GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 19, 2022

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

RE: License #: AS820014538
Investigation #: 2022A0901040
Hubbard

Dear Mr. 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,

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 #:	2022A0901040
Complaint Receipt Date:	08/17/2022
Investigation Initiation Date:	08/18/2022
Report Due Date:	10/16/2022
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:	10/28/2021
Expiration Date:	10/27/2023
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. **ALLEGATION(S)**

	Violation Established?
Resident A did not receive his 8:00 p.m. medications.	Yes

III. METHODOLOGY

08/17/2022	Special Investigation Intake 2022A0901040
08/17/2022	Referral - Recipient Rights
08/18/2022	Special Investigation Initiated - Telephone Staff, Heather Wallace Staff, Lisa McCracken
08/18/2022	APS Referral
08/19/2022	Contact - Telephone call made Staff, Diane Miller
08/19/2022	Inspection Completed-BCAL Sub. Compliance
10/14/2022	Exit Conference Licensee Designee, Robert Chapman

ALLEGATION:

Resident A did not receive his 8:00 p.m. medications.

INVESTIGATION:

On 08/17/2022, I received from the Office of Recipient Rights (ORR), a copy of an incident report for the above facility. It was dated for 8/13/2022 and was completed by staff, Diane Miller. It indicated that on 08/13/2022, Resident A's 8:00 p.m. medication, Lorazepam, 1mg tablet, was not available in the home. Therefore, he was agitated throughout the night. Management was notified and staff was advised to watch him through the night and to pick up the medication on that Monday.

On 08/18/2022, I made a telephone call to the facility and spoke with staff, Heather Wallace and Lisa McCracken. They verified that Resident A is nonverbal and he missed 2 days (08/13/2022 and 08/14/2022) of his Lorazepam, due to it not being available in the home. Since then, his medication was received on 08/15/2022 and is now in stock. They explained that there had been some changes at the home with staff and management and somehow the medication did not get refilled timely before it ran out.

On 08/19/2022, I made a telephone call to Ms. Miller. She verified that Resident A did not have his medication the weekend of 08/13/2022, which is why she wrote the incident report. She also stated that this was not the first time a medication error like this has occurred and that the home manager and the medication coordinator were responsible for keeping the residents' medications refilled and in stock.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information obtained during this investigation, Resident A's Lorazepam was not administered as prescribed. He missed 2 does of his medication due to it not being refilled timely and not being available in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

II. RECOMMENDATION

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

_____10/18/2022
Regina Buchanan Date
Licensing Consultant

Approved By:

_____10/19/2022
Ardra Hunter Date
Area Manager