GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 16, 2023

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

RE: License #: AL460070146
Investigation #: 2024A1032002
Citizens for Quality Care Morenc

Dear Ms. 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 #:	2024A1032002
Complaint Receipt Date:	10/06/2023
Investigation Initiation Date:	10/10/2023
Report Due Date:	12/05/2023
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 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:	04/21/2022
Expiration Date:	04/20/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL AGED ALZHEIMERS

ALLEGATION(S)

	Violation Established?
Medication errors led to Resident A's hospitalization.	No
Additional Findings	No

II. METHODOLOGY

10/06/2023	Special Investigation Intake 2024A1032002
10/10/2023	Special Investigation Initiated - On Site
10/19/2023	Contact - Telephone call received Interview with LCMHA casemanager Shiela Sears
10/31/2023	Contact - Face to Face Interview with Resident A
11/03/2023	Contact - Document Received Health Appraisal, Assessment Plan and MAR
11/16/2023	Exit Conference

ALLEGATION:

Medication errors led to Resident A's hospitalization.

INVESTIGATION:

On 10/10/23, I interviewed licensee Theresa Chang in the home. Ms. Chang stated that Resident A had been to the hospital on the evening of 10/5/23, then again on 10/8/23. Ms. Chang stated that Resident A called the ambulance to take her to the hospital but then returned to the home via taxi, without any discharge instructions and without any changes to her medication orders. Ms. Chang stated that Resident

A had a prescription for Flomax that had expired, and that only five pills were issued. Ms. Chang advised that she will be meeting with Resident A's case manager on 10/12/23.

I interviewed Resident A in the home. She was observed eating beef stew for lunch. Resident A advised that she went to the hospital initially because she felt she was having cardiac arrest. She advised that she has been unable to pass kidney stones for the past two weeks and was in some discomfort.

On 10/19/23, I interviewed Lenawee Community Health Authority case manager Shiela Sears, via telephone. I inquired if Ms. Sears had observed any issues with medication mismanagement at the home. She denied having any concerns with medication and was unsure of what issues arose to generate the complaint. Ms. Sears acknowledged that Resident A was never actually hospitalized, that she had called a ride to take her to the Emergency Room, and that Resident A did not provide anyone with discharge paperwork. She advised that Resident A wanted a follow up interview.

On 10/31/23, I interviewed Resident A in the home. Resident A added that she has been doing better and that she has follow up appointments to address her kidney stone issues. There was no further information provided about possible medication issues.

On 11/3/23, I reviewed Resident A's medication administration record for the first week of October, Resident A's health care appraisal and Assessment Plan. The documents reflected compliance with licensing rules. There was no evidence that medications had been mismanaged.

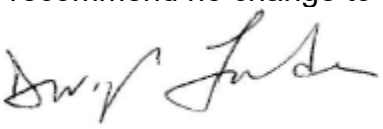
APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**

ANALYSIS:	There is insufficient evidence, based on the interviews conducted, and the documents reviewed, that Resident A was hospitalized due to a medication error.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 11/16/23, I conducted an exit conference with licensee designee Theresa Chang. I shared my findings, and Ms. Chang agreed with the conclusions reached.

III. RECOMMENDATION

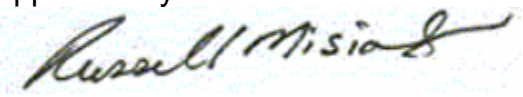
I recommend no change to the status of this license.



11/16/23

Dwight Forde Date
Licensing Consultant

Approved By:



11/20/23

Russell B. Misiak Date
Area Manager