GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 8, 2026

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

RE: License #: AS330294969
Investigation #: 2026A0007038
Kalkidan AFC

Dear Elsabeth Engeda:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330294969
Investigation #:	2026A0007038
Complaint Receipt Date:	08/14/2026
Investigation Initiation Date:	08/17/2026
Report Due Date:	10/13/2026
Licensee Name:	Elsabeth Engeda
Licensee Address:	2843 Turtle Creek Dr. East Lansing, MI 48823
Licensee Telephone #:	(517) 336-4490
Administrator:	Elsabeth Engeda
Licensee Designee:	N/A
Name of Facility:	Kalkidan AFC
Facility Address:	4464 Hickorywood Dr. Okemos, MI 48864
Facility Telephone #:	(517) 347-6982
Original Issuance Date:	01/28/2009
License Status:	REGULAR
Effective Date:	10/03/2025
Expiration Date:	10/02/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Kimone Roper, DCW, had her boyfriend, Matthew Hodges, staying in the home with her in the basement for a while. The boyfriend (Matthew Hodges) touched Resident A on the arm/shoulder more than once, which triggered some of their past trauma. The resident is terrified of the staff person's boyfriend, and of reporting anything, as they are afraid, they will be kicked out of the home or be retaliated against. Kimone Roper, DCW, was yelling at the adult and degrading her. It is unknown what exactly was being said. Some residents are fearful of reporting any concerns	No
Kimone Roper, DCW, has also left her boyfriend in the home to watch the residents while she was outside of the home on an unknown date. The boyfriend is not employed by the AFC home, but he is frequently in the home fixing things.	Yes
On several occasions, the residents are taken to another home, owned by the licensee, when there isn't adequate staffing at their home. Most recently, the floors were being redone in the home, and the residents were taken to another home (AFC Home #1) and did not get back to their AFC until late, which caused fatigue.	No

III. METHODOLOGY

08/14/2026	Special Investigation Intake - 2026A0007038
08/17/2026	Special Investigation Initiated – Letter - ORR Referral made.
08/20/2026	Contact - Telephone call received from Ashley Bailey, Office of Recipient Rights, CEI-CMH
08/20/2026	APS Referral - Received - Subsequent Allegations.
09/03/2026	Inspection Completed On-site - Unannounced - Face to face contact with Carise Swaby, DCW, Kimone Roper, DCW, Resident B, Resident C, and Matthew Hodges.

09/03/2026	Contact - Telephone call made to Ashley Bailey, no answer.
09/03/2026	Contact - Document Sent - Email to Ashley Bailey. Follow - up regarding on-site visit.
09/03/2026	Contact - Telephone call received from Ashley Bailey. Discussion.
09/04/2026	Contact - Telephone call made to and from Elsabeth Engeda, Licensee. Discussion.
10/07/2026	APS Referral Made.
10/08/2026	Exit Conference conducted with Elsabeth Engeda, Licensee.

ALLEGATIONS:

- **Kimone Roper, DCW, had her boyfriend, Matthew Hodges, staying in the home with her in the basement for a while. The boyfriend (Matthew Hodges) touched Resident A on the arm/shoulder more than once, which triggered some of their past trauma. The resident is terrified of the staff person's boyfriend, and of reporting anything, as they are afraid, they will be kicked out of the home or be retaliated against.**

- **Kimone Roper, DCW, was yelling at the adult and degrading her. It is unknown what exactly was being said.**

- **Some residents are fearful of reporting any concerns.**

INVESTIGATION:

On August 20, 2026, I spoke with Ashley Bailey, Office of Recipient Rights, CEI-CMH, and we discussed the allegations. She informed me that an unannounced on-site inspection was conducted. She interviewed Kimone Roper, direct care worker (DCW), and she did admit that her boyfriend was staying there (2 x per week). She spoke with Resident B, (almost non-verbal), and another male resident. The residents provided very little information, and the male resident he had not seen Matthew Hodges. The other residents were at the day program, so they were not interviewed. She interviewed Kimone Roper and she reported not to witness Matthew Hodges touching Resident A on the arm. It was noted that there was one resident who would ask for help when walking; and would state they needed help, because they were going to fall.

On September 3, 2026, I conducted an unannounced on-site investigation and made face to face contact with Carise Swaby, DCW, Kimone Roper, DCW, Resident B, Resident C, and Matthew Hodges. Upon arrival I met with Carise Swaby and

Kimone Roper. Kimone Roper reported that it was her day off. She also informed me that her boyfriend, Matthew Hodges, visits on her days off and that he sometimes stayed the night with her in the basement. She informed me that he does not live there and that he visits. She also stated that Matthew Hodges was there, visiting that day. He arrived after the residents left for program. She also informed me that a lady from APS came to the facility and asked questions. According to Kimone Roper, a lady from CMH (name not given) said Matthew Hodges could not be there, and the residents could not see him until the investigation was resolved. Once she was made aware of the report, Matthew Hodges stopped visiting. She informed me that Matthew Hodges was there visiting that day. Kimone Roper denied the allegations that she yelled at a resident or degraded them. She appeared to be shocked by the allegations and informed me that she never yelled or mistreated them.

