GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 3, 2026

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

RE: License #: AS330087738
Investigation #: 2026A1029023
Redwood 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 licensee designee 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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

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

I. IDENTIFYING INFORMATION

License #:	AS330087738
Investigation #:	2026A1029023
Complaint Receipt Date:	02/09/2026
Investigation Initiation Date:	02/10/2026
Report Due Date:	04/10/2026
Licensee Name:	Turning Leaf Res Rehab Svcs., Inc.
Licensee Address:	621 E. Jolly Rd., Lansing, MI 48909
Licensee Telephone #:	(517) 393-5203
Administrator:	Amber Ely-Costa
Licensee Designee:	Destiny Saucedo-Al Jallad
Name of Facility:	Redwood 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:	02/27/2025
Expiration Date:	02/26/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not want to leave school and direct care staff members Ms. Ciuferri and Mr. Morris physically dragged him to the car. Resident A has bruises on his body. This intervention was not specified in Resident A's *Assessment Plan for AFC Residents* or *Person Centered Plan* as an approved intervention.	Yes

III. METHODOLOGY

02/09/2026	Special Investigation Intake 2026A1029023
02/10/2026	APS Referral already assigned. Robert Lindley
02/10/2026	Special Investigation Initiated – Email to APS Mr. Lindley
02/12/2026	Inspection Completed On-site – Face to face with assistant program manager, Dan James, direct care staff members Rebecca Ciuferri, James Morris, Amber Ely-Costa, Candace Matthews at Redwood Cottage.
02/12/2026	Contact - Telephone call made to Courtney Platte -school social worker, Ms. Moro from Beekman Center School
03/11/2026	Contact - Telephone call made to licensee designee Destiny Al-Jallad. Left message and sent email.
03/12/2026	Contact - Telephone call received from licensee designee Destiny Al-Jallad.
03/13/2026	Contact - Document Received from Destiny Al-Jallad.
03/13/2026	Contact - Telephone call made to APS Robert Lindley
03/16/2026	Office of Recipient Rights made to OnPoint – Caring for Allegan County
03/16/2026	Contact – Telephone call made to telephone call to CMH case manager, Amanda Goodman, email from APS Robert Lindley, telephone call and email to ORR Samantha Dereski
03/25/2026	Exit conference with licensee designee Destiny Al-Jallad.

ALLEGATION: Resident A did not want to leave school and direct care staff members Ms. Ciuferri and Mr. Morris physically dragged him to the car. Resident A has bruises on his body. This intervention was not specified in Resident A's *Assessment Plan for AFC Residents* or *Person Centered Plan* as an approved intervention.

INVESTIGATION:

On 02/09/2026 a complaint was received via the Bureau of Community and Health Systems online complaint system with allegations Resident A did not want to leave school so direct care staff members Ms. Ciuferri and Mr. Morris physically dragged him to the car. The complaint stated Resident A has bruises on his body from this intervention which was not specified in Resident A's *Assessment Plan for AFC Residents* or *Person Centered Plan* as an approved intervention. According to the allegation the incident started because Resident A was upset at school and two direct care staff members, Ms. Ciuferri and Mr. Morris, came to pick him up from school. The complaint stated Resident A did not want to go. The complaint stated Resident A was dragged backwards by his feet while sitting on his bottom. According to the allegation, the direct care staff members were both making comments about dragging and pulling Resident A if he did not comply before they did so. According to the complaint allegations, Resident A had bruising on two separate occasions but it's unknown how the bruising occurred. Adult Protective Services (APS) Robert Lindley was also assigned to investigate the concerns. I also referred these concerns to Caring for Allegan County Office of Recipient Rights (ORR) and Samantha Deleski has been assigned to investigate.

On 02/12/2026 I completed an unannounced on-site investigation and interviewed assistant program manager, Dan James. Mr. James stated the two direct care staff members who were involved in the incident at the school were Ms. Ciuferri and Mr. Morris. Mr. James stated he has never had any concerns regarding either of these direct care staff members and was not aware of the incident because there was not an *AFC Incident / Accident Report* completed after this occurred. Mr. James stated he found out about the incident because Mr. Lindley came out from APS. Mr. James stated he believes the school had concerns after Resident A did not want to leave school. Mr. James stated direct care staff usually do not pick Resident A up from school. Mr. James stated there are times when Resident A will flop onto the ground and not want to move but he would never instruct a direct care staff member to drag Resident A.

