GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 23, 2024

Andrew Akunne
Homestead Residences, Inc.
3879 Packard
Suite A
Ann Arbor, MI 48108

RE: License #: AS630016029
Investigation #: 2024A0991009
Homestead Res Of Beverly Hills

Dear Andrew Akunne:

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:

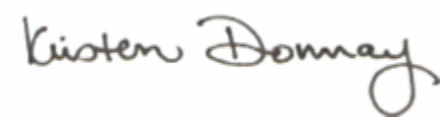
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,



Kristen Donnay, Licensing Consultant
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630016029
Investigation #:	2024A0991009
Complaint Receipt Date:	01/10/2024
Investigation Initiation Date:	01/10/2024
Report Due Date:	03/10/2024
Licensee Name:	Homestead Residences, Inc.
Licensee Address:	3879 Packard Suite A Ann Arbor, MI 48108
Licensee Telephone #:	(734) 973-7764
Licensee Designee:	Andrew Akunne
Name of Facility:	Homestead Res Of Beverly Hills
Facility Address:	16252 Elizabeth Beverly Hills, MI 48025
Facility Telephone #:	(248) 839-5486
Original Issuance Date:	11/18/1994
License Status:	REGULAR
Effective Date:	12/16/2023
Expiration Date:	12/15/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff, Shanta Brown, administered the wrong medications to Resident A on 01/08/2024. The resident was transported to the hospital and died on 01/09/2024.	Yes

III. METHODOLOGY

01/10/2024	Special Investigation Intake 2024A0991009
01/10/2024	Special Investigation Initiated - Telephone Call to area manager, Kim Scott
01/10/2024	Contact - Document Sent Email to Office of Recipient Rights (ORR)
01/10/2024	Referral - Recipient Rights Sent incident report and email to Alanna Honkanen
01/11/2024	Contact - Document Sent Email to/from assigned ORR worker, Lindsey Hebel
01/11/2024	Contact - Telephone call made Interviewed Dr. Bryant
01/12/2024	Contact - Telephone call made Interviewed home manager, Shanta Brown
01/12/2024	Contact - Telephone call made To Resident A's guardian
01/12/2024	Contact - Telephone call made To Resident A's case manager
01/16/2024	APS Referral Referral sent to Adult Protective Services (APS) for other residents in the home
01/16/2024	Contact - Document Sent Request for medical records

01/17/2024	Inspection Completed On-site Unannounced onsite inspection
01/17/2024	Contact - Document Received Medication records, staff logs, staff health information
01/17/2024	Contact - Document Sent Request for police records
01/17/2024	Contact - Telephone call made Interviewed staff, Tykia Tyson
01/19/2024	Contact - Telephone call received From Estelita Horton, Adult Protective Services
01/19/2024	Contact - Telephone call made To Beaumont Hospital Bereavement Department
01/19/2024	Contact - Telephone call made To Lindsay Hebel, Office of Recipient Rights
01/19/2024	Contact - Document Received Copy of death certificate
01/19/2024	Contact - Document Sent Email correspondence with Adult Protective Services and Office of Recipient Rights workers
01/20/2024	Contact - Document Received Medical records
01/23/2024	Contact - Telephone call made To Michigan Poison & Drug Information
01/23/2024	Contact - Telephone call received From Dr. Andrew King, Michigan Poison & Drug Information
01/23/2024	Contact - Document Received Copy of police report
01/23/2024	Contact - Telephone call made To Michigan Poison & Drug Information Center
01/23/2024	Contact - Telephone call received From Dr. Andrew King - Michigan Poison & Drug Information Center

01/24/2024	Contact - Telephone call made Call to Alliance Mobile Health
01/30/2024	Contact - Document Received Email from APS worker, Estelita Horton
02/13/2024	Contact - Telephone call made To Kim Scott
02/14/2024	Contact - Document Received Copies of disciplinary action/training verification
02/20/2024	Exit Conference Via telephone with licensee designee, Andrew Akunne

ALLEGATION:

Staff, Shanta Brown, administered the wrong medications to Resident A on 01/08/2024. The resident was transported to the hospital and died on 01/09/2024.

INVESTIGATION:

On 01/10/24, I received a complaint alleging that staff, Shanta Brown, administered the wrong medications to Resident A during the evening of 01/08/2024. Resident A was found nonresponsive on the floor on the morning of 01/09/24. She was transported to the hospital and was pronounced dead on 01/09/2024.

