GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 21, 2023

Aster Mekonnen
Noah's AFC Home, Inc.
2299 N. Vernon
Holt, MI 48842

RE: License #: AS330291616
Investigation #: 2023A0466042
Noah's AFC Home, Inc.

Dear Ms. Mekonnen:

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
THIS REPORT CONTAINS SEXUALLY EXPLICIT LANGUAGE

I. IDENTIFYING INFORMATION

License #:	AS330291616
Investigation #:	2023A0466042
Complaint Receipt Date:	04/26/2023
Investigation Initiation Date:	04/27/2023
Report Due Date:	06/25/2023
Licensee Name:	Noah's AFC Home, Inc.
Licensee Address:	2299 N Vernon Holt, MI 48842
Licensee Telephone #:	(517) 694-2351
Administrator:	Aster Mekonnen
Licensee Designee:	Aster Mekonnen
Name of Facility:	Noah's AFC Home, Inc.
Facility Address:	2297 North Vernon Holt, MI 48842
Facility Telephone #:	(517) 694-2351
Original Issuance Date:	08/22/2008
License Status:	REGULAR
Effective Date:	03/28/2022
Expiration Date:	03/27/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATIONS:

	Violation Established?
Resident A’s safety and protection are not being attended to.	No
The water and food source are contaminated.	No
Additional Findings	Yes

III. METHODOLOGY

04/26/2023	Special Investigation Intake- 2023A0466042.
04/26/2023	APS Referral Robert Lindley assigned.
04/27/2023	Special Investigation Initiated - Letter Complainant.
04/28/2023	Inspection Completed On-site.
04/28/2023	Contact-Telephone call made to Resident A’s case manager, Mary Brown, interviewed.
04/28/2023	Contact- Document sent/recevied from licensee designee Aster Mekonnen.
05/01/2023	Contact- Document sent/recevied from licensee designee Aster Mekonnen.
05/04/2023	Contact- Document recevied from APS Robert Lindley.
05/07/2023	Contact- Document recevied from licensee designee Aster Mekonnen.
05/12/2023	Contact- Document sent to licensee designee Aster Mekonnen.
06/12/2023	Contact- Document sent/recevied from APS Robert Lindley.
06/12/2023	Contact- Document sent/recevied from licensee designee Aster Mekonnen.
06/14/2023	Contact- Document sent to detective William Lo.
06/14/2023	Exit Conference with licensee designee Aster Mekonnen.

ALLEGATION: Resident A's safety and protection are not being attended to.

INVESTIGATION:

Complainant reported Resident A resides in Noah's AFC Home with Resident B and Resident C. Complainant reported Resident A was hit in the back of the head by Resident B and sexually assaulted by Resident C. Complainant reported that there are guns and rocks in Resident B's room and they are selling drugs from the home.

On 04/28/2023, Adult Protective Services (APS) Robert Lindley and I conducted an unannounced investigation and we interviewed Resident A who reported Resident B hit her on the back on the head but Resident A could not provide any additional details nor when this occurred. Resident A reported Resident B has guns in her room but she reported she has not seen them nor does she know where they are stored. Resident A reported Resident B has not threatened her with the guns or the rocks. Resident A reported that on date unknown, Resident B tried to get on top of her while she was asleep in bed so she soaked the bed with urine so that Resident B would get off of her. Resident A reported that on a date unknown, Resident C touched her buttocks while she was in bed asleep. Resident A reported when she woke up, her behind was wet and that is when she heard someone run out of her bedroom. Resident A reported she did not see Resident C touch her or runout of her room but reported she knows it was him. Resident A reported a police officer was here yesterday and interviewed her about Resident C sexually assaulting her. Resident A stated she also believes someone is selling drugs from the home but she does not know who. Resident A reported she has never seen anyone selling drugs and Resident A denied that there a lot of people coming in and out of the home.

APS Lindley and I interviewed Resident B who denied hitting Resident A on the back of the head. Resident B denied having guns in her room. Resident B did show us her rock collection which consisted of three small decorative rocks. Resident B reported that the rock collection is decorative and sits on her dresser. Resident B denied ever being Resident A's room. Resident B denied ever getting in bed with Resident A. Resident B reported that her room is on the same hallway as Resident A's and that she has never see Resident C in Resident A's bedroom. Resident B reported that she has never seen or heard anyone run out of Resident A's bedroom. Resident B reported that all the residents are afraid of Resident A. Resident B denied selling drugs out of the facility and reported that she had no knowledge or any reason to believe that anyone was selling drugs from the facility.

APS Lindley and I interviewed Resident C who reported Resident A has asked him to go to the store for her several times and Resident A yells for him to go to her room as she does not like to leave her bedroom. Resident C reported that he has only been in Resident A's bedroom during the day with the door open while she was giving him instructions as to what she wanted from the store. Resident C denied ever going into Resident A's bedroom while she was asleep. Resident C denied touching Resident A. Resident C denied Resident B hit Resident A in the back of the head. Resident C reported Resident A stays in her bedroom all day. Resident C

reported a police officer was here yesterday and interviewed him about sexually assaulting Resident A. Resident C reported that he has never seen anyone selling drugs and he denied that there a lot of people coming in and out of the home.

