GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 23, 2024

Laketa Brodnex
D.E.B. AFC Inc.
P.O Box 136
Bridgeport, MI 48722

RE: License #: AS730287431
Investigation #: 2024A0576042
D.E.B. AFC, Inc. #2

Dear Laketa Brodnex:

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.
- Be signed and dated.

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.

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.

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) 643-7960.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730287431
Investigation #:	2024A0576042
Complaint Receipt Date:	06/24/2024
Investigation Initiation Date:	06/26/2024
Report Due Date:	08/23/2024
Licensee Name:	D.E.B. AFC Inc.
Licensee Address:	P.O Box 136, Bridgeport, MI 48722
Licensee Telephone #:	(989) 475-4034
Administrator:	Laketa Brodnex
Licensee Designee:	Laketa Brodnex
Name of Facility:	D.E.B. AFC, Inc. #2
Facility Address:	3197 Studor, Saginaw, MI 48601
Facility Telephone #:	(989) 777-6903
Original Issuance Date:	05/16/2007
License Status:	REGULAR
Effective Date:	12/19/2023
Expiration Date:	12/18/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
On 6/22/2024 at 12:00am, Staff, Charricka Moten arrived for her shift. Staff Moten found Resident A lying on bedroom floor at 5am. Resident A was unresponsive at about 7am and 911 was called. Resident A was found with her pants and brief around her ankles. Resident A had adhesive marks with caked on dirt and her bed sheets were dirty. Resident A was pronounced dead, and the cause is presumed to be severe malnutrition.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/24/2024	Special Investigation Intake 2024A0576042
06/24/2024	APS Referral
06/26/2024	Special Investigation Initiated - On Site Interviewed Staff Tasha Weathers, Resident B, Resident C, and Resident D
07/01/2024	Contact - Telephone call made Interviewed La'key Woods, Saginaw County Medical Examiner Office
07/02/2024	Contact - Telephone call made Interviewed Guardian A
07/02/2024	Contact - Telephone call made Left message for Monica Burton, Saginaw County Community Mental Health Authority
07/02/2024	Contact - Telephone call made Interviewed Staff, Charrika Moten
07/02/2024	Contact - Telephone call made Interviewed Staff, Takearah Knickleberry
07/05/2024	Contact - Document Received Reviewed police report

07/05/2024	Contact - Document Sent Covenant Hospital records request sent for Resident A
07/08/2024	Contact - Telephone call made Interviewed Staff, Hattie Tillman
07/08/2024	Contact - Telephone call made Interviewed Debra Sharp, Friends for Recovery
07/09/2024	Contact - Face to Face Interviewed Staff, Marie Hall
07/20/2024	Contact - Document Received Reviewed Resident A's medical records from Covenant Hospital
08/13/2024	Contact - Face to Face Reviewed Resident A medical records
08/20/2024	Contact - Telephone call made Left message for Monica Burton to return call
08/23/2024	Exit Conference

ALLEGATION:

On 6/22/2024 at 12:00am, Staff, Charricka Moten arrived for her shift. Staff Moten found Resident A lying on bedroom floor at 5am. Resident A was unresponsive at about 7am and 911 was called. Resident A was found with her pants and brief around her ankles. Resident A had adhesive marks with caked on dirt and her bed sheets were dirty. Resident A was pronounced dead, and the cause is presumed to be severe malnutrition.

INVESTIGATION:

On June 26, 2024, I conducted an unannounced on-site inspection at DEB AFC #2 and interviewed Resident B. Resident B reported Resident A was sick in her room. Resident A would not eat or come out of her room unless staff asked her. Resident A was not eating that good and she did not talk much. According to Resident B, Resident A was displaying these behaviors “for a while, maybe a couple weeks.” No one was harming Resident A. When staff asked Resident A to take a bath, she would however she would refuse to wash her face or bathe herself. Resident B confirmed she receives enough to eat at her home, and she has clean bedding. Staff wash her bedding 1-2 per week. Resident B denied any concerns about her home. Staff treated Resident B and all the residents well.