I reviewed a copy of an incident report completed by Shanta Brown on 01/08/24. It indicates that while administering 8:00pm medications, Ms. Brown gave Resident A someone else's medications, which included Glipizide 5mg, Remeron 30mg, Clozaril 100mg, Clozaril 25mg, Lipitor 10mg, Neurontin 300mg, and Amoxicillin 875mg. Staff reported the medication error to the program manager, Kim Scott. Ms. Scott directed staff to notify the home physician, Dr. Bryant. Dr. Bryant instructed staff to monitor Resident A for any changes in her behavior and sleeping pattern. Page 2 of the incident report indicates that the wrong medications were passed due to Ms. Brown not following medication procedures because she was prepping for a colonoscopy, which had her running back and forth to the bathroom.

I reviewed a copy of an incident report completed by staff, Tykia Tyson, on 01/09/24. It notes that staff, Shanta Brown, told Ms. Tyson that they were monitoring Resident A throughout the night. Ms. Tyson monitored Resident A. Around 6:00am, she heard a boom and came to the dining room. Resident A was on the floor and was unresponsive. Staff immediately started chest compressions while on the phone with the paramedics until they arrived.

Shanta Brown completed an additional incident report on 01/09/24 at 8:30am, which notes that she received a call from Dr. Naik at Beaumont Hospital. He stated that Resident A had passed away. Staff called back and spoke to a nurse who stated that Resident A died at the hospital.

I initiated my investigation on 01/10/24 by making a referral to the Office of Recipient Rights (ORR). I also contacted the area manager, Kim Scott. Ms. Scott stated that she received a phone call from the home manager, Shanta Brown, stating that Resident A was given Resident B's medications. Ms. Scott advised Ms. Brown to contact Dr. Bryant. Ms. Brown told Dr. Bryant exactly what medications Resident A received and he advised her to monitor Resident A throughout the night. Ms. Scott stated that another staff was working in the morning when Resident A was found nonresponsive on the floor and was transported to Beaumont Hospital. She stated that she spoke to a nurse at the hospital, because the home manager was unavailable as she was undergoing a colonoscopy that morning. Ms. Scott stated that she was not sure if an autopsy was completed.

On 01/11/24, I interviewed Dr. Everett Bryant via telephone. Dr. Bryant stated that he is the visiting physician for Homestead Res Beverly Hills and is the primary care physician for Resident A. He stated that he is relatively new to the home and only met Resident A on a few occasions. Staff from Homestead Res Beverly Hills contacted Dr. Bryant around 9:00-9:30pm on 01/08/24 and told him that they gave Resident A someone else's medications for the bedtime dose. Staff gave Dr. Bryant the list of what medications Resident A received and wanted to know what to do. He stated that he thought the medications were two or three Clozaril, an antibiotic, and Neurontin. Staff reported that Resident A was drowsy, but she was not "out of it." Resident A was not vomiting, and her eyes were not rolling back in her head. He stated that Resident A seemed a little restless and he could hear her talking to staff in the background during the phone call. Resident A's speech was a little slurred. Dr. Bryant advised staff that if Resident A was drowsy, she needed to sleep it off. He stated that he felt Resident A just needed to rest, and staff eventually got Resident A to lie down. He stated that the medications Resident A received were someone else's prescribed dose, so it should not be an overdose amount of medication, as someone else is taking the medications with no problem. He stated that it was only one regimen and he felt Resident A would be okay if she slept it off. He did not feel the medications would cause any cardiac issues or serious problems.

Dr. Bryant stated that he did not advise staff to take Resident A to the hospital and he did not tell staff to closely monitor Resident A, because it did not seem like an emergency. He thought Resident A would just sleep through the night and would be okay. Dr. Bryant stated that he received a phone call the following morning around 6:00am stating that staff called 911 because Resident A was non-responsive after falling. Dr. Bryant stated that he was informed that Resident A fell, and he believed she hit her head on the bedpost or the floor. Dr. Bryant stated that he was not sure what happened, but he thought maybe Resident A was trying to get out of bed when she was

not ready to get up and fell. He did not know the cause of death, but he speculated that it might have been a head injury such as an epidural hematoma, which can cause death immediately as opposed to a subdural hematoma which causes a slow bleed. Dr. Bryant stated that he was not aware of Resident A having a history of falls. He stated that Resident A was obese and was not very active. She had a body mass index in the 40s and was prescribed Ozempic injections.

