GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 6, 2026

Esther Mwankenja
Zanzibar Adult Foster Care, LLC
520 S. Holmes St.
Lansing, MI 48912

RE: License #: AS330406614
Investigation #: 2026A1033044
Zanzibar Adult Foster Care, LLC

Dear Ms. Mwankenja:

Attached is the Special Investigation Report for the above referenced facility. Due to the multiple 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. 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 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,

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 #:	AS330406614
Investigation #:	2026A1033044
Complaint Receipt Date:	06/23/2026
Investigation Initiation Date:	06/26/2026
Report Due Date:	08/22/2026
Licensee Name:	Zanzibar Adult Foster Care, LLC
Licensee Address:	520 S. Holmes St., Lansing, MI 48912
Licensee Telephone #:	(517) 885-0716
Administrator:	Esther Mwankenja
Licensee Designee:	Esther Mwankenja
Name of Facility:	Zanzibar Adult Foster Care, LLC
Facility Address:	520 S. Holmes Street, Lansing, MI 48912
Facility Telephone #:	(517) 885-0716
Original Issuance Date:	02/17/2021
License Status:	REGULAR
Effective Date:	03/11/2026
Expiration Date:	03/10/2028
Capacity:	6
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff are not keeping a Medication Administration Record for the current residents.	Yes
Direct care staff are not providing proper supervision for the current residents to keep them safe.	Yes
Resident records are not available for review at the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/23/2026	Special Investigation Intake 2026A1033044
06/23/2026	Contact - Telephone call made- Attempt to interview Complainant. Left voicemail message, awaiting response.
06/26/2026	Special Investigation Initiated - On Site Interview conducted with direct care staff, Stella Sampeta. Walkthrough of the facility conducted. Review of available documentation completed.
06/26/2026	Contact - Face to Face Interview conducted with licensee designee, Esther Mwankenja.
06/26/2026	Contact - Telephone call made Interview conducted with Resident A's CEI-CMH case manager, Wycliffe Okenye, via telephone.
06/26/2026	Contact - Telephone call made Interview conducted with CEI-CMH, case manager, Nickolas Epifanio, via telephone.
06/26/2026	Contact - Telephone call made Interview conducted with Guardian B1 & Guardian B2, via telephone.
06/26/2026	Contact - Telephone call made Interview conducted with Guardian A1, via telephone.
06/26/2026	Contact - Telephone call received Telephone call from licensee designee, Esther Mwankenja.
06/26/2026	Contact - Telephone call made

	Interview conducted with Ms. Mwankenja and Resident B via telephone.
06/28/2026	APS Referral- Referral made per protocol.
06/29/2026	Contact – Document received- Email correspondence received from licensee designee, Esther Mwankenja.
07/06/2026	Exit Conference Conducted via telephone with licensee designee, Esther Mwankenja.

ALLEGATION: Direct care staff are not keeping a Medication Administration Record for the current residents.

INVESTIGATION: On 6/23/26 I received an online complaint regarding the Zanzibar Adult Foster Care, adult foster care facility (the facility). The complaint alleged that direct care staff members are not keeping *Medication Administration Records* (MARs) for the current residents. On 6/23/26 I attempted to interview the complainant, via telephone. I left a voicemail message and did not receive a response.

On 6/26/26 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff, Stella Sampeta. Ms. Sampeta reported that she has been working at the facility since licensee designee, Esther Mwankenja, traveled out of the country for a family trip. She reported that she has been covering shifts at the facility and providing care to Resident A and Resident B. She reported that she began providing care to the residents on 6/16/26. She reported that she has been staying at the facility providing for their care and I observed her belongings in one of the licensed resident bedrooms. She reported that the facility only has two residents and she was sleeping in one of the empty bedrooms. Ms. Sampeta presented the MARs she has been documenting during the time she has been caring for the residents. The MARs she provided were for June 2026. I observed the following information:

- Resident A's MAR did not contain any staff signatures from 6/12-6/15 and 6/25-6/26.
- Resident B's MAR had missing dates from 6/1-6/11. The dates 6/12-6/15 & 6/25-6/26 contained no staff signatures.
- Ms. Sampeta's initials or handwriting were observed on the dates 6/16-6/24. Some of the dates she had written "HP" and some she had written "HV". I asked Ms. Sampeta what these abbreviations referred to and she reported "HP" means "hospital" and "HV" means "home visit". I inquired of Ms. Sampeta what a "home visit" was referring to and she reported that she thought Resident B had gone to visit his family for a couple of days.

