GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 16, 2021

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

RE: License #: AL390392504
Investigation #: 2021A0462042
Birch Cottage II

Dear Mr. and Ms. Al Jallad:

Attached is the **ADDENDED and AMENDED** Special Investigation Report for the above referenced facility. **Additional information for this special investigation was added to pages three, four, five, six, and seven of the report.** 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) 284-9730.

Sincerely,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390392504
Investigation #:	2021A0462042
Complaint Receipt Date:	07/22/2021
Investigation Initiation Date:	07/22/2021
Report Due Date:	09/20/2021
Licensee Name:	Turning Leaf Res Rehab Svcs., Inc.
Licensee Address:	621 E. Jolly Rd. Lansing, MI 48909
Licensee Telephone #:	(517) 393-5203
Administrator:	Zeta Francosky
Licensee Designee:	Destiny Saucedo-Al Jallad Sami Al Jallad
Name of Facility:	Birch Cottage II
Facility Address:	13326 N. Boulevard St. Vicksburg, MI 49097
Facility Telephone #:	(269) 585-8762
Original Issuance Date:	11/14/2019
License Status:	REGULAR
Effective Date:	05/14/2020
Expiration Date:	05/13/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Facility staff members did not follow Resident A's assessment plan when they failed to provide Resident A with appropriate supervision while she was in the hospital.	Yes
Facility staff members did not follow Resident A's assessment plan and/or Community Mental Health treatment plan when they failed to assist Resident A with doing her hair while she was in the hospital, failed to make arrangements for Resident A to use the facility's iPad and/or "business phone" to communicate with others while she was in the hospital, and left Resident A alone in the facility with an American Sign Language Interpreter.	No
Facility staff members failed to notify Resident A's school when they stopped providing Resident A with transportation to and from school. Facility staff members failed to locate an alternative solution.	No
On an unknown date, facility staff members conducted a "search" of Resident A's bedroom without communicating to Resident A why the search was being conducted.	No

III. METHODOLOGY

07/22/2021	Special Investigation Intake 2021A0462042 Special Investigation Initiated - Email to Resident A's Responsible agency. Requested documentation.
07/23/2021	Contact- Received documentation via email from Resident A's Responsible agency.
07/25/2021	Contact- Received emailed from administrator Zeta Francosky.
07/28/2021	Contact- Received additional information via the BCHS' online complaint system.
07/30/2021	Contact- Unannounced investigation onsite. Face-to-face interview with administrator Zeta Francosky. Contact- Requested and received documentation.

08/05/2021	Contact- Received additional information via the BCHS' online complaint system.
08/24/2021	Contact- Telephone interview with administrator Zeta Francosky. Contact- Email exchange with administrator Zeta Francosky.
08/27/2021	Contact- Telephone interview with administrator Zeta Francosky, and DCWs Margaret Wieberg and Nevaeh Francosky.
09/10/2021	Contact- Email exchange with licensee designee Destiny Saucedo-Al Jallad. Exit conference with licensee designee Destiny Saucedo-Al Jallad via telephone.

ALLEGATION: Facility staff members did not follow Resident A's assessment plan when they failed to provide Resident A with appropriate supervision while she was in the hospital.

INVESTIGATION: On 07/22/2021 the Bureau of Community and Health Systems (BCHS) received this complaint via the BCHS' online complaint system. According to the written complaint, on 07/15 Resident A was transported to Borgess Hospital in Kalamazoo after it was established Resident A required inpatient psychiatric services. However, the psychiatric unit at Borgess Hospital was full. Subsequently, Resident A was temporarily admitted into Borgess Hospital's emergency room (ER) until either space became available at Borgess Hospital's psychiatric unit, or until hospital staff members and/or Resident A's responsible agency could locate alternative inpatient psychiatric placement for Resident A at another hospital. The written complaint indicated facility staff members were to supervise Resident A while she was at the hospital. However, on 07/19 facility staff members stopped providing this supervision. As of 07/22 Resident A was still at Borgess Hospital without facility staff members' supervision.

