GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 2, 2023

Todd Olivieri
Cencare Foster Care Homes
1933 Churchill
Mt Pleasant, MI 48858

RE: License #: AS370011292
Investigation #: 2023A1029014
Cencare #3

Dear Mr. Olivieri:

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370011292
Investigation #:	2023A1029014
Complaint Receipt Date:	01/06/2023
Investigation Initiation Date:	01/09/2023
Report Due Date:	03/07/2023
Licensee Name:	Cencare Foster Care Homes
Licensee Address:	1933 Churchill Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6200
Administrator:	Todd Olivieri
Licensee Designee:	Todd Olivieri
Name of Facility:	Cencare #3
Facility Address:	1066 N. School Road Weidman, MI 48893
Facility Telephone #:	(989) 644-3664
Original Issuance Date:	08/01/1989
License Status:	REGULAR
Effective Date:	05/31/2021
Expiration Date:	05/30/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Direct care staff members at Cencare #3 are sleeping during third shift.	No
Direct care staff members at Cencare #3 are “covering up” medication errors.	No
Resident funds were stolen during the holidays.	No
Direct care staff member Carolyn Roberts does not have proper training.	No
Additional Findings	Yes

III. METHODOLOGY

01/06/2023	Special Investigation Intake 2023A1029014
01/09/2023	Special Investigation Initiated – Letter to complainant
01/11/2023	Contact - Document Received from complainant
01/11/2023	Contact - Document Sent Email for more information but did not hear back and telephone call to Katie Hohner, ORR
01/20/2023	Inspection Completed On-site Contact - Face to Face with Carolyn Roberts, Sara Wojciechowski at Cencare #3
02/01/2023	APS Referral made referral to Centralized Intake
02/02/2023	Contact - Document Received APS referral was denied for investigation
02/15/2023	Contact - Telephone call made to direct care staff members, Nahla Gilbert, Grace Bass, Deanna Fenton, Laura Cole and AFC Licensing consultant, Rodney Gill and email sent to Todd Olivieri
02/23/2023	Exit conference with licensee designee, Todd Olivieri

ALLEGATION:

Direct care staff members at Cencare #3 are sleeping during third shift.

INVESTIGATION:

On January 6, 2023, a complaint was received via Bureau of Community and Health Systems online complaint system with concerns direct care staff members were sleeping on the midnight shift while working at Cencare #3. There was no information reported in the complaint which direct care staff members were sleeping or what dates this occurred.

On January 20, 2023, I completed an unannounced on-site investigation at Cencare #3. I interviewed direct care staff member whose current role is home manager, Carolyn Roberts. I reviewed the current employee schedule, which indicated that Nala Gilbert and Grace Bass were the two primary third shift direct care staff members at Cencare #3. Ms. Roberts stated she has not had any concerns regarding direct care staff members sleeping during third shift. Ms. Roberts stated they had this issue in the past, but it was more than one year ago and this was also covered when new direct care staff members start their employment. Ms. Roberts stated there are always two direct care staff members working during third shift.

On January 20, 2023, I interviewed direct care staff member Sara Wojciechowski. Ms. Wojciechowski stated she has worked for over two years at Cencare #3 and knew there was an employee who fell asleep on third shift over a year ago but not anyone recently. Ms. Wojciechowski stated there are always two direct care staff members during third shift and she did not recall a time a resident did not receive care because someone was asleep.

During the onsite investigation, I reviewed the Employee Handbook which states “#23 – Sleeping on Duty is strictly prohibited.” I also reviewed the staffing schedule for December 2022 and January 2023 which showed two direct care staff members working at all times on third shift.

On February 15, 2023, I interviewed direct care staff member Laura Cole who stated she does not work third shift and she is on second from 3:00-11:00 pm. Ms. Cole stated on the schedule, there are always two people working per shift. Ms. Cole stated some of them work double shifts and work sixteen hours. Ms. Cole stated she has never heard of anyone falling asleep on third shift. Ms. Cole stated it is against the rules to fall asleep during her shift and this was reviewed in training.

