/2024	Special Investigation Intake 2024A1032039
06/28/2024	Special Investigation Initiated - Telephone
07/03/2024	Inspection Completed On-site
07/03/2024	Contact - Telephone call received Interview with complainant
07/08/2024	Contact - Document Received Resident A's updated Assessment Plan
07/12/2024	Contact - Telephone call received Interview with Elara Caring Nurse Cassey Fee
07/18/2024	Contact - Telephone call received Interview with LCMHA case manager Sheila Sears
07/19/2024	Inspection Completed On-site
08/01/2024	Contact - Document Received email from Theresa Chang, forwarding employee Bonnie George's response about marijuana gummies.
08/15/2024	Exit Conference
08/23/2024	Contact - Document Received email received from employee Bonnie George

ALLEGATION:

Resident A is not receiving proper follow-up care in the facility

INVESTIGATION:

On 6/28/24, I interviewed Lenawee Community Mental Health Authority case manager Sheila Sears via telephone. Ms. Sears shared that she was told through another resident at the home, that Resident A is confined to his room. She advised that employee Chindarat Runteranoont had denied doing so in a subsequent conversation.

On 7/3/24, I interviewed employee Chindarat Runteranoont in the facility. Ms. Runteranoont denied confining Resident A to his bedroom. She stated that a few weeks prior, Resident A went out of his bedroom and indicated that he wanted to sit in the living room. She stated that she assisted him to the living room and he sat there watching television. Ms. Runteranoont reported that there was a group of residents outside smoking and Resident A indicated that he wanted to go outside with them, to which she declined, explaining that it was very hot outside and Resident A is somewhat fragile. Ms. Runteranoont stated that Resident B appeared to have taken offense and told her that she would be reporting the issue.

I observed Resident A's bedroom to be centrally located in the home and his door was opened. I was unable to interview Resident A due to cognitive and physiological issues, but he nodded his head in assent when I asked in general about his wellbeing. I observed a feeding tube in the room and signs posted that he is not to ingest anything orally.

Ms. Runteranoont reported that a nurse from Elara Caring comes in to see Resident A twice a week.

I interviewed Resident B in a parking lot adjacent to the home. Resident B stated that Ms. Runteranoont was giving her a difficult time over smoking and advised that she and the licensee designee came to an arrangement where she has to smoke away from the home. She was observed smoking with a woman who lives at another AFC home. Resident B was asked if she had seen employees prevent Resident A from leaving his room, and she replied that she had not. She stated that she has not seen Resident A come out of his room much and asserted that he should be walking more.

On 7/8/24, I reviewed Resident A's Resident Assessment Plan. The plan includes use of assistive devices, such as a wheelchair and walker. The feeding tube was included, as well as supplementary care from Elara Care.

On 7/12/24, I interviewed Elara Caring Nurse Cassey Fee, via telephone. Ms. Fee stated that she visits Resident A twice a week in the home. She stated that

employee Chindarat Runteranoont seems to be able to follow Resident A's plan of care appropriately. Ms. Fee stated that she has seen Resident A walk to the bathroom. She did not express any concern that Resident A is being confined to his room. She reported that she had a concern over being told by another employee that the feeding rate was being changed from 16 hours to 10 hours, and she made the visiting doctor aware, and he reiterated that the order needed to be followed, clearing up any issue.

On 7/18/24, I interviewed LCMHA case manager Sheila Sears via telephone. Ms. Sears stated that she had recently been in the home for another resident and had seen Resident A in his room. She reported that the resident for whom she had responsibility had mentioned to her that Resident A does come out of his room from time to time.

On 7/19/24, Ms. Runteranoont provided a doctor's order for Resident A's feeding tube rate. The document, generated from Optalis Health and Rehabilitation, detailed a feeding rate of 16 hours, for Resident A's nutrient beverage.

APPLICABLE RULE	
R 400.15310	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:	Based on interviews with Elara caring staff, as well as an employee at the home, there is insufficient evidence to establish a violation. It appears that the facility is following doctor instructions for Resident A's care.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

An employee sold gummies to Resident B.

INVESTIGATION:

On 7/3/24, I interviewed the complainant via telephone. The complainant added that an employee was supplying Resident B with marijuana gummies sourced through a relative.

On 7/19/24, I interviewed Resident B in the facility. Resident B was asked about an arrangement where she purchases CBD gummies from an employee. Resident B stated that she buys them from an employee named Bonnie. There are 10 gummies in the pack. She stated that she keeps them in her room in a locked box.

Employee Chindarat Runteranoont stated that she was unaware of any arrangement between Resident B and her coworker.

While discussing the issue with Ms. Runteranoont, Resident B approached. She denied having any gummies currently but displayed an empty wrapper. She then denied purchasing the gummies from an employee but stated that she would give the employee money for them out of a sense of decency.

On 8/1/24, I received an email response from licensee designee Theresa Chang. Ms. Chang forwarded a response from employee Bonnie George, denying supplying or selling Resident B with gummies.

On 8/24/23, I received an email from employee Bonnie George, directly denying supplying any resident with marijuana gummies.

APPLICABLE RULE	
R 400.15305	Resident protection.
	(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.
ANALYSIS:	There is insufficient evidence to establish that Bonnie George sold CBD or marijuana gummies to Resident B. Based on my interview with Resident B, the information provided was not reliable.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 8/15/24, I conducted an exit conference with licensee designee Theresa Chang. I shared my findings and Ms. Chang agreed with the conclusions reached.

IV. RECOMMENDATION

I recommend no change to the status of this license.

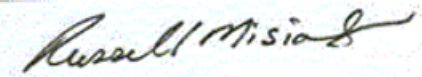


8/23/24

Dwight Forde
Licensing Consultant

Date

Approved By:



9/6/24

Russell B. Misiak
Area Manager

Date