Via email I requested from Resident A's mental health clinician Dawn Eldridge, who worked for Resident A's responsible agency Centre Wellness Network, a copy of Resident A's Community Mental Health (CMH) treatment plan (TP) and/or behavior treatment plan (BTP), if applicable.

On 07/23 Ms. Eldridge emailed to me a copy of Resident A's CMH TP. I reviewed Resident A's CMH TP and established it was recently updated on 07/08/21. There was no documentation on Resident A's CMH TP indicating facility staff members were to supervise Resident A when she was not at the facility. Via this email exchange, Ms. Eldridge informed me Resident A had a previous BTP but did not have one currently.

On 07/25 facility administrator Zeta Francosky forwarded to AFC consultant Cathy Cushman an email she sent to Resident A's legally appointed guardian. In the email, Ms. Francosky informed Resident A's legally appointed guardian that on 07/25, Resident A was discharged from Borgess hospital and transferred to a Neuropsychic hospital in Indiana. Subsequently, Resident A would not be returning to the facility.

On 07/30 I conducted an unannounced investigation at the facility and interviewed Ms. Francosky. Ms. Francosky provided me with a copy of a discharge notice provided to Resident A's legally appointed guardian on 05/11. Documentation on the discharge notice indicated facility staff members determined Resident A's pattern of unsafe behaviors placed herself and others' safety at risk. Subsequently, it was determined Resident A required a "higher level" of care than what was available at the facility. According to Ms. Francosky, Resident A was transported to Borgess Hospital on 07/14, and not on 07/15 as indicated in the written complaint. Ms. Francosky confirmed that on 07/14 Resident A was transported to Borgess Hospital after it was established that due to her physically aggressive behaviors, she required inpatient psychiatric services. Ms. Francosky also confirmed that on 07/14 Resident A was temporarily admitted into a "holding area" at Borgess Hospital until either space became available in their psychiatric unit, or until hospital staff members

and/or Resident A's responsible agency could locate alternative inpatient psychiatric placement for Resident A at another hospital. According to Ms. Francosky, due to a direct care staffing shortage at the AFC facility, facility staff members were only able to provide Resident A with supervision at Borgess Hospital's "holding area" until 07/19. Ms. Francosky confirmed Resident A remained in the "holding area" in from 07/20 to 07/25 without facility staff members' supervision. According to Ms. Francosky, the hospital's social worker expressed frustration with the facility's failure to provide Resident A with supervision in the "holding area" while she was awaiting inpatient placement. Subsequently, Ms. Francosky instructed facility staff members to make frequent telephone calls to the hospital social worker and/or the hospital's nurses' station to receive regular updates on Resident A's statis. Ms. Francosky confirmed that on 07/25 Resident A was discharged from the facility and transferred to an inpatient Neuropsychic hospital in Indiana.

While onsite I requested and received a copy of Resident A's *Assessment Plan for AFC Residents* (assessment plan), which was signed by licensee designee Destiny Saucedo-Al Jallad and Resident A's legally appointed guardian on 01/26/2021. According to documentation on Resident A's assessment plan, Resident A was to be supervised by facility staff members while in the community.

On 09/10 licensee designee Destiny Saucedo- Al Jallad forwarded an email she sent to Resident A's responsible agency, Resident A's legal guardian, and AFC licensing consultant Cathy Cushman on 07/15. This email read as follows;

"Hello

[Resident A] is currently at Borgess Hospital; she has been petitioned and awaiting an inpatient psych bed.

We are being fully transparent that we are extremely short staffed at this time. It is increasingly difficult to staff [Resident A] 24/7 with a staff member at the hospital while she is awaiting an inpatient bed. We understand this is our responsibility as an AFC but the realities of staffing shortages in our field are all too real in this situation.

Zeta is working tirelessly with her team to ensure staffing at the hospital and has tried to communicate to the hospital that we need assistance with staffing but the social worker has threatened to contact LARA if we cannot provide staff. Cathy I want you to be aware of our current situation.