Kimone Roper informed me that there was no facility file for Matthew Hodges. I then requested to interview Matthew Hodges, and I interviewed him in the basement of the facility. He was cooperative with the investigation. He provided his contact information and stated that he was Kimone Roper's boyfriend. He reported to live at another location. He reported to help around the facility fixing things. He stated he was not on payroll or employed. He also denied providing any kind of resident care. He does not provide medications, prepare meals etc., and he has not been trained to do so. I inquired if he assisted a resident, helping them not to fall and stated he did not; however, he stated if they asked for help, he would assist them. He denied observing Kimone Roper yelling or degrading any of the residents. Regarding the allegations of him touching a resident on the arm, he stated that he did not know where these allegations were coming from. He stated that he did not know why Resident A said this, and he has not even shaken hands with any of the residents, that he could recall. He stated that he's cordial, knows what type of establishment the facility is, and gives everyone their space.

I interviewed Resident B. She informed me that things were going "okay" at the facility and that the staff treated her "okay." She did not confirm that staff yelled at any of the residents. When specifically asked, she did not report any concerns about feeling uncomfortable around anyone in the home. She did not know who Matthew Hodges was. She did not have any questions or concerns.

I interviewed Carise Swaby, DCW. She reported to be fully trained as a direct care worker. She reported that she has not observed Kimone Roper yelling at the residents or observed anything concerning. She stated that she did her due diligence. She stated that she did not see Matthew Hodges during the shifts she worked, and if he was there, he was usually in the basement.

I interviewed Resident C. He reported to reside in the home for about 16 years. When asked how he was doing, he replied, "Better than usual." He informed me that he knew Matt (Matthew Hodges) and referred to him as a "Good buddy." He stated that Matthew Hodges would sleep downstairs at night, for about a year. He has not observed anything concerning. Resident C has not observed staff yelling at any of

the other residents or him. Resident C informed me that Matthew Hodges treated the other residents “fine” as far as he knew.

On September 3, 2026, I spoke with Ashley Bailey, ORR. She has been to the facility, unannounced, on two occasions. Residents reported that Matthew Hodges had not been to the facility in over a week. We discussed Resident A, who told her that she felt safe in the home, and said she did not want to make this an issue. Resident A stated that Matthew Hodges did touch her arm/shoulder, but not in a sexual manner. When Resident A was being interviewed, between answers, she would say that she did not want to do this and that she felt safe. Resident F was also interviewed and Ashley Bailey asked about Matthew Hodges; and he was described as really nice. Resident F had not seen Matthew Hodges in over a week. Resident F has not seen him touch anyone inappropriately, but Resident F reported that Resident A had. Resident F stated to Ashley Bailey that Resident A was “crazy” and did not believe he did anything. According to Ashley Bailey, Elsabeth Engeda said she told Kimone Roper that he was not allowed to be there; and if he makes anyone uncomfortable, he shouldn’t be there. Ashley Bailey informed me that she did not think this was an incident of sexual abuse.

On September 4, 2026, I spoke with Elsabeth Engeda, Licensee. She stated that Matthew Hodges did not have a role, as he was Kimone Ropers boyfriend. He stopped over on her day off to visit. She worked with a contractor and Matthew Hodges worked for him, and that’s how Kimone Roper and Matthew Hodges met. Matthew Hodges would change a light bulb and one time he fixed the garage door. According to Elsabeth Engeda, he is not an employee, and he is not left to supervise the residents. Elsabeth Engeda stated that he could not supervise them. She stated that he was there maybe once or twice a week, as he lives far away. In addition, Kimone Roper is working. She stated that he’s not there during the daytime hours. She provided me with Resident A’s weekly schedule. She stated that Resident A can get anxious about things. I inquired if she observed Matthew Hodges interacting with the residents. Elsabeth Engeda informed me that he would sit and talk with Resident C, when he was feeling depressed. She did not confirm that the residents appeared to be afraid when he was around. Elsabeth Engeda explained that she works in the facility, at least once a week, and she talks to the residents. She stated they deserve to have a nice place to live and be provided good care. She also informed me that there was one resident who was blind, who has been there for about 6-years, and has made statements that they were going to fall. Elsabeth Engeda stated that Matthew Hodges could not be at the facility until the investigation was completed. She also informed that there is a protocol in place for residents to make complaints, as there are papers posted on the bulletin board. She stated that residents have the right to complain, they can also talk to their case manager. If anything is brought to her attention, she will take action against staff, if necessary. She stated this is their home, they pay to be there, and it’s an issue if they’re not comfortable or happy. Elsabeth Engeda explained that she always asks them about how they’re doing. During the conversation, she asked if residents were not happy, why would they have they been there for 16, 13, or 7 years. Elsabeth Engeda stated that if Matthew

