



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

April 28, 2026

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

RE: License #: AM030420220  
Investigation #: 2026A0464028  
Woodlea Cottage

Dear Mrs. 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 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 (616) 356-0100.

Sincerely,  
Megan Leavitt, LMSW  
Megan Leavitt, Licensing Consultant  
Bureau of Community and Health Systems  
Unit 13, 7th Floor  
350 Ottawa, N.W.  
Grand Rapids, MI 49503  
(616) 438-3036

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AM030420220
<b>Investigation #:</b>	2026A0464028
<b>Complaint Receipt Date:</b>	02/25/2026
<b>Investigation Initiation Date:</b>	02/25/2026
<b>Report Due Date:</b>	04/26/2026
<b>Licensee Name:</b>	Turning Leaf Res Rehab Svcs., Inc.
<b>Licensee Address:</b>	621 E. Jolly Rd. Lansing, MI 48909
<b>Licensee Telephone #:</b>	(517) 393-5203
<b>Administrator:</b>	Destiny Saucedo-Al Jallad
<b>Licensee Designee:</b>	Destiny Saucedo-Al Jallad
<b>Name of Facility:</b>	Woodlea Cottage
<b>Facility Address:</b>	1565 Woodlea Dr Otsego, MI 49078
<b>Facility Telephone #:</b>	(269) 692-2536
<b>Original Issuance Date:</b>	02/18/2026
<b>License Status:</b>	TEMPORARY
<b>Effective Date:</b>	02/18/2026
<b>Expiration Date:</b>	08/17/2026
<b>Capacity:</b>	8
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL



**II. ALLEGATION(S)**

	<b>Violation Established?</b>
On 02/22/2026, staff failed to follow Resident A seizure protocol and administer her emergency seizure medication.	Yes
On 02/22/2026, Resident A was found in soiled bedding.	No

**III. METHODOLOGY**

02/25/2026	Special Investigation Intake 2026A0464028
02/25/2026	APS Referral Referral Came from APS
02/25/2026	Special Investigation Initiated - Telephone Kathleen Woodworth
03/25/2026	Inspection Completed On-site Melissa Bigalow (Staff), Amanda Vlietstra (Staff), & Resident A
03/25/2026	Contact - Document Received Facility Records
04/28/2026	Exit Conference Destiny Saucedo-Al Jallad, Licensee Designee

**ALLEGATION:** On 02/22/2026, staff failed to follow Resident A seizure protocol and administer her emergency seizure medication.

**INVESTIGATION:** On 02/25/2026, I received a complaint from Adult Protective Services (APS), which stated Resident A is diagnosed with cerebral palsy, grand mal seizures, epilepsy and paralysis. On 02/22/2026, Resident A suffered from a four-minute seizure. There is concern staff did not follow Resident A’s seizure protocol. Resident A was also left in soiled linens.

On 02/25/2026, I spoke to Allegan County APS worker, Kathleen Woodworth, to coordinate the investigation. Mrs. Woodworth reported she went out and made face-to-face contact with Resident A; however, she is nonverbal; therefore, she was unable to be interviewed. Mrs. Woodworth reported Petyon Kahn was the staff working when Resident A had the seizure. Mr. Kahn failed to administer Resident A’s nasal spray while Resident A was having the seizure.

On 03/25/2026, I completed an unannounced, onsite inspection at the facility. I interviewed staff, Melissa Bigalow and Amanda Vlietstra. Both staff denied they

were working the day Resident A experienced the seizure. Both reported Resident A is nonverbal and has been diagnosed with epilepsy. Ms. Bigalow and Ms. Vlietstra reported Resident A is supposed to be administered her seizure medication, Lamotrigine 225 mg, every twelve hours. Staff are given a one-hour window for the medication to be administered. Both staff reported that staff have all been trained on Resident A's seizure plan if Resident A experiences a seizure. Ms. Bigalow stated Resident A's guardian and physician were contacted when the seizure occurred. Ms. Bigalow then provided copies of Resident A's facility records.

I then made face-to-face contact with Resident A. She was clean and appropriately dressed. Resident A was unable to be interviewed as she is nonverbal. No concerns were observed.

