GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 8, 2023

Elsabeth Engeda
Kalkidan AFC LLC
4464 Hickorywood Drive
Okemos, MI 48864

RE: License #: AM330405074
Investigation #: 2023A1033041
Kalkidan AFC 2

Dear Ms. Engeda:

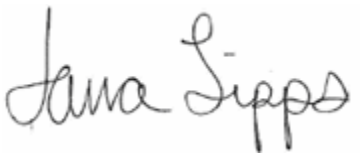
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9730.

Sincerely,



Jana Lipps, 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 #:	AM330405074
Investigation #:	2023A1033041
Complaint Receipt Date:	04/13/2023
Investigation Initiation Date:	04/13/2023
Report Due Date:	06/12/2023
Licensee Name:	Kalkidan AFC LLC
Licensee Address:	5340 Park Lake Road East Lansing, MI 48823
Licensee Telephone #:	(517) 402-6191
Administrator:	Elsabeth Engeda
Licensee Designee:	Elsabeth Engeda
Name of Facility:	Kalkidan AFC 2
Facility Address:	5340 Park Lake Road East Lansing, MI 48823
Facility Telephone #:	(517) 402-6191
Original Issuance Date:	04/04/2022
License Status:	REGULAR
Effective Date:	10/04/2022
Expiration Date:	10/03/2024
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A left the facility with family on 3/30/23 and did not return. The facility received a call on 3/31/23 from the Eaton County Jail that Resident A had been arrested. The facility had expected the resident to return on 3/30/23. No efforts were made to locate her when she did not return on 3/30/23.	Yes

III. METHODOLOGY

04/13/2023	Special Investigation Intake 2023A1033041
04/13/2023	Special Investigation Initiated – Letter- Email received from licensee designee, containing incident report regarding Resident A. Email exchange with licensee designee.
04/20/2023	Inspection Completed On-site- Interview with direct care staff, Yesew Cherie, & Licensee Designee, Elsabeth Engeda. Review of Resident A's records initiated and resident sign in/sign out log.
04/20/2023	APS Referral- Referral to APS via email, per protocol.
05/03/2023	Contact - Telephone call made- Attempt to interview Community Mental Health case manager, Aretha Ray-Kimbro via telephone.
05/03/2023	Contact - Document Received- Letter received appointing Adult Services Worker, Shawna Simms-Rosa, to Adult Protective Services investigation.
05/04/2023	Contact - Telephone call made- Interview with Adult Services Worker, Shawna Simms-Rosa, via telephone.
05/04/2023	Contact - Telephone call made- Attempt to interview Community Mental Health case manager, Aretha Ray-Kimbro. No answer, voicemail message left.
05/19/2023	Inspection Completed-BCAL Sub. Compliance
06/08/2023	Exit Conference Conducted with licensee designee, Elsabeth Engeda, via telephone.

ALLEGATION:

Resident A left the facility with family on 3/30/23 and did not return. The facility received a call on 3/31/23 from the Eaton County Jail that Resident A had been arrested. The facility had expected the resident to return on 3/30/23. No efforts were made to locate her when she did not return on 3/30/23.

INVESTIGATION:

On 4/12/23 I received an *AFC Licensing Division – Incident/Accident Report (IR)* form, via email, dated 4/11/23 and signed by licensee designee, Elsabeth Engeda, of Kalkidan AFC 2 adult foster care facility (the facility). The IR referenced an incident with Resident A and dated the incident as 3/30/23. Under section, *Explain What Happened/Describe Injury*, it stated, "Resident [Resident A] on 03/30/2023 at 3:30pm picked up by family from her residency. She didn't come back home for that night. On 03/31/2023 at 12:20p I got a call from Eaton County Jail and which stated, "[Resident A] is in Jail"." Under section, *Action taken by Staff/Treatment Given*, it reads, "Immediately I reported to her case manage and QCSRR-Quality Advisor CMH-CEI".

