GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 3, 2020

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

RE: License #: AS330087739
Investigation #: 2020A0783012
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.

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) 284-9730.

Sincerely,

Leslie Herrguth, 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 #:	2020A0783012
Complaint Receipt Date:	01/22/2020
Investigation Initiation Date:	01/23/2020
Report Due Date:	03/22/2020
Licensee Name:	Turning Leaf Res Rehab Svcs., Inc.
Licensee Address:	621 E. Jolly Rd. Lansing, MI 48909
Licensee Telephone #:	(517) 393-5203
Administrator:	Christine Barton – Young
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:	03/20/2019
Expiration Date:	03/19/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, ALZHEIMERS AGED, TRAUMATICALLY BRAIN INJURED

ALLEGATION(S)

	Violation Established?
Resident A's supervision and protection needs were not met when she cut herself with an unknown sharp object on January 13, 2020 and again on January 21, 2020.	No
Additional Findings	Yes

II. METHODOLOGY

01/22/2020	Special Investigation Intake 2020A0783012
01/23/2020	Special Investigation Initiated - Telephone With Complainant
01/23/2020	Contact - Document Received Written Incident/Accident Report and After Visit Summary for Resident A dated January 13, 2020
01/23/2020	Contact - Document Received Written Incident/Accident Report and After Visit Summary for Resident A dated January 21, 2020
01/29/2020	Inspection Completed On-site
01/29/2020	Contact - Document Received Written progress notes from Resident A's treating psychiatrists
01/29/2020	Contact - Document Received Resident A's resident record
02/10/2020	Inspection Completed On-site
02/10/2020	Contact - Document Received Facility employee schedule for January 2020
02/10/2020	Contact - Document Received written progress notes from direct care staff members for Resident A for the month of January 2020
02/10/2020	Contact - Face to Face Interviews with Destiny Al Jallad, Christine Barton - Young, Christa Campbell, and Resident A

02/27/2020	Contact - Telephone call made To Amy Kendall at St. Clair County Community Mental Health
02/28/2020	Contact - Telephone call made To direct care staff member Theolesia McRina
02/28/2020	Contact - Telephone call made To direct care staff member Laquita Thompson
03/02/2020	Exit Conference With licensee designee Sami Al Jallad

ALLEGATION:

Resident A's supervision and protection needs were not met when she cut herself with an unknown sharp object on January 13, 2020 and again on January 21, 2020.

INVESTIGATION:

On January 22, 2020 I received a complaint via central intake that stated Complainant received two written *Incident/Accident Reports* for Resident A dated January 13, 2020 and January 20, 2020 that indicated Resident A self–harmed with an unknown sharp object. The complaint stated Complainant requested additional information after the January 13, 2020 incident and Destiny Al Jallad stated, "This resident has a history of medication seeking behavior. On this day, she could not get any more PRNs due to max use. She threatened to harm self in attempts to gain more medication from the hospital. Between maxing out PRNs and resident cutting superficially to be taken to the hospital, staff attempted to provide support but Resident was goal focused on going to hospital." The complaint stated same day Complainant received the aforementioned incident report and follow-up information for Resident A she received a second written *Incident/Accident Report* dated January 20, 2020 indicating Resident A cut herself again. The complaint stated Complainant was concerned about how Resident A keeps gaining access to unknown sharp objects for self-harm behavior. The complaint cited concern of inadequate supervision to ensure Resident A's safety and protection needs are being met. The complaint stated Complainant was unsure if a safety plan had been implemented for Resident A or if assessment plan has been updated to reflect additional safety and supervision needs for Resident A.

On January 23, 2020 I spoke to Complainant who said she received several incident reports at once including two for Resident A dated approximately a week apart. Complainant said on or about January 13, 2020 Resident A cut herself with an

unknown object while alone in her room. Complainant said Ms. Al Jallad told her that Resident A's self–harm behavior is directed at gaining access to medication after she has taken the maximum prescribed dosage at the facility. Complainant stated an investigation is needed to determine what corrective measures were implemented for Resident A after she cut herself on January 13, 2020 and how Resident A continues to access things with which she can self–harm.

On January 23, 2020 I received a written *Incident/Accident Report* for Resident A dated January 13, 2020. According to the written report at approximately 7:30 pm Resident A "cut wrist with some unknown object." The written report stated Resident A came out of her bedroom and stated, "I cut myself I need to go to Sparrow." The written report indicated direct care staff member Theolesia McRina was working and she contacted 911 for assistance for Resident A along with several other staff members at the facility and redirected Resident A until an ambulance arrived, and Resident A was taken to Sparrow Hospital. In the corrective measures section of the written report it stated that Resident A was taken to Sparrow Hospital where she was treated and released the same day.

