



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 10, 2026

Elsabeth Engeda  
2843 Turtle Creek Dr.  
East Lansing, MI 48823

RE: License #: AS330367324  
Investigation #: 2026A0622019  
Kalkidan AFC 3

Dear Ms. Engeda:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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

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.

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) 335-5985.

Sincerely,

A handwritten signature in black ink, appearing to read 'Amanda Blasius', written in a cursive style.

Amanda Blasius, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS330367324
<b>Investigation #:</b>	2026A0622019
<b>Complaint Receipt Date:</b>	01/22/2026
<b>Investigation Initiation Date:</b>	01/22/2026
<b>Report Due Date:</b>	03/23/2026
<b>Licensee Name:</b>	Elsabeth Engeda
<b>Licensee Address:</b>	2843 Turtle Creek Dr. East Lansing, MI 48823
<b>Licensee Telephone #:</b>	(517) 336-4490
<b>Administrator:</b>	Elsabeth Engeda
<b>Licensee Designee:</b>	Elsabeth Engeda
<b>Name of Facility:</b>	Kalkidan AFC 3
<b>Facility Address:</b>	2121 Hopkins Avenue Lansing, MI 48912
<b>Facility Telephone #:</b>	(517) 402-6191
<b>Original Issuance Date:</b>	01/16/2015
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	04/24/2024
<b>Expiration Date:</b>	04/23/2026
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A is living in an AFC home approved for six residents, but currently seven residents are living there.	Yes
Resident A is forced to sleep in a chair, as he does not have a bedroom.	Yes
Additional Findings	Yes

**III. METHODOLOGY**

01/22/2026	Special Investigation Intake 2026A0622019
01/22/2026	Special Investigation Initiated – Interviewed assigned licensing consultant, Jana Lipps.
01/27/2026	Denied APS referral received. Requested complainant information from APS.
01/30/2026	Inspection Completed On-site
01/30/2026	Contact - Telephone call made to licensee designee, Elisabeth Engeda, Guardian A1, Recipient Rights and caseworker, Caroline Croom.
02/02/2026	Inspection Completed On-site
02/03/2026	Contact - Telephone call made to licensee designee, Elisabeth Engeda and Guardian B1.
02/10/2026	Inspection Completed On-site
03/02/2026	Phone call to Guardian B1, VM left for Resident A's doctor through Harmony Cares
03/11/2026	Exit conference with licensee designee, Elisabeth Engeda

**ALLEGATION: Resident A is living in an AFC home approved for six residents, but currently seven residents are living there.**

**INVESTIGATION:**

On 01/22/2026, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, Resident A is living at Kalkidan AFC 3, which is licensed for six residents, but currently has seven residents admitted to the facility.

On 01/22/2026, I interviewed the assigned licensing consultant via phone and obtained additional information regarding the home.

On 01/27/2026, a referral from adult protective services was received, as they denied the referral. Complainant information was requested from adult protective services, but was unavailable.

On 01/30/2026, I completed an unannounced onsite investigation to Kalkidan AFC 3. During the unannounced onsite investigation, I viewed seven residents within the home. I also viewed seven beds within the home but was informed by direct care worker, Bayoush Mekonen that the bed within bedroom five is only “for show” and is not used by Resident A. Resident A was unable to be interviewed as he is non-verbal. During the unannounced onsite investigation, a resident register could not be found to be viewed, therefore all resident files were reviewed. Seven resident files were available to be reviewed during the unannounced onsite investigation. According to the *AFC Resident Information and Identification Records* the residents were admitted on the following dates:

Resident A: 02/01/2023  
Resident B: 06/21/2019  
Resident C: 11/01/2025  
Resident D: 12/02/2025  
Resident E: 12/01/2021  
Resident F: 12/02/2022  
Resident G: 07/15/2025

On 1/30/2026, I viewed medical documentation for Resident A from Harmony Cares dated 12/22/2025. On the documentation it stated that Resident A was hospitalized from 12/12/2025-12/16/2025 and it was also recommended that he go back to the ER on 12/18/2025. Resident A was present in the home on 1/30/26.

On 01/30/2026, I interviewed direct care worker Bayoush Mekonen in person. She reported that Resident A has been sleeping in the living room in a chair, as he has no bed and/or bedroom available. Direct care worker Mekonen reported that Resident A needs to be upright and needs a hospital bed, but one is not available within the home for him, as Resident D is now in his bedroom and using the bed previously used by Resident A.

