GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 18, 2022

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

RE: License #: AS330087736
Investigation #: 2022A0783022
Poplar Cottage

Dear Ms. Saucedo-Al Jallad:

Attached is the amended 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 #:	AS330087736
Investigation #:	2022A0783022
Complaint Receipt Date:	01/20/2022
Investigation Initiation Date:	01/20/2022
Report Due Date:	03/21/2022
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:	Destiny Saucedo-Al Jallad
Name of Facility:	Poplar 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:	01/29/2021
Expiration Date:	01/28/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED TRAUMATICALLY BRAIN INJURED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly discharged due to an open LARA investigation involving Resident A.	Yes
Licensee designee and administrator Destiny Al Jallad told Resident A's guardian and Macomb County CMH that Resident A could not return to the facility because a LARA licensing consultant told them the license would be revoked which was misleading and affected Resident A's placement.	Yes

III. METHODOLOGY

01/20/2022	Special Investigation Intake – 2022A0783022
01/20/2022	Special Investigation Initiated – Telephone call with Complainant
01/20/2022	Contact - Telephone call made to Guardian A1
01/20/2022	Contact - Document Received – Review of facility electronic record for written discharge notice for Resident A
01/20/2022	Contact - Document Received – Forwarded email message from Ms. Al Jallad to MCCMH and Guardian A1
01/22/2022	Contact - Telephone call made to facility licensee designee and administrator Destiny Al Jallad
03/09/2022	Inspection Completed On-site
03/09/2022	Contact - Face to Face interview with Destiny Al Jallad
03/09/2022	Exit Conference with Destiny Al Jallad

ALLEGATION:

- **Resident A was improperly discharged due to an open LARA investigation involving Resident A.**
- **Licensee designee and administrator Destiny Al Jallad told Resident A's guardian and Macomb County CMH that Resident A could not return to the facility because a LARA licensing consultant told them the license**

would be revoked if he returned which was misleading and affected Resident A's placement.

INVESTIGATION:

On January 20, 2022, I received a complaint via telephone that stated Resident A was discharged from the facility via a written emergency discharge notice and not accepted back to the facility when there was not another placement available to meet Resident A's needs, as he was in jail after eloping from the facility on November 21, 2022. Complainant said licensee designee Destiny Al Jallad emailed her on January 5, 2022 and informed her that Resident A could not return to the facility despite the fact he was being released from jail and did not have another placement. Complainant said Ms. Al Jallad told her that Resident A could not return to the facility because LARA had an open special investigation involving Resident A's elopement on November 21, 2021, and that a rule violation would be cited in the special investigation report; therefore she "could not take the chance" of allowing Resident A to return to the facility. Complainant said Resident A was released from jail on January 13, 2022, and she had not been able to locate him as of the date of the interview.

On January 20, 2022, I spoke to Guardian A1 who confirmed the allegations alleged by Complainant.

On January 20, 2022, I reviewed the facility file and located a written email message dated November 23, 2021 concerning an emergency 24-hour discharge for Resident A. The written discharge notice stated, "At this time, I need to give an emergency discharge notice to [Resident A] in Poplar Cottage. He cannot return to Turning Leaf; we do not have the staff to keep him safe after his elopements from Poplar/jumping the fence. We had knowledge prior to admission that elopement was in his history but his documentation read "wandering" and "leaving from group homes" which is different from actively jumping fences within our secured setting. Also in the 5 months he was at Pontiac General awaiting placement, there was no indication that he would attempt to leave Turning leaf once admitted. I am extremely concerned about our ability to keep him safe from harm if he is returned to Poplar Cottage. Due to staffing shortages we cannot staff him 1:1 at this time. The best we can do is 15 minute checks and it is clear from multiple elopement attempts that he can elope within 15 minutes, so I feel that would be an ineffective strategy that would further put him at risk. I'm very sorry for this as I do not ever intend to admit someone we cannot serve and secondly discharge improperly; however we really do not have the means to keep him safe at this time. He is currently in Macomb County jail and should remain there until another placement can be found."

