GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 5, 2024

Mekdes Zewde
5909 Buttonwood Drive
Haslett, MI 48840

RE: License #: AS330404048
Investigation #: 2024A1033039
Big Hearts AFC

Dear Mekdes Zewde:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the quality of care violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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

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 #:	AS330404048
Investigation #:	2024A1033039
Complaint Receipt Date:	04/25/2024
Investigation Initiation Date:	04/25/2024
Report Due Date:	06/24/2024
Licensee Name:	Mekdes Zewde
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:	08/04/2023
Expiration Date:	08/03/2025
Capacity:	6

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

ALLEGATION(S)

	Violation Established?
On 4/23/24, Resident A was not provided adequate supervision by direct care staff, when she wandered away from the facility in the middle of the night and was hit by a car.	Yes
Additional Findings	Yes

II. METHODOLOGY

04/25/2024	Special Investigation Intake 2024A1033039
04/25/2024	Special Investigation Initiated – Telephone call made. Interview with Complainant.
04/25/2024	Contact - Telephone call made- Interview with City of East Lansing Police Department Social Worker, Taylor Knickerbocker, via telephone.
04/25/2024	Inspection Completed On-site- Interview with Residents B, C, D, E, licensee, Mekdes Zewde, direct care staff, Wami Tadele. Review of Resident A's resident record initiated. Attempted to review staff schedule and direct care staff file for Eba Daksa.
04/25/2024	APS Referral- Referral made per protocol.
04/29/2024	Contact - Telephone call made- Interview with East Lansing Police Department, Officer Jacob Jones, via telephone.
04/29/2024	Contact - Telephone call made Attempt to interview Clinton Eaton Ingham Community Mental Health case manager, Inger Lanese, via telephone. Left voicemail message, awaiting response.
04/29/2024	Contact - Document Sent Email to licensee, Mekdes Zewde, requesting additional documentation regarding investigation.
04/29/2024	Contact - Telephone call received-

	Interview with CEI CMH case manager, Inger Lanese, via telephone.
05/06/2024	Inspection Completed On-site- Follow up inspection completed. Interview with direct care staff, Wami Tadele.
05/07/2024	Contact - Telephone call made- Follow-up interview with licensee, Mekdes Zewde, via telephone.
05/07/2024	Exit Conference- Conducted via telephone with licensee, Mekdes Zewde.

ALLEGATION:

On 4/23/24, Resident A was not provided adequate supervision by direct care staff, when she wandered away from the facility in the middle of the night and was hit by a car.

INVESTIGATION:

On 4/25/24 I received an online complaint regarding the Big Hearts AFC adult foster care facility (the facility). The complaint alleged that on 4/23/24, Resident A wandered away from the facility, during the overnight hours, walked into the road and was hit by a vehicle. The complaint alleged that there may not have been direct care staff available at the facility to provide adequate supervision and protection for Resident A's needs. On 4/25/24 I interviewed Complainant via telephone. Complainant reported not having direct knowledge of the incident as they were informed of the events by Officer Jacob Jones of the East Lansing Police Department Patrol Division. Complainant stated Officer Jones reported he was called to the scene of the incident on Hagadorn Road in East Lansing as a pedestrian had been hit, crossing the road, by a moving vehicle. Complainant reported Officer Jones stated he arrived at the scene of the accident and determined the address where Resident A resided and Resident A's name. Complainant reported Resident A was transported to Sparrow Hospital for treatment of her injuries and Officer Jones reported that he then went to the AFC facility address, 540 N. Hagadorn Rd. East Lansing, MI, to inform direct care staff of the accident and that Resident A had been injured and was being transported to Sparrow Hospital. Complainant reported Officer Jones stated when he went to the facility he rang the doorbell and no one responded. He then reported to Complainant that he called Community Mental Health to get the phone number for the owner of the facility (name of homeowner not known to Complainant). Complainant reported Officer Jones stated when he called the telephone number for the AFC facility owner, the homeowner stated he was not currently at the facility but would contact the Community Mental Health case manager for Resident A.

On 4/25/24 I conducted an unannounced, on-site investigation at the facility. When I arrived at the facility, licensee, Mekdes Zewde, was driving into the driveway as I was getting out of my vehicle. A gentleman came out of the facility to assist Ms. Zewde with carrying groceries into the facility. I asked Ms. Zewde who the direct care staff assigned to provide supervision, personal care, and protection to the residents was while she was at the grocery store on 4/25/24. Ms. Zewde pointed to the gentleman who was assisting her and noted his name to be, Eba Daksa. Ms. Zewde reported that Mr. Daksa was just watching the residents for a few minutes while she traveled to and from the grocery store on this date. I asked to view Mr. Daksa's employee file but Ms. Zewde was unable to produce an employee file for Mr. Daksa at the time of the unannounced onsite investigation.

During the on-site investigation on 4/25/24 I interviewed Resident B who reported that he had no knowledge of the incident that occurred with Resident A on 4/23/24. He reported that he had heard she has a fall, but that he was sleeping when this occurred. Resident B reported that the staffing at the facility is "hit and miss." Resident B explained this comment to mean direct care staff who provide care during the day and on Sunday's changes and he does not consistently know who will be providing care, but he acknowledged that Mr. Daksa consistently provides care during the overnight hours and usually evening hours. He reported that on Sundays the facility is staffed by a gentleman named "BK." Resident B reported that during the day the facility is generally staffed by Ms. Zewde and direct care staff, Wami Tadele. Resident B reported that Mr. Daksa sleeps at night in a bedroom at the facility. He reported that there have been a couple of occasions where residents have needed to contact Ms. Zewde or Mr. Tadele to come assist as they could not wake up Mr. Daksa. He reported that he has Mr. Tadele's telephone number and will call him when needed. Resident B reported that to his knowledge there has been one occasion where no direct care staff members were present for resident care, but he could not give a specific date and reported that this was a brief period of time.