On 01/30/2026, I interviewed Resident C in person who confirmed that Resident A does not have a bedroom or bed and is sleeping in a chair within the resident living room. Resident C also reported that all Resident A's belongings are in the closet in the entry way behind the front door. I viewed the closet in the entry way and it was filled with men's clothes which direct care worker Bayoush Mekonen confirmed belonged to Resident A.

On 01/30/2026, I interviewed Resident D in person. He showed me his bed and bedroom and reported that Resident A sleeps in a chair in the living room. Resident D stated that Resident A has slept in the living room since he moved into the home.

On 01/30/2026, I called licensee designee Elisabeth Engeda via phone. I informed her I was at the home and that seven residents were within the home which is one over the maximum capacity for this license. I informed licensee designee Elisabeth Engeda that she needed to assure the facility came into licensed capacity immediately. Licensee designee Engeda initially explained being over capacity due to one resident recently returning to the facility from the hospital. However according to my review of the *AFC Resident Information and Identification Records* and medical documentation, the last admission to the home was 12/02/2025 and no other resident had been discharged regardless of any hospital admissions. Licensee designee Engeda reported that she would work on moving a resident as quickly as possible as she stated she has an opening at one of her other AFC licensed homes and planned to move Resident C there. Licensee designee Engeda stated this facility is located on Park Lake Road and has an opening.

On 01/30/2026, I completed an unannounced onsite investigation to Kalkidan AFC 2 at 5340 Park Lake Rd. East Lansing to determine if there was an opening to admit one resident from Kalkidan AFC 3. During the unannounced onsite investigation, the direct care worker informed me that this licensed AFC facility was full with ten residents. I viewed all bedrooms and confirmed that each bedroom was occupied. I confirmed that the licensed capacity for Kalkidan AFC 2 is 10 residents.

On 01/30/2026, I called licensee designee Engeda during my unannounced onsite investigation to Kalkidan AFC 2 and informed her that Resident C could not be moved to this home as it was also at capacity of 10 residents. I informed licensee designee Engeda that she needed to discharge a resident from Kalkidan AFC 3 before 02/02/2026 given that Resident A was moved out of his bedroom and is now sleeping in the resident living area in a recliner. She reported that she would work on discharging Resident B to a nursing home. Licensee designee provided Resident B's guardian information.

On 01/30/2026, I interviewed Guardian A1 via phone. He reported that he visits Resident A frequently at the home and they visit in the living room. Guardian A1 reported that he was aware that Resident A was preferring to sleep in a recliner due

to breathing concerns, but he was unaware that he did not have a bedroom at the home. Guardian A1 stated that he would follow up with licensee designee Engeda.

On 01/30/2026, I left voicemails for Resident A's caseworker and recipient rights.

On 01/30/2026, licensee designee Engeda sent a text that she was still working on getting Resident B moved to a nursing home.

On 02/02/2026, I completed an unannounced onsite investigation to Kalkidan AFC 3. During the unannounced onsite investigation, seven residents were still present at the home and Resident A remained sleeping in the living room in a recliner chair.

On 02/02/2026, I contacted licensee designee Engeda for an update and she reported that she is still working on getting Resident B discharged to a nursing home.

On 02/02/2026, I contacted Guardian B1 via phone and asked for an update on his discharge from Kalkidan AFC 3. Guardian B1 stated that they were working on paperwork to move Resident B, but were unsure when he would be moved.

On 02/03/2026, I received confirmation from Guardian B1 and licensee designee, Engeda that Resident B was discharged from the home at 4:30pm on 2/3/26.

On 02/10/2026, I completed an unannounced onsite investigation to Kalkidan AFC 3. During the inspection, I confirmed that Resident B was moved out of the home and that Resident A was now provided a bedroom, along with his personal belongings moved into the closet within the bedroom.

On 03/02/2026, I interviewed Guardian B1 via phone and confirmed that Resident B did not have any long-term hospital stays from November 2025-February 2026. She also confirmed that payment for room and board was made all of those months also.

