GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 20, 2021

Mekdes Zewde and Tadele Wami
5909 Buttonwood Drive
Haslett, MI 48840

RE: License #: AS330404048
Investigation #: 2022A0466006
Big Hearts AFC

Dear Mekdes Zewde and Tadele Wami:

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.

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) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330404048
Investigation #:	2022A0466006
Complaint Receipt Date:	10/26/2021
Investigation Initiation Date:	10/27/2021
Report Due Date:	12/25/2021
Licensee Name:	Mekdes Zewde and Tadele Wami
Licensee Address:	5909 Buttonwood Drive Haslett, MI 48840
Licensee Telephone #:	(517) 505-9422
Administrator:	Mekdes Zewde
Licensee Designee:	N/A
Name of Facility:	Big Hearts AFC
Facility Address:	540 N. Hagadorn Road East Lansing, MI 48823
Facility Telephone #:	(517) 402-9342
Original Issuance Date:	02/05/2021
License **Status:**	REGULAR
Effective Date:	08/04/2021
Expiration Date:	08/03/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS

	Violation Established?
Resident A is not being fed properly.	No
On 8/24/2021 resident fell and legal guardian requested emergency medical services (EMS) but co-licensee Tadele Wami failed to follow through.	No
Additional Findings	Yes

III. METHODOLOGY

10/26/2021	Special Investigation Intake-2022A0466006.
10/27/2021	Special Investigation Initiated – Telephone call to assigned licensing consultant Nile Khabeiry.
10/27/2021	Contact - Telephone call made, Guardian A1 interviewed.
11/04/2021	Inspection Completed On-site.
12/20/2021	Exit Conference with co-licensee Mekdes Zewde.

ALLEGATION: Resident A is not being fed properly.

INVESTIGATION:
On 10/26/2021, Complainant reported concern that Resident A was not being fed properly. Complainant reported that on 10/11/2021 Resident A was moved to another adult foster care (AFC) facility due to several complaints about Big Hearts and the facility's inability to care for Resident A. Complainant reported that on 10/25/21 the new AFC provider called and said that she felt that Resident A was being made to eat through a straw or not eat. Complainant reported that community mental health (CMH) case manager Jenna Lottes and Big Hearts co-licensee Tadele Wami had felt that all Resident A's behaviors were mental health related and that she could do everything on her own. Complainant reported repeatedly to Big Hearts that she felt that Resident A was declining and this was not her normal behavior. Complainant reported Resident A was trying to eat at the new AFC and was too weak to hold a spoon. Complainant reported Resident A asked staff to get her a straw. Complainant reported facility direct care staff members asked Resident A if this is how she had been eating previously and she said yes. Complainant reported Resident A went drastically downhill during the three months that she lived at Big Hearts.

On 10/27/2021, I interviewed Guardian A1 who reported that Resident A was supposed to be a fed a regular diet but her food was to be cut up. Guardian A1 did report Resident A does not have any teeth or dentures but that she has always been able to eat regular food and it was not required to be pureed. Guardian A1 believes facility direct care staff members did not have anyone to assist Resident A with eating and that is why they pureed the food. Guardian A1 reported that Resident A should have been eating with a utensils and not from a straw.

On 11/04/2021, I conducted an unannounced investigation and I reviewed Resident A's record which contained a *Health Care Appraisal* that was dated 7/14/2021 and documented in the "other health related information or concerns" section of the report that Resident A required "dysphagia 5 (minced/moist) think liquids. Medications crushed in puree." In the "weight" section of the report it documented that Resident A was 196 pounds.

I reviewed Resident A's *Assessment Plan for AFC Residents* that was dated 07/19/2021 and signed by Guardian A1. In the "eating feeding" section of the report it stated, "may need assistance puree food." In the "special diet" section of the report it stated, "puree food."

I reviewed Resident A's *Weight Record* which documented that on 07/19/2021, Resident A weighed 184 pounds. No other weighs were documented as it stated, "Can't step on scale, helped."

I interviewed co-licensee Wami and co-licensee Mekdes Zewde who reported that Resident A no longer lived at the facility and she moved out 10/10/2021. Co-licensee Wami and co-licensee Zewde reported they provide Resident A pureed food as prescribed. Co-licensee Wami reported that Resident A ate pureed food by hand or with a straw, however Resident A did better with the pureed food in a cup then finished with a straw. Co-licensee Wami reported that sometimes Resident A would request a straw. Co-licensee Zewde reported that Resident A was not always a good eater and at times she would throw her food all over the floor.