I interviewed administrator Amber Ely-Costa. Ms. Ely-Costa stated that typically when Resident A falls to the ground, he just needs a moment to reset and relax for a bit and then direct care staff will help him up. Ms. Ely-Costa and Mr. James both stated

sometimes he drags his feet but direct care staff would not continue to drag him. Ms. Ely-Costa stated she has observed Resident A do this a few times. Ms. Ely-Costa stated this incident wasn't reported to her either and she also found out because Mr. Lindley came to investigate the concerns. Ms. Ely-Costa stated she has never observed any bruises on Resident A. Ms. Ely-Costa stated the school nurse let her know Resident A needed some podiatry care but did not mention bruising on him. Ms. Ely-Costa was surprised to hear of these concerns because direct care staff member Ms. Ciuferri typically does really well with Resident A.

On 02/18/2026 I interviewed direct care staff member Rebecca Ciuferri. Ms. Ciuferri stated she has worked there for almost two years and described her position as "lead staff." Ms. Ciuferri stated this incident started in the lobby at the school because Resident A was having behavioral issues and was trying to hug, kiss, and touch the teachers while talking about kissing girls. Ms. Ciuferri stated these behaviors were unlike him. Ms. Ciuferri stated when they started taking him outside, he refused to go outside with them and staff at the school were unwilling to help them get him to the car. Ms. Ciuferri stated another direct care staff member James Morris was driving the car and he came out to assist. Ms. Ciuferri stated they tried to get him up off the floor to stand up but he went down to his knees. Ms. Ciuferri stated they learn MANDT training for physical intervention but stated she has never been in this situation before. Ms. Ciuferri stated she prompted him to leave about 4 or 5 times but he refused so they physically helped him move.

Ms. Ciuferri stated once they got outside, Mr. Morris held on to Resident A under his arms and got him out the door while she held the door open. Ms. Ciuferri stated she tried several times to put her hands under his knees and legs to assist but she wasn't strong enough to hold him so he struggled and dropped to the ground. Ms. Ciuferri stated Mr. Morris was able to drag him backward toward the car because he was refusing to walk to the car.

Ms. Ciuferri stated when he got to the car Resident A had his legs hanging out the car door because Mr. Morris had to "flip him around to get him in the car." Ms. Ciuferri stated he wouldn't put his seat belt on and she tried several times to assist but Resident A pushed her hands away and hit himself on the head showing he was stressed during this interaction so she does not believe he had his seat belt on when they drove away.

Ms. Ciuferri stated school staff members were watching this interaction but she was not paying attention to them once they got outside because they were just trying to get him to the car. Ms. Ciuferri has taken Resident A to school a dozen times since he moved in about six months prior and this has never occurred.

Ms. Ciuferri stated she did not know if there was any bruising on Resident A before or after this incident. Ms. Ciuferri stated it was possible he had bruising around his arm pits because she does not know how much she was having to hold him to get him to move because she did not want to drop him onto the ground. Ms. Ciuferri stated if there was a bruise near his legs it would have been when Mr. Morris was trying to get his legs

inside because they were hanging out the car. Ms. Ciuferri stated if there was a third person they would have had someone pull him through the van on the other side but it was only the two of them trying to transport him in a Prius. Ms. Ciuferri stated she would have preferred a van but this was not available. Ms. Ciuferri stated she had never observed Resident A this anxious in the past but she did not call any other direct care staff members, administrators, or law enforcement for assistance with this issue. Ms. Ciuferri stated if Mr. Morris was not there and she was on her own, then she would have called law enforcement to assist. Ms. Ciuferri stated while they were driving back to Redwood Cottage, they were trying to redirect him into the car and she tried to pull him back once he was in the car so Mr. Morris could get the window up and put the child lock on. Ms. Ciuferri stated she believed she remained calm during this interaction because she believed Resident A needed to see a calm person while this was occurring.

On 02/12/2026 I interviewed direct care staff member Candace Matthews at Redwood Cottage. Ms. Matthews stated she has never transported Resident A to school before because she mostly just provides personal care at the Redwood Cottage. Ms. Matthews stated she has observed him on the ground sometimes and they have to get him up but she has never observed anyone dragging him or him not getting up eventually. Ms. Matthews stated Resident A will get upset, go to the ground on his knees and direct care staff have to help him up by assisting and coaching because Resident A is a heavy man. Ms. Matthews stated the time it takes Resident A to get up from the ground/floor, usually depends on Resident A's mood. Ms. Matthews stated she has never observed Mr. Morris or Ms. Ciuferri drag Resident A anywhere and finds this unlikely because Ms. Ciuferri does not like to be touched so she wouldn't touch him unless it was necessary. Ms. Matthews stated Mr. Morris does not have regular contact with Resident A. Ms. Mathews stated she is usually the one who assists Resident A with showers and she's never observed any bruising anywhere on him.