Destiny"

Ms. Saucedo-Al Jallad forwarded me an email she sent to Resident A's responsible agency, Resident A's legal guardian, and AFC licensing consultant Cathy Cushman on 07/19. This email read as follows;

“Hello. I'm giving an update that we may not be able to staff [Resident A] at the hospital this week. We are extremely short staffed and we want to continue to be transparent that staffing the consumer at the hospital 24/7 while also appropriately staffing the home itself is really taxing this program. We are going to work with the hospital to get assistance with this matter as we understand the importance of staffing her while an inpatient bed is being located.

Destiny”

Ms. Saucedo-Al Jallad forwarded me an email facility staff member Jeff Ostrowski sent to Ms. Francosky on 07/19. This email read,

“Just got done speaking with Breanna Simmons (Hospital Social Worker) and she is aware that as of 4:00pm we will no longer have a physical presence at the hospital for [Resident A]. She informed me that she has to file a report with LARA for us not being physically at the hospital, despite me informing her that we don't have the staffing to do so. But will be conducting hourly phone-calls starting at 5:00pm. She is at the hospital until 6:00pm and then they have another social worker Evan who comes in after. Their office number is below, along with the direct line to the unit where [Resident A] currently is. Both the social worker, and the nurses station have the numbers of Angie, Margaret, me, and Karen. To ensure if anyone switches on-call rotations we are covered. I am sending you this separate as I am sure you have to forward to Destiny anyway. Let me know if you need anything else.”

On 07/19 Ms. Saucedo-Al Jallad forwarded Mr. Ostrowski’s email to Ms. Francosky onto Ms. Cushman. Ms. Saucedo-Al Jallad emailed the following to Ms. Cushman,

“Cathy, I’m including you on this email as most likely you will be receiving a complaint from a hospital SW that we have left [Resident A] from Birch 2 unstaffed at the hospital.

As we have previously communicated; We do not have the physical staff to sit with [Resident A] at the hospital 24/7 and also adequately staff Birch Cottage 2. I can tell you that this has never happened in our history (as a company) but the staffing shortage is real and we are only able to do what we can do and communicate accordingly.

[Resident A] is petitioned and certed [sic] and at the hospital ER awaiting an inpatient psych bed - she has been there since last week and there is not timeframe on when a bed will be found. We understand our obligations as an AFC - we do know her general whereabouts and our managers will be calling hourly for check ins with the hospital to ensure [Resident A] safety and knowledge about where she is at all times. The hospital is aware and has been in touch with [Resident A] guardian (her mom) as have we.

This is not ideal; however we did want to keep you informed as we were anticipating this happening at some point if she remained in the hospital ER.

Destiny Al Jallad”

On 07/20 Ms. Cushman emailed Ms. Saucedo- Al Jallad the following response,

“Thanks for keeping me in the loop. Does she require 1:1 staffing at all times, but you’re not able to provide that?”

Ms. Saucedo-Al Jallad emailed Ms. Cushman the following response,

“She does not require 1:1 staffing at all...
however we typically staff at the hospital until a resident is admitted as a policy.”

Ms. Cushman emailed Ms. Saucedo-Al Jallas the following response,

“I appreciate the clarification. The hospital may very well make a complaint and it could be assigned, but at this time, I am not opening a special investigation. I will make a note of our discussion on our system though.”

Ms. Saucedo-Al Jallad emailed Ms. Cushman the following response,

“Thank you Cathy”

On 09/10, via email, Ms. Saucedo-Al Jallad informed me that during her email exchange with Ms. Cushman on 07/20, she did not provide additional information regarding Resident A’s supervision needs and/or a copy of Resident A’s *Assessment Plan for AFC Residents* to Ms. Cushman, as Ms. Cushman did not request further information/documents at that time.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident’s resident care agreement and assessment plan.
ANALYSIS:	The On 07/14 Resident A was transported to Borgess Hospital after it was established she required inpatient psychiatric services and was placed in their “holding area” until 07/25. Ms. Francosky confirmed that due to a direct care staffing shortage, facility staff members only provided Resident A with supervision in the “holding area” from 07/14 to 07/19. Based upon my investigation, it has been established that per documentation on Resident A’s written assessment plan, Resident A was to be

