GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 12, 2024

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

RE: License #: AL380007072
Investigation #: 2024A0007017
Turner Powers AFC Home

Dear Jennifer Williams:

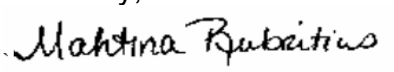
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (517) 284-9720.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL380007072
Investigation #:	2024A0007017
Complaint Receipt Date:	02/23/2024
Investigation Initiation Date:	02/27/2024
Report Due Date:	04/23/2024
Licensee Name:	Turner Powers AFC Home, Inc.
Licensee Address:	310 West Pearl Street Jackson, MI 49201
Licensee Telephone #:	(517) 414-5627
Administrator:	Jennifer Williams
Licensee Designee:	Jennifer Williams
Name of Facility:	Turner Powers AFC Home
Facility Address:	310 West Pearl Street Jackson, MI 49201
Facility Telephone #:	(517) 782-9123
Original Issuance Date:	03/30/1990
License Status:	REGULAR
Effective Date:	12/31/2022
Expiration Date:	12/30/2024
Capacity:	19
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is being discharged due to inappropriate substance usage. It is unknown if the resident was given a copy of the emergency discharge. The resident is currently in the hospital and will be homeless upon release.	Yes

III. METHODOLOGY

02/23/2024	Special Investigation Intake - 2024A0007017
02/27/2024	Special Investigation Initiated - On Site - Unannounced Face to face contact with Shawn Butler, Direct Care Staff, Resident A, and other residents.
03/11/2024	Contact - Telephone call received message from Shawn Butler. I was out of the office.
03/13/2024	Contact - Telephone call made to Shawn Butler, Discussion.
04/01/2024	Contact - Telephone call received from Shawn Butler, Discussion.
04/10/2024	Contact - Telephone call made to Shawn Butler, Discussion.
04/10/2024	Contact - Telephone call made to Justin Burke. Interview.
04/10/2024	Contact - Face to Face with Aubrey Lee, Adult Protective Services.
04/10/2024	APS Referral made.
04/10/2024	Preliminary Exit Conference conducted with Jennifer Williams, Licensee Designee.
04/12/2024	Exit Conference conducted with Jennifer Williams, Licensee Designee.

ALLEGATIONS:

Resident A is being discharged due to inappropriate substance usage. It is unknown if the resident was given a copy of the emergency discharge. The resident is currently in the hospital and will be homeless upon release.

INVESTIGATION:

It should be noted that prior to receiving this complaint, on February 22, 2024, Shawn Butler, Direct Care Staff, who also has the role of home manager, contacted me regarding Resident A. She stated that Resident A went for a visit with her family and was doing methamphetamine. Once she returned to the adult foster care home, Shawn Butler stated Resident A was having a breakdown. In addition, Shawn Butler stated Resident A was defecating in her room, leading to her mattresses, bedding, and any items that were ruined being thrown away. Shawn Butler stated Resident A also defecated in the living room and hallway of the home. Shawn Butler informed me that Resident A was currently in the hospital, and they said it would cost $1,300.00 a day for her to remain there (after she was ready for discharge). I informed Shawn Butler that if Resident A was ready for discharge, she would have to accept her back into the home until an appropriate placement could be located. Shawn Butler stated she would accept Resident A back into the home.

On February 27, 2024, I conducted an unannounced on-site investigation and made face to face contact with Shawn Butler, Resident A, and other residents.

I interviewed Shawn Butler who informed me that Resident A returned to the home on February 23, 2024. She stated that prior to speaking with me, Resident A's case manager, Justin Burke, asked if they would take Resident A back and she said no. She then contacted me to make sure she was following the rules, as this was new to her, and was informed that she had to accept Resident A back into the home until an acceptable new placement could be located. Shawn Butler stated that she then called Justin Burke and informed him that she was incorrect, and that she would accept Resident A back into the home. According to Shawn Butler, Justin Burke stated that he would still be looking for a specialized placement for Resident A.