Hodges touched her, Resident A could tell her. Elsabeth Engeda also recalled a situation in which Resident A had a boyfriend and she kept calling the boyfriend at work. She was encouraged to give him space. The boyfriend ended up telling her that it was not going to work. Resident A got sick and tried to harm herself as a result.

On October 7, 2026, I interviewed Resident A. She reported to get along with the other residents “really good.” Regarding how she got along with staff, she stated, “much better.” When asked for clarification, Resident A stated that she told Kimone Roper that when she raised her voice “She scared me.” Resident A stated that since then, she hasn’t been doing that. I asked about the incident in which Kimone Roper was yelling or raising her voice, but she did not describe the scenario. Resident A then stated she did not want to talk on the phone and wanted to call me from her cellular phone. She called me back and we discussed how she got along with Kimone’s boyfriend, Matthew Hodges. Resident A stated, “He’s not here anymore.” When asked why, she said she did not have any idea. Regarding her being touched on the arm/shoulder area, Resident A replied, “he touched me, not in a sexual way.” Resident A stated he touched her arm a couple of times, it seemed unnecessary to her, and she did not like it. Resident A stated it made her uncomfortable. She stated this occurred in the office, he was talking to her, and he came up to her. Resident A reported to be happy that he was no longer in the home. During the interview, Resident A asked if Elsabeth Engeda was going to kick her out of the home. She stated she was afraid to report her concerns to Elsabeth Engeda, and that was something she was working on. I explained the licensing rules related to discharged notices and steps to take if she received one. Resident A followed up by stated that she did not think that everyone in the home was afraid to report. When asked, Resident A did not provide any examples or describe situations that she thought would cause her to be afraid to report. She then stated that she did not want to talk anymore, as she wanted to relax.

On October 8, 2026, I conducted the exit conference with Elsabeth Engeda, Licensee. We discussed the investigation and my recommendations. She concurred with the conclusion of the investigation.

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 my investigation, which consisted of an unannounced on-site investigation, interviews with the residents, staff, licensee, and ORR, it's concluded that while Resident A informed that Matthew Hodges touched her on the arm a couple of times, making her uncomfortable; she also stated it was "not in a sexual way." In addition, Matthew Hodges denied these allegations and the other individuals interviewed did not report to observe this incident occurring. Thus, it is essentially Resident A's word against Matthew Hodges' word. In the future, should additional information be received, a new investigation should be conducted. Based upon this information, there is not a 51% preponderance of the evidence, at this time, to support the allegations that Resident A was not treated with dignity and respect, protected and safe. While it was noted that Matthew Hodges would visit Kimone Roper on her days off and stay the night, there is not a preponderance of the evidence, at this time, to support the allegations that he was residing in the facility. It is also concluded that there is not a 51% preponderance of the evidence to support the allegations that staff yell at the residents and they're afraid to report.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS: Kimone Roper, DCW, has also left her boyfriend in the home to watch the residents while she was outside of the home on an unknown date. The boyfriend is not employed by the AFC home, but he is frequently in the home fixing things.

INVESTIGATION:
On September 3, 2026, I interviewed Matthew Hodges in the basement of the facility. He reported to help around the facility fixing things. He stated he was not on payroll or employed. He also denied providing any kind of resident care. He does not provide medications, prepare meals etc., and he has not been trained to do so.

On September 3, 2026, Kimone Roper informed me that if she must step away, she does not leave the residents with Matthew Hodges. She informed me that she'll either call over another employee or depending on how many residents, she may take them over to AFC Home #1.

During the interview with Matthew Hodges, he denied supervising the residents or being left at the facility; and he stated he would not feel comfortable doing so. He stated he has never been alone with any residents and staff are always present.

During the interview with Resident C, he stated that Matthew Hodges "Worked his butt off," around the house, fixing things. I inquired if Matthew Hodges kept an eye

out for the residents and he replied, “Sure, he was our baby-sitter.” Resident C asked if Matthew Hodges was coming back, because he missed him.

