GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 12, 2022

Janet Turner
Turner Powers AFC Home, Inc.
310 West Pearl Street
Jackson, MI 49201

RE: License #: AL380007072
Investigation #: 2022A0007017
Turner Powers AFC Home

Dear Ms. Turner:

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:

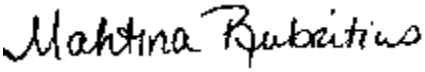
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 (313) 456-0380.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(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 #:** | AL380007072 |
| **Investigation #:** | 2022A0007017 |
| | |
| **Complaint Receipt Date:** | 03/28/2022 |
| | |
| **Investigation Initiation Date:** | 03/29/2022 |
| | |
| **Report Due Date:** | 05/27/2022 |
| | |
| **Licensee Name:** | Turner Powers AFC Home, Inc. |
| | |
| **Licensee Address:** | 310 West Pearl Street<br>Jackson, MI 49201 |
| | |
| **Licensee Telephone #:** | (517) 782-9123 |
| | |
| **Administrator:** | Janet Turner |
| | |
| **Licensee Designee:** | Janet Turner |
| | |
| **Name of Facility:** | Turner Powers AFC Home |
| | |
| **Facility Address:** | 310 West Pearl Street<br>Jackson, MI 49201 |
| **Facility Telephone #:** | (517) 782-9123 |
| | |
| **Original Issuance Date:** | 03/30/1990 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 12/18/2021 |
| | |
| **Expiration Date:** | 12/17/2023 |
| | |
| **Capacity:** | 19 |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| On March 24, 2022, Grant Turner, Staff, was outside and began harassing Resident A (about being outside) unless she was smoking. Resident A sat in a chair, and he told her to "fuck off." Grant Turner started screaming and getting in her face. Resident A kicked Grant Turner in the knee. It was reported that Grant Turner was raging and screaming outside, leaving the residents inside unattended. | Yes |
| There is concern that the residents are fearful of Grant Turner. | Yes |

## III. METHODOLOGY

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|---|---|
| 03/28/2022 | Special Investigation Intake - 2022A0007017 |
| 03/28/2022 | Contact - Telephone call received from Community Member #1. Interview. |
| 03/29/2022 | Special Investigation Initiated - On Site - Unannounced- Face to face contact with Ms. Turner, Licensee Designee, Resident A, Resident B, Resident D, Resident E, and Employee #1. |
| 03/29/2022 | Contact - Telephone call made to Ms. Turner. Case discussion. |
| 04/05/2022 | Contact - Telephone call made to Ms. Turner. Case discussion. |
| 04/07/2022 | Contact - Document Sent - Email to APS Worker #1. |
| 04/07/2022 | Contact - Document Received - From APS Worker #1. |
| 04/14/2022 | Inspection Completed On-site - Unannounced- Face to face contact with Mr. Turner and Ms. Turner. |
| 04/20/2022 | Contact - Telephone call received from Mr. Turner. |
| 04/21/2022 | Contact - Telephone call made to Mr. Turner. We discussed the information that was needed from the therapist. |
| 05/04/2022 | Contact - Telephone call made to APS Worker #1. |
| 05/09/2022 | Exit Conference conducted with Ms. Turner, Licensee Designee. |

**ALLEGATIONS:**

**On March 24, 2022, Grant Turner, Staff, was outside and began harassing Resident A (about being outside) unless she was smoking. Resident A sat in a chair, and he told her to "fuck off." Grant Turner started screaming and getting in her face. Resident A kicked Grant Turner in the knee. It was reported that Grant Turner was raging and screaming outside, leaving the residents inside unattended.**

**INVESTIGATION:**

On March 28, 2022, I interviewed Individual #1. Resident A informed them that on the day in question, she was sitting outside of the facility. Resident A had run out of cigarettes. Mr. Turner said she (Resident A) didn't need to be outside. Mr. Turner was screaming at Resident A and told her to "fuck off." Resident A was sitting in the chair, and she kicked Mr. Turner in the knee. Mr. Turner yells and screams in the home. There is a concern that the residents are afraid of Mr. Turner. Mr. Turner is angry and not following through with interventions to address his anger issues.

