



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 23, 2026

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

RE: License #: AM030420220
Investigation #: 2026A0464027
Woodlea Cottage

Dear Mrs. 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Megan Leavitt, LMSW

Megan Leavitt, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 438-3036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030420220
Investigation #:	2026A0464027
Complaint Receipt Date:	01/13/2026
Investigation Initiation Date:	01/13/2026
Report Due Date:	03/14/2026
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:	Woodlea Cottage
Facility Address:	1565 Woodlea Dr Otsego, MI 49078
Facility Telephone #:	(269) 692-2536
Original Issuance Date:	02/18/2026
License Status:	TEMPORARY
Effective Date:	02/18/2026
Expiration Date:	08/17/2026
Capacity:	8
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff got into an accident with residents and residents were incorrectly secured in the vehicle.	Yes

III. METHODOLOGY

01/13/2026	Special Investigation Intake 2026A0464027
01/13/2026	APS Referral
01/13/2026	Special Investigation Initiated - Telephone Michelle O'Brien, Allegan County APS
02/11/2026	Inspection Completed On-site Destiny Saucedo-Al Jallad, Licensee Designee
02/11/2026	Contact-Document received Facility Records
02/11/2026	Exit Conference Destiny Saucedo-Al Jallad, Licensee Designee

ALLEGATION: Staff got into an accident with residents and residents were incorrectly secured in the vehicle.

INVESTIGATION: On 01/13/2026, I received a complaint from Adult Protective Services (APS), which alleged that one week ago staff got into a car accident with residents in the vehicle. It was discovered the residents who were in wheelchairs were not properly secured in the van. It is unclear if any resident fell out of their wheelchair or was harmed.

On 01/13/2026, I exchanged emails with Allegan County APS worker, Michelle O'Brien. She reported she did not currently have an open investigation and that the new complaint was screened out, to not be investigated by Centralized Intake.

On 02/11/2026, I completed an unannounced onsite inspection at the facility. I interviewed licensee designee, Destiny Saucedo-Al Jallad. Mrs. Saucedo-Al Jallad reported staff, Ashley Kemp and Sage Stroia had gotten into a car accident on 12/26/2025. Mrs. Saucedo-Al Jallad reported Resident A sustained minor injuries. It was discovered that Resident A was not properly secured. Mrs. Saucedo-Al Jallad stated the home manager has since been terminated and staff are being retrained on how to properly secure residents with wheelchairs in the vans. Mrs. Saucedo-Al Jallad reported Northpointe Office of Recipient Rights completed an investigation

and cited the facility. Mrs. Saucedo-Al Jallad stated she would send a copy of the report.

On 02/11/2026, I received and reviewed a copy of the Northpointe ORR investigation, completed by ORR worker Katie Smith. The report indicated Resident A was interviewed by telephone on 12/29/2025. Resident A reported staff, Ashley Kemp and Sage Stroia, were taking her and other residents for a ride, so that Ms. Kemp could teach the new staff (Ms. Stroia) how to drive the van. The staff told the residents to put their seat belts on. Resident A reported she was in a wheelchair and could not buckle a seatbelt. Staff told her it was fine to not buckle. Resident A reported that while they were in the vehicle, Ms. Stroia had to hit their breaks hard. This caused Resident A to hit her face on the seat in front of her. Resident A reported she did not break anything, but her face is still bruised and hurts.

The report reflected Ms. Kemp was interviewed by telephone on 12/29/2025. Ms. Kemp reported she was in the passenger seat on the day of the accident. Ms. Kemp admitted that they were unable to find seatbelts for all of the residents; therefore, some remained unbuckled. Ms. Kemp then explained another vehicle had pulled out in front of them, causing Ms. Stroia to hit the breaks. Resident B was not securely fastened, so as a result he fell out of his wheelchair and hit his face. Ms. Kemp also reported Resident A hit her face on the seat in front of her.

The report also reflected that Ms. Stroia was interviewed by telephone on 12/29/2025. Ms. Stroia reported she and Ms. Kemp did not know how to secure all the residents in the vehicle and thought some would be fine, unbuckled to go to the store. Ms. Stroia reported she was driving and another vehicle pulled out in front of her, causing her to hit her breaks. This caused Resident A to hit her face on the back of the seat in front of her. Resident B also fell out of his wheelchair and hit his face. Ms. Stroia reported only Resident A and B were the ones who were not securely fastened in the van.

The ORR report reflected administrator, Kristen Counterman reported staff were trained on how to use the wheelchair tie downs in the van. Mrs. Counterman provided Ms. Smith with staff training records. The report reflected Ms. Smith substantiated the investigation, with a rule violation of neglect.

On 02/11/2026, I completed an exit conference with Mrs. Saucedo-Al Jallad. She was informed of the investigation findings and recommendations. Mrs. Saucedo-Al Jallad stated a corrective action plan would be submitted.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.

ANALYSIS:	<p>On 01/13/2026, a complaint was received alleging residents were not securely fastened in a vehicle.</p> <p>Licensee designee, Mrs. Saucedo-Al Jallad reported she had learned that on 12/26/2025 staff had gotten into a car accident and two of the residents were not properly secured, which resulted in minor injuries.</p> <p>Staff Asley Kemp and Sage Stroia were interviewed by Northpointe Office of Recipient Rights and admitted that on 12/26/2026, Resident A and Resident B were not securely fastened in the van.</p> <p>Based on the investigative findings, there is sufficient evidence to support a rule violation that staff failed to properly secure residents in the vehicle, resulting in a safety hazard.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Megan Leavitt, LMSW 02/23/2026

Megan Leavitt Date
Licensing Consultant

Approved By:
 02/23/2026

Jerry Hendrick Date
Area Manager