GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 1, 2025

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

RE: License #: AM090079854
Investigation #: 2025A0572041
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.
- The signature of the responsible party and a date.

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.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AM090079854
Investigation #:	2025A0572041
Complaint Receipt Date:	06/04/2025
Investigation Initiation Date:	06/06/2025
Report Due Date:	08/03/2025
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:	09/03/2024
Expiration Date:	09/02/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A got up in the middle of the night to sneak some ice cream. Home Manager Brandon Koste caught Resident A in the act and punched Resident A in the face and made Resident A crawl back to his bedroom.	No
Several unsuccessful attempts have been made to visit Resident B. Resident B reports neglect from the home.	No
Resident B had hospitalizations that were not reported to Resident B's Case Manager.	Yes

III. METHODOLOGY

06/04/2025	Special Investigation Intake 2025A0572041
06/04/2025	APS Referral APS referral was made.
06/06/2025	Special Investigation Initiated - On Site Home Manager, Brandon Koste and Resident A.
07/21/2025	Contact - Face to Face Home Manager, Brandon Koste.
07/21/2025	Contact - Face to Face Resident B.
07/23/2025	Contact - Telephone call made Complainant.
07/23/2025	Contact - Document Sent Complainant.
07/29/2025	Exit Conference Licensee Designee, Debra Fields.
07/31/2025	Contact - Telephone call made Home Manager, Brandon Koste.
07/31/2025	Contact - Document Sent Resident B's Case Manager, Norma Mason.
08/01/2025	Contact - Document Sent Davita Kidney Care Clinic.

08/01/2025	Contact - Telephone call made Home Manager, Brandon Koste.
08/01/2025	Exit Conference Licensee Designee, Debra Fields.

ALLEGATION:
Resident A got up in the middle of the night to sneak some ice cream. Home Manager Brandon Koste caught Resident A in the act and punched Resident A in the face and made Resident A crawl back to his room.

INVESTIGATION:
On 06/04/2025, the local licensing office received a complaint for investigation. Adult Protective Service (APS) and Recipient Rights also conducted their own investigation.

On 06/04/2025, I reviewed a report from APS Investigator, Chris Shores regarding the allegation. Chris Shores interviewed Resident A and Resident A indicated that it lied to mental health case worker about getting hit in the face by Home Manager, Brandon Koste because the home manager was upset that Resident A was stealing the other resident's ice cream in the middle of the night.

On 06/06/2025, I made an unannounced onsite at Abet AFC, located in Bay County Michigan. I interviewed Resident A and Home Manager, Brandon Koste.

On 06/06/2025, I interviewed Resident A regarding the allegations. Resident A admitted to being dishonest about what happened and denied that he was punched in the face by Home Manager, Brandon Koste. Resident A got out of bed around 4am to eat a half gallon of ice cream. Brandon Koste caught Resident A and took the spoon away from Resident A because Resident A is diabetic and should not be eating ice cream. Resident A stated, "I just overreacted because I got caught." Resident A informed that the ice cream did not belong to Resident A. Resident A indicated that he woke up shaking and sweating due to hyperglycemia (High blood sugar) and began to crave sugar. Resident A feels safe in the home and is not afraid of Bradon Koste.

On 06/06/2025, I interviewed Home Manager, Brandon Koste regarding the allegation. Brandon Koste informed that Resident A got up in the middle of the night to get ice cream. Staff Koste heard Resident A in the kitchen, so he got up and saw Resident A in the kitchen eating ice cream. Brandon Koste stated, "I asked what was going on and (Resident A), while breathing heavily, said that (Resident A's) sugar was low. I asked how do you know, did you check it? And (Resident A) said, "No." Brandon Koste took the ice cream and spoon away and told Resident A to wash his hands so they can check its sugar and also made Resident A a plate of grapes and

salad. During this time, Resident A kept yelling about his dialysis and dying. Resident A's sugar was checked before eating the grapes and salad and it was 93, which is within the normal range of 80 to 120. Resident A was in Resident A's bedroom, slamming his walker constantly, so he took the walker. Brandon Koste denied ever punching Resident A in the face.

On 07/31/2025, I reviewed Resident A's case file. In the file I observed a kidney friendly diet plan from Resident A's dietician. Ice cream should be limited to 4 ounces to a half a cup.

On 08/01/2025, I called Davita Kidney Care Clinic where Resident A's Dietician is employed. The Dietician was not in, but a staff member was able to read only certain details of Resident A's file. I was informed that they would never tell a patient to never eat ice cream, but if they do, it has to be in moderation. According to Resident A's chart, his Phosphorus Levels are trending up and has issues with potassium being too high. Since ice cream is high in Phosphorus, Resident A has to be very careful in eating ice cream.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on the interviews of Resident A and Home Manager, Brandon Koste; and review of the APS report, there is not enough evidence to establish a licensing rules violation. APS interviewed Resident A and Resident A admitted to making a false accusation. Resident A also admitted to me that the accusations were false and it was made because he overreacted to being caught eating ice cream. Home Manager, Brandon Koste denied hitting Resident A in the face. Staff Koste caught Resident A eating ice cream in the middle of the night. Staff Koste checked Resident A's blood sugar levels which were normal and gave Resident A some grapes and a salad to eat.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Several unsuccessful attempts have been made to visit Resident B. Resident B reports neglect from the home.**
- **Resident B had hospitalizations that were not reported to Resident B's Case Manager.**