On March 29, 2022, I conducted an unannounced on-site investigation and made face to face contact with Ms. Turner, Licensee Designee. She reported that things were going pretty good, and that Resident A would be moving to Facility A on April 1st, 2022. Resident A has resided in this home since 1985.

I then interviewed Resident A. Regarding the incident; Resident A informed me that she was just sitting outside in the back getting some fresh air. Resident A stated, "He [Mr. Turner] started yelling and screaming, calling me names." Resident A informed me that he [Mr. Turner] acted like he was going to attack her. Resident A went on to say that she kicked him (Mr. Turner) in the knees to get him away from her.

Mr. Turner said to Resident A "'Did you say fuck you to me?'" Resident A stated, "'I said yeah, because you said it to me.'"

Resident A stated, "He called me a bitch yesterday." Resident A stated, "He gets fired up; he gets mad if we talk to him the way he talks to us."

I then asked for clarification and Resident A stated that he (Mr. Turner) said "fuck you" to her first and she said it back to him. Resident A also demonstrated how Mr. Turner covered one hand with the other and then stuck up his middle finger.

Resident A also recalled that Mr. Turner was outside on the phone, yelling and screaming at his mother (Ms. Turner), and that everyone heard him yelling.

While at the home, I interviewed Resident B. Resident B informed me that he has resided at the home for 31-years. Resident B informed me that Mr. Turner yells every morning.

I interviewed Resident D. She did not confirm that she heard Mr. Turner on the phone yelling at Ms. Turner.

After conducting the interviews, I went back and spoke to Ms. Turner. I inquired about Mr. Turner yelling on the phone and she informed me that it was a mother and son disagreement. Ms. Turner did not recall what the disagreement was regarding. I inquired about him cursing on the phone and Ms. Turner stated that he did not always use bad language, and he wasn't talking directly to the residents. Regarding Resident A, Ms. Turner stated that Mr. Turner does not like to see her smoking (used) cigarette butts. Ms. Turner stated that Resident A was given a 30-day discharge notice. Ms. Turner stated that she has not heard Mr. Turner cursing at the residents; however, she has heard him raise his voice.

I informed Ms. Turner again, that Mr. Turners' behavior was unacceptable and that she needed to develop a plan to adequately address the problem. Ms. Turner informed me that he was probably going to quit. Ms. Turner also stated that she would probably close her home. Ms. Turner stated, "I'll fix it." I informed her that I would follow-up with her later that day. Mr. Turner was not at the facility at the time of the on-site investigation.

I interviewed Employee #1 and she was told that Mr. Turner was screaming and cursing at Ms. Turner, during a phone conversation. Regarding Resident A, she was sitting outside, and Mr. Turner started yelling that she (Resident A) had no smokes, so she had no reason to be outside. Mr. Turner was flipping Resident A off. Mr. Turner got into Resident A's face. Resident A was sitting in the chair, and she thought he was going to hit her; so Resident A kicked him. Employee #1 informed me that they walk on eggshells around Mr. Turner.

On March 29, 2022, I followed up with Ms. Turner and she informed me that Mr. Turner had taken the afternoon off, and he had not returned to the facility yet. She stated that she was not going to have him at the facility alone. He will work with Ms. Turner during day, and she will stay at the facility in the evening. According to Ms. Turner, Mr. Turner would not be working unsupervised. I questioned how long Ms. Turner would be able to maintain this plan and she informed that she may hire someone else. She also informed me that the business is up for sale. I informed her that whatever she decided, she was responsible for anything that occurred. Ms. Turner reported to understand.

On April 5, 2022, I contacted Ms. Turner for an update. She stated that things were going okay, and more smoothly now that Resident A was no longer in the home. Ms. Turner informed me that Mr. Turner continues to work supervised. In addition, that he (Mr. Turner) was sorry for what had occurred and that he was going to get help.

