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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 14, 2021

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

RE: License #: AS330386772
Investigation #: 2021A0783042
Dogwood 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,

A handwritten signature in cursive script that reads "Leslie Herrguth".

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 #:	AS330386772
Investigation #:	2021A0783042
Complaint Receipt Date:	07/26/2021
Investigation Initiation Date:	07/26/2021
Report Due Date:	09/24/2021
Licensee Name:	Turning Leaf Res Rehab Svcs., Inc.
Licensee Address:	621 E. Jolly Rd. Lansing, MI 48909
Licensee Telephone #:	(517) 393-5203
Administrator:	Destiny Saucedo-Al Jallad
Licensee Designee:	Sami Al Jallad
Name of Facility:	Dogwood Cottage
Facility Address:	621 E. Jolly Road Lansing, MI 48910
Facility Telephone #:	(517) 393-5203
Original Issuance Date:	10/11/2017
License Status:	REGULAR
Effective Date:	04/11/2020
Expiration Date:	04/10/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A, who requires staff supervision in the community per his written assessment plan, was left without a staff member at the hospital from July 25, 2021 – July 29, 2021 because there was not sufficient direct care staff on duty to supervise him at the hospital.	Yes

III. METHODOLOGY

07/26/2021	Special Investigation Intake – 2021A0783042
07/26/2021	Special Investigation Initiated - On Site
07/26/2021	Contact - Document Received – Written e-mail message from facility administrator Destiny Al Jallad
07/26/2021	Contact - Document Received – Written AFC Licensing Division Incident/Accident Report for Resident A
07/26/2021	Contact - Face to Face interview with Destiny Al Jallad
07/26/2021	Contact - Document Received – Resident A's written Assessment Plan for AFC Residents
07/27/2021	APS Referral
08/02/2021	Contact - Telephone call made to program manager Camie Blais
08/02/2021	Contact - Telephone call made to Christa Campbell who is Resident A's assigned case manager
08/02/2021	Contact - Telephone call made to Margaret Brandenburg who is Resident A's assigned public guardian, unsuccessful
09/10/2021	Contact - Telephone call made to Margaret Brandenburg, unsuccessful
09/10/2021	Exit Conference with Destiny Al Jallad as licensee designee Sami Al Jallad was unavailable

ALLEGATION:

Resident A, who requires staff supervision in the community per his written assessment plan was left without a staff member at the hospital from July 25, 2021 – July 29, 2021, because there was not sufficient direct care staff on duty to supervise him at the hospital.

INVESTIGATION:

On July 26, 2021, I received a written e-mail message from facility administrator Destiny Al Jallad that stated, "Around 11pm last night [Resident A] was taken by ambulance to McLaren Greater Lansing due to back and hip pain and difficulty ambulating. He remains in the ER this morning. Due to extreme staffing shortages, we have not been able to provide staffing while he is in the ER. This is not typical and we would like to be able to provide a staff member to sit with him per our policy but we do not have the staff. Instead, the hospital has all relevant contact info and our Managers have been calling periodically for updates. We know his whereabouts and we remain in constant contact with the hospital staff."

On July 26, 2021, I received a written *AFC Licensing Division Incident/Accident Report* for Resident A dated July 26, 2021. The written incident report stated Resident A was taken by ambulance to the hospital at about 11:00 pm on July 25, 2021. The written report stated Resident A was transported to the hospital due to hip and back pain and difficulty ambulating. The written report indicated Resident A was admitted to the hospital on July 26, 2021, at approximately 7:30 am.

On July 26, 2021, I received and reviewed Resident A's written *Assessment Plan for AFC Residents* dated March 1, 2021. According to the written assessment plan Resident A does not move independently in the community. The written assessment plan stated, "staff support [Resident A] in the community with questions, providing verbal prompts, assistance, health and safety, guidance on decision making, support, and transportation."