On 12/19/24 a previous special investigation report (2025A0466006) cited a rule violation of 400.14312 (4)(b). This investigation cited that direct care staff had initialed resident MARs for administration of medications that were not available on-site for administration. The corrective action plan, dated 1/27/25, indicated that medications would be audited weekly and always available on-site for resident administration. Adult foster care home rules were updated and promulgated on 11/3/2025 and Rule R 400.14312 (4)(b)) is equivalent to Rule R 400.675 (4)(b).

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(b) Complete an individual medication log that contains all of the following:** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initials of the individual who administered the medication at the time given.** **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.**
ANALYSIS:	Based upon the interview conducted with Ms. Sampeta and a review of the MARs provided it is determined that the MARs were not completed in a comprehensive manner as multiple dates contained no staff initials or reasonings as to why medications were not administered. Resident B's MAR only covered the dates 6/12-6/30. The entries for 6/1-6/11 were missing. Therefore, a violation is established.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED (See Special Investigation Report, 2025A0466006, dated 12/19/24, and Corrective Action Plan dated 1/27/25.)**

ALLEGATION:

- **The direct care staff are not providing proper supervision for the current residents to keep them safe.**

- **Resident records are not available for review at the facility.**

INVESTIGATION: On 6/23/26 I received an online complaint alleging staff are not providing adequate supervision for the current residents. The complaint reported that residents are leaving the facility without notice and are not completing a "sign out" sheet to indicate where they are going and when they will return. The complaint alleged that resident records were not available at the facility for review. The complaint further alleged direct care staff sleep during the day and are not providing adequate supervision to monitor the safety of the residents. On 6/23/26 I attempted to interview the complainant. A voicemail message was left, and a response was not received.

On 6/26/26 I conducted an unannounced, on-site investigation at the facility. The door was answered by Ms. Sampeta. Ms. Sampeta reported that she was alone in the facility. She reported that the facility currently has two residents, Resident A and Resident B, and neither resident was currently home. I asked Ms. Sampeta where the residents were at this time. She reported that she was not sure of the location of either resident. Ms. Sampeta then reported that she had incident reports regarding each resident. She provided me with incident reports and I observed the following information:

- The incident reports were handwritten notes on a blank piece of paper.
- Resident A's incident report was dated 6/22/26. It reads, *"Time around 8:00am – 9:00am. He left the premises without notice. Left his breakfast and morning meds. My co-worker later told me he was not in the room, though he went out in the morning for his cigarettes, and went upstairs [direct care staff, Brandi Usher-Gray] came to leave [sic] (relieve) me shortly because I needed some treatment was not feeling very well and also visit my case worker, unfortunately I didn't get appointment, so I came back. So, today is June 23rd he is not still home, and I notified my boss, about it, and let her know. So, am waiting for further direction, since am not the final say."* This note is signed by Ms. Sampeta.
- Resident B's incident report was dated 6/20/26. It reads, *"Today he came from so called aunties house, he left the premises without notice since 18th June 2026. Time: around 11:00am & 12:00am. Went into his room. Shortly, he came and telling me to answer the phone. I learned it was his new guardian, she urged me to call 911. I asked what happened he said he overdosed himself many pills and was feeling suicidal. Since he was feeling not well and according to his guardian, I called 911 he told them same story and they took him to Sparrow. I told the ambulance 911, that medication was administered in this premises. He came back today, 22nd June 2026 with his guardian, Time was noon. Since there was problem with electricity, I sent him to be attended to another house till there is electricity in the house, and left with my co-worker [Ms. Usher-Gray] at 904 Baker St."* This note is signed by Ms. Sampeta.

After reading the incident reports, I asked Ms. Sampeta to provide her verbal accounting of the last time she saw each resident. She reported that she started providing care to the residents on 6/16/26. She reported that Resident B left the facility without notice on 6/18/26 and returned on 6/20/26. She reported that when

he returned on 6/20/26 he made a telephone call to Guardian B1 and reported that he had taken a pill bottle full of pills that he had obtained in the community and he was feeling suicidal. Ms. Sampeta reported that she spoke with Guardian B1 via telephone on this date and was instructed to contact 911 and have Resident B sent to the emergency department. Ms. Sampeta reported that she does not know the name and telephone number of Guardian B1. She reported that Ms. Mwankenja did not leave any resident records with this information for her at the facility. She reported that she could not provide me with Guardian B1's name or telephone number today. Ms. Sampeta reported that Resident B returned to the facility on 6/21/26 and told her that he wanted to go "watch the World Cup." Ms. Sampeta reported that she allowed Resident B to leave the facility to go watch the World Cup. I inquired where Resident B went to watch the World Cup, who he went with, and whether Ms. Sampeta has had any contact with Resident B since this time. Ms. Sampeta reported that she did not ask Resident B where he was going, who he would be with, or for a contact telephone number. She reported that she handed him his medications to take with him so he could administer them himself while he was gone. Ms. Sampeta reported that she did not have a telephone number or name for Guardian B1 so she did not obtain permission for this outing for Resident B. She reported that this was the last time she saw Resident B and he has not returned to the facility since 6/21/26 when he stated he was going to go "watch the World Cup". I inquired whether Ms. Sampeta made any effort to locate Resident B since he left the facility on 6/21/26. She reported that the power went out at the facility and when the power came back on the Wi-Fi at the facility was no longer working. She reported that she could not call anyone for help because her phone only works with functioning Wi-Fi systems and she no longer had access to the facility Wi-Fi due to the power outage. Ms. Sampeta reported that she did not call the police or make any efforts to report Resident B as missing when he did not return from this outing.