On 02/12/2026 I interviewed direct care staff member James Morris. Mr. Morris said typically Resident A would have taken the bus but on 02/05/2026 he missed the bus because he wouldn't get on it so he had to go pick him up from school with direct care staff member Ms. Ciuferri. Mr. Morris stated he drove to the school and when they got there Resident A wouldn't leave school, so they tried for a long time to verbally convince Resident A to leave school. Mr. Morris stated the school staff members eventually locked the doors at the school so Resident A could not run back into the school to stay in the lobby where he wanted to be. Mr. Morris stated they tried to get him to leave so they escorted him out. I asked Mr. Morris how he helped him and he repeated, "We helped him along" because he was fighting trying not to go. Mr. Morris stated at one point he had his hands under Resident A's arm pits and he was kicking with his feet and he "was mostly dead weight." Mr. Morris stated that when he was doing this, Ms. Ciuferri was opening the school door and the car door because she wasn't strong enough to pick Resident A up so he had to do it. Mr. Morris stated that Ms. Ciuferri tried briefly to pick up Resident A's feet to get him to walk out but she couldn't sustain that and his legs dropped so Mr. Morris stated he told Ms. Ciuferri to just get to the door since she couldn't hold on to Resident A.

Mr. Morris stated Resident A did not get into the car willingly so he had to help Resident A get into the car as well. Mr. Morris stated he put Resident A's seatbelt on as Resident A was not willing to do it independently. Mr. Morris stated there was a brief time when Resident A tried to get out of the car window but he rolled up the window and used the child locks so Resident A couldn't stick his head out. Mr. Morris stated he would describe him getting to Resident A to the car as **"**dragging him because there was no other way**."** Mr. Morris stated this has never happened before and he did not want to do this either but it was the only way to get him to the car. Mr. Morris stated he did not call anyone else for assistance during this incident. Mr. Morris stated he was not sure if he completed an *AFC Incident / Accident Report* or documented the information anywhere. Mr. Morris stated there was no point where Resident A cried out into pain or said that he was hurting him and there were no bruises on Resident A after this incident.

During the on-site investigation I reviewed Resident A's *Assessment Plan for AFC Residents* completed on 10/14/2025 and signed by Guardian A1, Turning Leaf case manager Margo Higbie and licensee designee Destiny Saucedo-Al Jallad. The assessment documented the following:

- Resident A does not control his aggressive behavior. "[Resident A] has a history of physical aggression, patterns of dangerous behaviors including eloping behaviors, property destruction (broken chairs, broken tables and broken windows). These behaviors occur when [Resident A] is denied access to desired items, preferred activities or when he wants to return home to his parents. Per guardian statement [Resident A] does not swing on individuals but rather will grab onto individuals to push or pull. Staff will use calm yet firm directions to de-escalate tension and use MANDT when appropriate."

- Resident A does not get along with others. "At the time of this assessment [Resident A] has a history of verbal and physical aggression towards staff and other residents due to his diagnosis of Autism and when escalated communications [sic] through behaviors. Staff will use calm yet firm directions to de-escalate tension and us MANDT when appropriate."

- "Residential staff support [Resident A] in the community with questions, providing verbal prompts, assistance, health and safety, guidance, decision making, support, and transportation. [Resident A] has 1:1 staffing in the community due to a history of eloping, running into traffic, not looking both ways and knowing when to cross the street appropriately. Staff assist [Resident A] with crossing streets, verbal cues to assist [Resident A] in asking the right person for help, handling emergencies, stranger safety, personal boundaries and consent, recognizing potentially unsafe/dangerous situations."

On 02/12/2026 I interviewed Ingham ISD Special Education Instructional Coach Ashleigh Moro and school social worker Courtney Platte who both work at Beekman Center where Resident A attends school. Ms. Moro stated Resident A was having a

hard time and did not want to leave the school and during the behavior the male direct care staff member (James Morris) stated to Resident A, "I'm going to grab you and pull you out of there" before proceeding to do so. Ms. Moro stated Mr. Morris grabbed Resident A behind and under his armpits and proceeded to walk backwards so he was dragging him toward the car which was approximately 40 feet away. Ms. Moro stated she would describe it as Resident A going limp while the male staff (James Morris) walked backwards and Resident A's feet were dragging behind him as he was pulling him backwards.