On June 26, 2024, I interviewed Staff Tasha Weathers regarding the allegations. Staff Weathers reported that she arrived to work on June 22, 2024, at 8am and the police and ambulance were at the facility. Staff, Takearah Knickleberry worked from 4pm-12am on Friday, June 21, 2024. Staff Knickleberry called Manager Hattie Tillman to advise her that Resident A was laying on the floor and wanted to know if she needed to call the ambulance. Resident A was talking and confirmed she was okay when asked. Resident A was on the floor with a cover and Staff Knickleberry took the cover and tried to help Resident A up from the floor. Resident A grabbed the cover and put it back on her. Resident A was swatting away at staff's hand as the staff was trying to assist her. Staff Knickleberry observed that Resident A's pants and brief were on her ankles.

According to Staff Weathers, Resident A had been depressed lately and was sometimes refusing her medications and meals. Resident A was kicked out of her day program (Friends for Recovery) that she attended for socialization about one month ago due to trying to hit the bus driver. Since that time, Resident A would refuse to come out of her bedroom. Resident A would refuse to shower, and her hands were dirty because she refused to wash them. Resident A's Case Manager, Monica Burton came to see Resident A on June 4, 2024, while visiting another resident. Case Manager Burton was advised that Resident A was refusing medications, not showering, and refusing to eat. Staff Weathers reported that Resident A had a medication review on May 21, 2024, however she refused to come out of her bedroom and did not attend the appointment. Resident A had dirty bed sheets as she would get in bed with her coat and shoes on and would stay in her bed under the covers. Staff wash bedding on Saturdays however Resident A would become combative when staff wanted to wash her bed sheets. Resident A never used to wear briefs and was able to use the restroom on her own. Resident A would also shower, and staff would assist her however she started to refuse. Resident A would not respond to prompts and "just look at you".

While at the home I viewed and inspected Resident B, Resident C, and Resident D's beds and bedding. All beds and bed linens appeared clean and did not have any discernable odors. Resident E bedroom was not viewed as she was not home, and the door was locked.

On June 26, 2024, I interviewed Resident C. Resident C could not recall how long she has lived at her home. Resident C likes her home, and the staff are nice. None of the staff are mean and they take care of her. According to Resident C, staff wash her sheets and bedding however she was not sure how often. According to Resident C, her bed linens are never dirty. Resident C receives enough to eat, and she denied any current concerns. Resident C's speech was somewhat difficult to understand, and no other questions were asked of Resident C.

On June 26, 2024, I interviewed Resident D. Resident D reported the staff at her home are fine and they treat her well. Resident D confirmed she receives enough to eat at her home. Resident D's bedding and linens are washed every week and are clean. Regarding Resident A, Resident D reported she was extra quiet and did not talk much. Resident D was not sure how staff treated Resident A.

On June 26, 2024, I reviewed an AFC Licensing Division Incident / Accident Report (IR) dated for June 22, 2024, and authored by Charricka Moten. The IR documented that on June 22, 2024, at 7:05am a bed check was completed, and Resident A was found unresponsive. Staff performed CPR while on the phone with 911 until medical staff arrived.

On June 26, 2024, I reviewed a DEB AFC #2 staff communication log for June 2024 and Resident A's individual progress notes for June 2024. Staff noted numerous instances were Resident A refused meals, medications, and to shower. Between both documents, staff documented Resident A refused meals at least 13 times and refused to shower at least 15 times in June 2024. It was documented that Resident A's case manager came to see her on June 4, 2024, and advised she would be contacting Resident A's guardian.

On July 1, 2024, I interviewed La'Key Woods, Administrative Clerk from the Saginaw County Medical Examiner's Office. Clerk Woods advised that Resident A's autopsy was not complete, and it will take 14 weeks for completion. Clerk Woods reviewed Resident A's records and it was noted that Medical Examiner Investigator (MEI), Stella Kohloff documented that she spoke with Resident A's relative on the day of Resident A's death and the relative explained he was no longer Resident A's guardian because he "could not handle her". The relative had seen Resident A a month prior to her death and was alarmed at her appearance. Resident A was no longer talking but rather mumbling. Resident A was diagnosed with Schizophrenia 15 years prior. MEI Kohloff documented that Resident A had patches of dirt on her body and her hair appeared matted. Resident A's body appeared emaciated, and her brief was heavily soiled. Resident A was found with her pants and brief pulled down to her ankles however there were no obvious trauma to her exterior pelvis and genitals. Resident A had 2 small circular wounds that appeared to be bed sores. Clerk Woods advised that there are no preliminary findings, and they are awaiting toxicology results. At the time of her death Resident A was 5'1" and weighed 86 pounds.