During the on-site investigation on 4/25/24 I interviewed Resident C who reported that he was sleeping on 4/23/24 at the time of Resident A's accident. Resident C reported that he was told Resident A wandered away from the facility and had a fall. Resident C expressed concerns about Resident A living at the facility. He reported that he does not feel there is adequate supervision available for Resident A as she has a tendency to wander and has wandered away from the facility before. Resident C reported that the facility is staffed by Mr. Daksa after about 6pm each night. He reported that Mr. Daksa administers medications and provides independent care at the facility. Resident C reported that Mr. Daksa sleeps at the facility and has his own bedroom. Resident C reported that Ms. Zewde and Mr. Tadele stay at the facility through dinner and then they leave, and Mr. Daksa provides care and supervision to residents during the overnight hours. Resident C reported that he feels there is not adequate supervision for Resident A as she wanders and Mr. Daksa sleeps during the night. Resident C reported that on 4/24/24 Ms. Zewde and Mr. Daksa took a walk and left the residents unattended at the facility while they were on this walk. He could not give a specific timeframe for how long Ms. Zewde and Mr. Daksa were away from the facility on this date. Resident C reported

that English is a second language for Mr. Daksa and there are times it can be very difficult to communicate his needs to Mr. Daksa as there are words and phrases Mr. Daksa does not yet understand. Resident C reported an example of this occurred on 4/25/24 when Resident A's ex-husband, who frequently visits her, came to the facility to visit Resident A. Resident C stated Resident A was still hospitalized on this date and her ex-husband did not know she was hospitalized or the nature of the injuries/accident. Resident C reported that Mr. Daksa was the only staff member present at the time of Resident A's ex-husband visiting the facility and Mr. Daksa could not articulate to this gentleman what had happened to Resident A. Resident C reported that Mr. Daksa relied on Resident C to explain the situation to this individual as there were no other direct care staff available to relay this information to Resident A's relative. Resident C reported that there are times when a direct care staff will leave the facility unattended if it is close to shift change and one direct care staff needs to leave before the other arrives. He reported that these are brief periods of time when the residents are left unattended at the facility. Resident C reiterated during this conversation that he has great concern that Resident A's care needs are too intense for the amount of supervision being provided at the facility. He reported that Resident A has delusional thoughts and acts on them.

During on-site investigation on 4/25/24 I interviewed Resident D. Resident D reported that he was not present at the facility on the date of Resident A's accident. He reported that he had been on a leave of absence with family members. Resident D reported that he heard from others that Resident A fell and hurt herself, but he did not have any further information. He reported that he does not feel there is adequate supervision at the facility for Resident A's care needs. He reported that she demonstrates memory impairment and can become easily angered and will "take off walking" away from the facility. Resident D reported that when this happens the direct care staff member on duty will then be required to walk after her, which has left the facility unstaffed while the direct care staff is searching for Resident A. Resident D reported that Mr. Daksa is the primary direct care staff member at the facility. He reported that Mr. Daksa "pretty much" lives at the facility. He reported that Mr. Daksa is the only direct care staff during the evening hours and sleeps at the facility. He reported that if he needed help in the middle of the night he would go to Mr. Daksa's bedroom and knock on the door for assistance. Resident D reported that Mr. Daksa administers medications to residents but to his knowledge does not assist with personal care. He reported that English is a second language for Mr. Daksa and at times it can be difficult to communicate with him as he does not understand all words and phrases being spoken to him by the residents. Resident D reported that sometimes he must point to items for Mr. Daksa to understand what he is trying to say. Resident D reported that he is not aware of any instance when residents were left without a direct care staff member.

During the on-site investigation on 4/25/24 I interviewed Resident E. Resident E reported that she shares a bedroom with Resident A. Resident E reported she was told by direct care staff that Resident A has been hospitalized. She reported that the early morning of 4/23/24 direct care staff (individual unnamed by Resident E) came into her bedroom around 3:45am asking where Resident A was. Resident E reported that she

did not know where Resident A was at that time. Resident E reported that Mr. Daksa is a primary caregiver at the facility and that he sleeps at the facility. Resident E reported that Mr. Daksa administers her medications. Resident E reported that she is unaware of any time when the facility has not been staffed by a direct care staff member. She reported that she likes the direct care staff and "they treat us well." It was difficult to keep Resident E focused on questions being asked during this interview. Her ability to concentrate on specific questions was limited.

During the on-site investigation on 4/25/24 I interviewed Mr. Tadele. Mr. Tadele reported that during the early morning hours of 4/23/24 Resident A was involved in an automobile accident. He reported Ms. Zewde was working at the facility on this evening, noticed she was missing and went searching up and down Hagadorn Rd. looking for Resident A. Mr. Tadele reported Ms. Zewde explained to him that around 10pm the evening of 4/22/23 Ms. Zewde observed Resident A to be in her bedroom. He reported that Ms. Zewde stated she did regular rounding on all residents between 1am – 2am and discovered Resident A was missing. Mr. Tadele reported Ms. Zewde then started walking up and down the sidewalk of Hagadorn Rd. looking for Resident A. He reported that while out of the facility Mr. Daksa was present in the facility with the remaining residents. Mr. Tadele reported both Ms. Zewde and Mr. Daksa were at the facility during the time Resident A went missing. Mr. Tadele reported Ms. Zewde spoke with him on the phone around 2:30am to let him know that Resident A was missing, and she could not locate Resident A. Mr. Tadele reported he received a telephone call from Officer Jones around 3am on this date. He reported Officer Jones stated Resident A had been hit by a car on N. Hagadorn Rd. and transported to Sparrow Hospital. Mr. Tadele reported he called Sparrow Hospital to help them complete the admission process for Resident A as she was found at the scene of the accident without any identification. Mr. Tadele could not recall the name of the nurse he spoke to at Sparrow Hospital Emergency Department but stated they were able to locate Resident A's information in their computer system so they could begin to properly treat and care for Resident A. Mr. Tadele reported that he was informed by this nurse that Resident A had facial bruising and a possible dislocated left knee cap. He was told that Resident A will need to be seen by an orthopedic specialist for her leg/knee injuries and an Ear Nose & Throat doctor for her facial injuries. Mr. Tadele reported Officer Jones called him from the East Lansing Police Department. Mr. Tadele reported that he tried to contact the East Lansing Police Department the following morning and was told they had no record of the accident and for Mr. Tadele to contact the Meridian Township Police Department. Mr. Tadele reported that he then called the Meridian Township Police Department who also reported they had no record of the accident and redirected Mr. Tadele to the East Lansing Police Department. Mr. Tadele reported that he then called the East Lansing Police Department back and was then given a case number and was able to request the police report for the accident. Mr. Tadele reported that he made telephone contact with Resident A's Clinton Eaton Ingham Community Mental Health (CEI-CMH) case manager, Inger Lanese, on 4/23/24 at 10am to update her to Resident A's accident. Mr. Tadele reported that he then completed the CEI-CMH online incident report form and submitted this to Ms. Lanese as well. Mr. Tadele reported that Ms. Lanese noted she would go to Sparrow Hospital to see Resident A. Mr. Tadele reported that around 11am

