

GRETCHEN WHITMER GOVERNOR STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

November 30, 2022

Tenagne Mengistu 604 Jefferson Avenue SE Grand Rapids, MI 49503

RE: License #:	AF410315360
Investigation #:	2023A0467013
-	Emmanuel

Dear Mrs. Mengistu:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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 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 (616) 356-0183.

Sincerely,

anthony Mullim

Anthony Mullins, Licensing Consultant Bureau of Community and Health Systems Unit 13, 7th Floor 350 Ottawa, N.W. Grand Rapids, MI 49503

enclosure

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

### I. IDENTIFYING INFORMATION

	AE41021E260
License #:	AF410315360
Investigation #	202240467012
Investigation #:	2023A0467013
Compleint Dessint Deter	44/04/0000
Complaint Receipt Date:	11/21/2022
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Investigation Initiation Date:	11/21/2022
Demant Due Date:	04/00/0000
Report Due Date:	01/20/2023
Liconaco Nomo:	Tanagna Mangiatu
Licensee Name:	Tenagne Mengistu
Licensee Address:	604 Jefferson Avenue SE
	Grand Rapids, MI 49503
Licopoco Tolophore #:	(616) 580, 4600
Licensee Telephone #:	(616) 589-4609
	N1/A
Administrator:	N/A
Lieenees Designees	N1/A
Licensee Designee:	N/A
	Emmonuel
Name of Facility:	Emmanuel
Essility Address	604 Jefferson Avenue SE
Facility Address:	
	Grand Rapids, MI 49503
Facility Telephone #:	(616) 589-4609
Facility Telephone #.	(010) 309-4009
Original Issuance Date:	12/02/2011
Oliginal issuance Date.	
License Status:	REGULAR
Effective Date:	05/28/2022
Expiration Date:	05/27/2024
Capacity:	6
	V
Program Type:	DEVELOPMENTALLY DISABLED
	MENTALLY ILL
	AGED

# II. ALLEGATION(S)

 Violation

 Established?

 Residents were left in the home without proper supervision.
 Yes

## III. METHODOLOGY

11/21/2022	Special Investigation Intake 2023A0467013
11/21/2022	Special Investigation Initiated - Telephone Spoke to the complainant via phone.
11/30/2022	Inspection Completed On-site
11/30/2022	APS Referral Completed.
11/30/2022	Exit conference completed with licensee, Tenagne Mengistu

### ALLEGATION: Residents were left in the home without proper supervision.

**INVESTIGATION:** On 11/21/22, I received a call from the complainant stating that Resident A and B stated that the owner of their AFC home, Tenagne Mengistu has left the residents at the home alone on multiple occasions. The last time this was reported to the complainant was on 11/15/22.

On 11/23/22, I made an announced visit to Hope Network's Day Program. Upon arrival, I spoke to staff member Trisha Ancel-Supuk. Mrs. Ancel-Supuk assisted in having the residents come to a conference room to speak to me. I spoke to Resident A first. Resident A stated that she has lived in her current AFC home since May 2022 and things are going "good" for her. When asked if there was anything she doesn't like, Resident A stated, "me, (Resident B, and Resident C) doesn't like that we are left alone at the home". Resident A stated, "we thought we need someone at the house at all times." I confirmed with Resident A that per licensing rules, staff should be at the home at all times when one or more residents are present in the home.

Resident A stated that sometimes, staff members "Meme and Teri" go to work around 9:00 am and returns "sometime in the afternoon." Resident A stated that the owner of the home, Mrs. Mengistu goes to her other house and takes care of her family. Resident A stated that Mrs. Mengistu told her and the other residents are "big girls" and able to handle being at the home alone. Resident A stated that if staff aren't leaving to go to other jobs, they leave to meet Mrs. Mengistu at the other home to have lunch together. Resident A confirmed that Mrs. Mengistu and staff do return to the home to feed the residents lunch. After doing so, staff leave the home again. Resident A stated that she told Mrs. Mengistu that she can't leave her and other residents home alone last week, which reportedly caused Mrs. Mengistu to become mad at her. Resident A stated that Mrs. Mengistu told her that if she or other residents get her in trouble, she and the other residents will no longer live with her. Resident A stated that Mrs. Mengistu told the residents not to tell anyone about being left home alone. Since this issue was brought to Mrs. Mengistu's attention, Resident A stated that Mrs. Mengistu has made sure to have staff at the home while residents are present.

After speaking to Resident A, I attempted to speak to Resident B. Resident B stated, "I don't want to get my caregiver in trouble. Keep me out of this." Resident B then left the room and this interview concluded. Minutes later, Resident B returned to the conference room with Resident A. Resident A was encouraging Resident B to speak. However, Resident B was still reluctant to do so. Resident B appeared to be nervous as I observed her hands shaking and her voice trembling. Therefore, I told Resident B that I would not interview her since she previously stated that she did not want to be interviewed. Resident A and B then left the conference room.

After attempting to speak to Resident B, I spoke to Resident C. Resident C stated that she has lived in the home for a few years. Resident C confirmed that she and other residents have been left alone in the home by staff for two hours at a time. Resident C stated that she and her peers are left home alone maybe "1 or 2 times each week." Resident C stated that Mrs. Mengistu leaves the home to go to the store or her other home. Resident C confirmed that Mrs. Mengistu leaves in the morning and returns to feed the residents lunch prior to leaving the home again. Resident C stated that there are 2 other staff members that work in the home but Mrs. Mengistu is the only one that leaves the residents in the home by themselves. Resident C stated that the home has a total of 6 residents and 3 of them are in the home all day and the other 3 attend day program a few days per week. Resident C denied any other issues in the home and reported that she feels safe.

On 11/30/22, I made an unannounced onsite investigation to the home. Upon arrival, owner/licensee, Mrs. Mengistu answered the door and allowed entry in the home and agreed to discuss the case allegations. Mrs. Mengistu confirmed that the residents were alone in the home for, "30 minutes or more" approximately 2 to 3 weeks ago on a Saturday. On the day in question, Mrs. Mengistu stated that she was sick, became dizzy and did not have any energy. While sick, she went to her other home, which is located behind this AFC. Her sister, Tarikua Yehualast and her cousin, Lem Lem Achalu Teklewoled were working at the AFC while she was sick. Mrs. Mengistu admitted that her sister and cousin came to her home to have lunch with her while subsequently leaving the residents in the home without staff for at least 30 minutes. Mrs. Mengistu stated that Resident A and B expressed their concern about this as well. Mrs. Mengistu was adamant that this was a one-time incident.

Mrs. Mengistu stated that most of the women in her home are independent and able

to be in the community by themselves. I explained to Mrs. Mengistu that although that may be true, per AFC licensing rules, staff are required to be in the home when residents are present. Mrs. Mengistu stated that she understands.

At this point, I conducted an exit conference with Mrs. Mengistu and explained that she will be cited for leaving residents alone. Mrs. Mengistu stated that she understands and agreed to complete a corrective action plan within 15 days of receiving this report from me. Mrs. Mengistu denied having any questions.

APPLICABLE R	JLE
R 400.1410	Resident protection.
	A licensee or responsible person shall always be on the premises when a resident is in the home.
ANALYSIS:	Resident A and C confirmed that they have been left alone in the home by staff on multiple occasions. The owner, Mrs. Mengistu confirmed that residents were left alone in the home on one occasion for "30 minutes or more." Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION ESTABLISHED

#### IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.

nthony Mullin

11/30/2022

Anthony Mullins Licensing Consultant

Date

Approved By:

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11/30/2022

Jerry Hendrick Area Manager Date