GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 24, 2024

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

RE: License #: AL460070146
Investigation #: 2025A1032001
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.
- 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.

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 (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

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

I. IDENTIFYING INFORMATION

License #:	AL460070146
Investigation #:	2025A1032001
Complaint Receipt Date:	10/07/2024
Investigation Initiation Date:	10/08/2024
Report Due Date:	12/06/2024
Licensee Name:	Citizens For Quality Care Co.
Licensee Address:	2348 Estates Courts, Ann Arbor, MI 48103
Licensee Telephone #:	(734) 327-0818
Administrator:	Theresa Chang
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:	04/21/2024
Expiration Date:	04/20/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A received the wrong medication, requiring close monitoring at a hospital.	Yes
Additional Findings	No

III. METHODOLOGY

10/07/2024	Special Investigation Intake 2025A1032001
10/08/2024	Special Investigation Initiated - Telephone
10/11/2024	Inspection Completed On-site
10/14/2024	Contact - Telephone call received Interviews with employees Bonnie George and Shannon Torres
10/24/2024	Exit Conference

ALLEGATION:

Resident A received the wrong medication, requiring close monitoring at a hospital.

INVESTIGATION:

On 10/8/24, I verified the allegations with the complainant by telephone.

On 10/11/24, I interviewed licensee designee Theresa Chang at the facility. Ms. Chang reported that she had received information from staff that Resident A had mistakenly taken Resident B's medication. She advised that the medications were placed on paper towels near the residents. She discussed the relief staff monitoring Resident A, seeking advice from a medical professional, then having Resident A transported to the hospital, where he was monitored. Ms. Chang stated that all employees were directed to complete medication training and tested thereafter.

I interviewed Resident A in the facility. Resident A stated that during breakfast on the day in question, he took medication that had been set up near his plate. He denied

reaching over and taking medication from someone else's seating area. He stated that he is usually able to identify his medication, but that day he took them without question. He stated that he began to feel ill and thereafter had been taken to the hospital once the relief staff was advised that a medication error had occurred.

I interviewed Resident B in the facility. Resident B stated that on the day in question, resident medications were set up at their seats, as it was during breakfast. Resident B noticed that the medications that were assembled near his meal did not look familiar, and he alerted employee Bonnie George about the error. Once Ms. George realized that an error was made, Resident A stated that she attended to Resident B. He confirmed that he did receive his proper medication later on.

I observed Resident A's medication administration record, and there were no entries for the dates that he was in the hospital.

I reviewed an incident report authored by employee Bonnie George regarding the medication error.

On 10/14/24, I interviewed employee Bonnie George by telephone. Ms. George stated that she had been dispensing medications to the residents on the morning in question and mixed up two residents' medications. She stated that she wrote an incident report and let the incoming staff know what happened.

I interviewed employee Shannon Torres by telephone. Ms. Torres stated that she came into work and noted that Resident A had not received his medications. She was alerted to Resident A throwing up and asked what had happened to him. She stated that Resident A told her about the medication error and she called Elara Caring for advice and she was told to send Resident A to the emergency room.

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:	Based on interviews with residents and employees, resident medications were preset rather than provided one at a time and it does not appear that the right medication was given to the right resident, nor were the residents adequately supervised during med pass to ensure they were appropriately consumed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/24/24, I conducted an exit conference with licensee designee Theresa Chang. I shared my findings and Ms. Chang agreed to submit a corrective action plan upon receipt of the report. Ms. Chang also acknowledged that the incident was very serious and that regular training and review would be implemented.

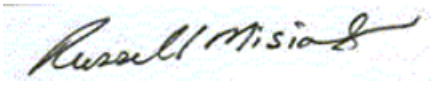
IV. RECOMMENDATION

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

10/24/24

Dwight Forde Date
Licensing Consultant

Approved By:



10/29/24

Russell B. Misiak Date
Area Manager