On 01/12/24, I interviewed the home manager, Shanta Brown. Ms. Brown stated that she has worked in the home since May 2023, but she has worked for the provider on and off for at least seven years. She stated that she made a mistake while passing medications during the evening on 01/08/24, because she was prepping for a colonoscopy and was going to the bathroom frequently. She stated that she set up everybody's medications in advance to make it easier since she was going back and forth to the bathroom. She put each resident's evening medications in a cup and kept them locked up. She did not label the cups. She stated that she knows all the residents' pills and she does not know how she "got it twisted." She stated that Resident A usually sits by the window to take her medications and Resident B sits in a chair by the desk. She stated that she called Resident B over to take her blood sugar and had her medication cup sitting near her. Resident A then went and took her medications very quickly. Resident B looked at her pill cup and told Ms. Brown, "These aren't mine." Ms. Brown said, "Yes, they are." Resident B told her again that they were not her pills, so Ms. Brown looked at the medications in the cup and realized that they were not Resident B's medications. Resident A was sitting in the living room. Ms. Brown asked her if she took the medications and Resident A said yes. Ms. Brown told her that they were Resident B's pills and Resident A gasped. Ms. Brown stated that Resident B said, "(Resident A) is going to sleep good tonight." Ms. Brown stated that Resident A always looks at her medications and will tell her if she doesn't want to take something, but that evening she took the medications really fast. She stated that she did not know how Resident A did not realize they weren't her pills, because Resident B gets a yellow pill and Resident A does not.

Ms. Brown called the program manager, Kim Scott, and wrote an incident report. She called Dr. Bryant who is the primary care physician for Resident A. He did not answer, so she texted him. Dr. Bryant called her back and stated that it was not an overdose, because it was someone's prescribed regimen. He told her to just let Resident A sleep it off and instructed her to watch and monitor Resident A. Ms. Brown stated that Resident A was okay for 30 minutes, but then she started acting lethargic and was slurring her words. She could barely speak and was fighting off sleeping. Ms. Brown stated she saw a different baseline after 30 minutes, so she walked Resident A to the living room and encouraged her to sit down so she could monitor her. Ms. Brown texted Dr. Bryant again and told him that Resident A was very lethargic. He again advised her that Resident A would be okay and to just let her sleep.

Ms. Brown stated that when the midnight staff arrived, they walked Resident A to her room and put her in bed. She advised the staff, Tykia Tyson, to continue monitoring Resident A throughout the night. She told Ms. Tyson that if Resident A wanted to go to

the hospital, Ms. Tyson should call 911. Ms. Brown stated that she was told the following morning that around 5:00am, Resident A came and sat in the chair in the dining room. She was sleeping and snoring in the chair. Ms. Tyson went to get another resident up and ready for the day when she heard a boom. Ms. Tyson found Resident A on the floor. Resident A was unresponsive. Ms. Tyson called 911 and the paramedics came to the home. Ms. Brown stated that they transported Resident A to the hospital, but she received a phone call from the doctor stating that Resident A did not make it. Ms. Brown stated that she thought maybe Resident A tried to get up and was still drowsy, so she fell. She fell backwards towards the window. The blinds were knocked down and there was blood on the windowsill. Ms. Brown stated that staff did not tell the paramedics or anyone at the hospital that there had been a medication error the night before. Resident A's mother had Resident A's body released to a funeral home that day. Her mother was not aware of the medication error either. Ms. Brown did not think an autopsy was completed. Ms. Brown stated that Resident A has a court appointed guardian. The guardian was not informed of the medication error until she received a copy of the incident report after Resident A's death. Ms. Brown stated that she sent the incident report to licensing, recipient rights, and Resident A's guardian.

Ms. Brown stated that she never sets up medications in advance, and she knows that this is not the proper medication passing procedure. She only did it that way because she was prepping for her colonoscopy. She stated that she should not have been working that day, but she was covering a shift because they were short staffed. Her doctor took her off work for two days, but she came into work anyway.

