



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

April 18, 2025

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

RE: License #: AL460070146  
Investigation #: 2025A1032021  
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) 356-0100.

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**

<b>License #:</b>	AL460070146
<b>Investigation #:</b>	2025A1032021
<b>Complaint Receipt Date:</b>	03/20/2025
<b>Investigation Initiation Date:</b>	04/03/2025
<b>Report Due Date:</b>	05/19/2025
<b>Licensee Name:</b>	Citizens For Quality Care Co.
<b>Licensee Address:</b>	2348 Estates Courts, Ann Arbor, MI 48103
<b>Licensee Telephone #:</b>	(734) 327-0818
<b>Administrator:</b>	Theresa Chang, Designee
<b>Licensee Designee:</b>	Theresa Chang, Designee
<b>Name of Facility:</b>	Citizens for Quality Care Morenc
<b>Facility Address:</b>	233 Baker Street, Morenci, MI 49256
<b>Facility Telephone #:</b>	(517) 458-2344
<b>Original Issuance Date:</b>	06/21/1996
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	04/21/2024
<b>Expiration Date:</b>	04/20/2026
<b>Capacity:</b>	20
<b>Program Type:</b>	PHYSICALLY HANDICAPPED MENTALLY ILL AGED ALZHEIMERS

## II. ALLEGATION(S)

	Violation Established?
Staff shouted at Resident A	No
Resident A was not provided lunch.	No
Additional Findings	No

## III. METHODOLOGY

03/20/2025	Special Investigation Intake 2025A1032021
04/03/2025	Special Investigation Initiated - On Site
04/18/2025	Contact - Telephone Call Made
04/18/2025	Exit Conference

### ALLEGATION:

**Staff shouted at Resident A.**

### INVESTIGATION:

On 4/3/25, I interviewed employee Chindarat Runteranoont in the facility. Ms. Runteranoont stated that Resident A left the facility for an appointment. Ms. Runteranoont stated that upon Resident A's return, it was disclosed that Resident A had norovirus, so an effort was made to usher her to her bedroom to avoid any contamination. Ms. Runteranoont stated that she had an appointment and left soon after. Ms. Runteranoont stated that she avoids any conflict with Resident A after Resident A assaulted her recently.

I interviewed Resident A in the facility. Resident A stated that on the day in question, she returned from a doctor's appointment in the early afternoon. She stated that Ms. Runteranoont yelled at her to go to her room.

On 4/18/25, I interviewed Lenawee Community Mental Health Authority Case Manager Sheila Sears by telephone. Ms. Sears reported being at the facility on the day in question. Ms. Sears stated that the staff were speaking with urgency toward Resident A, because Resident A contracted norovirus and they did not want the infection to spread. They asked Resident A several times to go to the bedroom. Ms. Sears stated that consequently the other residents contracted the virus.

<b>APPLICABLE RULE</b>	
<b>R 400.15305</b>	<b>Resident protection.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	While there may have been raised voices, there does not appear to be the malice of tone indicative of shouting. Resident A had an infectious disease and was being urged to go to her room to reduce the chance of it spreading.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### **ALLEGATION:**

**Resident A did not receive lunch.**

#### **INVESTIGATION:**

On 4/3/25, Ms. Runteranoont reported that Resident A had left the facility and did not disclose her whereabouts. Ms. Runteranoont stated that Resident A has a habit of doing so, whereas others in the home will let her know, so that meal service arrangements could be made.

Resident A reported that she did get a peanut butter and jelly sandwich when she returned from the doctor's appointment.

<b>APPLICABLE RULE</b>	
<b>R 400.15313</b>	<b>Resident nutrition.</b>
	<b>(1) A licensee shall provide a minimum of 3 regular, nutritious</b>

	<b>meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.</b>
<b>ANALYSIS:</b>	Resident A was provided with a sandwich, since she missed lunch.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

On 4/18/25, I reached out to licensee designee Theresa Chang to conduct an exit conference. Ms. Chang was not available however I left a message with my findings.

#### IV. RECOMMENDATION

I recommend no change to the status of this license.

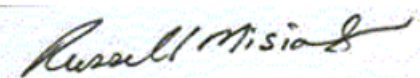


4/18/25

Dwight Forde  
Licensing Consultant

Date

Approved By:



4/24/25

Russell B. Misiak  
Area Manager

Date