GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 20, 2024

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

RE: License #: AS730287431
Investigation #: 2024A0576033
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 #:	2024A0576033
Complaint Receipt Date:	04/23/2024
Investigation Initiation Date:	04/25/2024
Report Due Date:	06/22/2024
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:	12/19/2023
Expiration Date:	12/18/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Concerns that Resident A was abused by staff. Resident B goes on errands with staff, Toni Gray and does not feel safe.	No
Resident A was observed to have bruising all over her face, chest, shoulders. Resident A has a large knot and bruising on her arm. Staff did not seek medical treatment for Resident A.	Yes

III. METHODOLOGY

04/23/2024	Special Investigation Intake 2024A0576033
04/23/2024	APS Referral
04/25/2024	Special Investigation Initiated - Letter Sent email to Rebecca Robelin, Saginaw County Adult Protective Services (APS)
04/30/2024	Inspection Completed On-site Interviewed Staff, Lakesha Mathious and Resident C
04/30/2024	Contact - Face to Face Interviewed Staff Hattie Tillman
04/30/2024	Contact - Face to Face Interviewed Resident A
05/02/2024	Contact - Face to Face Interviewed Staff Tasha Weathers and Resident D
05/09/2024	Contact - Telephone call made Interviewed Case Manager, Kathy Janeczek
06/03/2024	Contact - Telephone call made Interviewed Relative B
06/10/2024	Contact - Face to Face Unsuccessful contact with Resident B
06/18/2024	Contact - Telephone call made Unsuccessful phone contact with Staff Toni Gray

06/20/2024	Exit Conference

ALLEGATION:

Concerns that Resident A was abused by staff. Resident B goes on errands with staff, Toni Gray and does not feel safe.

INVESTIGATION:

On April 30, 2024, I conducted an unannounced on-site inspection at D.E.B. AFC #2 and interviewed Staff, Lakesha Mathious. Staff Mathious reported Resident A no longer lives at the home. Resident A lived at D.E.B. AFC #2 since January 2020, and has dementia. Regarding the allegations, Staff Mathious came into work on April 1, 2024, and observed Resident A with a bruise under her eye and chin and she asked Resident A what happened. Resident A reported that she fell out of bed and hit her face on a walker. Resident A did not tell staff she fell and got herself up. Staff Mathious reported she assists Resident A with showering and toileting, and she did not notice any other bruising on Resident A's body. Staff Mathious called Staff Hattie Tillman and Resident A's Case Manager about Resident A falling and an Incident Report (IR) was written. On April 19, 2024, the police were at the home for another resident and viewed Resident A to have bruising on her face. Resident A was sent to the hospital and has not returned to the home. Staff Mathious is not aware of Resident A having any other bruising than on her face. Resident A is honest and gets along well with staff. Some of the residents "fuss with each other usually over the television." Staff Mathious denied being aware of how Resident A received any other injures. Resident A is verbal and can report if someone were mistreating her. Resident A's talks about the past often and will say she talked to family members however she has not. Resident A is "outspoken" and Staff Mathious believes she would tell someone if she was being mistreated. Resident A never told Staff Mathious that someone hurt her.

Staff Mathious reported Resident B no longer lives at the home. Resident B is currently in jail for a possible charge of home invasion. Resident B and Staff Toni Gray are familiar with each other from the community. Staff Gray has taken Resident A to the store and Resident B never reported feeling unsafe with Staff Gray.

On April 30, 2024, I interviewed Resident C who reported she has lived at her home for 3 years. Resident C reported she does not have a lot of complaints regarding her home, and it is "satisfactory". Resident C confirmed she gets along with staff and staff are polite. Resident C feels safe at her home, and staff are attentive. Resident C reported staff have not mistreated her or any residents in any manner.

