GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 10, 2022

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

RE: License #: AS330087736
Investigation #: 2022A0783059
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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS330087736
Investigation #:	2022A0783059
Complaint Receipt Date:	08/15/2022
Investigation Initiation Date:	08/17/2022
Report Due Date:	10/14/2022
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, ALZHEIMERS, AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Kiara Cain "got loud with" Resident A after he became angry because Ms. Cain threw away Resident A's lunch and refused to make more.	Yes

III. METHODOLOGY

08/15/2022	Special Investigation Intake - 2022A0783059
08/17/2022	Special Investigation Initiated - Telephone call with Complainant
08/17/2022	Contact - Telephone call made to direct care staff member Kiara Cain
08/25/2022	Inspection Completed On-site
08/25/2022	Contact - Face to Face interviews with Resident A, administrator Destiny Al Jallad, program manager Amber-Ely Costa, and home manager Camie Blais
08/25/2022	Contact - Document Received - Text message sent by Ms. Cain to Ms. Blais
10/10/2022	Contact - Document Received - Resident A's written *Assessment Plan for AFC Residents* and *Person Centered Plan*
10/10/2022	Exit Conference with Destiny Al Jallad

ALLEGATION:

Direct care staff member Kiara Cain "got loud with" Resident A after he became angry because Ms. Cain threw away Resident A's lunch and refused to make more.

INVESTIGATION:

On August 15, 2022, I received a complaint via centralized intake that direct care staff member Kiara Cain refused to assist with food preparation and as a result, Resident A's food was thrown out after he did not come to get it. The written

complaint stated Resident A became aggressive and Ms. Cain told him “I’m not cooking it again, but there’s more and you are free to make it because it’s almost 3:00 pm.” The written complaint stated Resident A then called Ms. Cain a liar and said, “ fuck this Ima [sic] beat your ass.” The written complaint stated in response, Ms. Cain stood up and “got loud right back.” The written complaint stated Ms. Cain was suspended as a staff member. The written complaint stated this information was reported to the office of recipient rights (ORR) in Wayne County and an investigator initiated a call to the facility program manager, Amber Ely-Costa who advised that Resident A is verbal and was not harmed in any way. Ms. Ely-Costa confirmed the identity of the direct care worker as Kiara Cain and indicated the safety plan moving forward was to suspend Ms. Cain.

On August 17, 2022, I spoke to Complainant who said she spoke with facility managers Amber Ely–Costa and Camie Blais on August 15, 2022 and was told direct care staff member Kiara Cain was the only staff member at the facility at the time of the allegations which was August 11, 2022. Complainant said Ms. Cain reported this information directly to Camie Blais but did not complete a written incident report concerning the allegations.

On August 17, 2022, I spoke to direct care staff member Kiara Cain who stated on August 11, 2022 she prepared lunch for Resident A and the other residents at approximately 12:00 pm and knocked on Resident A’s bedroom door to let him know that lunch was ready and Resident A did not respond nor come out of his bedroom until approximately 2:45 pm. Ms. Cain said she threw away Resident A’s uneaten pulled pork sandwich at 2:30 pm because flies had been crawling on it and she did not think it was suitable for Resident A to eat. Ms. Cain said at 2:45 Resident A came out of his bedroom and asked for his lunch. Ms. Cain said she told Resident A at that time that she had thrown his plate away but there was more pulled pork in the refrigerator that Resident A could heat in the microwave, put on bread, and eat. Ms. Cain acknowledged that she told Resident A she would not prepare another sandwich for Resident A because it was nearly time for her shift to end. Ms. Cain said she was “cleaning” and “didn’t see a problem with” refusing to assist Resident A with making lunch after she threw his plate in the garbage when he did not come eat it by 2:30 pm. Ms. Cain said Resident A is capable of cooking but acknowledged that his written assessment plan indicates that staff members should prepare his meals. Ms. Cain said Resident A became angry when she told him she would not prepare another sandwich for him and said, “fuck that shit, I’m going to beat your ass.” Ms. Cain said at that time she stood up from her chair and told Resident A that he was being very disrespectful and that she had already explained why he needed to prepare his own lunch. Ms. Cain said Resident A began to yell at her and she said that she “yelled at [Resident A] because he yelled at [her].” Ms. Cain said Resident A “won’t listen unless you’re as loud as him.” Ms. Cain said she did not complete a written incident report to document the events she described as she did not believe it was necessary. Ms. Cain stated her employment was suspended that day.

