GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 19, 2023

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

RE: License #: AS730305099
Investigation #: 2023A0576063
D.E.B. AFC Inc. #3

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.

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 #:	AS730305099
Investigation #:	2023A0576063
Complaint Receipt Date:	07/26/2023
Investigation Initiation Date:	07/26/2023
Report Due Date:	09/24/2023
Licensee Name:	D.E.B. AFC Inc.
Licensee Address:	P.O Box 136, Bridgeport, MI 48722
Licensee Telephone #:	(989) 714-0793
Administrator:	Laketa Brodnex
Licensee Designee:	Laketa Brodnex
Name of Facility:	D.E.B. AFC Inc. #3
Facility Address:	3040 S. Towerline Rd., Bridgeport, MI 48722
Facility Telephone #:	(989) 777-2454
Original Issuance Date:	04/02/2010
License Status:	REGULAR
Effective Date:	10/13/2022
Expiration Date:	10/12/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A ran out of her medication, Depakote.	Yes

III. METHODOLOGY

07/26/2023	Special Investigation Intake 2023A0576063
07/26/2023	Special Investigation Initiated - Telephone Interviewed Staff, Hattie Tillman
08/03/2023	Inspection Completed On-site Interviewed Staff, Hattie Tillman, and viewed Resident A
09/18/2023	APS Referral Referral to APS
09/19/2023	Contact - Telephone call made Interviewed Lori Schnell, All Valley Home Health & Valley Hospice Care Nurse
09/19/2023	Contact - Telephone call made Interviewed Guardian A
09/19/2023	Exit Conference Exit Conference conducted with Licensee Designee, Laketa Brodnex

ALLEGATION:

Resident A ran out of her medication, Depakote.

INVESTIGATION:

On July 26, 2023, I interviewed Staff, Hattie Tillman regarding the allegations. Staff Tillman reported they did not know the doctor was going to abruptly quit the facility and the doctor quit over a month ago. Resident A is on hospice and missed some of her medication (Depakote) she takes for preventative seizures. Staff Tillman was able to get an order of the Depakote medication from hospice for 10 days for Resident A.

On August 3, 2023, I completed an unannounced on-site inspection at D.E.B. #3 and interviewed Staff, Hattie Tillman and reviewed the medication book and medications for Resident A. Staff Tillman reported Resident A's doctor, Dr. Kahn abruptly resigned, and no notice was given that he would not be returning to care for his patients. Resident A takes Depakote 125mg twice per day and she missed doses of this medication in July 2023, as there were no refills. Resident A's Nurse from All Valley Home Health & Valley Hospice Care, Lori Schnell helped Staff Tillman get the medication in the home. Resident A will have a new doctor, Dr. Zarillo who will be coming to the home tomorrow.

While at the home I viewed Resident A's Depakote 125 mg medication, which was in the home. Upon review of Resident A's medication administration log sheets, Resident A missed her Depakote 125 mg doses from July 1, 2023, through July 24, 2023.

On August 3, 2023, I viewed Resident A in a chair in the living room. Resident A appeared neat and clean in appearance and did not appear to be under any duress. Resident A appeared to be napping in her chair.

On September 19, 2023, I interviewed Lori Schnell, Nurse from All Valley Home Health & Valley Hospice Care who reported she is not sure why the home ran out of Depakote medication for Resident A. The last script was ordered on July 21, 2023, and was sent to the pharmacy. Nurse Schnell reported that Dr. Kahn will continue to see Resident A as she is on hospice however, he is no longer her primary doctor. According to Nurse Schnell, Staff Hattie Tillman was notified of this change a month in advance. Nurse Schnell was not aware that Resident A had run out of her medication and once she was made aware, she immediately wrote the script and sent the order to Dr. Kahn to be signed. Nurse Schnell reported all the home has to do is contact her that Resident A needs a medication, and she can get it ordered.

On September 19, 2023, I interviewed Resident A's guardian, Guardian A who reported he was aware that Resident A missed some doses of her medication in July 2023. Staff, Hattie Tillman informed him that there was an issue with the doctor and maybe he retired or something and he did not prescribe Resident A's medication. Guardian A denied any concerns regarding the home and advised staff do the best they can in caring for the residents.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the

	requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	It was alleged that Resident A ran out of her medication, Depakote. Upon conclusion of investigative interviews and an unannounced on-site inspection, there is a preponderance of evidence to conclude a rule violation. Resident A is ordered to receive Depakote 125mg twice a day. According to her medication administration sheets, Resident A did not receive this medication as ordered between July 1, 2023, through July 24, 2023. According to Staff, Hattie Tillman Resident A's doctor quit seeing Resident A as a patient and he did not write an order for the medication. Nurse, Lory Schnell from All Valley Home Health & Valley Hospice Care reported once she was made aware that Resident A had run out of the medication, she immediately wrote a script for Resident A's doctor, which was dated for July 21, 2023. There is a preponderance of evidence to conclude a rule violation as Resident A did not receive her medication as ordered for several days in July 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

On September 19, 2023, 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 violation.

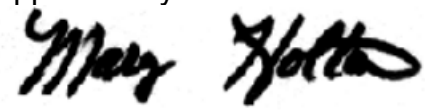
IV. RECOMMENDATION

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

9/19/2023

Christina Garza Date
Licensing Consultant

Approved By:



9/19/2023

Mary E. Holton Date
Area Manager