On April 30, 2024, I interviewed Staff, Hattie Tillman regarding the allegations. Staff Tillman reported Resident A has lived at the home for a few years. Staff Tillman has no knowledge of staff harming Resident A. Resident A has falls on occasion and takes a

medication (Coumadin) that causes her to bruise easily. Resident A has dementia and experiences hallucinations. Resident A gets names mixed up and says things that are not always true. Resident A would tell someone if staff were hurting her. Resident A never reported to Statt Tillman that staff mistreated her. No staff or residents have ever reported to Statt Tillman that anyone was mistreating Resident A.

Regarding Resident B, Staff Tillman reported Staff Toni Gray and Resident B know each other and may have lived together in the past. Staff Gray has taken Resident B to appointments and on one occasion Staff Gray took milk to her home after getting permission. Resident B never reported to Staff Tillman that she felt unsafe with Staff Gray.

On April 30, 2024, I interviewed Resident A at a nursing home she was currently residing. Resident A was viewed to have faint bruising on the left side of her chin and under her eye. Resident A had bruising on her right elbow area and left leg. Resident A was asked how she received the bruises and she reported she tripped over a walker. Resident A reported she wanted to go to the restroom and the walker was in the way. Resident A reported that after she fell, staff came to her bedroom and helped her up. She does not remember the staff person who helped her. After falling, she went to the living room to watch television. Resident A was in a little pain when she was watching television and she told staff. Resident A asked for pain medication, which she was given. Resident A asked to see the doctor however no one took her. Resident A denied staff hit her causing the bruising and stated her injuries are the result of her falling over the walker.

On April 30, 2024, I reviewed an AFC Licensing Division Incident / Accident Report (IR) dated for April 1, 2024, and authored by Lakisha Mathious. The IR documented that Staff Mathious came to work on April 1, 2024, and viewed Resident A. Staff Mathious asked Resident A what happened, and she said she fell out of bed over the weekend. Resident A denied she told anyone about falling out of bed and that she got herself up. Staff Mathious directed Resident A to tell staff when she wanted to get out of bed so they can help her and so she does not keep falling.

On April 30, 2024, I reviewed Resident A's AFC Assessment Plan which revealed Resident A is 64 years old. Resident A can communicate her needs and understands verbal communication. Resident A does not move independently in the community and requires staff assistance with toileting, bathing, grooming, dressing, and personal hygiene. Resident A uses a cane for walking. According to Resident A's Individual Plan of Service (IPOS) Resident A had a stroke in the past and dementia. Resident A is unable to make appropriate decisions for herself and lacks insight to her mental health. I viewed Resident A's health care appraisal, and it is documented that Resident A is diagnosed with schizophrenia, hypertension, hyperlipidemia, ischemic vascular dementia.

On May 2, 2024, I interviewed Staff Tasha Weathers regarding the allegations. Staff Weathers denied any knowledge of the allegations. Staff Weathers reported that she

saw a bruise on Resident A's chin and Resident A said she fell over the walker. Staff Weathers had been off for 3-4 days and when she can back to work, she saw Resident A with the bruise on her chin. In between Resident A's bed and Resident C's bed is Resident C's walker. Staff Weathers denied that any staff or resident told her that staff mistreated Resident A.

Regarding Resident B, Staff Weathers reported Resident B and Staff Toni Gray know each other personally. One day, Resident B reported she did not feel safe leaving with Staff Gray. Staff Weathers is not sure why Resident B said this, and she is not sure if she meant Staff Gray's driving.

On May 2, 2024, I interviewed Resident D at her home regarding the allegations. Resident D was aware that Resident A had a bruise under her eye and elbow. Resident D does not know how Resident A received the bruises. Resident A did not say how she received the bruises and did not say anyone hit her. Resident D did not witness staff, or resident hit Resident A. Resident D reported Resident A has fallen out of bed before however she does not remember when. Resident D heard a noise coming from Resident A's bedroom and Resident A yelled when she fell. Resident D did not do anything, and she is not sure if staff went to help Resident A. Resident D has never known of staff to hurt Resident A. Resident D feels safe at her home and denied any concerns.

Resident D reported she is familiar with Staff Toni Gray, and she is a nice person. Staff Gray has taken Resident D to the store before, and she did not do anything to make her feel unsafe. Resident D has no concerns regarding Staff Gray.

