GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 31, 2026

Darcy McNeal
Cencare Foster Care Homes
1933 Churchill
Mt Pleasant, MI 48858

RE: License #: AS370011291
Investigation #: 2026A1029052
Cencare Foster Home 4

Dear Ms. McNeal:

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 licensee designee 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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

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

I. IDENTIFYING INFORMATION

License #:	AS370011291
Investigation #:	2026A1029052
Complaint Receipt Date:	06/24/2026
Investigation Initiation Date:	06/24/2026
Report Due Date:	08/23/2026
Licensee Name:	Cencare Foster Care Homes
Licensee Address:	1933 Churchill, Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6200
Administrator:	Darcy McNeal
Licensee Designee:	Darcy McNeal
Name of Facility:	Cencare Foster Home 4
Facility Address:	2305 W. Deerfield, Mount Pleasant, MI 48858
Facility Telephone #:	(989) 773-7542
Original Issuance Date:	06/19/1989
License Status:	REGULAR
Effective Date:	06/06/2026
Expiration Date:	06/05/2028
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 06/16/2026 direct care staff member Joann Denaro administered Resident B's medications to Resident A in error.	Yes

III. METHODOLOGY

06/24/2026	Special Investigation Intake 2026A1029052
06/24/2026	Inspection Completed On-site - Special Investigation Initiated - Face to Face with Resident A and Madonna Garrett at Cencare Foster Home 4
07/08/2026	APS Referral made to Centralized Intake
07/23/2026	Contact - Telephone call made to direct care staff member Joann Denaro (Left message), licensee designee Darcy McNeal, and Amelia Abraham
07/28/2026	Contact – Email from Darcy McNeal with verification the two direct care staff members were retrained after the incident.
07/29/2026	Contact – Telephone call to Joann Denaro
07/29/2026	Exit conference with licensee designee Darcy McNeal, left message.

ALLEGATION: On 06/16/2026 direct care staff member Joann Denaro administered Resident B's medications to Resident A in error.

INVESTIGATION:

On 06/24/2026 a complaint was received via Bureau of Community and Health Systems online complaint system with concerns that on 06/16/2026 Resident A received Resident B's medications in error by Joann Denaro who was administering medications during this time. According to the complaint allegations, poison control and Downtown Drugs were contacted and Resident A was taken to the emergency room.

On 06/24/2026, I conducted an unannounced on-site investigation at Cencare 4 and interviewed direct care staff member whose role is home manager, Madonna Garrett. Ms. Garrett reported that a recent medication error had occurred and provided the *AFC Incident/Accident Report* documenting the event. She explained that direct care staff

member Joann Denaro prepared medications for Resident A and placed them on the medication desk for his scheduled 6:30 a.m. administration. Before Resident A arrived, the second direct care staff member on shift, Amelia Abraham, mistakenly informed Resident B that his medications were ready. Before the error was realized, Resident A entered the medication room and consumed the medications intended for Resident B. Staff immediately contacted Poison Control, and Resident A was subsequently transported to the emergency room for further evaluation.

Ms. Garrett stated that the medications taken by Resident A, which were prescribed to Resident B, included Omeprazole, Atenolol, Effexor, a multivitamin, Vitamin D3, Lisinopril, Flomax, and Clozapine. She reported that she has not had any prior concerns regarding Ms. Denaro or Ms. Abraham. Both employees began working at Cencare on 05/27/2026 and had previously been trained in medication administration at another AFC facility. Ms. Garrett stated that upon their hire, medication procedures were reviewed with them, and they successfully completed three supervised medication passes before being permitted to administer medications independently.

I reviewed the *AFC Incident / Accident Report* which documented that poison control was contacted, contacted management, spoke to consumers doctor, and took vital signs after the incident. Under How to Prevent Reoccurrence section, it documented for direct care staff to follow the 6 rights at all times, if unsure ask, allow a second checker, keep mind clear, make sure surface is clear of anything, and make sure only one resident medication is out at a time. Ms. Garrett had attached a summary of this incident which stated, in part, the following information:

> *"On 06/16/2026 Med pass staff J. Denaro had prepared medications for [Resident B] and placed them on the med desk as she was sitting at the desk waiting for [Resident B] to come into the med room to receive his 6:30am meds. [Resident A] entered the dining room and staff person A. Abraham told [Resident A] that his meds were prepared. [Resident A] then barged into the med room and grabbed the med cup and put them in his mouth before the two staff could stop him from swallowing them. Staff person J. Denaro was present in the room and told [Resident A] those are not your meds you need to spit them out. [Resident A] did not listen, and he swallowed the medication prepared for [Resident B]. Staff J. Denaro immediately called Cencare #4 by M. Garrett and informed her of the situation. APD F. Mead arrived at 6:51am and called poison control and informed Sarah of the situation. F. Mead also contacted Ray Rutkowski the on ph.[sic] pharmacist at Downtown Drugs. Ray was driving to the pharmacy, and he was unable to call him at the pharmacy after 8:00am. F. Mead called the pharmacy and reviewed the notes of medications with pharmacist R. Rutkowski, the pharmacist instructed the staff to transport [Resident A] to the Mclaren emergency room for further evaluation. [Resident A] was transported by d/c staff. doctor J. Carey D.O stated that they would need to contact poison control and follow their instructions as well as follow the hospital's protocol which was to monitor patient's blood pressure for*

