RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

August 1, 2017

Sami Al Jallad
Turning Leaf Residential Rehabilitation Services
P.O. Box 23218
Lansing, MI 48909

RE: License #: AS330087739
Investigation #: **2017A0783035**
Spruce Cottage

Dear Mr. 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 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.

Sincerely,

Leslie Barner, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330087739
Investigation #:	2017A0783035
Complaint Receipt Date:	06/01/2017
Investigation Initiation Date:	06/01/2017
Report Due Date:	07/31/2017
Licensee Name:	Turning Leaf Residential Rehabilitation Services
Licensee Address:	621 E. Jolly Rd. Lansing, MI 48910
Licensee Telephone #:	(517) 775-0207
Administrator:	Destiny Jallad
Licensee Designee:	Sami Al Jallad
Name of Facility:	Spruce 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:	03/20/2017
Expiration Date:	03/19/2019
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED TRAUMATICALLY BRAIN INJURED MENTALLY ILL AGED

ALLEGATION(S)

	Violation Established?
Resident A had medical concerns that were not addressed by the licensee.	Yes
Additional Findings	Yes

II. METHODOLOGY

06/01/2017	Special Investigation Intake 2017A0783035
06/01/2017	Special Investigation Initiated - Telephone From complainant
06/20/2017	Contact - Face to Face Interviews with assigned adult protective services (APS) investigator Talaina Cummins, Resident A, Resident B, direct care staff member Antanica Lyons, program director Jessica Rook
06/20/2017	Contact - Document Received Resident A's resident record
07/27/2017	Contact - Telephone call made To Talaina Cummins
07/27/2017	Contact - Telephone call made To Destiny Al Jallad
07/27/2017	Contact - Telephone call made To Jessica Rook
07/31/2017	Contact – Telephone call Received From Guardian Shiloh Ferguson
07/31/2017	Exit Conference

ALLEGATION:

Resident A had medical concerns that were not addressed by the licensee.

INVESTIGATION:

On June 1, 2017 I received a telephone call from Complainant who stated Resident A had been ill for several weeks as evidenced by extreme weakness to the point that Resident A cannot walk unassisted and falls on the floor regularly. Complainant stated Resident A is weak, unable to sit up or carry on a conversation due to her illness and that the licensee has not sought adequate treatment for Resident A.

On June 20, 2017 I interviewed assigned adult protective services (APS) investigator Talaina Cummins who stated that on June 2, 2017 she observed that Resident A was too weak to stand upright on her own, let alone transfer and ambulate. Ms. Cummins stated Resident A fell right in front of her when attempting get out of bed on her own and a staff person assisted Resident A off the floor. On July 27, 2017 Ms. Cummins stated she has an active case open, and will close it when she is certain Resident A is in a placement where all of her needs are being met. Ms. Cummins stated she completed a face to face interview with Resident A on July 18, 2017, and that Resident A was awake, alert, oriented and able to ambulate independently.

On June 20, 2017, I attempted to interview Resident A but she was in bed, extremely tired, and unwilling or unable to answer my questions. Ms. Cummins was also present, but Resident A did not answer any of her questions either.

On July 27, 2017, I interviewed facility administrator Destiny Al Jallad who stated Resident A started struggling with weakness and a urinary tract infection in April, 2017 and that Resident A was treated by her primary care physician, urgent care clinic, and McLaren Greater Lansing on several occasions before having an appendectomy on June 7, 2017. Ms. Al Jallad stated Resident A's appendix was biopsied after it was removed and it has been determined that Resident A has cancer. Ms. Al Jallad acknowledged that Resident A had many documented "falls" but that she observed that most of the time Resident A "placed" herself on the floor by sliding out of her chair or dropping to her knees rather than falling. Ms. Al Jallad stated every time Resident A fell, her guardian, primary care physician, psychiatrist and case manager were notified. Ms. Al Jallad stated Resident A was never injured or bruised when she "placed" herself or slid on the floor.

