GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 21, 2022

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

RE: License #: AS330087736
Investigation #: 2022A0783012
Poplar 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 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 #:	AS330087736
Investigation #:	2022A0783012
Complaint Receipt Date:	11/22/2021
Investigation Initiation Date:	11/23/2021
Report Due Date:	01/21/2022
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:	Poplar 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:	01/29/2021
Expiration Date:	01/28/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED, TRAUMATICALLY BRAIN INJURED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive supervision per his assessment plan, and he eloped from the facility on November 21, 2021.	Yes

III. METHODOLOGY

11/22/2021	Special Investigation Intake – 2022A0783012
11/23/2021	Special Investigation Initiated - On Site
11/23/2021	Contact - Document Received – Written email message from administrator Destiny Al Jallad
11/23/2021	Contact - Face to Face interviews with Destiny Al Jallad and direct care staff member Tayler Seyka
11/23/2021	Contact - Document Received – Resident A's written resident record
11/23/2021	Contact - Document Received –Written electronic message sent by Destiny Al Jallad to facility staff members
01/20/2022	Contact - Telephone call made to assistant program manager Camie Blais
01/20/2022	Contact - Telephone call made to program manager Amber Ely - Costa
01/20/2022	Contact - Telephone call made to Guardian A1
01/21/2022	Exit Conference with Destiny Al Jallad

ALLEGATION:

Resident A did not receive supervision per his assessment plan, and he eloped from the facility on November 21, 2021.

INVESTIGATION:

On November 22, 2021, I received a written *AFC Licensing Division Incident/Accident Report* dated November 22, 2021. The written incident report was signed by direct care staff member Tayler Seyka and facility administrator Destiny Al Jallad. The written incident report stated that on November 21, 2021 at approximately 8:30 pm, "staff got [Resident A's] meds ready and went to knock on his door, when Resident [A] did not answer staff opened door calling his name before turning on light noticing resident was not in his room. Staff called float and ran around perimeter and checked other rooms in cottage. Float came back to help search and staff called police." In the "action taken by staff" section of the written report it stated, "Called 911, notified [program manager], [assistant program manager], and campus float/lead of Cedar. Per [Ms. Seyka], [Resident A] was last seen sleeping in cottage around 4:00 pm on 11/21/21. Was sleeping in his bedroom." In the "corrective measures" section of the written report it stated, "This incident has been reported out. Police called immediately, a description was given of [Resident A's] physical appearance. Cottage staff, float, manager, and on – call manager came to the area to search for [Resident A.]"

On November 23, 2021, I received a written email message written by facility administrator Destiny Al Jallad on November 22, 2021 at 9:46 pm that stated, "I just got word that [Resident A] was located. A state trooper called one of our managers just now with the following info[rmation]: [Resident A] picked up walking on 96 by Howell trying to get 'home' to Detroit about 9:00 pm last night. [Resident A] told state trooper Leigh that an ambulance had taken him to Howell from St. Joseph Mercy hospital, he had a warrant out of Macomb so they took him to Livingston county jail and they were supposed to be transferring him to Macomb county today. Still confirming his whereabouts (which county jail) but he was picked up last night by a state trooper."

On November 23, 2021, I interviewed facility administrator Destiny Al Jallad who stated Resident A was admitted to the facility on November 16, 2021. Ms. Al Jallad said Resident A was referred for admission to the facility in May 2021 and that he had been in a hospital receiving inpatient psychiatric treatment until he was released on November 16, 2021 and admitted to the facility. Ms. Al Jallad said from May – November 2021 she had weekly communication with staff members at the hospital where Resident A was being treated and Resident A showed no indication he would elope. Ms. Al Jallad said Resident A had a history of elopement from previous group homes. Ms. Al Jallad stated the written documentation concerning Resident A indicated he "wanders." Ms. Al Jallad said in the six months prior to Resident A's admission to the facility he did not attempt to elope. Ms. Al Jallad said on November

17, 2021 Resident A jumped over the six – foot fence that surrounds the facility and attempted to elope but a staff member was following Resident A. Ms. Al Jallad stated Resident A returned to the facility with the assistance of police. Ms. Al Jallad stated Resident A reported that he wanted to go live with his sister which prompted the eloping behavior so a facility staff member facilitated a conversation between Resident A and his sister and Resident A was encouraged to stay at the facility , and Resident A said he would stay. Ms. Al Jallad said additionally, effective November 17, 2021, staff members were instructed to make visual contact with Resident A every 15 minutes. Ms. Al Jallad stated this communication was given to staff members in writing via a "message in the [online] scheduling system" that every staff member would see. Ms. Al Jallad said on November 21, 2021 at 4:00 pm Resident A was seen sleeping in his bedroom by staff member Tayler Seyka, who was the only staff member working. Ms. Al Jallad said Ms. Seyka noted that Resident A did not come to the dining room for dinner but did not find that unusual. Ms. Al Jallad said at approximately 8:30 pm Ms. Seyka went into Resident A's bedroom to administer medication and noticed that Resident A was not there. Ms. Al Jallad said Ms. Seyka did not monitor nor supervise Resident A between 4:00 pm and 8:30 pm.