on 4/23/24 he received a telephone call from someone at Sparrow Hospital (name not recalled) who reported they were ready to discharge Resident A back to the facility. He reported that he was told by this individual that they could not admit Resident A for her injuries, and she would need to follow up with her primary care doctor. Mr. Tadele reported that he felt it was too soon for the hospital to discharge Resident A back to the facility after the accident and he spoke with Ms. Lanese about going to the hospital and advocating for Resident A to be admitted for further observation. Mr. Tadele reported that this is not the first incident where Resident A has wandered away from the facility. He reported that her wandering behaviors usually happened during the daytime hours. Mr. Tadele reported that he has discussed the behaviors with Ms. Lanese but noted as of late the behaviors have been escalating. Mr. Tadele reported that he did not have a current copy of Resident A's *Assessment Plan for AFC Residents* form or the Individual Plan of Services (IPOS) document from CEI-CMH for review in the facility. He noted he would need to look in his computer and send these documents via email. Mr. Tadele was asked to present an employee schedule for the month of April 2024. Mr. Tadele reported that they do not keep a record of employee schedules. Mr. Tadele was asked for an employee file for Mr. Daksa. Mr. Tadele reported he did not have an employee file for Mr. Daksa or any identifying information to present regarding his citizenship or qualifications as a direct care staff.

During on-site investigation on 4/25/24 I interviewed Ms. Zewde. Ms. Zewde reported that on 4/22/23 she had been working at the facility and served dinner to the residents. She reported that she went home for about an hour and left Mr. Daksa responsible for resident care. She reported she returned to the facility around 11pm on 4/22/23. Ms. Zewde reported that she did rounding at the facility of each resident around 12am on 4/23/24 and saw Resident A in her bedroom, sleeping. She reported that she next did rounding around 1:30am and could not locate Resident A. She reported that she left Mr. Daksa in charge of the residents and went walking up and down Hagadorn Rd. looking for Resident A. She reported that she did not take a coat or even take time to put her shoes on as she was concerned to find Resident A. Ms. Zewde reported Resident A has a history of wandering and this was not the first time they have experienced her leaving the facility unattended. She reported that she could not find Resident A so returned to the facility to contact Mr. Tadele. She reported she called Mr. Tadele who reported to her that he had just spoken with Officer Jones and received the report that Resident A had been hit by a car and was hospitalized. Ms. Zewde reported that Mr. Daksa "sometimes lives here" at the facility. She reported that he provides direct care to residents and stays at the facility for overnight care. She reported that the policy of direct care staff is to round about every three hours during the evening to check on resident safety. Ms. Zewde reported that direct care staff can manage Resident A's wandering behaviors and have communicated this to Ms. Lanese. She did not provide information as to how direct care staff can manage her behaviors as licensee Ms. Zewde confirmed the facility has one direct care staff member at a time including during sleeping hours when the direct care staff member working is expected to round or check on residents every three hours. Ms. Zewde reported that Mr. Tadele was upset with her decision to immediately go looking up and down Hagadorn Rd. for Resident A instead of first contacting local police.

During the on-site investigation on 4/25/24 I reviewed Resident A's resident record. I reviewed the following documents:

- *AFC Licensing Division-Incident/Accident Report* for Resident A, dated 4/23/24. This document is signed by Mr. Tadele and noted next to the signature it reads, "Wami, Auth Rep". Under the section, *Explain What Happened/Describe Injury*, it reads, "[Resident A] left the home from sleep and while we are looking for her on the walkway where she goes out during day, it is found that she was hit by car and transported to Sparrow Hospital Emergency Room. [Ms. Zewde] called me and reported she is searching for her. In the mean time EL police called and told us her whereabout. I Immediately called Sparrow and helped them register her properly as they admitted her as "unknown person". The case is reported to CMH case worker and CMH incident portal. We are actively working with Sparrow, Mid Michigan Home Care, CMH and all that help in [Resident A's] recovery."
- *Healthcare Appraisal* for Resident A, dated 8/8/23. Under section, *7. Diagnoses*, it reads, "HTN, Schizoaffective d/o neurocognitive d/o, GERD, IBS, glaucoma, obesity, osteoarthritis." Under section, *11. Mental/Physical Status and Limitations*, it reads, "Neurocognitive disorder." Under section, *12. Mobility/Ambulatory Status*, it reads, "Fully Ambulatory." Under section, *13. Susceptibility to Hyper/Hypothermia and Related Limitations*, it reads, "Very poor memory." Under section, *16. Other Health-Related Information or Concerns*, it reads, "diagnoses cont. migraines, adrenal mass, fatty liver, history of hysterectomy, bilateral knee replacement, right shoulder replacement, history of falls."
- *PCP/IPOS In-Service Sign in Sheet* for Resident A for PCP dated 7/18/22. There were no signatures on this document and this was the only training record located in the resident record on this date.
- *Treatment Plan Annual/Initial,* for Resident A, dated 7/18/22. This was the only CMH treatment plan available to review at the time of the on-site investigation.
- *Assessment Plan for AFC Residents* form for Resident A, dated 7/15/22. On page one of this document, under section, *I. Social/Behavioral Assessment*, subsection, *A. Moves Independently in Community*, it reads, "yes".
- *AFC Resident Information And Identification Record* for Resident A. Under section, *Date of Admission*, it reads, "7/15/2022."

