GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 13, 2020

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

RE: License #: AS030394825
Investigation #: 2020A0350022
Woodlea 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 356-0183.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor, 350 Ottawa, N.W., Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AS030394825
Investigation #:	2020A0350022
Complaint Receipt Date:	02/23/2020
Investigation Initiation Date:	02/24/2020
Report Due Date:	03/24/2020
Licensee Name:	Turning Leaf Res Rehab Services, Inc.
Licensee Address:	621 E. Jolly Rd. Lansing, MI 48909
Licensee Telephone #:	(517) 393-5203
Administrator:	Sami Al Jallad
Licensee Designee:	Sami Al Jallad
Name of Facility:	Woodlea Cottage
Facility Address:	1565 Wood Lea Drive Otsego, MI 49078
Facility Telephone #:	(269) 692-2536
Original Issuance Date:	08/01/2018
License Status:	REGULAR
Effective Date:	02/01/2019
Expiration Date:	01/31/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, AGED, DEVELOP-MENTALLY DISABLED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
A staff member “smacked” Resident B in the back of his head.	Yes
Resident A’s bedsore opened up and began bleeding in November 2019 but he was not seen by a doctor for it until February 2020.	No
Resident B fell over while riding in the van as he was not buckled in.	Yes

III. METHODOLOGY

02/23/2020	Special Investigation Intake 2020A0350022
02/23/2020	APS Referral
02/24/2020	Special Investigation Initiated - Letter I arranged to meet Kathleen Woodworth at this home on 02/24/2020 at 11:30 a.m.
02/25/2020	Contact - Face to Face Ms. Woodworth and I interviewed staff member Destinie Shingledecker, saw residents
02/25/2020	Contact - Document Received I received an email from Zeta Francosky, Licensee Designee
02/25/2020	Contact - Telephone call made I discussed the complaint with Mandy Padget, Recipient Rigths Officer
02/26/2020	Contact - Telephone call made I discussed the complaint with Ms. Francosky
02/26/2020	Contact - Document Sent I sent an email to Ms. Francosky requesting some information
02/26/2020	Contact - Document Received I received an email from Ms. Francosky with the requested information

02/26/2020	Contact - Telephone call made I spoke with Jaleesa Moore, DCW
02/28/2020	Contact - Telephone call made I spoke with Kirsten Shears, DCW
03/02/2020	Contact - Telephone call made I spoke with Charnae Hunter, DCW
03/02/2020	Contact - Telephone call received I spoke further with Ms. Padget
03/02/2020	Contact - Document Received I received an email from Ms. Padget with a copy of her report attached
03/03/2020	Contact - Document Sent I sent an email to Ms. Padget requesting information
03/03/2020	Contact - Document Received I received an email reply from Ms. Padget
03/12/2020	Contact – Telephone call received I spoke with Sami Al Jallad and Zeta Francosky
03/13/2020	Contact – Telephone call made I spoke with Kirsten Shears
03/13/2020	Exit conference – Held with Sami Al Jallad, Licensee Designee

ALLEGATION: A staff member "smacked" Resident B in the back of his head.

INVESTIGATION: On 02/24/2020, through emails, I arranged to meet Kathleen Woodworth, Adult Protective Services (APS) investigator, at this home on 02/25/2020 at 11:30 a.m.

On 02/25/2020, I met Ms. Woodworth and her co-worker, Michael McClellan, at this home and we spoke with Destinie Shingledecker, Direct Care Worker (DCW). I informed Ms. Shingledecker that a complaint was made and asked her if the Home Manager was available. Ms. Shingledecker stated that this home currently did not have a Home Manager, but she agreed to help us as much as she could. We spoke privately in the laundry room/office, and I told Ms. Shingledecker what was specifically alleged. She did not have much information to give us as she was not involved in any of the alleged incidents. Ms. Shingledecker did say that she saw coworker Keefa Burnett smack Resident B in his head one time recently, but she

didn't report it to management. She said that Resident B was pulling on Keefa Burnett who smacked him in his head in response. Ms. Shingledecker took me, Ms. Woodworth, and Mr. McClellan to see each of the residents. There were no concerning marks on any of the residents from what I could see. However, Resident A had a bump on his forehead that was not discolored and of which Ms. Shingledecker said he has always had (See additional investigatory narrative under the next allegation). I asked Ms. Shingledededecker for Zeta Francosky's (Licensee Designee) phone number and requested for the APS investigators and I to use the home's office in private. Ms. Shingledecker gave me the phone number and left the office. I called Ms. Francosky's number but had to leave a message as she did not answer. Ms. Francosky is the Licensee Designee.

