STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

May 8, 2024

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

RE: License #:	AS700317947
Investigation #:	2024A0356026
	Blue Spruce Cottage

Dear Ms. Saucedo-Al Jallad:

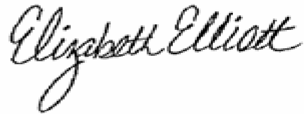
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS700317947
Investigation #:	2024A0356026
Complaint Receipt Date:	03/13/2024
Investigation Initiation Date:	03/13/2024
Report Due Date:	05/12/2024
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:	Blue Spruce Cottage
Facility Address:	5418 120th Ave. Holland, MI 49424
Facility Telephone #:	(616) 466-6885
Original Issuance Date:	11/14/2012
License Status:	REGULAR
Effective Date:	05/14/2023
Expiration Date:	05/13/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A died unexpectedly.	No
Direct Care Workers did not administer Resident B’s PRN medication as prescribed.	Yes

III. METHODOLOGY

03/13/2024	Special Investigation Intake 2024A0356026
03/13/2024	Special Investigation Initiated - Telephone Ann Koster, detective, Ottawa County Sheriff Dept.
03/13/2024	Contact - Document Sent Briana Fowler, ORR Ottawa Co. and Kelsey Newsome, Allegan Co. ORR.
03/13/2024	APS Referral
03/13/2024	Contact - Document Received Facility docs.
03/19/2024	Inspection Completed On-site
03/19/2024	Contact - Face to Face Briana Fowler, ORR, DCW's Brian Hunter, Chantelle Copeland, Anjelique Montgomery, Resident's B&C.
03/19/2024	Contact-Document Received. MAR for Resident B.
03/19/2024	Contact - Telephone call made. Carmen Strong-Levelston, Program Manager.
04/11/2024	Contact - Document Sent Carmen Strong-Levelston re: facility documents-received on this date.
04/15/2024	Contact-Document Received. Det. Koster-no further medical info on Resident A.
04/22/2024	Contact-Telephone call made. Ashley LaBrake-IPSG pharmacy.

05/08/2024	Exit conference-Destiny Al Jallad.

ALLEGATION: Resident A died unexpectedly.

INVESTIGATION: On 03/13/2024, I corresponded with Detective Ann Koster, Ottawa County Sheriff's Office, via email. Det. Koster reported she was following up on an unexpected death in the facility that took place on 02/02/2024. Det. Koster reported that she interviewed Direct Care Worker (DCW) Trent Knopf, and he had some concerns about Bryan Hunter, the DCW that worked at the facility the night Resident A died. Det. Koster reported that Mr. Knopf stated he (Mr. Knopf) took Resident A out that day, around 9-10 a.m. and they went to the bank, Dollar Tree, and Speedway gas station. Mr. Knopf reported Resident A bought snacks, drinks, and cigarettes. Mr. Knopf stated there was no alcohol or illegal drugs bought or consumed by Resident A and that she seemed fine and nothing urgent or different was noticed regarding her health. Mr. Knopf reported Resident A had been coughing more recently and confirmed that Resident A smoked a lot and rarely ever missed a cigarette break at the facility. Mr. Knopf reported Resident A gets her first cigarette at 7:00a.m. Mr. Knopf reported Mr. Hunter told other staff that Resident A seemed confused and "spacey" when she took her nighttime medications. Mr. Knopf reported Resident A urinated on herself and Mr. Hunter had Resident A take a shower to get cleaned up before she came up for her cigarette. Mr. Knopf stated that Resident A had said she did not feel right to Mr. Hunter, got her cigarette, and went outside to smoke. Approximately 10-15 minutes later Resident A was found unresponsive in a chair on the porch where she had gone to have her evening cigarette.

On 02/05/2024, I received and reviewed an IR (Incident Report) dated 02/02/2024, 9:20 p.m., written by Mr. Hunter and signed by Ms. Strong-Levelston. The IR documented the following information, '*Resident came to the staff office to take her bedtime meds and while taking her meds, resident had urine on herself, after taking her meds staff asked resident to clean herself up because it not a good idea to go outside when it's cold and you are wet. Resident said, "ok" and walked downstairs to take a shower and change her clothes. Resident returned to the staff office after taking her shower and changed her clothes to get her 9 p.m. cigar. Staff gave resident one cigar and resident walked outside the back door onto the deck to smoke, Consumer 2 came to the staff office to tell me to come outside. Staff came outside on to the deck and observed resident sitting in the chair she normally sits in, she was sitting upright position, and her head down. Staff immediately called 911 and was instructed by dispatcher to check to see if resident was breathing (was not), lay resident on her back, and do chest compressions and dispatcher stayed on the phone until paramedics arrived. After paramedics arrived staff notified PM* (program manager).' Ms. Strong-Levelston documented, '*staff called 911 and did chest compressions until EMS arrived and took over. PM notified guardian of the situation*.'

