GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 20, 2022

Samantha Nieuwenbroek
Life Center Inc
Ste. 100
36975 Utica Rd.
Clinton Twp., MI 48038

RE: License #: AS630389328
Investigation #: 2022A0605026
Lake Orion

Dear Ms. Nieuwenbroek:

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 (248) 975-5053.

Sincerely,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630389328
Investigation #:	2022A0605026
Complaint Receipt Date:	03/14/2022
Investigation Initiation Date:	03/14/2022
Report Due Date:	05/13/2022
Licensee Name:	Life Center Inc
Licensee Address:	Ste. 100 36975 Utica Rd. Clinton Twp., MI 48038
Licensee Telephone #:	(586) 739-9220
Administrator/Licensee Designee:	Samantha Nieuwenbroek
Name of Facility:	Lake Orion
Facility Address:	1025 Orion Road Lake Orion, MI 48035
Facility Telephone #:	(248) 814-7650
Original Issuance Date:	05/03/2018
License Status:	REGULAR
Effective Date:	11/03/2020
Expiration Date:	11/02/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 03/13/22, Resident A was rushed to the hospital and had a seizure. He received the wrong dose of Seroquel due to a direct care staff (DCS) error.	Yes

III. METHODOLOGY

03/14/2022	Special Investigation Intake 2022A0605026
03/14/2022	Special Investigation Initiated - Letter An email was sent to Office of Recipient Rights (ORR) Rishon Kimble.
03/14/2022	APS Referral Adult Protective Services (APS) referral made.
03/14/2022	Contact – Document received APS letter received. Assigned APS worker is T. Kelly.
03/15/2022	Contact - Telephone call made I left message for ORR Rishon Kimble.
03/17/2022	Contact - Face to Face I attempted an unannounced on-site investigation, but no one was home.
03/17/2022	Contact - Telephone call made I contacted licensee designee Samantha Nieuwenbroek and left message for the home manager Demitra Bonds.
03/17/2022	Contact - Face to Face I observed Resident A at his school, Pine Tree Center located at 590 Pine Tree Rd, Lake Orion. I interviewed Resident A's teacher.
03/24/2022	Contact - Telephone call made I left another message for the home manager Demitra Bonds.
03/24/2022	Contact - Document Received I received Resident A's discontinued script for his Seroquel from home manager Demitra Bonds.

04/07/2022	Contact - Telephone call made I interviewed direct care staff (DCS) Lillie Bonds, Resident A's mother and left message for Resident A's father regarding the allegations.
04/07/2022	Contact - Telephone call made I left message for ORR Rishon Kimble.
04/13/2022	Contact - Telephone call received Discussed allegations with ORR Rishon Kimble.
04/18/2022	Exit Conference I left detailed message for licensee designee Samantha Nieuwenbroek with my findings.

ALLEGATION:

On 03/13/22, Resident A was rushed to the hospital and had a seizure. He received the wrong dose of Seroquel due to a staff error.

INVESTIGATION:

On 03/14/2022, intake #185752 was assigned for investigation based on the incident report received dated 03/13/2022 regarding Resident A receiving an incorrect dosage of Seroquel which resulted in going to the hospital.

On 03/14/2022, I initiated the special investigation by making a referral to Oakland County of Office of Recipient Rights worker Rishon Kimble and Adult Protective Services (APS).

On 03/17/2022, I attempted an unannounced on-site investigation at Lake Orion, but no one was home.

On 03/17/2022, I contacted licensee designee Samantha Nieuwenbroek requesting the home manager's (HM) contact information and briefly discussed the allegations. Ms. Nieuwenbroek stated DCS Lillie Bonds gave the wrong dose of Seroquel to Resident A's father and then Resident A's father administered the wrong dose to Resident A. She stated that Lillie Bonds returned the Seroquel 100MG AM blister pack instead of the Seroquel 50MG AM. Therefore, Resident A's father administered 150MG instead of only 100MG of Seroquel in the AM on 03/13/2022. Ms. Nieuwenbroek stated that Resident A attends Pine Tree Center located in Lake Orion.

On 03/17/2022, I conducted a face-to-face contact with Resident A at Pine Tree Center located at 590 Pine Tree Road in Lake Orion. I was unable to interview Resident A as he is non-verbal. Resident A was watching TV during my visit. He appeared to have

good hygiene. I briefly spoke with Resident A's teacher Lisa Oja regarding Resident A and Lake Orion. Ms. Oja stated Resident A arrives at school always clean and overall has no issues with Lake Orion.

On 03/24/2022, the HM Demitra Bonds texted Resident A's blister pack medications and the new script after Resident A was in the hospital due to receiving the incorrect Seroquel dosage.