On February 15, 2023, I interviewed direct care staff member whose current role is a supervisor, Deanna Fenton. Ms. Fenton stated she does work third shift and there have not been any employees that have fallen asleep. Ms. Fenton stated in the beginning when the direct care staff member first starts some of the direct care staff members will have a hard time staying awake but they get used to it. Ms. Fenton stated there are

always two people on third shift. Ms. Fenton stated if she was working with someone who fell asleep she could easily wake them up so they could resume work.

On February 15, 2023, I interviewed direct care staff member Nahla Gilbert. She has worked for Cencare #3. Ms. Gilbert stated works primarily 3rd shift and has been filling in for other shifts because of short staffing. Ms. Gilbert stated she has not had any incidents where a direct care staff member has fallen asleep. She stated there are two direct care staff members on third shift. Ms. Gilbert stated there is enough to do during third shift that someone should not have time to sleep.

On February 15, 2023, Licensee designee Mr. Olivieri sent documentation confirming there were no direct care staff members who were disciplined for sleeping during third shift during the last two months.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	According to my review of the staffing schedules, Employee Handbook, and interviews with direct care staff members Ms. Cole, Ms. Roberts, Ms. Wojciechowski, Ms. Gilbert, and Ms. Fenton, there are no direct care staff members who are sleeping during third shift.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Direct care staff members at Cencare #3 are “covering up” medication errors.

INVESTIGATION:

On January 6, 2023, a complaint was received via Bureau of Community and Health Systems online complaint system alleging medication errors were being “covered up.” No information was provided described what type of medication errors were being covered up or who was involved.

On January 20, 2023, I completed an unannounced on-site investigation at Cencare #3 and interviewed direct care staff member whose current role is home manager, Ms. Roberts. Ms. Roberts stated she has never heard of medication errors or that a direct care staff member tried to “cover them up” or not be accountable because there have not been any medication errors. Ms. Roberts indicated when a medication error occurs

direct care staff members are supposed to write an incident report to document what happened, she is notified of the incident by phone, and the direct care staff member contacts the pharmacy to find out if they should hold the next medications or pass them. Miss Roberts stated there are two direct care staff member signature verifications for controlled substances and these are counted each shift. During the onsite investigation, I reviewed employee files for all direct care staff members to confirm they all received the required training to administer medication.

On February 15, 2023, I contacted AFC licensing consultant, Rodney Gill. Mr. Gill stated there were three medication errors reported to him recently which did not require medical treatment but resulted after resident ran out of medication because the pharmacy did not deliver them on time. Mr. Gill stated he received documentation of the *AFC Accident / Incident Reports* and direct care staff were upfront about the error. Mr. Gill completed an onsite investigation February 10, 2023 and this concern is being addressed in Special Investigation Report #2023A0790027. Mr. Gill also stated he reviewed all resident medication administration records (MARs) and no other errors were identified.

On February 15, 2023, I interviewed direct care staff member Laura Cole. Ms. Cole stated she has never been aware of a time that someone tried to cover up a medication error. Ms. Cole stated if there is a medication administration error they write an *AFC Accident / Incident Reports* and call Ms. Roberts to let her know what happened. Ms. Cole stated she has never been told not to be honest or not document the errors when they occur.

On February 15, 2023, I interviewed direct care staff member Deanna Fenton. Ms. Fenton stated she was unaware of any times where a medication error was covered up and did not do the *AFC Accident / Incident Report*. Ms. Fenton stated she has never been told by her supervision not to document an error or not to do an *AFC Accident / Incident Reports*. Ms. Fenton stated all direct care staff members are trained to write the *AFC Accident / Incident Report* when they begin their employment. Ms. Fenton stated she has had direct care staff members say they were not trained to do it in the past but this is not true because it is part of their initial training. Ms. Fenton stated she does not know if there is a separate list of medication errors but she knows the *AFC Accident / Incident Report* go to their main office and are sent to licensing.

