RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

April 20, 2018

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

RE: License #: AS330367324
Investigation #: **2018A0582013**
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.
- 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) 284-9727.

Sincerely,

Derrick Britton, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-9721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330367324
Investigation #:	2018A0582013
Complaint Receipt Date:	02/22/2018
Investigation Initiation Date:	02/26/2018
Report Due Date:	04/23/2018
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 is being hit and pushed by direct care staff member and does not feel safe in the facility.	No
Additional Findings	Yes

III. METHODOLOGY

02/22/2018	Special Investigation Intake 2018A0582013
02/26/2018	Special Investigation Initiated - On Site
02/27/2018	Contact - Telephone call made To Elsabeth Engeda, Licensee
02/27/2018	Contact - Telephone call made To Martha Callow-Rucker, CMH therapist
04/12/2018	Contact - Face to Face At the facility
04/13/2018	Contact - Telephone call made To Martha Callow-Rucker, CMH therapist
04/13/2018	Contact - Document Received 30-Day Notice
04/13/2018	Inspection Completed-BCAL Sub. Compliance
04/13/2018	Exit Conference With Elsabeth Engeda, Licensee
04/13/2018	Corrective Action Plan Requested and Due on 04/30/2018

ALLEGATION:

Resident A is being hit and pushed by direct care staff member and does not feel safe in the facility.

INVESTIGATION:

I received this complaint on 02/22/2018. I conducted an on-site investigation at the facility on 02/26/2018 and interviewed Resident A. Resident A stated that he has lived at the facility for about five years. Resident A stated that the staff members of the facility "take care of me," and "give me my pills." Resident A stated that he has been pushed and hit by the staff member who was working on this day. Although he did not know the name of the staff member, direct care staff Bayoush Mekonen, was on shift at the time. Resident A stated that Ms. Mekonen has pushed him a number of times in the past, but that "she's okay now." Resident A stated that he had not been injured from being hit or pushed by Ms. Mekonen. Resident A stated that he has not observed Ms. Mekonen hit or push another resident, and that this has only happened to him. Resident A stated that "I feel safe here now, but I want to live alone." Resident A stated that he would feel a lot better if he lived alone, but he currently feels good about his living situation at the AFC facility.

I also interviewed Resident B who stated that he witnessed Resident A being pushed by Ms. Mekonen a couple of days ago. Resident B stated that Resident A was having a bad day, and that Resident A kept messing with the television in the living room. Resident B stated that Ms. Mekonen pushed Resident A away from the television. Resident B described this alleged pushing as Ms. Mekonen moving Resident A away from the television rather than Resident A being pushed to the ground. Resident B stated that Resident A was fine afterwards; laughing and giggling. Resident B stated that he feels safe at the facility. Resident B stated that Ms. Mekonen gets upset with him once and a while, and they have differences. Resident B stated that Ms. Mekonen has never hit or push him or anyone else in the home, with the exception of Resident A.

I interviewed Resident C who stated he enjoys living at the facility. Resident C stated that staff treats him well. Resident C stated that he has never been pushed or hit by staff members. Resident C stated that he has never observed other residents being abused. When asked specifically about Resident A, Resident C stated that he may have heard noises that could have been Resident A being pushed or hit, but he has never observed Resident A being pushed or hit by Ms. Mekonen.

I interviewed Resident D who stated that she has never seen Resident A being hit or pushed by Ms. Mekonen. Resident D stated that she feels safe at the facility, and has not seen any other resident being abused by Ms. Mekonen or any other staff member.

I interviewed direct care staff member Bayoush Mekonen. Ms. Mekonen stated that she has worked at the facility for about one year. Ms. Mekonen denied ever hitting or pushing Resident A. Ms. Mekonen stated she is not aware of any other staff member abusing Resident A or any other resident. Ms. Mekonen stated that Resident A has had some behavioral problems, such as constantly turning the television on/off while others are watching, and repeatedly flushing the toilet. Ms. Mekonen stated that she has to redirect Resident A many times, but has never hit or pushed him.

I interviewed direct care staff member Kalkidan Tesfagiorgis. Ms. Tesfagiorgis stated that she has never pushed or hit Resident A, and has never observed Ms. Mekonen push or hit Resident A. Ms. Tesfagiorgis stated that Resident A requires a lot of redirecting for his behaviors, which upsets him. Ms. Tesfagiorgis stated that Resident A turns the volume up on the remote control repeatedly, which causes anxiety for another resident.

On 02/27/2018 I spoke with Elsabeth Engeda, Licensee. Ms. Engeda denied that Ms. Mekonen hit or pushed Resident A. Ms. Engeda stated that Resident A has some behavioral challenges that require a lot of redirecting, such as "digging in his butt" in front of everyone in the home and turning up the volume on the television.

On 02/27/2018 I spoke with Martha Callow-Rucker, mental health therapist. Ms. Callow-Rucker stated that she had never witnessed Resident A being hit or pushed, but was told about Resident A being hit, pushed, and feeling unsafe at the facility. Ms. Callow-Rucker stated that other residents had filed complaints of abuse in the past.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on interviews with Resident A, Resident B, Resident C, Resident D, direct care staff members Ms. Mekonen and Ms. Tesfagiorgis, there is not enough evidence to support the allegation that Resident A was being hit and pushed by Ms. Mekonen in a violent manner. Rather Ms. Mekonen was moving Resident A away from the TV (not pushing him), so that it was not disturbing other residents. Resident A stated that he felt safe at the facility during the interview on 02/26/2018.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

On 02/27/2018 I spoke with Ms. Callow-Rucker. Ms. Callow-Rucker stated that Ms. Engeda called her to inform her that she was giving Resident A a 30-day notice for discharge. On 04/12/2018 I conducted an unannounced investigation at the facility. I reviewed the *Resident Register*, which documented that Resident A was discharged from the facility on 03/30/2018.

On 04/13/2018 I spoke with Ms. Callow-Rucker, mental health therapist. Ms. Callow-Rucker stated that Resident A was discharged from the facility. Ms. Callow-Rucker stated that Ms. Engeda sent her a written notice for a 30-day discharge, but did not include any written reasons for the discharge. Ms. Callow-Rucker stated that she was verbally told that the reasons for discharging Resident A were for him "digging in his butt", watching television too loudly, and for staying in the bathroom too long.

On 04/13/2018 I received documentation from Ms. Callow-Rucker regarding the 30-day notice for Resident A. The document was from Elsabeth Engeda, Licensee and dated 02/28/2018. It was documented that "This is a 30-days' notice for (Resident A). (Resident A) last day from Kalkidan AFC 3 will be on 03/31/2018."

On 04/13/2018 I conducted an Exit Conference with Elsabeth Engeda, Licensee.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.

ANALYSIS:	Based on interviews with Licensee Ms. Engeda and therapist Ms. Callow-Rucker and a review of the *Resident Register* and Resident A's written 30-Day Discharge Notice from Ms. Engeda, Resident A was discharged from the facility without the written notice stating the reasons for his discharge as required. Ms. Engeda stated that she verbally informed Ms. Callow-Rucker of the reasons for the discharge, but the letter did not outline those reasons.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

04/13/2018

Derrick Britton — Date
Licensing Consultant

Approved By:

04/20/2018

Dawn N. Timm — Date
Area Manager