GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 31, 2022

Showanesh Mebratu
Helen AFC Homes Inc
PO Box 430481
Pontiac, MI 48343

RE: License #: AS630404757
Investigation #: 2022A0993022
Helen AFC Home I Inc

Dear Ms. Mebratu:

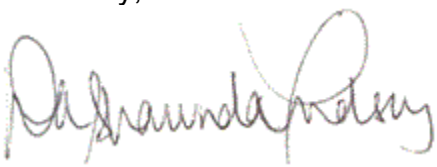
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
3026 W Grand Blvd.
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630404757
Investigation #:	2022A0993022
Complaint Receipt Date:	09/15/2022
Investigation Initiation Date:	09/15/2022
Report Due Date:	11/14/2022
Licensee Name:	Helen AFC Homes Inc
Licensee Address:	1616 Marshbank Drive Pontiac, MI 48340
Licensee Telephone #:	(248) 818-0451
Administrator:	Showanesh Mebratu
Licensee Designee:	Showanesh Mebratu
Name of Facility:	Helen AFC Home I Inc
Facility Address:	384 N Perry St Pontiac, MI 48342
Facility Telephone #:	(248) 818-0451
Original Issuance Date:	10/22/2020
License Status:	REGULAR
Effective Date:	04/22/2021
Expiration Date:	04/21/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 09/03/2022, Resident A left the facility in the night and was hit by a garbage truck. He was hospitalized due to injuries he sustained.	No
Additional Findings	Yes

III. METHODOLOGY

09/15/2022	Special Investigation Intake 2022A0993022
09/15/2022	Referral - Recipient Rights Received allegations from recipient rights advocate Aaron Winston
09/15/2022	APS Referral Received allegations from adult protective services (APS).
09/15/2022	Special Investigation Initiated – Telephone Telephone call made to APS specialist Heather Goodin
09/15/2022	Contact - Telephone call made Telephone call made to recipient rights advocate Aaron Winston. Left a message.
09/19/2022	Inspection Completed On-site Conducted an unannounced onsite investigation
09/19/2022	Contact - Face to Face Face to face contact with Resident A at Beaumont Royal Oak
09/19/2022	Contact - Telephone call made Telephone call made to Resident A's brother
09/19/2022	Contact - Telephone call made Telephone call made to Resident A's guardian. Left a message.
09/19/2022	Contact - Telephone call received Telephone call received from Resident A's guardian's legal assistant

10/17/2022	Contact - Telephone call made Telephone call made to APS specialist Heather Goodin
10/31/2022	Contact - Telephone call made Telephone call made to APS specialist Heather Goodin
10/31/2022	Comment Reviewed the original licensing study report (OLSR) and Bureau Information Tracking System (BITS)
10/31/2022	Contact - Telephone call made Telephone call made to licensee designee Meron Yosef
10/31/2022	Exit Conference Held with licensee designee Showanesh Mebratu

ALLEGATION:

On 09/03/2022, Resident A left the facility in the night and was hit by a garbage truck. He was hospitalized due to injuries he sustained.

INVESTIGATION:

On 09/15/2022, I received the allegations from Macomb Oakland Regional Center (MORC) office of recipient rights. I also received the allegations from adult protective services (APS).

On 09/15/2022, I conducted a telephone interview with APS specialist Heather Goodin. Ms. Goodin verified she is investigating the allegations. She stated Resident A was at Beaumont Hospital Royal Oak due to a leg injury sustained from being hit by a garbage truck. Resident A does not recall anything that occurred. Ms. Goodin stated she interviewed licensee designee Meron Yosef. Ms. Yosef was asleep when Resident A left the facility and learned he was missing when she woke up the next morning.

On 09/19/2022, I conducted an unannounced onsite investigation. I interviewed licensee designee Meron Yosef. Ms. Yosef stated Resident A was still at Beaumont Hospital Royal Oak. She checked on Resident A on 09/06/2022 at 11:45pm. He woke up and asked her to turn his light off and close his bedroom door. He informed her he was about to go to sleep. Ms. Yosef stated when she went into Resident A's bedroom the next morning at 7:00am he was not there. She called 911. She contacted Resident A's father, and his father informed her the hospital had contacted him. Ms. Yosef stated she did not know when Resident A would be discharged from the hospital.