While at the facility, Shawn Butler provided me with a copy of the written discharge notice, and the following was noted:

> "As of February 11, 2024, Turner Powers was giving [Resident A] an Emergency Discharge Notice. It was noted that [Resident A's] care needs were beyond the scope of care they could provide. There were hazards, as [Resident A] defecated all over the house, including the dining room, hallways, bathrooms, and she claimed she was not aware that she was having an issue. They noted there was a health risks to staff and residents. Additionally, that [Resident A's] admission of using meth was concerning as there were other vulnerable residents in the home that could be persuaded to unknowingly participate in substance use; thus, for their safety, they were issuing the emergency discharge notice."

I interviewed Resident A. She explained that historically, February was a bad month for her, as she does not get along with her friends. Regarding the discharge notice, Resident A stated she did not recall if she received the notice for February 11, 2024. She stated that she would like to stay in the home, if possible. Resident A also did not recall defecating in several different areas of the home.

On March 13, 2024, I spoke to Shawn Butler. She stated that Resident A was not taking her medications and she was being disruptive in the home. Shawn Butler stated Resident A kept going into Resident B's room, which was frustrating Resident B. At one point, Shawn Butler stated Resident B pushed a dresser in front of his door to keep her out of his room but then Resident A would then stand outside the door, which would cause Resident B's dog to continuously bark. Shawn Butler stated that Resident A was back at Henry Ford, in the Psychiatric ward; as her case manager came to visit and discuss her new placement. Resident A would not cooperate with him; therefore, he petitioned the court for assistance according to Shawn Butler. Shawn Butler stated the police came to the facility and escorted her to the hospital, where she remained, and Adult Protective Services (APS) also came to the home. Shawn Butler stated that they have not dealt with anything like this before; but the after-care plan is to hopefully have her discharged directly to the new home. However, Shawn Butler stated that if they still needed placement, Resident A could return to the home.

On April 1, 2024, Shawn Bulter contacted me to inform that Resident A refuses to go and see different placements. Resident A was also transitioning between case managers and there is a concern with follow-through. I encouraged Shawn Butler to contact the supervising agency and speak to case management or administration if necessary. I also informed her that she might have to evict Resident A through the court system.

On April 10, 2024, I spoke to Shawn Butler. Regarding the discharge notice that was dated for February 11, 2024, Shawn Butler stated that the notice was not given to Resident A. A copy of the discharge notice was given to Justin Burke; however, the "wires were crossed." Jennifer Williams, Licensee Designee, said she would take the discharge notice to Resident A at the hospital because Justin Burke said he did not know if he was allowed to give her the notice. Shawn stated that they accepted Resident A back into the home after speaking with me. Resident A was there another week, then had additional behaviors and was hospitalized again according to Shawn Butler. On March 6, 2024, a 30-Day discharge notice was issued, which Resident A signed that she received the document. A copy of this discharge notice was also provided to licensing. Shawn Butler stated that Resident A remains in the home, and they don't know what to do, as she keeps declining places to go. In addition, she is behind on her rent. We discussed the options the facility could take to address this matter.

On April 10, 2024, I spoke to Justin Burke. Regarding the discharge notice dated February 11, 2024, he stated the house was under false guidelines; as they stated the discharge notice had been provided to Resident A, but when he spoke to Resident A, she had not received it. The facility staff did not want to accept Resident A back into the home. Justin Burke stated that he and his supervisor educated the home, and then they took Resident A back. I informed Justin Burke that I had also

spoken to Shawn Butler regarding this matter and informed that she had to accept Resident A back into the home if she was ready for discharge from the hospital.

I inquired if he had received a copy of the first discharge notice and he stated he did; however, he told them he had no time to deliver it to Resident A, so Jennifer Williams was supposed to drop it off. However, when he spoke to Resident A, that did not occur. Justin Burke informed me that Resident A remains in the home, as they have had difficulties getting her to move. She had an interview at a different placement, and he hasn't heard back from them yet. He also has not had the opportunity to follow-up with them, but if they would take her, she could move today.

