GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 12, 2025

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

RE: License #: AS330087739
Investigation #: 2025A0007031
Spruce Cottage

Dear Destiny Saucedo-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) 284-9720.

Sincerely,

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS330087739
Investigation #:	2025A0007031
Complaint Receipt Date:	06/17/2025
Investigation Initiation Date:	06/18/2025
Report Due Date:	08/16/2025
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:	Spruce 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:	03/20/2025
Expiration Date:	03/19/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff at Turning Leaf are neglecting Resident A's basic care and medication needs, relying on ER visits for hygiene and treatment, despite multiple court orders, raising concerns about safety and inadequate support.	Yes

III. METHODOLOGY

06/17/2025	Special Investigation Intake - 2025A0007031
06/18/2025	Special Investigation Initiated – Letter APS Referral made
06/18/2025	APS Referral made.
06/26/2025	Inspection Completed On-site - Unannounced - Face to face contact with Destiny Al Jallad, Licensee Designee, Kiley Ostrowski, RN, Amber Ely-Costa, Program Manager, Michael Lagarde, DCW, and Resident A.
07/11/2025	Contact - Document Received - Copies of the Order of Non-Compliance dated 5/23/2025 and 7/10/2025.
08/04/2025	Contact - Document Sent - Email to and from RN #1.
08/06/2025	Contact - Telephone call made - Interview with RN #1.
08/06/2025	Contact - Document Sent - Email to Police Social Worker #1. Information requested.
08/07/2025	Contact - Document Received - Email from Police Social Worker #1. Information received.
08/08/2025	Contact - Document Sent - Email to and from Guardian A1.
08/08/2025	Contact - Telephone call made - Interview with Guardian A1.
08/08/2025	Contact - Telephone call made - Interview with Guardian A1.
08/08/2025	Contact - Document Sent - Email to Licensee Designee regarding the exit conference.
08/08/2025	Exit Conference conducted with Destiny Saucedo-Al Jallad, Licensee Designee.

ALLEGATION: Staff at Turning Leaf are neglecting Resident A's basic care and medication needs, relying on ER visits for hygiene and treatment, despite multiple court orders, raising concerns about safety and inadequate support.

INVESTIGATION:

As a part of this investigation, I reviewed the written complaint and the following additional information, in relevant part, was noted:

> Staff at Turning Leaf are not assisting Resident A with his ADL's. It appears he has not bathed or changed clothes in the past month and is only given new scrubs when taken to the emergency room. The facility staff are not providing Resident A with his oral and injectable medications. Resident A is on a Mental Health Court Order, and they have Filed 3 Orders of Non-Compliance (April 2025, May 2025, June 2025) in order to have Resident A taken to [Hospital ER #1] to be given his injection and sent back to the facility. The facility is relying on [Hospital ER #1] to provide Resident A's monthly injection and to clean up Resident A each month. It appears that Resident A does not leave the couch in the living room of the cottage, as when police are contacted to take him into protective custody, for the Order of Noncompliance, Resident A has been observed on the couch each time. It appears staff do not want to engage with him and just leave him on the couch.

A subsequent complaint was also received, and the following information was noted:

> Resident A has presented to [Hospital ER #1] on numerous occasions recently (2/19/2025, 4/25/2025, 5/23/2025, 6/13/2025), covered in filth - wearing the same behavioral health scrubs and socks that he was discharged in the month prior. Resident A comes in extremely disheveled; hair matted with food, clothes covered in old food and bodily fluids, socks worn completely through in the heels. Every visit, he gets a new pair of scrubs and socks, gets cleaned up and showered only to return in the same condition the next month, to get his monthly Haldol Deaconate injection. Resident A has been sent into the [Hospital ER #1] consistently for his injection because they don't feel safe administering his court ordered medication at the facility.