On April 14, 2022, I conducted an unannounced on-site investigation and made face to face contact with Mr. Turner and Ms. Turner.

I interviewed Mr. Turner. Mr. Turner stated, “I lost my grace.” Mr. Turner stated “I yelled at her for bugging [Resident F] for a cigarette. According to Mr. Turner, Resident A was following Resident F around “like a shadow.” Mr. Turner recalled that Resident A had been cursing at him and his mother (Ms. Turner) earlier that day.

Mr. Turner stated that he walked outside, and Resident A was following Resident F and when she saw him, she sat down in the chair. According to Mr. Turner, Resident F won’t tell her to get away from him. Mr. Turner stated, “I take full responsibility.” Mr. Turner stated, “I asked why she needed to be out there bugging [Resident F].” Then Resident A started cursing at him. He denied cursing at her or flipping her off. Mr. Turner stated, “I asked how long until you get out of here?” Mr. Turner also stated, “I was kind of close to her.” Resident A was sitting in a chair on the back porch. She then kicked him a couple of times. Mr. Turner stated that he was “embarrassed” that licensing had to come back to the facility for another investigation. Mr. Turner stated that he’s continuing with therapy. His last appointment was on Monday (4/11/2022). He is also taking his medications. I inquired what was addressed in therapy and he stated that they discussed this incident and other stressor(s) in his life. I requested that he contact the therapist and have them provide an overview of the treatment provided, specific lessons addressed to deal with anger issues, and interventions.

On April 21, 2022, I spoke with Mr. Turner again, as he was inquiring as to what was needed from the therapist. I reiterated the information needed. Mr. Turner stated that the therapy sessions were helpful and that they were working through the issues with the insurance coverage.

On May 4, 2022, I spoke with APS Worker #1. He informed me that he investigated this incident, and the allegations were substantiated. He will provide a copy of the report for the file.

| **APPLICABLE RULE** | |
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| **R 400.15308** | **Resident behavior interventions prohibitions.** |
| | **(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:**<br>**(a) Use any form of punishment.**<br>**(b) Use any form of physical force other than physical restraint as defined in these rules.**<br>**(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia,** |

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|---|---|
| | **contraptions, material, or equipment for the purpose of immobilizing a resident.**<br>**(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**<br>**(e) Withhold food, water, clothing, rest, or toilet use.**<br>**(f) Subject a resident to any of the following:**<br>**(i) Mental or emotional cruelty.**<br>**(ii) Verbal abuse.**<br>**(iii) Derogatory remarks about the resident or members of his or her family.**<br>**(iv) Threats.**<br>**(g) Refuse the resident entrance to the home.**<br>**(h) Isolation of a resident as defined in R400.15102(1)(m).**<br>**(i) Any electrical shock device.** |
| **ANALYSIS:** | According to Resident A, Mr. Turner was yelling, screaming, and cursing at her. Resident A reported that she thought he was going to attack her; therefore, she kicked him.<br><br>Mr. Turner stated, “I lost my grace.” He admitted to being embarrassed that licensing was there to investigate another complaint. He admitted to yelling at Resident A and being kind of close.<br><br>Based on the information gathered during this investigation and provided above, it’s concluded that there is a preponderance of the evidence to support the allegations that Mr. Turner yelled at Resident A.<br><br>**This is a REPEAT VIOLATION** – Please See SIR # 2021A0007016 |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATIONS:**

**There is concern that the residents are fearful of Grant Turner.**

**INVESTIGATION:**

During the interview with Individual #1, they stated that there was a concern that the residents were afraid of Mr. Turner. In addition, that Mr. Turner is angry and not following through with interventions to address his anger issues.

During the interview on March 29, 2022, Resident A stated, “He [Mr. Turner] started yelling and screaming, calling me names.” Resident A informed me that he [Mr. Turner] acted like he was going to attack her. Resident A also recalled that Mr. Turner was outside on the phone, yelling and screaming at his mother (Ms. Turner), and that everyone heard him yelling.