On 4/29/24 I interviewed Officer Jones, via telephone. Officer Jones reported that on 4/23/24 The Meridian Township Police were dispatched to a traffic accident involving a motor vehicle and pedestrian on N. Hagadorn Rd. in East Lansing, MI. He reported that the Meridian Township Police officer arrived on the scene only to identify that the accident was actually in the jurisdiction of East Lansing Police Department. Officer Jones reported that he was dispatched to the scene and spoke with the Meridian Township Police officer who reported that they had obtained information from the victim to determine her identity as Resident A. He reported that the Meridian Township Police officer stated they had previous experience with Resident A and were able to identify her. Officer Jones reported that Resident A was alert but confused during his interactions with her. He reported that Resident A stated that she thought she had been

on the sidewalk, but she had been walking out into the road. Officer Jones reported that the driver of the vehicle acted quickly and swerved their vehicle to avoid Resident A, which caused the vehicle to hit Resident A with the upper corner of the vehicle. Officer Jones reported that Resident A was transported to Sparrow Hospital, and it was believed at the time that her knee was broken. Officer Jones reported that the accident was reported between midnight and 1am on 4/23/24. He reported that he followed Resident A to Sparrow Hospital and then he drove to the facility, at 540 N. Hagadorn Rd. East Lansing, MI, to inform direct care staff of the accident and Resident A's whereabouts. Officer Jones reported that he arrived at the facility around 3am and rang the doorbell. He reported that all the lights were off and there was not a vehicle in the driveway. He reported that he then sat in his patrol car and called CEI-CMH to obtain the telephone number for the homeowner. He reported that he spoke with Mr. Tadele who reported that he was not at the facility, but he did not ask Mr. Tadele if any other direct care staff was present. He reported that he discussed Resident A's accident and current location as Sparrow Hospital Emergency Department.

On 4/29/24 I interviewed Ms. Lanese via telephone. Ms. Lanese reported that she is the CEI-CMH, Older Adult Services Program, case manager for Resident A. She reported that she has been working with Resident A since around June of 2022. She reported Resident A attends the Older Adult Services day program twice per week. Ms. Lanese reported that on 4/23/24 she had made a telephone call to Mr. Tadele to discuss an unrelated issue and at the time she made this telephone call she had not received any information regarding Resident A's accident. She reported that Mr. Tadele reported the accident to her during this telephone conversation. Ms. Lanese reported that Mr. Tadele reported to her that Resident A had been "hit by a car" and was at Sparrow Hospital. She reported Mr. Tadele did not have an explanation for how the accident occurred during this conversation. She reported that she had asked Mr. Tadele for a copy of the police report for the accident but Mr. Tadele did not yet have this report. She reported that to this date she has not yet received the police report. Ms. Lanese reported that she did go to the hospital on 4/23/24 to visit Resident A and advocate for Resident A to be considered for subacute rehabilitation services at a local rehabilitation center. She reported Resident A was experiencing difficulty with weight bearing due to the injury she sustained to her knee during the motor vehicle accident. Ms. Lanese reported Mr. Tadele requested Resident A have an evaluation before returning to the facility. Ms. Lanese reported that she was not sure what Mr. Tadele was referring to in asking for this. Ms. Lanese confirmed Resident A has demonstrated prior incidents of wandering away from the facility and at least two different occasions the police were involved and had to bring her back to the facility. Ms. Lanese reported that she believes direct care staff were aware of Resident A's wandering on these dates and were the ones who contacted the police on those dates. Ms. Lanese reported primary direct care staff members she has communicated with at the facility are Mr. Tadele and Ms. Zewde. She reported she has not held any interactions with Mr. Daksa. Ms. Lanese reported that she has held a training, on 7/27/23, regarding Resident A's IPOS document with direct care staff, Angel and Tamaroon. She reported that she did not have their last names to provide.

On 4/30/24 I had email correspondence with Mr. Tadele regarding the employment status of Eba Daksa and "BK". Mr. Tadele confirmed that direct care staff member "BK"'s name is Berhane Kana. As of the date of this email correspondence licensee Mekdes Zewde had not provided an employee file or any verification Mr. Daksa or Mr. Kana had completed any direct care staff requirements such as employee fingerprinting, healthcare appraisal, or training prior to working independently with residents. I asked Mr. Tadele, "Has [Mr. Daksa] move out of the facility and is no longer providing care?" Mr. Tadele responded, "He has moved out. I won't make him help us until all his paperwork and full background check is completed." I asked Mr. Tadele, "How long have [Mr. Kana] and [Mr. Daksa] been providing care?" Mr. Tadele responded, "[Mr. Kana] for about 5 Sundays of 5 hour average. [Mr. Daksa] is my relative and came over for a visit and about 3 weeks." I asked Mr. Tadele if this was all the paperwork documentation he had for Mr. Kana as he only provided a document the size of a business card which was titled, *CMHA-CEI-TU-17*, which stated Mr. Kana's name, date of hire, & last four digits of his social security number, for a separate AFC employer. Mr. Tadele reported that he had a copy of Mr. Kana's driver's license (which he provided) and that Mr. Kana had previously worked for a different adult foster care facility.

During this email correspondence I requested Mr. Tadele to send Resident A's IPOS document and corresponding training record that were in place on 4/23/24. I reviewed the following forms supplied by Mr. Tadele.

