GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 10, 2023

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

RE: License #: AS370011292
Investigation #: 2023A0790027
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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Rodney Gill, 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 #:	2023A0790027
Complaint Receipt Date:	02/07/2023
Investigation Initiation Date:	02/10/2023
Report Due Date:	04/08/2023
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?
Resident A did not receive the correct amount of a prescribed medication on 02/06/2023 and 02/07/2023. Resident B did not receive a prescribed medication at the prescribed time on 02/07/2023.	Yes

III. METHODOLOGY

02/07/2023	Special Investigation Intake 2023A0790027
02/10/2023	Special Investigation Initiated - On Site- Interviewed direct care staff member (DCSM) Laura Cole and DCSM Christina Roberts.
02/10/2023	Inspection Completed On-site
02/10/2023	APS Referral not necessary as the allegations do not meet assignment criteria for APS.
02/23/2023	Inspection Completed-BCAL Sub. Compliance
02/23/2023	Corrective Action Plan Requested and Due on 03/13/2023.
02/28/2023	Contact – Telephone call made to interview DCSM Carolyn Roberts who functions as the program director.
02/28/2023	Exit Conference with licensee designee Todd Olivieri.

ALLEGATION:

Resident A did not receive the correct amount of a prescribed medication on 02/06/2023 and 02/07/2023. Resident B did not receive a prescribed medication at the prescribed time on 02/07/2023.

INVESTIGATION:

I reviewed an *AFC Licensing Division – Incident / Accident Report* dated 02/07/2023 which documented the following medication issue: “while completing 8:00 p.m. medication pass on 02/06/2023, [Resident A] only had 10 ml of the 25 ml of Keppra he is prescribed. Direct care staff members (DCSMs) administered the 10 ml of Keppra. Keppra was ordered on 02/06/2023 @ 8:12 a.m. DCSMs spoke with Joan from

Downtown Drugs. The report stated the action taken by DCSMs was "called P.D. (pharmacy department) and fill out an *AFC Licensing Division – Incident / Accident Report."* The corrective measures taken to remedy and/or prevent recurrence was "will call Downtown Drugs and check status."

I reviewed an *AFC Licensing Division – Incident / Accident Report* dated 02/07/2023 indicating Resident A did not receive his 25 ml of Levetiracetam 100 mg at 5:00 a.m. The report stated the medication had not been delivered yet. The report indicated the action taken was "P.D. (pharmacy department) already notified". "Wrote an *AFC Licensing Division – Incident /Accident Report."* Corrective measures taken to remedy and/or prevent recurrence was to "call Downtown Drugs and check status when they open."

I reviewed an *AFC Licensing Division – Incident / Accident Report* dated 02/07/2023 indicating while DCSMs were giving Resident B her 5:00 p.m. prescribed medications on 02/06/2023, Resident B had no more Docusate. DCSMs called the pharmacy, and the medication was delivered after 5:00 p.m. medication pass. DCSMs gave Resident B her Docusate during 8:00 p.m. medication pass. The action taken by DCSMs was to "call P.D. (pharmacy department) and fill out an *AFC Licensing Division – Incident / Accident Report."* There were no corrective measures documented to remedy and/or prevent reoccurrence.

I conducted an unannounced onsite investigation on 02/10/2023. The facility appeared clean and well kempt. The residents were eating or getting ready to eat dinner. They all appeared to be cared for appropriate, clean, neat, and dressed appropriately.

I interviewed direct care staff members Laura Cole and Christina Roberts. Ms. Roberts said she has not been trained as a medication passer and does not do anything related to giving residents medications.

Ms. Cole said she is trained as a medication passer and administers medication on second shift. Ms. Cole allowed me to review documentation relating to the missed medications outlined in the *AFC Licensing Division – Incident / Accident Reports*. She showed me Resident A's *Medication Administration Record* for February 2023. Ms. Cole had initialed indicating Resident A received his full 25 ml dose of Levetiracetam (Keppra) at 8:00 p.m. on 02/06/2023 although according to the report he only received a 10 ml dose. Ms. Cole disclosed Resident A received 10 ml of Levetiracetam (Keppra) even though he is prescribed 25 ml because there was only 10 ml remaining.

Resident A's *Medication Administration Record* was also initialed for his 25 ml prescribed dose of Levetiracetam (Keppra) for 5:00 a.m. medication pass on 02/07/2023 by DCSM Wendy Davy indicating the medication was administered to Resident A. Ms. Cole indicated Resident A did not receive his Levetiracetam (Keppra) at 5:00 a.m. on 02/07/2023 even though his *Medication Administration Record* showed he did because he had run out of the medication.