INVESTIGATION:

On 06/06/2025, I interviewed Home Manager, Brandon Koste regarding the allegation. Brandon Koste informed me that Resident B is currently at a Nursing Home. Brandon Koste stated that this investigation started when Resident B's case manager came out to visit, but Resident B was in the hospital. Resident B was discharged that day or soon after, so the case manager had scheduled to come out and visit Resident B again. When the Case Manager came out to the home again, Resident B was back in the hospital. The Case Manager appeared to be upset because she wasn't aware that Resident B was in the hospital. Brandon Koste indicated that the case manager called several hospitals and Resident B was not at any of the local hospitals. Brandon Koste believed the Case Manager became suspicious, so she called him asking where Resident B was. When he didn't answer, she called the Licensee Designee. Brandon Koste called the hospital, and there was no record of Resident B being in the hospital because Resident B was discharged. The hospital would not release any information as to where Resident B was transferred to because Resident B is its own guardian. Brandon Koste was able to find out from the hospital's social worker that Resident B was transferred to a Nursing Home. Resident B is doing a lot better and there's a plan for Resident B to return.

On 07/21/2025, I made another unannounced onsite at Abet AFC home. I spoke with Home Manager, Brandon Koste and he reiterated what he said during the previous interview. Resident B remains in the Nursing Home.

On 07/21/2025, I visited Resident B at the Nursing Home. Resident B was very lively and energetic. Resident B was sitting at the table and had just received Resident B's lunch. Resident B informed me that he loves the home and hopes the plan is for Resident B to return. Resident B states, "Brandon (Koste) is a good guy. They take great care of me. They provide me with all of my needs." Resident B says that it feels safe at the home and has no issues or concerns.

On 07/23/2025, I made a call to Resident B's Case Manager, Norma Mason, regarding the allegation. I was unable to leave a message on the main office number but was able to leave a voicemail message on her cellphone. I also sent an email to Norma Mason. Norma Mason responded via email stating, "As far as I am concerned this client was making allegations of abuse and neglect from Brandon of not being taken care of properly. (Resident B) is now changing the statements."

On 07/31/2025, I spoke with Home Manager, Brandon Koske, regarding dates of hospitalization and the Incident Reports for those hospitalizations. Brandon Koske

informed me that he wasn't sure if one was written. Staff Koske was asked if he had informed Resident B's Case Manager that Resident B was in the hospital. Staff indicated that he didn't know that he had to contact the case manager as he contacted Resident B's Family Member #1.

On 07/31/2025, I contacted Resident B's Case Manager, Norma Mason, and asked if she had received any Incident Reports or notifications for Resident B's recent hospitalizations. Norma Mason informed me that she had not received any notifications.

On 08/01/2025, I contacted Brandon Koske again regarding dates of hospitalization and Resident B's initial move-in date and discharge date. Resident B moved into Abet AFC Home on 09/13/2019 and was discharged from the home on 04/03/2025. Brandon Koste informed me that Resident B returned home for a couple hours but had to be sent back the same day due to contracting pneumonia in the hospital. The hospital held Resident B in the hospital for weeks because he needed a public guardian to be able to transfer Resident B to a nursing 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:	Based on my interviews with Home Manager, Brandon Koste, Resident B, and Resident B's Case Manager, Norma Mason, there is not enough evidence to establish a licensing rules violation. Resident B denied any abuse or neglect from the home and wants to return. Brandon Koste denies that there is any abuse and/or neglect in the home. Resident B's Case Manager informed me that initially Resident B had said this but now has changed its story.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(b) Unexpected and preventable inpatient hospital admission.**

ANALYSIS:	Based on my interviews with Home Manager, Brandon Koste, Resident B's Case Manager, Norma Mason, and review of Resident B's files, there is enough evidence to establish a violation of this rule. Brandon Koste informed me that he wasn't aware that he had to notify Resident B's case manager of hospitalization. There also was no incident report in the file regarding the hospitalizations.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/29/2025, I held an exit conference with Licensee Designee, Debra Fields regarding the results of the special investigation. On 08/01/2025, I held another exit conference with Licensee Designee, Debra Fields. I informed Debra Fields that there was a rule violation. Debra Fields understood and stated that she will write a corrective action plan once she receives the report.

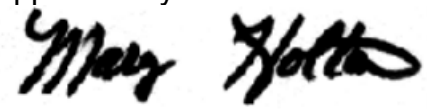
IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this medium sized adult foster care group home, pending the receipt of an acceptable corrective action plan (capacity 7-12).

08/01/2025

Anthony Humphrey Date
Licensing Consultant

Approved By:



08/01/2025

Mary E. Holton Date
Area Manager