On 01/12/24, I interviewed Resident A's guardian via telephone. Resident A's guardian stated that she received a phone call from staff at the home when Resident A passed away. She was informed that staff found Resident A slumped over in a chair and started CPR immediately. Resident A was taken to the hospital by the paramedics, where she later died. Resident A's guardian was not aware that there had been a medication error until after she received a copy of the incident report. Resident A's body was released to the family and taken to a funeral home. An autopsy was not completed. Resident A's guardian stated that Resident A passed away on 01/09/24 and she received a copy of the incident report on 01/10/24. She stated that she spoke to the staff who gave Resident A the wrong medications, and she was devastated. Resident A's guardian stated that she has a background in nursing, and she did not think any of the medications Resident A received would have caused an issue, but Resident A was also on Ozempic and there were some changes to her medications recently.

On 01/12/24, I interviewed Resident A's case manager, Raquel Roney. Ms. Roney stated that she was not aware of the medication error or Resident A's death until the guardian told her two days later on 01/11/24. She stated that nobody asked for an autopsy and Resident A's body was released to the funeral home. She was not aware of Resident A having a history of falls. She stated that she fell once because a chair gave way and broke under her weight.

On 01/17/24, I conducted an unannounced onsite inspection at Homestead Res of Beverly Hills. I conducted another interview with the home manager, Shanta Brown. Ms. Brown recounted the information she provided during my phone interview and provided some additional information. Ms. Brown stated that direct care worker, Nancy Miller, was scheduled to work on 01/08/24, but she was suspended, and another staff had a death in the family. There was nobody else available to cover the shift, so she had to work. She stated that she had gone in for a colonoscopy on the morning of 01/08/24, but she had not prepped well enough, and the images were not clear, so they scheduled another colonoscopy for the following morning. Tykia Tyson covered the morning shift from 7:00am-3:00pm on 01/08/24 and Ms. Brown came in from 3:00-11:00pm since she had been sedated for the colonoscopy procedure that morning. She stated that she had to complete the colonoscopy prep again that night so they could repeat the procedure the next morning. Ms. Brown stated that she always passes medications individually, but she decided to set them up in advance that day to make it easier while she completed the colonoscopy prep since she was going back and forth to the bathroom frequently while working.

Ms. Brown provided a copy of her medical documentation from the Eastside Endoscopy Center. It notes she was seen for a procedure on 01/08/24 and 01/09/24 and would be able to return to work on 01/10/24. The discharge paperwork notes that Ms. Brown had a colonoscopy on 01/08/24 and 01/09/24. It indicates:

> Following sedation, your judgment, perception, and coordination are considered impaired for up to 12 hours after leaving the center. Therefore, we recommend that you:
> - Do not drive or operate appliances or machinery that require quick reaction time.
> - Do not sign legal documents or be involved in work decisions.
> - Do not smoke tobacco products or drink alcoholic beverages.
> - Plan to restrict your activities and rest the remainder of the day. You may resume normal activity tomorrow.

Ms. Brown stated that despite these restrictions, she came to work on 01/08/24 and 01/09/24 following her procedures. She came in on 01/08/24 because there was nobody else to cover the shift, and she came in on 01/09/24 because she felt she had to be at the home after hearing the news that Resident A had passed away.

Ms. Brown showed me the text messages that she sent to Dr. Bryant on 01/08/24. At 8:20pm she texted, “Hi…Dr. Bryant, sorry for contacting you by phone and text, I gave (Resident A) someone else evening medications that included: flooded 5mg, Remeron 30mg, Clazaril 25mg, Lipitor 10mg, Neurontin 300mg, Amoxicillin 875mg…” She stated that Dr. Bryant called in response to her text message and informed her that Resident A should sleep it off. She texted Dr. Bryant again at 9:37pm. The text states, “Hi again (Resident A) is very sleepy and seems to be lethargic now…” She stated that Dr. Bryant again responded with a phone call and said to let Resident A sleep. He never advised

her to take Resident A to the hospital. Ms. Brown stated that Dr. Bryant told her not to give Resident A her evening medications that night, but she could receive her medications in the morning. Resident B was given her evening medications on 01/08/24.