On January 22, 2022 I spoke to facility licensee designee and administrator Destiny Al Jallad who stated she never would have admitted Resident A to the facility if she

had any reason to believe that he would try to get over the fence and successfully elope from the facility, thus she issued a 24-hour emergency discharge notice to Resident A's placing agency and Guardian, and LARA on November 23, 2022. Ms. Al Jallad said he was discharged from the facility for the elopement behavior and because the facility was cited for not providing supervision to Resident A according to his written assessment plan when he eloped from the secured setting.

On March 9, 2022 I spoke to facility licensee designee and administrator Destiny Al Jallad who said Resident A was emergently discharged from the facility because there were not available staff members to provide Resident A with 1:1 supervision to prevent him from eloping from the facility. Ms. Al Jallad said prior to admitting Resident A to the facility she thoroughly assessed him and was led to believe he did not have eloping behavior, but only "wandering" behavior. Ms. Al Jallad said Resident A attempted to elope on November 17, 2021, and at that time she informed Macomb County Community Mental Health (MCCMH) and Guardian A1 that if Resident A attempted to elope from the facility again a 24-hour emergency discharge notice would be issued. Ms. Al Jallad said after Resident A eloped on November 21, 2022, she issued a written 24 – hour emergency discharge notice to Resident A which was copied to Guardian A1, MCCMH, and LARA. Ms. Al Jallad said the emergency discharge notice was issued due to Resident A's continuous elopements which meant he required 1:1 staff supervision which she did not have the staff to provide. Ms. Al Jallad said at the time of Resident A's emergency discharge he was in jail, "where he should have remained until another placement was found."

Regarding the second part of this allegation, on January 20, 2021 I spoke to Guardian A1 who said Ms. Al Jallad explicitly told her that there had been an open special investigation at the facility regarding Resident A and that the assigned licensing consultant advised that if Ms. Al Jallad accepted Resident A back to the facility the "license would be in jeopardy." Guardian A1 provided a written e-mail message from Destiny Al Jallad dated January 5, 2022 that stated, "I'm very sorry but when [Resident A] eloped /jumped the fence, a Special Investigation was opened with LARA which is not yet closed but will be substantiated against Turning Leaf. We were advised at that time by our LARA consultant to discharge him immediately and not accept him back into any licensed program or it would be considered a repeat offense and possibly jeopardize our licenses in Lansing. I cannot take that chance and I do apologize for the issue that has caused to [Resident A] and Macomb!"

On January 20, 2022 I spoke to facility licensee designee and administrator Destiny Al Jallad who acknowledged that she wrote this email statement and said, "licensing would revoke the license if I took [Resident A] back." Ms. Al Jallad stated and clarified that licensing consultant Leslie Herrguth, who investigated Resident A's elopement, did not tell her to refuse to accept Resident A back to the facility upon his elopement when there was not another available placement to meet his needs.

On March 9, 2022 I spoke to Ms. Al Jallad who said MCCMH did not offer any assistance with meeting Resident A's needs and continuously asked her to take him back after the emergency discharge notice was issued so she told them "that there was an open investigation and LARA said [Resident A] needed to be discharged." Ms. Al Jallad acknowledged that the licensing consultant did not actually make that recommendation.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**

ANALYSIS:	Based on statements from Complainant which were verified by Guardian A1 and documented in writing, Ms. Al Jallad issued a 24 – hour emergency discharge notice to Guardian A1 and MCCMH which was in part issued due to an open special investigation at the facility concerning Resident A. Further, according to the written documentation provided and statements made by those interviewed I determined that Ms. Al Jallad refused to let Resident A return to the facility upon release from jail when he did not have an appropriate setting to meet his immediate needs. Ms. Al Jallad's written and verbal statements to Guardian A1 also affected Resident A's return to the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Leslie Herrguth

03/18/2022

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Leslie Herrguth Date
Licensing Consultant

Approved By:

Dawn Timm

03/17/2022

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Dawn N. Timm Date
Area Manager