GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 11, 2021

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

RE: License #:	AS610317388
Investigation #:	2021A0356021
	Eastwood Cottage I

Dear Mr.& Ms. 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610317388
Investigation #:	2021A0356021
Complaint Receipt Date:	03/16/2021
Investigation Initiation Date:	03/16/2021
Report Due Date:	05/15/2021
Licensee Name:	Turning Leaf Res Rehab Svcs., Inc.
Licensee Address:	621 E. Jolly Rd. Lansing, MI 48909
Licensee Telephone #:	(517) 393-5203
Administrator:	Sami Al Jallad, Designee
Licensee Designee:	Sami Al Jallad, Designee
Name of Facility:	Eastwood Cottage I
Facility Address:	1137 East St. Muskegon, MI 49442
Facility Telephone #:	(231) 563-6306
Original Issuance Date:	08/07/2013
License Status:	REGULAR
Effective Date:	02/07/2020
Expiration Date:	02/06/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, ALZHEIMERS, AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A left the facility without staff supervision.	Yes
Resident B fell in the shower and staff failed to assist Resident B.	No

III. METHODOLOGY

03/16/2021	Special Investigation Intake 2021A0356021
03/16/2021	APS Referral Denied for investigation.
03/16/2021	Special Investigation Initiated - Telephone Carmen Strong Levelston, Home Manager.
03/17/2021	Contact - Document Received Facility documents for Resident A sent by Carmen Strong, Program Manager.
03/31/2021	Inspection Completed On-site
03/31/2021	Contact - Face to Face Pam Gentry, staff, Resident's A&B.
04/01/2021	Contact - Telephone call made. Anissa Goodno, West Michigan CMH, left voicemail (no return call).
04/01/2021	Contact - Document Sent Request for more facility documents from Carmen Strong.
04/02/2021	Contact-Document Received Facility documents from Carmen Strong.
05/11/2021	Contact-Telephone call made. Karen Ellison, PW Guardianship Services.
05/11/2021	Exit Conference-Destiny Al Jallad, Licensee Designee.

ALLEGATION: Resident A left the facility without staff supervision.

INVESTIGATION: On 03/16/2021, I received an Adult Protective Service (APS) Referral that documented Resident A ate pebbles out of the driveway and swallowed them. A piece of wood fell on Resident A, it is unknown when these incidents occurred. Resident A did not receive any medical treatment for either incident. APS denied this referral for investigation and forwarded it to LARA.

On 03/16/2021, I interviewed Carmen Strong Levelston, home manager via telephone. Ms. Levelston stated Resident A reported she ate rocks, so staff took Resident A to the hospital for an evaluation but, according to the hospital, she did not eat rocks. Ms. Levelston stated Resident A did not report that wood fell on her and they have no information about wood falling on Resident A, that she is aware of. Ms. Levelston stated Resident A leaves the property often and has no "walking pass."

On 03/17/2021, I reviewed an IR (Incident Report) dated 01/25/2021, written by Doris Wilkins, Direct Care Worker (DCW) and documented, *'(Resident A) told staff she was leaving because this house is crazy and they are driving her crazy. Staff tried talking with (Resident A) she refused and left. Staff called 911 and per dispatch (Resident A) was at Jack's corner store. (Resident A) had told staff at the store to call 911 (Resident A) was feeling suicidal and having stomach pain. Transported to Mercy Hospital. Ms. Levelston documented that an appointment was made with family doctor, hospital called and stated (Resident A) said she swallowed rocks.'*

On 03/17/202, I reviewed an after-visit summary from Mercy Health dated 01/25/2021 that documented Resident A was seen at the Mercy Health Campus ER for abdominal pain and a psychiatric evaluation with a diagnosis of schizoaffective disorder, depressive type and foreign body in colon, initial encounter. An X-ray was completed on 01/25/2021 and another appointment set for 02/08/2021 with Dr. Gregory Holton Jr. MD.

On 03/17/2021, I reviewed an after-visit summary report dated 02/09/2021 and signed by Edward D. Sara that documents an X-ray was completed on this date and compared to the 01/25/2021 X-ray, findings are documented as 'the density in the left lower quadrant on the prior study is no longer present. Previously seen foreign body is no longer identified.'