On 03/06/2026, I interviewed licensee designee Engeda via phone. She provided further information on how her capacity reached seven residents. Ms. Engeda reported that Resident B was supposed to be discharged to a nursing home as his care was becoming too much for one staff member. Ms. Engeda stated that the process of getting Resident B discharged into a long term care home was delayed as he was having tests completed regarding a possible cancer diagnosis. Ms. Engeda reported that she did not want to lose the option to take placement of Resident D, therefore she accepted Resident D before Resident B was discharged. Ms. Engeda reported that she made a "huge mistake" and should not have admitted Resident D. Ms. Engeda reported that the process to discharge Resident B took time as it was difficult to find the appropriate placement for him into a nursing home.

On 03/09/2026, I interviewed direct care worker Bayoush Mekonen via phone. DCW Mekonen confirmed that licensee designee Elisabeth Engeda was aware that seven

residents were living and receiving care in the home from 12/02/2025 through 02/03/2026.

<b>APPLICABLE RULE</b>	
<b>R 400.613</b>	<b>Licensed capacity, occupants.</b>
	<b>(1) The number of residents and number of resident beds must not be greater than the capacity authorized on the license.</b>
<b>ANALYSIS:</b>	Based upon the unannounced onsite investigation, interviews and documentation reviewed it was determined that Kalkidan AFC 3 was over capacity from 12/02/2025-02/03/2026. On 01/30/2026 and 02/02/2026, I observed seven residents within the home, along with seven beds. During both unannounced onsite investigations, direct care worker Bayoush Mekonen and Residents C and D confirmed that Resident A has to sleep in the living room in a recliner and his clothes are kept in the closet in the entry way. A violation was established as Kalkidan AFC 3 was knowingly over capacity by one resident from 12/02/2025-02/03/2026 and had more beds than the capacity authorized on the license.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.657</b>	<b>Bedrooms.</b>
	<b>(2) Living rooms, dining rooms, hallways, or other rooms that are not ordinarily used for sleeping, or a room that contains a required means of egress, must not be used for sleeping purposes by anyone.</b>
<b>ANALYSIS:</b>	Based upon the unannounced onsite investigation, it was found that Resident A was sleeping in the resident living room, as he did not have a bedroom available. Direct care worker Bayoush Mekonen and two other residents interviewed confirmed that Resident A has to sleep on the couch or reclining chair near the TV as he does not have a bedroom or bed.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(3) A licensee and staff shall respect and safeguard all of the following resident rights to:</b> <b>(q) Access their bedroom at their own discretion.</b>

<b>ANALYSIS:</b>	During the unannounced onsite investigation, a violation was established as it was determined that Resident A did not have access to a bedroom within the home and he was sleeping in the living room and his personal belongings were in the entry way closet.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

Upon observing that Kalkidan AFC 3 was over capacity on 01/30/2026 and had been since 12/02/2025, I contacted licensee designee Engeda to determine what her next course of action would be to bring the facility back to capacity. Licensee designee Engeda reported that she would work on moving a resident as quickly as possible and stated that she has an opening at one of her other licensed AFC home on Park Lake Road and planned to admit Resident C to that facility.

On 01/30/2026, I completed an unannounced onsite investigation to Kalkidan AFC 2 at 5340 Park Lake Rd. East Lansing to determine if they had an opening for an additional resident. During the unannounced onsite investigation, the direct care worker informed me that this facility was at capacity with 10 residents. I viewed all bedrooms and confirmed that each bedroom was occupied. I also reviewed the facility file and confirmed that the licensed capacity for Kalkidan AFC 2 was 10 residents.

On 01/30/2026, I called licensee designee Engeda during my unannounced onsite investigation to Kalkidan AFC 2 and informed her that Resident C could not be moved to this home as it is at capacity of 10 residents. I informed licensee designee Engeda that she needed to discharge a resident from Kalkidan AFC 3 as soon as possible as Resident A could not continue to sleep in a recliner in the resident living area with his belongings stored in a hall closet.

During my interview with licensee designee Engeda on 03/06/2026, Ms. Engeda did not have a reasonable explanation regarding her decision to admit a seventh resident on 12/02/2025. Ms. Engeda stated she did not want to miss out on Resident D's placement, so she made the decision to admit Resident D even though the facility was at capacity with six residents.

