



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

July 21, 2023

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

RE: License #: AL460070146
Investigation #: 2023A1032043
Citizens for Quality Care Morenc

Dear Theresa Chang:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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
350 Ottawa, N.W. Unit 13, 7th Floor
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 #:	2023A1032043
Complaint Receipt Date:	06/26/2023
Investigation Initiation Date:	06/27/2023
Report Due Date:	08/25/2023
Licensee Name:	Citizens For Quality Care Co.
Licensee Address:	2348 Estates Courts Ann Arbor, MI 48103
Licensee Telephone #:	(734) 327-0818
Licensee Designee:	Theresa Chang
Name of Facility:	Citizens for Quality Care Morenci
Facility Address:	233 Baker Street, Morenci, MI 49256
Facility Telephone #:	(517) 458-2344
Original Issuance Date:	06/21/1996
License Status:	REGULAR
Effective Date:	04/21/2022
Expiration Date:	04/20/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Employees did not properly administer Resident A's medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/26/2023	Special Investigation Intake 2023A1032043
06/27/2023	Special Investigation Initiated - On Site
06/28/2023	Contact - Telephone call made Interview with complainant
07/17/2023	Exit Conference
07/17/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Employees did not properly administer Resident A's medication.

INVESTIGATION:

On 6/27/23, I interviewed Employee #1 in the home. Employee #1 stated that Resident A's medication issues had been rectified, and that a new supply had been received on 6/23/23. I observed a pill bottle labeled ALPRAZOLAM, with a count of 120 pills, and instructions for as needed doses up to four times daily. The prescriber was listed as a Dr. Scott and was issued by Mike's Pharmacy. There were staff initials on 6/23/23, 6/26/23, with four doses each day. There were two doses initialed for 6/27/23. Employee #1 and I counted 100 pills. We acknowledged that there should be 102 pills given the dosing from 6/23/23, to 6/27/23. I asked if there was a

system in place to document the number of pills given vs the original number, to reflect greater accuracy or reduce instances of medication errors. Employee #1 stated that there was no such process at this time, other than to balance the number of pills given, with the original number supplies, in bubble packed cards that are typically provided by the pharmacy.

I asked Employee #1 to demonstrate how she administers medications. Employee #1 stated that she calls residents one at a time, gives them their medication, makes sure that they take them, then makes a note in the record.

I interviewed Resident A in the home. Resident A was asked to describe the process for employees dispensing medication. Resident A stated that the medication is in a locked closet, and only employees have the key. Once a resident is called for medication, the employee gives the medication and watches the resident swallow the pills. Resident A stated that she was out of her Xanax medication on two occasions.

On 6/28/23, I interviewed the complainant via telephone. The complainant verified the accuracy of the complaint information.

APPLICABLE RULE	
R 400.15312	Resident medications.
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Employee #1 acknowledged that there were prior occasions where the home ran out of Resident A's medication before the medication supply should have been depleted. Employee #1 and I counted the pills left over, and based on the original supply and the number of days since the prescription was filled, there were less pills than there should be. Employee #1 was unable to provide an explanation for the discrepancy.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

I observed pre-filled medicine cups with resident pills in them on the med cart, with name labels attached.

While inspecting the home I found the medication room was unlocked.

APPLICABLE RULE	
R 400.15312	Resident medications.
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	The allowance of staff presetting resident medications and leaving the medication room door unsecured are demonstrations of a medication administration program that does not reasonably comply with this administrative rule.
CONCLUSION:	VIOLATION ESTABLISHED

On 7/17/23, I conducted an exit conference with licensee designee Theresa Chang. I shared my findings, and Ms. Chang agreed to furnish a Corrective Action Plan.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of this license.

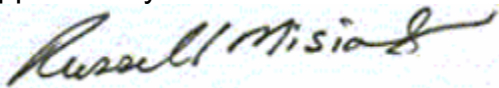


7/17/23

Dwight Forde
Licensing Consultant

Date

Approved By:



8/15/23

Russell B. Misiak
Area Manager

Date