RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

October 30, 2017

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

RE: License #: AS330367324
Investigation #: **2017A0582016**
Kalkidan AFC 3

Dear Ms. Engeda:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 284-9727.

Sincerely,

Stephanie Gonzalez, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 243-6063

enclosure

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

I. IDENTIFYING INFORMATION

License#:	AS330367324
Investigation #:	2017A0582016
Complaint Receipt Date:	08/25/2017
Investigation Initiation Date:	08/28/2017
Report Due Date:	10/24/2017
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 3
Facility Address:	2121 Hopkins Avenue Lansing, MI 48912
Facility Telephone #:	(517) 402-6191
Original Issuance Date:	01/16/2015
License Status:	REGULAR
Effective Date:	03/11/2016
Expiration Date:	03/10/2018
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was strapped down in a wheelchair and had fingerprint marks on both arms and wrists. There is a concern that other residents may also be being restrained.	No
Additional Findings	Yes

III. METHODOLOGY

08/25/2017	Special Investigation Intake 2017A0582016
08/28/2017	Special Investigation Initiated - Telephone Spoke to Complainant
08/28/2017	APS Referral Online complaint submitted
08/30/2017	APS Referral Complaint submitted via electronic email
09/28/2017	Contact - Telephone call received Spoke to Complainant
10/02/2017	Contact - Telephone call made Spoke to Complainant
10/26/2017	Inspection Completed On-site
10/26/2017	Exit Conference Spoke to licensee in-person at facility
10/26/2017	Contact - Telephone call made Follow Up call with licensee
10/26/2017	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A was strapped down in a wheelchair and had fingerprint marks on both arms and wrists. There is a concern that other residents may also be being restrained.

INVESTIGATION:

On 8/25/2017, a complaint was received, alleging that on 7/26/2017, Relative A1 observed Resident A strapped in a wheelchair. Resident A was moved from the home on 8/25/2017 by Relative A1.

On 8/28/2017, AFC Consultant Derrick Britton spoke to Complainant via telephone. Complainant reported that Resident A only lived at the facility from 07/21/2017 to 07/26/2017. Complainant stated that she did not directly witness the information contained in the complaint. Complainant reported that she was told by Relative A1, that on 7/26/2017 he witnessed Resident A strapped in a wheelchair when he went to visit her at the facility. Complainant stated that Resident A was removed from the facility and taken to the hospital on 7/26/2017. Complainant stated that she has pictures of bruising on the wrists of Resident A, which she believed were caused by the staff and the restraints. Complainant provided Mr. Britton with pictures of Resident A's bruises.

On 9/5/2017, I reviewed the photos of Resident A that were provided by Complainant. I observed bruises on both of Resident A's wrists, however I was unable to determine what the cause of the bruising was based on a review of the pictures. In the pictures, Resident A is sitting in a chair and there are no visible restraints on her arms or legs.

On 9/28/2017 and 10/2/2017, I spoke to Complainant via telephone. Complainant reported that she did not directly observe Resident A restrained to a wheelchair. Complainant reported that Relative A1 is the person that witnessed Resident A restrained in a wheelchair on 7/26/2017. However, Complainant reported that Relative A1 is not available to be interviewed. Complainant reported that Resident A is currently on hospice and that Relative A1 is "frail and grieving." Complainant reported that Resident A has a diagnosis of dementia, is currently receiving hospice care, and is unable to be interviewed regarding this complaint. Complainant stated that she is not aware of other residents at the facility being restrained but included this in the original complaint out of concern for the other residents residing at the facility.

On 10/26/2017, I conducted an onsite investigation at Kalkidan AFC 3. I interviewed staff member Bayoush Mekonen. Ms. Mekonen stated that she is the live-in staff for the facility. Ms. Mekonen reported that Resident A resided at the facility for "about three days." Ms. Mekonen reported that Resident A was able to walk with minimal assistance and was not wheelchair bound. Ms. Mekonen reported that Resident A

did require use of a wheelchair if she needed to walk long distances. Ms. Mekonen stated that Resident A lived at the facility for only three days, and did not use a wheelchair during the time that she resided at the facility. Ms. Mekonen denied that Resident A was ever restrained to a wheelchair. Ms. Mekonen stated that she has never used straps or restraints to confine Resident A, nor any other resident, to a wheelchair.

I requested to review Resident A's file, however, was informed by Ms. Mekonen that "we don't have anything for her." Ms. Mekonen was unable to find any documentation in the facility for Resident A. I reviewed the *Resident Registrar*, which did not have Resident A's name on it.