Ms. Sampeta was asked about Resident A's whereabouts during the on-site investigation on 6/26/26. Ms. Sampeta reported that the last time she saw Resident A was 6/22/26. She reported that Resident A left the facility on 6/22/26 without notice and did not tell her where he was going. Ms. Sampeta reported that she thinks Resident A is at the hospital. I inquired whether she has called the hospitals or Guardian A1 to confirm his whereabouts. Ms. Sampeta reported, "no Wi-Fi", indicating her telephone does not work to make telephone calls due to the current issues with the Wi-Fi at the facility. She reported that she also does not have a resident record for Resident A and does not know the name or telephone number for his guardian. Ms. Sampeta reported that when Resident B returned to the facility on 6/21/26 he informed her that he saw Resident A at Sparrow Hospital in the psychiatric unit. She reported that this is why she thinks Resident A is hospitalized. I inquired how Resident B could have seen Resident A at Sparrow if Resident B was discharged from Sparrow on 6/21/26 and Resident A did not leave the facility until 6/22/26. Ms. Sampeta did not have an answer to this question. Ms. Sampeta reported that she has not seen Resident A since 6/22/26, and has not contacted the police or Guardian A1. She reported that she has tried to contact Ms. Mwankenja

regarding the missing residents, but Ms. Mwankenja has been out of the country and her telephone calls to Ms. Mwankenja do not go through. Ms. Sampeta reported that direct care staff, Rachel Opara, was supposed to be covering for Ms. Mwankenja in her absence but two weeks ago Ms. Opara reported that she no longer worked for Ms. Mwankenja and quit. Ms. Sampeta informed me that it has been between 4-5 days since she has seen Resident A or Resident B and she has no idea as to their whereabouts.

During the on-site investigation I walked through the facility with Ms. Sampeta. I observed that there was no other person at the facility besides Ms. Sampeta. I observed that there were no resident records available at the facility on this date. There were no face sheets, no Community Mental Health Individual Plan of Service documents, no assessment plans, or any other required resident records. I observed that both Resident A and Resident B's medications were in the medication cart.

On 6/26/26 I conducted a face-to-face interview with licensee designee, Esther Mwankenja, at 904 Baker St., Lansing, MI. Ms. Mwankenja reported that she had just returned from her trip on this date. Her baggage was sitting on the front porch of the home. I inquired whether Ms. Mwankenja had been briefed on the situation concerning Resident A and B. Ms. Mwankenja reported that Ms. Sampeta was responsible for their care and she had not informed Ms. Mwankenja that the residents were missing. Ms. Mwankenja reported that this was the first time she had heard of this situation. She reported that several days prior she received a text message from Ms. Sampeta reporting that Resident B had been taken to the hospital via ambulance. Ms. Mwankenja showed me her telephone and the text message with a photo image of the ambulance in front of the facility. Ms. Mwankenja reported that she was greatly distressed by the news of the residents missing and stated she feels Ms. Sampeta is trying to ruin her business. Ms. Mwankenja was able to provide the names and telephone numbers of the guardians and Community Mental Health case workers for both residents. I asked Ms. Mwankenja about Ms. Opara working as the acting licensee designee in her absence. Ms. Mwankenja reported that this was true and that Ms. Opara was available for Ms. Sampeta. I asked how frequently Ms. Opara checked in with Ms. Sampeta during Ms. Mwankenja's absence. Ms. Mwankenja could not report the frequency of contact between Ms. Sampeta and Ms. Opara. Ms. Mwankenja reported that even if Ms. Sampeta's telephone was not working, the telephone at the facility should have been working. She was not sure why Ms. Sampeta did not use the telephone at the facility.

