GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 18, 2023

Debra Field
Field LLC
1415 E. Smith
Bay City, MI 48706

RE: License #: AM090079854
Investigation #: 2023A0576053
Abet AFC Home

Dear Debra Field:

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.

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 #:	AM090079854
Investigation #:	2023A0576053
Complaint Receipt Date:	06/22/2023
Investigation Initiation Date:	06/27/2023
Report Due Date:	08/21/2023
Licensee Name:	Field LLC
Licensee Address:	1415 E. Smith, Bay City, MI 48706
Licensee Telephone #:	(989) 450-1391
Administrator:	Debra Field
Licensee Designee:	Debra Field
Name of Facility:	Abet AFC Home
Facility Address:	2561 N. Garfield, Pinconning, MI 48650
Facility Telephone #:	(989) 879-5655
Original Issuance Date:	10/01/1998
License Status:	REGULAR
Effective Date:	09/03/2022
Expiration Date:	09/02/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, ALZHEIMERS, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 6/20/23, at 9:30am several residents were walking around inside and outside with no supervision. There were no staff around and no one answered the door. The room to where the owners lived was locked even for the residents so they had no access to anyone in case of an emergency.	No
Resident A is locked in his bedroom at night.	No
Additional Findings	Yes

III. METHODOLOGY

06/22/2023	Special Investigation Intake 2023A0576053
06/22/2023	APS Referral
06/27/2023	Special Investigation Initiated - Letter Sent email to John Jones Adult Protective Services (APS)
08/07/2023	Inspection Completed On-site Interviewed Staff, Brandon Koste, Resident B, Resident C, Resident D, and Resident E
08/18/2023	Contact - Telephone call made Interviewed Resident A
08/18/2023	Exit Conference Exit Conference conducted with Licensee Designee, Debra Field

ALLEGATION:

On 6/20/23, at 9:30am several residents were walking around inside and outside with no supervision. There were no staff around and no one answered the door. The room to where the owners live was locked and the residents did not have no access to anyone in case of an emergency.

INVESTIGATION:

On August 7, 2023, I completed an unannounced on-site inspection at Abet AFC. Upon arriving to the facility, several residents were outside the home. 3 residents, Resident

B, Resident C, and Resident D were in the middle of driveway towards the road. The residents reported they were waiting for their ride to go to program. There were 2 other residents outside the home and closer to the facility. These 2 residents were walking around and smoking.

While at the home, I interviewed Staff, Brandon Koste. Staff Koste reported he is live-in staff along with his wife, Jeanine Koste. There are 11 residents who reside at the home, all are high functioning, and they can access the community without staff, according to Staff Koste. Staff Koste reported there is always staff at the home to provide for the care and supervision of the residents. Staff Koste explained that there is sliding door between the area of the house where the resident bedrooms are and staff sleeping quarters. This door is closed and locked at nighttime during sleeping hours due to residents stealing from the kitchen when staff are asleep. Staff Koste reports staff sleep during the night, and he wakes up daily at 7am to attend to the residents. If the residents need something during the night, they will knock on the sliding door and Staff Koste can hear if they knock. The residents have access to the home phone and some of the residents also have cell phones and can call Staff Koste when needed.

While at the home, I viewed a sliding door that separates a small living room area, bathroom, and resident bedrooms from the kitchen, another living room area, and staff bedrooms. This sliding door is equipped with a padlock and is locked at nighttime during sleeping hours. The area where resident bedrooms are located has 2 separate means of egress from the small living room.

On August 7, 2023, I interviewed Resident G who reported he has lived at the home for 10 years and he likes his home. Resident G reported there is always staff at home when he is there. Resident G reported he is not sure what time staff wake up in the morning. There is a door that locks residents from the staff bedroom area and kitchen at nighttime. There is a lock because people were going into the kitchen and stealing. If there were an emergency, Resident G would call Staff, Brandon Koste on the phone. Resident G does not have a phone however other residents have cell phones. Resident G has never had to knock on the locked sliding door to get staff. The door has been locked for about one year.

On August 7, 2023, I interviewed Resident H who reported the sliding door in the middle of the home is locked at night due to residents stealing from the kitchen. The door is opened in the morning so residents can eat breakfast and get their medications. If there were an emergency in the middle of the night, Resident H would use his cell phone to call staff. Resident H reported there is always staff at the home and residents are never left home without staff supervision. Resident H advised that when the sliding door is locked at night, he has to drink water from bathroom sinks using his hands. Resident H would prefer to drink from the kitchen.

On August 7, 2023, I reviewed resident records including AFC Assessment Plans. It appears that staffing at the home is adequate to meet the needs of the residents.

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:	It was alleged that there was no staff supervision and residents were left unattended. Upon completion of an unannounced on-site inspection and investigative interviews, there is not a preponderance of evidence to conclude a rule violation. An unannounced on-site inspection was made to the home on August 7, 2023, and found several residents outside the home smoking and waiting for transportation to their day program. Staff, Brandon Koste was available and attending to residents at the home. Staff Koste reported there is a locked door in between the area of the home where residents and staff sleep, which was viewed. If the residents needed anything at nighttime, they knock on the door or can call for assistance via the telephone. Resident records were viewed, and it appears the licensee has sufficient staff on duty for the supervision and protection of the residents and as specified in the resident assessment plans.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is locked in his bedroom at night.