On July 2, 2024, I interviewed Resident A's guardian who advised Resident A was sent out for an autopsy and Resident A had no known major medical issue. Guardian A reported he is confused as to what happened to Resident A. According to Guardian A, Resident A wanted to sleep on the floor, and she did strange and erratic things. Resident A's mental state was not good since she moved from her prior AFC home and there were too many changes at one time. Resident A liked consistency and she had lived at her prior home for over 10 years. Guardian A was thinking of moving her however he is not sure if this would have helped or made her more upset. Guardian A was asked if he was made aware that Resident A was refusing to shower, and he confirmed he was however maybe not to the extent that it was occurring. Guardian A advised he did not realize Resident A was isolating as much as she was. Guardian A did not have concerns regarding Resident A however he was aware of past injuries Resident A had without explanations. Guardian A did not feel Resident A was unsafe however things may have not been "adding up".

On July 2, 2024, and August 20, 2024, I left a message for Resident A's Case Manager, Monica Burton to return my call.

On July 2, 2024, I interviewed Staff, Takearah Knickleberry who reported she was working on June 21, 2024, from 4pm-12am. During the shift, Resident A was on the floor and did not want to get off the floor. Staff Knickleberry checked on Resident A and asked Resident A if she could help get her up. Resident A sat up and pulled a blanket on her. Staff Knickleberry noticed Resident A was on the floor at about 5:30pm and Resident A had a brief on her legs. Resident A's pants and brief were on her legs and Staff Knickleberry asked to help pull her brief and pants up and Resident A said no. Staff Knickleberry asked Resident A if she wanted a peanut butter and jelly sandwich and Resident A just stared at Staff Knickleberry. Staff Knickleberry checked on Resident A every 2 hours and at about 6:30pm-7pm, Staff Knickleberry reached for Resident A's pants to try to help pull them up and Resident A fanned her hand in the air, which Staff Knickleberry took to mean not to touch Resident A. During her shift, Staff Knickleberry called Manager Hattie Tillman to inform her of what was occurring and to see if she should call for an ambulance. It was decided that Resident A did not require medical attention. At 12am Resident A was still laying in the same spot, and Staff Knickleberry advised the next staff person coming on duty that Resident A was awake and did not want to get in bed.

On July 2, 2024, I interviewed Staff, Charricka Moten. Staff Moten worked on the day of Resident A's death, June 22, 2024, from 12am-8am. Staff Moten explained when she arrived at work, she was told by the coworker she relieved that Resident A was laying on the floor and would not get up. The other staff person left, and Staff Moten went to Resident A's bedroom and was prompting Resident A to get up from the floor. Resident A did not get up and Staff Moten tried to help Resident A up from the floor by grabbing a hold of Resident A's arm. Resident A pulled her arm away and said "no". Resident A was covered up with blankets and had her jacket on that she never took off. Staff Moten could not recall if Resident A had a pillow however, she had a couple blankets and Resident A's legs were covered. Staff Moten could not tell if Resident A had pants on as they were covered up with the blankets. Staff Moten completed bed checks every 2 or 2 ½ hours throughout the shift and at 5am Staff Moten checked on Resident A. Resident A moved her arm and Staff Moten believed Resident A to be alive at that time. Staff Moten did not talk to Resident A and felt she was okay because she moved her arm. Staff Moten checked on Resident A at around 7am-7:15am and to ask her if she wanted breakfast. Resident A did not respond, and Staff Moten tried talking to Resident A and moving her. Resident A's eyes were open, and she did not respond to Staff Moten. Staff Moten called 911 and Manager Hattie Tillman. 911 instructed her to do CPR and she did for about 7 minutes. 911 was on the phone with Staff Moten and directed her to do CPR until the paramedics arrived. Staff Moten did what 911 instructed and when paramedics arrived, they took over CPR. Staff Moten explained that Resident A was still under the blankets, and she never saw Resident A's legs. Staff Moten did not check Resident A's brief during her checks of Resident A.

Staff Moten explained that when she first started working at the facility in May 2024, Resident A was livelier. Resident A could not talk much other than yes or no. There were times when Resident A would go walk and then sit in the van. During the last 3 weeks, Resident A refused to get up, come out of her bedroom, and would not get in the shower. Staff Moten would try to direct her to get in the shower however Resident A would refuse.