On April 10, 2024, I made face-to-face contact with Aubrey Lee, Adult Protective Services worker. He stated that he has an open investigation regarding Resident A. He received a complaint in March 2024 because Resident A was very disruptive in her current placement, and she was unwilling to move out of the home. He made face to face contact with Resident A today and she appeared to be calmer. He stated that he would not be substantiating any allegations against the home, as the complaint was regarding self-neglect.

On April 10, 2024, I spoke to Jennifer Williams, Licensee Designee. She stated that it was her understanding that Justin Burke took a copy of the 24-hour discharge notice, and since he was going to the hospital, he was taking the notice to her. Jennifer Williams later learned that somewhere down the line, Justin Burke said he was not taking the discharge notice to her.

According to Jennifer Williams, Shawn Butler later said that she spoke to Justin Burke, and he said he did not say he was going to take the discharge notice to Resident A. Jennifer Williams stated that she didn't know that she was supposed to deliver the discharge notice, because if so, she would have. She stated that she wished she had delivered the notice herself. Jennifer Williams further stated that the 24-hour time frame had already passed, and she did not think she could give the notice (after being notified there was an issue) since they had already accepted her back into the home. I also conducted the preliminary exit conference with Jennifer Williams and informed that I would follow-up with her if the recommendations changed.

On April 12, 2024, I conducted the exit conference with Jennifer Williams, Licensee Designee. I informed her that while I understood there was some confusion regarding who was going to deliver the original emergency discharge notice, dated February 11, 2024, to Resident A; per the rule, it was still her (Jennifer William's) responsibility to provide a copy to Resident A, and that did not occur. Therefore, I would be requesting a written corrective action plan to address the established violation. Jennifer Williams reiterated that had she known she was supposed to deliver the discharge notice to Resident A, she would have. I explained that the emergency discharge notice was dated for February 11, 2024, and Shawn Butler contacted me on February 22, 2024; thus, they had time to provide Resident A with

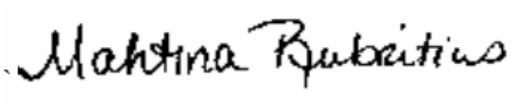
a copy of the discharge notice. Jennifer Williams agreed to submit a written corrective action plan to address the established violation.

APPLICABLE RULE	
R 400.15302	**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.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.**

ANALYSIS:	During my interview with Resident A on February 27, 2024, she stated she did not recall if she received the notice. While at the facility, Shawn Butler provided me with a copy of the written discharge notice, dated February 11, 2024. Shawn Butler later informed me that the notice was not given to Resident A. A copy of the discharge notice was given to Justin Burke; however, the "wires were crossed." Jennifer Williams, Licensee Designee, said she would take the discharge notice to Resident A at the hospital because Justin Burke said he did not know if he was allowed to give her the notice. Shawn stated that they accepted Resident A back into the home after speaking with me on February 22, 2024. Justin Burke informed me that he received a copy of the first discharge notice; however, he told them he had no time to deliver it, so Jennifer Williams was supposed to drop it off. However, when he spoke to Resident A, that did not occur. According to Jennifer Williams, Shawn Butler later said that she spoke to Justin Burke, and he said he did not say he was going to take the discharge notice to Resident A. Jennifer Williams stated that she didn't know that she was supposed to deliver the discharge notice, because if so, she would have. Jennifer Williams further stated that the 24-hour time frame had already passed, and she did not think she could give the emergency notice (after being notified there was an issue), since they had already accepted her back into the home. While it appears that there was a misunderstanding about who would deliver the discharge notice, it is the license's responsibility to provide a copy of the notice to the resident. 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 Resident A was not provided with a copy of the original discharge notice, dated February 11, 2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.



4/12/2024

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Mahtina Rubritius Date
Licensing Consultant

Approved By:

04/12/2024

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Dawn N. Timm Date
Area Manager