GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 11, 2020

Melody Relerford
Turn Key Adult Care Inc.
1780 Brookside Drive
Flint, MI 48503

RE: License #: AS250389103
Investigation #: 2020A0576046
Turn Key Adult Care

Dear Ms. Relerford:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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. 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 (810) 787-7031.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250389103
Investigation #:	2020A0576046
Complaint Receipt Date:	09/09/2020
Investigation Initiation Date:	09/11/2020
Report Due Date:	11/08/2020
Licensee Name:	Turn Key Adult Care Inc.
Licensee Address:	1780 Brookside Drive Flint, MI 48503
Licensee Telephone #:	(810) 237-0671
Administrator:	Joslyn Austin
Licensee Designee:	Melody Relerford
Name of Facility:	Turn Key Adult Care
Facility Address:	1780 Brookside Drive Flint, MI 48503
Facility Telephone #:	(810) 237-0671
Original Issuance Date:	10/23/2017
License Status:	REGULAR
Effective Date:	04/23/2020
Expiration Date:	04/22/2022
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has repeatedly been observed to be in a urine-soaked bed and his underwear was on the floor.	Yes
Resident A has not received his medication properly.	Yes
He has gone without lunch and breakfast. Staff report that he has refused but it is unknown if that is true.	No
Additional Findings	Yes

III. METHODOLOGY

09/09/2020	Special Investigation Intake 2020A0576046
09/09/2020	APS Referral Referral received from Adult Protective Services (APS)
09/11/2020	Special Investigation Initiated - Letter Sent Email to Tiffany Williams, Genesee County APS
09/11/2020	Contact - Telephone call made Spoke to Tiffany Williams
11/05/2020	Inspection Completed On-site Interviewed Staff, Sonya Mason and Mary Davis, Resident C and Resident D
11/05/2020	Contact - Telephone call made Left message for POA to return call
11/06/2020	Contact - Telephone call received Spoke to POA
11/06/2020	Contact - Telephone call made Left message for Relative A1 to return call
11/06/2020	Contact - Telephone call made Spoke to Erica Anquetil-Myers, Nurse
11/09/2020	Contact - Document Received Email received from Tiffany Williams

11/09/2020	Contact - Telephone call received Message received from Relative A1
11/09/2020	Contact - Face to Face Spoke to Administrator, Joslyn Austin
11/20/2020	Exit Conference Exit conference conducted with Administrator, Joslyn Austin
12/10/2020	Contact - Telephone call made Spoke to Relative A1

ALLEGATION:

Resident A has repeatedly been observed to be in a urine-soaked bed and his underwear was on the floor.

INVESTIGATION:

On September 9, 2020, I received this intake from Adult Protective Services (APS). On September 11, 2020, I sent Tiffany Williams, Genesee County APS Investigator an email regarding updates she can provide. On September 11, 2020, I spoke to Ms. Williams who reported she has spoken to Resident A's nurse and she had concerns regarding the care he was receiving. The nurse reported she discovered Resident A in a urine-soaked bed and underwear on 2 occasions. The home calls the nurse often and there are concerns they cannot handle the behaviors the resident presents. Ms. Williams advised Resident A is receiving hospice care. On November 9, 2020, Ms. Williams advised she will likely substantiate her investigation for abuse/neglect involving Resident A.

On November 5, 2020, I completed an unannounced on-site inspection at Turn Key AFC and spoke to Staff, Sonya Mason and Mary Davis, Resident C and Resident D. Ms. Mason reported Resident A no longer lives at the home and moved out at the end of September 2020. Resident A now lives with his daughter who is caring for him. The allegations were discussed with Ms. Mason and she reported Resident A would pull his brief to the side. Ms. Mason denied Resident A was left in bed that was soaked in urine.

On November 5, 2020, I spoke to Resident C who reported he has lived at the home for 6 months and he knows Resident A. Resident C reported Resident A "had dementia" and would take off his briefs. Resident C did not know if Resident A's bed was wet with urine and Resident A's bedroom smelled like urine. Resident C reported Resident A urinated "everywhere" and staff would clean it up. Staff would clean Resident A and

wash his sheets. Resident C stated Resident A did not walk too well and staff did what they could to keep him clean.

On November 5, 2020, I spoke to Resident D who reported she has lived at the facility since July 2020 and “it can be okay”. Resident D confirmed she was familiar with Resident A and staff tried to keep him clean. Resident D stated Resident A would sometimes sit in his chair without anything on. Resident A would take off his brief and “he gave the nurses a terrible time”.

On November 5, 2020, I spoke to Staff, Mary Davis who reported she has worked at the home for 2 months. Ms. Davis denied Resident A was left in a urine-soaked bed. Ms. Davis reported Resident A required briefs and he always had his brief on.