Resident A could not be interviewed as she no longer lives at the facility.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.

ANALYSIS:	Resident A's *Health Care Appraisal* dated 7/14/2021 documented in the "other health related information or concerns" section of the report that Resident A required "dysphagia 5 (minced/moist) think liquids. Medications crushed in puree." Resident A's *Assessment Plan for AFC Residents* dated 07/19/2021 and signed by Guardian A1 stated in the "eating feeding" section of the report "may need assistance puree food." In the "special diet" section of Resident A's *Assessment Plan for AFC Residents* report it stated, "puree food." Co-licensee Wami and co-licensee Zewde reported that they provided Resident A pureed food as prescribed therefore a violation has not been established as the facility provided the diet that was prescribed by Resident A's physician.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On 8/24/2021 Resident A fell and legal guardian requested emergency medical services (EMS) but co-licensee Tadele Wami failed to follow though.

INVESTIGATION:
On 10/26/2021, Complainant reported that on 8/24/2021, co-licensee designee Wami reported Resident A had intentionally fallen on the floor. Complainant reported she advised co-licensee designee Wami to call EMS because Resident A could have an injury. Complainant reported she found out the next day co-licensee designee Wami did not call EMS because co-licensee designee Wami thought the fall was behavioral in nature. Complainant reported she explained that any time an elderly client falls on the floor and it is not possible for a doctor or nurse to evaluate the resident, it is safer to send them to the ER. Complainant reported that she is concerned facility direct care staff members were not reporting falls.

On 10/27/2021, I interviewed Guardian A1 who reported that on 8/24/2021, co-licensee designee Wami called reporting Resident A had intentionally fallen on the floor. Guardian A1 reported she told co-licensee designee Wami to call EMS to have Resident A assessed for any injuries that could have occurred. Guardian A1 reported finding out the next day that EMS was not called to evaluate Resident A for injury because co-licensee designee Wami felt the fall was behavioral and that Resident A was not injured. Guardian A1 reported that her concern is that any time an elderly client falls on the floor it is safer to send them to the ER to ensure no injury has occurred. Guardian A1 reported that she is concerned that the facility was not reporting falls to her because she and the facility had a difference of opinion on how to handle Resident A's falls. Guardian A1 was not aware of any dates that Resident A fell and she was not notified. Guardian A1 reported that to the best of her knowledge Resident A was not injured from any fall that occurred in the facility while Resident A lived there. Guardian A1 reported that no injuries have been reported to her about Resident A from the new AFC where she is now residing.

On 11/04/2021, I conducted an announced investigation and I reviewed Resident A's record which contained an *After Visit Summary* of an ER Visits on 08/07/2021 and on 08/25/2021 for a fall.

On 11/04/2021, I reviewed Resident A's record which contained a *Health Care Appraisal* that was dated 7/14/2021 and documented in the "mobility/ambulatory status" section of the report as Resident A being "fully ambulatory." In the "diagnosis" section of the report it described Resident A as having, "intermittent explosive disorder in adult."

On 11/04/2021, I reviewed Resident A's *Assessment Plan for AFC Residents* that was dated 07/19/2021 and signed by Guardian A1. In the "walking/mobility" section of the report that help is required but nothing else is documented. In the "use of assistive devices" section of the report it stated "walker/cane."

On 11/04/2021, I interviewed co-licensee Wami and co-licensee Zewde who reported that Resident A no longer lived at the facility as she moved out 10/10/2021. Co-licensee Wami and co-licensee Zewde reported Resident A was provided with an Emergency Discharge Notice on 08/11/2021 as she had behaviors of throwing herself on the ground or intentionally spilling juice, walking in it so that she would fall. Co-licensee Wami and co-licensee Zewde reported that Resident A did not fall on 08/24/2021 rather she fell on 08/25/2021. Co-licensee Wami and co-licensee Zewde reported anytime Resident A reported a fall that they did not see, they would call EMS for evaluation but the times that they saw her fall purposely, co-licensee Wami and co-licensee Zewde reported they would continue to assess her to determine if there were any injuries or signs of any injures. Co-licensee Wami and co-licensee Zewde reported that they reported every fall to Guardian A1 and even if they disagreed with Guardian A1 wanting them to call EMS, they always did it per her direction. Co-licensee Wami and co-licensee Zewde reported that Resident A fell on 07/19/2021, twice on 07/22/2021, 08/07/2021 and 08/25/2021. Co-licensee Wami and co-licensee Zewde reported EMS was called for each of these falls and EMS was called twice on 0722/2021 for both of Resident A's falls. Co-licensee Wami and co-licensee Zewde reported they continued to monitor Resident A after each fall for a change in condition and reported that Resident A never requested any type of pain medication after any of the falls.