On June 26, 2025, I conducted an unannounced on-site investigation and made face to face contact with Destiny Saucedo-Al Jallad, Licensee Designee. We discussed the allegations. She informed me that Resident A is prescribed morning and evening medications and that he has been refusing all oral medications for almost a year. Destiny Saucedo-Al Jallad stated hey have a protocol to prompt Resident A three times, within the allotted time frames, before disposing of the medications. For the most part, Resident A is non-verbal, but he can indicate when he is not interested, such as turning his back to staff. Staff document medication refusals. Resident A is also prescribed Haldol Decanoate 100 mg/ml intramuscular solution, (Inject 3.5 ml intramuscularly every three weeks). Destiny Saucedo-Al Jallad provided a copy of the medication logs and prescription for review. According to Destiny Saucedo-Al

Jallad, Resident A has been refusing the injections. In the past, Resident A would receive the injection at the facility and then he would get to pick out a Band-Aid or something else. They have a nurse on duty, who will attempt to administer the injection once or twice, and any refusals are documented. When Resident A refuses the injection at the facility, they have a process in place, in which case management can pull a court order for Non-Compliance; and arrangements are made, so that Resident A can be transported to the hospital (Hospital ER #1) for the injection. They send the red folder to the hospital, which includes a face sheet, list of medications, the court order, guardianship paperwork and any other pertinent information. Destiny Saucedo-Al Jallad informed me that Resident A has a team of professionals managing his case and they have had discussions about placement and if this is the appropriate setting for him. She informed me that he could be unpredictable but questioned the benefits of him being in a state hospital. She stated that his most recent refusal for an injection was on June 12, 2025. In addition, there was an issue this time with Resident A going to Hospital ER #1, despite them taking the court order and providing a copy of the prescription. The hospital staff were saying that Resident A was supposed to receive his injection every four weeks; however, according to the prescription, it's to be administered every three weeks. Hospital staff reported to the facility staff that the injection wasn't due until June 20, 2025, and facility staff originally thought they sent him early, but later discovered that they were correct. Resident A was then kept in the hospital until June 20, 2025, the injection was administered and then he returned to the facility. The month prior, Resident A received his injection on May 23, 2025. Destiny Saucedo-Al Jallad recalled that when Resident A went to the hospital in April, he fought with the police. Destiny Saucedo-Al Jallad informed me that they don't prefer to send Resident A to the hospital for the injections. Destiny Saucedo-Al Jallad also expressed concern, as she reported that there appeared to be a disconnect with hospital staff, and hoped to open the lines of communication should Resident A need intervention in the future. She stated that the hospital staff can give the injection medication against Resident A's will, where the AFC facility staff cannot. She informed me that APS also investigated the allegations, but she could not recall the individual's name. Destiny Saucedo-Al Jallad provided multiple copies of incident reports, documenting Resident A's medication refusals.

I interviewed Kiley Ostrowski, who is nurse at the facility. She stated that Resident A has the right to refuse the medications, and he often becomes agitated. Regarding the oral medications, Resident A is prompted three times before they are disposed of, and an incident report is written. Resident A is prescribed to receive his Haldol injection every three weeks, and there have been months when he would accept the injection in the facility. In June 2025, staff tried earlier in the day to administer the medication; however, he refused and became aggressive. Staff left for a few hours and returned to re-offer and Resident A was still having behaviors. Regarding Resident A's general appearance, Kiley Ostrowski informed me that he was unkempt, his long hair disheveled, food in his beard, and maybe a slight odor. According to Kiley Ostrowski, Resident A refused assistance with ADLs, and this information is documented on the medication logs. According to Kiley Ostrowski,

after checking the records, the last time Resident A received the injection in the facility was May 10, 2024.