- *Community Mental Health Clinton-Eaton-Ingham Assessment*, for Resident A, dated 6/12/23. On page one of this document under section, *New and Ongoing Presenting Problems since Last Annual Assessment*, it reads, "[Resident A] remains a resident at Big Hearts AFC in East Lansing. This transition has been helpful in myriad ways, including no inpatient psychiatric encounters. She is consistently struggling with memory loss Remote and short term) and often presents with confusion/questionable reality orientation." Under section, *Desired Outcomes for the Coming Year*, paragraph one, it reads, "[Resident A] would benefit from remaining in the AFC home. Her needs are met and her health and safety concerns are consistently addressed." Paragraph two reads, "Continued attention to health/safety and wellness concerns coupled with alternative to increase frequency of social interactions are clinically recommended at this time. Increased CLS sessions to assist in improving self-determination by facilitating decision making opportunities, as well as MHW to link to resources, provide supports, and offer 1:1 activities are clinically recommended." Paragraph three reads, "Per most recent psychiatry note-Alisa Schlacht, DO (6/5/2023): "Refer to neurology regarding memory loss, progressive, suspect Alzheimer's disease, has not improved as mood stabilized.""
- *PCP/IPOS In-Service Sign In Sheet,* for Resident A for PCP dated 7/18/22. This document was signed by Mr. Tadele (8/16/22) and Ms. Zewde (8/17/22). These were the only two signatures on the document.

On 4/30/24 Mr. Tadele also emailed a copy of the *State of Michigan Traffic Crash Report* dated 4/23/23. This report was completed by Officer Jones. The report identifies the date and time of the accident as 4/23/24 at 00:24. Resident A is identified as the

pedestrian on the report. On page 2, under the section, *Narrative*, it read, “Unit 2 was traveling Southbound on N. Hagadorn Rd. passing Crestwood Dr. when the pedestrian suddenly entered the roadway outside of a crosswalk. Driver of Unit 2 stated he attempted to swerve but was unable to miss the pedestrian. The pedestrian struck the front right fender of Unit 2.” The location where Resident A was hit by the motor vehicle is approximately 1.1 miles from the facility. It should be noted that it is unknown the path Resident A walked to arrive at the location where she was struck by the vehicle.

On 5/6/24 I conducted a follow up, unannounced, on-site investigation at the facility. I attempted to interview Ms. Zewde at the time of this inspection however, Ms. Zewde was not present at the facility on this date. Mr. Daksa was present at the facility and the only individual providing personal care, supervision, and protection to the residents. Mr. Daksa made a telephone call to Ms. Zewde who stated she had gone to the grocery store and would be returning shortly. About 20 – 25 minutes after my arrival, Mr. Tadele arrived at the facility. He reported that Mr. Daksa no longer resides at the facility, but he was filling in while Ms. Zewde made a quick trip to the grocery store. Mr. Tadele provided a telephone number for Ms. Zewde to conduct a follow-up interview. I explained to Mr. Tadele that Mr. Daksa cannot be in the facility independently providing care to residents when he has not been cleared through the *Michigan Workforce Background Check* system, has no documentation of completed trainings, completed medical clearance, or completed negative TB testing.

On 5/7/24 I conducted a follow-up interview with Ms. Zewde via telephone regarding the motor vehicle accident with Resident A on 4/23/24. Ms. Zewde reported that she had left the facility on 4/22/24, after dinner was served, and returned to the facility around 11pm on 4/22/24 for the evening. Ms. Zewde reported that she drove her car to the facility and parked it at the facility on this date. Ms. Zewde reported that she conducted rounding on all residents around midnight on 4/23/24 and then went to an empty bedroom to rest and fell asleep. She reported that when she woke to conduct rounding around 3am she realized Resident A was not in her bed and not in the facility. She reported that at this time she left the facility, leaving Mr. Daksa in charge of resident care, and began looking for Resident A by walking up and down the sidewalk on Hagadorn Rd. She reported that she left the facility without her phone and without shoes. She reported that she did not drive her car, rather she left it at the facility. She reported that she walked for about an hour and returned to the facility around 3:52am. She reported that at this time she made a telephone call to Mr. Tadele who reported to her that he had spoken with Officer Jones and Resident A was at Sparrow Hospital. Ms. Zewde reported that she does not recall any prior history of the police being involved when Resident A had wandered from the facility. She reported during Resident A’s prior wandering episodes, direct care staff were able to locate Resident A without police involvement. Ms. Zewde reported that on 5/6/24 she had left the facility for a brief period of time to get milk for the residents. She reported that she had left Mr. Daksa in charge when she made this trip to the grocery store.

On 5/9/24 I had email correspondence with Ms. Lanese regarding Resident A’s CEI-CMH treatment plan. I inquired about Resident A’s CEI-CMH Assessment written in

June 2023 which noted a possible concern for Alzheimer's Disease for Resident A. I inquired whether testing had been conducted to determine whether Resident A had this diagnosis. Ms. Lanese replied that Resident A was evaluated by Memorial Neuroscience, Cara Leahy, DO, in November 2023 and had preliminary testing. She reported that an MRI scan was ordered and based upon abnormal Tau ratio results, an Amyloid PET scan was ordered. She reported that this was scheduled for April 2024 but needed to be rescheduled. She did not provide a date for the rescheduled scan. I also inquired if Ms. Lanese had any specific information on previous elopements from the facility, concerning Resident A, which resulted in police involvement. Ms. Lanese reported that she had a contact note in Resident A's record dated 11/8/22 which reads, "[Mr. Tadele] called MHT [mental health therapist] and informed that [Resident A] reported she was "going to go vote" and has left the AFC on foot. MHT instructed [Mr. Tadele] to contact the Police Department." Finally, I inquired whether the CEI-CMH assessment dated 6/12/23 was the most recent assessment that the direct care staff at the facility should be following for Resident A. Ms. Lanese reported, "The assessment is dated 7/14/23 is the current treatment plan. A treatment plan review was completed 1/4/24; no changes no amendments were required at the time." She further clarified that the two documents, the Assessment dated 6/12/23 & Treatment Plan dated 7/14/23, are both the most up to date documents for Resident A at this time.