INVESTIGATION:

On June 27, 2023, I sent an email to Jon Jones, Bay County Adult Protective Services (APS) Investigator who reported he denied his case involving Resident A. Resident A no longer lives at Abet AFC and is receiving inpatient mental health services at McLaren Hospital.

On August 7, 2023, I completed an unannounced on-site inspection at Abet AFC. I interviewed live-in staff, Brandon Koste who reported Resident A moved from the home in July 2023. Resident A required placement to a psychiatric ward due to having mental health issues. Resident A has a history of multiple psychiatric placements and lived at

Abet AFC for 2 months. Resident A had panic attack and wanted to go to the hospital. The ambulance transported Resident A to the hospital and Resident A advised he did not want to return to Abet AFC. Regarding the allegations, Mr. Koste denied Resident A was locked in his bedroom. Mr. Koste reported that none of the resident bedrooms were equipped with locks.

While at the home resident bedrooms were viewed. None of the bedrooms were equipped with locks.

On August 7, 2023, I interviewed Resident H who confirmed he was familiar with Resident A. According to Resident H, Resident A was quiet person. Resident H denied Resident A was ever locked in his bedroom. Resident H denied he has ever been locked in his bedroom.

On August 7, 2023, I interviewed Resident G who denied he has ever been locked in his bedroom and advised his bedroom door does not have a lock. Resident G reported his bedroom door will not open as it is too tight. Resident G reported his door needs to be filed down “because it sticks”.

On August 18, 2023, I interviewed Resident A. Resident A reported he lived at Abet AFC for about 3 months. Regarding the allegation, Resident A denied he was locked in his bedroom.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**

ANALYSIS:	It was alleged that Resident A was locked in his bedroom at night. There is not a preponderance of evidence to conclude a rule violation. On August 7, 2023, I conducted an unannounced on-site inspection at Abet AFC and interviewed staff and residents. Staff, Brandon Koste denied Resident A was ever locked in his bedroom. Staff Koste advised none of the resident bedroom doors have locks. Resident A, Resident G, and Resident H were interviewed and denied ever being locked in their bedrooms. Resident bedrooms were viewed and none of the bedroom doors were equipped with locks. There is not a preponderance of evidence to conclude Resident A was confined to his room as alleged.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On August 7, 2023, I interviewed Resident D at his home. Resident D reported he does not have a lock on his bedroom door however the door will not open because it is too tight. I went to Resident D's bedroom and the door was difficult to open as it was stuck. I was able to push open the door by using my shoulder to force open the door. The door required a fairly significant amount of force in order to push open.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	On August 7, 2023, I completed an unannounced on-site inspection to the home. Resident D reported his bedroom door was difficult to open. I went to Resident D's bedroom door and the door was hard to open and appeared to be stuck. The door was able to open using some force and by pushing through with my shoulder. This resident bedroom is not maintained for the safety of the residents given it is difficult to open and presents a hazard if the residents needed to evacuate the room immediately.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On August 7, 2023, I completed an unannounced on-site inspection at Abet AFC. Staff, Brandon Koste advised that there is a door that is locked at night that keeps residents from the kitchen due to problems with stealing. The locked door separates resident bedrooms, a living room, and a resident bathroom from the kitchen, a second living room, a second bathroom, and staff sleeping quarters. According to Staff Koste, the door is locked nightly. While at the facility I viewed a sliding door equipped with a padlock that separates the 2 areas of the home as noted above.

On August 18, 2023, I reviewed the Original Licensing Study Report, which indicated there are two living/sitting room areas in the home providing the required minimum 35 square foot of living room space for 12 residents: the sitting room area on the east side of the home measures 315 square feet and the living room area on the staff west side of the home measures 204 square feet.

APPLICABLE RULE	
R 400.14405	**Living space.**
	(1) A licensee shall provide, per occupant, not less than 35 square feet of indoor living space, exclusive of bathrooms, storage areas, hallways, kitchens, and sleeping areas.

ANALYSIS:	On August 7, 2023, I completed an unannounced on-site inspection at Abet AFC. Staff, Brandon Koste advised that at nighttime a door separates and locks out residents from the west living room area of the home. Keeping residents from this living room area does not provide each occupant at least 35 square feet of indoor living space, which is a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On August 18, 2023, I conducted an Exit Conference with Licensee Designee, Debra Fields. I advised Licensee Designee Fields I would be requesting a corrective action plan for the cited rule violations.

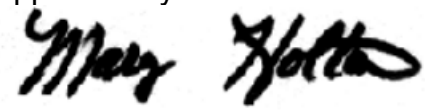
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change to the license status is recommended.

8/18/2023

Christina Garza Date
Licensing Consultant

Approved By:



8/18/2023

Mary E. Holton Date
Area Manager