On November 23, 2021, I interviewed direct care staff member Tayler Seyka who stated she arrived at 3:00 pm on November 21, 2021 and was scheduled to work alone until 11:00 pm. Ms. Seyka said she went into Resident A's bedroom at 4:30 pm and saw him sleeping in his bed. Ms. Seyka said between 4:30 pm and 8:30 pm she did not see Resident A and did not go into his bedroom to check on him. Ms. Seyka said on November 21, 2021 Resident A did not have any specific supervision requirements, and she thought he was asleep in his bedroom. Ms. Seyka said Resident A was to be visually monitored every 15 minutes the day after he attempted to elope from the facility but the 15 – minute line-of-sight supervision requirement only applied to Resident A on November 18, 2021, the day after Resident A attempted to elope from the facility. Ms. Seyka stated the staff member who worked the shift prior to her on November 21, 2021 told her she did not visually monitor Resident A every 15 minutes during her shift, and "nobody told" Ms. Seyka to visually monitor Resident A every 15 minutes. Ms. Seyka said she spent much of her shift in the kitchen because two different residents made sexually inappropriate comments to her, and she was not comfortable being in the common area of the facility. Ms. Seyka said Resident A did not come to the dining room to eat dinner, but she did not find that unusual because she thought Resident A was asleep. Ms. Seyka said at approximately 8:30 pm she went into Resident A's bedroom to administer his medication and noticed that Resident A was not in his room. Ms. Seyka said she checked throughout the facility and outside on the property and could not locate Resident A, so the police were notified. Ms. Seyka said she did not know what time Resident A left the facility nor how he left, but she believed Resident A left via the back door which is in the living room/dining room area of the facility. Ms. Seyka said she thought Resident A was sleeping in his bedroom between 4:30 and 8:30 pm and did not directly supervise him during that time.

On January 20, 2022, I interviewed assistant program manager Camie Blais who said Resident A was admitted to the facility approximately one week prior to November 21, 2021 when he eloped from the “secured” facility. Ms. Blais said Resident A had a history of elopement in his previous placements which is why Resident A was placed in Poplar Cottage which is surrounded by a 6 – foot – tall fence. Ms. Blais said Resident A “jumped the fence” once prior to November 21, 2021, but he remained within sight of a staff member who was following him on that occasion. Ms. Blais said after Resident A attempted to elope an email message was sent to all staff members to be alert that Resident A may elope and to do “eyes on checks” of Resident A which are generally done every 15 minutes to one hour. Ms. Blais said she was on – call on November 21, 2021 when direct care staff member Alexis Bence telephoned her at approximately 9:00 pm and told her that Resident A “was missing.” Ms. Blais said she was told that Resident A was last seen by a staff member at approximately 4:00 pm. Ms. Blais said she was not given an explanation as to why staff member Tayler Seyka did not make visual contact with Resident A for four hours. Ms. Blais said Resident A was “obsessed with” leaving the facility and going “home” and that “pretty much all [Resident A] talked about” was leaving the facility.

On January 20, 2022, I interviewed program manager Amber Ely – Costa who said Resident A was admitted to the facility approximately one week prior to November 21, 2021 when he eloped from the facility and was located in jail in another county approximately two days later. Ms. Ely – Costa said Resident A had been verbalizing that he wanted to leave and “get home” since he was admitted to the facility but when she spoke with him on November 19, 2021, Resident A agreed not to elope at least through the weekend and the two would speak again on November 22, 2021. Ms. Ely – Costa said staff members were aware that Resident A eloped from previous placements and that is why he was admitted to Poplar Cottage which is “secured” with a six – foot fence. Ms. Ely – Costa said Resident A attempted to elope prior to November 21, 2021, but a staff member was able to follow him, and he remained within the staff member's line – of – sight. Ms. Ely – Costa said Resident A did not have any specific supervision requirements except for being aware of his general whereabouts. Ms. Ely – Costa said Resident A was seen on November 21, 2021 at 4:00 pm and then not checked again until approximately 8:30 pm because Tayler Seyka who was working believed Resident A was asleep throughout those four and a half hours.