On July 5, 2024, I reviewed Bridgeport Township Police Department Case Report #2486300660 dated for June 22, 2024, and authored by Officer Larry Biniecki. Nature of Incident is listed as death investigation of Resident A. The report documented that Resident A was pronounced dead at 7:57am. Resident A was wearing a heavily soiled diaper that had been cut by paramedics. Resident A's bed was noted to be soiled. Resident A was odorous, and it appeared that she had not been properly clean "in a long time". The officer noted Resident A's weight loss and stated Resident A was "mostly bones and skin". Staff Charricka Moten was interviewed and reported she checked on checked on Resident A at 5:15am and Resident A was lying on the floor. Staff Moten asked her if she wanted to get up yet and Resident A indicated she did not. The next time Staff Moten checked on Resident A was at 7:05am and she was unresponsive. Staff Moten denied Resident A was having "difficulty breathing or anything". Staff Moten reported she started her shift at 12am and Resident A was on the floor. The prior shift staff reported that she had been like that and did not want to get up. Staff Moten reported Resident A does not eat a lot of her food and was at the hospital about 3 weeks ago.

On July 6, 2024, I called Licensee Designee, Laketa Brodnex and requested Resident A's AFC assessment plan, weight record, resident care agreement, health care appraisal, and record of medical appointments. Records will be provided on Monday.

On July 6, 2024, I sent a request for medical records to Covenant Hospital for Resident A. On July 11, 2024, I received Resident A's medical records from Covenant Hospital and reviewed. Medical records indicated Resident A was 62-years old. Resident A was examined at Covenant Hospital Emergency Department on February 6, 2024, due to a fall. Resident A was noted to have a medical history of hypothyroidism and schizophrenia with psychosis. It was documented that Resident A got excited, tripped, and hit her head causing a laceration on the right side of her forehead "with bleeding controlled". The laceration was noted to be "superficial". Resident A was noted to be awake and alert, able to follow simple commands, and baseline confusion. Resident A had no other signs of injury and "primary exam shows airway, breathing, circulation to be intact." Resident A's weight was documented to be 140 pounds.

Resident A was examined at the Covenant Hospital Emergency Department on November 11, 2023, for aggressive behavior. Resident A was noted to have a past medical history of mental retardation, seizure disorder, and schizophrenia. Resident A had become aggressive with staff and the police were called to the AFC home. Resident A was examined and "workup was ordered to make sure the patient does not have a medical reason for aggressive behavior." Resident A was noted to be

interacting appropriately, although speech is mumbled, which appears to be her baseline. Resident A was discharged home in stable condition. Resident A's weight was documented to be 142 pounds.

On July 8, 2024, I interviewed Manager Hattie Tillman who reported Resident A fell into a depression and was not taking her medications or eating. These issues were reported to Resident A's case manager and guardian. Manager Tillman explained that Resident A's decline started when she was not allowed to return to her day program, Friends for Recovery. After that, Resident A would not come out of her room or shower. Resident A would get in bed with her clothes and shoes on, Resident A would not speak and just stare at whoever was speaking to her. Resident A had a medication review however Resident A did not attend the appointment because she refused to get in the vehicle. Resident A began to soil herself which was not normal for Resident A.

Regarding the Resident A's death, Manager Tillman reported Resident A took the blankets off her bed and lied on the floor. Staff faced timed Manager Tillman around 2am on June 22, 2024. Manager Tillman was speaking with Resident A however Resident A would not get off the floor and she would not respond. Resident A was moving around and got on her knees. Resident A took blankets from her bed and put them on the floor. Resident A was dressed and had her coat on. Manager Tillman did not see Resident A's bottom half of her body or her legs. Manager Tillman asked Resident A to get off the floor and get in bed and Resident A did not respond and just looked at Manager Tillman. Manager Tillman advised that she was not aware that Resident A had a soiled brief and did not think there was any reason to send Resident A to the hospital at that time.

Manager Tillman was asked when Resident A was last seen by her doctor. Manager Tillman explained Resident A was recently at the hospital (St. Mary's on May 24, 2024) due to her walking away from the home. The police were called by someone in the community and Resident A was sent to St. Mary's hospital. While at the hospital, Manager Tillman and Staff Marie Hall advised hospital personnel that Resident A was not eating or taking her medications. Resident A was not admitted to the hospital.