On 04/06/2022, I conducted another unannounced on-site investigation. There are four residents residing at Lake Orion. Resident B was present but did not want to speak with me; therefore, he was not interviewed. Resident B appeared to have good hygiene. Resident C and Resident D were at workshop. I interviewed the HM Demitra Bonds regarding the allegations. The HM has been working for this corporation for 13 years. The HM manager stated on 11/02/2021, Resident A's script for Seroquel was 50MG in the AM and 100MG in the PM. However, on 03/10/2022, after Resident A was seen by his neurologist, the neurologist modified the Seroquel script to 100MG in the AM and 100MG in the PM. Resident A's mother arrived at Lake Orion the night of 03/11/2022 after the pharmacy dropped off the blister packs. The HM stated DCS Lillie Bonds was on shift. The mother explained to Lillie that the script changed and to ensure that Resident A's father received the correct blister pack with the father came to pick Resident A up on 03/12/2022 for an overnight visit. The HM stated it seemed that Lille was confused and instead of pulling out the Seroquel 50MG 8AM, Lillie pulled out the Seroquel 100MG 8PM. On 03/12/2022, while the HM was working, Resident A's father arrived at Lake Orion to pick Resident A up. The HM placed the blister packs into Resident A's overnight bag without verifying if the correct medications were provided to Resident A's father. The father administered Resident A the 100MG of Seroquel on 03/12/2022 in the PM and then 150MG of Seroquel the morning of 03/13/2022 as the 50MG blister pack was rubber banded with the other 8AM medications. Resident A had a seizure and was hospitalized. The HM stated Resident A returned to Lake Orion on 03/14/2022. She stated after the seizure, Resident A's neurologist modified the script to 50MG of Seroquel twice daily; once in the AM and again in the PM. The HM stated this was an isolated incident and she will be conducting a staff meeting on 04/16/2022 to in-service all staff on verifying medication when they arrive at Lake Orion. The HM stated although she did not verify the medication in Resident A's overnight bag, it was the responsibility of DCS Lillie Bonds to ensure that the correct medication was being returned to the pharmacy and that the correct medication was in Resident A's overnight bag.

I reviewed Resident A's medications and there were only two blister packs of the Seroquel: one blister pack for the 8AM 50MG and another blister pack for the 8PM 50MG. I reviewed the new script which verified the new dosage of Seroquel 50MG take one tablet twice daily.

On 04/07/2022, I contacted DCS Lillie Bonds via telephone regarding the allegations. Lillie is the HM's mother and has been working for this corporation since 10/2022. Lillie works all shifts and states she completed medication training. Lillie reported there is a

process for checking medication once the pharmacist delivers it to Lake Orion. The process is to check the medication book, check the script, and then to double check to ensure the correct medication is sent back to the pharmacy and the correct medication is in the home. Lillie stated, “I didn’t double check to make sure on which medication to return to the pharmacy.” Lillie stated on 03/11/2022, Resident A’s mother informed Lillie of the medication change. Lillie stated she was a bit confused of the change and that the pharmacy usually calls Lake Orion to notify them of the change, but the pharmacy did not call. The pharmacy just dropped off the medications. Lillie stated she reviewed the script and the blister packs but was confused as to which blister pack to remove so she removed the 8PM 100MG of Seroquel instead of the 8AM 50MG of Seroquel. Lillie stated she did not double check after pulling the 100MG of Seroquel if that was the correct blister pack. On 03/12/2022, the HM Demitra Bonds arrived for her shift and Lillie left. Lillie stated, “I only sent the wrong medication back to the pharmacy.” I wasn’t the one who gave Resident A’s dad the wrong medications.” Lillie stated this was an isolated incident and that she understands she should have rechecked the script and the blister packs to ensure she pulled the correct dosage to send back to the pharmacist.