I interviewed Amber Ely-Costa, who has the role of Program Manager. We discussed the investigation and the allegations. She also informed me that APS had been out to the facility. Amber Ely- Costa informed me that the injection is sent from the pharmacy, and the nurse, Kiley Ostrowski will attempt to administer the injection. If Resident A refuses, the non-compliance paperwork is filed, and the court order is provided to the police. The police complete the pickup order, they send out an officer, and Resident A is then taken to the hospital for the injection. Facility staff noted that Resident A was to receive the injection on June 13, 2025, as the prescription was written to be administered every three weeks. Once Resident A arrived at Hospital ER #1, the nurse stated that it was too early for the injection to be administered, and the plan was to keep him until June 20, 2025; as that was the next injection date they had on file. After Resident A was kept and then administered the injection, he returned to the facility. According to Amber Ely-Costa, they tried to explain that the hospital didn't have to keep Resident A until June 20, 2025. Regarding ADLs, Amber Ely-Costa informed me that Resident A does not need physical assistance; they prompt him, but he doesn't follow through. They also document on the medication log when Resident A is prompted to bathe.

After the interviews, Amber Ely- Costa and I walked over to the facility. Staff encouraged me to stand a certain distance away from Resident A. I observed Resident A sitting on the living room couch. He was wearing burgundy scrubs and green socks from the hospital. There was food observed on the front of his scrubs. He was having a snack, and the snack was also observed in his beard. His hair and beard were somewhat disheveled. I attempted to speak to Resident A, but he only looked at me and did not reply. Michael Lagarde, DCW and I checked Resident A's bedroom, and shoes and clean clothing were observed.

On August 6, 2025, I interviewed the Behavioral Health Manager (RN #1) from Hospital ER #1. She recalled that in February of 2025, Resident A was brought in on a LPD (Legal documentation for inpatient services) to receive his Haldol injection. When Resident A arrived, he appeared to be extremely disheveled; his hair was matted with old food, mold was observed in his beard, and his clothes were covered in old food and bodily fluids. Resident A was cleaned up, administered the medication, and he also required restraints during that time. Resident A was admitted and remained in the hospital during the month of March 2025. Resident A was then discharged and returned to the facility. In April, another order of non-compliance was filed and Resident A returned to the hospital. Resident A was observed to be wearing the same scrubs he was wearing when he was previously discharged (exact date unknown). Again, Resident A appeared extremely disheveled, his hair was matted with old food, and his clothes were covered in old food and bodily fluids. Resident A was observed to be in the same condition when he arrived in May and June 2025. According to RN #1, there was only one visit, in which Resident A accepted a bed bath with wipes and did not require restraint. She

also recalled that in April of 2025, Resident A assaulted five caregivers and a security guard, while at the hospital.

We discussed the protocol and processes for when Resident A was brought to the hospital for an injection. According to RN #1, they just developed a process, and she informed me that she would now receive notification that Resident A would be arriving at the hospital. RN #1 stated that change and progress had been slow, but that Resident A has been doing better in these situations. RN #1 stated that in July (on or about 7/31/25), the social worker from LPD went to the facility and asked Resident A if he would take the injection, which he did, and he was not required to go to the hospital. Resident A was also observed to be wearing regular clothes (not scrubs).

As a part of this investigation, I reviewed medication logs and prescriptions for Resident A, the signed petition for Mental Health Treatment (Order expires 9/6/2025), *Assessment Plan for AFC Residents*, and multiple incident reports. Staff documented when Resident A refuses his oral medications and Haldol injections. Specifically, on May 23, 2025, Amber Ely- Costa documented an incident report that Resident A refused his Haldol injection on May 22, 2025. The Non-Compliance order was taken to LPD for a pickup order on May 23, 2025. Resident A was transported to Hospital ER #1, where he received the injection and returned to the facility on May 24, 2025.

On May 27, 2025, Ashley Walker documented that Resident A refused to shower, and he expressed verbal agitation. Corrective measures included encouraging healthy hygiene habits. On May 28, 2025, staff documented they prompted Resident A several times to evacuate the facility for a fire drill; however, he refused. Resident A also refused to participate in the severe weather drill that was conducted at the facility.

