

GRETCHEN WHITMER GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

September 13, 2022

Roman Avant W C Turner Living Centers Inc P.O. Box 2463 Detroit, MI 48202

RE: License #: AG820015456

W C Turner I 48 Chandler Detroit, MI 48202

Dear Mr. Avant:

Attached is the Licensing Study Report for the above referenced facility. The study has determined substantial compliance with applicable licensing statutes and rules. Your license and special certification are renewed. It is valid only at your present address and is nontransferable.

Please contact me with any questions. In the event that I am not available and you need to speak to someone immediately, you may contact the local office at (313) 456-0380.

Sincerely,

Edith Richardson, Licensing Consultant

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Bureau of Community and Health Systems

Cadillac Pl. Ste 9-100 3026 W. Grand Blvd Detroit, MI 48202 (313) 919-1934

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS BUREAU OF COMMUNITY AND HEALTH SYSTEMS RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #: AG820015456

Licensee Name: W C Turner Living Centers Inc

Licensee Address: 48 Chandler

Detroit, MI 48202

Licensee Telephone #: (313) 875-8867

Licensee/Licensee Designee: Roman Avant, Designee

Administrator: Roman Avant

Name of Facility: W C Turner I

Facility Address: 48 Chandler

Detroit, MI 48202

Facility Telephone #: (313) 875-8867

Original Issuance Date: 01/31/1984

Capacity: 44

Program Type: DEVELOPMENTALLY DISABLED

MENTALLY ILL

AGED

Certified Programs: DEVELOPMENTALLY DISABLED

MENTALLY ILL

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 08/31/2022	
Date of Bureau of Fire Services Inspection if applicable:	
Date of Health Authority Inspection if applicable:	
Insp	pection Type: ☐ Interview and Observation ☐ Worksheet ☐ Combination ☐ Full Fire Safety
No. of staff interviewed and/or observed No. of residents interviewed and/or observed No. of others interviewed Role:	
•	Medication pass / simulated pass observed? Yes \boxtimes No \square If no, explain.
•	Medication(s) and medication record(s) reviewed? Yes ⊠ No ☐ If no, explain
•	Resident funds and associated documents reviewed for at least one resident? Yes \boxtimes No \square If no, explain. Meal preparation / service observed? Yes \boxtimes No \square If no, explain.
•	Fire drills reviewed? Yes ⊠ No □ If no, explain.
•	Fire safety equipment and practices observed? Yes \boxtimes No \square If no, explain.
•	E-scores reviewed? (Special Certification Only) Yes No N/A If no, explain. Water temperatures checked? Yes No If no, explain.
•	Incident report follow-up? Yes ☐ No ☒ If no, explain. N/A
•	Corrective action plan compliance verified? Yes ☐ CAP date/s and rule/s: N/A ☒
•	Number of excluded employees followed-up? N/A ⊠
•	Variances? Yes ☐ (please explain) No ☐ N/A ☒

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was determined to be in substantial compliance with rules and requirements.

The facility is in compliance with all applicable rules and statutes.

IV. RECOMMENDATION

I recommend issuance of a 2-year regular adult foster care license.

Edith Richardson

Licensing Consultant

09/13/2022

Date