On 03/17/2021, I reviewed an IR dated 03/09/2021, written by Pan Gentry, DCW. The date of the incident is 03/09/2021 at 11:43AM. Ms. Gentry documented, *'(Resident A) was out on the patio smoking. Staff went back out to check on her and she was gone. Staff walked around the yard and noticed (Resident A) walking from the SIL (semi-independent living apartments). (Resident A) told staff the swing came down while she was swinging. (Resident A) said she fell on the ground. (Resident A) has a small scratch on her right hand, staff asked if she got hit by the board that came down and she said no. (Resident A) was also asked if she wanted to go to the hospital and she said no. Full body check was done and no other physical injuries.'*

On 03/31/2021, I interviewed Pam Gentry, DCW at the facility. Ms. Gentry stated Resident A was outside the facility smoking, left the facility grounds and walked over to the neighboring apartments (the apartments are semi-independent living owned by the same corporation as this facility). Ms. Gentry stated there was a sign on the swing set that said, “do not use” but Resident A did anyway, fell off the swing set and sustained a scratch to her head but was ok. Ms. Gentry stated she has no knowledge of Resident A eating pebbles or rocks in the driveway at the facility. Ms. Gentry stated Resident A did go to the hospital recently for threatening suicide, but Resident A has never reported she ate rocks/pebbles.

On 03/31/2021, I interviewed Resident A at the facility. Resident A stated she ate pebbles outside of the facility when she was outside by herself. Resident A stated she went to the hospital and told staff at the hospital she ate rocks/pebbles at the facility. Resident A stated they took X-ray’s and said she was “ok” and “sent me home.” Resident A stated she left the facility grounds and went to the apartment complex to “visit people,” sat on a swing and the board that makes the seat of the swing was cracked and she fell. Resident A said the board fell on her and hit her knee, not her head. Resident A stated she did not go to the hospital for that incident, and stated she is able to be independent in the community without staff supervision.

On 04/02/2021, I received and reviewed Resident A’s assessment plan for AFC residents that was signed on 02/16/2021 by Ms. Levelston, on 02/18/2021 by legal guardian, Tammy Dykstra and on 03/30/2021 by CMH (Community Mental Health) case manager, Tony Secord. Resident A’s assessment plan documents that Resident A can move independently in the community but that she must be ‘with staff at all times.’

On 05/11/2021, I conducted an Exit Conference with Destiny Al Jallad, Licensee Designee, via telephone. Ms. Al Jallad stated she will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	The complainant reported Resident A swallowed rocks or pebbles in the driveway at the facility and during a separate incident, a piece of wood fell on Resident A. Based on investigative findings, on 01/25/2021 and 03/09/2021, Resident A was in the community without staff supervision, swallowed pebbles and fell off a swing in a neighboring

	apartment complex area, sustaining a scratch that did not require medical attention. A review of Resident A's assessment plan for AFC residents documents that while in the community, Resident A should be in the presence of staff at all times and on these two occasions, staff were not with Resident A. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B fell in the shower and staff failed to assist Resident B.

INVESTIGATION: On 03/16/2021, I received an Adult Protective Service Referral that documented Resident B is incontinent and when she defecates, staff puts kitty litter on the feces and asks Resident B to clean the feces up herself. When Resident B urinates, staff tell her to go take a shower. Resident B fell in the shower and when she called out for help, staff made her scoot to her bedroom before they helped her. APS denied this referral for investigation and forwarded it to LARA.

On 03/16/2021, I interviewed Carmen Strong Levelston, home manager via telephone. Ms. Levelston stated Resident B is incontinent of bowel and bladder, on occasion, not all the time. Ms. Levelston stated Resident B has urinated and/or defecated on herself or on the floor at the facility and staff do use kitty litter to put over the area to help with the smell and clean it up especially if it is in a common area or the kitchen area. Ms. Levelston stated this is part of the prevention and containment of communicable diseases staff are trained to do. Ms. Levelston stated staff always clean the area when Resident B has an accident, Resident B assists when she wants to, and Resident B cleans herself up after an accident with staff assistance. Ms. Levelston stated staff do not refuse to assist Resident B and Resident B is capable and willing to do as much as she can on her own. Ms. Levelston stated no one has reported that Resident B fell in the shower and staff failed to assist Resident B.

