STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 5, 2024

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

RE: License #: AS730287431
Investigation #: 2024A0576009
D.E.B. AFC, Inc. #2

Dear Laketa Brodnex:

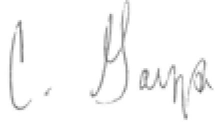
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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 #:	2024A0576009
Complaint Receipt Date:	11/14/2023
Investigation Initiation Date:	11/16/2023
Report Due Date:	01/13/2024
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. #2
Facility Address:	3197 Studor, Saginaw, MI 48601
Facility Telephone #:	(989) 777-6903
Original Issuance Date:	05/16/2007
License Status:	REGULAR
Effective Date:	12/19/2021
Expiration Date:	12/18/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A is not allowed to use the phone.	No
On November 11, 2023, Resident A was hit in the face by staff, and she is abused daily.	No
Resident A went to emergency room because she was throwing property and threatening staff. No staff member was present with her at the hospital.	Yes
Resident A is not allowed to shower, and she is not provided with shampoo.	No

III. METHODOLOGY

11/14/2023	Special Investigation Intake 2024A0576009
11/14/2023	APS Referral
11/16/2023	Special Investigation Initiated - On Site Interviewed Staff, Edesha Bradley, Resident B and Resident C
11/21/2023	Contact - Face to Face Interviewed Licensee Designee, Laketa Brodnex
01/04/2024	Contact - Face to Face Interviewed Resident A
01/05/2024	Contact - Telephone call made Interviewed Judy Schiavone, Schiavone AFC Inc. Licensee Designee
01/05/2024	Contact - Telephone call made Interviewed Guardian A
01/05/2024	Exit Conference

ALLEGATION:

Resident A is not allowed to use the phone.

INVESTIGATION:

On November 16, 2023, I conducted an unannounced on-site inspection at D.E.B. #2 and interviewed Staff, Edesha Bradley. Staff Bradley reported the facility has a house phone for resident use. According to Staff Bradley, the residents can use the phone whenever they want.

On November 16, 2023, I interviewed Resident B regarding the allegations. Resident B reported there is a home phone, and she can use the phone whenever she wants. I also interviewed Resident C who confirmed she can use the home phone when she wants however it can be hard to see the numbers.

While at the facility I viewed the facility phone. The phone appeared to be in good working condition.

On November 4, 2024, I attempted to interview Resident A regarding the allegations however her speech was difficult to understand.

On January 5, 2024, I interviewed Resident A's Guardian, Guardian A regarding the allegation. Guardian A reported Resident A does not have any phone restrictions in place. Resident A does have a history of abusing the phone at her previous placement. Guardian A met with Resident A in December 2023, and she did not report that she was not being allowed to use the telephone at her home. Guardian A reported he has other residents who reside at the home, and they report no concerns about the home.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.**

ANALYSIS:	It was alleged that Resident A is not allowed to use the phone. Upon conclusion of investigative interviews, there is not a preponderance of evidence to conclude a rule violation. On November 16, 2023, I conducted an unannounced on-site inspection and discovered the facility has a home phone available for resident used. An attempt to interview Resident A regarding the allegation was conducted however much of her speech could not be understood. Resident A's guardian was interviewed and denied Resident A has any phone restrictions. Resident A has not reported to her guardian that she is not allowed phone access at her home. Resident B and Resident C were interviewed and denied they are not allowed to use the telephone when they want. Staff, Edesha Bradley was interviewed and denied Resident A is not allowed to use the phone. There is not a preponderance of evidence to conclude Resident A is not allowed reasonable phone access.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- On November 11, 2023, Resident A was hit in the face by staff, and she is abused daily.
- Resident A went to emergency room because she was throwing property and threatening staff. No staff member was present with her at the hospital.

INVESTIGATION:

On November 16, 2023, I completed an unannounced on-site inspection at D.E.B. #2 and interviewed Staff, Edesha Bradley who has worked at the facility for almost 1 year. Regarding the allegations, Resident A was sent to the hospital and was fighting with police. Resident A thought it was Thursday, and wanted to attend her day program, Friends for Recovery however it was Saturday. Resident A tried to leave the home and hitchhike to program. Resident A was agitated and started flipping furniture over in the home. 911 was called and the police and emergency medical technicians (EMT) arrived. They tried to tell Resident A it was Saturday, and she did not believe them. Resident A was throwing herself on the ground and threw herself on the living room floor where there was broken glass from a table that she broke. According to Staff Bradley, Resident A was out of control and staff did not abuse or mistreat her in any manner. Resident A was transported to the hospital and no staff accompanied her. Staff Bradley reported that Resident A's guardian, Guardian A was called, and he

reported he would go up to the hospital. Resident A was at the hospital for 2-3 hours and was not admitted. Resident A is not allowed to access the community on her own.