On May 9, 2024, I interviewed Resident B's Case Manager, Kathy Janeczek who reported Resident B does not have a guardian and is court ordered to live at an AFC home. Resident B may have not felt safe at the home because some of the staff may have known Resident A personally. Resident B lived at D.E.B. AFC #2 for about two months, and she has been given a discharge notice. Resident B often left the home to meet with a boyfriend and she is currently in jail for domestic violence/assault with additional charges pending.

On June 3, 2024, I interviewed Resident B's relative, Relative B who reported Resident B is no longer in jail and lives at another home however Relative B was not sure where. Relative B denied Resident B reported to her that she was being mistreated by staff at D.E.B. AFC #2 or that she felt unsafe.

On June 10, 2024, I attempted to visit with Resident B at her new home in Saginaw. A staff person, Pam advised that Resident B was not there. Pam did not know Resident B's phone number.

On June 18, 2024, I attempted to call Staff Toni Gray. A recording stated the person I was calling cannot accept calls at this time.

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 may have been abused by staff and that Resident B feels unsafe with Staff Tony Gray when she goes on errands. Upon conclusion of investigative interviews there is not a preponderance of evidence to conclude a rule violation. Resident A was viewed to have bruises on multiple parts of her body. According to Resident A she fell causing the bruising. An incident report was viewed and documented that Resident A reported to falling out of her bed causing her injuries. Resident C and Resident D were interviewed and denied staff mistreat residents. Additionally, Resident D reported she goes on errands with Staff Toni Gray and does not feel unsafe. Resident B was unable to be located during the course of this investigation and was unable to be interviewed. There is not a preponderance of evidence to conclude residents were not treated with dignity or their safety and protection was not adhered to at all times.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was observed to have bruising all over her face, chest, shoulders. Resident A has a large knot and bruising on her arm. Staff did not seek medical treatment for Resident A.

INVESTIGATION:

On April 30, 2024, I conducted an unannounced on-site inspection at D.E.B. AFC #2 and interviewed Staff, Lakesha Mathious. Regarding the allegation, Staff Mathious came into work on April 1, 2024, and saw Resident A with a bruise under her eye and chin and she asked Resident A what happened. Resident A reported that she fell out of bed and hit her face on a walker. Resident A did not tell staff she fell and got herself up. Resident A was not sent to the hospital or urgent care after falling. Staff Mathious

contacted Staff Hattie Tillman and Resident A's Case Manager about Resident A falling and an Incident Report (IR) was written.

On April 30, 2024, I interviewed Resident A at a nursing home she was currently residing. Resident A was viewed to have faint bruising on the left side of her chin and under her eye. Resident A had bruising on her right elbow area and left leg. Resident A was asked how she received the bruises and she reported she tripped over a walker. Resident A reported she wanted to go to the restroom and the walker was in the way. Resident A reported that after she fell, staff came to her bedroom and helped her up. She does not remember the staff person who helped her. After falling, she went to the living room to watch television. Resident A was in a little pain when she was watching television and she told staff. Resident A asked for pain medication, which she was given. Resident A asked to see the doctor however no one took her.

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:	It was alleged that Resident A had bruising on multiple parts of her body and the facility did not seek medical treatment for Resident A. Resident A was viewed on April 30, 2024, and had multiple areas of bruising. Resident A reported that she fell causing the bruising and was in pain. Resident A stated she requested to see a doctor however she was not taken. Resident A and staff, Lakesha Mathious confirm Resident A was not taken for medical care after falling. There is a preponderance of evidence to conclude Resident A had an accident and the group home did not obtain needed care immediately.
CONCLUSION:	**VIOLATION ESTABLISHED**

On June 20, 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.

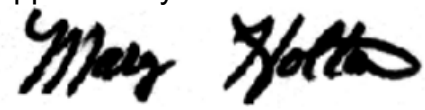
IV. RECOMMENDATION

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

6/20/2024

Christina Garza Date
Licensing Consultant

Approved By:



6/20/2024

Mary E. Holton Date
Area Manager