Ms. Brown stated that she did not document the medication error in the staff log or in Resident A's Health Care Chronological. She stated, "People talk, and I did not want them gossiping." She stated that the area manager, Kim Scott, and Dr. Bryant knew about the medication error. She verbally told Tykia Tyson who was working the midnight shift and advised her to continue monitoring Resident A. She did not believe the paramedics, or any hospital staff, were made aware of the medication error. She did not tell Resident A's family members what happened. She stated that she was scared, and she felt she had to be careful with this company, as she did not want to get in trouble for saying or doing the wrong thing. Ms. Brown stated that she knows the medication error had something to do with Resident A dying. She stated that Resident A was sick anyway, but the medications might have triggered it.

I reviewed the staff log entries from 01/08/24 for the 3:00pm-11:00pm and 11:00pm-7:00am shifts. The log entry for the 3:00pm-11:00pm shift written by Shanta Brown notes, "…Resident A, Resident B, and Resident C received evening meds. All ladies socialized with each other, watched tv, and went to bed for the night. Monitored health and safety."

The log entry for the 11:00pm-7:00am shift written by Tykia Tyson notes, "All ladies was inside upon arrival (Resident B, Resident C, and Resident D) was all sleeping upon my arrival. Resident A was up watching tv. Soon went to sleep. All residents was been monitored for safety and health. Resident B and Resident D was assisted in the AM with the everyday ADL. They also took medication and breakfast both at 100%. Resident A, Resident B, Resident C, and Resident D all-both ate 100% breakfast. All medication/documentation/house chores has been completed."

I reviewed a copy of Resident A and Resident B's medication administration records and observed their medication bubble packs. I also reviewed a copy of Resident A's health care appraisal completed by Dr. Bryant on 06/24/23. I noted the following with regards to the medications Resident A received and the medications she was prescribed, as well as her preexisting conditions.

Resident B's medications administered to Resident A on 01/08/24:

- Neurontin 300mg
- Lipitor 10mg
- Clozaril 100mg
- Clozaril 25mg
- Remeron 30mg
- Glipizide 5mg
- Amoxicillin 875mg

Resident A's prescribed medications:

8:00am:

- Metformin Hydrochloride E 500mg
- Colace 100mg
- Lopressor 25mg
- Zestoretic 25mg/20mg PO tab
- Lasix 20mg
- Lamictal 200mg

12:00pm

- Risperdal 1mg

- 8:00pm (Not Administered on 01/08/24):
  - Metformin Hydrochloride E 500mg
  - Colace 100mg
  - Zyrtec 10mg
  - Lopressor 25mg
  - Risperdal 4mg
  - Lamictal 200mg
  - Benadryl 50mg

- Weekly:
  - Ozempic 2 Mg/3ml 0.25mg weekly injection

Resident A's pre-existing conditions:

- Lower extremity swelling
- Hypoxia
- Morbid obesity
- Hypothyroidism
- Diabetes
- Hypertension
- Sleep apnea

On 01/18/24, the assigned Office of Recipient Rights (ORR) worker and I interviewed direct care worker, Tykia Tyson, via telephone. Ms. Tyson stated that she has worked in the home for two months. She stated that she came in for her shift at 11:00pm on 01/08/24. The home manager, Shanta Brown, told her that Resident A was not feeling well, and someone gave her the wrong medications. Resident A was fighting going to sleep at first. She stated that they walked Resident A to her bed when she first came in for her shift, but after an hour or two, Resident A got up and slept in the chair in the dining room for the rest of the night. Resident A slept very well throughout the night. She typically gets up every two hours, but she did not get up at all that night after she moved to the chair. Ms. Tyson stated that around 5:00am she went to the back of the house to help another resident. Around 5:40am she heard a boom. She found Resident A on the floor, flat on her back near the dining room chair which was next to the window.