On July 26, 2021, I interviewed Destiny Al Jallad who said Resident A went to the hospital at 11:00 pm on July 25, 2021 and was still at the hospital at the time of the interview. Ms. Al Jallad stated per his written assessment plan Resident A requires staff supervision in the community, and facility policy is to have a staff member accompany Resident A, however, no staff member was available to supervise Resident A at the hospital. Ms. Al Jallad said Resident A is from another part of the state and he requires staff supervision in the community because he may get "confused" because he is not familiar with the Lansing area. Ms. Al Jallad stated since Resident A has been at the hospital program manager Camie Blais has been in "constant" communication with staff members at the hospital and that she is aware of Resident A's general whereabouts. Ms. Al Jallad stated Ms. Blais telephoned the hospital to inquire about Resident A approximately hourly. Ms. Al Jallad stated one staff member is scheduled to work at the facility, and there is typically a "floating"

staff member available to accompany residents in the community. Ms. Al Jallad stated while the facility policy is to have the “floating” staff member accompany a resident to the hospital, due to the extreme staffing crisis there was no “floating” staff member available to accompany Resident A to the hospital on July 25, 2021. Ms. Al Jallad stated with the number of staff members presently employed at the facility all shifts are covered, however if an employee does not report for his/her shift, there is no one available to replace that person. Ms. Al Jallad stated licensee designee Sami Al Jallad has increased pay and offered financial incentives for attendance and will continue to pursue hiring more staff members. Ms. Al Jallad stated in addition the facility management staff members are also trained and working as direct care staff members at the facility.

On August 2, 2021, I spoke to program manager Camie Blais who said per his written assessment plan Resident A requires staff supervision in the community due to lack of safety skills and an unsteady gait. Ms. Blais said on July 25, 2021, Resident A was transported to the hospital via ambulance for difficulty ambulating due to hip and back pain. Ms. Blais said she telephoned someone at the hospital before Resident A arrived to explain that due to a staffing shortage, no staff member was available to accompany Resident A to the hospital on July 25, 2021. Ms. Blais said the hospital staff member was “upset” that Resident A would not be accompanied by a staff member, but there was no staff member available, so she telephoned hospital staff hourly to stay in communication about Resident A. Ms. Blais said one staff member was scheduled to work at the facility but historically there was a “floating” staff member assigned to work his/her shift at multiple facilities that could accompany Resident A to the hospital. Ms. Blais said due to the staffing crisis there is no longer a “floating” staff member available. Ms. Blais said, “staffing is bare minimum” at the facility.

On August 2, 2021, I spoke to Christa Campbell who is Resident A’s assigned case manager. Ms. Campbell said per his written assessment plan Resident A requires staff supervision in the community because he has been diagnosed with dementia and his baseline functioning is “confused.” Ms. Campbell said Resident A also has medical concerns that may require staff intervention in the community. Ms. Campbell said on July 25, 2021, Resident A was taken via ambulance to the emergency room because he was experiencing hip and back pain and was having trouble ambulating. Ms. Campbell said Resident A was admitted to the hospital on July 26, 2021 and discharged on July 29, 2021. Ms. Campbell said despite Resident A’s written assessment plan and facility policy that require a staff member accompany Resident A into the community, no staff member was present to supervise Resident A while he was hospitalized due to the current staffing crisis.

On September 10, 2021, I completed an exit conference with administrator Destiny Al Jallad due to licensee designee Sami Al Jallad being unavailable. Ms. Al Jallad did not agree with the findings of this report. Ms. Al Jallad stated the word “community” on the written *Assessment Plan for AFC Residents* does not or should not include the hospital. Ms. Al Jallad stated Resident A was not unattended in a

store, restaurant nor friend's home but rather in the hospital being cared for and Ms. Blais telephoned the hospital regularly to monitor Resident A. Ms. Al Jallad added that the licensee continues to make great efforts to hire new staff members and incentivize current staff members, but the turnover rate remains 40 %.

APPLICABLE RULE	
R 400.14206	Staffing requirements.
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on a written email message from Ms. Al Jallad as well as statements from Ms. Al Jallad, Ms. Campbell, and Ms. Blais it can be determined that Resident A was sent into the community without a staff member because no staff member was available to accompany Resident A when he went to the hospital on July 25, 2021. Based on statements from those interviewed and written documentation at the facility it can be determined that Resident A requires staff supervision in the community per his written assessment plan due to being "confused," which is his baseline level of functioning. Thus, there was not sufficient staff on duty for the supervision of Resident A from July 25, 2021, when Resident A arrived at the hospital via ambulance until July 29, 2021 when Resident A was released from the hospital, as according to his written assessment plan Resident A requires staff supervision when he is in the community.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

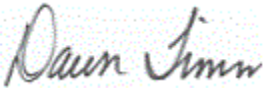


09/14/2021

Leslie Herrguth
Licensing Consultant

Date

Approved By:



09/14/2021

Dawn N. Timm
Area Manager

Date