On 03/19/2024, I conducted an unannounced inspection at the facility with Ottawa County Director of Recipient Rights, Briana Fowler. Ms. Fowler and I interviewed

Ms. Strong-Levelston via telephone. Ms. Strong-Levelston explained that Resident A was a heavy long-time smoker. Her cigar smoking was limited to certain times of the day and a certain amount of smoking each day and Resident A adhered to those times. Ms. Strong-Levelston stated it was not out of the ordinary that Resident A may have had an accident and needed to be instructed to clean herself up. Ms. Strong-Levelston stated she was on the telephone with Mr. Hunter at the time Resident A came in to get her evening cigar, so Ms. Strong-Levelston spoke on the phone with Resident A just to say hi and see how she was doing. Ms. Strong-Levelston stated during this conversation, Resident A did not say anything about feeling sick or different, or that she did not feel right or out of the ordinary. In addition, Ms. Strong-Levelston stated Mr. Knopf never reported any of the information relayed to Det. Koster to her (Ms. Strong-Levelston) as the program manager. None of these concerns were ever brought to her attention prior to now.

On 03/19/2024, I interviewed Mr. Hunter at the facility. Mr. Hunter stated he was covering the evening shift for Mr. Knopf when Resident A came to the med room for her evening medications. Mr. Hunter stated he noticed that Resident A was wet with urine and told her that before she goes outside, she should clean herself up. Mr. Hunter reported that Resident A took a shower, put clean clothing on and came back to the medication room to get her evening cigar. Mr. Hunter stated Resident A never said she did not feel right, spacey or that she felt ill. Mr. Hunter stated Resident A appeared normal, took her medications as normal and acted as she usually did. Mr. Hunter stated Resident A's normal routine was not disrupted. It was all "as usual," and she "did all the same things she does every day."

On 03/19/2024, I attempted to interview Resident B at the facility. Resident B is not capable of providing information pertinent to this investigation due to cognitive delays.

On 03/19/2024, I interviewed Resident C who stated Resident A was acting as she normally did on the day of her death and that she did not appear to be ill or not well.

On 03/19/2024, I interviewed Resident D who stated he was with Resident A on the deck for their evening cigarette when Resident A's head dropped down. Resident D stated Resident A remained in the seated position, but he knew something was going on. Resident D stated he went into the facility and got Mr. Hunter. Resident D stated Mr. Hunter called 911 right away and did CPR until the ambulance arrived. Resident D stated he and Resident A went outside at 9:00p.m. and at 9:20 p.m. he noticed she was no longer responding, and he went to get Mr. Hunter. Resident D stated Resident A was acting as she normally did, that she never said anything about feeling ill or different and was the same as she is every day.

On 03/19/2024, I interviewed DCW's Chantelle Copeland and Angelique Montgomery at the facility. Ms. Copeland and Ms. Montgomery stated Resident A never stated she felt ill or acted out of the ordinary prior to her death. Ms. Copeland and Ms. Montgomery stated there was nothing that seemed out of the norm that

would have alerted them or made them think Resident A needed immediate treatment or medical assistance. Ms. Copeland and Ms. Montgomery stated Mr. Hunter did not say anything to them about Resident A feeling spacey or acting differently on the evening of her death.

On 04/11/2024, I reviewed Resident A's healthcare appraisal (HCA) signed by Dr. Jeffrey Stevens, DO. The HCA documented Resident A's age as 59 years old, with a diagnosis of COPD (chronic obstructive pulmonary disease), CKD (chronic kidney disease), mixed hyperlipidemia. The HCA documented Resident A's lungs as "abnormal" with "decreased breath sounds."

On 04/11/2024, I reviewed a Harmony Cares Medical Group communication record signed by Dr. Justin Davies, MD and dated 01/03/2024 that documented Resident A's, 'concerns, goals, test results discussed' as 'hyperlipidemia, continue atorvastatin, check labs, COPD/ smoking, continue nebulizer treatments, try to cut down on smoking.'

On 04/11/2024, I reviewed Resident A's assessment plan for AFC residents. The assessment plan documented under 'physical limitations' that Resident A does not have physical limitations but noted that Resident A uses 'an inhaler and a nebulizer/oxygen PRN (as needed), she frequently appears out of breath.' The assessment plan documented that Resident A smokes and that she 'has a behavior plan to encourage her to limit her cigarette use. Staff will follow and document on her plan as required.'

On 05/08/2024, I conducted an exit conference with Destiny Al Jallad, Licensee Designee via telephone. Ms. Al Jallad agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Det. Koster reported Mr. Knopf reported Resident A seemed confused and "spacey" when she took her nighttime medications just prior to her death on 02/02/2024. An IR written by Mr. Hunter does not indicate that Resident A acted out of the ordinary or in need of medical attention prior to 911 being called by Mr. Hunter.

