GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 11, 2025

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

RE: License #: AS730315015
Investigation #: 2025A0576039
D.E.B. AFC Inc. #4

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 #:	AS730315015
Investigation #:	2025A0576039
Complaint Receipt Date:	05/19/2025
Investigation Initiation Date:	05/20/2025
Report Due Date:	07/18/2025
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. #4
Facility Address:	901 S. Fayette, Saginaw, MI 48602
Facility Telephone #:	(989) 790-0882
Original Issuance Date:	02/01/2012
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
On 5/15/2025, Resident A was left unattended at the facility. It is unknown how long Resident A was left alone.	Yes

III. METHODOLOGY

05/19/2025	Special Investigation Intake 2025A0576039
05/19/2025	APS Referral
05/20/2025	Special Investigation Initiated - Letter Sent email to Rebecca Robelin, Saginaw County Adult Protective Services (APS)
05/20/2025	Contact - Document Received Received email from Rebecca Robelin
05/29/2025	Inspection Completed On-site Interviewed Staff Jarvara Murphy, Resident A, Resident B, and Resident C
07/08/2025	Contact - Telephone call made Message for Resident A's Case Manager, Bria Smith to return call
07/10/2025	Contact - Telephone call made Interviewed Kathy Janeczek, Hope Network Clinical Supervisor
07/10/2025	Contact - Telephone call made Left message for Guardian to return call
07/10/2025	Contact - Telephone call made Message for Staff, Clematee Davis to return call
07/10/2025	Contact - Document Sent Sent email to Rebecca Robelin
07/10/2025	Contact - Document Received Email received from Rebecca Robelin
07/10/2025	Contact - Telephone call made

	Interviewed Staff, Clematee Davis
07/11/2025	Contact - Telephone call returned Interviewed Guardian C1
07/11/2025	Contact - Telephone call made Interviewed Staff Erinn Oleary
07/11/2025	Exit Conference

ALLEGATION:

On 5/15/2025, Resident A was left unattended at the facility. It is unknown how long Resident A was left alone.

INVESTIGATION:

On May 20, 2025, I sent an email to Rebecca Robelin, Saginaw County Adult Protective Services (APS) Investigator regarding this investigation. Investigator Robelin confirmed she has an investigation regarding Resident A being left unattended at his AFC home. Investigator Robelin reported that she interviewed all the residents, and they denied being left at their home without staff supervision. Staff also denied residents were alone at the AFC home. On July 10, 2025, Investigator Robelin advised she denied her investigation regarding Resident A.

On May 29, 2025, I conducted an unannounced on-site inspection at D.E.B. AFC #4 and interviewed Staff Jarvara Murphy. Staff Murphy advised there are 5 residents who reside at the home. Regarding the allegations, Staff Murphy denied any knowledge. Staff Murphy denied residents are left alone at home without staff supervision. Staff Murphy confirmed she worked on May 15, 2025.

On May 29, 2025, I interviewed Resident A who stated his home is alright. The allegations were discussed with Resident A and he does not remember being left alone at his home. Resident A reported staff are always at his home. Staff ensure Resident A takes showers in the morning. Resident A has no concerns about living at his home. Resident A reported his case manager is from Saginaw County Community Mental Health and her name is Bria Smith.

On May 29, 2025, I interviewed Resident B. Resident B likes his home and staff treat him well. The allegations were discussed with Resident B and he denied them being true. According to Resident B, there is always staff on duty at his home and he is never left alone. Resident B denied any concerns about his home. Resident B denied having a guardian or case manager.

On May 29, 2025, I interviewed Resident C. Resident C was asked about any concerns they have regarding their home and Resident C reported there was an occasion when Staff Clematee Davis did not have another staff person arrive to relieve her and the Staff Davis left anyway. Resident C was left alone at the facility for about 20 minutes before the next staff person came on duty. Resident C could not recall who the staff person was that came on after Staff Davis and reported this occurred sometime in the afternoon. Resident C stated this was the only time she was left without staff at the facility.

On July 10, 2025, I called Bria Smith Case Manger from Saginaw County Community Mental Health. Manager Smith was not available, and a message was left requesting she return my call.

On July 10, 2025, I left a message for Resident C's guardian, Guardian C1 to return my call. On July 11, 2025, I interviewed Guardian C1 regarding the allegations to which they denied any knowledge. Guardian C1 stated they visited the home on one occasion and there were staff present however Resident C was not at home.

On July 10, 2025, I interviewed Staff Clematee Davis regarding the allegations. Staff Davis confirmed she worked on May 15, 2025, and that residents were left unattended for about 2 hours on that day due to confusion on her part. Staff Davis misunderstood what home she was supposed to be working at causing the residents to be alone without staff. Staff Davis said this was not intentional and she made a mistake. Once the mistake was discovered another staff member went to the facility so the residents were no longer left alone.

On July 11, 2025, I interviewed Staff Erinn Oleary. Staff Oleary stated she no longer works at the facility. Staff Oleary stated she was familiar with the allegations and confirmed they are true. Staff Oleary reported she went to work on May 15, 2025, for the midnight shift and when she got there no staff were there. Staff Oleary did not know what staff was supposed to be working prior to her arrival. Staff Oleary checked on the residents and they were fine and in bed. Staff Oleary stated she tried to call the licensee designee Laketa Brodnex however she did not answer. Staff Oleary informed Licensee Designee Brodnex via a text message that there were no staff upon her arrival. At this time Staff Oleary stated I was "cutting out" and the phone hung up. I tried to call Staff Oleary back twice and there was no answer. I left a message asking for her to return my call.

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 on May 15, 2025, residents were left alone without staff supervision. Upon conclusion of investigative interviews there is a preponderance of evidence to conclude a rule violation. Resident C was interviewed and voiced concern about a time when there were no staff on duty. Staff Clematee Davis was interviewed and confirmed she was supposed to be at the facility working but due to confusion on her part, was not at the correct facility causing residents at D.E.B. AFC #4 to be left along without staff supervision on May 15, 2025. Staff Erinn Oleary confirmed that on May 15, 2025, she arrived on duty and found there to be no staff on duty. There is a preponderance of evidence to conclude that there was not sufficient staff on duty on May 15, 2025, to ensure the safety and protection of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On July 11, 2025, I conducted an exit conference with Licensee Designee Laketa Brodnex. I advised Licensee Designee Brodnex of the findings of my investigation and advised I would be requesting a corrective action plan for the cited rule violation.

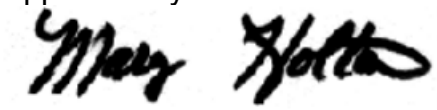
IV. RECOMMENDATION

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

7/11/2025

Christina Garza — Date
Licensing Consultant

Approved By:



7/11/2025

Mary E. Holton — Date
Area Manager