GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 19, 2024

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

RE: License #:	AM410409791
Investigation #:	2024A0356024
	Kentwood Cottage

Dear Ms. Saucedo-Al Jallad:

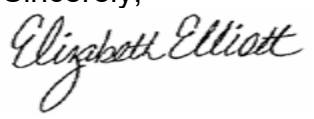
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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
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 #:	AM410409791
Investigation #:	2024A0356024
Complaint Receipt Date:	02/23/2024
Investigation Initiation Date:	02/29/2024
Report Due Date:	04/23/2024
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:	Kentwood Cottage
Facility Address:	4345 36th St. SE Kentwood, MI 49512
Facility Telephone #:	(517) 393-5203
Original Issuance Date:	05/25/2022
License Status:	REGULAR
Effective Date:	11/25/2022
Expiration Date:	11/24/2024
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A refused medications and appropriate medical professionals were not notified.	Yes
Resident A's medications were not administered as prescribed.	Yes

III. METHODOLOGY

02/23/2024	Special Investigation Intake 2024A0356024
02/29/2024	Special Investigation Initiated – Telephone. Megan Aukerman with Michelle, Network 180, Office of Recipient Rights.
03/06/2024	Contact - Telephone call made. Megan Aukerman, Licensing Consultant.
03/13/2024	Contact - Document Sent Email to Martha Bailey, Network 180 nurse.
03/14/2024	Contact - Telephone call made. Martha Bailey, Network 180 nurse.
03/15/2024	Inspection Completed On-site
03/15/2024	Contact - Face to Face DCW's Terrah Earvin, Shaetiaunna Green.
03/15/2024	Contact - Telephone call made. Donica Wilson, home manager and Cindy Figueroa, program manager.
03/15/2024	Contact - Telephone call made. Requested facility documents from Donica for this complaint.
03/17/2024	Contact-Documents received. IR's
04/10/2024	Contact - Telephone call made. Case manager, Maggie Hanson, Network 180.
04/10/2024	Contact - Telephone call made.

	Relative #1, legal guardian.
04/10/2024	Contact - Document Sent Requested facility and resident documents from Zeta Francosky, Program Administrator and Cindy Figueroa, manager.
04/11/2024	Contact - Document Received Documents rec'd from Maggie Hanson.
04/11/2024	Contact-APS referral made.
04/19/2024	Exit Conference-Licensee Designee, Destiny Al Jallad.

ALLEGATIONS:

- **Resident A refused medications and appropriate medical professionals were not notified.**

- **Resident A's medications were not administered as prescribed.**

INVESTIGATION: On 02/23/2024, I received a BCAL (Bureau of Children and Adult Licensing) online complaint. The complainant reported that Resident A did not receive his medications for nearly three weeks and Network 180 (Community Mental Health) was not notified of Resident A's need for medication refills by the facility or pharmacy. Once this was discovered, staff at the facility advised Network 180 that Resident A had refused his psychotropic medications prior to running out of medications for the past three weeks and the complainant reported this information was never communicated to the Network 180 office. Megan Aukerman, Adult Foster Care Licensing Consultant initiated the complaint and spoke to Michelle Richardson, Office of Recipient Rights (ORR) Network 180. Ms. Aukerman stated ORR does not have an open complaint and will not be investigating.

On 03/14/2024, I interviewed Network 180 RN (registered nurse) Martha Bailey via telephone. Ms. Bailey stated she is part of the team that oversees Resident A's care. Ms. Bailey stated over a 3-week period, Resident A did not receive his psychotropic medications and Resident A's doctor at Network 180 (Dr. Regina Lopez) along with Ms. Bailey RN and Maggie Hanson, case manager was not alerted that Resident A was refusing his medications or that he did not have the medications to take. Ms. Bailey reported in addition, Resident A's legal guardian was not informed either. Ms. Bailey stated they are getting different stories from staff at the facility. One being that due to Resident A missing a medication review appointment on 01/26/2024, Ms. Hanson, the case manager told them (staff) that Network 180 would not provide medications to Resident A. Ms. Bailey stated Ms. Hanson has denied telling staff at the facility that misinformation. Ms. Bailey reported she contacted IPSG Pharmacy to inquire about why Resident A's psychotropic medications had not been refilled and