On November 16, 2023, I interviewed Resident B regarding the allegations. Resident B reported she has lived at the home for 2 years and it is alright. Resident B is familiar with Resident A. Regarding the allegations, Resident B reported Resident A was waiting for a ride and kept going in and out of the home. Resident A was “waiting for the truck from Friends for Recovery and the truck didn’t come”. According to Resident B, the truck did not come because it was the weekend and Resident A thought it was a weekday. Resident A does not go to program on the weekend and Resident A became upset. Resident A knocked over a glass cup causing it to break. Resident B denied that staff hit or pushed Resident A. Staff were trying to calm Resident A down and told her there was no program. The police and EMT arrived and transported Resident A to the hospital. Resident B has never witnessed staff hit or push any residents and they have never hit or pushed her. Resident B denied any concerns regarding her home.

On November 16, 2023, I interviewed Resident C who reported staff have never hit or pushed Resident A. Staff have never hit or abused any residents.

On November 16, 2023, I reviewed Resident A’s Health Care Appraisal. The appraisal indicated that Resident A is diagnosed with hypertension, epilepsy, and severe schizophrenia. I also reviewed Resident A’s AFC Assessment Plan, which revealed Resident A does not move independently within the community as she gets dizzy is a fall risk.

On November 21, 2023, I interviewed Licensee Designee, Laketa Brodnex regarding the allegations. Licensee Designee Brodnex reported Resident A got her days mixed up and thought she was to attend her day program on the weekend however the program is not open on the weekends. Resident A fought with the police and was taken to the hospital. No staff accompanied Resident A to the hospital. Resident A was not hit or assaulted by staff in any manner.

On January 4, 2024, I reviewed an AFC Licensing Division – Incident / Accident Report (IR) authored by Edesha Bradley and dated for November 11, 2023. The IR documented that on November 11, 2023, Resident A wanted to go to Friends for Recovery on a Saturday. Resident A was told she attends her program on Monday through Friday. Resident A started to throw books and glass everywhere and she was trying to catch a ride from drivers on the street. Corrective measures include police and guardian were contacted and Resident A was transported to the hospital.

On January 4, 2023, I interviewed Resident A regarding the allegations. Resident A was difficult to understand as her speech was limited past yes or no answers. Resident A denied liking her home and denied that she feels safe at home. The interview was concluded as I could not understand Resident A’s responses. Resident A appeared neat and clean with no discernable odors. Resident A did not have any marks or bruises on her face or hands.

On January 5, 2024, I interviewed Judy Schiavone, Licensee Designee for Schiavone AFC VI where Resident A previously resided for 8 years. Resident A moved to D.E.B. AFC #2 from Schiavone AFC VI on November 1, 2023, due to the facility closing. Resident A has a diagnosis of Schizophrenia and can become assaultive toward staff. In the past, Resident A has gone after staff with her fists and will dig her nails into staff. Resident A "is not mild-mannered" and Resident A's relatives are not able to take her home as they did in the past due to behaviors she presents. Resident A is not always credible and likes to get others in trouble. Resident A responds to internal stimuli and "is in and out of reality". Resident A will get paranoid if she cannot attend program and there was an occasion when Resident A called Friends for Recovery 96 times on a Saturday for them to pick her up. Resident A would not believe staff that the program was closed due to it being a weekend.

On January 5, 2024, I interviewed Resident A's Guardian, Guardian A regarding the allegations. Guardian A reported staff called him on November 11, 2023, when the incident with Resident A was happening. Resident A can get confused easily and she thought she was to attend her day program on the weekend. Resident A became agitated and started to break things at the home. Resident A was transported to the hospital, and she was not admitted. Resident A returned to the home after hospital staff examined her and concluded she had a mental health episode. Guardian A did not go to the hospital when Resident A was transported there, and Resident A cannot access the community without staff supervision. According to Guardian A, AFC staff have a responsibility to accompany Resident A to the hospital until such a time that she is admitted. Guardian A reported Resident A's move to the home is likely confusing to her and there is an adjustment period. Staff are trying to learn Resident A and her behaviors and what causes her to become upset. Guardian A denied any concerns about the home.