On June 20, 2017 and July 27, 2017 I interviewed program director Jessica Rook who stated Resident A began showing an adverse change in her medical condition in April, 2017. Ms. Rook stated medical treatment was sought for Resident A and that all follow–up instructions were followed, including medical appointments and

medications for Resident A. Ms. Rook described Resident A's falls as "plopping down" or "sliding out of her seat" though she did acknowledge some of Resident A's falls were related to "weakness or illness." Ms. Rook stated Resident A "plopped" on the floor, "slid" out of her chair, or fell even as staff were present with her. Ms. Rook stated Resident A refused assistance in the bathroom and often "plopped" down, "slid" or fell while she was toileting. Ms. Rook stated facility staff requested an assistive device such as a walker or wheelchair from Resident A's primary care physician, which was not ordered by the physician. Ms. Rook stated every time Resident A fell, her guardian, primary care physician, psychiatrist and case manager were notified. Ms. Rook stated Resident A was never injured or bruised when she "plopped," "slid" or fell onto the floor.

On July 31, 2017 I spoke to Resident A's public guardian, Shiloh Ferguson who stated Resident A began declining in health several months ago, which also resulted in changes in her behavior. Ms. Ferguson stated she was not notified each time that Resident A fell and that on June 20, 2017 she received approximately 12 to 15 *Incident/Accident Reports* for Resident A all at once. Ms. Ferguson stated Resident A has received medical treatment for her illness on several occasions and that she was not contacted each time Resident A required medical treatment. Ms. Ferguson stated she was not contacted on May 31, 2017 regarding Resident A's physician recommending she be evaluated in the emergency room after not being able to walk into the clinic. Ms. Ferguson stated she did not refuse medical treatment on Resident A's behalf on May 31, 2017 nor on any other day.

On June 20, 2017, I received copies of facility *Incident/Accident Reports* for Resident A. The *Incident/Accident Reports* documented 33 falls in total from April 3, 2017 until June 19, 2017. The corrective measures listed on each report include notification of Resident A's primary care physician, notification of Resident A's guardian, notification of Resident A's psychiatrist, and notification of Resident A's case manager. Additional corrective measures indicated on the reports were assisting Resident A with walking, reminding Resident A to request assistance, requesting a review of Resident A's medications, and use of positive reinforcement after Resident A's falling was suspected to be behavioral.

On June 20, 2017, I reviewed Resident A's Heath Care Appraisal dated December 20, 2016. Resident A's diagnoses were listed as schizoaffective disorder, PTSD, dandruff, bilateral bunions, and rectal bleeding. Resident A was noted to have knee pain and dorsalgia of lumbosacral region but was not indicated to require assistance with transfer and ambulating.

On June 20, 2017 I reviewed Resident A's *Medication Administration Records* which indicated her medications, including antibiotics, were administered as prescribed.

On June 20, 2017 I reviewed *Progress Notes* completed by Dr. Joel Sanchez, Resident A's psychiatrist. On June 6, 2017 Dr. Sanchez wrote "I do not ID *[sic]* any

direct psychotropic concerns and suspect a separate non–psychiatric general medical process is the most likely cause" of Resident A's condition.

On June 20, 2017 I reviewed Resident A's *Assessment Plan for AFC Residents* dated December 22, 2016. There is no indication per the assessment plan that Resident A requires assistance with transferring, ambulation, nor that she has any needs related to behavior that causes her to fall.

On June 20, 2017 I reviewed Resident A's *Person Centered Plan* (PCP) dated March 22, 2017. There is no indication per the PCP that Resident A requires assistance with transferring, ambulation, nor that she has any needs related to behavior that causes her to fall.

On June 20, 2017 I reviewed Resident A's resident record. According to documentation in the record, Resident A was evaluated by her primary care physician on April 4, 2017 and diagnosed with a urinary tract infection and chronic bilateral low back pain without sciatica. Resident A was prescribed an antibiotic medication and instructed to follow up in two weeks, increase fluid intake, and to participate in exercises for her back pain. The doctor performed imaging on Resident A's spine due to chronic pain but did not order any additional follow-up treatment. Resident A was evaluated by her primary care physician on April 10, 2016 for follow-up treatment. According to the documentation, also addressed were vomiting, imbalance of gate, lethargy, and inability to grasp objects. Resident A was instructed to go to the emergency room for fluid rehydration and follow up with the primary care physician in three to seven days. On April 10, 2017 Resident A was treated in the emergency room and her diagnosis was COPD flair. On April 24, 2017 Resident A was treated by her primary care physician for follow up evaluation of a urinary tract infection. The documentation indicated that a urinalysis showed that Resident A had trace amounts of bacteria in her urine and that the physician ordered an antibiotic for Resident A and ordered her to return in two weeks for follow up treatment. The documentation indicated that if laboratory testing indicated Resident A still had a urinary tract infection at her follow-up visit that she would be referred to a urologist or receive a straight catheter. On May 5, 2017 Resident A was evaluated by Sparrow Laboratories to determine if her UTI had resolved and no follow up treatment was indicated. On May 12, 2017 Resident A was evaluated at an urgent care clinic and diagnosed with a urinary tract infection. Resident A was prescribed an antibiotic medication and instructed to get follow-up medical treatment if her symptoms did not begin to resolve within three days. On May 17, 2017 Resident A was treated at McLaren Greater Lansing and diagnosed with a bladder infection and dehydration and was prescribed an antibiotic, no additional follow-up or referrals were ordered. On May 31, 2017 Resident A had an appointment with her primary care physician who refused to examine her because she could not walk into the building because she was too weak. Facility documentation indicated that Resident A's primary care physician recommended she be taken to the emergency room, which was refused by Resident A's guardian. *Patient Discharge Instructions* from McLaren Greater Lansing stated Resident A was admitted to the hospital on June 5, 2017 for