Attached to the written *Incident/Accident Report* was a written *After Visit Summary* for Resident A dated January 13, 2020. According to the written report the reason for Resident A's visit to the hospital was "suicide attempt." Resident A was diagnosed with "wrist laceration, right, initial encounter." The written report indicated Resident A was given information about wound care and self–destructive behavior and that she should follow up with her primary care provider within three days.

On January 23, 2020 I received a written *Incident/Accident Report* for Resident A dated January 20, 2020. According to the written report at approximately 11:53 pm Resident A "was rude and angry because she couldn't get meds. She went in her room slamming things around. Staff went in to check she slammed the door. 2 minutes later she came out and her wrist was slit." The written report went on to state that Resident A "has a long history of med seeking. Client had received all PRN's available for day." The written report indicated the corrective measure was for staff to be proactive and use prevention strategies to engage with Resident A.

Attached to the written *Incident/Accident Report* was a written *After Visit Summary* for Resident A dated January 21, 2020. According to the written report the reason for Resident A's visit to the hospital was "psychiatric evaluation," and "extremity laceration." Resident A was diagnosed with "self–mutilation." The written report indicated Resident A was given information about self–destructive behavior and that she should follow up with the facility psychiatrist.

On February 10, 2020 I received a written employee schedule for the facility that indicated on January 13, 2020 at approximately 7:30 pm direct care staff member Theolosia McRina was "responsible for all cottage duties." According to the written employee schedule on January 20, 2020 at approximately 11:53 pm direct care staff member Laquita Thompson was "responsible for all cottage duties."

On February 10, 2020 I received Resident A's written person-centered plan (PCP) dated April 9, 2019 which stated Resident A has a "history of self-harm and suicidal ideation." The PCP provided instructions to direct care staff members working with Resident A related to Resident A's self–harm behavior. The PCP stated staff members should, "teach/coach skills needed to successfully participate in cottage/campus life. Demonstrate/teach skills being addressed in groups/skill buildings. Model use of skills. Provide positive feedback related to successful skill use and provide feedback/redirection as needed. Provide validation and support as stressors or issues arise and assist in learning problem solving/coping skills as needed." The PCP stated Resident A is diagnosed with schizoaffective disorder, bipolar type, and paranoid schizophrenia.

On February 10, 2020 I received written progress notes from direct care staff members for Resident A for the month of January 2020. I noted that on January 6, 2020 direct care staff member Theolosia McRina wrote, "Consumer has had 3 busporin and the PRN liquid medication 2 times, and she is asking for it again, consumer is still medication seeking. I just letting you guys be aware of this and if staff refuses, she really acts up and tries to harm herself." I noted that later the same day staff member Quan Hamilton wrote, "Consumer got up around 1pm and staff was on computer and consumer stated she cut herself last night. Staff checked it over, look more like scratches and it was reported to PM." I noted that on January 13, 2020 staff member Theolosia McRina wrote that during her shift from 3:00 pm to 11:00 pm Resident A did not follow her treatment plan and wrote that Resident A "cut wrist and was taken to Sparrow for evaluation around 7:30 during the sift. Staff could not find what consumer used to cut wrist." I noted that the following day assistant program manager Quan Hamilton wrote Resident A "went to hospital due to cutting herself on her left wrist and she went by ambulance." The note indicated Resident A was advised to keep the wound dry and follow up with a physician if the wound becomes infected. The notes indicated that Resident A spent the majority of her time isolated in her bedroom and continued to seek medication. On January 19, 2020 assistant program manager Quan Hamilton wrote, "Consumer was walking through the house talking to herself about going to Port Huron where she stated the people down there will hurt and that she will go back to jail. The progress notes did not document that Resident A cut her wrist and was hospitalized on January 20/21, 2020. The notes indicated that on January 23, 2020 Resident A's case manager wrote that, "At the beginning of next month a new [plan of service] would be completed for [Resident A]. Discussed reward system which would include cooking, getting own coffee, activities such as painting nails, makeup, making smoothies, listening to music, watching movies. DBT skills would also be taught and roll modeled with [Resident A] as [case manager] will meet with [Resident A] weekly. Individual therapy each week will also be done to solidify the teaching of the DBT skills at the therapeutic level." I noted that effective January 23, 2020 direct care staff members began documenting that they visually checked Resident A every 15 minutes during their shifts.