On November 5, 2020, I left a message for Resident A’s Power of Attorney, POA to return call. On November 6, 2020, I spoke to the POA who reported Resident A lived at Turn Key AFC for less than 2 months and is living with her at this time. POA stated Resident A went to the hospital on or about October 8, 2020 and spent a week in the hospital. After Resident A was discharged from the hospital, he went to POA’s home. According to POA, Resident A went to the hospital due to a fall and dehydration. Resident A is doing “a little better” and is not walking. POA and Resident A’s sister, Relative A1 visited with Resident A often while he lived at Turn Key Adult AFC. POA never found Resident A to be in a urine-soaked bed however Relative A1 reported to POA that she found Resident A in a urine-soaked bed. POA stated she was at the facility almost every day and would help dress and feed Resident A. POA stated she did not find Resident A to be wet from urine nor was his bed wet from urine. POA stated she will not have Resident A return to Turn Key as she did not feel the facility took care of Resident A to her satisfaction.

On November 6, 2020, I spoke to Erica Anquetil-Myers, All America Home Care and Hospice Nurse. Ms. Myers reported Resident A was her patient while he lived at Turn Key AFC Home. Ms. Myers reported Resident A is currently living with his daughter. The allegations were discussed with Ms. Myers and she reported she found Resident A in a urine-soaked bed when she went to see him at the AFC home. Ms. Myers stated she would clean Resident A’s hospital bed mattress with Lysol wipes. Ms. Myers stated there was a strong smell of urine in Resident A’s bedroom when she visited with Resident A at the facility. Resident A was difficult for staff to take care of and Resident A became confused. Staff would say Resident A would refuse their help and he did not refuse Ms. Myers help. Ms. Myers went to see Resident A 2-3 times per week and as needed and the home should have called her more. Ms. Myers stated when she went to the home Resident A had a brief on and it was wet from urine. Ms. Myers stated she believed some staff worked better with Resident A than others. Ms. Myers stated she was concerned with how the home was caring for Resident A and did not think staff were working with Resident A as diligently as they could. Ms. Myers stated the facility should have had more staff available for times when Resident A became combative. According to Ms. Myers, Resident A’s family was not happy with the care Resident A was receiving at the home. After Resident A went to the hospital, the family decided to

take Resident A to a family home rather than have him return to Turn Key AFC. Ms. Myers stated Turn Key AFC was not equipped to care for Resident A and he is doing better with his family.

On November 6, 2020, I left a message for Resident A's relative, Relative A1 to return my call. On November 9, 2020, Relative A1 left a message returning my call. On December 10, 2020, I spoke to Relative A1 who reported Resident A was abused by Turn Key Staff. Relative A1 stated she went to visit Resident A and staff tried to stop her from entering the facility. Relative A1 walked past the staff and Resident A's bedroom door was closed. Upon entering the bedroom, Resident A was found wearing only a t-shirt. Resident A was in his bed, which was soiled with urine and feces and there were dirty briefs on the floor of the bedroom. Staff said they would clean Resident A and Relative A1 left the facility for a short time. Relative A1 returned to the facility and another staff was on duty. According to Relative A1, Resident A was in the same condition as earlier and she showered Resident A. Relative A1 and the staff person changed his mattress with a new one.

APPLICABLE RULE	
R 400.14305	**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.
ANALYSIS:	It was alleged that Resident A was found in a urine-soaked bed and without a brief on. Resident A's nurse, Erica Anquetil-Myers reported visiting with Resident A at Turn Key AFC home and he would be in a urine-soaked brief and bed. Ms. Myers also reported Resident A's bedroom would smell of urine. Relative A1 reported to finding Resident A with only a shirt on laying in his bed with urine and feces and dirty briefs on the floor. Resident A was not treated with dignity and his personal needs were not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A has not received his medication properly.

INVESTIGATION:

On November 5, 2020, I completed an unannounced on-site inspection at Turn Key AFC and spoke to Resident C and Resident D. Both residents indicate they received

their medications as prescribed. I requested to review Resident A's medication administration sheets (MARS) however staff was unable to locate the MARS.

On November 6, 2020, I spoke to Erica Anquetil-Myers, All America Home Care and Hospice Nurse. Ms. Myers reported Resident A was not getting his medications as prescribed. Ms. Myers stated some of Resident A's prescribed medications were not in the home, so he was not receiving them. Ms. Myers stated staff said they were administering Resident A his medications and the medication would still be in the packs. Ms. Myers stated the facility's organization with respect to medication administration was lacking and very confusing.

On November 6, 2020, I spoke to the POA who reported the facility was not giving Resident A his medications a prescribed. POA advised there were times she would be at the home visiting with Resident A at approximately 10:30am-11am and she would ask staff about Resident A's 8am medications. POA stated Resident A had not received his 8am medications and she would give them to him while she was there. The staff would say "the other staff" on the previous shift did not administer Resident A his 8am medications so POA did.

