GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 17, 2023

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

RE: License #: AS370011292
Investigation #: 2023A1033009
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. 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 #:	AS370011292
Investigation #:	2023A1033009
Complaint Receipt Date:	11/20/2022
Investigation Initiation Date:	11/23/2022
Report Due Date:	01/19/2023
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 receive insufficient training based on current resident assessment plans.	Yes
There is not adequate staffing at the facility to manage Resident A's G-tube.	Yes

III. METHODOLOGY

11/20/2022	Special Investigation Intake 2023A1033009
11/22/2022	APS Referral No APS referral needed at this time- no allegation of abuse or neglect.
11/23/2022	Special Investigation Initiated - On Site Interview Home Manager, Carolyn Roberts, direct care staff, Sara Wojciechowski, & Lisa Vogel. Interview Resident B. Initiated review of resident records. Reviewed staff training records.
12/01/2022	Contact – Telephone call made Voicemail message left for Darcy McNeil with Cencare Foster Care Homes, regarding employee training materials for Carolyn Roberts. Awaiting a call back.
12/02/2022	Contact - Telephone call made Interview with direct care staff, Wendy Smoot, via telephone.
12/02/2022	Contact - Telephone call made Interview with direct care staff, Nahla Gilbert, via telephone.
12/06/2022	Inspection Completed-BCAL Sub. Compliance
01/04/2023	Contact – Telephone call made Voicemail message left for Darcy McNeil with Cencare Foster Care Homes, regarding employee training materials for Carolyn Roberts. Awaiting a call back.
01/04/2023	Exit Conference completed with Licensee Designee, Todd Olivieri, via telephone.

ALLEGATION:

- **Direct care staff receive insufficient training based on current resident assessment plans.**
- **There is not adequate staffing at the facility to manage Resident A's G-tube.**

INVESTIGATION:

On 11/21/22 I received an online complaint regarding the Cencare #3 (the facility) adult foster care facility. The complaint alleged facility direct care staff have not been adequately trained to perform their job responsibilities. The complaint specified that there is a resident at the facility, Resident A, who has a percutaneous endoscopic gastrostomy tube (G-tube) for tube feedings, and he continually pulls the G-tube out of his abdomen. The direct care staff have not been properly trained on how to reinsert the G-tube and rely on on-call management staff to arrive to reinsert the G-tube. The complaint alleges that there is a narrow window of time for this task to be accomplished before the entry point in the abdomen closes where the G-tube has become dislodged.

On 11/23/22 I completed an on-site investigation at the facility. I interviewed Home Manager, Carolyn Roberts who reported the facility has two residents who have feeding tubes, Resident A and Resident B. Ms. Roberts reported Resident A tends to pull out his G-tube more regularly than Resident B. Ms. Roberts reported most recently Resident A pulled out his G-tube on 11/17/22 and had to be sent to the emergency department to have the tube replaced. Ms. Roberts reported she was on-call on 11/17/22 but by the time she reached the facility the opening for the G-tube, in Resident A's abdomen, had closed to the point she could not reinsert the tube. Ms. Roberts reported not all direct care staff are trained to reinsert the G-tube for Resident A and Resident B. Ms. Roberts reported she was trained by direct care staff member Sara Wojciechowski to reinsert the G-tube. Ms. Roberts reported there are shifts where there is not a trained staff member available to manage the G-tube reinsertion. Ms. Roberts reported all direct care staff have been trained to keep the area clean and dry and call an on-call staff for assistance if Resident A or Resident B removed their G-tube. Ms. Roberts reported that if an on-call, trained, staff member is not available then the direct care staff are trained to call emergency services to have the G-tube reinserted.

On 11/23/22, during on-site investigation, I interviewed direct care staff member Sara Wojciechowski. Ms. Wojciechowski reported she has worked for the facility for about 2.5 years. She reported she was trained in handling Resident A's G-tube reinsertion from the previous Home Manager, Jeanette Beebe. Ms. Wojciechowski reported she was not given a competency sign off from Ms. Beebe but felt confident in her training to reinsert Resident A's G-tube if it is pulled from his abdomen. Ms. Wojciechowski reported she believes Ms. Beebe was trained by Resident A's physician, Dr. James Pilkington, but she could not be certain about this information. Ms. Wojciechowski reported there are shifts in which there is not a direct care staff

member scheduled who has been trained to reinsert Resident A or Resident B's G-tubes. She reported that when this incident occurs and an untrained staff member is present, the staff member is instructed to keep the area clean and dry and call for an on-call staff member to come to the facility to assist.

On 11/23/22, during on-site investigation, I interviewed direct care staff, Lisa Vogel. Ms. Vogel reported that she has worked for the facility for around 1.5 months. Ms. Vogel reported that she has not received direct training to reinsert the G-tube but has been observing other trained staff with this task. Ms. Vogel reported that she was working on 11/17/22 when Resident A pulled his G-tube from his abdomen. Ms. Vogel reported that there was not a trained staff on shift to manage reinserting the G-tube and she needed to contact Ms. Roberts to assist. Ms. Vogel reported that Ms. Roberts had to send Resident A to the emergency department as the opening for the G-tube had closed before she was able to arrive on-site to reinsert the G-tube.

