GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 5, 2026

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

RE: License #: AL460070146
Investigation #: 2026A1032031
Citizens for Quality Care Morenci

Dear Theresa 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

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 #:	2026A1032031
Complaint Receipt Date:	04/14/2026
Investigation Initiation Date:	04/21/2026
Report Due Date:	06/13/2026
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 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:	04/21/2024
Expiration Date:	04/20/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility has an uncontrolled pest infestation.	No
The facility smells of urine.	No
Resident A's personal care issues were not adequately addressed.	No

III. METHODOLOGY

04/14/2026	Special Investigation Intake 2026A1032031
04/14/2026	Contact - Document Received Incident Report reviewed
04/21/2026	Special Investigation Initiated - Letter Health care appraisal and resident notes requested
04/21/2026	Contact - Document Received Documents requested were received.
04/21/2026	Contact - Telephone call made Interview with Adult Protective Services Specialist Jason Harris
05/13/2026	Inspection Completed On-site Interview with Evergreen licensee designee May Delosh, employee Chindarat Runteranoont and Resident B
06/04/2026	Contact - Telephone call made voicemail left for Guardian A1
06/05/2026	Exit Conference

ALLEGATION:

The facility has an uncontrolled pest infestation.

INVESTIGATION:

On 4/14/26, I received this complaint as an Adult Protective Services Screenout.

On 5/13/26, during an onsite inspection, Evergreen licensee designee May Delosh was interviewed regarding a pest infestation. Ms. Delosh stated that she had applied bedbug spray as needed, to two previously affected rooms. She provided a tour and I noted that there did not seem to be any visible evidence of bedbugs such as blood tracks. I also noted that there was a bed in the room previously occupied by Resident A. Ms. Delosh displayed the products she used to treat the facility, such as ant traps and Harris Bed Bug Killer. I observed mattresses to have protective covers as well.

APPLICABLE RULE	
R 400.645	**Environmental health.**
	(6) An insect, rodent, or pest control program must be maintained and carried out in a manner that continually protects the health of residents.
ANALYSIS:	During my onsite inspection, I did not see any evidence of bedbugs or other insect infestations. Ms. Delosh reported that she had treated the facility with traps and sprays. There were also protective covers on the mattresses. Therefore I was unable to establish a violation due the efforts made to control the insects.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility smells of urine.

INVESTIGATION:

On 5/13/26, I interviewed Resident B in the facility. Resident B appeared to be well bonded with Ms. Delosh, trading jokes with her. He was unable to provide any information about Resident A. He reported that the facility is well maintained.

I toured the facility and noted that there did not appear to be any foul smells that would indicate problems with sanitation or housekeeping standards. There were residents in the living room watching television. The dining room area was clean.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.
ANALYSIS:	During my onsite inspection, the facility appeared to be clean and I did not detect any foul odors typically associated with lack of cleaning standards.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's personal care issues were not adequately addressed.

INVESTIGATION:

On 4/21/26, I reviewed Resident A's health care appraisal. The document did not reflect any chronic health issues. Resident A's age was listed as 86.

I reviewed an incident report documenting Resident A's passing.

I reviewed notes indicating behavioral changes for Resident A such as declining food and water. The notes detailed the facility's efforts to provide her with sustenance.

On 4/22/26, I interviewed APS Specialist Jason Harris by telephone. Mr. Harris stated that he had helped secure placement for Resident A at the facility a few years ago but denied having ongoing case management responsibility for her. He stated that he would check in on her from time to time when he had visits for other residents on his caseload.

On 5/13/26, I interviewed employee Chindarat Runteranoont and Evergreen licensee designee May Delosh in the facility. They denied that Resident A was covered in bugs. Ms. Runteranoont stated that Resident A would often refuse to use an adult diaper, resulting in frequent bedding and clothing changes. She stated that these items were laundered regularly. She denied that Resident A had no blanket. I observed Resident A's former bedroom to be clean and properly furnished with a bed, chair, dresser and mirror. The room was unoccupied.

On 6/4/26, I left a voicemail for Guardian A1 to obtain feedback about Resident A's care while she was alive and living at the facility.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional. **(2) Refusal by a resident to follow the instructions and recommendations must be recorded in the resident's record.** **(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.**
ANALYSIS:	Given Resident A's age, no indication otherwise on the health care appraisal, as well as efforts to blunt Resident A's own refusal to eat or accept help with personal care, there does not seem to be enough evidence to support the claim that the facility ignored a rapid decline in Resident A's health.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 6/5/26, I shared my findings with Evergreen licensee designee May DeLosh during an exit conference.

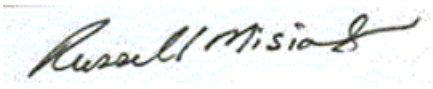
IV. RECOMMENDATION

I recommend no change to the status of this license.

6/5/26

Dwight Forde — Date
Licensing Consultant

Approved By:



6/16/26

Russell B. Misiak — Date
Area Manager