On 11/04/2021, Resident A could not be interviewed as she no longer lives at the facility.

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:	Complainant and Guardian A1 reported concern that Resident A's falls were not being reported. Guardian A1 reported she was contacted by the facility when falls occurred. Guardian A1 was not aware of any dates when Resident A fell and she was not notified. Guardian A1 reported that to the best of her knowledge Resident A was not injured from any fall that occurred in the facility while she lived there. Guardian A1 reported no injuries have been reported to her from the new AFC where Resident A is now residing. Co-licensee Wami and co-licensee Zewde reported anytime Resident A fell, it was reported to Guardian A1 and per her direction EMS was contacted therefore there is not enough evidence to establish a violation as medical care was sought for Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**

ANALYSIS:	I reviewed Resident A's *Assessment Plan for AFC Residents* that was dated 07/19/2021 and signed by Guardian A1. In the "walking/mobility" section of the report it stated that help is required but nothing else is documented describing what is meant by help. In the "use of assistive devices" section of the report it stated "walker/cane." Resident A's *Assessment Plan for AFC Residents* did not document that Resident A falls nor that Guardian A1 wanted Resident A to be assessed by EMS for every fall therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 11/04/2021, I reviewed Resident A's record which contained a *Health Care Appraisal* that was dated 7/14/2021 and documented in the "mobility/ambulatory status" section of the report "fully ambulatory."

On 11/04/2021, I reviewed Resident A's *Assessment Plan for AFC Residents* that was dated 07/19/2021 and signed by Guardian A1. In the "use of assistive devices" section of the report it stated "walker/cane."

On 11/04/2021, I reviewed Resident A's record and at the time of the unannounced investigation Resident A's record did not contain a physician order for Resident A to use a walker/cane.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Resident A's *Assessment Plan for AFC Residents* was dated 07/19/2021 and signed by Guardian A1. In the "use of assistive devices" section of the report it stated "walker/cane." Resident A's record did not contain a physician order for the therapeutic support therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 11/04/2021, I reviewed Resident A's record which contained a *Weight Record* which documented that on 07/19/2021, Resident A weighed 184 pounds. No other

weights were documented on Resident A's *Weight Record* as it stated, "Can't step on scale, helped." Resident A's *Weight Record* did not contain weights for the months of August 2021 and September 2021. Resident A moved from the facility in October 2021.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	A licensee is responsible to keep a *Weight Record* and to record the resident's weight monthly. Resident A's *Weight Record* did not have weights documented for the months of August 2021 and September 2021 therefore a violation has been established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

INVESTIGATION:

On 11/04/2021, co-licensee Wami and co-licensee Zewde reported that Resident A fell on 07/19/2021, 07/22/2021, twice, 08/07/2021 and 08/25/2021. Co-licensee Wami and co-licensee Zewde reported that EMS was called for each of these falls including calling EMS twice on 07/22/2021 for both of Resident A's falls. Co-licensee Wami and co-licensee Zewde reported that some of the falls were Resident A falling intentionally because of behavioral issues. The department did not receive an *Incident/Accident Reports* for the two incidents on 07/19/2021, 07/22/2021 and 08/25/2021. I reviewed Resident A's record and at the time of inspection the record did not contain an *Incident/Accident Report* for the two incidents on 07/19/2021, 07/22/2021 and 08/25/2021.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(ii) Hospitalization.**

ANALYSIS:	*Incident Reports* were not received by the department for Resident A's hospitalizations on 07/19/2021, 07/22/2021 and 08/25/2021 therefore a violation has been established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

12/20/2021

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Julie Elkins Date
Licensing Consultant

Approved By:

12/20/2021

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Dawn N. Timm Date
Area Manager