APS Lindley and I interviewed direct care worker (DCW) and live in staff Daniel Collar and licensee designee Aster Mekonnen separately who reported that they have no knowledge that Resident A was hit in the back of the head by Resident B. DCW Collar and licensee designee Mekonnen both reported they did not observe nor did Resident A or any other resident report to them that Resident A was hit in the back of the head by Resident B. DCW Collar and licensee designee Mekonnen reported they did not have any knowledge that Resident B and Resident C sexually assaulted Resident A. DCW Collar and licensee designee Mekonnen reported they did not observe this nor did Resident A or any other resident report this incident to them. DCW Collar and licensee designee Mekonnen reported there are no guns in the facility. DCW Collar and licensee designee Mekonnen reported resident belongings are inspected by them when they move into the facility. DCW Collar and licensee designee Mekonnen confirmed Resident B does have a small decorative rock collection that she keeps in her room. DCW Collar and licensee designee Mekonnen reported they have never seen anyone selling drugs nor are there a lot of people coming in and out of the home.

I interviewed Resident A's case manager Mary Brown by phone who reported that Resident A did not report to her that she was hit in the back of the head by Resident B nor that she was sexually assaulted by Resident B and/or Resident C. Case manager Brown reported that she has been to the facility and she has not seen any guns nor does she have any reason to believe that anyone is selling drugs from the home. Case manager Brown reported Resident A has a history of filing false police reports and she is not a reliable historian. Case manager Brown reported Resident A used to live in an apartment by herself and she is not happy living in a licensed AFC with rules to follow. Case manager Brown reported that even when Resident A lived alone she continually made allegations to the police about things that had happened to her.

On 05/04/2023, APS Lindley reported detective William Lo reported that on 04/27/2023 he met with Resident A and he was told that a road patrol police officer was at the facility that same day as Resident A made the same allegations to them. APS Lindley reported Detective Lo stated interviews conducted by himself and the road patrol officer did not find any evidence to support Resident A was sexually assaulted, that she was hit in the back of the head by Resident B, that there were guns in the home nor that anyone was selling drugs out of the facility. APS Lindley reported Detective Lo spoke with both the direct care workers and the alleged perpetrator and did not obtain any evidence to corroborate the allegation. APS Lindley reported Detective Lo stated Resident A has a history of reporting similar allegations to police. APS Lindley reported Detective Lo stated that Resident A is moving out of the facility and in with a family member. APS Lindley reported that he did not substantiate this case and its closed.

I reviewed Resident A’s written *Assessment Plan for AFC Residents* which was signed by case manager Brown on 03/31/2023 and documented that Resident A has “some delusional thoughts” and “some problems getting along with others.”

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Complainant reported Resident A’s safety and protection needs were not being attended to but Resident B, Resident C, DCW Collar and licensee designee Mekonnen all denied harming Resident A in any manner. Additionally, APS Lindley reported Detective Lo and the road patrol officer did not find any evidence to support Resident A was sexually assaulted, that she was hit in the back of the head by Resident B, that there were guns in the home or that anyone was selling drugs out of the facility therefore no violations have been established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The water and food source are contaminated.

INVESTIGATION:
On 04/26/2023, Complaint reported that the water from the faucet is slimy and tastes like urine. Complainant reported residents in the home are putting acid sheets in everyone’s food.

On 04/28/2023, APS Lindley and I conducted an unannounced investigation and we interviewed Resident A who reported she does not like to drink the water at the home as the water tastes like urine. Resident A reported she has never observed anyone putting acid sheets in her food but Resident A reported that she could taste it. Resident A reported DCW Collar and licensee designee Mekonnen prepare food for the facility.

APS Lindley and I interviewed Resident B, Resident C, DCW Collar and licensee designee Mekonnen who all denied the water at the facility is slimy and tastes like urine. Resident B, Resident C, DCW Collar and licensee designee Mekonnen all reported they drink the water from the tap at the facility. Resident B, Resident C, DCW Collar and licensee designee Mekonnen all denied putting acid sheets in everyone’s food. Resident B, Resident C, DCW Collar and licensee designee Mekonnen all reported the food at the facility was safe for consumption, free from spoilage and adulteration. Resident B, Resident C, DCW Collar and licensee

designee Mekonnen all reported DCW Collar and licensee designee Mekonnen are responsible for the cooking for the facility.

At the time of inspection, I ran the water from the tap and it appeared to be clean and odor free. I inspected the food that was available in the facility, and it appeared to be safe for consumption, clean, free from spoilage and adulteration.

I interviewed Resident A's case manager Brown by phone who reported Resident A has not reported that the water from the faucet is slimy and tastes like urine. Case manager Brown reported Resident A never reported to her that everyone in the home is putting acid sheets in everyone's food.

