GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 27, 2025

Destiny Saucedo-Al Jallad
Turning Leaf Res Rehab Svcs., Inc.
P.O. Box 23218
Lansing, MI 48909

RE: License #: AS330092645
Investigation #: 2025A1029022
Elm Cottage

Dear Ms. Saucedo-Al Jallad:

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330092645
Investigation #:	2025A1029022
Complaint Receipt Date:	03/10/2025
Investigation Initiation Date:	03/11/2025
Report Due Date:	05/09/2025
Licensee Name:	Turning Leaf Res Rehab Svcs., Inc.
Licensee Address:	621 E. Jolly Rd., Lansing, MI 48909
Licensee Telephone #:	(517) 393-5203
Administrator:	Destiny Saucedo-Al Jallad
Licensee Designee:	Destiny Saucedo-Al Jallad
Name of Facility:	Elm Cottage
Facility Address:	621 E. Jolly Road, Lansing, MI 48910
Facility Telephone #:	(517) 393-5203
Original Issuance Date:	05/09/2000
License Status:	REGULAR
Effective Date:	05/31/2024
Expiration Date:	05/30/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

ALLEGATION(S)

	Violation Established?
Resident A was given an extra 100 mg tablet of Briviact in error on March 3, 2025 by direct care staff member Alexandra Berry.	Yes

II. METHODOLOGY

03/10/2025	Special Investigation Intake 2025A1029022
03/11/2025	Special Investigation Initiated – Letter - Email to complainant
03/12/2025	APS Referral made to Centralized Intake (online)
03/19/2025	Contact - Telephone call made to program manager, Amber Ely-Costa
03/26/2025	Inspection Completed On-site - Face to Face with Resident A, Amber Ely Costa, Quantella Hamilton, and Sylvia Patrick at Elm Cottage
03/27/2025	Contact – Telephone call to former direct care staff member Alexandria Berry and licensee designee Destiny Saucedo-Al Jallad
03/27/2025	Exit conference with licensee designee Destiny Saucedo-Al Jallad

ALLEGATION: Resident A was given an extra 100 mg tablet of Briviact in error on March 3, 2025 by direct care staff member Alexandra Berry.

INVESTIGATION:

On March 10, 2025 a complaint was received via Bureau of Community and Health Systems online complaint system with concerns Resident A was given an extra 100 mg tablet of Briviact in error on March 3, 2025 by direct care staff member Alexandra Berry.

On March 19, 2025, I interviewed direct care staff member whose role is program manager, Amber Ely-Costa. Ms. Ely-Costa stated they did complete an *AFC Incident / Accident Report* for the incident. Ms. Ely-Costa stated Resident A typically receives one tablet of 100 mg and a 50 mg of the same medication however direct care staff member

Ms. Berry accidently administered two of the 100 mg tablets and did not give the 50 mg tablet. Ms. Ely-Costa stated Ms. Berry has had a medication error in the past and she had been retrained on medication administration because of a previous error in September 2024. Ms. Ely-Costa stated they called poison control and she stated she had to keep an eye out for drowsiness and dizziness. Ms. Ely-Costa stated when Resident A realized why the questions were being asked, she got nervous and anxious and wanted to go to the emergency room to be safe, not because she was feeling unwell. Ms. Ely-Costa stated Ms. Berry was on a performance improvement plan as a result of the previous error November 5, 2024 and attendance so when this occurred Ms. Berry was terminated.

On March 26, 2025, I completed an unannounced on-site investigation at Turning Leaf Elm Cottage and interviewed direct care staff member whose role is assistant program manager Quantella Hamilton. Direct care staff member Ms. Patrick was also present for this interview; however, she stated she was not working during this incident and she was not aware of previous medication errors from Ms. Berry.