On 12/2/22 I interviewed direct care staff, Nahla Gilbert, via telephone. Ms. Gilbert reported that she has been trained to administer tube feedings, via Resident A and Resident B's G-tubes, but she has not been trained how to reinsert the G-tubes if they are pulled out of the abdomen. Ms. Gilbert reported that Resident A's G-tube was pulled out of his abdomen on 11/16/22 at 5am and the on-call staff did not arrive to reinsert the G-tube until 6:15am. She reported that she has not been directed to send Resident A or Resident B to the emergency department if the on-call staff is not immediately available to reinsert the G-tube. Ms. Gilbert reported that she feels her training on how to administer the tube feedings was rushed and she has not received any trainings on how to reinsert the G-tube once it is pulled from the abdomen.

On 12/2/22 I interviewed direct care staff, Wendy Smoot. Ms. Smoot reported she has been trained how to reinsert the G-tube, but she does not feel confident in this training. Ms. Smoot reported she has worked for the facility for about five years and was trained how to reinsert the G-tube by direct care staff, Valerie Mears (who she noted is now deceased). Ms. Smoot reported there are shifts where there are no direct care staff members working who are trained in how to reinsert the G-tube. Ms. Smoot reported she has been instructed to contact on-call staff when the G-tube has become dislodged from the abdomen and on-call staff come to the facility to manage the issue.

During on-site investigation I reviewed employee training files for the following direct care staff members:

- Nahla Gilbert
- Aleshia Esch
- Lisa Vogel
- Teagen Esch
- Deanna Fenton

- Wendy Davy (Smoot)
- Sara Wojciechowski

As a result of this employee training review, I found that the following direct care staff had no evidence of G-tube training in their employee files:

- Nahla Gilbert
- Aleshia Esch
- Lisa Vogel
- Teagen Esch
- Sara Wojciechowski

During the on-site investigation, on 11/23/22, I attempted to interview Resident B. Resident B has a difficult time with communication and was not able to offer detailed insight into her care at the time of this interview.

During the on-site investigation, on 11/23/22, I reviewed the resident records for Resident A and Resident B. Resident A's resident record indicated that he is non-verbal. I reviewed Resident A's *Person Centered Plan (PCP)* completed through the Community Mental Health for Central Michigan agency and dated for 1/4/22. On page 3, under the section, *Indicate the need for supports in any of the following safety domanins*, it reads, "[Resident A] does have a tube feeding that was put in place due to choking and swallowing issues. Because he has pulled his feeding tube out on several occasions, there is always a trained staff available (trained by the gastroenterologist) to deal with that situation and to assist with re-insertion of the tube." Also, in this section of page 3 it states, "[Resident A] has a history of pulling out his peg tube. As noted, specific staff have been trained to replace the peg tube. Someone should be available on each shift to be able to address this need. Generally, this is not an "emergency" situation, as the ER doesn't carry supplies to replace the tube."

On 11/23/22 I reviewed Resident B's PCP completed by Community Mental Health for Central Michigan and dated for 5/13/22. Resident B's PCP indicates that she has a G-tube for tube feedings but it does not specify a level of staff training needed to manage her G-tube.

On 12/1/22 and 1/4/23 I made requests to review the training records for Home Manager, Carolyn Roberts. I have not received these records to date.

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 fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Based upon interviews with direct care staff members Ms. Roberts, Ms. Wojciechowski, Ms. Vogel, Ms. Gilbert, and Ms. Smoot, as well as my review of employee training files and Resident A and Resident B resident records, it can be determined direct care staff have not been adequately trained to administer re-insertion of Resident A's G-tube. Ms. Roberts reported she has been trained to re-insert the G-tube by Ms. Wojciechowski, but there was no evidence in Ms. Wojciechowski's file that indicated she has received any training in this area or has the competency to be a trainer. Ms. Wojciechowski reported she was trained by a direct care staff member who no longer works for the facility and the facility could not produce documentation that Ms. Wojciechowski was trained by a competent direct care staff. Resident A's *Person Centered Plan* indicated that there must be one available direct care staff member, per shift, who has been trained by Resident A's Gastroenterologist, yet Ms. Gilbert, Ms. Roberts, Ms. Wojciechowski, Ms. Vogel, and Ms. Smoot, all reported there are shifts where there is not a direct care staff scheduled who has competent training in managing Resident A's G-tube re-insertion.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based upon interviews with Ms. Roberts, Ms. Wojciechowski, Ms. Vogel, Ms. Gilbert, Ms. Smoot, as well as review of employee training files and Resident A and Resident B's resident records, it can be determined there is not adequate staffing to manage the re-insertion of Resident A's G-tube, should it become dislodged, as identified in his Person Centered Plan. Resident A's Person Centered Plan indicated there must be one available staff, per shift, who has been trained by Resident A's Gastroenterologist, yet Ms. Gilbert, Ms. Roberts, Ms. Wojciechowski, Ms. Vogel, and Ms. Smoot, all reported there are shifts where there is not a direct care staff scheduled who has competent training in managing Resident A's G-tube re-insertion.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the approval of an acceptable corrective action plan, no change to the status of the license is recommended at this time.

01/17/2023

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Jana Lipps Date
Licensing Consultant

Approved By:

01/17/2023

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Dawn N. Timm Date
Area Manager