She stated that it looked like Resident A tried to stand up and fell. She started giving chest compressions and called 911. She stated that she told the dispatcher to please send someone right away because a resident was nonresponsive. She stated that she was very scared and was screaming for help. She kept calling Resident A's name and they told her to stop yelling her name. Ms. Tyson could not recall if she told the dispatcher about the medication error that happened the night before. Ms. Tyson stated that the paramedics arrived within three or four minutes. Ms. Tyson stated that she did not notice any injuries on Resident A. There were no cuts, bruises, or blood. She stated that she believed the blood on the windowsill came from the paramedics working on Resident A when they started an IV or inserted a tube. Ms. Tyson stated that she did not tell the paramedics which medications Resident A received the night before. She did not know exactly what medications Resident A received. The home manager just told her that she talked to the doctor because she made a mistake and gave her the wrong medications. She told her to monitor Resident A throughout the night, but she did not tell her whose medications Resident A took. Ms. Tyson stated that she followed the instructions and monitored Resident A throughout the night. There were no concerns other than the fact that Resident A was more sleepy than usual and was not up and down or yelling during the night like she usually does. Ms. Tyson stated that after the paramedics arrived, she called the area manager, Kim Scott. She did not call Resident A's guardian or family members. She stated that she gave the police the information for Resident A's guardian. Ms. Tyson stated that nobody witnessed Resident A falling, as the other residents were still in their rooms.

On 01/19/24, I received and reviewed a copy of Resident A's death certificate. It notes that Resident A died at Corewell Health William Beaumont University Hospital at 7:27am on 01/09/24. The manner of death was determined to be natural, caused by arteriosclerotic cardiovascular disease. The death certificate lists asthma, obesity, and diabetes mellitus as other significant conditions contributing to death but not resulting in the underlying cause.

I received and reviewed a copy of the 911 recording from the Beverly Hills Public Safety Department. The call was received on 01/09/24 at 6:12am. Direct care worker, Tykia Tyson can be heard yelling Resident A's name as the dispatcher answers the call. He states, "911, what's your emergency?" There is no response, so he says, "Hello? 911." After ten seconds, Ms. Tyson says, "Can you send the ambulance to…um…can you please hurry up." The dispatcher asks, "What's the address?" Ms. Tyson replies, "16252 Elizabeth Road." The dispatcher states, "Okay, in Beverly Hills? What's going on there?" Ms. Tyson responds, "Yes, please hurry, hurry, hurry." The dispatcher again asks, "What is going on there?" Ms. Tyson says, "Huh?" The dispatcher says, "What is going on there?" Ms. Tyson states, "A lady has just passed out. She's not breathing. She's turning blue." The dispatcher tells Ms. Tyson to stay on the line while he transfers her to the ambulance company.

I received and reviewed a copy of the Beverly Hills Public Safety Department case report. The report notes that they were dispatched to the home at 6:13am on 01/09/24

for a witnessed cardiac arrest with the patient not breathing and unconscious. When the officers entered the home, they were directed to the kitchen by the witness, Tykia Tyson, who is an employee of the group home. Ms. Tyson stated that she observed Resident A standing in the kitchen and fall suddenly. Resident A was observed lying supine in the kitchen, unconscious and not breathing. Resident A was warm to the touch but did not have a pulse and appeared blue. The officers positioned Resident A properly and began manual CPR. A LUCAS device (mechanical chest compression device) was on scene and was used to continue chest compressions. Officers opened an airway and used a bag valve mask (BVM) for ventilation along with oxygen. They attached automated external defibrillator (AED) pads to Resident A, but a shock was never advised. Emergency Medical Services (EMS) arrived on scene and care was transferred to them. EMS administered seven doses of epinephrine (EPI) but no pulse was felt from Resident A. EMS was directed by Dr. Maik with Beaumont Hospital to bring Resident A to the hospital for further care.

I reviewed copies of Resident A's pre-hospital care report from Alliance Mobile Health and her medical records from Corewell Health William Beaumont University Hospital Emergency Department. There is no indication that EMS or medical personnel at the hospital were informed that there was a medication error the night before Resident A was found nonresponsive. The request for lab work on Resident A's blood was cancelled by hospital staff because the specimen was unacceptable, as it was contaminated and was mostly saline.

On 01/23/24, I contacted the Michigan Poison & Drug Information Center at the Wayne State University School of Medicine, which is a nonprofit organization whose mission is to prevent poisonings, reduce severity of toxic exposures, educate caregivers and professionals, and promote poison prevention by providing high quality toxicological expertise. Physicians, pharmacists, poison center specialists, and educators with the Michigan Poison and Drug Information Center are principle information resources available to Michigan residents and health care professionals for poisonings and toxin-related emergencies. I provided them with the information regarding the medications that Resident A received on 01/08/24, as well as the medications she was prescribed and her preexisting conditions.

