



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

September 29, 2025

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

RE: License #: AS730315015  
Investigation #: 2025A0576049  
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,

A handwritten signature in cursive script that reads "C. Garza".

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**

<b>License #:</b>	AS730315015
<b>Investigation #:</b>	2025A0576049
<b>Complaint Receipt Date:</b>	08/04/2025
<b>Investigation Initiation Date:</b>	08/04/2025
<b>Report Due Date:</b>	10/03/2025
<b>Licensee Name:</b>	D.E.B. AFC Inc.
<b>Licensee Address:</b>	P.O Box 136, Bridgeport, MI 48722
<b>Licensee Telephone #:</b>	(989) 475-4034
<b>Administrator:</b>	Laketa Brodnex
<b>Licensee Designee:</b>	Laketa Brodnex
<b>Name of Facility:</b>	D.E.B. AFC Inc. #4
<b>Facility Address:</b>	901 S. Fayette, Saginaw, MI 48602
<b>Facility Telephone #:</b>	(989) 790-0882
<b>Original Issuance Date:</b>	02/01/2012
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	08/01/2024
<b>Expiration Date:</b>	07/31/2026
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED, ALZHEIMERS

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A stated she is forced to go to church.	Yes
Staff did not ensure Resident B had his medications in the home resulting in him not receiving his medications.	Yes

**III. METHODOLOGY**

08/04/2025	Special Investigation Intake 2025A0576049
08/04/2025	Special Investigation Initiated - Telephone Left message for Complainant
08/04/2025	APS Referral
08/18/2025	Inspection Completed On-site Interviewed Licensee Designee, Laketa Brodnex and Resident C
08/29/2025	Contact - Telephone call made Interviewed Resident A
09/25/2025	Contact - Telephone call made Interviewed Guardian B1
09/25/2025	Contact - Telephone call made Interviewed Guardian A1
09/29/2025	Exit Conference

**ALLEGATION:**

**Resident A stated she is forced to go to church.**

**INVESTIGATION:**

On August 18, 2025, I conducted an unannounced on-site inspection at D.E.B. AFC #4 and interviewed Licensee Designee Laketa Brodnex regarding the allegations. Licensee Designee Brodnex reported Resident A moved from the home last week and moved into another AFC home. Resident A was given a 30-day discharge notice due to

behaviors she was presenting in the home including stealing from other residents and becoming verbally aggressive with staff. Resident A lived at the facility for approximately 2 months. Licensee Designee Brodnex denied the allegations and stated Resident A liked going to church and never complained about church. Resident A had the choice if she wanted to attend church or not.

On August 18, 2025, I interviewed Resident C regarding the allegations. Resident C reported they have lived at the home for several years. Resident C reported that they do not attend any program during the week. Resident C attends church every Sunday and Resident C does not mind going. Resident C reported that it is a rule that you must go to church per Licensee Designee Laketa Brodnex. All the residents who live at the home go to church because they have to.

On August 29, 2025, I interviewed Resident A regarding the allegations. Resident A reported they no longer live at D.E.B. AFC #4 and moved out on August 11, 2025. Resident A did not live at the facility long. Regarding the allegations, Resident A reported that all the residents who reside at the facility had to go to church on Sundays. All the residents must go to church unless they had somewhere else to go because there was no staff at the home when they went to church. Resident A reported she went to church because she had to, did not have anywhere else to go, and because there were no staff at the home when staff and residents went to church.

On September 25, 2025, I interviewed Resident B's guardian, Guardian B1 who reported Resident B attends church on Sundays and likes to attend church. Guardian B1 is not sure if church attendance is a requirement to live at the facility. When residents attend church on Sundays, they attend with one staff, there are no other staff on duty at the home.

On September 25, 2025, I interviewed Resident A's guardian, Guardian A1 who reported that she is not sure if the allegation is true. Resident A reported that she was required to attend program throughout the week which she did. Resident A is currently living at another AFC home and moves frequently.