Ms. Moro stated that Ms. Ciuferri tried to pick up Resident A's feet but she wasn't able to sustain it. Ms. Moro stated when they arrived at the car, Mr. Morris shoved him into the car and his feet were up by the ceiling and they tried to slam the door. Ms. Moro said she is concerned after this incident that direct care staff members do not have adequate training to support Resident A's needs.

Ms. Moro stated after they got in the car and took off Resident A was sitting upright but they did not see the staff put on his seat belt and the student was hanging out the window yelling "teacher help me, teacher help me."

Ms. Moro stated Resident A has limited verbal abilities which usually are focused on what is happening at the time. Ms. Moro stated Resident A can respond to very simplistic questions depending on his level of anxiety but Ms. Moro stated she does not believe Resident A could complete an interview regarding this incident. Ms. Moro stated the intervention used to assist Resident A to the car was not an approved Crisis Prevention Institute (CPI) technique that would support Resident A. Ms. Moro stated she knows this because she is a trainer for CPI. Ms. Moro stated she has provided transport to individuals in distress and she does not understand why they walked backwards with Resident A because that's a safety concern. Ms. Moro stated it seemed like the two direct care staff members were just stressed and wanted this done as opposed to using what techniques they have been trained in to complete the task of getting Resident A to the car as safely as possible. Ms. Moro stated the sidewalk was clear and salted but the weather wasn't great and if Resident A had resisted more, this could have led to an injury.

School social worker Ms. Platte stated Resident A has come to school with bruises on his arms and legs but stated Resident A exhibits self-injurious behavior that may have contributed to bruising previously observed. Ms. Platte stated she became concerned after observing this incident that some bruising may be from interactions with direct care staff. Ms. Platte stated recently on either 02/05/2026 or 02/09/2026 she noticed a handprint shaped bruise on Resident A's upper arm of which she took a picture. Ms. Moro stated Resident A does not point out or identify the bruising and she does not think that he would be able to identify the source. Ms. Moro confirmed Resident A hits himself on occasion but she hasn't seen any residual marking from this type of self-injurious behaviors. Ms. Moro and Ms. Platte both stated when Resident A is in distress at school they are the most frequent responders to the incidents, but they have never seen Resident A in distress like he was during this incident.

I reviewed pictures which were emailed to me by Ms. Moro. The pictures did not show Resident A's face in any of them. These pictures were taken by Ms. Moro and Ms. Platte and there were 6 pictures in total which included the following images. There was one additional picture which was his foot showing he needed podiatry care, however, that was unrelated to this incident.

1. Resident A's right arm hanging loosely at his side but I could not verify any bruises in this picture. I could not verify the date this picture was taken.
2. Appears to be a closer picture of #1 taken on 02/09/2026 and I could make out a bruise on the inside of the top part of Resident A's arm. The bruise is yellow in color and approximately two inches long in an oblong shape.
3. Resident A's waist area taken on 02/09/2026 near the top of his pants which documents an approximate two inch long bruise.
4. Resident A's waist area was taken on 02/09/2026 which may be the other side of his waist near the top of his pants but I cannot confirm a bruise in this picture.
5. Resident A's waist area taken on 02/09/2026 which appears to be a closer version of picture #4 which is the other side of his waist near the top of his pants which shows a long skinny bruise about three inches long.
6. A picture of the outside of the school taken 02/12/2026 showing the walkway.

I did not view any picture of a hand print.

On 03/12/2026 I interviewed licensee designee Destiny Al-Jallad. Ms. Al-Jallad stated she was unaware of this incident before APS Mr. Lindley came to complete an investigation. Ms. Al-Jallad initially stated it's possible the school thought they were observing something worse than it was because Resident A does need a guiding arm at times to get where he needs to go. Ms. Al-Jallad stated to her knowledge Resident A has not refused to leave the school before however he had a couple instances where he ran toward the road when the bus came and there were 4-5 people who would redirect him back toward Redwood Cottage. Ms. Al-Jallad stated she has never observed Resident A drop to the ground when he does not want to move. Ms. Al-Jallad stated direct care staff members are trained using the behavioral intervention method, MANDT, but with this method direct care staff wouldn't learn anything like dragging a resident rather would be trained to encourage walking along them at their side. Ms. Al-Jallad stated she is concerned because if Resident A was this upset, direct care staff should not have walked with Resident A this way. Ms. Al-Jallad stated she does not know if any direct care staff members have observed any bruising on Resident A because nothing was reported to her.

