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 #: AS410397772
Investigation #: 2022A0467036
Angel Care Adult Foster Home II

Dear Mrs. Bedada:

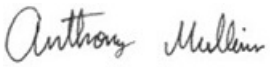
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS410397772
Investigation #:	2022A0467036
Complaint Receipt Date:	05/11/2022
Investigation Initiation Date:	05/12/2022
Report Due Date:	07/10/2022
Licensee Name:	Yeshi Bedada
Licensee Address:	1446 Emerald Ave. NE Grand Rapids, MI 49505
Licensee Telephone #:	(616) 337-4247
Administrator:	Yeshi Bedada
Licensee Designee:	Yeshi Bedada
Name of Facility:	Angel Care Adult Foster Home II
Facility Address:	543 College Avn NE Grand Rapids, MI 49503
Facility Telephone #:	(616) 337-4247
Original Issuance Date:	07/11/2019
License Status:	REGULAR
Effective Date:	01/11/2022
Expiration Date:	01/10/2024
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The facility is not documenting Resident A's medications as required.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/11/2022	Special Investigation Intake 2022A0467036
05/11/2022	APS Referral Referral received from APS
05/12/2022	Special Investigation Initiated - On Site
06/07/2022	An exit conference was completed with licensee designee, Yeshi Bedada.

ALLEGATION: The facility is not documenting Resident A's medications as required.

INVESTIGATION: On 5/11/22, I received a BCAL online complaint from Adult Protective Services (APS). The complaint stated that the week of 4/25/22, Resident A was pushed into the sofa by another resident at the home, causing her to hit her head. Resident A complained of tenderness but declined medical treatment. The complaint also stated that the facility is not keeping medication logs for Resident A and not providing her with information regarding her medication, despite her request. It is alleged that the AFC home is not responding to the Community Mental Health (CMH) request for a meeting regarding Resident A's care.

On 5/12/22, I made an unannounced onsite investigation to the facility. Upon arrival, I spoke to Resident A in the backyard. Resident A stated that she has been at the facility for approximately 4 to 5 months. Resident A stated that things are going well "but she (owner) wants me to find somewhere else to live." Resident A stated that the owner/designee, Yeshi Bedada told her that she gave her a 30-day discharge notice but hasn't explained why.

Resident A stated that approximately 1 or 2 weeks ago**,** she was hit in the chest by Resident B, causing her to "fly in the air and hit my head on the back of the couch." Resident A was unsure why Resident B hit her. Resident A stated that Resident B is always telling her to "shut up" and has knocked her glasses off in the past. As a result of the incident with Resident B, Resident A stated that she went to the Emergency Room (ER). ER staff reportedly told Resident A that she had a bump on her head and that she should "take some time off." Resident A could not elaborate

on this further. Resident A added that due to ongoing issues with Resident B, she doesn't feel safe in the home and wants to move. She acknowledged that her guardian and case manager are aware of this and seeking placement elsewhere.

Resident A was asked about receiving her medications at the facility. Resident A stated that she does not receive her medications on time because "sometimes she's busy," referring to Mrs. Bedada. Resident A stated that her previous AFC homes were much better due to the cleanliness and staff "not putting her meds in a cup" before she takes them. Resident A stated that when she would ask Mrs. Bedada questions related to her medications, Mrs. Bedada would state, "that's what the doctor prescribed you so take it" and would not explain further.

After speaking to Resident A, I spoke to licensee designee/owner, Mrs. Bedada. Mrs. Bedada was asked about the incident that led to Resident A being pushed by another resident. Although Resident A stated she was pushed by Resident B, Ms. Bedada stated that Resident A was pushed onto the sofa by Resident C. Ms. Bedada stated that Resident A was asked to go to the ER and she refused as there was no injuries.

Mrs. Bedada stated that she does provide Resident A with information on the medication she takes, as well as giving her the medications as prescribed and on time. Mrs. Bedada stated that prior to giving Resident A her medication, she has to open it in front of her because "she thinks she's getting the wrong medication." Mrs. Bedada stated that she's only providing care for Resident A to help her mother, who is reportedly aware of ongoing behavior issues with her. Mrs. Bedada stated that Resident A has been stealing from residents, poking them, shaking their beds while their asleep, and turning up her radio in the middle of the night, disturbing everyone. As a result of Resident A's behavior, other residents take their personal belongings with them to prevent Resident A from stealing. Mrs. Bedada stated that Resident A was giving a 30-day discharge on 5/2/22 due to the behaviors listed above and she has to be out of the home by 6/2/22.

I asked Mrs. Bedada to see Resident A's MAR. I observed Resident A's MAR and it was documented that the following medications were last given to Resident A on 5/6/22: Sertraline HCL 100 MG Tablet, Vitamin D3, 2,000 Unit Tab, Thera Tablet, and Losartan Potassium 50 MG Tab. The MAR also indicated that the following medications were last given on 5/5/22: Seroquel 50 MG Tablet, Melatonin 5MG Tablet, and Quetiapine Fumarate 300 MG Tab. Per the MAR, Resident A has not received her medications in the last 5 to 6 days. Ms. Bedada was adamant that she did provide Resident A's medication as prescribed and forgot to update the MAR. There is no way to prove that Ms. Bedada statement is true. Therefore, I explained to Ms. Bedada that she will be cited for this rule violation.