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 Resident A was mistreated by staff, and she was not accompanied to the hospital after being transported by emergency personnel. Upon conclusion of investigative interviews and a review of documentation, there is a preponderance of evidence to conclude a rule violation. Attempts to interview Resident A were unsuccessful as her speech is very limited. Resident A's guardian was interviewed and was aware of the incident involving Resident A and had no concerns that Resident A was mistreated by staff. Resident B

	and Resident C were interviewed and denied staff hit or harmed Resident A. The 2 residents deny staff hit or push residents who live at the home.
CONCLUSION:	**VIOLATON NOT ESTABLISHED**

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:	On November 11, 2023, Resident A became agitated due to believing she was to attend her day program. Staff tried to advise Resident A that it was Saturday, and the program was closed. Resident A broke things in the home and was out of control. 911 was called and Resident A was transported to the hospital. No staff accompanied Resident A to the hospital. Resident A was at the hospital for a few hours, was not admitted and returned to her home. When Resident A went to the hospital, no staff accompanied her. According to Resident A's AFC Assessment Plan, Resident A does not access the community alone. Resident A's protection and safety was not adhered to at all times given staff did not accompany her while in the community.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is not allowed to shower, and she is not provided with shampoo.

INVESTIGATION:

On November 16, 2023, I conducted an unannounced on-site inspection at D.E.B. #2 and interviewed Staff, Edesha Bradley. Staff Bradley reported Resident A can shower anytime she wants. Resident A requires some assistance from staff with showering, which is provided to her. All the residents have their own baskets with toiletries that are kept in their respective bedrooms.

While at the home I viewed each resident have a plastic basket in their respective bedrooms that contained several toiletry items. Each basket was a different color and residents had their own lotion, shampoo, body wash, and deodorant for use.

On November 16, 2023, I interviewed Resident B regarding the allegation. Resident B reported she can shower anytime she wants. Resident B has soap and shampoos in her room, and they were viewed.

On November 16, 2023, I interviewed Resident C who reported can shower whenever she wants. Resident C has soap and shampoo in her bedroom, which was viewed.

On November 16, 2023, I reviewed Resident A's AFC Assessment Plan. The plan indicated that Resident A requires some assistance with showering. Staff are to monitor that Resident A washes all her body as she likes to stand under the water neglecting to fully wash herself.

On November 21, 2023, I interviewed Licensee Designee, Laketa Brodnex regarding the allegations. Licensee Designee Brodnex reported Resident A can shower anytime she wants, and Resident A is provided shampoo.

On January 4, 2023, I attempted to interview Resident A regarding the allegations. Resident A was difficult to understand as her speech was limited past yes or no answers. Resident A confirmed she showers at home. Resident A appeared neat and clean with no discernable odors.

On January 5, 2024, I interviewed Resident A's Guardian, Guardian A regarding the allegations. Guardian A reported Resident A does require staff prompts for showering and D.E.B. AFC #2 staff provide Resident A such prompts. Resident A has a history of refusing to shower however this is not the fault of staff.

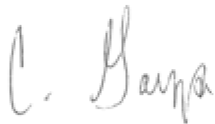
APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	It was alleged that Resident A is not allowed to shower and is not provided shampoo. Upon conclusion of investigative interviews, there is not a preponderance of evidence to conclude a rule violation.

	Resident A was interviewed and, although difficult to understand, she did confirm she showers at home. Resident A's guardian was interviewed and reported Resident A requires prompts to shower, which is provided by staff. Guardian A denied any concerns with staff not ensuring Resident A's showers. Resident B and Resident C confirmed they can shower when the want and that they are provided all needed toiletries. While at the home on November 16, 2023, I viewed all the residents to have their own soap, shampoo, body wash, and deodorant for use. There is not a preponderance of evidence to conclude Resident A is not allowed the opportunity for bathing and personal hygiene.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On January 5, 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 violation.

IV. RECOMMENDATION

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



1/5/2024

Christina Garza Date
Licensing Consultant

Approved By:

1/5/2024

Mary E. Holton Date
Area Manager