I reviewed Resident B's *Medication Administration Log* and found no initials for Resident B's Docusate 100 mg capsule at 5:00 p.m. on 02/07/2023 indicating Resident B did not receive the prescribed medication. Ms. Cole stated Resident B had run out of the medication. She said she called Downtown Drugs after finding out Resident B's Docusate had run out and they delivered the medication later that evening. Ms. Cole stated she gave Resident B her 5:00 p.m. dose of Docusate during the 8:00 p.m. medication pass on 02/07/2023. Ms. Cole admitted she did not document on Resident B's *Medication Administration Record* she gave Resident B her Docusate 100 mg capsule at 8:00 p.m. on 02/07/2023.

I reviewed Pharmacy Call-In Logs for Resident A and Resident B. Resident A's Pharmacy Call-In Log showed DCSMs ordered more prescribed Levetiracetam (Keppra) for Resident A on 02/06/2023 and 02/07/2023. Resident B's Pharmacy Call-In Log showed DCSMs ordered her prescribed Docusate on 01/31/2023.

I called and interviewed DCSM Carolyn Roberts who functions as the program director. Ms. Roberts provided additional information regarding the medication errors. Ms. Roberts indicated DCSMs initialed the *Medication Administration Record* for Resident A's 25 ml dose of Levetiracetam (Keppra) 100 mg indicating he received the full amount of the medication at 8:00 p.m. on 02/06/2023 and 5:00 a.m. on 02/07/2023. Ms. Roberts admitted Resident A did not receive the full prescribed amount of his Levetiracetam (Keppra) on 02/06/2023 at 8:00 p.m. because there were only 10 ml left of the medication and the facility did not receive any Levetiracetam (Keppra) at 5:00 a.m. on 02/07/2023 because Resident A had completely run out of the medication with no refills.

Ms. Roberts explained Resident B receiving her 5:00 p.m. Docusate 100 mg capsule at 8:00 p.m. on 02/07/2023 falls within the allotted timeframe or window in which she is allowed to receive the medication because Resident B receives the medication once a day (q.d.) according to the physician's order. Ms. Roberts stated to her knowledge Resident A and Resident B suffered no side effects because of the medication errors.

I reviewed all training completed by DCSMs Ms. Cole and Ms. Devy and confirmed Ms. Devy completed medication administration training on 11/05/2017 and Ms. Cole completed medication administration training on 01/03/2023.

I conducted an exit conference with licensee designee Todd Olivieri on 02/28/2023 informing him violations were established because of this special investigation. Mr. Olivieri was asked to complete a Correction Action Plan (CAP).

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on information gathered during this investigation through review of documentation and interviews with DCSMs Laura Cole, Christina Roberts, and Carolyn Roberts there is evidence indicating Resident A ran out of a prescribed medication and was not given the medication pursuant to label instructions on 02/06/2023 and 02/07/2023. Resident B ran out of a prescribed medication on 02/07/2023 and did not receive the medication pursuant to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	Based on information gathered during this investigation through review of documentation and interviews with DCSMs Laura Cole, Christina Roberts, and Carolyn Roberts there is evidence indicating on 02/06/2023 Ms. Cole gave Resident A a reduced amount of his prescribed Levetiracetam (Keppra) without instructions from a physician or a pharmacist who had knowledge of the medical needs of Resident A nor did any direct care staff member follow-up with a physician to report a reduced amount of medication had been given to determine if this would have a negative side effect.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(b) Complete an individual medication log that contains all the following information:**

	(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Based on information gathered during this investigation through review of documentation and interviews with DCSMs Laura Cole, Christina Roberts, and Carolyn Roberts there is evidence indicating on 02/06/2023 Ms. Cole initialed she gave Resident A a 25 ml prescribed dose of Levetiracetam (Keppra) but only gave him 10 ml because there was only 10 ml of the medication left. Ms. Cole admitted she gave Resident B her 5:00 p.m. prescribed Docusate 100 mg capsule at 8:00 p.m. on 02/07/2023 but failed to initial Resident B's *Medication Administration Record.* Ms. Devy initialed Resident A's *Medication Administration Record* for his 25 ml prescribed dose of Levetiracetam (Keppra) at 5:00 a.m. on 02/07/2023 but did not administer it because Resident A had run out of the medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

02/24/2023

Rodney Gill Date
Licensing Consultant

Approved By:

03/10/2023

Dawn N. Timm Date
Area Manager