On July 8, 2024, I interviewed Debra Sharp, Director at Friends for Recovery. Director Sharp explained that Resident A was kicked out of program on May 2, 2024, due to bizarre behavior she began to display. Resident A would scream and try to get in the van when she was not supposed to or would refuse to get into the van when she was supposed to. Resident A was asked not to return to program for health and safety reasons as Resident A became a danger to herself and those around her. On May 2, 2024, Resident A was in the van and unbuckling her seat belt on the way to program. Resident A got up and was walking around in the van. Resident A was getting physically aggressive with the assistant director and scaring others at program. Director Sharp stated that Resident A had been deteriorating since the time she moved from her previous AFC home.

On July 9, 2024, I interviewed Staff, Marie Hall. Staff Hall reported Resident A went to the St. Mary's hospital on May 24, 2024, as she left the home and was trying to get in someone's car. The police were called, and Resident A was transported to the emergency room. According to Staff Hall, staff were aware that Resident A was not eating and refusing medications and Manager Hattie Tillman was calling the psychiatrist seeking an evaluation for Resident A. Manager Tillman contacted Saginaw County Community Mental Health Authority the week of June 17, 2024, and Resident A was scheduled a psychiatric appointment on July 2, 2024.

On July 9, 2024, I reviewed Resident A's AFC documents including identification record, AFC Assessment Plan, Resident Care Agreement, health care appraisal, and weight record. According to the documents, Resident A moved to DEB AFC #2 on November 1, 2023. Resident A was 62-years old. Resident A was not able to move independently in the community. Resident A sometimes communicates needs and sometimes understands verbal communication. Resident A sometimes follows instructions, sometimes controls aggressive behavior, and sometimes gets along with others. Resident A requires staff assistance with bathing and staff will assist with washing Resident A's hair and body. Resident A requires staff assistance with dressing and personal hygiene. Resident A requires assistance with grooming and staff will provide Resident A reminders for brushing her hair and teeth.

On August 13, 2024, I reviewed Resident A's medical records from St. Mary's hospital. The documents indicated Resident A was examined at St. Mary's Hospital on May 24, 2024. Resident A was transported by ambulance (Mobile Medical Response-MMR) and it was documented that Resident A's "Chief Complaint Organ System" was "Behavioral/Psychiatric". "Barriers to Patient Care" indicated "Altered Mental Status, Uncooperative". Resident A's symptoms included restlessness and agitation, unspecified urinary incontinence, repeated falls, difficulty walking, combative, disorientation, uncooperative, and strange and inexplicable behavior. Resident A was examined at 7:20pm and AFC home staff reported that Resident A was combative and would not let anyone bathe her, locked herself in her room, and is noncompliant with her medications. Resident A's weight was noted to be 40.8 kg (89.94 pounds) and height was 150 cm (4'11"). Resident A appeared "cachectic and disheveled". Resident A had a CT scan completed due to indication of altered mental status. The CT scan impression indicated no acute intracranial pathology. Resident A had an X-ray of her abdomen completed and there were no acute abnormalities noted. Resident A was reexamined at 3:06am on May 25, 2024, and it was noted that Resident A was in and out of her room and she was provided "another dose of Zyprexa". "Clinical Impression" indicated "Dementia with behavioral disturbance." Resident A had a nursing assessment completed and it was noted that Resident A was "combative when touched." Resident A was noted to be aggressive and attempting to hit staff. Resident A was transferred to the AFC home.

On August 20, 2024, I interviewed Stella Kohloff, Medical Examiner Investigator (MEI) from the Saginaw County Medical Examiner's Office who reported the full autopsy report for Resident A continues to be pending. MEI Kohloff reported that when she

arrived at the home when Resident A died, staff did not appear to know much and could not provide documents (i.e. an incident report). Resident A appeared very thin, malnourished and her bones could be seen. Resident A was very dirty, and her hair was matted and tangled. Resident A was wearing a diaper that was pulled down to her ankles along with her pants and the brief was soiled with feces. MEI Kohloff reported that staff indicated that they were checking on Resident A throughout the night before her death. Staff were aware that she was laying non the floor, and they did not help her up.