On January 20, 2022, I spoke to Guardian A1 who is Resident A’s assigned public guardian. Guardian A1 said Resident A has a history of eloping from every group home in which he resided, of which Poplar Cottage administrator Destiny Al Jallad was aware. Guardian A1 said Resident A was placed at Poplar Cottage because it is a “secure” setting enclosed by a fence. Guardian A1 said approximately two days after Resident A was admitted to the facility, he jumped the fence and attempted to board a public transportation bus but returned to the facility. Guardian A1 said given that incident, Resident A’s written assessment plan was updated to require staff members to make visual contact with Resident A every 15 minutes. Guardian A1

said on November 21, 2021 a staff member noted that Resident A was not in his bedroom nor anywhere in the facility or on the campus so police were telephoned at 8:54 pm. Guardian A1 said she was told that Resident A was last seen by a staff member at 4:00 pm and that he was not supervised per his written assessment plan from 4:00 pm until almost 9:00 pm when a staff member realized Resident A was not at the facility.

On November 23, 2021, I received and reviewed Resident A's written *Assessment Plan for AFC Residents* dated November 19, 2021 which stated Resident A does not move independently within the facility "campus" but rather he should "remain within the limits of the secured perimeter to include: cottage, common outdoor area with secured fencing. [Resident A should] remain within staff proximity. [Resident A is] escorted by staff when moving around Turning Leaf Behavior Health campus." Resident A's written assessment plan stated he does not move independently in the community but rather "residential staff support [Resident A] in the community. [Resident A] has a history of wandering and staff will remain present with [Resident A] when engaging in the community. Initially, due to his history of wandering, all community engagement will occur 1:1 with staff. Within 24 hours of admission, [Resident A] made an attempt AWOL and was found at the bus stop outside of Turning Leaf. For this reason, 15 minute checks were implemented to ensure his safety and security."

On November 23, 2021, I received and reviewed written notes pertaining to Resident A recorded by the staff member assigned to work at the facility during each shift. There was a written "misc note" from staff member Tayler Seyka concerning Resident A for her shift from 3:00 pm – 11:00 pm on November 21, 2021. The written documentation stated Ms. Seyka provided "standard supervision/general whereabouts" to Resident A during her shift. The written note stated, "A little after four the float during this shift came back to verify with staff in cottage that [Resident A] was in his room. While cooking dinner, staff was dealing with two other residents who kept saying inappropriate things that had the staff very uncomfortable and made it so staff had to write IRs. During bedtime med pass, staff got [Resident A's] medications and went to his room. When [Resident A] did not respond staff opened resident's door and called his name. Staff realized the resident's room was empty and ran around the cottage to see if he was in the bathroom or the room of any other residents. Staff then called police." I noted that between November 19, 2021 when the written assessment plan was completed stating that Resident A required eyes – on supervision every 15 minutes and November 21, 2021 when he eloped there were five different shifts worked by four different staff members that indicated the supervision that was provided was "standard supervision/general whereabouts" rather than "15 minute checks."

On November 23, 2021, I received a written "whentowork message" sent by Destiny Al Jallad to staff members at the facility dated November 17, 2021 that stated "Please be alert – resident in secured elopement/jumping fence." The message stated, "Our new resident [Resident A] has already jumped the fence and was

returned by police this afternoon. Please be alert. It may happen again. If he jumps the fence again or otherwise leaves campus, call 911 and report this to the police immediately. Be descriptive with what he is wearing and what he looks like. You can call a manager after you call police. Let them know he eloped from a locked group home. It is most important that we know where residents are at all times and report immediately especially in the cold weather months."

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:	Based on statements from Ms. Al Jallad, Ms. Seyka, Ms. Blais, Ms. Ely – Costa, and Guardian A1 along with written documentation at the facility I determined that Resident A had a known history of elopement from previous placements, that he continuously vocalized thoughts of elopement, and he first jumped over the fence that surrounds the facility on or about November 17, 2021. Resident A's written assessment plan dated November 19, 2021 indicated he was to be visually monitored by a staff member every 15 minutes and interviews and written documentation indicated Resident A was not supervised according to his written assessment plan when he eloped from the facility on November 21, 2021 and on several other occasions as well.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/21/2022

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Leslie Herrguth Date
Licensing Consultant

Approved By:

01/21/2022

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Dawn N. Timm Date
Area Manager