On February 10, 2020 I received written progress notes from Resident A's treating psychiatrists, Dr. Dave Lyon and Dr. Joel Sanchez. According to the written notes on January 24, 2020 Dr. Lyon saw Resident A for follow-up post hospitalization. The written note indicated Resident A told Dr. Lyon she wanted to continue the medication regiment established in her most recent hospital visit, which Dr. Lyon agreed to. The note indicated Resident A has been diagnosed with borderline personality disorder with a history of self–harm. The note indicated the plan for Resident A was to continue medication as prescribed in the hospital, encourage DBT skills training. According to the written notes indicated Resident A threatened to self–harm if she did not receive an increase in her medication. Prior to January 13, 2020 which was not Resident A's first episode of self-harm, she was evaluated by the facility psychiatrist several times between May 4, 2019 and November 5, 2019. According to the written report on May 4, 2019 Resident A was seen for recent self-harm since she was admitted to the emergency department on May 3, 2019 due to self–harm. The note indicated Resident A had three cuts on her right wrist but was otherwise the same as usual in her appearance. The note stated Dr. Joel Sanchez stated he would order that Resident A's medication be administered in liquid form. The next note is dated June 8, 2019 and indicated that Resident A did not want to take her medication in liquid form and was experiencing continued heightened anxiety, paranoia, hallucinations, and self–harm thoughts. The note stated Dr. Sanchez ordered one of Resident A's medications back to tablet form, per Resident A's request. The next note is dated September 20, 2019. The note signed by Dr. Dave Lyon stated Resident A was having an increase in self–harm behavior. The next note dated October 25, 2019 stated Resident A reported she was doing "good" and several medications were discontinued. The next note dated November 5, 2019 indicated Resident A told Dr. Dave Lyon that she wanted her medication in liquid form, and he agreed to prescribe one medication in liquid form.

On February 10, 2020 I received Resident A's *Behavioral Assessment* (assessment) dated May 30, 2019. The assessment identified self-injury as a current target behavior. The operational definition was "punching self in eye with fist and cutting self with a shaver." The assessment stated there was one incident of Resident A cutting herself with a shaver so at this time she does not have access to a shaver. The plan stated if Resident A is not responding to internal stimuli, she can have the shaver with supervision and staff will maintain the shaver. The assessment outlines a plan for Resident A to eventually shave independently by receiving and participating in proactive strategies with Resident A. According to the assessment staff will review problem solving steps with Resident A, staff will schedule a time to sit in a quiet area of the home and assist Resident A to use her strengths to solve problems. The plan lists many calming activities for staff to try with Resident A such as deep breathing and five senses mindfulness. The assessment indicated Resident A was not participating in group activities and staff should develop rewards and incentives for attending group. The assessment indicated staff should be aware of Resident A's signals of escalation and validate her feelings before redirecting her to a calming activity. The assessment states staff should praise any step down in

escalation displayed by Resident A and monitor her environment for safety concerns.

On February 10, 2020 I received Resident A's written *Assessment Plan for AFC Residents* dated January 27, 2020. According to the written assessment plan Resident A "has a history of and currently engages in self harming behaviors (i.e. cutting. [Resident A] has a history of verbal aggression toward others and also self-inflicted aggression through acts of self harm." The written assessment plan reflects Resident A's medication seeking behavior and stated she requests multiple trips to the emergency department where she attempts to gain a prescription for an anti–anxiety medication.

On February 10, 2020 I interviewed director of operations Destiny Al Jallad who stated she assessed Resident A in person many times at her previous placement before admitting her to the facility on April 2, 2018. Ms. Al Jallad said at that time Resident A's primary treatment concerns were substance abuse, trauma, and response to internal stimuli, but nothing was communicated to her verbally nor in writing to indicate Resident A had a problem with self–harming behavior. Ms. Al Jallad said since she was admitted to the facility Resident A has had several instances of self–harm which have been discussed with her treatment team and her treating psychiatrist on numerous occasions. Ms. Al Jallad stated representatives from the Community Mental Health representing Resident A advised her that Resident A's self–harm behavior did not justify a restriction in her written plan. Ms. Al Jallad stated Resident A had "multiple" appointments with psychiatrist Dr. Lyon when most residents only see the doctor quarterly. Ms. Al Jallad said Resident A's "plan" does not specify what staff members should do after Resident A self–harms but the protocol is to keep Resident A safe, call 911, and contact a manager.

