RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

June 6, 2017

Sami Al Jallad
Turning Leaf Residential Rehabilitation Services
P.O. Box 23218
Lansing, MI 48909

RE: License #: AS330087739
Investigation #: **2017A0466021**
Spruce Cottage

Dear Mr. 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 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 (517) 284-9727.

Sincerely,

Julie Elkins, 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 #:	AS330087739
Investigation #:	2017A0466021
Complaint Receipt Date:	04/11/2017
Investigation Initiation Date:	04/14/2017
Report Due Date:	06/10/2017
Licensee Name:	Turning Leaf Residential Rehabilitation Services
Licensee Address:	621 E. Jolly Rd. Lansing, MI 48910
Licensee Telephone #:	(517) 775-0207
Administrator:	Destiny Saucedo-Al Jallad
Licensee Designee:	Sami Al Jallad
Name of Facility:	Spruce Cottage
Facility Address:	621 E. Jolly Rd. Lansing, MI 48910
Facility Telephone #:	(517) 393-5203
Original Issuance Date:	12/01/1999
License Status:	REGULAR
Effective Date:	03/20/2017
Expiration Date:	03/19/2019
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED TRAUMATICALLY BRAIN INJURED

	MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was kicked in the left knee by direct care worker (DCW) Mercedes Colenburg.	Yes

III. METHODOLOGY

04/11/2017	Special Investigation Intake 2017A0466021
04/14/2017	Special Investigation Initiated – Letter email to Complainant
04/14/2017	APS Referral made to Michelle.
04/14/2017	Contact - Document Sent email sent to Jessica Rook requesting information.
04/14/2017	Contact - Document Received email back from Jessica Rook with requested information.
06/02/2017	Exit Interview with Destiny Saucedo-Al Jallad

ALLEGATION: Resident A was kicked in the left knee by direct care worker (DCW) Mercedes Colenburg.

INVESTIGATION:

On 04/11/2017, a complaint was received that stated that Resident A was kicked in the left knee by direct care worker (DCW) Mercedes Colenburg.

On 04/09/2017a *Incident/Accident Report* and a *Recipient Rights Complaint* was received from the facility via fax. Both documents were reviewed by this consultant. The *Incident/Accident Report* was completed by Edward Allen II and stated that Resident A reported on 04/07/2017 being kicked in the left knee by DCW Colenburg and DCW Colenburg admitted to kicking Resident A in the left knee after being hit in the butt twice by Resident A. The facility notified the guardian of the incident and DCW Colenburg was sent home.

The *Recipient Rights Complaint* was signed and completed on 04/07/2017 by Resident A. Resident A reported that DCW Colenburg was doing dishes while talking on her personal cellular phone and Resident A admitted to saying “something smart” to DCW Colenburg and then being kicked in the knee.

On 04/14/2017, Jessica Rook Program Director at Turning Leaf provided me with a copy of a statement from DCW Colenburg and her contact information. Ms. Rook reported that DCW Colenburg's employment with Turning Leaf was terminated on 4/10/2017. A copy of the discipline form that DCW Colenburg refused to sign on 04/07/2017 as well as a letter Ms. Rook sent to DCW Colenburg on 04/10/2017 was provided for review. I reviewed the above documents and confirmed that Resident A resides at Turning Leaf Residential Rehabilitation Services in Spruce Cottage. On 04/07/17 at 8:35pm, Resident A was standing at the kitchen counter putting groceries away while DCW Colenburg, was doing dishes and talking on her personal cellular phone. Resident A admitted saying "something smart" and DCW Colenburg kicked Resident A in the left knee. The documentation provided states that DCW Colenburg admitted to kicking Resident A in the knee, however reported that it "wasn't hard" and it was because Resident A had hit her on the butt twice. DCW Colenburg was sent home on suspension immediately following the incident on 04/07/2017 and terminated on 04/10/2017.

On 05/30/2017, I called DCW Colenburg and left a message on her voice mail and never received a return call.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	DCW Colenburg admitted that while doing dishes and talking on her personal cellular phone, DCW Colenburg kicked Resident A in the left knee as a behavioral management technique which compromised the safety of Resident A. Although Resident A was not injured, DCW Colenburg did not utilize a behavior management technique recommended in the resident's assessment plan. Turning Point immediately suspended and then terminated DCW Colenburg which assured the safety and well-being of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

After the receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

06/02/2017

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Julie Elkins Date
Licensing Consultant

Approved By:

06/06/2017

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Dawn N. Timm Date
Area Manager