why they (Network 180) had not been notified by the pharmacy or the facility that Resident A's medications were not refilled. Ms. Bailey stated staff at the pharmacy told her that they received an email from Kentwood Cottage AFC staff stating that Network 180 was not going to refill the medications because Resident A missed a medication review with Dr. Lopez on 01/26/2024. Ms. Bailey stated this was not true as they would always make sure Resident A had the prescribed psychotropic medications that he required, and changes would only be made at the time Resident A saw Dr. Lopez. Ms. Bailey stated Resident A is prone to serious self-harm, is court ordered to take psychotropic medications and is a very sick man who requires medications and close monitoring. Ms. Bailey stated she has reviewed Resident A's MARs (medication administration records) and has determined that on 01/27/2024, Resident A's psychotropic medications, were not administered to Resident A as prescribed and it was not until 02/22/2024 that Ms. Hanson was notified. Ms. Bailey stated Ms. Hanson informed her and she (Ms. Bailey) then informed Dr. Lopez that Resident A was not taking his psychotropic medications, Paliperidone, Caplyta, Lorazepam, Lamotrigine and Melatonin. Ms. Bailey stated she determined after a review of the MAR's for Resident A, that all Resident A's regular medications were administered as prescribed. It was only the psychotropic medications that were not. Ms. Bailey stated neither she nor Dr. Lopez, as the medical part of the team, were notified that Resident A was not taking medications that were critical to his overall health.

On 03/15/2024, I conducted an unannounced inspection at the facility and interviewed Direct Care Workers (DCWs) Terrah Earvin and Shaetiaunna Green. Ms. Earvin and Ms. Green stated they documented each time Resident A refused his medications or when there were no medications to give him and wrote an IR (Incident Report). Ms. Earvin and Ms. Green stated those IR's went to their supervisor, Donica Wilson to be submitted to Network 180. Ms. Green and Ms. Earvin stated Resident A had an appointment to go to Network 180 because he needed to see the doctor before his psychotropic medications could be refilled and when the date came for that appointment, 01/26/2024, Resident A refused to go to the doctor's appointment. Ms. Earvin and Ms. Green stated an Uber was arranged to pick him up from the facility and transport him to the appointment because there was not enough staff at the facility to transport Resident A to Network 180, but once the Uber arrived, Resident A refused to go and therefore, Resident A did not get refills on his psychotropic medications.

On 03/15/2024, While at the facility, I called and interviewed Donica Wilson, home manager and Cindy Figueroa, program manager via telephone. Ms. Wilson stated on 01/25/2024 she called Ms. Hanson to report that Resident A was not at "baseline" with his behaviors and that he "might need a medication review," Ms. Hanson came to the facility and saw Resident A on 01/25/2024 and said he appeared to be at "baseline" and, a med review was set for the following day on 01/26/2024. Ms. Wilson stated when Ms. Hanson comes to the facility to see Resident A, she does not check in with staff, she only sees Resident A. Ms. Wilson explained on 01/25/2024, Ms. Hanson came into the facility, saw Resident A and left giving no

opportunity for staff to confer with her about Resident A's medication refills being out or Resident A's refusal to take medications.

Ms. Wilson acknowledged and confirmed that Resident A missed approximately three weeks of his psychotropic medications, Lamotrigine, Caplyta, Paliperidone, Lorazepam and Melatonin from 01/26/2024-02/22/2024 due to running out of the medications with no refills after Resident A refused to go to an appointment with Dr. Lopez on 01/26/2024. Ms. Wilson stated IR's were written each time Resident A refused medications and when the medications ran out and there were no more refills. Ms. Wilson stated the IR's were sent to Resident A's case manager, Maggie Hanson and Resident A's guardian was notified by telephone that Resident A was not taking his psychotropic medications each time Resident A refused or missed his medications. Ms. Wilson stated she spoke with Ms. Hanson and informed her that Resident A was refusing his medications. Ms. Wilson stated, "they all knew" and Resident A's legal guardian, Relative #1 "used leverage" with Resident A to get him to take his psychotropic medications by telling him he would not be able to return to live near family if he did not take his medications.