	supervised by facility staff members while in the community, which would include the "holding area" of a hospital. Subsequently, Resident A was without her required supervision at Borgess Hospital from 07/20 to 07/25.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Facility staff members did not follow Resident A's assessment plan and/or Community Mental Health treatment plan when they failed to assist Resident A with doing her hair while she was in the hospital, failed to make arrangements for Resident A to use the facility's iPad and/or "business phone" to communicate with others while she was in the hospital, and left Resident A alone in the facility with an American Sign Language Interpreter.

INVESTIGATION: On 07/28 the BCHS received a second complaint via the BCHS' online compliant system. The second written complaint indicated that due to her ethnicity, Resident A utilized special hair products. Upon Resident A's admission to Borgess Hospital's "holding area" on 07/14, facility staff members did not make arrangements for Resident A to receive her special hair products. According to the second written complaint, Resident A's family member demanded facility staff members bring Resident A's personal care items to the hospital. The second written complaint indicated facility staff members also did not assist Resident A with "self-care" while she was at the hospital. Subsequently, Resident A was observed in the hospital with "matted and uncared for hair."

According to the second written complaint the facility arranged for Resident A, who is hearing impaired, to utilize an American Sign Language (ASL) interpreter to communicate while at the facility. In addition to this, Resident A also used the facility owned iPad and "business phone" to communicate with others. Facility staff members failed to make arrangements for Resident A to use the facility's iPad and facility "business phone" to communicate with her family members while she was at Borgess hospital from 07/14 to 07/25.

During my unannounced face-to-face interview with Ms. Francosky at the facility on 07/30, Ms. Francosky stated facility staff members typically did not send hygiene supplies to the hospital when residents were admitted there. According to Ms. Francosky, during Resident A's stay at Borgess Hospital, facility staff members made daily contact, either in-person or via telephone, with hospital staff members. During this daily communication, facility staff members were never told Resident A was in need of any hygiene supplies. Subsequently, facility staff members assumed Resident A was provided with basic hygiene supplies made available to her at the hospital. According to Ms. Francosky, while Resident A was at Borgess Hospital, Resident A's aunt came to the facility to collect Resident A's personal hygiene supplies. Ms. Francosky stated that had it been communicated to facility staff members that Resident A was without any hygiene supplies and/or needed a specific hygiene supply, she would have made arrangements for Resident A to be provided

with these items. Ms. Francosky stated Resident A was “very clean” and tended to her own personal care independently. According to Ms. Francosky, facility staff members occasionally assisted Resident A with doing her hair. However, it was typical for Resident A to then immediately get her hair wet and/or “redo her hair” by putting it in multiple ponytails. Ms. Francosky stated that on 07/14, facility staff members called emergency medical technicians (EMTs), via 911, when Resident A became physically aggressive with facility staff members. Both EMTs and local law enforcement responded to the facility. According to Ms. Francosky, Resident A was so physically combative, EMTs had to administer Resident A the sedative Ketamine, via injection, prior to transporting her to the ER. According to Ms. Francosky, ensuring Resident A received appropriate medical treatment was facility staff members main priority. Subsequently, given Resident A’s mental health status at the time she was at Borgess Hospital, it was unlikely Resident A would have requested and/or even allowed facility staff members to assist her in doing her hair.

Ms. Francosky confirmed Resident A had a hearing impairment and was deaf. Ms. Francosky also confirmed that while at the facility, Resident A utilized an ALS interpreter, the facility owned iPad, and on occasion facility staff members’ personal cellular telephones, to communicate. According to Ms. Francosky, Borgess Hospital provided Resident A with an ALS interpreter while she was admitted to their “holding area” from 07/14 to 07/25, as they were required to do so, “per the law”. Ms. Francosky confirmed facility staff members did not allow Resident A to keep the facility owned iPad and/or one of the facility staff members’ personal cellular telephones with her at the hospital and stated she did not believe they were required to do that.

