GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 11, 2024

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

RE: License #: AL460070146
Investigation #: 2024A1032046
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,

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 #:	2024A1032046
Complaint Receipt Date:	08/13/2024
Investigation Initiation Date:	08/16/2024
Report Due Date:	10/12/2024
Licensee Name:	Citizens For Quality Care Co.
Licensee Address:	2348 Estates Courts, Ann Arbor, MI 48103
Licensee Telephone #:	(734) 327-0818
Administrator:	Theresa Chang
Licensee Designee:	Theresa Chang
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 AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
An employee inappropriately touched Resident A.	No
Additional Findings	No

III. METHODOLOGY

08/13/2024	Special Investigation Intake 2024A1032046
08/16/2024	Special Investigation Initiated - Telephone
08/19/2024	Inspection Completed On-site
10/07/2024	Contact - Document Received Email from APS Specialist Samantha Garcia
10/08/2024	Exit Conference

ALLEGATION:

An employee inappropriately touched Resident A.

INVESTIGATION:

On 8/16/24, I interviewed Adult Protective Services specialist Samantha Garcia by telephone. Ms. Garcia provided some details of her interview with Resident A. According to Ms. Garcia, Resident A stated that employee Chindarat Runteranoont was pressed against her at the dinner table and asked her to pull her pants down because they were too high. When Resident A sat down, Ms. Runteranoont reportedly stuck her finger in a hole in Resident A's shirt. Resident A reportedly stated that there were other residents in the dining room at the time but that Resident A could not remember who was there. Ms. Garcia stated that Resident A's presentation was not well orientated to person, time and place.

On 8/19/24, I interviewed employee Chindarat Runteranoont alongside APS specialist Samantha Garcia in the facility. Ms. Runteranoont denied touching Resident A's breasts or asking her to pull her pants down. Ms. Runteranoont stated that she noticed what appeared to be a mark on Resident A's pink shirt, pointed it out to her and then attempted to wipe it off. During that process, Ms. Runteranoont stated that it became apparent that the spot was in fact a hole. She stated that she advised Resident A as such. Ms. Runteranoont reported that Resident A does take her time to eat, and that she recently had to allay Resident A's fears about being slow to finish meals by telling her that meals were by no means timed and that eating slowly was not a problem.

I spoke with Resident A during meal service. Resident A reported that she was doing well in the facility.

On 10/7/24, I received an email from Samantha Garcia, stating that her case was closed due to insufficient evidence.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on interviews conducted in coordination with Adult Protective Services, it was plausible that employee Chindarat Runteranoont's contact with Resident A was accidental, given that there was a hole in Resident A's shirt that Ms. Runteranoont mistook for a soiled spot.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/8/24, 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.

10/11/24

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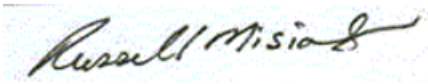
Dwight Forde — Date
Licensing Consultant

Approved By:



10/16/24

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Russell B. Misiak — Date
Area Manager