On 4/12/23 I emailed licensee designee, Elsabeth Engeda, regarding the IR, who stated Resident A left with her family but was expected to return to the facility on the same day 03/30/2023.

On 4/20/23 I completed an on-site investigation at the facility. I interviewed Ms. Engeda, via telephone, during my on-site investigation. Ms. Engeda reported on 3/30/23 direct care staff, Yesew Cherie, was working at the facility. She further reported Resident A signed herself out on the sign out log around 3:30p and went with Citizen 1. Ms. Engeda reported Resident A has been on outings with Citizen 1 previously and sometimes Citizen 1 does not bring her back to the facility for more than 24 hrs. Ms. Engeda reported direct care staff never know when Resident A will return to the facility when she leaves with Citizen 1. She further reported not knowing the relationship between Citizen 1 and Resident A. Ms. Engeda reported that they expected Resident A to return on 3/30/23 but she did not return. She reported that they did not report Resident A as "missing" to the police as they must wait 24 hours to report someone as missing. She further reported that on 3/31/23 she received a telephone call from someone (name unknown) at the Eaton County Jail who stated that Resident A had been arrested and was currently in the Eaton County Jail. Ms. Engeda reported she reported this incident to Resident A's Community Mental Health Case Manager, Aretha Ray-Kimbro, immediately. Ms. Engeda reported she had spoken with Citizen 1 after she had heard from the police. She reported Citizen 1 stated, Resident A "took off" and he did not know her location. Ms. Engeda reported she has held numerous conversations with Ms. Ray-Kimbro about feeling uneasy allowing Resident A to leave the facility with Citizen 1,

but she has been told Resident A has no restrictions and can go with whomever she chooses, by Ms. Ray-Kimbro.

During on-site investigation, on 4/20/23, I interviewed Ms. Cherie. Ms. Cherie confirmed that she was working on 3/30/23 when Resident A left the facility with Citizen 1. Ms. Cherie reported that Resident A has a history of going on outings with Citizen 1 and not returning when expected. She reported that often Resident A will stay out for more than 24 hours, and they are not aware of her whereabouts. She further reported that she was under the understanding that they must wait 24 hours before they can contact the police to report Resident A as missing. Ms. Cherie reported that she worries about Resident A when she goes on outings with Citizen 1 as she has a bad feeling about Citizen 1. She reported that Citizen 1 usually comes around to visit Resident A after she has received her monthly allowance. Ms. Cherie reported that on the day of 3/30/23 Citizen 1 did come to the facility and picked up Resident A. She reported Resident A signed out on the sign out log and she had expected Resident A to return that evening. She reported Resident A did not return, and they later found, on 3/31/23, that Resident A had been arrested. Ms. Cherie reported that when Resident A leaves the facility for an outing, they do not give her medications to her to administer, she must take them when she returns to the facility. She reported Resident A did not have her medications with her on 3/30/23.

During on-site investigation I reviewed the document, *Kalkidan's AFC 2 In-Out Sign Log Sheet.* Under the date 3/30/23 Resident A had signed herself out at 3:30pm. Under the section, *Reason for leaving*, there was no notation, this section remained blank.

During on-site investigation, on 4/20/23, I reviewed the *Assessment Plan For AFC Residents* document for Resident A, dated 6/8/22. Under section, *Social/Behavioral Assessment*, subsection, *A. Moves Independently in Community*, it is marked "No" with the following notation, "r/t disease process and forgetfulness."

During on-site investigation, on 4/20/23, I also reviewed the Community Mental Health document, *Assessment*, dated 6/20/22, for Resident A. On page 1 of this form under section, *Summary of Progress and Involvement in Treatment*, is documented, "[Resident A] has been able to leave her current AFC Home as she pleases." On page 5 of this document is documented, "Client will call AFC Home if she is going to be late coming back to the home. Client sign in and sign out upon leaving the home."