During the interview with Resident B, Resident B informed me that Mr. Turner yells every morning. Mr. Turner yells about being tired of the job, he sometimes curses, and says that he’s going to quit. Resident B also informed me that Mr. Turner sometimes calls Resident A and Resident C, names such as “stupid.” Resident B stated that Mr. Turner calls Resident A “a whore.” Resident B informed me that Mr. Turner puts his fist in his hand and smacks it, like he’s going to hit them. I inquired if Mr. Turner has ever hit him and stated he had not. Resident B reported that he was not afraid of Mr. Turner. Resident B informed me that he feels safe in the home.

I interviewed Resident D. She did not confirm that she heard Mr. Turner on the phone yelling at Ms. Turner. Regarding cursing, she stated that residents use the “F-word,” but not staff. Resident D reported that she is not afraid of Mr. Turner.

I interviewed Resident E. He stated that he is treated “alright” by staff, and he gets along with Mr. Turner. He did not confirm that Mr. Turner has called residents names or cursed at them. He stated that he was not afraid of Mr. Turner, and he did not know if any of the other residents were afraid of him.

According to Employee #1, they walk on eggshells when Mr. Turner is around.

During the interview, Mr. Turner stated that he was “embarrassed” that licensing had to come back to the facility to another investigation. Mr. Turner admitted to yelling at Resident A and he was “kind of close to her [Resident A].” He denied cursing at Resident A or flipping her off. Mr. Turner stated that he’s continuing with therapy, and he is taking his medications. In the last therapy session, they discussed this incident and other stressor(s) in his life.

On May 9, 2022, I conducted the exit conference with Ms. Turner, Licensee Designee. I informed her of my findings and recommendations. Ms. Turner stated that Mr. Turner was not working unsupervised but that it was a lot to be at the facility

for such long periods of time. I concurred and expressed my concerns with this plan as well. I explained to her that the safety plan was that he would not work unsupervised, and possibly being more supportive with duties offsite such as book-keeping, grocery shopping and errands. In addition, that if she had a different plan, she just needed to inform me of the plan. We also discussed staffing options.
Ms. Turner stated that Resident F was moved from the facility, and they were told that it was because the facility was for sale. Ms. Turner was wondering what was going on. I explained to her that placement changes were up to the responsible agency and guardians, not licensing. Ms. Turner inquired if she could continue to accept placements, while on a provisional license. I later informed her that she could accept placements, during the provisional license.

During the interview, Ms. Turner stated that they're doing what they're supposed to do and following the rules. I informed Ms. Turner that once she received the signed report, she could let licensing know how she would like to proceed.

| **APPLICABLE RULE** | |
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| **R 400.15305** | **Resident protection.** |
| | **(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.** |

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|---|---|
| **ANALYSIS:** | Resident A informed that Mr. Turner yelled and screamed at her and called her names. Resident A informed me that Mr. Turner acted like he was going to attack her.<br><br>According to Resident B, Mr. Turner yells every morning and that he calls the residents names. In addition, that he puts his fist in his hand and smacks it, like he's going to hit them.<br><br>According to Employee #1, they walk on eggshells when Mr. Turner is around.<br><br>Mr. Turner admitted to yelling at Resident A and he was "kind of close to her [Resident A]." He denied cursing at Resident A or flipping her off. Mr. Turner stated that he's continuing with therapy, and he is taking his medications.<br><br>Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that the residents are not treated with dignity and their personal needs including protection and safety were not attended to at all times, in accordance with the provisions of the act. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of a detailed acceptable written corrective action plan, it's recommended that a six-month provisional license be issued.

Mahtina Rubritius 05/11/2022

Mahtina Rubritius Date
Licensing Consultant

Approved By:

A. Hunter 05/12/2022

Ardra Hunter Date
Area Manager