During the on-site investigation on 6/26/26 I reviewed the MARs for the two residents. I observed the following:

- Resident A's MAR did not contain any staff signatures from 6/12-6/15 and 6/25-6/26.
- Resident B's MAR had missing dates from 6/1-6/11. The dates 6/12-6/15 & 6/25-6/26, contained no direct care staff signatures.
- Ms. Sampeta's initials or handwriting was on the dates 6/16-6/24. Some of the dates she had written "HP" and some she had written "HV". I asked Ms. Sampeta what these abbreviations were referring to and she reported "HP" means "hospital" and "HV" means "home visit". I inquired of Ms. Sampeta what a "home visit" was referring to and she reported that she thought Resident B had gone to visit his family for a couple of days. Resident B's MAR documents "HP" or hospital on 6/19 & 6/21/26. The MAR documents "HV" or home visit on 6/17-6/18 & 6/22-6/24.Resident A's MAR documents "HP" on 6/23-6/24.

During the face-to-face interview with Ms. Mwankenja, she called Ms. Usher-Gray and had this telephone conversation on speaker phone. I could hear and communicate with Ms. Usher-Gray during this conversation. Ms. Usher-Gray reported that she worked at Ms. Mwankenja's other licensed adult foster care facility at 904 Baker St. during the time Ms. Mwankenja was out of the country. She reported that she would speak with Ms. Sampeta and did provide groceries for Ms. Sampeta and the residents. Ms. Usher-Gray reported that Resident B "comes and goes as he pleases." She reported that frequently Resident B will just leave and not tell staff where he is going or when he will return. Ms. Usher-Gray reported that she did pick up Resident B on the date the power went out at the facility. She could not recall which date this occurred. She reported that he spent a few hours at the facility she works at and then she took him back to the facility. Ms. Usher-Gray reported that she does not know the whereabouts of Resident A or Resident B. She reported that the power went out at the facility due to confusion with the electric bill. She reported that the bill was paid but somehow not received prior to the shut off notice being activated. Ms. Usher-Gray reported that things were corrected and the power at the facility was restored. She reported that Ms. Sampeta did mention that she did not have a working telephone to call for assistance. Ms. Usher-Gray did not know if there was another telephone available at the facility.

On 6/26/26 I interviewed Wycliffe Okenye, case manager for Resident A, with Clinton-Eaton-Ingham Counties Community Mental Health (CEI-CMH), via telephone. Mr. Okenye confirmed he is the case manager for Resident A. He initially reported that he did not know the whereabouts of Resident A. Mr. Okenye reported that the "housing team" with CEI-CMH had made a visit to the facility this week and based on their findings from this site visit they decided to terminate the housing contract with this facility. Mr. Okenye reported that the residents were told they would be moving to another location. Mr. Okenye reported that the housing team requested he submit paperwork to begin the process of finding Resident A a new placement. Mr. Okenya reported that Resident A started experiencing suicidal ideation this week and went to UofM Sparrow Health System Emergency Department for evaluation. He reported that he received a "Crisis Note" regarding

Resident A on 6/23/26. This document noted that Resident A was transported to the Stone Crest mental health facility in Detroit, MI, at 15000 Gratiot Ave. Mr. Okenye reported that to his knowledge, Resident A is still at this facility, receiving mental health treatment. Mr. Okenye stated that it was reported to him that when Resident A was instructed by the housing team that he would need to move from the facility he began to have anxiety about the possibility of becoming homeless again and in turn became suicidal.

On 6/26/26 I interviewed Nickolas Epifanio, case manager for Resident B, with CEI-CMH, via telephone. Mr. Epifanio reported that he did not know the whereabouts of Resident B. He reported that he had just spoken with Ms. Mwankenja, via telephone, who informed him that Resident B was at his “aunts house”. I inquired whether Mr. Epifanio is aware of who this person is, where she lives, or a contact telephone number. Mr. Epifanio reported he does not know any of the requested information. He reported that he had heard Resident B talk about going to his aunt’s house before but has never questioned him about the details surrounding this individual. Mr. Epifanio reported that Resident B has experienced multiple episodes of suicidal ideation in the month of June 2026. He reported known dates of hospital admissions of 5/28/26-6/5/26, 6/15/26-6/15/26, 6/21/26-6/23/26. He reported that the last hospital encounter on 6/21/26 was due to Resident B claiming he had attempted suicide by taking medications. He reported emergency department staff did not find any evidence that Resident B had taken pills and worked with the CEI-CMH team to keep Resident B at the hospital for two days until they could get him scheduled to meet with a provider at CEI-CMH for additional mental health support. Mr. Epifanio reported that Resident B was picked up at Sparrow on 6/23/26 and taken to his appointment at CEI-CMH and then returned to the facility on this date. He reported that he tried to contact the direct care staff on 6/16/26 to discuss Resident B’s care and had to leave a voicemail message. He reported that he did not receive a return call. He reported that he is not certain the direct care staff knew of any of Resident B’s hospitalizations this month. Mr. Epifanio reported that a “mental health worker” (name unknown) from CEI-CMH made a visit to the facility on 6/25/26 to drop off legal paperwork for Resident B and was informed by direct care staff at the facility that Resident B was not at the facility. The “mental health worker” reported that direct care staff stated Resident B was “at his aunt’s house”. He reported there is no documentation that anyone at CEI-CMH has seen Resident B since he was dropped off at the facility on 6/23/26. Mr. Epifanio reported that there are plans in process to move Resident B to another licensed adult foster care setting.