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 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Resident A stated that she is not given her medication on time because Mrs. Bedada is busy. On 5/12/22, Mrs. Bedada provided me with a copy of Resident A's MAR, which indicated that the MAR was not updated for the past 5 to 6 days. Despite this, Ms. Bedada was adamant that she has given Resident A her medications as prescribed. Mrs. Bedada acknowledged that she forgot to update Resident A's MAR. Therefore, there is a preponderance of evidence 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 was sharing staff between two of her AFC homes. Resident A was asked about staffing at the facility. Resident A stated that on a daily basis, all of the residents are left in the home without any staff in the facility. Resident A stated this occurred yesterday (5/11/22) and today (5/12/22) as well. The facility can be described as a two-story home that represents ½ of a duplex. Angel Care Adult Foster Home III (AS410397841) represents the other half of the duplex, which is also owned and operated by licensee, Mrs. Bedada. The two separately licensed AFC homes share a porch and a backyard.

On 5/12/22, Mrs. Bedada acknowledged that she was working both homes by herself right now. Ms. Bedada stated that she sent her staff member, "Benzo" to the store, which meant that the residents in this facility, as well as residents in Angel Care III were left without a responsible person present for an unknown period of

time. This was confirmed by Mrs. Bedada stating that she has went back and forth between both homes. I explained to Mrs. Bedada that it is a violation of licensing rules for residents to be left alone at any time and whenever there is a resident in the home, there must always be a staff member in that home as well. Mrs. Bedada stated that she understands.

On 5/25/22, I made an unannounced onsite investigation to the facility. Upon arrival, I knocked on the door several times and no one answered. Due to their being concerns regarding the lack of staffing, I entered the home and it was obvious that no staff were present. I said hello a few times and I could hear a woman's voice. The woman acknowledged me and I introduced myself and asked if I could speak to her and she agreed. The woman speaking was Resident D, who remembered me being at the home for previous inspections/investigations. I spoke to Resident D. Resident D stated that Mrs. Bedada leaves her and the other three residents in the home alone "just about every day." Resident D stated that a typical morning will consist of Mrs. Bedada leaving during breakfast time and not returning for a "few hours." Resident D stated that Mrs. Bedada returns to the facility by lunch time, and occasionally before then. Resident D stated that Mrs. Bedada makes sure all of the residents eat and then she leaves the home to go down the street to her other AFC home, Angel Care I (AS410397771), which is approximately a quarter mile away. After Mrs. Bedada leaves the home after lunch, Resident D stated that she doesn't return to the home until dinner time. Resident D stated that Mrs. Bedada usually remains in the home for the night after dinner. Resident D stated that Mrs. Bedada has provided her with her phone number to call her if an emergency happens while she is away from the home. Resident D stated that she has been a resident of the home for approximately two years and this schedule has been consistent for Mrs. Bedada.

After speaking to Resident D, I spoke to Resident C. Resident C stated that she has been in the home for approximately five months and things are going "okay." Resident C confirmed that no staff were present at the home at the time of our interview. Resident C stated that she did not know where Mrs. Bedada was, but she did add that Mrs. Bedada "goes home during the day and brings us food and gives us medication." Resident C acknowledged that she and the other three residents are at the facility alone every day for an unknown amount of time.

After speaking to Resident C, I spoke to Resident A. Resident A confirmed that Mrs. Bedada was not currently at the home. Resident A stated that Mrs. Bedada leaves her and the other three residents' home alone every day. Resident A stated that a typical day at the home consist of Mrs. Bedada providing residents with breakfast and their medication. After doing so, she leaves for approximately 5 to 6 hours. Resident A stated that Mrs. Bedada "sometimes" returns to the home for lunch and on the days she doesn't return, she and other residents make themselves a sandwich in the kitchen. Resident A added that Mrs. Bedada typically returns home by dinner time.

While concluding my interview with Resident A, Mrs. Bedada arrived at the home and agreed to speak on the main floor. Before I could ask Mrs. Bedada any questions, she stated that she went down the street to Angel Care I (AS410397771) AFC to drop off her husband's medication and immediately came back to the home. It should be noted that I was at the home for approximately 20 to 25 minutes prior to Mrs. Bedada arriving. Angel Care I is just over a quarter mile away from this facility, which is a home I license and have been to multiple times. If Mrs. Bedada dropped medication off to her husband and returned to the home immediately after, it would not take nearly 25 minutes to do so. However, Mrs. Bedada continued to provide this as her explanation as to why she was away from the home. It should also be noted that I could hear Resident D speaking to Mrs. Bedada on the phone prior to her arriving.