<b>APPLICABLE RULE</b>	
<b>R 400.14304</b>	<b>Resident rights; licensee responsibilities.</b>
	<p><b>(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:</b></p> <p style="padding-left: 40px;"><b>(c) The right to refuse participation in religious practices.</b></p>

<b>ANALYSIS:</b>	<p>It was alleged that residents are required to go to church. Upon conclusion of investigative interviews, there is a preponderance of evidence to conclude a rule violation.</p> <p>Resident A and Resident C were interviewed and confirmed that residents are required to attend church on Sundays. Resident C stated it is a rule that residents who reside at the home attend church. Resident A reported residents must go to church or find somewhere else to go because there are no other staff on duty when they go to church. Guardian B1 reported Resident B likes to go to church and he attends. Guardian B1 confirmed that when the residents go to church with staff there are no staff at the facility that would allow for residents who do not want to go to church to remain at home.</p> <p>There is a preponderance of evidence to conclude residents do not have the right to refuse participation in religious practices.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Staff did not ensure Resident B had his medications in the home resulting in him not receiving his medications.**

**INVESTIGATION:**

On August 18, 2025, I conducted an unannounced on-site inspection at D.E.B. AFC #4 and interviewed Licensee Designee Laketa Brodnex regarding the allegations. Licensee Designee Brodnex reported Resident B moved into the facility in April 2025. In July 2025, Licensee Designee Brodnex changed Resident A's pharmacy so the facility could receive all resident medications from one pharmacy. The new pharmacy said that Resident B's August 2025 medications would be delivered along with all the other resident medications, however they were not. This occurred on a weekend, and staff notified Licensee Brodnex on Saturday, August 2, 2025, that Resident B did not have any of his medications. According to Licensee Brodnex, the medication coordinator did not review resident medications when they were delivered to the home, so no one knew that Resident B's medications did not get delivered with other resident medications. Licensee Brodnex reported that the pharmacy did not deliver Resident B's medications, and the pharmacy told her she was supposed to call back and tell them that they needed his medications. Resident B was able to get his medications the following day, and Resident B's guardian switched Resident B back to his original pharmacy.

On August 18, 2025, I reviewed the medication book and Resident B's medications. Resident B's medication administration sheets verify that he did not receive his prescribed medications on August 1, 2025, and August 2, 2025. The missed medications were Aptiom 600mg at 8am, Benzoyl Per Liq 10% at 8am, Clindamycin Sol 1% at 8am, Docusate Sod Cap 100mg at 8am, Fluticasone Spr 50mcg at 8am, Levocetirizi Tab 5 mg at 8am, Montelukast Tab 10mg at 8am, Sertraline Tab 100mg at 8am, Vraylar Cap 3mg at 8am, Hydroxyz Pam Cap 50mg at 8am, 12pm, and 8pm, Divalproex Tab 250mg at 8am and 8pm.

On August 18, 2025, I interviewed Resident C regarding the allegations. Resident C reported that they are prescribed medications. Staff provide Resident C with their medications and Resident C receives all medications as prescribed. Resident C denied any concerns regarding medications.

On September 25, 2025, I interviewed Resident B's guardian, Guardian B1 who reported Resident B ran out of medications "because they changed pharmacies without letting" her know. Resident B did not receive part of his medications on Friday, August 1, 2025, and all of Saturday, August 2, 2025. Guardian B1 picked up Resident B and took him to Guardian B1's home to care for him as he was experiencing tremors from not having his medications. Guardian B1 was able to obtain Resident B's medications on Sunday, August 3, 2025, and he has been switched back to his previous pharmacy.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(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 S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.</b>
<b>ANALYSIS:</b>	It was alleged that Resident B did not receive his medications. Upon completion of investigative interviews and a review of documentation there is a preponderance of evidence to conclude a rule violation.  Licensee Designee Laketa Brodnex was interviewed and confirmed that staff did not review resident medications when they were delivered by the pharmacy. Resident B's medications did not arrive along with other resident medications because it appears there was some confusion due to him being new to the facility pharmacy. As a result, Resident B did not receive his

	<p>medication on August 1, 2025, and August 2, 2025. Resident B's guardian was interviewed and reported that Resident B recently moved home, and his pharmacy was switched without her knowledge. The new pharmacy did not deliver Resident B's medication and Resident B did not receive his medications on August 1, 2025, and August 2, 2025. Resident B's medication administration sheets were reviewed and confirmed Resident B did not receive his prescribed medications for the 2 days.</p> <p>There is a preponderance of evidence to conclude Resident A was not given his medication as prescribed.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On September 29, 2025, I conducted an exit conference with Licensee Designee Laketa Brodnex and advised her of the findings of my investigation. I advised Licensee 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 in the license status is recommended.



9/29/2025

Christina Garza  
Licensing Consultant

Date

Approved By:



9/29/2025

Mary E. Holton  
Area Manager

Date