I received a return phone call from Dr. Andrew King, who is the interim medical director of the Michigan Poison & Drug Information Center and a medical toxicology specialist. Dr. King stated that he could not provide case specific information and that it would be difficult to speculate what happened in the absence of an autopsy report for Resident A. He stated that he could provide general guidance regarding what the recommendation would be for someone who took the medications that Resident A received. Dr. King stated that Neurontin, Lipitor, and Amoxicillin are typically well tolerated, and they do not worry too much if someone took these medications. He stated that the biggest concern would be if someone had an allergic reaction to Amoxicillin. Dr. King stated that Clozaril can be sedating. In very rare instances, Clozaril can cause bone marrow suppression and it can interfere with the "QT interval" causing changes in heart rhythm. Dr. King stated that Remeron also induces sleep, but it is typically pretty well tolerated. Dr. King

stated that Glipizide is the medication that would be the most concerning, as it can cause hypoglycemia (low blood sugar). He stated that the recommendation for this drug would be to send the individual to the hospital for continuous glucose checking, unless there was a highly reliable person in the home to closely monitor the individual and check their blood sugar levels throughout the night. He stated that the effects of this medication can last up to 24 hours. Dr. King stated that blood sugar levels can slowly trend down, so he would not necessarily say that an individual should “sleep it off”, unless they were being closely monitored and having their sugar levels checked. Dr. King stated that if someone was in cardiac arrest, blood sugar readings taken after the fact may not be accurate depending on the length of time they had been in arrest. Dr. King stated that there is also concern that if someone takes enough of a medication, or a combination of medications, that make them get too sleepy, this could depress the respiratory drive which can lead to cardiac arrest. Individuals with certain preexisting conditions would be at higher risk for this, including individuals with obesity, sleep apnea, or upper respiratory issues.

On 01/30/24, I received an email from the assigned APS worker, Estelita Horton. She stated that she received a phone call from Sergeant Baller with the Beverly Hills Public Safety Department, and he stated that he was closing his case due to no autopsy or bloodwork being completed. There were no criminal charges to pursue.

On 02/13/24, I spoke with the area manager, Kim Scott, via telephone. She stated that Ms. Brown was suspended for five days due to the medication error. She stated that all staff at the home were retrained regarding proper medication procedures.

On 02/14/24, I received and reviewed a copy of the employee disciplinary action form from Ms. Scott. It notes that the home manager, Shanta Brown, was disciplined for the infraction of failure to follow instructions of procedures, violation of company policy or work rule, and a failure to document and/or administer medications. Ms. Brown was removed from the schedule from 01/29/24-02/02/24. A mandatory medication class was scheduled for 01/29/24, which Ms. Brown must attend prior to returning to work. Ms. Brown was also placed on a 30-day probation period as of 01/24/24. Any incident pertaining to medication or clients within 30 days of probation would be reevaluated and followed up on according to the infraction. I reviewed a copy of the sign in sheet for a medication refresher training that was held at Homestead Res Beverly Hills on 01/29/24. Ms. Brown and four other employees participated in the training.

On 02/20/24, I conducted an exit conference via telephone with the licensee designee, Andrew Akunne. I advised Mr. Akunne that I was recommending a six-month provisional license due to the violations. Mr. Akunne did not have any additional information to share regarding the investigation. Mr. Akunne stated that he would submit a response after receiving and reviewing the special investigation report.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A's protection and safety were not attended to at all times when she received the wrong medications on 01/09/24. The home manager, Shanta Brown, set up the residents' medications in advance, which resulted in Resident A taking Resident B's medications. Resident A was observed to be very lethargic throughout the night following the medication error. She was found nonresponsive on the floor the following morning and was pronounced dead after being transported to the hospital. An autopsy was not conducted, as the hospital staff, Resident A's guardian, and family members were not made aware of the medication error until after Resident A's body was released to the funeral home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information that prescription medications were not kept in the original pharmacy supplied container. On 01/08/24, the home manager, Shanta Brown, set up the residents' evening medications in advance. She popped each