On 5/3/23 I attempted to interview Ms. Ray-Kimbro, regarding Resident A's plan of care and recent arrest. Ms. Ray-Kimbro reported that she was not aware of Resident A's current location and would not share information with this licensing consultant until 5/4/23 at 4pm, after she had reviewed Resident A's file. I returned a call to Ms. Ray-Kimbro on 5/4/23 at 4pm and she did not respond to this telephone call and voicemail message left requesting a follow-up response.

On 5/4/23 I interviewed Adult Services Worker with Adult Protective Services (APS), Shawna Simms-Rosa. She reported that an Eaton County APS worker had made a visit to Resident A, at the Eaton County Jail, and reported to Ms. Simms-Rosa that Resident A revealed she had existing warrants for her arrest and had turned herself in to the police on 3/30/23. Ms. Simms-Rosa reported she attempted to interview Ms. Ray-Kimbro but was told that information could not be shared with APS due to confidentiality and that Ms. Simms-Rosa would need a release of information from Resident A, who is currently in jail.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based upon interviews with Ms. Engeda and Ms. Cherie as well as review of Resident A's resident record it can be determined direct care staff did not provide for Resident A's supervision and protection as specified in her written assessment plan. Resident A's *Assessment Plan for AFC Residents* form documented that she cannot move independently in the community due to her "disease process and forgetfulness." However, Ms. Engeda & Ms. Cherie both acknowledged allowing Resident A on repeated outings with Citizen 1, who they had no information about in terms of his relationship to Resident A or whether he could provide for her care needs. Resident A's *Assessment* document from Community Mental Health, documented that Resident A is to call the facility should she be late returning from a scheduled outing. Resident A did not return or call the facility to advise of being later than expected. The direct care staff did not make any efforts to locate Resident A when she did not return to the facility. It was not until the following day, when Ms. Engeda received a telephone call from the Eaton County Jail, that they knew of her whereabouts and could account for her personal safety. Both, Ms. Engeda and Ms. Cherie, reported they did not call the police as they did not think they could contact the police for a missing resident until the resident had been missing for over 24-hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(3) If a resident is absent without notice, the licensee or direct care staff shall do both of the following: **(a) Make a reasonable attempt to contact the resident's designated representative and responsible agency.** **(b) Contact the local police authority.**
ANALYSIS:	Based upon interviews with Ms. Engeda & Ms. Cherie, Resident A did not return to the facility on 3/30/23, as was expected. The direct care staff did not contact the Community Mental Health case manager, Ms. Ray-Kimbro, until the following day, 3/31/23, when they received telephone call from the Eaton County Jail that Resident A had been arrested. Based upon interviews with Ms. Engeda and Ms. Cherie, Resident A signed out of the facility on 3/30/23 with the expectation that she would return to the facility on the same day. When Resident A did not return to the facility the direct care staff made no efforts to contact the local police authority regarding her absence. Both, Ms. Engeda & Ms. Cherie, reported that they thought they had to wait 24 hours in order to report a resident as missing to the police.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(4) A licensee shall make a reasonable attempt to locate the resident through means other than those specified in subrule (3) of this rule.

ANALYSIS:	Based upon interviews with Ms. Engeda & Ms. Cherie, on 3/30/23, when Resident A left the facility, she was scheduled to return to the facility on the same date. When Resident A did not return to the facility the direct care staff made no stated efforts to locate Resident A to account for her safety. Ms. Cherie and Ms. Engeda both reported that Resident A has stayed out overnight with Citizen 1 before, and they assumed this was what had occurred on this date. There were no efforts to call/locate Resident A, despite Resident A's *Assessment* document through Community Mental Health highlighting that if Resident A was planning to be late, she should contact the direct care staff at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(5) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.
ANALYSIS:	Resident A was absent from the facility, overnight on 3/30/23 and reported to be arrested and in jail on 3/31/23. I did not receive a copy of a completed incident report until 4/12/23 from Ms. Engeda.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

05/24/23

Jana Lipps Date
Licensing Consultant

Approved By:

06/08/2023

Dawn N. Timm Date
Area Manager