Ms. Hamilton stated on the evening of March 3, 2025 Ms. Berry texted her and stated there was a discrepancy in the medication count and she thought she gave Resident A an extra Briviact tablet. Ms. Hamilton stated Resident A went to the emergency room that night. Ms. Hamilton stated she did not stay overnight at the hospital and returned to Elm Cottage around 4:45 AM. Ms. Hamilton stated poison control was also contacted and informed Ms. Berry that the medication was not in the “harm range” and they would not have sent her to the hospital. Ms. Hamilton stated at the hospital they did an EKG and her heart was fine but they informed her if she kept having panic attacks to contact her primary doctor. Ms. Hamilton stated Ms. Berry no longer works at Elm Cottage as a result of this incident.

On March 26, 2025 I interviewed Resident A. Resident A stated the direct care staff members administer her medications to her and she did not have any concerns about receiving the wrong medications. Resident A stated she did go to the hospital in the beginning of March because she either had a panic attack or seizure but she could not recall which one. Resident A stated the direct care staff members do a “good job” and she receives her medications when she is supposed to receive them.

On March 26, 2025, I interviewed Ms. Ely-Costa who was able to provide documentation regarding the incident. I reviewed the following documentation for this incident:

1. *AFC Incident / Accident Report* for the incident written by Ms. Berry with the following documentation:
    a. Incorrect dosage of Briviact 100 mg. Called poison control after notifying APM. Was advised to watch [Resident A] and call poison control if developing symptoms. None noted but client requested to go to emergency room.

b. Corrective Measures: Client was supposed to receive 150 mg dose. Poison control stated to watch client for dizziness and drowsiness at 11:00 PM client asked to go to emergency room staff transported client returned about 5:00 AM will inform primary care and psychologist.

2. Resident A's Medication Administration Record (MAR) for the month of March 2025. According to the MAR the medication was given correctly and there was no notation of the error on the MAR.
3. Resident A's *Assessment Plan for AFC Residents* which indicates under medication: Turning Leaf Behavioral Health staff dispense and administrator all primary prescribed medications. [Resident A] is primarily medication compliance staff adhere to the proper medication administration guidelines.
4. *Turning Leaf Payroll Change Form* showing Ms. Berry's last day worked was March 3, 2024 because she was terminated as a result of the medication error.

On March 27, 2025, I interviewed former direct care staff member Alexandria Berry. Ms. Berry stated she had just had two weeks off work. Ms. Berry stated Resident A has two different seizure medications that look the same and one was 100 mg and the other was 50 mg. Ms. Berry stated the medications were put together and there was no separation from the different milligrams. Ms. Berry stated Resident A was supposed to have a 100 and a 50 mg but she accidently gave Resident A two 100 mg tablets. Ms. Berry stated she did take her vitals and check her over and Resident A seemed to be okay. Ms. Berry stated she contacted poison control after the wrong medication was administered and they told her to monitor her closely and call them back with any updates. Ms. Berry stated Resident A did not have side effects from receiving the wrong medication. Ms. Berry stated Resident A was having some anxiety but Ms. Berry stated she did not think it was related to the medications because the night before she wanted to go the hospital as well. Ms. Berry stated she stated this is the reason why she is not working there any longer, however she also had a lot of attendance issue that also factored in.

On March 27, 2025, I interviewed licensee designee Destiny Saucedo-Al Jallad. Ms. Saucedo-Al Jallad stated she was supposed to receive 150 mg of the medication and she received 200 mg instead. Ms. Saucedo-Al Jallad was informed there would be a violation for the medication error and she stated she would prepare a Corrective Action Plan for these concerns.

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

ANALYSIS:	Resident A did not receive her medications as prescribed because Resident A typically receives one 100 mg tablet and one 50 mg of tablet of Briviact however direct care staff member Ms. Berry accidently administered two of the 100 mg tablets and did not administer the 1 tablet of 50 mg tablet. Ms. Berry contacted poison control and Resident A was taken to the hospital after the incident, however due to her previous medication errors and attendance issues, Ms. Berry was terminated from her position as a result on March 3, 2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

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

Jennifer Browning _____03/27/2025_____

Jennifer Browning
Licensing Consultant
Date

Approved By:

Dawn Timm 03/27/2025

_____

Dawn N. Timm
Area Manager
Date