



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 19, 2026

Robert Chapman
Community Choices, Inc.
26405 Plymouth Rd
Redford, MI 48239

RE: License #: AS820014538
Investigation #: 2026A0901019
Hubbard

Dear Robert Chapman:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (313) 456-0380.

Sincerely,

A handwritten signature in black ink that reads "Regina Buchanan". The signature is written in a cursive, flowing style.

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820014538
Investigation #:	2026A0901019
Complaint Receipt Date:	02/09/2026
Investigation Initiation Date:	02/09/2026
Report Due Date:	04/10/2026
Licensee Name:	Community Choices, Inc.
Licensee Address:	26405 Plymouth Rd Redford, MI 48239
Licensee Telephone #:	(313) 937-4170
Administrator:	Robert Chapman
Licensee Designee:	Robert Chapman
Name of Facility:	Hubbard
Facility Address:	3188 Hubbard Wayne, MI 48184
Facility Telephone #:	(734) 721-0861
Original Issuance Date:	04/01/1991
License Status:	REGULAR
Effective Date:	10/28/2025
Expiration Date:	10/27/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was given the wrong medication which caused an ER visit.	Yes

III. METHODOLOGY

02/09/2026	Special Investigation Intake 2026A0901019
02/09/2026	Referral - Recipient Rights (ORR)
02/09/2026	Adult Protective Services Referral
02/09/2026	Special Investigation Initiated - Telephone ORR, Griffin Sherbert
02/09/2026	Contact - Document Received Incident report, medical documentation, reprimand
02/11/2026	Inspection Completed On-site
02/12/2026	Contact - Telephone call made Staff, Solana Williams
02/13/2026	Contact - Document Received Incident report, medical documentation, reprimand
02/27/2026	Contact - Telephone call made Guardian A1
03/18/2026	Exit Conference Licensee designee, Robert Chapman
03/18/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A was given the wrong medication which caused an ER visit.

INVESTIGATION:

On 02/09/2026, I made a telephone call to Griffin Sherbert, from ORR. He stated Resident A was treated at the hospital and released back to the facility. He also said he had an incident report and other information he would send me.

On 02/09/2026 I received an email from Griffin that consisted of a copy of the incident report, medical documentation, medication log sheets, and staff reprimand. The incident report was dated 02/02/2026 and was written by the home manager, Patrice Polk. It indicated that staff, Solana Williams, called Patrice to let her know that she gave Resident A another resident's medication, and that she vomited up the medication and food. Patrice instructed Solana to not give Resident A her medication and to arrange for her to go to the hospital. There was a medical consultation form that verified Resident A was seen at Corwell Wayne Hospital for an accidental medication error. Her vital signs were stable, and it was recommended that she follow-up with her personal physician. There were copies of Resident A and Resident B's medication log sheets that showed the medications Resident A were given and what she should have received. Solana's written reprimand indicated she was suspended and placed on monitoring for five days for setting up and passing medication.

On 02/11/2026, I conducted an onsite inspection at the facility. Patrice was present and interviewed. She stated Resident A was given Resident B's medication and Resident B was given her own medication. She indicated Resident A did not display any signs or symptoms from the medication error and only required observation while at the hospital. Patrice said in addition to being suspended, Solana was also re-trained on medication passing. She agreed to send me verification.

During the onsite inspection on 02/11/2026, I interviewed Resident A. She said staff made a mistake and gave her the wrong medications, but she was ok because she vomited afterwards. Resident A also indicated she went to the hospital, and they kept her a while then let her go home. She said she has been fine since then and has not had any issues.

On 02/12/2026, I made a telephone call to Solana. She stated she was moving too fast when she gave Resident A the wrong medication. Solana was very apologetic and stated this was the first time she had ever made this type of mistake. She explained that as soon as she realized the error, Resident A had vomited everything

up. She said the pills she gave her were similar to her own and therefore did not cause any negative reactions.

On 02/13/2026, I received a fax from Patrice that consisted of the same information I received from Griffin in addition to verification of Solana’s medication in-service training that was completed on 02/09/2026. There was a copy of the hospital discharge paperwork from her ER visit on 02/02/2026, which verified she was seen for accidental medication error. There was also verification of Resident A’s post follow-up visit with her doctor on 02/10/2026, which was recommended during her ER visit.

On 02/27/2026, I made a telephone call to Resident A’s guardian, Guardian A1. She was aware of the incident and stated staff notified her right away. She spoke well of the facility and stated it was a one-time occurrence. She reported never having any problems with the facility or the care staff provide. Guardian A1 indicated she likes the facility and Resident A is doing well there.

On 03/18/2026, I made a telephone call to the licensee designee, Robert Chapman, for an exit conference. I informed him of my investigative findings, which he conveyed he understood and stated medication training is something they continuously go over with staff.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based on the information obtained during this investigation, Resident A’s medication was not given as ordered. She was mistakenly given Resident B’s medication. Solana admitted to making the error. Resident A was subsequently taken to the hospital for examination and observation, and it was noted in the discharge paperwork that she was seen for accidental medication error.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.



Regina Buchanan
Licensing Consultant

03/19/2026
Date

Approved By:



Ardra Hunter
Area Manager

03/19/2026
Date