On 02/25/2020, I received an email from Ms. Francosky apologizing for not being able to answer my call earlier as she was in a meeting.

On 02/26/2020, I called and spoke with Ms. Francosky, asking her about this incident. Ms. Francosky stated that she terminated Keefa Burnett because a relatively new staff member told her that within the past week Keefa Burnett "popped" Resident B in his head and Renee Burnett "popped" Resident A in his head, and that she witnessed both incidents. Ms. Moore reported these incidents to Zeta Francoskly, Licensee Designee, who then terminated both Keefa Burnett and Renee Burnett.

On 02/26/2020, I called and spoke with Jaleesa Moore (DCW), who verified that within the past week Keefa Burnett "popped" Resident B in his head and Renee Burnett "popped" Resident A in his head, and that she witnessed both of these incidents.

On 02/28/2020, I called and spoke with Kirsten Shears, DCW. Ms. Shears stated that she had not witnessed any other staff member hitting any of the residents; she only heard about it.

On 03/02/2020, I called and spoke with Charnae Hunter, DCW. Ms. Hunter said that she has not observed any staff member hit any of the residents.

Resident A and Resident B are both non-verbal, and the staff who perpetrated these incidents, Keefa Burnett and Renee Burnett, were terminated. Therefore, none of these people were interviewed for this investigation.

On 03/13/2020, I held an exit conference with Sami Al Jallad, Licensee Designee. I informed Mr. Al Jallad that I was citing violation of this rule. Mr. Al Jallad thanked me and had no further comment.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(f) Subject a resident to any of the following:** **(ii) Verbal abuse.**
ANALYSIS:	Destinie Shingledecker, DCW, reported that she witnessed Keefa Burnett, DCW, smack Resident B in his head one time and Jaleesa Moore, DCW, stated that within the past week Keefa Burnett "popped" Resident B in his head and Renee Burnett "popped" Resident A in his head. Ms. Moore reported these incidents to Zeta Francoskly, Licensee Designee, who then terminated Keefa and Renee. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's bedsore opened up and began bleeding in November 2019 but he was not seen by a doctor for it until February 2020.

INVESTIGATION: On 02/25/2020, I met Ms. Woodworth and her co-worker, Michael McClellan, at this home and we spoke with Destinie Shingledecker, Direct Care Worker (DCW). Ms. Shingledecker stated that Resident A has always had a bump on his forehead and that he has self-injurious behaviors (SBI) such as scratching himself with his thumb nails. Ms. Shingledecker informed the APS investigators and me that when Resident A goes into SIBs, a staff member will put his helmet on him and if it involves him scratching himself, a staff member will first put a blanket on him, and if that doesn't prevent him from scratching himself, mittens will be put on him. Ms. Shingledecker also stated that Resident A gets bedsores and that special pillows and an air mattress have been ordered for him. She said that Resident A went to the doctor this same morning (02/26) about his bedsore and I requested a copy of the medical report from that visit and she provided one to me and APS. She reported that this was the first time Resident A was medically examined and treated for this wound. I also requested a copy of the staff list and she gave APS and me a copy of that as well. She pointed out that two people on the list, Kalynn Burnett and Renee Burnett, were suspended, and another person, Keefa Burnett, was terminated. Renee Burnett is the mother of Kalynn and Keefa. I requested to see all of the residents and Ms. Shingledecker took me, Ms. Woodworth, and Mr. McClellan

to see each of them. There were no concerning marks on any of the residents from what I could see. However, Resident A had a bump on his forehead that was not discolored and of which Ms. Shingledecker said he has always had. Resident A also had gauze bandages on his left wrist and forearm and on his right shoulder to protect his bedsores and SIB scratches. I observed two large, long pillows on Resident A's bed that were to help prevent him for getting bedsores by rubbing against the wall next to his bed.

On 02/26/2020, I called and spoke with Ms. Francosky, who reported that Kirsten Shears, DCW, told her she was concerned about Resident A's bedsore on his right shoulder on or near January 30th 2020. She informed me that the home's protocol is to keep an eye on such wounds, and if a wound "breaks open," they notify Community Mental Health (CMH). Ms. Francosky told me that they ordered pillows and special bedding to help prevent bedsores for Resident A.