On 08/05 the BCHS received a third complaint, via the BCHS’ online compliant system. According to the third written complaint, facility staff members left Resident A alone with her ALS interpreter in the facility, which was “against the rules”.

On 08/24 I conducted a second interview with Ms. Francosky, via telephone. Ms. Francosky stated Resident A did not require 1:1 enhanced supervision at any time while she was at the facility. Ms. Francosky denied the facility and/or Resident A’s ALS interpreter had any official policies and/or procedures indicating Resident A was not to be left alone with her interpreters while at the facility. According to Ms. Francosky, after meeting several times with Resident A, one of the interpreters eventually requested not to be left alone with Resident A in her bedroom, as some of Resident A’s behaviors made her feel uncomfortable. Ms. Francosky stated that upon receiving this request, facility staff members made arrangements for Resident A to meet with her interpreters in shared living areas throughout the facility.

On 08/27 I conducted separate telephone interviews with direct care workers Margaret Wieberg and Nevaeh Francosky. Both Ms. Wieberg and Nevaeh Francosky confirmed Resident A was “very clean” and tended to her own personal care independently, including doing her own hair. Neither Ms. Wieberg and/or Nevaeh Francosky recalled anyone notifying the facility and demanding facility staff

members bring Resident A's personal care items to the hospital while Resident A was there. According to Ms. Wieberg, she was one of the facility staff members who provided Resident A with supervision at the hospital for the first several days she stayed there. Ms. Wieburg stated Resident A was provided with personal care items available to her at the hospital and was encouraged to shower. However, according to Ms. Wieberg, Resident A chose not to shower and/or attend to her personal care needs while at the hospital, which was unusual for her. Both Ms. Wieberg and Nevaeh Francosky's statements regarding the allegation Resident A was left alone with her ALS interpreter in the facility were consistent with the statements Ms. Francosky provided to me.

While at the facility on 07/30, I requested and received a copy of Resident A's *AFC-Resident Care Agreement* (RCA) and assessment plan. According to documentation on Resident A's written RCA, which was signed by Resident A's legally appointed guardian on 01/21/2021 and licensee designee Destiny Saucedo-Al on 01/26/2021, Resident A's basic fee for the AFC services included basic hygiene supplies. There was no documentation on Resident A's written RCA indicating Resident A's basic fee for AFC services included the use of the facility's owned iPad and/or a telephone, or supervised meetings at the facility with an ALS interpreter.

According to documentation on Resident A's assessment plan, Resident A did not require assistance from facility staff members with personal hygiene tasks. Documentation on Resident A's assessment plan read in part, "[Resident A] is able to tend to her personal hygiene and will ask to shower if she feels she doesn't smell clean". There was no documentation on Resident A's assessment plan indicating facility staff members were to assist Resident A in doing her hair. Documentation on Resident A's assessment plan confirmed Resident A was hearing impaired and had a cochlear implant. According to Resident A's assessment plan, the facility arranged for Resident A to utilize an ALS interpreter at the facility from 3:30PM to 7:00PM Monday through Friday and for a "few hours" on the weekend. Resident A also had a personal "video phone". Resident A's assessment plan read in part, "TL has provided a tablet for communication." There was no documentation on Resident A's assessment plan specifically indicating Resident A was to be given access to the facility owned iPad and/or a "business phone" to communicate while she was out in the community. According to documentation on Resident A's assessment plan, Resident A was to be supervised by facility staff members while in the community. However, there was no documentation on Resident A's assessment plan indicating Resident A was to receive 1:1 enhanced supervision by a facility staff member at any time while at the facility, nor was there any documentation indicating Resident A was not to be left alone in the facility with her ALS interpreter.

