GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 21, 2024

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

RE: License #: AL390392502
Investigation #: 2025A0578002
Birch Cottage I

Dear Destiny Saucedo-Al Jallad and Zeta Francosky:

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) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390392502
Investigation #:	2025A0578002
Complaint Receipt Date:	10/20/2024
Investigation Initiation Date:	10/20/2024
Report Due Date:	12/19/2024
Licensee Name:	Turning Leaf Res Rehab Svcs., Inc.
Licensee Address:	621 E. Jolly Rd. Lansing, MI 48909
Licensee Telephone #:	(517) 393-5203
Administrator:	Maura Salemka
Licensee Designee:	Destiny Saucedo-Al Jallad, Zeta Francosky
Name of Facility:	Birch Cottage I
Facility Address:	13326 N. Boulevard St. Vicksburg, MI 49097
Facility Telephone #:	(269) 585-8761
Original Issuance Date:	02/25/2020
License Status:	REGULAR
Effective Date:	08/25/2024
Expiration Date:	08/24/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly discharged from this facility.	Yes

III. METHODOLOGY

10/20/2024	Special Investigation Intake 2025A0578002
10/20/2024	Special Investigation Initiated - Telephone
10/21/2024	Contact-Telephone -Interview with licensee designee Destiny Saucedo-Al Jallad and licensee designee Zeta Francosky.
10/24/2024	Special Investigation Completed On-site.
10/31/2024	Contact-Document Reviewed -*Vicksburg Police Department Incident No: 24-000529.*
11/14/2024	Contact-Document Reviewed -Email correspondence provided by licensee designee Destiny Saucedo-Al Jallad.
11/20/2024	Contact-Telephone -Interview with Allegan On pointe case manager Todd Rockhill.
11/21/2024	Exit Conference -With licensee designee Destiny Saucedo-Al Jallad and licensee designee Zeta Francosky.

ALLEGATION:

Resident A was improperly discharged from this facility.

INVESTIGATION:

On 10/20/2024, I received this complaint by telephone. Complainant reported Resident A was previously arrested at this facility and taken to Kalamazoo County Jail for being assaultive and aggressive with other residents and direct care staff. Complainant reported Resident A was unexpectedly released from Kalamazoo Sheriff's Department County Jail and direct care staff at this facility reported

Resident A as a “missing person” as a result. Complainant reported Vicksburg Police Department coordinated Resident A’s return to this facility after working with Relative A1 and the Kalamazoo Department of Public Safety on 10/19/2024. Complainant reported once Resident A was returned to this facility, law enforcement was told Resident A was discharged from this facility and not allowed to return. Complainant reported that when staff at this facility were informed by law enforcement this facility was Resident A’s place of residency as Resident A still had personal belongings at this facility, law enforcement was told by staff at this facility they did not care what law enforcement did with Resident A, and they did not care if this resulted in an investigation by this department, but that Resident A was not allowed to return and Resident A’s personal belongings would be “shipped to him wherever he goes.”

On 10/21/2024, I interviewed licensee designee Destiny Saucedo-Al Jallad and licensee designee Zeta Francosky regarding the allegation. Zeta Francosky clarified that Resident A was not reported as missing from this facility but missing due to Resident A being released from Kalamazoo County Sheriff’s Department Jail without any notice on 10/19/2024. Zeta Francosky reported Resident A was arrested earlier in the week and clarified that Resident A had a recent history of being physically and sexually aggressive with direct care staff and residents at this facility. Zeta Francosky reported Resident A’s case manager and guardian were provided with a written discharge notice on 10/17/2024, due to the concerns for the health and safety of other residents at this facility. Zeta Francosky confirmed that Resident A was not allowed to return to this facility due to the discharge notice being provided to Resident A and the concerns for the health and safety of the other residents at this facility.

Destiny Saucedo-Al Jallad reported that due to the unsafe behavior demonstrated by Resident A, it was their intent to move Resident A to another secured setting in the Lansing area owned and operated by the licensee. Destiny Saucedo-Al Jallad reported that immediate transfers to a secured setting are no longer possible, as Resident A’s move to this facility would first have to be approved by MDHHS and HCBS. Destiny Saucedo-Al Jallad reported in addition to these approvals, an approved Behavior Treatment Plan for Resident A which included a restriction of movement would also be necessary before Resident A could be moved to this secured setting. Destiny Saucedo-Al Jallad reported Resident A’s case manager was aware of these requirements and there were several email correspondences that were sent to obtain these approvals for Resident A. Destiny Saucedo-Al Jallad reported that placement for Resident A at the secured setting in Lansing was available, but they would not be provided with payment for providing Resident A with the elements of adult foster care at this secured setting until approvals were completed.

On 10/31/2024, licensee designee Destiny Saucedo-Al Jallad provided the following email correspondence to Resident A’s case manager and Allegan County Community Mental Health after I requested a copy of the written discharge notice provided to Resident A:

"If a secured setting is not possible when [Resident A] discharges from jail then allow this email to serve as a discharge notice because [Resident A] cannot return to Vicksburg after these incidents. Others in the VB home are not feeling safe.

Maura/Zeta - i realize the guardian is not on this email chain so please make sure that information is communicated to guardian as well. We are working with CMH to find appropriate placement within Turning Leaf however if that placement is not approved by the state MDHHS he cannot return to Birch."

Destiny Saucedo-Al Jallad reported they were still in the process of gaining approval for Resident A to move to a secured setting in Lansing operated by the licensee designee.

On 10/31/2024, I reviewed received emails from licensee designee Destiny Saucedo-Al Jallad and licensee designee Zeta Francosky. I did not receive any notice of Resident A's discharge from this facility 24 hours before discharge.