On 03/31/2021, I interviewed Pam Gentry, DCW at the facility. Ms. Gentry stated Resident B is incontinent of both bladder and bowel but not all the time and staff do not make Resident B clean up her own incontinence accidents. Ms. Gentry stated staff use kitty litter out of the "spill kit" to harden the urine or stool so it can be easily scooped up and cleaned. Ms. Gentry stated often Resident B's accidents occur in the shower and Resident B and/or staff will rinse it down the drain and that is mainly how Resident B assists with cleaning up any accidents she has. Ms. Gentry stated Resident B is not physically capable of getting on her hands and knees and cleaning up her own accidents and staff always clean it up. Ms. Gentry stated Resident B does not mind helping staff, but they would never make her clean up after herself all alone. Ms. Gentry stated staff told Resident B the shower chair in the bathroom

across the hall from her (Resident B's) room was broken and asked her not to use that shower but to use the shower down the hall. Ms. Gentry stated Resident B used the shower across the hall from her room and when she sat in the shower chair, realized the chair was broken. Ms. Gentry stated Resident B did not fall out of the chair but got herself down onto the floor and began to scoot towards her bedroom. Ms. Gentry stated when she and Ms. Hattie came to Resident B's aid, Resident B was in a spot where they could not get on the sides of Resident B to lift Resident B up safely and properly. Resident B scooted to an area where staff could lift her up, get her dressed and back to her walker. Ms. Gentry stated at no time did staff require Resident B scoot on her bottom from the bathroom to her bedroom before they picked her up. Ms. Gentry stated a work order was placed immediately to get the shower chair replaced so Resident B could resume showers in the bathroom closest to her room.

On 03/31/2021, I interviewed Resident B at the facility. Resident B stated she has continence issues and sometimes has accidents before she can make it to the commode. Resident B stated she does not have accidents all the time but when she does, staff clean it up. Resident B stated staff puts kitty litter on it if it happens on the floor, staff do not make her clean it up herself but at times, staff asks her to assist them. Resident B stated she does the best she can to clean herself up, when she has accidents on herself, but staff always help her. Resident B stated, "it's all ok with me." Resident B stated she took a shower and when she sat on the shower chair, it broke, and she had difficulty getting up after falling out of the shower chair. Resident B stated Ms. Gentry and Ms. Hattie assisted her with getting up but she had to scoot out of the area of the bathroom so they could fit next to her to lift her up. Resident B stated Ms. Gentry and Ms. Hattie did not make her scoot on the floor, they suggested she scoot out of the shower area, so they had room to lift her up. Resident B stated she scooted to her room where staff could lift her up easier.

On 04/02/2021, I received and reviewed Resident B's assessment plan for AFC residents and signed on 02/08/2021 by Ms. Levelston and on 02/10/2021 by Karen Ellison, PW Guardianship Services, on 02/18/2021 by Michelle Lyons, case manager at Health West (Community Mental Health). The assessment plan documents Resident B does not needs assistance with toileting but explains that Resident B does have accidents of urine and BM on herself often. Resident B needs staff prompting for grooming and personal hygiene. The assessment plan documents that Resident B participates in household chores including cleaning with the assistance of staff.

On 05/11/2021, I interviewed Karen Ellison, Resident B's legal guardian from PW Guardianship Services, Inc. Ms. Ellison stated she has no complaints or concerns about Resident B's care at the facility.

On 05/11/2021, I conducted an Exit Conference with Ms. Al Jallad. Ms. Al Jallad agrees with the information, analysis, and conclusion of this applicable rule.

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 investigative findings, there is not a preponderance of evidence to show that staff purposely makes Resident B clean up urine and feces when she has an accident. In addition, there is not a preponderance of evidence to show that staff made Resident B scoot on the floor from the bathroom to her bedroom before they assisted her. Therefore, a violation of this applicable rule is not established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Elizabeth Elliott

05/11/2021

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Elizabeth Elliott Date
Licensing Consultant

Approved By:

Jerry Hendrick

05/11/2021

_____

Jerry Hendrick Date
Area Manager