On 10/26/2017, I interviewed licensee, Elsabeth Engeda. Ms. Engeda initially denied that Resident A ever resided at the facility, but later recanted this statement after she was reminded by Ms. Bayoush of a brief description of Resident A. Ms. Engeda acknowledged that Resident A did reside at the facility but "only for three days as a tryout." Ms. Engeda elaborated by stating that she sometimes allows individuals to visit the home and stay the night, to see if the facility and potential occupant are compatible. Ms. Engeda stated that no paperwork was completed for Resident A and that "we didn't do anything, then she left." Ms. Engeda stated that Resident A had bruises on her body at the time of admission to the facility. Ms. Engeda stated that Resident A was "demented" and bruised easily. Ms. Engeda stated that Resident A consistently would bang her hands against the wall and say "take me back to my people." Ms. Engeda stated that during the time that Resident A resided at the facility, she was ambulatory and could walk short distances with assistance from staff. Ms. Engeda stated that Resident A did not have a wheelchair during the time that she resided at the facility. Ms. Engeda denied that Resident A, or any other resident, has ever been restrained or strapped to a wheelchair.

I interviewed Resident B, who reported that he remembered interacting with Resident A during the time that she resided at the facility. Resident B reported remembering seeing bruises on Resident A but did not know what caused them. Resident B reported that he never saw Resident A or any other resident strapped or restrained to a wheelchair. Resident B reported that Ms. Mekonen is "really nice" and that he enjoys living at this facility.

I interviewed Resident C, who reported that he does not remember Resident A and was unable to provide any information regarding the time that she resided at the facility. Resident C stated that he has never been restrained while residing at this facility and has never observed any other residents be restrained.

I interviewed Resident D, who reported that she does not remember Resident A and was unable to provide any information regarding the time that she resided at the facility. Resident D stated that she has never been restrained while residing at this facility and has never observed any other residents be restrained.

I interviewed Resident E, who reported that he vaguely remembered Resident A. Resident E reported that Resident A was able to walk and did not use a wheelchair. Resident E stated that he did not remember seeing bruises on Resident A and did not remember seeing her strapped to or restrained to a wheelchair. Resident E stated that he has never been restrained and has never witnessed other residents be restrained.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**
ANALYSIS:	Based on interviews with Complainant, Ms. Mekonen, Ms. Engeda, and Resident's B, C, D, and E, there is not sufficient information to establish that staff at Kalkidan AFC 3 restrained Resident A to a wheelchair and caused bruising or caused bruising to Resident A in any other way. A review of the pictures of Resident A confirm that Resident A had bruises on her wrists, however there is no way to determine how these bruises were sustained or by whom.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/26/2017, I conducted an onsite investigation at Kalkidan AFC 3. I requested to review Resident A's file, however, was informed by Ms. Mekonen that "we don't have anything for her." Ms. Mekonen was unable to find any documentation in the facility for Resident A.

On 10/26/2017, I interviewed licensee, Elsabeth Engeda. Ms. Engeda acknowledged that Resident A did reside at the facility but "only for three days as a tryout." Ms. Engeda elaborated by stating that she sometimes allows individuals to visit the home and stay the night, to see if the facility and potential occupant are compatible. Ms. Engeda stated that she did not complete any resident record forms for Resident A at the time of admission to the facility.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(6) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.** **(c) Date of discharge and the place to which the resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.** **(h) Incident reports and accident records.** **(i) Resident funds and valuables record and resident fund agreement.** **(j) Resident grievances and complaints.**

ANALYSIS:	On 10/26/2017, I conducted an onsite investigation at Kalkidan AFC 3. I was informed by both Ms. Mekonen and Ms. Engeda that no paperwork was completed for Resident A. Both Ms. Mekonen and Ms. Engeda acknowledged that Resident A did reside at the facility for approximately three days, but stated this was considered a "tryout" and therefore resident record documents were not completed for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/26/2017, I conducted an Exit Conference with licensee, Elsabeth Engeda. Ms. Engeda is in agreement with the findings of this report but reported that she did not know she was required to have admission paperwork completed prior to allowing a resident to move into the home. Ms. Engeda stated that she thought she was able to offer "tryouts" in which a potential resident can stay overnight for an undetermined amount of time to determine compatibility, without having to complete AFC paperwork.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

10/30/2017

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Stephanie Gonzalez Date
Licensing Consultant

Approved By:

10/30/2017

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Dawn N. Timm Date
Area Manager