	Ms. Strong-Levelston, Mr. Hunter, Ms. Copeland, and Ms. Montgomery stated Resident A acted as she normally did prior to and on the date of her death. Resident's C & D stated Resident A acted as she normally did on the day of her death and that she did not appear to be ill or not well. A review of Resident A's HCA and medical notes document Resident A's diagnosis of COPD, CKD (chronic kidney disease), & mixed hyperlipidemia. The HCA documented Resident A's lungs as "abnormal" with "decreased breath sounds" and "try to cut down on smoking." Resident A's assessment plan documented Resident A uses 'an inhaler and a nebulizer/oxygen PRN (as needed), she frequently appears out of breath.' Based on investigative findings, there is no evidence to indicate that prior to 9:20p.m. on 02/02/2024, Resident A presented as sick or in need of medical attention. Resident A did not exhibit a sudden adverse change in medical condition until approximately 9:20p.m. on 02/02/202 and 911 was immediately called. Therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Direct Care Workers did not administer Resident B's PRN medication as prescribed.

INVESTIGATION: On 03/13/2024, I corresponded with Detective Ann Koster, Ottawa County Sheriff's Office, via email. Det. Koster reported that she interviewed Mr. Knopf at the facility and Mr. Knopf reported he had concerns regarding DCW Brian Hunter and Mr. Hunter has been seen giving PRN medication Ativan to residents when they do not request them. Det. Koster stated Mr. Knopf also reported a resident drank someone else's laxative and Mr. Hunter did not write it up for State reporting.

On 03/19/2024, I conducted an unannounced inspection at the facility with Ottawa County Director of Recipient Rights, Briana Fowler. Ms. Fowler and I interviewed Ms. Strong-Levelston via telephone and Mr. Hunter in the office at the facility. Ms. Strong-Levelston stated the only resident taking Ativan-Lorazepam is Resident B. Ms. Strong-Levelston stated Mr. Hunter is not the only person that administers medications to the residents and staff have never reported anything like this to her as the manager of the facility. Ms. Strong-Levelston stated she would have

investigated and addressed this with staff had she been told. Mr. Hunter stated Resident B is prescribed Ativan, 1 tablet daily as needed and it is given as prescribed.

Mr. Hunter stated Resident C was sitting at the table, drinking a glass of water with MiraLAX in the water. Resident B sat next to Resident C and took Resident B's cup and took a sip of Resident C's laxative water. Mr. Hunter stated he notified Ms. Strong-Levelston, documented it in the shift notes and relayed the incident to the following shift. Mr. Hunter stated he did not complete an IR (Incident Report) because Resident B did not consume the glass of water and only got a small sip before staff and Resident C stopped her from drinking his water. Mr. Hunter reported Resident B had no ill effects from the incident.

On 03/19/2024, Ms. Fowler and I requested Resident B's MAR (medication administration records) and reviewed the narcotic count book kept by staff that documented the medication count for Resident B's Ativan. The narcotic count was accurate.

On 03/19/2024, Ms. Fowler and I interviewed Resident B at the facility. Resident B is not a good source of information due to cognitive delays, but she stated she "gets her medications the way she is supposed to."

On 04/22/2024, I interviewed Ashley LaBrake at Innovative Pharmaceutical Solutions Group (IPSG) who is the pharmacy for this facility. Ms. LaBrake stated the prescription is written for Lorazepam/Ativan one tab; one time daily as needed which means it is written only for administration to Resident B one time daily (PRN), not multiple times a day.

On 04/22/2024, I reviewed Resident B's MARs for the months of September, October, November, December 2023, January and February 2024. The MARs documented Resident B's Ativan was administered as prescribed on an as needed basis in September, October, and December 2023. On 11/23/2023 Resident B was given Lorazepam/Ativan, 0.5mg, take 1 tab my mouth daily as needed two times, once at 2:00a.m. and the second time at 11:37 p.m. On 01/03/2024, Ativan was administered two times, at 7:40 a.m. and 1:45 p.m. and on 02/16/2024 Ativan was administered three times, at 12:39 a.m., 6:10 a.m. (or 8:10 a.m., cannot decipher the first number) and at 7:43 p.m. Mr. Hunter was not the only staff that administered the medication Ativan more than one time per day.

On 05/08/2024, I conducted an exit conference with Ms. Al Jallad, LD via telephone. Ms. Al Jallad stated the directions on the medication is confusing as it is written and suspects this was a mistake, and nothing done on purpose by staff. Ms. Al Jallad stated she will submit an acceptable corrective action plan that includes retraining staff on the administration of resident medications.

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 S333.1101 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:	The complainant reported staff administered Lorazepam/Ativan prescribed as an as needed medication when Resident B does not request to take one. Ms. Strong-Levelston stated she has never been told about this by any staff. Mr. Hunter stated Resident B is given medications including Ativan as prescribed. Mr. Hunter stated Resident B drank a small amount of Resident C's water that had MiraLAX in it. Resident B stated she "gets her medications the way she is supposed to." Ms. LaBrake stated the prescription is written for one tab; one time daily as needed which means it is written only for administration to Resident B one time daily (PRN), not multiple times a day. A review of Resident B's MAR documented that Resident B's medication Lorazepam/Ativan was administered more than once in a day on November 23, 2023, January 3, 2024, and February 16, 2024. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/08/2024

Elizabeth Elliott
Licensing Consultant

Date

Approved By:

05/08/2024

Jerry Hendrick
Area Manager

Date