I reviewed the facility's file in the Bureau Information Tracking System (BITS) which documented that the facility is on city water and not on a private well. The bureau does not require any water testing for public water.

APPLICABLE RULE	
R 400.14402	**Food service.**
	(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.
ANALYSIS:	Although Complainant and Resident A reported that food at the facility is being contaminated with acid sheets, Resident B, Resident C, DCW Collar and licensee designee Mekonnen all denied putting acid sheets in everyone's food. Resident B, Resident C, DCW Collar and licensee designee Mekonnen all reported that the food at the facility was safe for consumption, free from spoilage and adulteration and therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 04/28/2023, APS Lindley and I conducted an unannounced investigation and we interviewed Resident B who had several over-the-counter medications on her dresser in her bedroom. Resident B reported DCW Collar and licensee designee Mekonnen told her they cannot administer her any over-the-counter medications without a physician's order. Resident B reported DCW Collar and licensee designee Mekonnen told her that if she wanted any over the counter medications that she would need to purchase them and keep them in her room. The following medications were observed in Resident A's bedroom not secured:

- Glucose tablets- package of 50.

- Omeprazole- 14 tablets.
- Tylenol 650 mg- 100 caplets.
- Air Shield- 42 gummies.
- Antacid-150 tablets.
- Airborne- 32 tablets.
- Kaopectate-42 caplets.
- Loperamide, hydrochloride tablets, 2mg- 24 caplets.
- A second bottle of Tylenol 650mg, 100 caplets.

I reviewed Resident B's medication administration record and medication administration record (MAR) and none of the above medication were prescribed to Resident B by a physician.

I reviewed Resident B's record which did not contain any written physician order allowing Resident B to self-administer any medications.

I reviewed Resident A's record which did not contain any written physician order allowing Resident A to self-administer any medications.

I interviewed DCW Collar and licensee designee Mekonnen who both reported that Resident A and Resident B both have inhalers on their person although those inhalers could not be located while I was at the facility. Neither Resident A's nor Resident B's records contained physician orders for self-administration of the inhaler.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(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 {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	On 04/28/2023, APS Lindley and I observed Resident B to have Glucose tablets, Omeprazole, two bottles of Tylenol, Air Shield, Antacid, Airborne, Kaopectate and Loperamide all in her room without a physician order and unsecured therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	I reviewed Resident B's record and it did not contain any written physician order allowing Resident B to self-administer any medications therefore a violation has been established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

INVESTIGATION:
On 04/28/2023, I reviewed Resident A's MAR and conducted a medication review that showed that Resident A is prescribed:

- Loratadine-1 tablet daily, polyethylene glycol daily.
- Dulera 2-puffs every 12 hours.
- Metamucil -daily.

According to Resident A's April 2023, MAR, none of the above medications have been administered to Resident A nor are these medications available to be administered as they are not available at the facility. Additionally, Resident A's PRN, Nicotine chewing gum is not available for administration. Resident A's record did not contain any physician discontinue orders for these medications.

I interviewed Resident A who reported that she has been having breathing concerns because she has not had access to her inhaler.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A's prescribed medication Loratadine, Dulera, Metamucil and Nicotine chewing gum are not being administered as prescribed and they are not available for administration as they are not at the facility therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 04/28/2023, APS Lindley and I conducted an unannounced investigation and when we walked into the facility, we immediately smelled cigarette smoke. APS Lindley and I went to Resident A's bedroom and observed ash trays in the bedroom

full of cigarette butts. Resident A admitted she had been smoking in her bedroom. Additionally, the designated smoking area for the facility is on the front porch and it is not 25 feet from the facility and therefore is in violation of the Public Health Law.

APS Lindley and I interviewed licensee designee Mekonnen and DCW Collar who both reported Resident A has been smoking in the house since her admission. Licensee designee Mekonnen and DCW Collar reported they have asked Resident A to smoke outside but some days she refuses. Licensee designee Mekonnen reported she and DCW Collar do not know what to do as she will not follow their directives.

I interviewed Resident B and Resident C both reported Resident A has been smoking in the house since she moved in. Resident B and Resident C reported licensee designee Mekonnen and DCW Collar reported they have asked Resident A to smoke outside but some days she refuses.

APS Lindley and I observed the furniture on the first porch to be broken. There was no back on the glider chair and the facility was using a wood board as a back rest which was not safe.

APS Lindley and I observed the stove to have only has two working burners.

INVESTIGATION:

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	DCW reported that Resident A has been observed smoking in the facility. The designated smoking area for the facility is not 25 feet from the facility Based on the information above the home was not constructed adequately for the health safety, and well-being of the residents and therefore a violation has been established. The furniture that is on the porch is broken and need to be removed/replaced immediately. The stove only has two working burners and need to be repaired/replaced.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in license status.

06/14/2023

Julie Elkins | Date
Licensing Consultant

Approved By:

06/21/2023

Dawn N. Timm | Date
Area Manager