GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 12, 2023

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

RE: License #: AS370011309
Investigation #: 2023A1033016
Cencare #5

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 (517) 284-9730.

Sincerely,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370011309
Investigation #:	2023A1033016
Complaint Receipt Date:	12/16/2022
Investigation Initiation Date:	12/16/2022
Report Due Date:	02/14/2023
Licensee Name:	Cencare Foster Care Homes
Licensee Address:	1933 Churchill Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6200
Administrator:	Todd Olivieri, Designee
Licensee Designee:	Todd Olivieri, Designee
Name of Facility:	Cencare #5
Facility Address:	4600 Crawford Mount Pleasant, MI 48858
Facility Telephone #:	(989) 773-1023
Original Issuance Date:	08/12/1993
License **Status:**	REGULAR
Effective Date:	04/12/2022
Expiration Date:	04/11/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A took Resident B's Zonisamide medication on 12/15/22.	Yes

III. METHODOLOGY

12/16/2022	Special Investigation Intake 2023A1033016
12/16/2022	APS Referral No referral indicated as no current suspicion of abuse/neglect.
12/16/2022	Special Investigation Initiated - Telephone Interview with Licensing Consultant, Rodney Gill.
12/27/2022	Inspection Completed On-site Interview with direct care staff, Natasha Carll, Tamika Carll, Amber Gale, Theresa Brinkman, Sierra Mosby, and Home Manager, Sarah Carll. Review of Resident A & B Medication Administration Records, and review of medication room and medication passing process observed.
12/27/2022	Inspection Completed-BCAL Sub. Compliance
01/04/2023	Exit Conference completed with Licensee Designee, Todd Olivieri, via telephone.

ALLEGATION:

Resident A took Resident B's Zonisamide medication on 12/15/22.

INVESTIGATION:

On 12/16/22 an AFC Licensing Division Incident/Accident Report (IR) was received regarding the Cencare #5 (the facility) adult foster care facility. The IR reported Resident A had mistakenly taking Resident B's Zonisamide medication on 12/15/22. On 12/27/22 I completed an on-site investigation at the facility. I interviewed direct care staff, Natasha Carll who reported she had knowledge of the incident concerning Resident A and Resident B's medications, but she was not working the date of the incident. Ms. Carll reported proper medication administration procedure at the facility is to administer one resident's medications at a time and not to set up more than one

resident's medications to avoid mistakenly giving the wrong medications to the incorrect resident. Direct care staff members Tamika Carll, and Amber Gale were also present at the facility on 12/27/22 and reported that they have not witnessed any staff members setting up more than one resident's medications at a time.

On 12/27/22, during on-site investigation, I interviewed Home Manager, Sarah Carll. Ms. Carll reported she was not working on the night of 12/15/22, when the incident was reported. Ms. Carll reported she received a phone call that evening from direct care staff member Theresa Brinkman. Ms. Carll reported Ms. Brinkman stated she and direct care staff member Sierra Mosby were working the night shift at the facility and Ms. Mosby was passing medications. Ms. Carll further reported Ms. Brinkman had noted on the telephone that Resident A had taken Resident B's medication. Ms. Carll reported she advised Ms. Mosby and Ms. Brinkman to send Resident A to the hospital for evaluation. Ms. Carll reported Ms. Mosby stated she was setting up Resident A's medication and had just completed setting up Resident B's medication when Resident A came into the medication room and mistakenly took Resident B's medication, which was sitting on the desk in a medication cup, waiting to be administered to Resident B. Ms. Carll reported Resident A was released from the emergency room and had no residual effects from taking Resident B's Zonisamide medication.

On 12/27/22, during on-site investigation, I interviewed Ms. Brinkman. Ms. Brinkman reported that she had been working with Ms. Mosby the evening of 12/15/22. Ms. Brinkman reported she was assisting a resident, in the restroom, with personal care, while Ms. Mosby was administering medications. Ms. Brinkman reported that Resident A had been exhibiting behaviors during their shift related to his colostomy bag. She reported Ms. Mosby had asked Resident A to get a glass of water to take his pills. Ms. Brinkman reported that the next thing she heard was Ms. Mosby saying, "[Resident A] why did you do that?" Ms. Brinkman reported Resident A had mistakenly taken Resident B's Zonisamide medication. She reported they gave Resident A fluids and Ms. Mosby transported him to the emergency department for assessment.

On 12/27/22, during on-site investigation, I interviewed Ms. Mosby. Ms. Mosby reported that on the evening on 12/15/22 she had been working at the facility with Ms. Brinkman. Ms. Mosby reported she was administering medications and had fallen behind in her nightly tasks. She reported she was preparing the two resident medications at the same time. Ms. Mosby reported that she had prepared Resident A's medications and was working on preparing Resident B's medications. She reported she had called Resident A to the medication room to take his medications and he arrived to take the medications and grabbed the wrong pill cup. She reported there was a pill cup on the counter for Resident A and one for Resident B and her back was to the cups when Resident A appeared in the medication room. She reported Resident A picked up the cup for Resident B and consumed the medications. Ms. Mosby reported Home Manager, Sarah Carll, was called and they were instructed to take Resident A to the emergency department. Ms. Mosby reported she took Resident A to the emergency department. Ms. Mosby reported Ms. Brinkman had been assisting another resident in

the restroom at the time of the incident. Ms. Mosby reported this was not typical practice for her to set up more than one resident's medications at a time.

During on-site investigation, on 12/27/22, I did review the employee file for Ms. Mosby. There was documented training in medication administration found in this employee file. Also noted in Ms. Mosby's employee file was an *Employee Write Up* form dated for 12/16/22. This form noted, "Sierra left meds unattended resulting in [Resident A] taking [Resident B's] medications. 3 capsules of Zonisamide 100mg. Also lied to manager when 1st asked what happened. Was also on the phone during med passing time. Sierra will study the 5 rights of medication, complete the basic medication test again. Sierra will not be on her phone at work! Sierra will follow the correct medication med protocol. Only 1 residents meds at a time!" Ms. Mosby and Home Manager, Sarah Carll, both signed this form.

APPLICABLE RULE	
R 400.14312	**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 upon interviews with direct care staff members Sierra Mosby and Theresa Brinkman, and direct care staff member/Home Manager, Sarah Carll, as well as review of *Medication Administration Records* for Resident A and Resident B, it can be established that Ms. Mosby reported being distracted, rushing through medication administration, by preparing more than one resident's medications at the same time. This ultimately leading to Resident A mistakenly taking Resident B's Zonisamide medication on the evening of 12/15/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

01/09/23

_____

Jana Lipps Date
Licensing Consultant

Approved By:

01/12/2023

_____

Dawn N. Timm Date
Area Manager