I explained to Mrs. Bedada that she cannot leave residents in the home without staff present for any period of time. This is now the 3rd time I've had this conversation with Mrs. Bedada in the last five months and the second conversation this month. Mrs. Bedada stated that her staff (Mr. Benzo) told her that he was not coming in this morning. Mrs. Bedada acknowledged that she did not know the last name of Mr. Benzo. Mrs. Bedada expressed concern for staffing challenges. I acknowledged her concern and explained that despite this, it is her job as the licensee to make sure she is in compliance with all licensing rules.

Mrs. Bedada stated that her husband worked at this facility yesterday, as well as Angel Care III, while she worked Angel Care I by herself. After I explained that her husband working Angel Care II and III by himself is a licensing violation because it leaves one home without staff, Mrs. Bedada stated that her employee Mr. Benzo worked with her husband as well.

I then explained to Mrs. Bedada that three residents confirmed that she leaves them home alone for hours every day. Mrs. Bedada stated, "that's not true. If I'm not here, my husband or Mr. Benzo is here." I asked Mrs. Bedada if the residents were lying about her leaving the home for several hours a day and she stated, "I don't know what they're talking about."

Mrs. Bedada stated, "if you want to shut this house down, then do what you want." Mrs. Bedada then stated that she will rent out her home instead of operating it as an AFC. I told Mrs. Bedada that she is free to do as she pleases but again, if she plans to continue to operate the AFC home, she must be in compliance with licensing rules.

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:	Resident A stated that residents are left alone in the home daily for hours. On 5/12/22, Mrs. Bedada acknowledged that she was the only staff member working at two of her AFC homes, meaning that she was going back and forth between the two AFC homes to check on residents. On 5/25/22, Resident A and D confirmed that Mrs. Bedada leaves all residents home alone for hours every day. Resident D has been at the home for approximately two years and stated that this has always been Mrs. Bedada's routine. Resident C acknowledged that she and other residents are left alone in the home for an unknown period of time every day. During this onsite investigation, I discovered that there were no staff working. Therefore, there is a preponderance of evidence to support the allegation. It should be noted that this facility was cited for leaving residents in the home unsupervised during a scheduled renewal inspection on 12/9/21. It has been less than six months since Mrs. Bedada was cited for the same rule violation and she has yet to rectify the issue. Therefore, it is recommended that the facility receives a six-month provisional license due to a repeated violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** (12/17/21 Renewal Inspection Report)

INVESTIGATION: While investigating the allegations listed above, Mrs. Bedada stated that she did not know the last name of her employee, who she referred to as "Benzo." Due to this, I made a 2nd unannounced onsite investigation to the facility on 5/25/22 at 4:50 pm in attempt to review Mr. Benzo's staff file. Upon arrival, I knocked on the door. Resident A opened the door and stated that Mrs. Bedada was not present. She also confirmed that there were no other staff present in the home. Therefore, I was unable to review Mr. Benzo's employee file.

On 5/26/22, I emailed Mrs. Bedada requesting verification of the following trainings for Mr. Benzo: First aid, CPR, Resident Rights, Safety and fire prevention. On the same day, I called Mrs. Bedada and asked if she had received my email. Mrs. Bedada stated that she had not and that she would review it and call me back. Mrs. Bedada returned my call and confirmed that Mr. Benzo has not completed the requested trainings, including reporting requirements, personal care, supervision, and protection, and Prevention and containment of communicable diseases. I explained to Mrs. Bedada that all staff are required to complete these trainings prior to being assigned job duties. Mrs. Bedada stated that she understands, and that Mr. Benzo has not completed said trainings because of his availability.

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 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Mrs. Bedada confirmed that her employee, Mr. Benzo has not completed all of the trainings listed above. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegations listed above, Mrs. Bedada acknowledged during a 5/26/22 phone call that she did not have a statement from Mr. Benzo's physician attesting to the knowledge of his physical health as required by licensing. Mr. Benzo has been employed at the facility for a few months and this has yet to be addressed.

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 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.
ANALYSIS:	Mrs. Bedada confirmed that her employee, Mr. Benzo does not have a signed statement by his physician attesting to the knowledge of his physical health. Therefore, a preponderance of evidence exists to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegations listed above, Mrs. Bedada acknowledged during a 5/26/22 phone call that her staff member, Mr. Benzo has not completed a TB test. Mr. Benzo has been employed at the facility for a few months and this has yet to be addressed.

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 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained

	before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.
ANALYSIS:	Mr. Bedada stated that Mr. Benzo has not completed a TB test since his employment started at the facility. Therefore, a preponderance of evidence exist to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegations listed above, Mrs. Bedada acknowledged during a 5/26/22 phone call that her staff member, Mr. Benzo has not completed a background check, which is required by licensing.

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 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.
ANALYSIS:	Mrs. Bedada acknowledged that her staff member, Mr. Benzo has not completed a background check/record clearance prior to and during his employment. Therefore, a preponderance of evidence does exist 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.

Anthony Mullins 06/07/2022

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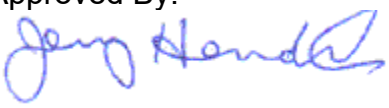
Anthony Mullins, Licensing Consultant Date

Approved By:



06/07/2022

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Jerry Hendrick, Area Manager Date