On February 15, 2023, I interviewed direct care staff member Nahla Gilbert who stated the narcotic counts are off sometimes. This concern is being investigated in Special Investigation Report #2023A0790027. Ms. Roberts has been informed that the narcotics count is off a few times with Resident D's Gabapentin. Ms. Gilbert stated she does not know how this happens because she only passes midnight and 4 am medications. Ms. Gilbert stated she will write an *AFC Accident / Incident Reports* when this occurs. Ms. Gilbert stated she has worked with staff that have forgotten to pass a medication and then they will fill in the MAR that it was complete. Ms. Gilbert stated the direct care staff members that work second shift have done this often but she did not have information regarding what medications were missed or what direct care staff

member made the error. Ms. Gilbert stated they do not track the medication errors. Ms. Gilbert stated she has written at least six Incident Reports for medication errors in the last two months.

On February 15, 2023, Licensee designee Mr. Olivieri sent documentation confirming there were medication errors on the following dates:

- December 4, 2022 and December 5, 2022: Resident E missed medication because medication was not delivered on time.
- December 7, 2022: Resident E's medication count was off by two Trazadone tablets.
- December 14, 2022: Resident E's medication count was off by two Trazadone tablets.
- December 18, 2022: Resident B was given his medication at the wrong time because they did not notice the time had changed.
- December 20, 2022: Resident E medication was administered at the wrong time.
- January 11, 2023: Resident B was given the wrong dosage of his medication
- January 27, 2023: Resident E's medication was administered at the wrong time.

APPLICABLE RULE	
R 400.14312	**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: (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.
ANALYSIS:	There is no indication the direct care staff members, Ms. Roberts, or licensee designee Mr. Olivieri are trying to "cover up" medication errors at Cencare #3. Licensee designee Mr. Olivieri sent documentation of all medication errors recently and there is documentation and the direct care staff members are contacting the appropriate health care professionals when this occurs. There is also a current investigation regarding medication errors with AFC Licensing consultant Rodney Gill (See SI# #2023A0790027).
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident funds were stolen during the holidays.

INVESTIGATION:

On January 6, 2023, a complaint was received via Bureau of Community and Health Systems online complaint system alleging direct care staff members stole residents' funds during the holidays. There was no information included in the complaint regarding which residents were missing their funds or which employee was involved in the theft of the funds.

On January 20, 2023, I completed an unannounced on-site investigation at Cencare #3 and interviewed direct care staff member whose current role is home manager, Ms. Roberts. Ms. Roberts showed me the lock box that all resident funds are secured in. Ms. Roberts stated she was the only one who has access to the resident funds and she is the only one that fills out the *Resident Funds Part II*. Ms. Roberts denied any direct care staff member is using the residents' personal funds for their benefit or mismanaging the funds. I counted the resident funds for Resident A, Resident B, and Resident C and matched this amount to the balance on their *Resident Funds Part II*. All three residents accounts did not match the balance listed on their *Resident Funds Part II.*

- Resident A's account balance on the *Resident Funds Part II* was $100.86 and after her money was counted, she had $96.66. Ms. Roberts stated it was likely they were missing one of the receipts from their trip to the Dollar Store.
- Resident B's account balance on the *Resident Funds Part II* was $135.59 and after the money was counted Resident B had $143.43.
- Resident C's account balance on the *Resident Funds Part II* was $62.56 and after the money was counted Resident B had $62.75.

On February 15, 2023, I interviewed direct care staff member Laura Cole. Ms. Cole stated the direct care staff members do not have access to resident funds. Ms. Cole stated she has not taken the residents on an outing but if they do, there has to be two or three staff available and that is usually done in the morning on first shift. Ms. Cole stated Ms. Roberts is the only one that has access to the money and updates the *Resident Funds Part II* forms. Ms. Cole stated she has no concerns any direct care staff member would take funds for their own personal use out of the safe. Ms. Cole stated some receipts documenting resident outings could be missing from the box. Ms. Cole stated Resident A goes to MMI during the day and she receives a certain amount of money each day and she will bring the receipts back which they post on the refrigerator until Ms. Roberts can enter them into the book and update the records.