four hours, administer an IV drip of saline, perform a EEG and draw labs. After the testing and monitoring of [Resident A] was completed [Resident A] was released from the hospital at 1:23pm. J. Carey instructed staff to hold [Resident A] pm meds (Thorazine 25mg & Clozapine 75mg) for 6/16. [Resident A]'s blood pressure was monitored throughout the day & night.

I reviewed documentation confirming both Ms. Denaro and Ms. Abraham completed medication administration training. I also reviewed the vitals monitoring sheet, which showed that they monitored Resident A's vital signs from 6:27 a.m. until approximately 9:00 a.m., when he was transported to the hospital. Resident A's vitals were monitored further at McLaren Hospital. The physician order directed staff to hold Resident A's 2:00 p.m. medications and administer his 9:00 p.m. medications after he returned from the hospital. I also reviewed the hospital discharge instructions, which indicated he was treated for accidental drug ingestion related to this incident.

I interviewed Resident A, who stated he did not recall taking medications prescribed for another resident. He reported no health concerns and stated that he felt well.

On 07/23/2026, I interviewed direct care staff member Amelia Abraham. She explained direct care staff member Ms. Denaro was assigned to administer medications and she had contacted her stating she believed she was missing one medication. Ms. Abraham recounted the medications and she counted eight medications; she assumed they belonged to Resident A and informed him they were ready. She stated that Resident A then entered the medication room and took the medications before she could intervene when she realized they were Resident B's medications. Ms. Abraham reported immediately notifying the assistant manager, contacting Poison Control, and the pharmacy. Ms. Abraham confirmed she had received three days of training on medication administration before being permitted to administer medications independently. She reported that Resident A was transported to the hospital, where his blood pressure was monitored and it was initially stable but later decreased because he had ingested blood pressure medication not prescribed to him. Ms. Abraham stated she also notified ORR and said she believed Ms. Denaro was "devastated by the incident and did not act intentionally." Ms. Abraham suggested implementing a second-checker system during medication administration, noting that two direct care staff members are always on shift and that this practice was used at her previous AFC facility where she was employed.

On 07/23/2026, I interviewed licensee designee Darcy McNeal. Ms. McNeal stated that Resident B's medications had been prepared and left out, and Resident A entered and took them. She reported that both direct care staff members were retrained on medication administration and reviewed medication guidelines following the incident. Ms. McNeal stated no further issues have occurred since the retraining. She confirmed that while both direct care staff members had prior medication training from another AFC, they were new to Cencare 4 at the time of the incident.

On 07/29/2026, I interviewed direct care staff member Joann Denaro. Ms. Denaro stated that she had prepared the medications and inadvertently administered them to the wrong resident when Resident A entered the medication room. She explained that she initially believed she was missing a pill for Resident B's medication set and asked her coworker to assist in verifying the count. Once the missing pill was located, Ms. Abraham, who was in the kitchen at the time, mistakenly told Resident A that his medications were ready. Before she could correct herself, Ms. Denaro handed Resident A the cup containing Resident B's medications. Ms. Denaro reported that Ms. Abraham attempted to intervene, telling Resident A to stop, but he had already swallowed the medications.

Ms. Denaro stated that she immediately notified management, monitored Resident A's vital signs, and arranged for him to be transported to the hospital when his blood pressure began to decline and he became drowsy later in the day. She reported that following the incident, both she and Ms. Abraham were retrained in medication administration procedures. Ms. Denaro stated that the shift had been hectic and she made an error, but the incident reinforced the importance of slowing down, staying focused during medication preparation, and ensuring accuracy before administering medications. She stated she is concerned about the potential consequences of medication errors and views this event as a reminder to remain attentive and deliberate.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on the interviews with direct care staff members Ms. Garrett, Ms. Denaro, Ms. Abraham, and licensee designee Ms. McNeal, each provided consistent accounts describing how the error occurred, explaining that medications prepared for Resident B were handed to Resident A before Ms. Denaro realized the mistake. Ms. Denaro had the medication prepared and Ms. Abraham told the wrong resident that the medications were ready leading to the error. Ms. Denaro and Ms. Abraham contacted management and poison control, checked Resident A's vitals, and he was taken to the hospital for further monitoring. Since this incident, both Ms. Denaro and Ms. Abraham have been retrained on medication administration and there have been no further incidents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

_____07/29/2026_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

07/31/2026

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Dawn N. Timm
Area Manager

Date