GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 16, 2021

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

RE: License #:	AS700317947
Investigation #:	2021A0356026 Blue 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS700317947
Investigation #:	2021A0356026
Complaint Receipt Date:	04/21/2021
Investigation Initiation Date:	04/21/2021
Report Due Date:	06/20/2021
Licensee Name:	Turning Leaf Res Rehab Svcs., Inc.
Licensee Address:	621 E. Jolly Rd. Lansing, MI 48909
Licensee Telephone #:	(517) 393-5203
Administrator:	Sami & Destiny Al Jallad, Administrator
Licensee Designee:	Sami & Destiny Al Jallad, Designee
Name of Facility:	Blue Spruce Cottage
Facility Address:	5418 120th Ave. Holland, MI 49424
Facility Telephone #:	(616) 466-6885
Original Issuance Date:	11/14/2012
License Status:	REGULAR
Effective Date:	05/14/2021
Expiration Date:	05/13/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff at the facility left residents unsupervised for an unknown period of time.	Yes

III. METHODOLOGY

04/21/2021	Special Investigation Intake 2021A0356026
04/21/2021	Special Investigation Initiated – Telephone CJ Verhey, home manager.
04/21/2021	Contact - Telephone call made. Briana Fowler, Ottawa County Office of Recipient Rights.
04/29/2021	Contact-Telephone call received. Ms. Fowler stated she has already interviewed Resident A and staff Catrice Hawkins.
05/06/2021	Inspection completed- onsite.
05/11/2021	Contact - Document Received Interview with Resident B. Info. CJ Verhey.
05/14/2021	Contact - Document Received Resident Assessments, OLSR and picture.
06/09/2021	Contact - Document Received Briana Fowler, ORR.
06/15/2021	Contact-Telephone call made. DCW Eric Syrba.
06/16/2021	Exit Conference-Licensee Designee, Destiny Al Jallad.

ALLEGATION: Staff at the facility left residents unsupervised for an unknown period of time.

INVESTIGATION: On 04/21/2021, I received an Office of Recipient Rights complaint. The complainant reported staff at the facility did not adequately supervise residents because she was sleeping.

On 04/21/2021, I interviewed home manager, CJ Verhey via telephone. Ms. Verhey stated Resident A reported on 04/18/2021 that Direct Care Worker (DCW) Catrice Hawkins was sleeping on 3rd shift and Resident A took a picture and sent it to Ms. Verhey. Ms. Verhey reported that nothing happened to any of the residents while Ms. Hawkins was sleeping, and that Ms. Hawkins was the only staff on duty during the 3rd hour shift which is from 11:00 p.m.-7:00 a.m.

On 04/29/2021, I interviewed Briana Fowler, Ottawa County Office of Recipient Rights Director via telephone. Ms. Fowler stated she conducted an interview with Ms. Hawkins via telephone on 04/29/2021. Ms. Fowler reported that Ms. Hawkins confirmed she worked 3rd shift, as the only staff on 04/18/2021. Ms. Hawkins reported to Ms. Fowler that she watches "tv sometimes, I don't do that often. I lay on the couch with a blanket. The residents open the window so that's why I bring a blanket to work." Ms. Hawkins reported she watches tv in the living room at the facility. Ms. Fowler stated Ms. Hawkins denied sleeping and said she was watching tv in the living room. Ms. Fowler informed Ms. Hawkins she had a picture of her all covered up, laying on the couch in the living room. Ms. Fowler stated Ms. Hawkins replied, "I'll hire a lawyer. I'm not having anything on my record. I don't sleep. I tried to leave before because the residents are hitting me. CJ (Ms. Verhey) did not fill out any employee accident reports. I quit on the 18th. No way am I going back. I told CJ to take me off. I can do better than this. I quit so I am done with it." Ms. Fowler stated Ms. Hawkins hung up on her and then called back 4 times but did not leave a message on Ms. Fowlers telephone.

On 04/29/2021, I interviewed Ms. Fowler via telephone. Ms. Fowler stated she interviewed Resident A and Resident A confirmed that she took a photo of Ms. Hawkins during the nighttime shift. Ms. Fowler asked Resident A if she could see Ms. Hawkins face and if Ms. Hawkins was facing the wall or the living room television. Ms. Fowler stated Resident A stated, "I have no idea what way she was facing. She was all covered up. (Resident B) was up. He was sitting in the chair next to the couch where Catrice (Ms. Hawkins) was sleeping. He was watching tv." Ms. Fowler stated she asked Resident A if she had seen Ms. Hawkins sleeping while on duty before and Resident A answered, "yup!" Resident A told Ms. Fowler "it was 4:00 a.m. and I got up to get a fruit cup or something. I was hungry."

