GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 14, 2021

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

RE: License #: AS330087738
Investigation #: 2021A0783043
Redwood 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) 284-9730.

Sincerely,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330087738
Investigation #:	2021A0783043
Complaint Receipt Date:	07/26/2021
Investigation Initiation Date:	07/26/2021
Report Due Date:	09/24/2021
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:	Sami Al Jallad
Name of Facility:	Redwood 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:	02/27/2021
Expiration Date:	02/26/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED, TRAUMATICALLY BRAIN INJURED, ALZHEIMERS

611 W. OTTAWA • P.O. BOX 30664 • LANSING, MICHIGAN 48909
www.michigan.gov/lara • 517-335-1980

ALLEGATION(S)

	Violation Established?
Resident A, who is an elopement risk, was left without staff supervision at the hospital on July 24, 2021, because there was not sufficient direct care staff on duty to supervise him at the hospital.	Yes

II. METHODOLOGY

07/26/2021	Special Investigation Intake – 2021A0783043
07/26/2021	Special Investigation Initiated - On Site
07/26/2021	Contact - Document Received – Written e-mail message from facility administrator Destiny Al Jallad
07/26/2021	Contact - Document Received – Written *Incident/Accident Report* for Resident A
07/26/2021	Contact - Face to Face interview with Destiny Al Jallad
07/26/2021	Contact - Document Received – Resident A's written Assessment Plan for AFC Residents
07/27/2021	APS Referral
08/02/2021	Contact - Telephone call made to Christa Campbell who is Resident A's assigned case manager
08/02/2021	Contact - Telephone call made to program manager Camie Blais
08/02/2021	Contact - Telephone call made to Guardian A1
08/02/2021	Contact - Document Received – Resident A's written Behavior Treatment Plan
09/10/2021	Exit Conference with administrator Destiny Al Jallad as licensee designee Sami Al Jallad was unavailable

ALLEGATION:

Resident A, who is an elopement risk, was left without staff supervision at the hospital on July 24, 2021, because there was not sufficient direct care staff on duty to supervise him at the hospital.

INVESTIGATION:

On July 26, 2021, I received an email message from facility administrator Destiny Al Jallad dated July 24, 2021, that stated, "Tonight 7/24 [at] 7pm [Resident A] was transported to Sparrow Hospital in Lansing Michigan via ambulance. He was exhibiting signs of psych instability: refused medication increased, increased agitation, refusing to change his colostomy bag/covered in feces, kicked out screen to his bedroom window and throwing items around the cottage. He has been transported to Sparrow. Due to the extreme staffing shortage our company is experiencing we are not able to staff him at the hospital ER. This is not typical and we wish we were able to accompany him; however, we know his whereabouts and will remain in constant communication with the Sparrow ER in order to ensure his safety and supervision."

On July 26, 2021, I received a written *Incident/Accident Report* for Resident A dated July 26, 2021. The written incident report stated, "Resident reported suicidal thoughts and was taken to McClaren hospital by police." The written report stated the facility manager was notified, an incident report was written, and "petition completed by program manager." The written report stated Resident A has a history of "schizoaffective disorder, chronic renal insufficiency, and colostomy."

On July 26, 2021, I interviewed facility administrator Destiny Al Jallad who stated Redwood Cottage, where Resident A resides is a "secure" setting due to Resident A having a history of elopements. Ms. Al Jallad said a 30-day discharge notice was issued to Guardian A1 and Resident A's placing agency on June 16, 2021, because Resident A's medical and behavioral needs exceed what can be provided at the facility. Ms. Al Jallad said on July 24, 2021, Resident A was "very [emotionally] dysregulated" and a petition for inpatient mental health treatment was completed by program manager Camie Blais, and police transported Resident A to the hospital. Ms. Al Jallad stated Resident A was taken to McLaren Hospital where he remained without a staff member present from approximately 7:00 pm until 11:00 pm on July 24, 2021. Ms. Al Jallad stated Resident A requires assistance from a staff member while in the community. Ms. Al Jallad stated the facility policy is to have a staff member accompany a resident to the hospital, however, due to the extreme staffing crisis at the facility there was no staff member available to accompany Resident A to the hospital on July 24, 2021. Ms. Al Jallad stated with the number of staff members presently employed at the facility all shifts are covered, however if an employee does not report for their shift, there is no one available to replace that person. Ms. Al Jallad stated licensee designee Sami Al Jallad has increased pay, offered financial incentives for attendance, and actively pursued hiring new individuals with daily

interviews and weekly orientation and will continue to pursue hiring more staff members.

On August 2, 2021, I spoke to Resident A's assigned case manager Christa Campbell who said Resident A has a written behavior treatment plan addressing his history of elopements, which is in part why Resident A requires assistance from a staff member when he is in the community. Ms. Campbell said in addition to being an elopement risk, Resident A regularly experiences auditory hallucinations, has physical medical concerns, and has been diagnosed with dementia. Ms. Campbell said on July 24, 2021, Resident A refused his medication, removed all clothing except for a shirt, was on his hands and knees, removed his colostomy bag, broke out his bedroom window and climbed out and then tried to get past the secured gate outside the facility. Ms. Campbell said at approximately 7:00 pm Resident A expressed that he was suicidal. Ms. Campbell said program manager Camie Blais completed a written petition to have Resident A treated at an inpatient psychiatric treatment facility and police came and transported Resident A to the hospital. Ms. Campbell said Resident A was at the hospital for "a few hours" without a staff member because no facility staff member was available to accompany Resident A to the hospital. Ms. Campbell said Resident A "returned to baseline" and was transported back to the facility via Ambucab later in the evening on July 24, 2021.