Another incident report was completed documenting that on June 12, 2025, at 1:50 p.m. the RN and case manager entered the facility and observed Resident A resting comfortably on the couch. The case manager offered an incentive to obtain the scheduled injection from the RN, in the facility. Resident A “shouted F *** off” and “get the f*** away from me.” The case manager explained to Resident A that if he were agreeable to take the medication, incentives would be provided. Resident A continued to refuse and ended up leaving the area of the facility. It was documented that another attempt would be made that day, and case management would start the Non-Compliance Order. At 2:50 p.m., Kiley Ostrowski returned to the facility, observed Resident A resting on the couch. She offered for Resident A to obtain his scheduled injection in the home. She also informed him that if he refused the injection in the facility, he might be picked up by the local police department to receive his injection at the hospital. Resident A shouted, “get the f*** away from me,” and walked towards his bedroom. Due to irritable behavior, no additional attempts were made.

On June 13, 2025, staff documented that Resident A was taken to the hospital because he refused injections the day before. It was also documented that per ER Nurse, hospital staff are to give the injection on June 20, 2025, and then return Resident A to the facility. Administration discussed the information with the team and Resident A was sent on the correct injection administration schedule.

I reviewed the AFC Assessment Plan for Resident A, and the following was noted:

> At the time of the assessment (dated March 27, 2025), Resident A is diagnosed with Paranoid Schizophrenia, and his symptoms include paranoia, mutism, isolation, and aggression. It was noted that Resident A can eat independently, and staff will encourage him to eat each meal. Resident A will throw food that he does not like.Resident A is independent with all toileting regimens, but he has had urinary incontinence while lying on the couch. Resident A has a history of being independent with all bathing needs, but at the time of the assessment, he did not choose to engage in bathing. It was also noted that staff would utilize gentle teaching techniques to provide daily reminders for Resident A to shower. Regarding medications, it was documented that Resident A is non-medication compliant, regularly refusing all mediations. Per doctors' orders, all medications, with the exception of the injections were discontinued on 2/08/2024. Resident A stopped taking his injections and was hospitalized on 4/10/2024 for elopement and assaultive behavior. He returned to the facility on 4/17/2024 and eloped again. On 2/19/2025, Resident A was petitioned again due to not being on any medications or injections, as there were also concerns for his well-being. Resident A was discharged from the hospital on 3/12/2025 and prescribed medications. Since being discharged from the hospital, Resident A has refused all dispensed medications.

On July 11, 2025, it was noted that another petition for non-compliance had been filed.

On August 6, 2025, I contacted Police Social Worker #1 to inquire about Resident A's condition when local police interacted with him on or about July 11, 2025.

On August 7, 2025, Police Social Worker #1 informed me that they were at the facility on July 11, 2025, and when they arrived, he was lying on the couch. Resident A was observed to be wearing rust colored hospital scrubs, which appeared to be soiled with food stains and other possible unknown substances. Resident A had a pungent odor, his hair and beard were greasy, there was food entangled in his beard, and it appeared that he had not bathed.

On August 8, 2025, I interviewed Guardian A1. We discussed the allegations and the investigation. She informed me that when observing Resident A during a visit (specific date unknown), his hair did not appear to be matted; however, she did not know if it had been washed. Resident A appeared to be clean, and no odor was observed. Resident A did not acknowledge her presence. Resident A has a history