Ms. Wilson stated Ms. Hanson told her (Ms. Wilson) that she thought staff were reporting that Resident A was refusing his regular, primary care physician prescribed medications, not his psychiatric medications. She speculated that this is why she (Ms. Hanson) is reporting that she was never told Resident A was not taking his medications. Ms. Wilson stated she called the pharmacy, and they gave them a 5 day "bridge" supply of Resident A's psychiatric medications to hold them over until Resident A was able to get to the doctor for a prescription refill, but that appointment was not until 02/26/2024 and Resident A went approximately three weeks without psychotropic medications. Ms. Wilson stated Zeta Francosky, program administrator, has monthly meetings with Network 180 and she (Ms. Wilson) provided monthly updates to Ms. Francosky to take to the monthly meetings. Ms. Wilson reiterated the information provided by Ms. Green and Ms. Earvin stating once Resident A refused to take the Uber ride to his doctor's appointment for a medication review, she (Ms. Wilson) contacted Ms. Hanson and informed her that Resident A refused to go to the doctor, and Ms. Hanson set up another appointment for 02/26/2024 but Ms. Wilson told Ms. Hanson that was too long of a time for Resident A to be without medications. Ms. Figueroa and Ms. Wilson acknowledged that they did not talk directly to the team nurse, Ms. Bailey or Dr. Lopez about Resident A refusing medications or that Resident A ran out of his psychotropic medications and was without medications for approximately three weeks. Ms. Wilson stated she spoke to Ms. Hanson, the case manager and provided IR's and monthly information to Ms. Francosky to take to the meetings at Network 180 and felt as though she did her job informing the necessary people regarding Resident A's lack of medications, refills, and his refusals to take his psychotropic medications.

On 03/15/2024, Resident A is no longer a resident in the facility and is not available to be interviewed.

On 04/10/2024, I interviewed Relative #1 via telephone. Relative #1 confirmed that he is Resident A's legal guardian. Relative #1 stated he was not notified by staff at the facility that Resident A was not taking his medications either because he refused or because the medications were not able to be refilled. Relative #1 stated Resident A told him that he was not taking his medications and agreed with Relative #1 to take an Uber to his doctor's appointment on 01/26/2024, but when it came time to go, his anxiety was so bad, he refused to go. Relative #1 stated, Resident A did not get medication refills or medication from that point on until it was discovered on 02/22/2024 by Ms. Hanson. Relative #1 stated the main person he talks to at the facility is Ms. Wilson but stated he was not notified by staff at the facility of Resident A's psychotropic medication issues.