SIR #2024A0576009, dated January 5, 2024, substantiated violation to R 400.14305(3) due to staff not accompanying Resident A to the hospital emergency department. Resident A's safety and protection was not adhered to at all times given staff did not accompany her while in the community, which is a requirement per her assessment plan. On January 8, 2024, Licensee Designee, Laketa Brodnex submitted a corrective action plan indicating staff would accompany residents when they go to the hospital.

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 on June 22, 2024, at 5am Resident A was found to be lying on the floor. At 7am Resident A was found unresponsive and 911 was called. Resident A was found with her brief around her ankles, and it was alleged that Resident A was dirty. Resident A was pronounced dead, and cause is presumed to severe malnutrition. Upon conclusion of investigative interviews and a review of documentation, there is a preponderance of evidence to conclude a rule violation. Resident A's autopsy has not been completed during the course of this investigation and the cause and manner of Resident A's death is unknown. AFC Staff were interviewed, and it is apparent that they were aware Resident A was under significant distress for several weeks prior to her death. Resident A was removed from attending day program on May 2, 2024, due to increasing behavior issues she presented including physical aggression toward others. After not being allowed to attend program, Staff, Tasha Weathers reported Resident A began exhibiting signs of depression and refused to eat or take her medications. Resident A began to isolate and would refuse to shower.

	Resident A began to soil herself which was something that had not occurred in the past. Although Resident A was seen at St. Mary's hospital on May 24, 2024, due to leaving the home and displaying concerning behavior in the community, at no other time did AFC staff take Resident A for medical examination by a doctor. Additionally, on the day of her death Resident A was found lying on her bedroom floor for several hours and facility staff decided that Resident A did not require medical attention. Lastly, Resident A moved into DEB AFC #2 and there is no indication Resident A was taken for any routine medical examination by her primary care doctor during the time she lived at the facility. There is a preponderance of evidence to conclude Resident A's safety and protection was not adhered to at all times given the lack of routine medical care secured for her during the time she lived at the AFC home or in the immediate hours preceding her death on June 22, 2024.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2024A0576009 dated January 5, 2024.**

ADDITIONAL FINDINGS:

INVESTIGATION:

On July 9, 2024, I reviewed Resident A's AFC documents including identification record, AFC Assessment Plan, Resident Care Agreement, health care appraisal (HCA), and weight record. Resident A's HCA was blank and had not been completed.

On July 9, 2024, I interviewed Staff, Marie Hall regarding Resident A's HCA. Staff Hall indicated the home never obtained a HCA because Resident A came to the home "on an emergency basis."

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 designated 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 July 9, 2024, I reviewed Resident A's health care appraisal. The appraisal was blank and had not been completed during the time Resident A lived at DEB AFC #2.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On July 9, 2024, I reviewed Resident A's AFC documents including identification record, AFC Assessment Plan, Resident Care Agreement, health care appraisal (HCA), and weight record. Resident A's AFC Assessment plan was not fully completed and did not have signatures of Resident A, Guardian A, or the Licensee Designee. Resident A's assessment of her being alert to surroundings, participation in social activities, and toileting were not answered.

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 July 9, 2024, I reviewed Resident A's written assessment plan was reviewed. The assessment plan did not contain required signatures and valuable information regarding Resident A's needs had not been assessed and documented.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On June 26, 2024, I interviewed Staff, Tasha Weathers. Staff Weathers reported that Resident A had been depressed lately and was sometimes refusing her medications and meals. Resident A was kicked out of her day program (Friends for Recovery) on May 2, 2024, due to trying to hit the bus driver. Since that time, Resident A would refuse to come out of her bedroom. Resident A would refuse to shower, and her hands were dirty because she refused to wash them. Staff Weathers reported that Resident A had a medication review on May 21, 2024, however she refused to come out of her bedroom and did not attend the appointment. Resident A never used to wear briefs and was able to use the restroom on her own. Resident A would also shower, and staff would assist her however she started to refuse. Resident A would not respond to prompts and "just look at you".

On June 26, 2024, I reviewed a DEB AFC #2 staff communication log for June 2024 and Resident A's individual progress notes for June 2024. Staff noted numerous instances were Resident A refused meals, medications, and to shower. Between both documents, staff documented Resident A refused meals at least 13 times.