On 04/07/2022, I contacted Resident A’s mother via telephone regarding the allegations. Resident A’s mother picked Resident A up on 03/10/2022 for his neurologist appointment. The neurologist changed Resident A’s Seroquel medication to 100MG in the AM instead of 50MG. On 03/11/2022, Resident A’s mother picked Resident A up for an event and then dropped him off that night. When Resident A’s mother dropped Resident A off, DCS Lillie Bonds was on shift. The pharmacy had dropped the new medications, but the mother stated that Lillie seemed “unsure,” about the medication change which did not sit well with the mother. Therefore, the morning of 03/12/2022, Resident A’s mother called the HM Demitra Bonds specifically about the Seroquel medication change. Resident A’s mother advised the HM that the mother wanted to ensure the correct medication is getting sent with Resident A’s father who was going to pick Resident A up later this day as Resident A was going to have an overnight. The mother stated that the HM reassured her in saying that “we (staff) got everything taken care of when the father picks Resident A up and the medication.” The mother stated the morning of 03/13/2022, she received a frantic call from Resident A’s father stating that Resident A had a seizure and was in the hospital. Resident A’s mother went to the hospital. Resident A’s body had tightened up and his fingers were curling up as it was determined he had a seizure. Resident A’s father had Resident A’s bag with the medications. The mother went through the bag and discovered that the 50MG of Seroquel in the AM was still rubber banded along with the 100MG Seroquel in the AM as well. Resident A’s mother told the father that the neurologist changed the Seroquel dosage to 100MG in the AM and 100MG in the PM. The mother stated Lillie never pulled out the 50MG blister pack in the AM; therefore, the father administered a 150MG of Seroquel in the AM instead of only 100MG. The mother stated she never contacted Resident A’s father regarding the change of the Seroquel; therefore, the father did not verify at the time he picked Resident A up from Lake Orion if he had the correct Seroquel dosage. Since Resident A’s seizure, the neurologist modified the Seroquel script to 50MG of Seroquel at 8AM and 50MG at 8PM. Resident A’s mother stated Lake

Orion is a good group home that has been providing very well care to Resident A. She stated this was an isolated incident and that she does not have any concerns about staff at Lake Orion.

On 04/07/2022, I interviewed Resident A's father via telephone regarding the allegations. On 03/12/2022, Resident A's father went to Lake Orion to pick Resident A up for an overnight visit. He does not recall which staff was present but believes it was either Lillie Bonds or the HM Demitra Bonds. Resident A's father stated he grabbed Resident A's bag which had already been packed. Resident A's father put his hands inside the bag and felt around for Resident A's medication. He felt for the blister packs which were inside the bag; however, he did not pull the blister packs out to see if all the medications were there. Resident A's father stated he was not aware that Resident A's neurologist made a change to the Seroquel dosage as Resident A's mother never informed him. Resident A's father left with Resident A. That night, Resident A received his 100MG of Seroquel at 8PM. The next morning on 03/13/2022, Resident A's father saw two blister packs for the Seroquel for 8AM. He stated one blister pack was 100MG with 8AM written and the other blister pack was 50MG also with 8AM written. Resident A's father administered both the 100MG and the 50MG of Seroquel to Resident A at 8AM. About an hour later, Resident A appeared to look like he was having a leg cramp and then his hands curled, and his eyes rolled back. Resident A's saliva was foaming and Resident A bit his tongue causing it to bleed. Resident A's father called the ambulance and Resident A was transported to the hospital. Resident A's father called Resident A's mother who informed the father after looking at the medications that the 50MG of Seroquel at 8AM should have not been provided to the father due to the script changed by the neurologist. Resident A's father stated that a toxicology was not completed; however, according to Resident A's pediatrician, the Seroquel would not show on the toxicology. It is still unclear if the medication caused Resident A's seizure, but it was a coincidence that the seizure occurred an hour after administering the 150MG of Seroquel to Resident A. Resident A's father stated this was an isolated incident and that the staff at Lake Orion are attentive to Resident A's needs. Resident A's father does not have any concerns and reported this to be an isolated incident.

On 04/13/2022, I received a telephone call from ORR Rishon Kimble. I advised Ms. Kimble I will be substantiating my investigation. Ms. Kimble stated she will also be substantiating her case.

On 04/19/2022, I received a return call from APS T. Kelly regarding her case. Ms. Kelly substantiated her case.

On 04/18/2022, I left a detailed message for licensee designee Samantha Nieuwenbroek with my findings.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Based on my investigation and the information gathered, the home manager Demitra Bonds and direct care staff (DCS) Lillie Bonds did not ensure that Resident A's father had all the appropriate medication when the father picked Resident A up on 03/12/2022. Resident A's Seroquel dosage was modified on 03/10/2022 by Resident A's neurologist. The new script was 100MG of Seroquel at 8AM and 100MG of Seroquel at 8PM. Lillie did not remove the 50MG of Seroquel blister pack from Resident A's medications. Therefore, when Resident A's father picked Resident A up on 03/12/2022, Resident A's father received a 100MG of Seroquel at 8AM and a 50MG of Seroquel at 8MA. Therefore, the father administered the incorrect dosage of Seroquel to Resident A at 8AM on 03/13/2022. An hour later, Resident A had a seizure and was hospitalized.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend no modification to the status of the license.

Frodet Dawisha 04/19/2022

Frodet Dawisha Date
Licensing Consultant

Approved By:

Denise Y. Nunn 04/20/2022

Denise Y. Nunn Date
Area Manager