On August 25, 2022 I spoke to facility administrator Destiny Al Jallad who said she was familiar with the allegations described in this complaint as Ms. Cain directly told manager Camie Blais that she “got loud with” Resident A and she refused to make him another sandwich after she threw his away because he had not eaten it two hours after she knocked on his door to tell him lunch was being served. Ms. Al Jallad stated a written incident report was not completed but a complaint was filed with ORR and Ms. Cain was suspended from working at the facility indefinitely. Ms. Al Jallad stated if ORR found a violation of Resident A’s resident rights occurred, Ms. Cain would be terminated. Ms. Al Jallad said the policy is and what Ms. Cain should have done is wrapped Resident A’s lunch plate in cling wrap and put it in the refrigerator, so he had access to the food when he was ready. Ms. Al Jallad said according to his written assessment and treatment plans staff members should prepare Resident A’s meals.

On August 25, 2022, I spoke to program manager Amber Ely–Costa who said home manager Camie Blais told her that direct care staff member Kiara Cain reported via text message that she “got loud with” Resident A because he was being disrespectful toward her. Ms. Ely–Costa said she briefly spoke with Ms. Cain who acknowledged yelling at Resident A and said she “did nothing wrong” because Resident A was being disrespectful toward her. Ms. Ely–Costa said she and Ms. Cain did not discuss her throwing Resident A’s lunch away and then refusing to make him more, but according to Resident A’s written assessment and treatment plans staff members should prepare all Resident A’s meals. Ms. Ely–Costa said if Resident A did not come to the table to eat lunch Ms. Cain should have wrapped the food in cling wrap, put it in the refrigerator and rewarmed the food later when Resident A indicated he wanted to eat it.

On August 25, 2022 I spoke to home manager Camie Blais who said on August 11, 2022 she received a text message from then direct care staff member Kiara Cain that stated, “[Resident A] was throwing a fit because I threw his lunch away because he never came to get it and he just went off and I told him look, I made your food, I knocked on your door and you never came and he got aggressive and disrespectful and so I told him I’m not cooking it again but there is more and you are free to make it because its almost 3. He called me a liar and I told him I’m not and he said fuck this ima [sic] beat your ass so I stood up and got loud right back but he really was acting like he was going to hit me over some damn food.” Ms. Blais forwarded the text message to me and stated Ms. Cain was suspended immediately and that there were no current plans for her to be put back on the employee schedule at the facility.

On August 25, 2022, I interviewed Resident A who has been diagnosed with a traumatic brain injury and struggles with memory deficits. Resident A was not able to answer any questions related to the allegation in the written complaint.

On October 10, 2022, I received and reviewed Resident A’s current written *Assessment Plan for AFC Residents* which stated Resident A requires assistance with eating/feeding and that staff members plan the menu, shop, prepare the food,

serve, and clean up all three meals for Resident A. The assessment plan stated Resident A can feed himself meals that are served but staff should prepare the plate with appropriate serving sizes. The same day I received and reviewed Resident A's current written *Person Centered Plan (PCP)* which did not indicate that Resident A has any goals, responsibilities, nor steps for making his own meals. I noted the PCP noted that Resident A has a brain injury and is unable to recall information.

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 Complainant, Ms. Cain, Ms. Al Jallad, Ms. Ely–Costa, and Ms. Blais along with written documentation in Resident A's resident record I determined that Resident A did not receive assistance according to the act and his written assessment plan when he was not served lunch on August 11, 2022 due to direct care staff member Kiara Cain throwing away Resident A's uneaten lunch and then refusing to make his lunch when he requested it at approximately 2:45 pm.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14304	**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 on statements from Complainant, Ms. Cain, Ms. Al Jallad, Ms. Ely – Costa, Ms. Blais, and a written text message forwarded by Ms. Blais I determined that direct care staff member Kiara Cain did violate Resident A's right to be treated with dignity and respect when she "got loud with" and "yelled at" him on August 11, 2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/10/2022

Leslie Herrguth — Date
Licensing Consultant

Approved By:

10/10/2022

Dawn N. Timm — Date
Area Manager