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:	Based upon interviews with Complainant, Mr. Tadele, Ms. Zewde, Officer Jones, Ms. Lanese, Residents B, C, D, & E as well as review of Resident A's resident record and additional documentation supplied by Mr. Tadele via email, it can be determined that on 4/22/24 into 4/23/24, direct care staff did not provide for Resident A's personal needs, including protection and safety in accordance with the provisions of the act. There is documentation dating back to the year 2022 indicating that Resident A has a history of wandering, confusion, and memory loss. Most recently she was being evaluated for a potential Alzheimer's Disease diagnosis. Every person interviewed verified that Resident A was confused, had wandering tendencies, and required consistent supervision and monitoring. Ms. Zewde states that she was present at the facility the evening of 4/22/24 into the morning of 4/23/24 when Resident A wandered away from the facility in the middle of the night and was hit in the road by a motor vehicle. She reported that she was sleeping between 12am and 3am and woke to check on the residents for regular rounding. There were no provisions in place to assist a sleeping staff member to ensure Resident A's safety and protection from her own confused state of mind, and history of wandering when she eloped in early morning hours of 4/23/24, was struck by a vehicle, and sustained injuries to her face and knee. There were noted discrepancies in the accounts of the evening concerning whether licensee Ms. Zewde was at the facility or whether Mr. Daksa, who is not trained or approved to work in an AFC, was the only person at the facility providing for resident safety. Ms. Zewde reported that she drove her car to the facility that evening and left it parked at the facility. However, Officer Jones reported no vehicles in the driveway and no lights on at the facility at 3am on 4/23/24. Ms. Zewde reported that at 3am she noticed Resident A missing from the facility and quickly left on foot to find her. Furthermore, Mr. Tadele and Ms. Zewde did not have an employee schedule to reference, per Mr. Tadele's verbal report, making it impossible to verify whether Ms. Zewde was scheduled to be at the facility on the evening of 4/22/24 – 4/23/24. Based upon this information a violation has been established at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 4/25/24 I conducted on unannounced, on-site investigation at the facility. When I arrived at the facility, the licensee, Mekdes Zewde, was driving into the driveway as I was getting out of my vehicle. A gentleman came out of the facility to assist Ms. Zewde with the groceries. I asked Ms. Zewde who the direct care staff assigned to provide supervision, personal care, and protection to the residents was while she was at the grocery store. Ms. Zewde pointed to the gentleman who was assisting her and noted his name to be, Eba Daksa. Ms. Zewde reported that Mr. Daksa was just watching the residents for a few minutes while she traveled to and from the grocery store on this date. I asked to view Mr. Daksa's employee file and Ms. Zewde was unable to produce an employee file for Mr. Daksa on this date. Ms. Zewde reported that Mr. Daksa does work independently at the facility and provides for resident care while she and Mr. Tadele are away from the facility. She reported that he has stayed nights at the facility with the residents to provide protection, safety, and personal care.

On 4/25/24 during the on-site investigation I interviewed Mr. Tadele. Mr. Tadele reported that he does not have an employee file for Mr. Daksa for my review. He reported that Mr. Daksa has not had a *Michigan Workforce Background Check* completed. I asked if Mr. Daksa has a social security number and Mr. Tadele responded that Mr. Daksa does not have a social security number. I requested Mr. Tadele produce any type of legal documentation for Mr. Daksa of citizenship or a work/travel Visa. Mr. Tadele reported he would send this information via email as he did not have it currently. Mr. Tadele reported that Mr. Daksa just fills in at the facility when Ms. Zewde or himself are unable to be present with the residents. Mr. Tadele could not produce any documentation regarding background check clearances for Mr. Daksa on this date.

On 4/25/24 during on-site investigation I interviewed Resident B. He reported that consistently the facility is staffed by Mr. Daksa during the evening and overnight hours. He reported that on Sundays the facility is staffed by a gentleman named Mr. Kana.

On 4/25/24 during the on-site investigation I interviewed Resident C. Resident C reported that the facility is staffed by Mr. Daksa after about 6pm each night. He reported that Mr. Daksa administers medications and provides independent care at the facility. Resident C reported that Mr. Daksa sleeps at the facility and has his own bedroom. Resident C reported that Ms. Zewde and Mr. Tadele stay at the facility through dinner and then they leave and Mr. Daksa provides the care during the overnight hours.

On 4/25/24 during the on-site investigation I interviewed Resident D. Resident D reported that Mr. Daksa is the primary direct care staff member at the facility. He reported that Mr. Daksa "pretty much" lives at the facility. He reported that Mr. Daksa is the only direct care staff during the evening hours and sleeps at the facility.

On 4/25/24 during the on-site investigation I interviewed Resident E. Resident E reported that Mr. Daksa is a primary caregiver at the facility. She reported that he sleeps at the facility. Resident E reported that Mr. Daksa administers her medications.

On 4/29/24, via email, Mr. Tadele provided a copy of Mr. Daksa's *Visa for the United States of America*. The issue date is 11/29/23, the expiration date is 11/27/25, and the Visa Type/Class is R B1/B2. On the U.S. Department of State website, Travel.State.Gov, it lists a B1/B2 Visa as a Visitor Visa, Business (B-1), Tourism (B-2). Under the category B-1 are the following guidelines, "consult with business associates, attend a scientific, educational, professional, or business convention or conference, settle an estate, negotiate a contract." Under the category B-2 are the following guidelines, "Tourism, vacation, visit with friends or relatives, medical treatment, participation in social events hosted by fraternal, social, or service organizations, participation by amateurs in musical, sports or similar events or contests, if not being paid for participating, enrollment in a short recreational course of study, not for credit toward a degree (for example, a two-day cooking class while on vacation)." The description of a Visitor Visa, on this website, read as follows, "Generally, a citizen of a foreign country who wishes to enter the United States must first obtain a visa, either a nonimmigrant visa for a temporary stay, or an immigrant visa for permanent residence. Visitor visas are nonimmigrant visas for persons who want to enter the United States temporarily for business (visa category B-1), for tourism (visa category B-2), or for a combination of both purposes (B-1/B-2)." On this same website under the section, Visitor Visa, subsection, Additional Information, it reads, "An individual on a visitor visa (B1/B2) is not permitted to accept employment or work in the United States."