On July 8, 2024, I interviewed Manager Hattie Tillman who reported Resident A fell into a depression and was not taking her medications or eating. These issues were reported to Resident A's case manager and guardian. Manager Tillman explained that Resident A's decline started when she was not allowed to return to her day program, Friends for Recovery. After that, Resident A would not come out of her room or shower. Resident A would get in bed with her clothes and shoes on, Resident A would not speak and just stare at whoever was speaking to her. Resident A had a medication review however Resident A did not attend the appointment because she refused to get in the vehicle. Resident A began to soil herself which was not normal for Resident A. Manager Tillman was asked when Resident A was last seen by her doctor. Manager Tillman explained Resident A was examined at St. Mary's Hospital on May 24, 2024, due to her walking away from the home and that was the last time she was seen by a doctor. There is a doctor that comes to the home however the doctor did not examine Resident A during the time she lived at the facility.

Upon review of medical records, the following are documented weights for Resident A during the time she lived at DEB AFC #2; On November 11, 2024, Resident A weighed 142 pounds per Covenant Hospital. On February 6, 2024, Resident A weighed 140 pounds per Covenant Hospital. On May 24, 2024, Resident A weighed 89.94 pounds per St. Mary's Hospital. On July 1, 2024, I interviewed La'Key Woods, Administrative Clerk from the Saginaw County Medical Examiner's Office. Clerk Woods advised that at the time of her death on June 22, 2024, Resident A weighed 86 pounds.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Staff were interviewed and reported that after Resident A was removed from her day program on May 2, 2024, she began exhibiting signs of depression including refusing to eat. Staff documented at least 13 times Resident A refused to eat from June 1, 2024, through June 21, 2024. Staff also reported Resident A became incontinent and began wearing briefs. Medical records were reviewed and indicated Resident A lost a significant amount of weight in a very short time period. Resident A's hospital medical records indicate she weighed 140 pounds on February 6, 2024, and 89.94 pounds on May 24, 2024, a 50-pound weight loss in 15 weeks. Given Resident's change in condition, including incontinence, refusal to eat, and sudden and drastic weight loss, the home should have obtained medical care for Resident A immediately.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On July 6, 2024, I sent a request for medical records to Covenant Hospital for Resident A. On July 11, 2024, I received Resident A's medical records from Covenant Hospital and reviewed. Resident A was examined at the Covenant Hospital Emergency Department on November 11, 2023, for aggressive behavior. The record indicated that AFC staff was advised to have Resident A follow up with her primary care doctor for reevaluation and to contact their office to schedule an appointment.

On July 8, 2024, I interviewed Manager Hattie Tillman. Manager Tillman was asked when Resident A was last seen by her primary doctor. Manager Tillman explained Resident A was recently at the hospital (St. Mary's on May 24, 2024) and that was the last time she was seen by a doctor. Manager Tillman advised there is a doctor that comes to the home however the doctor did not examine Resident A during the time she lived at the facility.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's

	physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Resident A was examined at the Covenant Hospital Emergency Department on November 11, 2023, for aggressive behavior. The medical records from this encounter were viewed and indicated that AFC staff was advised to have Resident A follow up with her primary care doctor for reevaluation. AFC were directed to contact their office to schedule an appointment. Upon review of records and staff interviews, there is no indication that AFC followed through with health care professionals' recommendation that she follow up with her primary care doctor. The licensee did not follow the instructions of hospital staff with regard to health care needs that can be provided in the home (i.e. scheduling and follow through of follow up medical appointment).
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On July 9, 2024, I reviewed Resident A's AFC documents including identification record, AFC Assessment Plan, Resident Care Agreement, health care appraisal (HCA), and weight record. Resident A's weight record was blank and there were no weights recorded for Resident A since the time she lived at DEB AFC #2.

On July 9, 2024, I in On July 9, 2024, I interviewed Staff, Marie Hall regarding Resident A's weight record and why Resident A had no weights documented. Staff Hall advised that Resident A may have refused to get weighed.

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 July 9, 2024, I reviewed Resident's A weight record. Resident A's weight record was blank and there were no weights recorded for Resident A since the time she lived at DEB AFC #2.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On July 9, 2024, I reviewed Resident's A file. I was unable to locate any record of physician contacts.