On February 10, 2020 I interviewed administrator Christine Barton-Young who stated she has worked at the facility since November 2019 and is familiar with Resident A. Ms. Barton–Young said she is responsible for quality and compliance of treatment at the facility and stated she has spent significant time with Resident A. Ms. Barton–Young described Resident A as complex and said self–injury is one of Resident A's challenges but has not presented as the most significant challenge. Ms. Barton–Young said she has instructed staff members to be proactive to redirect Resident A before she gets to the point that she engages in self–harming behavior. Ms. Barton–Young stated she trains staff members daily that they should praise Resident A or desired behavior. Ms. Barton–Young said Resident A uses perfume bottles, compact disks, and hair pins among other things to self–harm. Ms. Barton–Young explained that since Resident A has demonstrated a pattern of self–harm staff members remove anything sharp from Resident A's room such as broken plastic. Ms. Barton–Young added that while facility staff members can restrict Resident A's access to sharp objects, "cutters will make something to cut with." Ms. Barton–Young said staff members have responded appropriately to Resident A's instances of self–harm by contacting 911 immediately and following the hospital's discharge instructions and recommendations.

On February 10, 2020 I interviewed Resident A's case manager Christa Campbell who stated she has worked at the facility for one month and has met Resident A twice and each time they met it was along with Dr. Lyon. Ms. Campbell said Resident A is struggling with internal stimuli, increased hallucinations and that she stays isolated in her bedroom most of the time. Ms. Campbell said she was aware of Resident A's tendency to self – harm and that on or about January 27, 2020 she approached a representative from Resident A's community mental health agency and requested that Resident A be restricted from all glass and was told that Resident A could only be restricted after she hurt herself. Ms. Campbell stated the facility responded to Resident A's self – harm behavior by taking her to the hospital when needed, a referral for trauma focused dialectical behavioral therapy, skill building in 1:1 sessions with Ms. Campbell, medication adjustments, and increased appointments with Dr. Lyon. Ms. Campbell stated Resident A's treatment plan will be updated to address self – harm.

On February 27, 2020 I spoke to Amy Kendall who is a supervisor at St. Clair County CMH. Ms. Kendall stated she is familiar with Resident A and her treatment plan. Ms. Kendall stated Resident A's treatment plan indicates that she is restricted from "sharps" but Resident A is breaking everyday items and using them to self–harm. Ms. Kendall stated she has reviewed many written incident reports related to Resident A self–harming and based on the written reports it does not appear that staff members are following Resident A's treatment plan when she is having "emotional issues." Ms. Kendall stated per Resident A's written treatment plan staff members are to verbally and physically engage with Resident A while trying to redirect her to another activity. Ms. Kendall stated Resident A's treatment plan also includes directions for staff members to work with Resident A on breathing techniques and affirmative statements and the written incident reports submitted by the licensee "do not mirror" the directions in Resident A's treatment plan. Ms. Kendall stated since by all accounts Resident A spends most of her time alone in her room staff members should "look in on her more often," and regularly checking Resident A's room for other items that could be used to self–harm.

On February 28, 2020 I spoke to Theolesia McRina who stated she was working on January 13, 2020 when Resident A cut herself with an unknown object. Ms. McRina stated Resident A continuously wanted more medication and that she would have behaviors including self–harm, throwing objects, and severe verbal abuse. Ms. McRina stated she was trained in the interventions noted in Resident A's treatment plan such as understanding her trigger which is not getting her medication as requested, methods to calm her such a breathing technique, affirmative statements, or redirecting Resident A to another activity. Ms. McRina stated she was able to successfully use the techniques with Resident A on January 13, 2020 but Resident A was determined to self–harm to "either get out or get more drugs." Ms. McRina stated because Resident A does have a history of self–harm when Resident A is in her room, she checks on her several times hourly and regularly searches for and removes objects that Resident A could use to self–harm. Ms. McRina said Resident

A breaks everyday items such as compact disks or perfume bottles and uses them to self–harm. Ms. McRina stated she is familiar with direct care staff member Laquita Thompson and has no concerns regarding Ms. Thompson's ability to understand and implement Resident A's treatment plan.