appendicitis and weakness. On June 7, 2017 Resident A received a lap appendectomy and instructed to follow up with the surgeon within 10 days. On June 10, 2017 Resident A was admitted to the emergency room at McLaren Greater Lansing and diagnosed with constipation and urinary retention. Resident A was instructed to follow up with her primary care provider within one week, take a stool softener, keep the follow–up appointment with the surgeon that completed the appendectomy, and to discuss medication side effect of fluid retention with the psychiatrist. On June 27, 2017 Resident A had a follow-up appointment with the surgeon and was diagnosed with goblet cell carcinoma.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	According to those interviewed and Resident A's resident record, she began to show adverse changes in her medical condition in April 2017 as evidenced by the fact that she began falling frequently, showing signs of weakness, lethargy, and imbalance of gate. The licensee sought medical treatment for Resident A on seven occasions between April 4, 2017 and June 1, 2017 when the complaint was made. All follow-up appointments and treatment recommendations were followed, according to the documentation. However, on May 31, 2017 when Resident A went to the Birch Clinic and was to weak and imbalanced to exit the vehicle and go into the clinic to be evaluated by her primary care physician, the physician recommended Resident A be taken to the emergency room for treatment, as her condition could not be safely treated in his office based on Resident A's condition. According to those interviewed and written documentation at the facility, that recommendation was not followed, as it was not authorized by Resident A's guardian. Ms. Ferguson stated she did not refuse to follow the instructions and recommendations on behalf of Resident A. Resident A did not refuse the instructions and recommendations of the doctor and should have been transported to the emergency room, per the instructions and recommendations of her primary care physician. Ms. Ferguson stated as Resident A's guardian, she never refused the instructions and recommendations of Resident A's physician on May 31, 2017. Resident A was hospitalized days later with appendicitis and later diagnosed with goblet cell carcinoma.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On June 1, 2017 I interviewed Complainant who stated other residents assist Resident A when she falls because staff members are unable to assist Resident A on their own.

On June 20, 2017 I interviewed Resident B who stated that Resident A falls frequently and that she has helped her up on occasion. Resident B stated staff members usually assist Resident A when she falls, however, she has fallen when no staff member was present and Resident B assisted her.

On July 27, 2017 I interviewed Destiny Al Jallad who stated there was an incident when staff member Antanica Lyons requested assistance from another resident rather than requesting assistance from another staff person when she needed help assisting Resident A after she fell. Ms. Al Jallad stated Ms. Lyons was verbally redirected never to request assistance from a resident.

On June 20, 2016 I reviewed incident reports related to Resident A falling. One incident report dated May 16, 2017 indicated that staff member Antanica Lyons called upon another resident to assist her when Resident A fell that day.

On June 20, 2017 I interviewed Antanica Lyons who stated she completed the incident reported dated May 16, 2017 wherein she explained that she requested assistance from another resident to help Resident A because she wanted to get her off the floor immediately and requesting assistance from the resident was faster than requesting assistance from another staff member, who was not immediately available. Ms. Lyons stated she was verbally counseled never to request assistance from a resident.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule. **(o) The right to be treated with consideration and respect, with due consideration of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	Based on statements from those interviewed as well as written documentation from the facility, on at least one occasion, staff member Antanica Lyons called upon Resident B for assistance with Resident A after she fell. This practice jeopardizes the personal dignity and individuality of both Resident A and Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

08/01/17

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Leslie Barner Date
Licensing Consultant

Approved By:

08/01/2017

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Dawn N. Timm Date
Area Manager