On 04/11/2024, I interviewed Maggie Hanson, Network 180 case manager via telephone. Ms. Hanson stated she is part of the ICM Team, Integrated Case Management Team that includes Ms. Bailey, Nurse Practitioner and Dr. Lopez, psychiatrist. Ms. Hanson stated she did not know Resident A was refusing his psychotropic medications or not taking his psychotropic medications. Ms. Hanson stated Resident A was reportedly "not doing well" and needed to be seen by the psychiatrist, Dr. Lopez for a medication review but when Ms. Hanson saw Resident A on 01/25/2024, she thought Resident A presented at "baseline" but reported that Resident A is good at hiding his symptoms. Ms. Hanson stated at that meeting, Resident A discussed, his wish to have his medication Lorazepam (Ativan) changed to a different medication and Ms. Hanson told Resident A that the Lorazepam could not be changed until he saw Dr. Lopez. Ms. Hanson stated on this date, 01/25/2024, no one at the facility reported that Resident A was not taking his medications or that he was out of medications. Ms. Hanson stated the appointment was scheduled for 01/26/2024 and transportation set up via Uber by Network 180 to transport Resident A to the appointment. Ms. Hanson stated on 01/26/2024, Resident A refused to go to the appointment via Uber. Ms. Hanson stated in turn, Resident A told staff at the facility that he could not get any more medications. Ms. Hanson stated she said she could not change Resident A's medications, but denied stating that he was not going to get any more medications. Ms. Hanson stated staff at the facility never followed up with her or she would have corrected this misinformation. Ms. Hanson stated on 02/22/2024, she went to the facility and spoke to Ms. Figueroa and Ms. Wilson and discovered Resident A had run out of medications the week before she saw him on 01/25/2024. She also learned that he had been refusing to take his medications since the beginning of January 2024 but prior to 02/22/2024, she did not know this was happening. Ms. Hanson stated when she discovered Resident A was not on his medications for weeks, she informed Ms. Bailey and Dr. Lopez and neither of them knew. In addition, Ms. Hanson stated on 02/22/2024, when she discovered that Resident A was not taking his medications, she received, while at the facility, all the IR's showing Resident A's refusal or inability to take his psychotropic medications because they were not refilled along with the MARs for review. Ms. Hanson stated on 02/22/2024, she spoke to Relative #1 via telephone and Relative #1 stated he was not notified that Resident A was refusing medications or that he had run out of refills.

On 04/11/2024, I reviewed IR's written by Ms. Wilson, Ms. Earvin, Ms. Green, Tyesha Flowers and signed by Ms. Figueroa. IR dates 01/26/2024, written by Ms. Wilson documented, *'9:00 a.m., (Resident A) cancelled his appointment with Network 180, due to not wanting to ride in an Uber. Called case manager and explained medication needed to be refilled. Case manager checked into virtual appointment, called me back and stated provider will not see (Resident A) unless in person. (Resident A) appt at Network 180 with Dr. Lopez 02/26/2024.'* The IR documented that Network 180 was contacted on 01/26/2024 at 10:30 a.m. and Relative #1 was contacted on 01/26/2024 at 10:00 a.m. The IR is signed by Ms. Wilson and Ms. Figueroa. The remainder of the IR's dated 01/31/2024 daily through 02/21/2024, documented the same information every day as follows, *'(Resident A) is out of the following meds due to refusing to go to med review. The doctor will not fill it until he goes in person. Caplyta, Lorazepam and Paliperidone. Staff talked with guardian, manager, and Network; staff was told to write IR's.'*

On 04/11/2024, I reviewed Ms. Hansons Network 180 notes dated 02/22/2024 that on this date, Resident A mentioned he had been off his medications for 3 weeks. Ms. Hanson documented then staff informed her that Resident had been refusing medications the last few months, they told her Relative #1 has been informed of Resident A's refusal to take his medications back in January and they also informed Relative #1 that Resident A was out of medications. Ms. Hanson documented staff informed her that they reported Resident A's lack of medications and refusal to take them to their '*administrator who allegedly coordinated with Network 180 monthly. They gave me the names of who they meet with, and I will be following up with them to see if they knew about this and if it was just never coordinated to us. They also stated they had informed the pharmacy of the fact they needed refills and were given a 5-day supply for (*Resident A*) until get more but never got any more medications or heard back regarding this. It seems from my end they were under the impression that when (*Resident A*) did not come in for his appointment with Dr. Lopez that he was no longer allowed to have his medications until he saw her. I explained to them multiple times that this was not the case and that (*Resident A*) was informed he is not able to have his medications CHANGED until he sees the doctor. The is because the day before he was supposed to see Dr. Lopez, he asked me about multiple medication changes such as adding a clinical trial med being taken off the Invega and Caplyta and being given more Ativan. It is clear in my notes that I informed (*Resident A) *he was not going to be able to have these changes if he did not come in to see the doctor. I am unsure how AFC staff got the understanding that he would not be able to get a refill and I am also unsure who would have told them that.'* Ms. Hanson documented on 02/22/2024, she contacted Relative #1 who informed her that he did not know that Resident A had been off his medications for the past 3 weeks or that Resident A had refused medications until 02/21/2024 when he was informed that Resident A would be moving.