On 05/06/202, I conducted an inspection at the facility and interviewed Ms. Verhey. Ms. Verhey stated Ms. Hawkins no longer works at the facility and she had reports from the residents that Ms. Hawkins was sleeping during her nighttime shift. Ms. Verhey stated she addressed the issue with Ms. Hawkins and thought the issue was resolved until Resident A showed her the picture she had taken of Ms. Hawkins under a blanket on the couch at the facility.

On 05/11/2021, Ms. Fowler interviewed Resident B via telephone. Ms. Fowler stated she explained the complaint to Resident B and that he had been named as a person awake and in the living room with Ms. Hawkins when she was on the couch under a blanket. Ms. Fowler stated Resident B stated, “oh yes. She is right. I was sitting there. Hold on I will think of the staff’s name.” Ms. Fowler stated Resident B thought a bit about what staff’s name was and came up with “Catrice” and then stated, “she was not sleeping. She was talking to me.” Ms. Fowler asked Resident B if Ms. Hawkins was covered up with a blanket and he stated, “yes, she was resting. She was not sleeping.” Ms. Fowler asked Resident B if he recalled another resident coming upstairs and taking a picture of Ms. Hawkins on the couch covered in a blanket and Resident B stated, “no. I believe I am the only one up at 4:00 a.m. I am an amateur astronomer. I like to go out and check out the stars.”

On 05/11/2021, Ms. Verhey expressed concern via an email to Ms. Fowler and I about Resident B going outside of the facility and star gazing if the 3rd shift staff is resting or sleeping. Ms. Verhey stated it is not unusual for Resident B to go outside during 3rd shift hours to gaze at the stars.

On 05/14/2021, I reviewed the Original Licensing Study Report dated 11/14/2012 that states the facility will have direct care staff that will be awake during sleeping hours.

On 05/14/2021, I received and reviewed the picture taken by Resident A of staff under a blanket on the couch at the facility. The blanket was pulled up over her face and she was laying horizontally on the couch.

On 05/14/2021, I received and reviewed Resident A, B, C, D, E & F’s assessment/treatment plans. Resident A’s plan documents that she ‘*benefits from 24-hour care with awake staff, medication management and assistance to deal with high anxiety and to avoid verbal outbursts/aggressive behaviors.*’ Resident E’s plan documents that she ‘*has 24-hour care and will have access to staff in the event of a crisis.*’ None of the assessment plans document residents require 1:1 supervision or a heightened level of supervision that would require more staff on duty during 3rd shift.

06/09/2021, I received and reviewed Turning Leaf policy which describes this facility as a ‘*24-hour, awake facility that requires staff continuous monitoring and supervision of consumers. Sleeping on duty is prohibited, at any time, for any reason or length of time and is subject to disciplinary action. Definition: sleeping includes having eyes shut for an extended amount of time at any times during their scheduled shift. Being unresponsive when spoken to or lying horizontally is considered sleeping on the job.*’

06/15/2021, I interviewed DCW Eric Syrba via telephone. Mr. Syrba stated Resident A told him that Ms. Hawkins was sleeping on the couch during 3rd shift and that she took a picture. Mr. Syrba stated Resident A is not known to lie to get others into

trouble and it was not unusual for Resident A to get up and go upstairs where staff is to get a drink during 3rd shift hours. Mr. Syrba stated Resident B is often up during the nighttime hours and likes to go out and look at the stars.

06/16/2021, I conducted an Exit Conference with Licensee Designee, Destiny Al Jallad. Ms. Al Jallad stated she understands the information, analysis and conclusion of this applicable rule and will submit an acceptable corrective action plan.

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:	Based on investigative findings, there is a preponderance of evidence to show that during 3rd shift hours on 04/18/2021, Resident A & B were awake during the time Ms. Hawkins was laying on the couch, under a blanket with her face covered up. Ms. Hawkins was not providing the required protection and safety to the residents as required by the provisions of the act. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

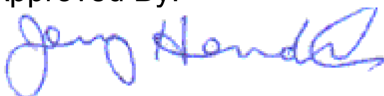
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

06/16/2021

Elizabeth Elliott Date
Licensing Consultant

Approved By:



06/16/2021

Jerry Hendrick Date
Area Manager