On 6/26/26 I interviewed Guardian B1 and Guardian B2 via telephone. I was informed that Guardian B1 has been granted full guardianship of Resident B, and this took effect 1/24/25. Guardian B2 reported that quarterly visits are made to the facility to check on Resident B. It was reported that attempts were made to visit Resident B at the facility on 6/16/26 & 6/18/26 but Resident B was not present on either date. Guardian B1 and Guardian B2 reported that they know Resident B goes out into the community independently. They reported that if Resident B were

eloping from the facility on a frequent basis, they would expect direct care staff to follow-up with them to address this concern. Both confirmed that they received a telephone call from the UofM Sparrow Health System on 6/21/26 that Resident B was at the hospital for mental health treatment. They reported that transportation was provided for Resident B to attend his mental health appointment on 6/23/26 and return to the AFC facility on this date. They reported that they had not had contact with Resident B since this date. When questioned about Resident B's statement that he was "going to go watch the World Cup" they reported that he does do things like this but usually returns. They reported that they do not know who Resident B's "auntie" is and have no contact information for this individual.

On 6/26/26 I received a telephone call from Ms. Mwankenja. She reported that she had contacted Resident B and found him at his "aunts" home. She reported that she had picked him up and was transporting him back to the facility. She reported that Ms. Sampeta had been terminated and would not be providing resident care at the facility. I spoke with Resident B, via telephone, on this date. He reported his full legal name and noted that he had been staying with his aunt, Ashley (last name not disclosed), at the corner of Edgewood Blvd. and Cedar St. in Lansing, MI. He noted that he had been gone for a two-day period. He reported that he was fine and not harmed. He reported that he wanted to return to the facility with Ms. Mwankenja.

On 6/26/26 I interviewed Guardian A1, via telephone. Guardian A1 reported that she is aware of Resident A's whereabouts. She reported that Resident A had called her and indicated he had been feeling suicidal and she directed him to go to the UofM Health Sparrow Hospital Emergency Department for a psychiatric evaluation. She reported that this occurred on 6/23/26 and he was seen at Sparrow on 6/24/26. She reported that he was then transferred to an inpatient psychiatric facility in Detroit on 6/25/26, where he currently remains. She reported she made several attempts to reach direct care staff at the facility to inform them of Resident A's whereabouts, but she could not get anyone to answer the telephone and she could not leave a voicemail message because the voicemail system was "full". Guardian A1 reported that she sent an email to Ms. Mwankenja regarding Resident A's location and current situation. Guardian A1 reported that she feels direct care staff who cover when Ms. Mwankenja is away cannot provide adequate supervision and support to Resident A. She reported that she was upset due to someone coming to the facility and telling Resident A he would have to move from the facility, without first consulting with her. She reported that Resident A finds Ms. Mwankenja and direct care staff, Patrobah Mazara, helpful and calming. She reported that when Resident A was told he would need to move from the facility he immediately began to experience a mental health crisis and was feeling overwhelmed and suicidal.

I reviewed the website, 911.gov, for the purposes of this investigation. I observed the following *Frequently Asked Question*, "Can I dial 911 from a wireless phone without a wireless calling plan?" I observed the following answer, "All wireless

phones, even those that are not subscribed to or supported by a specific carrier, can call 911. However, calls to 911 on phones without active service do not deliver the caller's location to the 911 call center, and the call center cannot call these phones back to find out the caller's location or the nature of the emergency. If disconnected, the 911 center has no way to call back the caller."

On 6/29/26 I received email correspondence from Ms. Mwankenja. Ms. Mwankenja provided the following documents for my review:

- CEI-CMH, *Treatment Plan Annual/Initial*, for Resident B, dated 10/31/25. On page one, under the section, *Areas of Need*, it reads, "The clinician has recommended the following areas be addressed in the treatment plan: Physical Aggression and/or other risk factors, suicidality, current health issues, abuse/trauma, housing/AFC, activities/groups/engagement." Under the section, *Desired Outcomes*, it reads, "[Resident B] wants to make money, continue working on his art, and does not want to overdose on medications. Client would like to get a place of his own, but said he will remain at AFC." On page two, under the section, *Needs/Strengths/Barriers*, subsection, *Barriers pertinent to this goal*, it reads, "[Resident B] is easily manipulated by his family, who do not have his best interest at heart."
    - Direct care staff who signed acknowledgement of receiving training on this document are Ms. Usher-Gary, Ms. Opara, Ms. Mwankenja, and Ms. Sampeta.
- CEI-CMH, *Assessment*, for Resident A, dated 2/13/25. This document identifies that Resident A has a history of unstable housing, required guardianships, suicidal ideation, and involvement with Adult Protective Services.
- CEI-CMH, *Treatment Plan Addendum-Review*, for Resident A, dated 8/21/25. Direct care staff who signed acknowledgement of receiving training on this document are Ms. Usher-Gray, Ms. Opara, Ms. Mwankenja, Mr. Mazara, and Ms. Sampeta.
- *Assessment Plan for AFC Residents*, for Resident A, dated 3/24/25. This document is signed by Guardian A1 and Ms. Mwankenja. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *A. Moves Independently in Community*, the document is marked, "Yes". Under subsection, *Communicates Needs*, the document is marked, "No".
- *Assessment Plan for AFC Resident,* for Resident B, dated 7/22/25. This document is signed by Resident B and Ms. Mwankenja. Guardian B1's signature does not appear on this document. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *A. Moves Independently in Community*, the document is marked, "Yes". Under subsection, *Communicates Needs*, the document is marked, "No". Under the subsection, *Exhibits Self Injurious Behavior*, the document is marked, "No".

  On 12/19/24 a previous special investigation report, 2025A0466006 cited a rule violation for 400.14316 (2). This investigation cited that resident records were not readily available on-site at the time of the on-site investigation for consultant review. The corrective action plan, dated 1/27/25, indicated that there would be

keys available for direct care staff to be able to access resident documents when needed. Adult foster care home rules were updated and promulgated on 11/3/2025 and Rule 400.14316 (2) is equivalent to Rule R 400.691 (3).

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based upon the interviews conducted, documentation reviewed, and observations made during the unannounced on-site investigation it can be determined that Resident A and Resident B were not protected and safe at the facility. Ms. Sampeta reported that both residents left the facility on different dates and did not return. She reported both residents were gone for multiple days and acknowledged she did not contact the guardians, the police, the CEI-CMH case managers for assistance in locating these residents. She reported that Resident B simply stated he wanted to go “watch the World Cup” and she did not ask clarifying questions about where he would be, how long he would be gone, or who he would be with. She reported that she gave him his medications to take with him and did not question whether he could administer his own medications. Mr. Epifanio reported that Resident B had three separate episodes of suicidal ideation in the month of June 2026 and Ms. Sampeta confirmed she was aware of the most recent episode, however she allowed Resident B to leave the facility with his medications, and travel to an unknown location for an undetermined amount of time. Ms. Sampeta reported that both residents had been gone from the home for multiple days and she could not call the police because she did not have Wi-Fi to make a telephone call from her cellular telephone. She reported that she did not have another telephone available to her at the facility. She reported that Ms. Mwankenja did not leave her with contact telephone numbers for Guardian A1 and Guardian B1 and stated she had no one to contact to report the two residents missing from the facility. Ms. Sampeta did not try to contact 911 on her wireless device, despite this being an available resource for her use. She also did not leave the facility to walk to a police station, or a neighboring home, to request the use of a telephone to contact the police. Ms. Sampeta, instead, chose to stay at the facility and hope the two residents would return. She made no efforts to locate either of the missing residents, therefore a violation has been established.

CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.619	**Emergency preparedness plan.**
	(5) A licensee shall have a telephone available and accessible to anyone in the facility for emergency use and emergency telephone numbers posted in a conspicuous location that includes fire, police, and medical emergency services.
ANALYSIS:	Based on the interviews conducted it can be determined that Ms. Sampeta was left to provide direct care services for Resident A and B and required to utilize her own cellular device for communication. Ms. Mwankenja was out of the country and the facility telephone listed was her personal cell phone number. This telephone was not at the facility for direct care staff use. When the power went out and the Wi-Fi system was no longer functioning correctly, Ms. Sampeta reported she was left with no means of communication via telephone. Based on these findings a violation has been established as Ms. Sampeta reported having no way to call for assistance or check on the whereabouts of the two residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.691	**Resident records.**
	(3) Resident records must be kept on file in the facility for 2 years after the date of resident discharge unless a shorter retention is specified elsewhere in these rules.