Ms. Al-Jallad provided me with training records verifying that Ms. Ciuferri completed the MANDT training on 10/02/2025 and Mr. Morris completed this training on 09/18/2025. This training addresses prevention, deescalation, and intervention during behavioral challenges. I also reviewed verification from the Michigan Workforce Background Check system documenting that Ms. Ciuferri and Mr. Morris were both eligible to work in an AFC setting.

On 03/13/2026 I received a call from Ms. Al-Jallad who stated both Ms. Matthews and Mr. Morris were terminated from their positions at Redwood Cottage due to this incident.

On 03/13/2026 I interviewed APS Mr. Lindley. Mr. Lindley stated he did not know if there was bruising on Resident A but he was going to meet with Detective Hackenburg to view the video which he subpoenaed from the school entry way. Mr. Lindley stated both Ms. Ciuferri and Mr. Morris blamed the school because they locked the door and wouldn't help them. Mr. Lindley stated he was also able to interview Resident A but he wasn't able to answer questions about this incident. Mr. Lindley stated Resident A only talked to him about his grandma's house. Mr. Lindley stated he saw Resident A on two different occasions however he had on pants and a shirt so he did not see any bruises, however, he did observe the pictures mentioned above from Ms. Moro. Mr. Lindley stated he will be substantiating both Ms. Ciuferri and Mr. Morris for physical abuse even if law enforcement does not send this information to the prosecutor.

I received an email after Mr. Lindley watched the video and he confirmed Resident A was dragged by Mr. Morris backwards and that Detective Hackenburg would be sending these concerns to the prosecutor's office to review for 4th degree criminal charges.

On 03/17/2026 I received a call from CMH case manager Amanda Goodman. Ms. Goodman stated she did not receive an *AFC Incident / Accident Report* for this incident. Ms. Goodman stated there is a protocol in place if a direct care staff member needs assistance that they can call administration for assistance. Ms. Goodman stated they have previously called law enforcement when he has eloped so the direct care staff members know this is an option if needed. Ms. Goodman stated there are times that Resident A will refuse to move after sitting down and if Resident A was sitting on the ground/floor during this incident, direct care staff should have called the call supervisor or law enforcement. Ms. Goodman is concerned direct care staff members went straight to dragging him to the car instead of requesting help especially because he was not harming direct care staff members or himself. Ms. Goodman stated dragging Resident A to the car was not an acceptable response to him not wanting to leave school. Ms. Goodman stated there is nothing in his *Person Centered Plan* that would indicate this is an appropriate response either.

On 03/25/2026 I completed an exit conference with licensee designee Ms. Al-Jallad. Ms. Al-Jallad again reiterated she was "deeply saddened Ms. Ciuferri and Mr. Morris treated [Resident A] like this" and explained they were not trained to handle situations in this manner. Ms. Al-Jallad stated administrator Ms. Ely-Costa is the one who terminated Ms. Ciuferri and Mr. Morris and in that meeting they both appeared calm and did not have a reason why they handled the situation this way.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(2) Interventions must be specified in the resident's assessment plan and performed in accordance with that

	plan. Interventions must ensure that the safety, welfare, and rights of the resident are adequately protected. If an intervention is needed to address the unique programmatic needs of a resident, the intervention must be developed in consultation with, or obtained from, a professional or professionals licensed, certified, or registered in that scope of practice.
ANALYSIS:	When Resident A did not want to leave school, direct care staff members Ms. Ciuferri and Mr. Morris placed arms underneath Resident A's armpits and walked backwards with him to the facility vehicle. Direct care staff member Mr. Morris stated, "dragging him (Resident A) because there was no other way" when describing how direct care staff got Resident A to the vehicle. Upon review of Resident A's *Assessment Plan for AFC Residents* and *Person Centered Plan,* taking Resident A under the arms and walking backwards with him was not listed as an approved intervention specified to use when Resident A refuses to move. Licensee designee Ms. Al-Jallad stated direct care staff members Ms. Ciuferri and Mr. Morris were trained in MANDT training however confirmed that dragging Resident A backwards is not an approved technique in any physical intervention program. Ms. Al-Jallad stated direct care staff members are not instructed to use this as an intervention.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

_ ___________03/31/2026_______________

Jennifer Browning   Date
Licensing Consultant

Approved By:

04/03/2026

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Dawn N. Timm   Date
Area Manager