While at the facility, I reviewed Resident A's assessment plan. Per the plan, dated and signed by Resident A's guardian and licensee designee Showanesh Mebratu, Resident A can move independently in the community. I also review the incident report (IR). Per

the IR, Resident A walked out the facility on around 11:45pm on 09/06/2022. Licensee designee Meron Yosef checked on him that night at 11:30pm. She went to check on him for breakfast and he was not in his bedroom. She learned he got into a car accident.

On 09/19/2022, I attempted to interview Resident A at Beaumont Hospital Royal Oak. Resident A stated he did not want to talk about the accident.

On 09/19/2022, I conducted a telephone interview with Resident A's father. He stated he did not know why Resident A left out of the facility. He confirmed Resident A can move independently in the community. He stated he did not have any concerns about the care Resident A receives in the facility. He asked that I contact Resident A's guardian for more information.

On 09/19/2022, I conducted a telephone interview with Resident A's guardian's legal assistant. She confirmed Resident A can move independently in the community. Resident A moved into the facility on 08/19/2022. He left out of the facility at night and was hit by a garbage truck on or around 09/04/2022. She stated Resident A has displayed behavioral changes since his parents moved out of the state. She did not have any concerns about the care Resident A receives in the facility.

On 10/17/2022, I conducted a telephone interview with APS specialist Heather Goodin. She stated Resident A was discharged from the hospital and sent to a rehab. Resident A died while at rehab on 10/09/2022. She did not know the cause of death.

On 10/31/2022, I conducted a follow-up call with Ms. Goodin. She stated she closed her investigation. She did not substantiate as Resident A had community access. In addition, per the Wayne County Medical Examiner's Report, Resident A died of natural causes.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A left out of the facility on 09/06/2022 and was later hit. He was hospitalized as a result. Per Resident A's assessment plan, Resident A can move independently in the community.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	Resident A left out of the facility on 09/06/2022 and was later hit. He was hospitalized as a result. Per Resident A's assessment plan, Resident A can move independently in the community.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 09/15/2022, I conducted a telephone interview with APS specialist Heather Goodin. Ms. Goodin stated she interviewed licensee designee Meron Yosef. Ms. Yosef was asleep when Resident A left the facility and learned he was missing when she woke up the next morning.

On 09/19/2022, I conducted an unannounced onsite investigation. I interviewed licensee designee Meron Yosef. She stated she was asleep when Resident A left the facility on 09/06/2022. She confirmed she lives in the facility. She sleeps at night but wakes up to check on the residents.

On 10/31/2022, I reviewed the original licensing study report (OLSR) as well as Bureau Information Tracking System (BITS). Per the OLSR, staff are to be awake during sleeping hours. Per BITS, there are no live-in staff.

On 10/31/2022, I conducted a follow-up call with Ms. Yosef. She stated she has lived in the facility for about one year.

On 10/31/2022, I conducted an exit conference with licensee designee Showanesh Mebratu. I informed her of the findings. She acknowledged staff are supposed to be awake at night. In addition, she stated Ms. Yosef operated another adult foster care (AFC) facility out of her residence. She closed it during COVID and moved into this facility. Ms. Mebratu agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(5) An applicant of licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license , including any changes in the household and in personnel-related information, within 5 business days after the change occurs.
ANALYSIS:	On 09/06/2022, Ms. Yosef was asleep at night when Resident A left out of the facility. Per the OLSR, staff are supposed to be awake during sleeping hours. Ms. Yosef moved into the facility about one year ago, but the department was not notified.
CONCLUSION:	**VIOLATION ESTABLISHED**

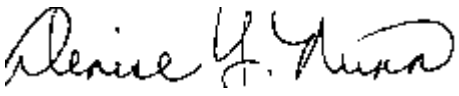
IV. RECOMMENDATION

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

10/31/2022

DaShawnda Lindsey Date
Licensing Consultant

Approved By:



10/31/2022

Denise Y. Nunn Date
Area Manager