ANALYSIS:	Based upon the findings of this investigation it can be determined that the resident records for Resident A and Resident B were not available at the facility at the time of the unannounced, on-site investigation. Therefore, a violation has been established.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED (See Special Investigation Report 2025A0466006, dated 12/19/24, and Corrective Action Plan dated 1/27/25.)**

APPLICABLE RULE	
R 400.693	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(e) Elopement from the facility if the resident's location is unknown.** **(2) If an elopement occurs, facility staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the initiation of the search, staff shall contact law enforcement.**
ANALYSIS:	Based upon the interview conducted with Ms. Sampeta and the incident reports written and provided by Ms. Sampeta it is concluded that a violation has occurred. Ms. Sampeta reported that she did not know the whereabouts of either resident. She reported she did not call the guardians or the police for assistance in locating the residents and she did not conduct a local search in any effort to find the residents. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 6/26/26 I conducted a review of the *Michigan Workforce Background Check* account for the facility. I reviewed the active direct care staff applications for this facility. I did not find a *Michigan Workforce Background Check* eligibility letter for Ms. Sampeta. On 6/29/26 I had a telephone conversation with Ms. Mwankenja and inquired about Ms. Sampeta's fingerprinting status and results. Ms. Mwankenja reported that Ms. Sampeta had been previously fingerprinted and stated

she would email me the results. I also inquired about Ms. Sampeta's employee file. Ms. Mwankenja stated she would email me completed trainings for Ms. Sampeta as well as her completed physical and negative tuberculous test results.

On 6/29/26 I received email correspondence from Ms. Mwankenja that contained a copy of the eligibility letter for Ms. Sampeta. This letter noted her eligibility for a different licensed adult foster care facility, run by Ms. Mwankenja. I then reviewed the *Michigan Workforce Background Check* account for this facility and selected, "all applications". I did find Ms. Sampeta's eligibility letter for this facility which was dated 3/28/24. Ms. Sampeta is marked as "Withdrawn" in the system and not as "Hired". She was "withdrawn" in the system on 3/5/26. I conducted a renewal inspection at the facility on 3/5/26 and discussed with Ms. Mwankenja the importance of keeping her *Michigan Workforce Background Check* account current. On 3/5/26 Ms. Mwankenja and I went through his account together and "resigned" any individuals she noted were no longer direct care staff members at the facility. Ms. Mwankenja stated that Ms. Sampeta was no longer working at the facility and she did not have plans for her to resume working at the facility. Ms. Sampeta's name was "resigned" from the *Michigan Workforce Background Check* account for the facility on 3/5/26.

Also received in the email correspondence from Ms. Mwankenja on 6/29/26 was a list of completed trainings for Ms. Sampeta.

APPLICABLE RULE	
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 on the information gathered during this investigation it is determined that Ms. Sampeta was a previously hired direct care staff member at the facility. On 3/5/26 Ms. Mwankenja reported that Ms. Sampeta was no longer a direct care staff member and was resigned from the *Michigan Workforce Background Check* system. Ms. Mwankenja decided to use Ms. Sampeta as a direct care staff member during her absence from the facility while she was out of the country during the month of June 2026. Ms. Mwankenja did not reactivate Ms. Sampeta as a direct care staff member listed as working at the facility in the *Michigan Workforce Background Check* system. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.631	**Health screenings.**
	(2) A licensee shall have on file a statement signed by a licensed physician or physician's designee attesting to the physical health of the licensee, staff, and members of the household. Statements for the licensee and administrator must be signed no more than 6 months before the issuance of a temporary license and at any other time requested by the department. Statements for staff and members of the household must be obtained within 30 days of employment start date, assumption of duties, or occupancy in the facility. **(5) A licensee shall maintain documentation of a baseline screening for communicable diseases and records of illness on hiring. Staff who have direct physical contact with residents or resident food may perform those duties only when they are noninfectious or when proper precautions are taken to prevent the spread of a communicable disease. A licensee shall follow a staff's health care professional or local health department guidance on controlling the spread of a communicable disease when identified.**
ANALYSIS:	I requested to review the signed statement from a licensed physician and the communicable disease questionnaire or current negative TB result, for Ms. Sampeta. As of 6/30/26 I have not received these documents from Ms. Mwankenja. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 5/12/26 I received a telephone call from licensee designee, Esther Mwankenja. She reported that she was planning a trip out of the country and would be gone for about one month. She reported she was leaving soon and needed to know the expectations for coverage for her two adult foster care facilities. She explained that direct care staff, Rachel Opara, would be the acting licensee designee/Administrator in her absence. I explained to Ms. Mwankenja that she would need to demonstrate that Ms. Opara met the criteria of a licensee designee and gather a file on this individual proving they meet the criteria to carry out the licensee designee's responsibilities in Ms. Mwankenja's absence. I noted I would send her an email highlighting the information she would need to provide.