I reviewed a copy of Resident A's recently updated CMH TP, received via email on 07/23 from Ms. Eldridge. There was no documentation on Resident A's CMH TP indicating Resident A required any assistance with personal care, including assistance with caring for her hair. There was no documentation in Resident A's CMH TP indicating Resident A's use of the facility owned iPad and/or "business

phone” to communicate while at the facility and/or while out in the community. There was no documentation on Resident A’s CMH TP indicating Resident A was to receive 1:1 enhanced supervision by a facility staff member at any time while at the facility, nor was there any documentation indicating Resident A was not to be left alone in the facility with her ALS interpreter.

APPLICABLE RULE	
R 400.15303	**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:	Resident A’s written RCA indicated Resident A’s basic fee for AFC services included basic hygiene supplies. According to administrator Zeta Francosky, had it been communicated to facility staff members that Resident A was without basic hygiene supplies and/or needed a specific hygiene supply while she was at the hospital, she would have made arrangements for Resident A to be provided with these items. DCW Margaret Wieburg stated Resident A was provided with personal care items available to her at the hospital and was encouraged to shower. However, Resident A chose not to shower and/or attend to her personal care needs while at the hospital. There was no documentation on Resident A’s assessment plan indicating facility staff members were to assist Resident A with doing her hair. While Resident A’s assessment plan indicated the facility provided Resident A with a “tablet” for communication purposes, there was no documentation on Resident A’s assessment plan specifically indicating Resident A could utilize the facility owned iPad and/or “business phone” to communicate while in the community. There was no documentation on Resident A’s assessment plan indicating Resident A was to receive 1:1 enhanced supervision by a facility staff members at any time while at the facility, nor was there any documentation indicating Resident A was not to be left alone in the facility with her ALS interpreter. Based upon my investigation, there is no evidence to substantiate the allegation facility staff members did not follow Resident A’s assessment plan when they failed to assist Resident A with doing her hair while she was in the hospital, failed to make arrangement for Resident A to use the facility’s iPad and/or “business phone” to communicate with others while she was at the hospital, and left Resident A alone in the facility with an American Sign Language Interpreter.

CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	It has been established there was no documentation in Resident A's recently updated CMH TP indicating Resident A required any assistance with personal care, including assistance with caring for her hair. There was no documentation on Resident A's recently updated CMH TP indicating Resident A's use of the facility owned iPad or "business phone" to communicate while at the facility and/or while out in the community. There was also no documentation on Resident A's recently updated CMH TP indicating Resident A was to receive 1:1 enhanced supervision by a facility staff member at any time while at the facility, nor was there any documentation indicating Resident A was not to be left alone in the facility with her ALS interpreter. Based upon my investigation, there is no evidence to substantiate the allegation facility staff members did not follow Resident A's CMH TP when they failed to assist Resident A with doing her hair while she was in the hospital, failed to make arrangement for Resident A to use the facility's iPad and/or "business phone" to communicate with others while she was at the hospital, and left Resident A alone in the facility with an American Sign Language Interpreter.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Facility staff members failed to notify Resident A's school when they stopped providing Resident A with transportation to and from school. Facility staff members failed to locate an alternative solution.

INVESTIGATION: This allegation was included in the third written complaint filed with the BCHS on 08/05.

While at the facility on 07/30, I requested and received a copy of the emergency discharge notice provided to Resident A's legally appointed guardian, via email, on

05/11, as well as a copy of Resident A's written RCA, and assessment plan. Documentation on Resident A's emergency discharge notice read in part;

"5/10-Refused to get out of the van for school. Staff began to transport her back when [Resident A] began to kick the driver's seat repeatedly. Staff pulled over in hopes that [Resident A] would calm down. After a few minutes she stopped kicking so staff began to drive again. [Resident A] then grabbed staff by the hair and began to pull repeatedly. While she was pulling staff's hair she picked up a bottle of hand sanitizer and kept acting like she was going to throw it at another resident and the driver. Upon returning to the home [Resident A] refused to get out of the van.

[Resident A] has also had multiple incidents at school regarding negative behaviors and just recently has begun to walk away from the teachers towards the main road after school before staff arrive to pick her up."