	resident's medications into cups, which were not labeled, and stored them in the medication cabinet until it was time to pass medications. Ms. Brown stated that she set up the medications in advance to make it easier to pass medications, because she was prepping for a colonoscopy and was going to the bathroom frequently during her shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that medications were not given as prescribed on 01/08/24 when the home manager, Shanta Brown, gave Resident B's medications to Resident A. Resident A received Resident B's 8:00pm medications, which included: Neurontin 300mg, Lipitor 10mg, Clozaril 100mg, Clozaril 25mg, Remeron 30mg, Glipizide 5mg, Amoxicillin 875mg. Resident A did not receive her prescribed 8:00pm medications on 01/08/24, which included: Metformin Hydrochloride E 500mg, Colace 100mg, Zyrtec 10mg, Lopressor 25mg, Risperdal 4mg, Lamictal 200mg, and Benadryl 50mg. The home manager stated that the medication error happened due to her setting up the medications in advance, as she was prepping for a colonoscopy and was going to the bathroom frequently.
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: (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff contacted the appropriate health care professional when a med error occurred. The home manager, Shanta Brown, called and texted Resident A's primary care physician, Dr. Everett Bryant, shortly after the medication error on 01/08/24. She followed the instructions given by Dr. Bryant to let Resident A sleep it off. Dr. Bryant confirmed that these were the instructions given and he did not advise staff to take Resident A to the hospital, as he did not feel Resident A would overdose from the medications she received, since it was someone else's prescribed dose.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the home manager, Shanta Brown, was not suitable to meet the needs of the residents when she worked shifts in the home on 01/08/24 and 01/09/24. Ms. Brown had a colonoscopy on the morning of 01/08/24 and had to prep that evening to have the procedure repeated on the morning of 01/09/24. The discharge instructions noted that following the procedure, her judgment, perception, and coordination are considered impaired for up to 12 hours after leaving the center. The discharge instructions also recommended that she not be involved in work decisions and that she should restrict activities for the remainder of the day. Ms. Brown had a note from her physician, which stated that she could return to work on 01/10/24. Despite these restrictions, Ms. Brown worked a shift at the home on 01/08/24, because the home was short staffed. She was not suitable to meet the needs of the residents, as she had been under sedation that morning and was also prepping for her second colonoscopy, which meant she was using the bathroom frequently. Ms. Brown used poor judgment when she set up the residents' medications in advance rather than following the required medication passing protocol.

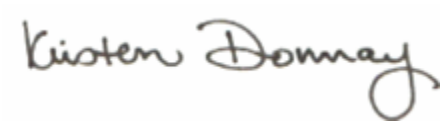
	After the medication error occurred, Ms. Brown did not tell the next staff on shift, Tykia Tyson, exactly which medications Resident A received in error. This information was not documented in the staff log or Resident A's health care chronological. Neither Ms. Tyson, nor Ms. Brown, conveyed information about the medication error to the responding officers, paramedics, hospital personnel, Resident A's family members, or guardian, until after Resident A's death. As such, an autopsy was not requested or performed following Resident A's death.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not appropriately handle an emergency situation when Resident A was found nonresponsive on the floor on the morning of 01/09/24. Direct care worker, Tykia Tyson, called 911; however, there were several delays during the phone call before she relayed the home's address and the nature of the emergency to the dispatcher. She did not tell the 911 dispatcher, responding officers, or paramedics about the medication error that occurred the night before. A list of the medications that Resident A received in error was never provided to the emergency responders or hospital personnel. Ms. Tyson told responding officers that she saw Resident A fall suddenly; however, it was reported on the incident report and during her interview that she was helping another resident, heard a loud boom, and then discovered Resident A on the floor. The staff communication log and Resident A's health care chronological did not include any information from the home manager, Shanta Brown, or staff, Tykia Tyson, regarding the medication error or medical emergency at the home. Resident A's guardian and family members were not made aware of the medication error until after Resident A's death when Resident A's guardian received an incident report on 01/10/24. As such, an autopsy was not

	requested or conducted and it cannot be determined if the medication error was a contributing factor in Resident A's death.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #2021A0605019 dated 04/29/2021; CAP dated 06/15/2021**

IV. RECOMMENDATION

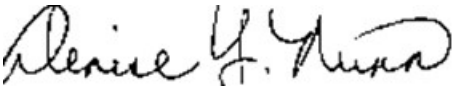
Contingent upon the receipt of an acceptable corrective action plan, I recommend the issuance of a first provisional license.



02/20/2024

Kristen Donnay Date
Licensing Consultant

Approved By:



02/23/2024

Denise Y. Nunn Date
Area Manager