On 11/14/2024, I reviewed the *Vicksburg Police Department Incident No: 24-000529* relating to the allegations, dated 10/19/2024. The *Vicksburg Police Department Incident No: 24-000529* documented that Kalamazoo County Sheriff's Department Jail had released Resident A without notifying this facility. The *Vicksburg Police Department Incident No: 24-000529* documented Resident A was reported missing and that direct care staff at this facility were attempting to locate Resident A and were working with Relative A1 to track Resident A's debit card usage to facilitate locating Resident A. The *Vicksburg Police Department Incident No: 24-000529* documented that Vicksburg Police Department was informed by direct care staff at this facility they would be contacted if they obtained more information relating to Resident A's whereabouts.

The *Vicksburg Police Department Incident No: 24-000529* documented that after being contacted by Relative A1, Vicksburg Police Department arranged for a Kalamazoo Department of Public Safety officer to meet Resident A at Kalamazoo Department of Public Safety station #3 after Resident A was transported to KDPS station #3 by a witness.

The *Vicksburg Police Department Incident No: 24-000529* documented that when Vicksburg Police Department contacted administrator Maura Salemka at this facility to inform them of Resident A's location, Maura Salemka reported she would not be sending a direct care staff to KDPS station #3 and that Vicksburg Police Department would have to go and get Resident A, and that she would not accept or allow Resident A to return to this facility. The *Vicksburg Police Department Incident No: 24-000529* documented that Vicksburg Police Department explained that Resident A's personal belongings were still at this facility, and this was identified as Resident A's residency and Maura Salemka explained that she had applied for emergency

placement at a “high security” facility in Lansing, but this placement had not been approved yet. The *Vicksburg Police Department Incident No: 24-000529* documented that due to Resident A's assault on staff and malicious destruction of property, Maura Salemka was not allowing Resident A to return to the facility. The *Vicksburg Police Department Incident No: 24-000529* documented that when asked about Resident A’s personal belongings, Maura Salemka reported she would “ship them to wherever [Resident A] needs them to go.”

The *Vicksburg Police Department Incident No: 24-*000529 documented that Vicksburg Police Officer picked up Resident A at KDPS station #3 and found Resident A to be tired but complimentary.

The *Vicksburg Police Department Incident No: 24-000529* documented that licensee designee Zeta Francosky indicated that Resident A had received his discharge and that she would not accept Resident A back at this facility. The *Vicksburg Police Department Incident No: 24-000529* documented that Zeta Francosky reported that emergency placement for Resident A at a high security facility in Lansing was pending but had not yet been approved. The *Vicksburg Police Department Incident No: 24-000529* documented that Zeta Francosky informed Vicksburg Police Department that Resident A was dangerous and that she needed to keep her staff safe. The *Vicksburg Police Department Incident No: 24-000529* documented Zeta Francosky reported she was “willing to take any licensing violation or licensing citation.”

On 11/20/2024, I interviewed Allegan On Pointe case manager Todd Rockhill regarding the allegations. Todd Rockhill denied ever receiving a written notice of discharge for Resident A. Todd Rockhill denied agreeing with the emergency discharge of Resident A related to the events that led to Resident A’s arrest. Todd Rockhill reported that while he was working on approval for Resident A to be moved to a secured setting after multiple occurrences of physical and sexual assault, administrator Maura Salemka had made comments about providing Resident A with a discharge notice, but Todd Rockhill reported that he then appealed to the licensee designees for this facility and it “seemed like they were on board” with Todd Rockhill continuing to make efforts to obtain approvals for Resident A. Todd Rockhill reported being unaware that Resident A was not allowed to return to this facility due to discharge and thought Resident A just happened to end up staying with family. Todd Rockhill denied ever receiving an email that served as notice of discharge for Resident A. I reviewed the email correspondence provided to me by licensee designee Destiny Saucedo-Al Jallad. Todd Rockhill reported that he would have expected something more formal for a written notice of discharge and did not consider this email a notice of discharge.

On 11/21/2024, I completed an exit conference with licensee designee Destiny Saucedo-Al Jallad and licensee designee Zeta Francosky. Destiny Saucedo-Al Jallad reported it was her intention the written notice of discharge she had provided was immediate. Zeta Francosky reported multiple contacts were made regarding the

behaviors demonstrated by Resident A as an alternative to discharge. Licensee designee Destiny Saucedo-Al Jallad and licensee designee Zeta Francosky did not disagree with my findings.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home.** **(b) Substantial risk, or an occurrence, of self-destructive behavior.** **(c) Substantial risk, or an occurrence, of serious physical assault.** **(d) Substantial risk, or an occurrence, of the destruction of property.** **(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident:** **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.**

	(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply: **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with licensee designee Destiny Saucedo-Al Jallad, licensee designee Zeta Francosky, and Allegan On Pointe case manager Todd Rockhill, as well as a review of pertinent documentation relevant to this investigation, a written discharge was provided to Resident A but this written discharge did not identify if Resident A's discharge's was an emergency or a 30-day notice of discharge. Resident A was issued a written notice of discharge on 10/17/2024 but was not allowed to return to the facility on 10/19/2024. During an exit conference, licensee designee Destiny Saucedo-Al Jallad clarified the written notice of discharge provided to Resident A was intended to be an emergency discharge, but did not include the reason for the proposed discharge, including the specific nature of the substantial risk, and the alternatives to discharge that had been attempted by the licensee designee. This department was also not notified of Resident A's immediate discharge not less than 24 hours before Resident A's discharge occurred.

CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

11/21/2024

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Eli DeLeon Date
Licensing Consultant

Approved By:

11/21/2024

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Dawn N. Timm Date
Area Manager