On February 28, 2020 I spoke to Laquita Thompson who stated she was working on January 20, 2020 when Resident A cut herself with the glass from a candle she broke. Ms. Thompson stated when she arrived for her shift at 11:00 pm Resident A was "agitated" because she wanted more medication but per physician's orders Resident A could not have any more medication for "a few hours." Ms. Thompson said wanting medication and not being able to have it is a trigger for Resident A to have behaviors such as self–harm, throwing and slamming things, and verbal abuse toward staff members. Ms. Thompson said she was trained on how the use the interventions noted in Resident A's treatment plan including breathing techniques, affirmative statements and redirecting Resident A to another activity. Ms. Thompson said she attempted to use the techniques on Resident A on January 20, 2020 but Resident A went into her room, slammed the door, and then slammed it on Ms. Thompson when she tried to enter the room. Ms. Thompson said she regularly checks Resident A's bedroom for things with which Resident A could harm herself, including on January 20, 2020. Ms. Thompson stated, "I didn't think there was anything in there she could hurt herself with." Ms. Thompson said she regularly works from 11:00 pm to 7:00 am and that she visually checks Resident A every 15 minutes. Ms. Thompson stated she is familiar with Ms. McRina and has no concerns regarding her ability to understand and implement Resident A's treatment plan.

On February 10, 2020 I interviewed Resident A who confirmed that she recently cut herself with glass but would not say where she obtained the glass. Resident A said staff members regularly check her room for things she could use to harm herself with and remove those things. Resident A said, "they check on me all the time."

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based on written documentation at the facility, Resident A's written treatment plan indicated staff should be aware of Resident A's signals of escalation and validate her feelings before redirecting her to a calming activity. The plan stated staff should praise any step down in escalation displayed by Resident A and monitor her environment for safety concerns. Based on statements from Ms. McRina and Ms. Thompson both understood and attempted to implement Resident A's treatment plan when she cut herself on January 13, 2020 and January 20, 2020. According to Ms. Barton–Young she has spent additional time skill building and training staff members to successfully implement Resident A's treatment plan. Based on statements from Ms. Al Jallad, Ms. Barton–Young, and Ms. Campbell as well as written documentation at the facility, the licensee has implemented other interventions such as referring Resident A for trauma focused dialectical behavioral therapy, skill building in 1:1 sessions with Ms. Campbell, advocacy and documentation concerning medication adjustments, and increased appointments with the facility psychiatrist. There is lack of evidence to substantiate the allegation that Resident A did not receive protection, and supervision as outlined in her written documentation at the facility nor that she did not receive those things in accordance with the Act.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Although the written *Incident/Accident Report* dated January 21, 2020 was submitted timely, based on written documentation at the Bureau and statements from Ms. Al Jallad and Mr. Al Jallad, the written *Incident/Accident Report* submitted for Resident A dated January 13, 2020 was submitted to LARA employee Cedric Maxwell on January 17, 2020.

On March 2, 2020 I spoke to director of operations Destiny Al Jallad who stated she learned on January 16, 2020 that administrator Ms. Barton–Young was not aware of her responsibility to submit written *Incident/Accident Reports* to LARA within 48 hours of the reportable incident. Ms. Al Jallad stated she spoke with her assigned licensing consultant Stephanie Gonzalez via telephone regarding submission of the written reports, followed up with an email to Ms. Gonzalez and then forwarded approximately seven written reports that had not been submitted including the written report for Resident A dated January 13, 2020. Ms. Al Jallad said Ms. Barton–Young now understands the procedure and all written *Incident/Accident Reports* have been submitted timely since.

On March 2, 2020 I spoke to licensee designee Sami Al Jallad who stated on January 16, 2020 Ms. Barton–Young who was appointed administrator in early December informed him that she had not been sending written *Incident/Accident Reports* to LARA, as she was not aware that was her responsibility. Mr. Al Jallad stated he immediately notified his assigned licensing consultant Stephanie Gonzalez and submitted all required written *Incident/Accident Reports* that had not been sent, including the written report for Resident A dated January 13, 2020. Mr. Al Jallad stated all incident reports were submitted on January 17, 2020 and since then all written *Incident/Accident Reports* have been submitted timely.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that require hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.**
ANALYSIS:	According to statements from Mr. Al Jallad and Ms. Al Jallad as well as written documentation obtained during this investigation on January 13, 2020 Resident A was hospitalized for a suicide attempt and the licensee did not submit the written *Incident/Accident Report* until January 17, 2020 which was not within 48 hours as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

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

3/2/2020

_____

Leslie Herrguth Date
Licensing Consultant

Approved By:

03/03/2020

_____

Dawn N. Timm Date
Area Manager