Documentation on Resident A's written RCA indicated the basic fee for AFC services included transportation to and from medical, legal, psychological, and court appointments, as well as transportation to community integration outings. According to documentation on Resident A's assessment plan, "[Resident A] begins school on 01/27/2021. She will attend KRESA."

I reviewed a copy of Resident A's recently updated CMH TP, received via email on 07/23 from Ms. Eldridge. One of the goals indicated on Resident A's CMH TP was that Resident A would attend educational programming through the local school district without "issues" 50% of the time. According to documentation on Resident A's CMH TP, transportation was a barrier to this goal as Resident A "acts out or refuses to go at times."

Ms. Francosky denied the allegation during my telephone interview with her on 08/24. Ms. Francosky confirmed that due to Resident A's unsafe behavior while riding in the facility van, which placed both herself, other residents, and facility staff members in extreme danger, on 05/11 facility staff members made the decision to stop providing Resident A with transportation to and from school in the facility's van. According to Ms. Francosky, facility staff members immediately notified Resident A's school of this decision and requested staff members from Resident A's school assist in providing an alternative solution.

Ms. Francosky forwarded me several email exchanges between facility staff members and Dr. Jeanine Mattson-Gearheart, who is the Director of Special Education at Kalamazoo Regional Educational Service Agency (KRESA), starting on 05/11 through 05/19. These email exchanges confirmed that on 05/11, facility staff member Jeffery Ostrowski, whose title is Community Integration Coordinator, notified Dr. Mattson-Gearheart, via email, that due to Resident A's unsafe behaviors while riding in the facility van, facility staff members could no longer provide Resident A with transportation to and from school. These email exchanges confirmed that Dr. Mattson-Gearheart requested a meeting with facility staff

members to discuss the incidents that lead to this decision. According to these email exchanges, Dr. Mattson-Gearheart arranged for KRESA staff members to provide Resident A with transportation to and from Vicksburg Public School starting on 05/18. However, according to a follow up email Dr. Mattson-Gearheart sent to Mr. Ostrowski on 05/17, she determined KRESA staff members riding the bus with Resident A required additional training before this plan could be implemented. Subsequently, per this email, Dr. Mattson-Gearheart requested to "move the target start date" to 05/20 and asked if facility staff members could transport Resident A to and from school until this time.

Ms. Francosky forwarded me an email she received on 06/01 from KRESA staff member Shelly Hawthorne, which read;

"Good afternoon-

[Resident A] arrived at school today but has been refusing to work. She is stating that she will not get on the bus when it comes to pick her up. Whom should we call if she refuses to get on the bus? The bus will typically wait 10 minutes before they leave to head to their next route. Jeff stated that he was in Lansing today and is unavailable when Lisa texted him. We will just need a plan B if she refuses.

Shelly"

On 06/01 Ms. Francosky provided Ms. Hawthorne with the following response via email;

"Plan B would be that me and another staff pick her up. Keep me posted."

Via email on 08/24, Ms. Francosky informed me facility staff members did not provide Resident A with transportation to and from school on 05/18 and 05/19, per Dr. Mattson-Gearheart's request via email on 05/17, as they determined Resident A's previous unsafe behaviors while riding in the facility van were too serious and placed Resident A, other residents, and facility staff members in danger.

APPLICABLE RULE	
R330.1805	**Accessibility**
	Common use areas of the facility are accessible to all clients in residence or an individual plan of service addresses the removal of imposed restrictions. The facility shall be capable of meeting the transportation needs of all clients the facility accepts for service.
ANALYSIS:	According to Resident A's CMH TP, "transportation" was a barrier to Resident A's identified goal that she would attend educational programming through the local school district without "issues" 50% of the time, as she "acts out or refuses to

