GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 20, 2020

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

RE: License #: AS250389103
Investigation #: 2021A0576001
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 #:	2021A0576001
Complaint Receipt Date:	10/02/2020
Investigation Initiation Date:	10/06/2020
Report Due Date:	12/01/2020
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?
• Staff would not answer the phone or door when Resident B was ready for hospital discharge. EMS had to return Resident B to the hospital due to no staff response after discharge. • Residents were kicked out of the home without proper discharge and sent to the hospital.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/02/2020	Special Investigation Intake 2021A0576001
10/02/2020	APS Referral Intake received from Adult Protective Services (APS)
10/02/2020	Special Investigation Initiated - Telephone Spoke to Tiffany Williams, Genesee County Adult Protective Services (APS)
10/02/2020	Contact - Telephone call made Spoke to Paula Walko, Hurley Hospital Social Worker
10/02/2020	Contact - Telephone call made Spoke to Administrator, Melody Relerford
10/02/2020	Contact - Telephone call made Spoke to Anthony Willis, Turn Key Inc., Board Member
11/05/2020	Inspection Completed On-site Spoke to Staff, Sonya Mason and Mary Davis, and Resident C and Resident D
11/06/2020	Contact - Telephone call made Spoke to Relative D
11/06/2020	Contact - Telephone call made Left message for previous Administrator, Melody Relerford
11/06/2020	Contact - Telephone call made Spoke to Administrator, Joslyn Austin

11/06/2020	Exit Conference Exit Conference conducted with Administrator, Joslyn Austin
11/09/2020	Contact - Face to Face Spoke with Administrator, Joslyn Austin
11/16/2020	Contact - Telephone call made Spoke to Staff, Sonya Mason
11/16/2020	Contact - Telephone call made Spoke to Melody Relerford
11/19/2020	Contact - Telephone call received Spoke to Staff, Cory Pierce
11/20/2020	Exit Conference Conducted with Joslyn Austin

ALLEGATION:

- Staff would not answer the phone or door when Resident B was ready for hospital discharge. EMS had to return Resident B to the hospital due to no staff response after discharge.
- Residents were kicked out of the home without proper discharge and sent to the hospital.

INVESTIGATION:

On October 2, 2020, received intake from Adult Protective Services (APS). On October 2, 2020, I spoke to Tiffany Williams, Genesee County APS who reported it appears Resident B was sent to the hospital without a medical reason. Ms. Williams stated Resident B had to stay the night at the hospital as the hospital personnel could not get in contact with staff at the facility to take care of Resident B. According to Ms. Williams, the administrator, Melody Relerford advised staff to “get rid” of the residents because the owner was not paying staff.

On October 2, 2020, I spoke to Paula Walko, Hurley Hospital Social Worker. Ms. Walko stated Resident B arrived at Hurley Hospital on October 1, 2020, and there was nothing medically wrong with him. Ms. Walko stated there was no staff at the facility to take care of Resident B, so he was sent to the hospital. Ms. Walko stated the doctor wanted to speak with staff regarding Resident B and hospital personnel could not reach anyone at the facility. Ms. Walko stated on October 1, 2020, Resident B was transported back to the facility via ambulance and no staff were at the facility to take care of him.

According to Ms. Walko, Resident B had to return to the hospital due to no staff being at the facility.

On October 2, 2020, I spoke to administrator, Melody Relerford who stated the facility was being closed due to staffing issues and the owner was not paying staff. Ms. Relerford stated Resident B had not eaten and that is why he went to the hospital. Ms. Relerford stated there were no staff at the facility on the evening of October 1, 2020 because staff would not work due to not being paid their wages. Ms. Relerford stated there will be staff at the facility today for residents to return.

On October 2, 2020, I spoke to Anthony Willis, Board Member for Turn Key, Inc. Mr. Willis stated the residents will return home today. Mr. Willis was asked why the residents were sent to the hospitals and he stated he believes the administrator, Melody Relerford "sent them out because she was mad".

On November 5, 2020, I completed an unannounced on-site inspection at Turn Key Adult Care and interviewed Staff, Sonya Mason and Mary Davis, Resident C, and Resident D regarding the allegations. Ms. Mason stated the previous administrator, Melody Relerford and the owner, Anthony Willis "got into it". According to Ms. Mason, Ms. Relerford told staff to "pack everyone up" and Resident B was sent to Hurley Hospital, Resident C was sent to the McLaren Hospital, and Resident D was sent to her daughter's home. Ms. Mason was told by Ms. Relerford that the facility was being closed because of the problem with Mr. Willis. Ms. Mason stated there was no medical reason for the residents to go to the hospitals and sending them to hospitals was "the best place to send them" given the problem between Ms. Relerford and Mr. Willis. According to Ms. Mason, residents were not provided any notice that they would need to the leave the facility. I requested to see resident documents and Ms. Mason advised she was a new employee and was not aware of where resident documents were kept.

On November 5, 2020, I interviewed Resident C regarding the allegations. Resident C stated there was a "difference of opinion" between the owner and administrator, Melody Relerford. The administrator said, "we are closing this place down" and Resident C said there was an issue with staff pay. Resident C stated there was no medical reason for him to go to the hospital and he was given a couple hours' notice that he would be going to the hospital. Resident C stated he was at the hospital for 2-3 days and there was no medical reason for him to be there. Resident C stated he likes his home however the facility is unable to keep staff.

On November 5, 2020, I interviewed Resident D regarding the allegations. Resident D stated the facility was closed for two days and during that time she went to her daughter's home. Resident D stated she was not given notice that she would need to leave the facility and go to her daughter's home.