On 03/25/2026, I received and reviewed a copy of Resident A's seizure action plan. The plan reflected Resident A experiences grand mal seizures that can last one to seven minutes. The plan reflected a description of what Resident A experiences when having a seizure, such as tongue clicking, facial tics and excessive drooling. If Resident A experiences a seizure, staff are to perform basic seizure first aid and issue seizure nasal spray, Nayzilam 5mg to stop the seizure. Staff are allowed to administer the medication up to two times. If the seizure does not stop staff are to contact 911.

On 03/25/2026, I received and reviewed a copy of Resident A's Medication Administration Record (MAR). The MAR reflects Resident A is prescribed Lamotrigine 225 mg twice per day for epilepsy. The MAR reflected Resident A was administered the Lamotrigine 225 mg as prescribed. The MAR also reflected Resident A is prescribed Nayzilam 5mg spray as a PRN medication. The MAR reflects Resident A was not administered Nayzilam the day of the seizure.

On 04/28/2026, I completed an exit conference with licensee designee, Destiny Saucedo-Al Jallad. She was informed of the investigation findings and recommendations. Mrs. Saucedo-Al Jallad stated she understood the reasoning for the citation and would complete a corrective action plan.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.</b>
<b>ANALYSIS:</b>	On 02/25/2026, a complaint was received alleging Resident A experienced a seizure on 02/22/2026 and staff failed to administer Resident A's emergency seizure medication.

	<p>Neither staff Melissa Vliestra or Amanda Bigalow were working the day Resident A had the seizure. Both staff reported Resident A is prescribed daily, preventative seizure medication as well as a rescue seizure medication.</p> <p>Resident A's seizure protocol reflected Resident A is to be administered Nayzilam 5mg spray if she has a seizure. Resident A's Medication Administration Record indicated Resident A was not administered Nayzilam 5mg spray on 02/22/2026.</p> <p>Based on the investigative findings, there is sufficient evidence to support a rule violation that staff did not administer Resident A the Nayzilam 5mg.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: On 02/22/2026, Resident A was found in soiled bedding.**

**INVESTIGATION:** On 02/25/2026, I spoke to Mrs. Woodworth. She reported she visited Resident A. She did not have any concerns regarding Resident A being left in soaked briefs or linens.

On 03/25/2026, I completed an unannounced, onsite inspection at the facility. Face-to-face contact was made with Resident A. The interview was not completed as Resident A is nonverbal. Resident A appeared to be clean and appropriately dressed. There was no evidence of her being left in soiled briefs or clothes. I also toured Resident A's bedroom. Resident A's bedding appeared to be clean and well maintained.

I then spoke to Ms. Bigalow and Ms. Vlietstra. Both staff reported Resident A is routinely changed as well as her bedding. They denied witnessing a time when Resident A was left in soiled briefs or linens.

On 03/25/2026, I received and reviewed a copy of Resident A's Medication Administration Record (MAR). The MAR reflects Resident A's brief must be changed every morning, as well as throughout the day. The MAR includes staff initials, indicating this has been occurring.

On 04/28/2026, I completed an exit conference with licensee designee, Destiny Saucedo-Al Jallad. She was informed of the investigation findings and recommendations.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>

	<b>(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.</b>
<b>ANALYSIS:</b>	<p>On 02/22/2026, a complaint was received alleging Resident A is left in soiled briefs and linens.</p> <p>On 03/25/2026, an unannounced, onsite inspection was completed at the facility. Resident A was observed to be clean and appropriately dressed. Her bed linens were also observed to be clean.</p> <p>Facility staff, Melissa Bigalow and Amanda Vlietstra reported Resident A's brief and linens are routinely changed.</p> <p>Resident A's Medication Administration Record (MAR) indicated staff change Resident A's brief in the morning and throughout the day.</p> <p>Based on the investigative findings, there is insufficient evidence to support a rule violation that staff leave Resident A in soiled briefs and linens.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**IV. RECOMMENDATION**

I recommend that the licensing status remain unchanged.

Megan Leavitt, LMSW

04/28/2026

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Megan Leavitt  
Licensing Consultant

Date

Approved By:

04/28/2026

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Jerry Hendrick  
Area Manager

Date