<b>APPLICABLE RULE</b>	
<b>R 400.623</b>	<b>Applicant, licensee and administrator qualifications; licensee, administrator and staff requirements; parole or probation or convicted of felony.</b>
	<b>(1) An applicant, licensee, and administrator shall have the financial and administrative capability to operate a facility as specified in the act and these rules.</b>

<b>ANALYSIS:</b>	Licensee designee Engeda knowingly allowed the facility to become and remain over capacity after she admitted a seventh resident to a facility which had a licensed capacity of six residents and currently had six residents admitted to the facility. Ms. Engeda knew the facility was over the licensed capacity after admitting a seventh resident on 12/02/2025 and stated she thought it would be short term. Licensee designee Engeda also knowingly moved Resident A out of a bedroom that he was paying for and into the resident living area to sleep on a recliner. Licensee designee Engeda's voluntary decision to go over capacity and remain so for at least two months along with displacing Resident A out of his bedroom to sleep on a recliner demonstrates disregard for the act and these rules and her lack of administrative capability to operate the facility.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 01/30/2026, during the unannounced onsite investigation, I asked to review the resident register and direct care worker, Bayoush Mekonen was unable to find the resident register during the unannounced onsite investigation. In order to determine the information for all seven residents, I was able to view each residents file to determine their admission date.

<b>APPLICABLE RULE</b>	
<b>R 400.615</b>	<b>Resident register.</b>
	<b>A licensee shall maintain a chronological register of all residents admitted that includes the following information for each resident:</b> <b>(a) Resident full name.</b>
<b>ANALYSIS:</b>	During the unannounced onsite investigation on 01/30/2026, a resident register was unable to be reviewed or found, therefore a violation was established.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 02/02/2026, I viewed Resident A's *Resident Funds Part II form*. According to the form, Resident A has made payment of \$1,080.00 for room and board for the months of November 2025-January 2026. I also viewed Resident A's *AFC Resident Care Agreement*, which was dated 01/12/2026 and signed off by Guardian A1, community mental health caseworker Caroline Croom and licensee designee Elisabeth Engeda. The *AFC Resident Care Agreement*, stated that Resident A will pay a basic fee monthly for room and board, along with care management and doctors visits. The monthly amount for the basic fee was left blank on the form.

I did not observe any documentation of a decrease in room and board payment for 12/02/2025 through 02/03/2026 since Resident A did not have a room available for his use.

<b>APPLICABLE RULE</b>	
<b>R 400.685</b>	<b>Resident admission; resident assessment plan; resident care agreement; health care appraisal.</b>
	<b>(6) A licensee shall complete a written resident care agreement at the time of a resident's admission that includes all of the following:</b> <b>(i) An agreement by the licensee to provide care, supervision, and protection to the resident and to ensure transportation services as indicated in the resident's assessment plan and resident care agreement.</b>
<b>MCL 400.704 Definitions; C to F.</b>	<b>(8) "Foster care" means the provision of supervision, personal care, and protection in addition to room and board, for 24 hours a day, 5 or more days a week, and for 2 or more consecutive weeks for compensation provided at a single address. Providing room under a landlord and tenant arrangement does not, by itself, exclude a person from the licensure requirement under this act.</b>
<b>ANALYSIS:</b>	Based upon the documentation reviewed and interviews conducted, Guardian A1 and licensee designee Engeda signed an <i>AFC Resident Care Agreement</i> on 01/12/2026 agreeing to provide Resident A with the elements of adult foster care which includes personal care, supervision and protection in addition to room and board. Per Resident A's <i>Resident Funds Part II form</i> , Resident A was paying \$1,080.00 for adult foster care services and room and board from 12/02/2025 through 02/03/2026, despite licensee designee Engeda knowingly moving Resident A out of his assigned bedroom and into a recliner in the resident living area. Ms. Engeda did this so another resident could live in that bedroom. Resident A also did not have access to a bedroom closet as his belongings were moved into a hall closet accessible to anyone. Consequently, Resident A was not provided with all the elements of adult foster care as agreed upon, specifically the room portion, yet was charged the same price of \$1080.00 as previously agreed upon.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Due to the severity and number of quality of care violations, I recommend a six month provisional license for this facility upon receipt of an acceptable corrective action plan.



03/09/2026

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Amanda Blasius  
Licensing Consultant

Date

Approved By:



03/09/2026

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Dawn N. Timm  
Area Manager

Date