On 5/12/26 I sent email correspondence to Ms. Mwankenja requesting the following information for Ms. Opara:

- Copy of her Michigan Workforce Background Check eligibility letter
- Copy of Drivers License
- Copy of high school diploma or equivalent
- Copy of medical clearance/physical
- Proof of the following trainings:
    - CPR
    - Medication Administration
    - Recipient Rights
    - Nutrition
    - Bloodborne pathogens
    - AFC licensing rules/Foster Care as defined in the ACT
    - Safety and fire prevention
    - Knowledge of the needs of the population served
- A signed letter identifying the dates Ms. Mwankenja would be absent, identifying that she is appointing Ms. Opara to act in the capacity of licensee designee, and contact information.

On 5/14/26 I received, via email, from Ms. Mwankenja proof of the following trainings for Ms. Opara:

- Blood Borne Pathogens & Infection Control
- Corporate Compliance
- Cultural Competency & Diversity
- De-Escalation Skills
- Environmental Safety
- HIPAA Privacy & Security
- Limited English Proficiency
- Person Centered Planning
- Trauma Informed Care
- Recipient Rights
- Medication Administration
- CPR certification

I also received the following:

- Ms. Opara's Michigan Workforce Background Check eligibility letter for the facility dated 3/2/26.
- Ms. Opara's drivers license.
- Employee physical and TB test results for Ms. Opara.

On 5/20/26 I sent email correspondence to Ms. Mwankenja and confirmed receipt of the submitted documentation for Ms. Opara and again requested a written letter identifying the dates she would be out of the country and contact information for Ms. Opara and Ms. Mwankenja in the event of an emergency. I also requested Ms. Opara's high school diploma or equivalent, proof of her knowledge of the needs of

the populations served, and proof of training about the AFC licensing ACT. I did not receive a response to this request.

On 6/26/26 I interviewed Ms. Sampeta regarding Ms. Opara acting in the capacity of the licensee designee during Ms. Mwankenja's absence. Ms. Sampeta reported that two weeks prior, Ms. Opara reported she was no longer working for Ms. Mwankenja. Ms. Sampeta provided three telephone numbers for Ms. Opara. I tried to call each number to contact Ms. Opara. The first number had a voicemail box that was "full" and could not accept messages. The second number went to a voicemail and I left a voicemail message. The third number was not a working telephone number. As of 6/30/26 I have not received a returned call from Ms. Opara.

On 6/26/26 I interviewed Ms. Mwankenja and inquired about Ms. Opara providing coverage for the facility while Ms. Mwankenja was out of the country. Ms. Mwankenja reported that to her knowledge Ms. Opara did provide coverage and was still providing coverage. Ms. Mwankenja could not confirm how frequently Ms. Opara provided oversight or support to the direct care staff in Ms. Mwankenja's absence. Ms. Mwankenja stated she was surprised to hear that Ms. Sampeta reported that Ms. Opara had quit two weeks prior.

APPLICABLE RULE	
R 400.623	**Applicant, licensee and administrator qualifications; licensee, administrator and staff requirements; parole or probation or convicted of felony.**
	(7) A licensee or administrator shall designate, in writing, an individual who is on-site or who is immediately available, and who has the authority to carry out the licensee's or administrator's responsibilities in the temporary absence of the licensee or administrator. The identified designated individual shall be made known to all staff.

ANALYSIS:	Based upon the interviews conducted and review of communications previously held with Ms. Mwankenja it is determined that Ms. Mwankenja had intentions for Ms. Opara to act as the licensee designee for the facility in her absence, however she did not put this request in writing and provide details of the length of the absence and appropriate contact numbers for herself and Ms. Opara in the event of an emergency. Ms. Mwankenja also did not provide proof of all requested training and education verification for Ms. Opara prior to leaving the country. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 6/26/26 I interviewed Ms. Sampeta during the unannounced on-site investigation. Ms. Sampeta reported that on 6/21/26 Resident B came to her and stated he wanted to go "watch the World Cup". Ms. Sampeta reported that she agreed Resident B could go and gave him his medications to take with him. Ms. Sampeta reported that she was not certain whether Resident B could administer his own medications or whether he has a physician's order to self-administer medications.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(3) Giving, taking, or applying of prescription medications must be supervised by a licensee, administrator, or direct care staff unless otherwise directed by an appropriately licensed health care professional in writing.
ANALYSIS:	Ms. Sampeta acknowledged she gave Resident B his medications without confirming whether he had approval from a medical provider for self-administration. Ms. Sampeta reported that she did this after Resident B was released from the hospital due to a potential overdose with unidentified pills. Based upon this information a violation has been established as Ms. Sampeta could not ensure proper administration of these medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Given the number and severity of quality of care and repeat violations cited in the report, I recommend a six-month provisional license be issued.

07/06/2026

Jana Lipps Date
Licensing Consultant

Approved By:

07/06/2026

Dawn N. Timm Date
Area Manager