GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 7, 2022

Yeshi Bedada
1446 Emerald Ave. NE
Grand Rapids, MI 49505

RE: License #: AS410397771
Investigation #: 2022A0467041
Angel Care Adult Foster Home I

Dear Mrs. Bedada:

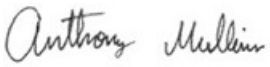
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (616) 356-0183.

Sincerely,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410397771
Investigation #:	2022A0467041
Complaint Receipt Date:	05/25/2022
Investigation Initiation Date:	05/25/2022
Report Due Date:	07/24/2022
Licensee Name:	Yeshi Bedada
Licensee Address:	1446 Emerald Ave. NE Grand Rapids, MI 49505
Licensee Telephone #:	(616) 337-4247
Administrator:	N/A
Licensee Designee:	Yeshi Bedada
Name of Facility:	Angel Care Adult Foster Home I
Facility Address:	833 College Avn NE Grand Rapids, MI 49503
Facility Telephone #:	(616) 337-4247
Original Issuance Date:	03/03/2021
License Status:	REGULAR
Effective Date:	03/02/2022
Expiration Date:	03/01/2024
Capacity:	6
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 5/25/22, residents were in the home for hours without staff supervision.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/25/2022	Special Investigation Intake 2022A0467041
05/25/2022	Special Investigation Initiated - On Site
06/07/2022	Exit conference completed with licensee designee, Yeshi Bedada.

ALLEGATION: On 5/25/22, Residents were in the home for hours without staff supervision.

INVESTIGATION: On 5/25/22, I made an unannounced onsite investigation to Angel Care II AFC (AS410397772) and Angel Care III AFC (AS410397841) to speak with Mrs. Bedada regarding staffing issues. I knocked on the doors of both homes and residents in each home confirmed that Mrs. Bedada was not present. Being aware that Mrs. Bedada owns and operates this facility (Angel Care AFC I), which is located just over a quarter mile down the road, I made an unannounced onsite inspection to speak with her. Upon arrival, I observed Resident A and B outside the home. Resident A stated that Mrs. Bedada and her husband, Guleta Kuratu were not home and that they usually return around 5:30pm to 6:00 pm. I asked Resident A how often he and other residents are left alone at the home and he stated, “I can’t answer that.” Resident A denied that anyone told him to withhold information from me.

Resident B was outside smoking a cigarette while speaking to someone on the phone. Therefore, I did not attempt to interview her. I made my way to the front porch of the home, which is when Resident C opened the door and allowed entry into the home. Resident C confirmed that Mrs. Bedada and Mr. Kuratu were not home. I asked Resident C how often he and other residents are left alone in the home. Resident C stated, “practically every day.” Resident C continued as he stated that in the mornings, he and the other three residents are served breakfast and given their medication. After this is done, they (Mrs. Bedada or Mr. Kuratu) leave the home for a few hours. Resident C stated that someone returns to the home to serve them lunch. After doing so, staff leaves again for several hours and returns to the home sometime after 6:00 pm for dinner. Resident C stated that he has lived at the home for a little over five months and Mrs. Bedada and her husband, Mr. Kuratu have had the same schedule.

Resident C stated that the last time a staff member was in the home today was around lunch time. At the time of this interview, it was approximately 5:10 pm. Resident C stated that Mr. Kurato is only there for lunch and then he leaves again. It should be noted that Resident A was sitting near Resident C. I asked Resident A if the statement made by Resident C was true and he stated “basically, yes.” He also confirmed that “sometimes” Mrs. Bedada leaves the home after giving residents breakfast and their medication. Resident A stated that the last time he saw a staff member today was at lunch time. I thanked Resident A and C for their time and this interview concluded.

As I was walked out of the home, I observed Mrs. Bedada’s husband, Mr. Kuratu park his vehicle directly behind my vehicle. I attempted to make eye contact with Mr. Kuratu but he would not look at me. I then entered my vehicle and drove my vehicle down the street to turn around since the road has one entry and exit. As I was driving down the road, I observed Mr. Kuratu get out of his vehicle, put his hood over his head, and walk towards Resident A in the backyard. Prior to leaving the street, I noticed that Mr. Kuratu was walking towards my vehicle. I let down my window and explained to him that I was just in the home speaking to residents, and he was not present. I asked Mr. Kuratu where he was and he stated. “I was in the basement.” I explained to Mr. Kuratu that I observed him park his vehicle behind mine, exit the vehicle and put his hood on while he walked to the backyard. Mr. Kuratu remained adamant that he had been in the basement of the home the whole time I was there. I explained to Mr. Kuratu that he was lying to me as the residents in the home already confirmed that he had been away from the home for hours. Mr. Kuratu continued to state that he’s not a liar and that he was in the basement. I told Mr. Kuratu that the home needs to have staff present at all times. This interview concluded.