On December 10, 2020, I spoke to Relative A1 who reported she worked in the health care field and reviewed Resident A's medication record while she visited Resident A at the facility. Relative A1 reported Resident A was not receiving his medications as prescribed. Relative A1 said staff were not signing the medication log to indicate medications were being administered to Resident A.

APPLICABLE RULE	
R 400.14312	**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 {333.1101 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:	It was alleged that Resident A was not receiving his medications properly. Resident A's nurse, Erica Anquetil-Myers stated she reviewed Resident A's medications and discovered some of his prescribed medications were not in the home to be administered. Ms. Myers reported staff said they were administering Resident A his medications however the medication would still be in its container.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A has gone without lunch and breakfast. Staff report that he has refused but it is unknown if that is true.

INVESTIGATION:

On November 5, 2020, I completed an unannounced on-site inspection at Turn Key AFC and spoke to Resident C and Resident D. Both residents indicate they received breakfast, lunch, and dinner. Resident C reported there is plenty to eat at the facility. Resident D stated they get snacks, fruits, and vegetables. Resident D stated there is not enough desserts. I viewed the home to have adequate food in the refrigerator, freezer, and pantry.

On November 6, 2020, I spoke to Erica Anquetil-Myers, All America Home Care and Hospice Nurse. Ms. Myers reported she believed Resident A lost weight during the time he lived at Turn Key AFC. Staff would report Resident A refused to eat and some staff were able to work with Resident A better. Ms. Myers stated Resident A may have needed to be fed and his daughters could get him to eat as they would feed him. Ms. Myers stated there was food and meals for the residents however no prompts or additional help to get Resident A to eat and this could have been because he was a difficult resident. Ms. Myers stated Resident A was verbal and could complete a sentence. Resident A did not report that he was not being provided meals.

On November 6, 2020, I spoke to the POA who reported she would often take Resident A food to eat, especially breakfast. POA stated staff made lunch however she often brought food for Resident A. Resident A never complained to her that he was not being provided meals.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form,

	consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	It was alleged that Resident A has gone without breakfast and lunch and staff indicate he refused meals. Other residents of the home indicate there is adequate food and meals being provided. Residents reported being provided a minimum of 3 regular and nutritious meals daily. Resident A's POA advised she often fed Resident A during her visits with Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On November 9, 2020, I spoke to Turn Key AFC Administrator, Joslyn Austin at Turn Key AFC and requested to view Resident A's assessment plan. Ms. Austin could not provide me with Resident A's assessment plan.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	On November 9, 2020, I spoke to Turn Key AFC Administrator, Joslyn Austin and requested to view Resident A's assessment plan. Ms. Austin could not provide me with Resident A's assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On November 9, 2020, I spoke to Turn Key AFC Administrator, Joslyn Austin at Turn Key AFC and requested to view Resident A's health care appraisal. Ms. Austin could not provide me with Resident A's health care appraisal.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designate representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	On November 9, 2020, I spoke to Turn Key AFC Administrator, Joslyn Austin and requested to view Resident A's health care appraisal. Ms. Austin could not provide me with Resident A's health care appraisal.
CONCLUSION:	**VIOLATION ESTABLISHED**

On November 9, 2020, I spoke to Turn Key AFC Administrator, Joslyn Austin at Turn Key AFC and requested to view Resident A's weight record. Ms. Austin could not provide me with Resident A's weight record.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	On November 9, 2020, I spoke to Turn Key AFC Administrator, Joslyn Austin and requested to view Resident A's weight record. Ms. Austin could not provide me with Resident A's weight record.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On November 5, 2020, I viewed Resident D's medications and requested to view her medication administration sheets (MARS). There were no MARS or medication log for Resident D. Staff were stapling the plastic envelopes that the medications were packaged in to a piece of white paper as verification she was receiving her medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	On November 5, 2020, I viewed Resident D's medications and requested to view her medication log. There was no medication log for Resident D.
CONCLUSION:	**VIOLATION ESTABLISHED**

On November 20, 2020, I completed an Exit Conference with Administrator, Joslyn Austin. I advised Ms. Austin I would be citing rule violations with respect to this investigation and requesting a corrective action plan to address cited violations. I advised Ms. Austin I would be recommending a provisional license.

IV. RECOMMENDATION

SIR #2021A0576001 dated November 20, 2020, for this facility recommended a provisional license. Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional.

12/10/2020

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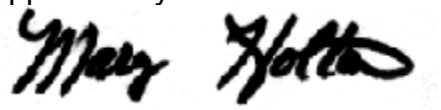
Christina Garza Date
Licensing Consultant

Approved By:



12/11/2020

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Mary E Holton Date
Area Manager