On July 9, 2024, I interviewed Staff, Marie Hall regarding Resident A's record of physician contacts. Staff Hall could not account for Resident A's record of physician contacts.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.**
ANALYSIS:	On July 9, 2024, I reviewed Resident's A file. I was unable to locate any record of physician contacts. Staff, Marie Hall regarding Resident A's record of physician contacts. Staff Hall could not account for Resident A's record of physician contacts.

	The licensee did not maintain in the home a record of Resident A's physician contacts.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On June 26, 2024, I interviewed Staff, Tasha Weathers, who reported Resident A had been depressed lately and was sometimes refusing her medications and meals. Resident A was kicked out of her day program (Friends for Recovery) about one month ago due to trying to hit the bus driver. Since that time, Resident A would refuse to come out of her bedroom. Resident A would refuse to shower, and her hands were dirty because she refused to wash them. Staff Weathers reported that Resident A had a medication review on May 21, 2024, however she refused to come out of her bedroom and did not attend the appointment. Resident A had dirty bed sheets as she would get in bed with her coat and shoes on and would stay in her bed under the covers. Staff wash bedding on Saturdays however Resident A would become combative when staff wanted to wash her bed sheets. Resident A never used to wear briefs and was able to use the restroom on her own. Resident A would also shower, and staff would assist her however she started to refuse. Resident A would not respond to prompts and "just look at you".

On June 26, 2024, I reviewed a DEB AFC #2 staff communication log for June 2024 and Resident A's individual progress notes for June 2024. Staff noted numerous instances were Resident A refused meals, medications, and to shower. Between both documents, staff documented Resident A refused meals at least 13 times and refused to shower at least 15 times in June 2024.

On July 8, 2024, I interviewed Manager Hattie Tillman who reported Resident A fell into a depression and was not taking her medications or eating. Manager Tillman explained that Resident A's decline started when she was not allowed to return to her day program, Friends for Recovery. After that, Resident A would not come out of her room or shower. Resident A would get in bed with her clothes and shoes on, Resident A would not speak and just stare at whoever was speaking to her. Resident A had a medication review however Resident A did not attend the appointment because she refused to get in the vehicle.

On July 8, 2024, I interviewed Debra Sharp, Director at Friends for Recovery. Director Sharp explained that Resident A was kicked out of program on May 2, 2024, due to bizarre behavior she began to display. Resident A would scream and try to get in the van when she was not supposed to or would refuse to get into the van when she was supposed to. Resident A was asked not to return to program for health and safety reasons as Resident A became a danger to herself and those around her. On May 2, 2024, Resident A was in the van and unbuckling her seat belt on the way to program.

Resident A got up and was walking around in the van. Resident A was getting physically aggressive with the assistant director and scaring others at program.

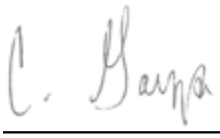
On July 9, 2024, I reviewed Resident A's AFC documents including identification record, AFC Assessment Plan, and Resident Care Agreement. According to the documents, Resident A moved to DEB AFC #2 on November 1, 2023.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instruction; health care appraisal.**
	(2) A licensee shall accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**
ANALYSIS:	Resident A moved into DEB AFC #2 on November 1, 2023. In May 2024, Resident A began to display significant behavior changes at home and the day program she attended. Resident A became more aggressive with others and did not follow directives. Resident A's condition continued to deteriorate as she displayed symptoms of depression (i.e. isolation, refusing to shower) and her physical health declined as evidenced by her becoming incontinent and losing weight. These ailments continued until her death on June 22, 2024. There is a preponderance of evidence to conclude that due to Resident A's change of services and skills required, the facility was no longer able to meet Resident A's needs and she should not have been retained at the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

On August 23, 2024, I conducted an Exit Conference with Licensee Designee, Laketa Brodnex. I advised Licensee Designee Brodnex I would be requesting a corrective action plan for the cited rule violations. I advised Licensee Designee Brodnex I would be recommending a provisional license.

IV. RECOMMENDATION

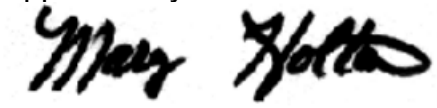
Contingent upon receipt of an acceptable corrective action, I recommend issuance of a provisional license.



8/23/2024

Christina Garza — Date
Licensing Consultant

Approved By:



8/23/2024

Mary E. Holton — Date
Area Manager