On 04/11/2024, I reviewed an email message dated 02/14/2024 from the Kentwood APM (Ms. Wilson) to Zeta Francosky, Cindy Figueroa and Tyrell Waldrip, Assistant Program Manager, Silver Maple, Turning Leaf. The email message documented the

following information, '(Resident A) *refused appointment to see Dr. Lopez a couple weeks ago. Case manager and guardian is aware currently out of 3 medications due to provide needing to see him inpatient before prescription can be filled.'*

On 04/11/2024, I reviewed Resident A's MARs for the months of December 2023, January, and February 2024. The MAR document the following:

- December 2023, Caplyta, Cap, 42 mg, take one capsule by mouth at bedtime, prescribed by Dr. Regina Lopez. The medication was not administered 12/27, 12/28, 12/29, 12/30, 12/31/2023 and the reasons documented for not administering this medication are documented by staff as, '*withheld per Dr. order, DC'd* (discontinued).' Ms. Bailey reported Dr. Lopez never DC'd or requested this medication to be withheld at any time.
- December 2023, Melatonin, 3 mg, take one tablet by mouth at bedtime, prescribed by Dr. Daniel DeYoung. The medication was not administered 12/23, 12/24, 12/25, 12/27, 12/28, 12/29, 12/30, 12/31 and the reasons documented for not administering this medication are documented by staff as, 'withheld per Dr. order, DC'd.'
- January 2024, Caplyta, 42 mg, take one capsule by mouth at bedtime, prescribed by Dr. Lopez. The medication was not administered 01/01, 01/02, 01/03/2024 and the reason documented is 'withheld per doctor's order, DC'd.' Ms. Bailey reported Dr. Lopez did not DC or request this medication to be withheld at any time. The medication was DC'd on 01/04/2024 and changed to a different dosage.
- January 2024, Caplyta, 21 mg, take one capsule by mouth at bedtime. Resident A 'refused' to take the medication on 01/14/2024.
- January 2024, Paliperidone tab ER 6mg, take one tablet by mouth at bedtime. Resident 'refused' to take the medication on 01/14/2024.
- January 2024, Lorazepam tab, 1 mg, take one tab by mouth at bedtime. This medication was not administered from 01/19/2024-01/31/2024. The reason documented on the MAR is '*medication not available, contact management*.'
- January 2024, Melatonin, 3 mgs. Take 3 tabs by mouth at bedtime. This medication was not administered from 01/25/2024-01/31/2024, and the reason documented on the MAR is, '*medication not available, contact management.'*
- February 2024, Caplyta, 21 mg, take one capsule by mouth at bedtime. The medication was not administered from 02/04-02/21/2024. The reason documented on the MAR is 'medication not available, contact management.'
- February 2024, Paliperidone tab ER 6mg, take one tablet by mouth at bedtime. This medication was not administered from 02/02-02/21/2024. The reason documented on the MAR is 'medication not available, contact management.'
- February 2024, Lorazepam, 1 mg, take one tablet by mouth at bedtime. The medication was not administered 02/01-02/21/2024. The reason documented on the MAR is, '*medication not available, contact management*.'

- February 2024, Melatonin, 3 mg, take 3 tabs by mouth at bedtime. The medication was not administered 02/01-02/21/2024. The reason documented on the MAR is, '*medication not available, contact management.*'

On 04/19/2024, I conducted an exit conference with Destiny Al Jallad and Zeta Francosky via telephone. Ms. Al Jallad and Ms. Francosky stated they understand the information, analysis, conclusion of these applicable rules and will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all the following provisions: (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.
ANALYSIS:	Information provided by Ms. Wilson, Ms. Figueroa, Ms. Green, Ms. Earvin, Ms. Bailey, Relative #1 and Ms. Hanson indicate that staff failed to contact an appropriate health care professional when Resident A refused psychotropic medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being §333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Resident A did not receive his psychotropic medications as prescribed due to the medication not being refilled.

CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

04/18/2024

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

04/19/2024

Jerry Hendrick — Date
Area Manager