On 4/30/24 I held email correspondence with Mr. Tadele. I inquired about *Michigan Workforce Background Checks* for Mr. Kana. Mr. Tadele reported that Mr. Kana had been cleared through another adult foster care facility, but not through the Big Hearts AFC facility. He did not have a copy of the *Michigan Workforce Background Check* clearance he referenced from the other licensed adult foster care facility. I asked Mr. Tadele, "Has [Mr. Daksa] move out of the facility and is no longer providing care?" Mr. Tadele responded, "He has moved out. I won't make him help us until all his paperwork and full background check is completed." I asked Mr. Tadele, "How long have [Mr. Kana] and [Mr. Daksa] been providing care?" Mr. Tadele responded, "[Mr. Kana] for about 5 Sundays of 5 hour average. [Mr. Daksa] is my relative and came over for a visit and about 3 weeks." I asked Mr. Tadele if this was all of the paperwork documentation he had for Mr. Kana as he only provided a document the size of a business card which was titled, *CMHA-CEI-TU-17*, which stated Mr. Kana's name, date of hire, & last four digits of his social security number, for Noah's AFC Home. Mr. Tadele reported that he had a copy of Mr. Kana's driver's license (which he provided) and that Mr. Kana had previously worked for a different adult foster care facility.

On 5/6/24 I conducted a follow up, unannounced, on-site investigation at the facility. I attempted to interview Ms. Zewde at the time of this inspection. Ms. Zewde was not present at the facility on this date. Mr. Daksa was present at the facility and the only individual providing personal care, supervision, and protection to the residents. Mr.

Daksa made a telephone call to Ms. Zewde who stated she had gone to the grocery store and would be returning shortly. About 20 – 25 minutes after my arrival, Mr. Tadele arrived at the facility. He reported that Mr. Daksa no longer resides at the facility, but he was filling in while Ms. Zewde made a quick trip to the grocery store. Mr. Tadele provided a telephone number for Ms. Zewde to conduct a follow-up interview. I explained to Mr. Tadele that Mr. Daksa cannot be in the facility independently providing care to residents when he has not been cleared through the *Michigan Workforce Background Check* system, has no documentation of completed trainings, completed medical clearance, or completed negative TB testing.

On 6/4/24 I corresponded with Department Analyst, Katelyn Haskin, with the State of Michigan, Licensing & Regulatory Affairs, regarding the status of previous Michigan Workforce Background Checks for Mr. Kana. Ms. Haskin reported that Mr. Kana was previously processed through the Michigan Workforce Background Check system on 8/13/15 for Noah's AFC Home, which is currently an inactive facility, on 10/21/19 for Rachel's Adult Foster Care, which is currently an inactive facility, and on 5/4/24 for Big Hearts AFC (the facility).

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(3) An individual who applies for employment either as an employee or as an independent contractor with an adult foster care facility or staffing agency and who has not been the subject of a criminal history check conducted in compliance with this section shall give written consent at the time of application for the department of state police to conduct a criminal history check under this section, along with identification acceptable to the department of state police. If the individual has been the subject of a criminal history check conducted in compliance with this section, the individual shall give written consent at the time of application for the adult foster care facility or staffing agency to obtain the criminal history record information as prescribed in subsection (4) or (5) from the relevant licensing or regulatory department and for the department of state police to conduct a criminal history check under this section if the requirements of subsection (11) are not

	met and a request to the Federal Bureau of Investigation to make a determination of the existence of any national criminal history pertaining to the individual is necessary, along with identification acceptable to the department of state police. Upon receipt of the written consent to obtain the criminal history record information and identification required under this subsection, the adult foster care facility or staffing agency that has made a good-faith offer of employment or an independent contract to the individual shall request the criminal history record information from the relevant licensing or regulatory department and shall make a request regarding that individual to the relevant licensing or regulatory department to conduct a check of all relevant registries in the manner required in subsection (4). If the requirements of subsection (11) are not met and a request to the Federal Bureau of Investigation to make a subsequent determination of the existence of any national criminal history pertaining to the individual is necessary, the adult foster care facility or staffing agency shall proceed in the manner required in subsection (5). A staffing agency that employs an individual who regularly has direct access to or provides direct services to residents under an independent contract with an adult foster care facility shall submit information regarding the criminal history check conducted by the staffing agency to the adult foster care facility that has made a good-faith offer of independent contract to that applicant.
ANALYSIS:	Based upon interviews with Mr. Tadele, Ms. Zewde, Resident B, Resident C, Resident D, Resident E as well as email correspondence with Mr. Tadele and review of Mr. Daksa's Visa it can be determined that Ms. Zewde and Mr. Tadele did not conduct *Michigan Workforce Background Checks* on Mr. Daksa or Mr. Kana as required by the AFC Licensing Act. Upon review of Mr. Daksa's Visa, it was determined that he is not eligible for employment in the United States due to the status of his current Visa being a Visitor Visa. A violation has been established as it was reported by every resident interviewed, as well as Ms. Zewde, that Mr. Daksa has been living in the facility and providing supervision, protection, and personal care to the current residents, independently. It was also determined that Mr. Tadele did not conduct a documented background check on Mr. Kana before 05/04/2024 and prior to employing him at the facility and scheduling him to cover for multiple hours on Sundays as the only direct care staff member providing for resident supervision, protection, and personal care.

CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During on-site investigations on 4/25/24 and 5/6/24 I arrived at the facility to find the only person providing protection, supervision, and personal care for residents was Mr. Daksa. As stated above, Mr. Daksa is not a trained direct care staff member and cannot work independently with residents.