On 6/6/22, I spoke to Mrs. Bedada via phone. I explained to her that when I went to the facility on 5/25/22, there were no staff present, leaving residents unsupervised. I explained to Mrs. Bedada that resident A and C confirmed that they were home alone since lunch time on 5/25/22. Mrs. Bedada interjected and denied this statement, saying that residents were not left alone since lunch time. I then asked Mrs. Bedada where Mr. Kuratu was when I arrived at the home and she stated, “he told me that he was at the party store” which is a block away from the home. I explained to Mrs. Bedada that her husband reportedly told her that he was at a party store buying items and he told me that he was in the basement. This is clear evidence that Mr. Kuratu lied to me about his whereabouts and that he was not in the home when I arrived. I asked Mrs. Bedada why her husband would lie about his whereabouts and she stated, “maybe he was scared about what would happen.”

Despite acknowledging that her husband told her that he was at the party store, Mrs. Bedada stated that her husband was home all day. I attempted to explain to Mrs. Bedada how her statements contradict each other. However, she remained adamant that her husband was home all day. I explained to Mrs. Bedada that I will follow-up with her to discuss the plan regarding her license.

On 06/07/2022, I conducted an exit conference with licensee designee, Yeshi Bedada. She was informed of the investigative findings and agreed to complete a CAP within 15 days.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	On 5/25/22, I observed three residents in the home without staff supervision. Resident A and C confirmed that Mrs. Bedada and her husband, Mr. Kuratu were not present in the home. Resident A stated that he and the other residents are left in the home without staff "practically daily." Resident A and C stated that staff had not been at the home sinch lunch time, and it was approximately 5:10 pm. Mr. Kuratu lied to me about being in the basement of the home after I observed him driving up, parking his vehicle behind mine and exiting the vehicle to pretend that he was at the home the whole time. Mrs. Bedada initially stated that her husband was at the "party store" near the home to get a few items. Mrs. Bedada stated that her husband lied to me because "maybe he was scared about what would happen." Mrs. Bedada later stated that her husband was home all day on 5/25/22. Based on the disclosure from Resident A, C, and Mrs. Bedada, there is a preponderance of evidence that exist to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While investigating the allegation listed above, it was brought to my attention that Mrs. Bedada does not have a telephone accessible to residents in the home. On 5/25/22, Resident A and Resident C both confirmed this. Resident A stated, "it would be nice to have a phone in the home but she's not going to spring for it." Resident C stated that he and other residents have already talked to Mrs.

Bedada about having a phone in the home and she reportedly told residents that she is not paying for a phone.

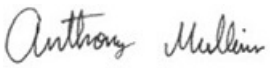
On 6/6/22, I spoke to Mrs. Bedada via phone and explained that Resident A and C told me that there was no phone available to them in the home. Mrs. Bedada confirmed this as she stated, “they (residents) chose cable. I can cut cable and put a phone on for them.” I explained to Mrs. Bedada that residents having access to a phone is not a choice. Instead, it is a requirement per rule 304(1)(e) listed below. Mrs. Bedada stated that she now understands.

On 06/07/22, I conducted an exit conference with licensee designee, Yeshi Bedada. She was informed of the investigative findings and agreed to complete a CAP within 15 days.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(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: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.** **(2) A licensee shall respect and safeguard the resident’s rights specified in subrule (1) of this rule.**
ANALYSIS:	Resident A and C both confirmed that the home does not have a phone. Resident C stated Mrs. Bedada stated that she is not paying for a phone. Mrs. Bedada also confirmed that residents do not have access to a phone in the home. Therefore, a preponderance of evidence does exit to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

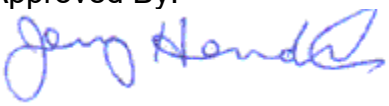
Contingent upon receipt of an acceptable corrective action plan, issuance of a provisional license is recommended for the above-cited quality of care violations.



06/07/2022

Anthony Mullins Date
Licensing Consultant

Approved By:



06/07/2022

Jerry Hendrick Date
Area Manager