On 02/26/2020, I reviewed the doctor's report pertaining to Resident A's appointment on 02/26/2020. The reports states that Resident A was diagnosed with having a "Pressure ulcer of left heel, stage 3" and "Pressure ulcer, shoulder blades, stage III."

On 03/12/2020, I spoke with Sami Al Jallad, Licensee Designee. Mr. Al Jallad was adamant that staff didn't know about Resident A's open wound until February 25 2020 and said that he was seen by a doctor that very same day. Mr. Al Jallad put Ms. Francosky on the phone for a three-way conversation, and she confirmed what Mr. Al Jallad said. Ms. Francosky informed me that Resident A receives his baths in the mornings, during first shift, and either Kirsten Shears or Destinie Shingledecker give him his bath, since they both work first shift. Ms. Francosky told me that Ms. Shears filled out an Incident Report on 01/30/2020 regarding Resident A having a bedsore on his shoulder and that he was seen by a doctor for it that same day. I asked her to send me both the IR and the medical report, and she said she would.

On 03/12/2020, I received an email from Ms. Francosky with the IR and medical report attached. The IR states "Staff notice what appears to be a bed sore on (Resident A's) R upper shoulder the size of a quarter. Notified supervisor and called doctor to schedule an appointment." The medical documentation states that Resident A was seen by a doctor on 01/30/2020 for a "skin check;" and that he was found to have a "Pressure sore on upper right should and left knee x 1 week."

On 03/13/2020, I called and spoke with Kirsten Shears who reported that she first noticed that Resident A's bedsore had opened sometime at the "beginning, middle of February (2020)," and she immediately notified the House Manager, Renee Burnett, who called a doctor and made an appointment for Resident A.

On 03/13/2020, I held an exit conference with Sami Al Jallad, Licensee Designee. I informed Mr. Al Jallad that I was not citing violation of this rule. Mr. Al Jallad thanked me and had no further comment.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Zeta Francosky stated that Resident A open wound was not discovered until February 25, 2020, and that he was seen by a doctor that same day. I was provided medical documentation that shows he was seen on this day. My findings do not support that this rule had been violated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident B fell over while riding in the van as he was not buckled in.

INVESTIGATION: On 02/26/2020, I called and spoke with Ms. Francosky, asking her to fill me in on what has been going on at this home. Ms. Francosky stated that she believes staff "got too comfortable", which she explained to mean they weren't doing their jobs as expected. Ms. Francosky informed me that Renee Burnett was the Home Manager until recently, but she was suspended because she was experiencing some personal problems that were affecting her ability to perform her job adequately. Ms. Francosky told me that Renee's two daughters, Kalynn Burnett and Keefa Burnett, who both worked there, were covering her responsibilities. Ms. Francosky informed me that she terminated and suspended several employees, including suspending Kalynn for "driving recklessly."

On 02/26/2020, I called and spoke with Jaleesa Moore, Direct Care Worker, who confirmed that she was recently riding in the van with Kalynn Burnett, who was driving, and Keefa Burnett, who was sitting on the floor of the van. Ms. Moore said that Kalynn made a sharp turn and Resident C, who was not buckled in, fell on another staff member. Ms. Moore then buckled him in. Ms. Moore informed me that on a different occasion Resident A hit his head against the side of the van while Kalynn Burnett was driving, but it was not severe enough to have him medically checked out.

On 02/28/2020, I called and spoke with Kirsten Shears, DCW. Ms. Shears stated that when the residents go places in the van, she drives because she "doesn't trust anyone else." However, she said that she has not observed reckless driving or residents not being buckled in whenever another staff member drove the van.

On 03/02/2020, I called and spoke with Charnae Hunter, DCW. Ms. Hunter said that she had not observed any staff member not putting residents' seatbelts on in the van.

On 03/13/2020, I held an exit conference with Sami Al Jallad, Licensee Designee. I informed Mr. Al Jallad that I was citing violation of this rule. Mr. Al Jallad thanked me and had no further comment.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Jaleesa Moore, DCW, reported that she witnessed two occasions of Kalynn Burnett, DCW, driving recklessly and not making sure all of the residents were buckled in. As a result, Ms. Francoskly, Licensee Designee, suspended Kalynn Burnett. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

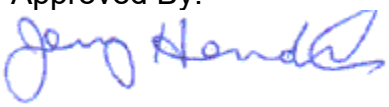
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

March 13, 2020

Ian Tschirhart — Date
Licensing Consultant

Approved By:



March 13, 2020

Jerry Hendrick — Date
Area Manager