According to Elsabeth Engeda, Matthew Hodges is not an employee, and he is not left to supervise the residents. Elsabeth Engeda stated that he could not supervise them. She stated that he was there maybe once or twice a week, as he lives far away. In addition, Kimone Roper is working. She stated that he’s not there during the daytime hours.

During the interview with Resident A, she confirmed that staff had left Matthew Hodges at the facility. She stated, “He stayed here because a staff had something to do.”

On October 8, 2026, during the exit conference with Elsabeth Engeda, Licensee, we discussed the findings. She stated that as far as she knows, she did not think he was left there; however, she is not there all the time. She also stated that during the summer, they would BBQ, gathering residents from the homes and he would cook for them outside. Kimone Roper would cook things in the facility, such as macaroni and cheese. They also played games. She agreed to submit a written corrective action plan to address the established violation.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(3) An individual, including a volunteer, cook, or private duty staff shall not be considered in determining the ratio of direct care staff-to-residents unless the individual meets the qualifications of a direct care staff member and is providing direct care to residents on behalf of the licensee.
ANALYSIS:	Based upon my investigation, which consisted of an unannounced on-site investigation, interviews with the residents, staff, licensee, and ORR, it’s concluded that there is a preponderance of the evidence to support the allegations that at some point, even for a short period of time, Matthew Hodges was left at the facility, and he is not trained as a direct care worker.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS: On several occasions, the residents are taken to another home, owned by the licensee, when there isn't adequate staffing at their home. Most recently, the floors were being redone in the home, and the residents were taken to another home (AFC Home #1) and did not get back to their AFC until late, which caused fatigue.

INVESTIGATION:

On August 20, 2026, I spoke with Ashley Bailey, Office of Recipient Rights, CEI-CMH, and we discussed the allegations. She informed me that the facility has been under construction as the bathroom and floors were being redone. There was a delay as the flooring was ordered but did not arrive on time. During her investigation, it was noted that the residents had gone over to the facility (AFC Home #1), which is also operated by the licensee. The residents went over to the facility three or four days, prior to last week. They would go over for dinner and then return home. The construction was loud. Ashley Bailey informed me that licensee Elsabeth Engeda gave the residents a choice to stay or leave. Ashely Bailey informed me that it was the right decision. The live in staff also went to the home with the residents. She also informed me that some of the residents went to day programs on a regular basis.

On September 3, 2026, Kimone Roper confirmed that there had been construction in the home and the hardwood flooring had been redone. She confirmed that the residents were taken over to AFC Home #1, only during the daytime, and they did not spend the night. Several of the residents also attend day programs during the week. She recalled taking two residents over to the home when the other residents were at program. They ate dinner and returned to the home.

Matthew Hodges informed me that he did not know anything about the residents going to another AFC home.

Carise Swaby, DCW, informed me that most of the residents (4) attend a day program, and when the construction was taking place, Resident B and Resident C went to the other AFC home. She informed me that there were four residents at the other home and staff would go with the two residents from this home to look after them.

During the interview with Resident C, he confirmed there was construction in the home and when the floors were being redone, they went to Elsabeth Engeda's sister's AFC home. According to Resident C, the sister opened the AFC home about half a year ago. He stated they were there all day and would return around 3:00 p.m. or 8:00 p.m. They also had dinner at the other AFC home.

On September 4, 2026, Elsabeth Engeda stated that the residents deserve a nice home. During the construction, when the flooring was getting done, some of the residents were getting annoyed and could not handle the noise (Resident A, Resident C, and Resident F). Therefore, she had staff to supervise them at the other home. Kimone Roper would go to the other home with the residents. They also went to the farmers market, listened to music etc. Other days, after breakfast, they would go over to AFC Home #1, but not always. She also informed me that on Tuesday, Thursday, and Friday, some of the residents were at program. The residents had dinner at the other place and then returned to the facility.

Resident A informed me that they had to go to another home (AFC Home #1) when the floors were being done, and the staff went with them. They did not spend the night at the other facility.

During the exit conference with Elsabeth Engeda, Licensee, we discussed the investigation and my recommendations. She concurred with the conclusion of the investigation.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(b) 12 residents for small group and family homes.**
ANALYSIS:	Based upon my investigation, which consisted of an unannounced on-site investigation, interviews with the residents, staff, licensee, and ORR, it's concluded that while there was construction being completed at the facility, the residents were taken in the community or to another location, as the construction was loud and bothersome. The assigned staff went with the residents to the other locations. Based upon this information, there is not a preponderance of the evidence to support the allegations that the licensee did not have sufficient direct care staff on duty to provide the care for the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.

Mahtina Rubritius

10/08/2026

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Mahtina Rubritius Date
Licensing Consultant

Approved By:



10/08/2026

Dawn N. Timm Date
Area Manager