On August 2, 2021, I spoke to facility program manager Camie Blais who said on July 24, 2021, Resident A was physically aggressive and throwing things so she completed a written petition to have Resident A admitted into an inpatient psychiatric treatment facility and when filed the police came to take Resident A to the hospital at which time Resident A reported being suicidal. Ms. Blais said Resident A is an elopement risk, resides in a "secure" setting, and requires assistance from a staff member while in the community. Ms. Blais said there was one staff member working at the facility and that person could not leave to accompany Resident A to the hospital. Ms. Blais said Resident A was at the hospital for approximately six hours and he was released, as his behavior returned to baseline while he was at the hospital. Ms. Blais said while Resident A was in the hospital, she telephoned staff at the hospital regularly to monitor Resident A.

On August 2, 2021, I spoke to Guardian A1 who said she was informed that Resident A was taken to the emergency room due to a change in his mental health and there was no staff member available to accompany Resident A to the hospital. Guardian A1 stated Resident A requires assistance from a staff member while in the community because he has a history of elopements. Guardian A1 stated the facility is short staffed despite great efforts from the licensee designee and she understood why no staff member was available to accompany Resident A to the hospital.

On July 26, 2021, I received and reviewed Resident A's written *Assessment Plan for AFC Residents* dated February 19, 2021. The written assessment stated Resident A does not move independently in the community, and specified, "Secured residential clients like [Resident A], remain within the limits of the secured parameter to include

cottage, common outdoor area with secured fencing. Residential clients within the secured setting remain within staff proximity. Secured residential clients are escorted by staff when moving around campus." The assessment plan also stated, "staff support [Resident A] in the community with questions, providing verbal prompts, assistance, health and safety, guidance and decision making, support, and transportation." The assessment plan documented that Resident A has psychosis and responds to internal stimuli. The assessment plan stated Resident A "has a diagnosis of dementia. During a recent hospitalization he was diagnosed with Type 3 diabetes which is a combination of Diabetes with Alzheimer's Dementia. For these reasons staff presence is needed to provide safety, security, and direction for [Resident A] when he is engaged in community based activities and appointments."

On August 2, 2021, I received and reviewed Resident A's *Behavior Treatment Plan* dated May 19, 2021. The treatment plan stated, "[Resident A] exhibits elopement, verbal and physical aggression, medication and self-care refusals and confusion. [Resident A] will look for an opportunity to elope. He has limited awareness of his surroundings and can easily get confused. He does not abide by safety protocols, i.e., looking before crossing the street, where he is and how to get where he is going, or even have a plan of where he is going. When [Resident A] is delusional he thinks that he is Lucifer and this is not good for [Resident A]. The auditory hallucinations are evil and tell [Resident A] to do "bad" things. These delusions create agitation and anxiety in [Resident A] which often results in physical aggression. He will punch staff, consumers, or physical property. [Resident A's] physical aggression appears to be triggered by his delusional thoughts. He has attacked other residents and has gotten punched back. [Resident A] is constantly responding to internal stimuli. He appears very harassed by these voices, often appearing agitated and upset. There does not appear to be any physical or verbal antecedents before he is physically aggressive. He always appears to be having auditory hallucinations but staff have not been able to distinguish between the hallucinations that may contribute to his physical aggression. [Resident A] has limited insight into his mental and physical health. He will often deny he is talking or hearing anything. There are days where [Resident A] is unaware of anyone and everything around him. [Resident A] has diabetes and will refuse to eat/drink which exacerbates his diabetes. [Resident A] has a colostomy bag and struggles with maintenance of this bag. He often refuses daily self-care (eating, personal hygiene) which has resulted in hospitalizations. Staff prompt daily hygiene but he often refuses and may become verbally aggressive. [Resident A's] baseline is described as being agitated and displays constant verbal responding to internal stimuli. He rarely exhibits tangential thought patterns and conversation." The "target behaviors" noted in the treatment plan were physical aggression, self-care refusals, refusals to eat, medication refusals, and elopement.

On September 10, 2021, I completed an exit conference with administrator Destiny Al Jallad due to licensee designee Sami Al Jallad being unavailable. Ms. Al Jallad did not agree with the findings of this report. Ms. Al Jallad stated the word "community" on the written *Assessment Plan for AFC Residents* does not or should

not include the hospital. Ms. Al Jallad stated Resident A was not unattended in a store, restaurant nor friend's home but rather in the hospital where Resident A was being cared for and Ms. Blais called the hospital regularly to monitor Resident A. Ms. Al Jallad added that the licensee continues to make great efforts to hire new staff members and incentivize current staff members, but the turnover rate remains 40 %.

APPLICABLE RULE	
R 400.14206	**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:	Based on a written email message from Ms. Al Jallad as well as statements from Ms. Al Jallad, Ms. Campbell, and Ms. Blais it can be determined that Resident A was sent into the community without a staff member because no staff member was available to accompany Resident A when he went to the emergency room on July 24, 2021. Based on statements from those interviewed and written documentation at the facility it can be determined that Resident A requires staff supervision in the community per his written assessment plan due to a history of elopement, limited awareness of his surroundings, confusion, and neglecting to abide by standard safety protocols. Thus, there was not sufficient staff on duty for the supervision of Resident A according to his written assessment plan which requires staff supervision for Resident A when he is in the community.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in the status of the license.

09/10/2021

Leslie Herrguth Date
Licensing Consultant

Approved By:

09/14/2021

Dawn N. Timm Date
Area Manager