GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 28, 2025

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

RE: License #: AL390392502
Investigation #: 2025A0578036
Birch Cottage I

Dear Destiny Saucedo-Al Jallad and Zeta Francosky:

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) 335-5985.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390392502
Investigation #:	2025A0578036
Complaint Receipt Date:	06/05/2025
Investigation Initiation Date:	06/06/2025
Report Due Date:	08/04/2025
Licensee Name:	Turning Leaf Res Rehab Svcs., Inc.
Licensee Address:	621 E. Jolly Rd. Lansing, MI 48909
Licensee Telephone #:	(517) 393-5203
Administrator:	Maura Salemka
Licensee Designee:	Destiny Saucedo-Al Jallad, Zeta Francosky
Name of Facility:	Birch Cottage I
Facility Address:	13326 N. Boulevard St. Vicksburg, MI 49097
Facility Telephone #:	(269) 585-8761
Original Issuance Date:	02/25/2020
License **Status:**	REGULAR
Effective Date:	08/25/2024
Expiration Date:	08/24/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A is oxygen dependent and attended a medical appointment without portable oxygen.	Yes

III. METHODOLOGY

06/05/2025	Special Investigation Intake 2025A0578036
06/05/2025	APS Referral
06/06/2025	Special Investigation Initiated - On Site
06/06/2025	Unannounced Special Investigation Completed On-site -Interview with licensee designee Zeta Francosky. Interview with Resident A.
06/06/2025	Contact-Documentation Reviewed -*Medication Administration Records* for Resident A, June 2025.
06/06/2025	Contact-Documentation Reviewed -*Visit Notes Report* for Resident A, dated 05/15/2025.
06/06/2025	Exit Conference -Completed with licensee designee Zeta Francosky.

ALLEGATION:

Resident A is oxygen dependent and attended a medical appointment without portable oxygen.

INVESTIGATION:

On 06/05/2025, I received this complaint through LARA-BCHS-Complaints@michigan.gov. Complainant reported Resident A is diagnosed with chronic obstructive pulmonary disease, congestive heart failure, bipolar disorder, depression, anxiety and chronic pain. Complainant alleged on 06/03/2025, Resident A was sent to an appointment without her prescribed oxygen. Complainant reported Resident A's oxygen saturation had dropped to 89% when attending this appointment. Complainant added that Resident A's oxygen concentration increased to 90% after Resident A was rested and using room air. Complainant reported

Resident A only has an oxygen concentrator and does not have a portable oxygen tank. Complainant reported the staff accompanying Resident A reported Resident A does not have travel oxygen available for her at this facility. Complainant reported Resident A's portable oxygen tank has been ordered but has not yet been delivered to this facility.

On 06/06/2025, I completed an unannounced special investigation on-site and interviewed licensee designee Zeta Francosky regarding the allegations. Zeta Francosky acknowledged that Resident A is oxygen dependent and uses oxygen while in the community. Zeta Francosky reported Resident A has a hand cart to transport her oxygen tanks in the community but recently obtained an order for a smaller portable oxygen tank that could be carried in a bag. Zeta Francosky denied having any issues with having oxygen delivered by Airway Oxygen and reported that Resident A always has oxygen tanks present in the facility. Zeta Francosky clarified that Resident A may refuse oxygen on occasion at night but added that Resident A recently obtained a concentrator mask to wear over her nose at night. Zeta Francosky denied that Resident A has never had her oxygen provided for any reason.

While at the facility, I interviewed Resident A regarding the allegations. Resident A acknowledged using oxygen daily as prescribed to her. Resident A acknowledged being provided with an oxygen tank on wheels that she takes when going into the community. Resident A clarified that she could use this oxygen tank on wheels independently and described it as not being heavy. Resident A clarified that a smaller, portable oxygen tank that could be attached to her walker has been ordered for her. Resident A reported being on oxygen for over a month. Resident A acknowledged not having her oxygen available on 06/03/2025, when she was transported to a medical appointment. Resident A reported she was without her oxygen for about thirty minutes and as a result, felt, "quite faint." Resident A reported that when she returned to the facility, she immediately used the oxygen concentrator located in her bedroom. Resident A denied ever not being provided with her oxygen before or since this incident. Resident A suspected the direct care staff that was with her may not have been trained on how to change Resident A's air tank.

On 06/06/2025, I reviewed the *Medication Administration Records* for Resident A for the month of June 2025. The *Medication Administration Records* for Resident A documented that Resident A is prescribed continuous oxygen at 3 liters, with an oxygen goal at or above 89%. I noted the *Medication Administration Records* for Resident A documented that Resident A was provided with continuous oxygen from 7AM to 3PM and 3PM to11PM on 06/03/2024 with two entries by direct care staff encompassing both shifts. I noted this prescribed continuous oxygen at 3 liters was ordered on 03/31/2025.

On 06/06/2025, I reviewed the *Visit Notes Report* completed by Sophia Alvarez, RN for Resident A at Resident A's Hospice appointment. The *Visit Notes Report* for Resident A documented that on 05/15/2025, Resident A arrived at this appointment

with an empty oxygen tank. The *Visit Notes Report* for Resident A documented that Resident A's oxygen saturation was 80% and after sitting a few moments only on room air, Resident A's oxygen saturation went to 84%. The *Visit Notes Report* documented that once Resident A was supplied with oxygen, her oxygen saturation increased to 94% with 4 liters of oxygen.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A and licensee designee Zeta Francosky, as well as a review of pertinent documentation relevant to this investigation, Resident A was not provided with her prescribed oxygen while out in the community on at least two occasions. In an interview, Resident A disclosed not having her oxygen available during an appointment in the community on 06/03/2025, as corroborated by Complainant. During an unannounced investigation on-site, documentation identified as a *Visit Notes Report* documented that Resident A was without her prescribed oxygen at a separate appointment on 05/15/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

07/28/2025

Eli DeLeon Date
Licensing Consultant

Approved By:

07/28/2025

Dawn N. Timm Date
Area Manager