	go at times." To assist Resident A in meeting her treatment goals, the facility was equipped with a van to transport Resident A to and from school. However, due to Resident A's unsafe behavior while riding in the facility van, which placed both herself, other residents, and facility staff members in extreme danger, on 05/11 facility staff members made the decision to stop providing Resident A with transportation to and from school. Subsequently, on 05/11 Resident A was also issued an emergency discharge notice. Administrator Zeta Francosky provided sufficient evidence, in the form of email exchanges between facility staff members and KRESA staff members, confirming facility staff members immediately notified Resident A's school of their decision to stop transporting Resident A to and from school. Per these email exchanges, it was established KRESA came up with a plan to provide Resident A with transportation to and from school. There is no evidence to substantiate the allegation facility staff members failed to notify Resident A's school when they stopped providing Resident A with transportation to and from school, or that they failed to locate an alternative solution.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On an unknown date, facility staff members conducted a "search" of Resident A's bedroom without communicating to Resident A why the search was being conducted.

INVESTIGATION: This allegation was also included in the third written complaint filed with the BCHS on 08/05.

On 08/27 I conducted a third interview with Ms. Francosky via telephone. Ms. Francosky stated she was not aware of any occasions when it was necessary to do an emergency unannounced "search" of Resident A's bedroom without informing Resident A. According to Ms. Francosky, Resident A would often attempt to steal the facility's iPad by placing it under her shirt and walking into her bedroom. On these occasions, facility staff members followed Resident A into her bedroom to retrieve the iPad. Ms. Francosky stated she also recalled an incident when facility staff members observed Resident A exit another resident's bedroom with some of their personal belongings. According to Ms. Francosky, this facility staff member followed Resident A into her bedroom to retrieve the other resident's personal belongings.

Both Ms. Wieberg and Nevaeh Francosky denied this allegation during my separate telephone interviews with them on 08/27. Ms. Wieberg stated facility staff members found ways to communicate with Resident A in various ways. However, upon attempting to communicate with Resident A, she would often roll her eyes, put her

hands up, and walk away. According to Ms. Wieberg, “sometime in June”, another resident accused Resident A of stealing her personal belonging. Ms. Wieburg stated she entered Resident A’s bedroom and communicated to Resident A, via writing on a “white board”, that she was looking for this resident’s personal items. According to Ms. Wieburg, Resident A “rolled her eyes, sat down on her bed, and crossed her arms.” Ms. Wieburg stated she found several items in Resident A’s bedroom that did not belong to Resident A. Nevaeh Francosky confirmed Resident A would often steal the facility iPad and hide it in her bedroom. According to Nevaeh Francosky, on these occasions facility staff members went into Resident A’s bedroom and retrieved the iPad. Nevaeh Francosky stated this was always communicated to Resident A, who was often in her bedroom when facility staff members went in there to collect the iPad.

I reviewed a copy of Resident A’s emergency discharge notice, which I collected during my onsite investigation on 07/30. Documentation on Resident A’s emergency discharge notice read in part;

“Turning Leaf has also tried to utilize interpreter services to effectively communicate with [Resident A] since she is deaf, but she routinely refuses to engage in conversations by looking away from staff/interpreters.”

APPLICABLE RULE	
R400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident’s admission to the home, a licensee shall inform a resident or the resident’s designated representative of, explain to the resident or the resident’s designated representative, and provide to the resident or the resident’s designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident’s rights specified in subrule (1) of this rule.**
ANALYSIS:	Based upon my investigation, which included interviews with multiple facility staff members, other than what was indicated in the written complaint filed with the BCHS on 08/05, there is no evidence to substantiate the allegation facility staff members conducted a “search” of Resident A’s bedroom without communicating to Resident A why the search was being conducted.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 09/09/2021 I conducted an exit conference with licensee designee Destiny Saucedo-Al Jallad via telephone and shared with her the findings of this

investigation. According to Ms. Saucedo-Al Jallad, the COVID-19 pandemic amplified the already existing shorting of direct care workers in long term care facilities. Ms. Saucedo-Al Jallad stated the facility recently implemented several strategies to recruit direct care workers, such as wage increases and employee bonus systems.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

Michele Streeter 08/27/2021 and 09/09/2021

Michele Streeter Date
Licensing Consultant

Approved By:

Dawn Timm 09/07/2021 and 09/09/2021

Dawn N. Timm Date
Area Manager