During the on-site investigation on 4/25/24 I requested to review employee files for Mr. Daksa. I was told by Ms. Zewde and Mr. Tadele that Mr. Daksa does not have an employee file. Ms. Zewde and Residents B, C, D, & E reported on this date that Mr. Daksa provides for resident protection, supervision, and personal care while Ms. Zewde and Mr. Tadele are away from the facility. Residents B, C, D & E also reported Mr. Daksa also administers resident medications.

On both 4/25/24 and 5/6/24, during portions of time during my on-site investigation I found the facility to be staffed solely by Mr. Daksa on these dates.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	Based upon findings of the on-site investigations on 4/25/24 & 5/6/24, as well as discoveries made regarding Mr. Daksa not having a current *Michigan Workforce Background Check*, required trainings, medical clearance, or TB testing, it can be determined that the facility was not adequately staffed to sufficiently implement the plans of service for any resident residing in the facility on the dates 4/25/24 and 5/6/24.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(2) All staff who work independently and staff who function as lead workers with clients shall have successfully completed a course of training which imparts basic

	concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training shall address all the following areas: **(a) An introduction to community residential services and the role of direct care staff.** **(b) An introduction to the special needs of clients who have developmental disabilities or have been diagnosed as having a mental illness. Training shall be specific to the needs of clients to be served by the home.** **(c) Basic interventions for maintaining and caring for a client's health, for example, personal hygiene, infection control, food preparation, nutrition and special diets, and recognizing signs of illness.** **(d) Basic first aid and cardiopulmonary resuscitation.** **(e) Proper precautions and procedures for administering prescriptive and nonprescriptive medications.** **(f) Preventing, preparing for, and responding to, environmental emergencies, for example, power failures, fires, and tornados.** **(g) Protecting and respecting the rights of clients, including providing client orientation with respect to the written policies and procedures of the licensed facility.** **(h) Nonaversive techniques for the prevention and treatment of challenging behavior of clients.**
ANALYSIS:	Based upon interviews with Ms. Zewde, Mr. Tadele, and Residents B, C, D, & E, it can be determined that Mr. Daksa has been providing care to the residents of this facility and has not been trained in any of the required trainings for a facility with a special certification license. Therefore, a violation has been established at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based upon interviews with Ms. Zewde, Mr. Tadele, and Residents B, C, D, & E, it can be determined that Mr. Daksa has been providing care to the residents of this facility and has not been trained in any of the required trainings. There is no way to determine Mr. Daksa's level of competence in the required training areas. Furthermore, the only training record Mr. Tadele and Ms. Zewde were able to produce for Mr. Kana was the business card which was titled, *CMHA-CEI-TU-17*, which stated Mr. Kana's name, date of hire, & last four digits of his social security number, for Noah's AFC Home, which Mr. Tadele provided via email on 4/30/24. This document did not list induvial trainings completed and provided no manner for assessing whether Mr. Kana is competent in all of the required training areas. Therefore a violation has been established at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Based upon interviews with Ms. Zewde, Mr. Tadele, and Residents B, C, D, & E, it can be determined that Mr. Daksa has been providing care to the residents of this facility and has not been trained in the area of medication administration. There is no way to determine his level of competence in the required training area. Therefore, a violation has been established at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

At the time of the on-site investigation on 4/25/24 I interviewed Mr. Tadele. Mr. Tadele reported that he does not have documentation of medical clearance signed by a licensed physician for Mr. Daksa. Mr. Tadele also reported that Mr. Daksa does not have a current negative tuberculosis test within the last three years.

On 4/30/24 I held email correspondence with Mr. Tadele. Mr. Tadele reported that he does not have current documentation of medical clearance for Mr. Kana signed by a licensed physician. Mr. Tadele also was not able to provide proof of a negative tuberculosis test for Mr. Kana within the past three years.

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 physician's 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. **(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:	Based upon interviews with Mr. Tadele it can be determined that Mr. Daksa and Mr. Kana have been working at the facility and providing direct care to residents without having a completed medical clearance form signed by a licensed physician. It can be determined that both, Mr. Daksa and Mr. Kana, have been working as direct care staff and Mr. Tadele and Ms. Zewde did not have copies of proof of negative tuberculosis tests within the past three years for either individual. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the on-site investigation on 4/25/24 I interviewed Ms. Zewde and Mr. Tadele. I asked them both for an employee file for Mr. Daksa. They both reported that there is not an employee file for Mr. Daksa on this date.

On 4/30/24 I had email correspondence with Mr. Tadele regarding an employee file for Mr. Kana. Mr. Tadele reported that the only information he had to present for Mr. Kana's employee file was his driver's license.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(a) Name, address, telephone number, and social security number.** **(b) The professional or vocational license, certification, or registration number, if applicable.** **(c) A copy of the employee's driver license if a direct care staff member or employee provides transportation to residents.** **(d) Verification of the age requirement.** **(e) Verification of experience, education, and training.** **(f) Verification of reference checks.** **(g) Beginning and ending dates of employment.** **(h) Medical information, as required.** **(i) Required verification of the receipt of personnel policies and job descriptions.**

ANALYSIS:	Based upon interviews with Ms. Zewde and Mr. Tadele it can be determined the licensee did not maintain employee files and required documentation for employee files for Mr. Daksa or Mr. Kana on 4/25/24.
CONCLUSION:	**VIOLATION ESTABLISHED**

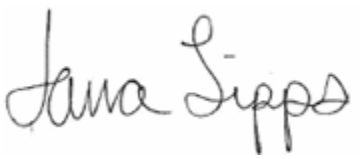
INVESTIGATION:

During the on-site investigation on 4/25/24 I interviewed Mr. Tadele and requested to review a copy of the April 2024 employee schedule. Mr. Tadele reported that they do not keep track of employee schedules at the facility. He could not produce this documentation.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	Based upon the interview with Mr. Tadele it can be determined that there was no employee schedule to review during the on-site visit, therefore a violation has been established at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Based upon the severity of the findings of this investigation related to quality of care, revocation of the license is recommended at this time.



5/16/24

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Jana Lipps
Licensing Consultant

Date

Approved By:

06/03/2024

Dawn N. Timm
Area Manager

Date