On November 5, 2020, I interviewed staff, Mary Davis regarding the allegations. Ms. Davis stated the residents were sent to the hospital or to family. Ms. Davis stated the residents were gone for a few days and then came back to the facility. Ms. Davis stated she did not know much about this or why the residents had to leave the facility.

On November 6, 2020, I interviewed Resident D's relative, Relative D. Relative D stated she had to pick up Resident D from the facility last month. Relative D stated she had to take Resident D to her home due to staff walking off duty and there was an issue with staff pay. Relative D stated she was not given notice that she would have to move Resident D. Relative D stated Resident D stayed at Relative D's home for two days and then returned to the facility.

On November 6, 2020, I left a message for the previous administrator, Melody Relerford to return my call. I received an email from Melody Relerford on October 4, 2020, indicating she was terminated from employment on October 4, 2020. I was informed that the new administrator will also become the licensee designee (LD) once she completes the correct fingerprints.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(9) A licensee and the administrator shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.**
ANALYSIS:	Three residents of the facility left the home on or about October 1, 2020. Residents were made to leave the home due to staffing issues. Two residents were sent to the hospital and one resident was sent to a relative's home. The administrator/ licensee designee, Melody Relerford, sent the residents out of the home without providing proper discharge notice to the residents or their guardians/relatives due to a disagreement she had with the company. Ms. Relerford did not display proper concern for the residents by disrupting their lives in a hastily manner likely due to being upset. Ms. Relerford actions displayed that she is not suitable to meet the physical, emotional, social, and intellectual needs of each resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Three residents of the facility left the home on or about October 1, 2020. Residents were made to leave the home due to staffing issues. Two residents were sent to the hospital and one resident was sent to a relative's home. When Resident B was ready to be returned home from the hospital on October 1, 2020, there were no staff on duty to care for the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	Three residents of the facility were made to leave on or about October 1, 2020 due to staffing issues. Two residents were sent to the hospital and one resident was sent to a family members home. The residents nor relative were given proper notice that the residents would have to leave the facility. Residents were not provided with proper notice of discharge from the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On November 16, 2020, I interviewed Sonya Mason, Turn Key AFC Staff. Ms. Mason stated there have not been problems with staff pay. Ms. Mason stated staff are paid under minimum wage and are paid by the day. Ms. Mason is paid on the 15th and the 30th. There are three staff and an administrator that work at the facility.

On November 16, 2020, I interviewed Melody Relerford, previous Licensee Designee at Turn Key AFC. Ms. Relerford stated staff did not receive their pay on time and some staff did not get paid at all. In June 2020 and July 2020 staff including herself were being shorted their wages and she would pay staff out of her own pocket. On September 30, 2020, all staff were short on their wages and did not receive the correct amount they should have. Ms. Relerford did not receive her final paycheck and the reason why staff were being shorted was because the clientele in the facility were not able to pay top dollar amounts.

On November 19, 2020, I interviewed Cory Pierce, previous staff member at Turn Key AFC. Mr. Pierce stated he started working at the facility in May 2020. Mr. Pierce was paid bi-monthly on the 15th and 30th and there were times he had to wait up to 4 days to receive his paycheck. According to Mr. Pierce, there was always an excuse for why he was not paid on the 15th or 30th. Mr. Pierce stated he was paid $50.00 per day and no taxes were taken out. When Mr. Pierce started his employment at the facility, he was receiving paper checks for his pay and then received cash for his pay toward the end of his employment in September 2020. Mr. Pierce stated he has not received his final paycheck from the facility. Mr. Pierce advised that the problem he had with receiving his pay happened to other staff also.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(2) A licensee shall have the financial and administrative capability to operate a home to provide the level of care and program stipulated in the application.

ANALYSIS:	Two staff members, Melody Relerford and Cory Pierce indicate they were not paid their wages on time or at all. The result has caused high staff turnover and an inability to keep adequate staff to ensure for the welfare of the residents of the home. The licensee demonstrates not having the financial and administrative capability to operate the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On November 6, 2020, I spoke to the new administrator, Joslyn Austin. Ms. Austin stated she just started working at the facility in early October 2020 (I was notified of the change in administrator and she is qualified). Ms. Austin stated she was not aware of Incident Reports (IR's) being completed for Resident B and Resident C hospitalizations in October 2020. On November 9, 2020, I spoke to Ms. Austin at Turn Key Adult Care. Ms. Austin stated she has not found IR's relating to the hospitalizations of Resident B and Resident C.

On November 6, 2020, I conducted an exit conference with administrator, Joslyn Austin. I advised Ms. Austin I would be citing rule violations and requesting a corrective action plan regarding the cited rule violations. On November 9, I spoke to Ms. Austin and advised her I would be recommending a provisional license.

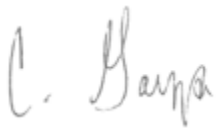
On November 20, 2020, I completed an exit conference with Ms. Austin to inform her of additional rule violations and recommendation of provisional license.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(ii) Hospitalization.**

ANALYSIS:	Resident B and Resident C were taken and admitted to the hospital on October 1, 2020, and a written report was not provided to the foster care licensing division regarding these hospitalizations.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional.



11/20/2020

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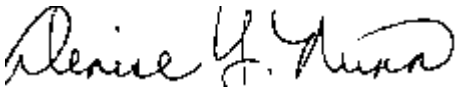
Christina Garza Date
Licensing Consultant

Approved By:



11/20/2020

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Denise Y. Nunn Date
Area Manager