On February 15, 2023, I interviewed direct care staff member Ms. Fenton. Ms. Fenton stated only the home manager, Ms. Roberts has access to the resident funds. Ms. Fenton stated there are times that Resident A may have something to do and not bring

a receipt to document what she spent her money on. Ms. Fenton stated Resident C has family who pays for everything. Ms. Fenton stated Ms. Roberts does a good job on tracking the receipts. Ms. Fenton stated they are not allowed to touch the residents' funds unless they take them to the zoo or the store and Ms. Roberts will give them funds to do these events. Ms. Fenton stated the funds are kept separate while they are out with their money and the change, they keep the receipts, and then bring them back to the home. Ms. Fenton stated there were no concerns that anyone took money for their own financial gain during the holidays or any other time.

On February 15, 2023, Licensee designee Mr. Olivieri sent documentation of the Employee Handbook on page 10 which states *"Employees are not permitted to borrow money from residents or family members or petty cash under any circumstances."*

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Based on this investigation, there is no indication that Resident Funds were stolen from any of the residents. Although there were three resident accounts that were off, with two benefitting the residents, the accounts were not off by more than a few dollars and interviews with direct care staff members Ms. Cole, Ms. Roberts, Ms. Wojciechowski, Ms. Gilbert, and Ms. Fenton all confirmed there were no suspicions of resident funds which were stolen over the holidays or any other time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Direct care staff member Carolyn Roberts does not have proper training.

INVESTIGATION:

On January 6th 2023, a complaint was received via Bureau of Community and Health Systems online complaint system with concerns the direct care staff member whose current role is home manager, Ms. Roberts, did not have the proper training for her position.

On February 15, 2023, I interviewed direct care staff member Laura Cole. Ms. Cole stated she has never had any concerns about Ms. Roberts not receiving proper training. Ms. Roberts handles situations properly and she has never felt that she needed

direction in a situation and Ms. Roberts could not help her deal with a situation and how to move forward.

On January 20, 2023, I completed on an onsite investigation at Cencare #3 and met with Ms. Roberts. Ms. Roberts stated she has been in this role for over two years. Ms. Roberts stated she receives regular training and feels competent in her position as a result of her experience and training.

Licensee designee Mr. Olivieri sent documentation showing Ms. Roberts has completed all required licensing trainings in March 2020.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: (a) Reporting requirements. (b) First aid. (c) Cardiopulmonary resuscitation. (d) Personal care, supervision, and protection. (e) Resident rights. (f) Safety and fi re prevention. (g) Prevention and containment of communicable diseases.
ANALYSIS:	There is no indication that Ms. Roberts has not been trained for her role as a direct care staff member. Mr. Olivieri sent documentation showing she has completed all her required licensing trainings of (a) Reporting requirements. (b) First aid. (c) Cardiopulmonary resuscitation. (d) Personal care, supervision, and protection. (e) Resident rights. (f) Safety and fire prevention. (g) Prevention and containment of communicable diseases in March 2020.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite investigation on January 20, 2023, I counted the resident funds for Resident A, Resident B, and Resident C and matched this amount to the balance on their *Resident Funds Part II*. All three residents accounts did not match the balance that was listed on their *Resident Funds Part II.* Resident A's account balance on the *Resident Funds Part II* was $100.86 and after her money was counted, she had $96.66. Ms. Roberts stated there were likely receipts from the Dollar Store which did not get

deducted on their *Resident Funds Part II*. Resident B's account balance on the *Resident Funds Part II* was $135.59 and after the money was counted Resident B had $143.43. Resident C's account balance on the *Resident Funds Part II* was $62.56 and after the money was counted Resident B had $62.75.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	During the onsite investigation on January 20, 2023, I counted the resident funds for Resident A, Resident B, and Resident C and matched this amount to the balance on their *Resident Funds Part II*. All three residents accounts did not match the balance that was listed on their *Resident Funds Part II.* Resident A's account balance on the *Resident Funds Part II* was $100.86 and after her money was counted, she had $96.66. Ms. Roberts stated it was likely they were missing one of the receipts from their trip to the Dollar Store. Resident B's account balance on the *Resident Funds Part II* was $135.59 and after the money was counted Resident B had $143.43. Resident C's account balance on the *Resident Funds Part II* was $62.56 and after the money was counted Resident B had $62.75.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning

__ ____02/23/2023_____

Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 03/02/2023

_____

Dawn N. Timm Date
Area Manager