of refusing showers but sometimes will accept bed baths. Regarding medications, Guardian A1 stated that Resident A has a history of refusing medications. Guardian A1 informed that while they're not notified about all medication refusals or when non-compliance orders are filed, her office was notified about the medication refusals, and court ordered non-compliance in May and June 2025. Guardian A1 recalled that in April of 2024, one of her staff went to visit Resident A in the facility. The staff person introduced herself, Resident A jumped up off the couch, grabbed her by the neck and started choking and punching her. One of the direct care staff ran out of the facility and the other attempted to verbally redirect Resident A. The other residents assisted with getting her staff free from Resident A. Her staff had to contact the police regarding the incident. The staff member remains off work due to the injuries she sustained during the incident. We discussed that Resident A can refuse medications (excluding court order medications); but the licensee is still responsible to provide the care Resident A requires, including assistance with ADLs. I informed Guardian A1 that licensing does not make recommendations for placement; however, it is the licensee's responsibility to assess the resident and determine if the needs of the resident can be met in the facility. The licensee can either meet with Resident A's case management team and modify the plan and meet the needs of the resident or they may determine that they cannot meet the needs of Resident A and issue a discharge notice.

On August 8, 2025, I spoke with Destiny Saucedo-Al Jallad, Licensee Designee. She informed me that in April of 2024, to be in compliance with HCBS rules, Resident A's behavioral treatment plan included that he could go for walks in the community, and they were following the plan. Resident A darted out from campus, and he has no safety skills. The facility is located on a busy street. This was very concerning for the licensee. Resident A's Guardian came to visit, and he attacked her. Destiny Saucedo-Al Jallad confirmed that Resident A resided in the facility after he returned from the hospital on or about April 17, 2024.

Destiny Saucedo-Al Jallad informed me that in July 2025 there was more coordination with Resident A receiving his injection, and he went on July 11, 2025, received the injection and returned to the facility the same day. Regarding what Resident A was wearing when he went for the injection on July 11, 2025, Destiny Saucedo-Al Jallad informed me that it was possible that he may have been wearing the scrubs, as that was a pattern of his behavior, but she really did not know. Destiny Saucedo-Al Jallad also informed me that after the July 11, 2025, injection was received, Resident A became med complainant and has been taking all oral medications since that time. According to Destiny Saucedo-Al Jallad, on July 31, 2025, Kiley Ostrowski, RN, administered Resident A's injection in the facility. Since then, Resident A has also taken a shower, his monthly vitals were taken, and he has changed his clothes.

I also conducted the exit conference, and we discussed the investigation and my recommendations. Destiny Saucedo-Al Jallad was not in agreement with the findings and stated that she had been in constant contact with his external team regarding

his condition and doing everything she could to address the situation, as she was not passive in dealing with these matters. She stated that she understood that if Resident A could get his medications, then he would have been more willing to follow through with ADLs. Destiny Saucedo-Al Jallad informed me that she has diligently worked with the external treatment team, and she was willing to provide documentation of the multiple meetings. She reported that there was nothing more they could have done. It was also noted that while there have been some recent improvements, at the time when the allegations were made, Resident A was observed to be unkempt, and his needs were not being met. After our discussion, I informed her that I would be sending a copy of the signed report, which would be requesting a written corrective action plan, and it was up to her on how to proceed.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**

ANALYSIS:	Resident A has a documented history of refusing to take his prescribed medications. While Resident A has the right to refuse prescribed medications, the court has determined and ordered in situations of non-compliance that the injectable medication, Haldol Decanoate 100 mg/ml intramuscular solution, be administered. Resident A has a documented history of refusing assistance with showers and on multiple occasions, he has been observed to be extremely disheveled, food in his beard, hair matted, and wearing the same scrubs from a previous hospital visit. In addition, staff documented a refusal to participate in emergency evacuation drills. The licensee has the responsibility to assess and ensure that the needs of the resident can be met in the facility. Based upon my investigation, which consisted of an on-site investigation, interviews with multiple facility and hospital staff, local professionals, and review of pertinent documents, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A was retained in the facility, and during the time frames reviewed, beginning in February of 2025, the amount of personal care and protection that Resident A required was not provided, as the facility often relied on Hospital ER #1 to assist with Resident A's needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of a very detailed written corrective action plan, it's recommended that the status of license remains unchanged.

08/08/2025

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Mahtina Rubritius Date
Licensing Consultant

Approved By:

08/12/2025

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Dawn N. Timm Date
Area Manager