GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 7, 2024

Ketema Beshah & Asnakech Mengistu
5875 Green Rd
Haslett, MI 48840

RE: License #: AS330413152
Investigation #: 2024A0466025
AZMED AFC

Dear Ketema Beshah & Asnakech Mengistu:

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,

Julie Elkins

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330413152
Investigation #:	2024A0466025
Complaint Receipt Date:	01/19/2024
Investigation Initiation Date:	01/22/2024
Report Due Date:	03/19/2024
Licensee Name:	Ketema Beshah & Asnakech Mengistu
Licensee Address:	5875 Green Rd Haslett, MI 48840
Licensee Telephone #:	(517) 993-6192
Administrator:	Ketema Beshah
Licensee Designee:	N/A
Name of Facility:	AZMED AFC
Facility Address:	1950 North Waverly Rd. Lansing, MI 48906
Facility Telephone #:	(517) 515-3060
Original Issuance Date:	12/20/2022
License Status:	REGULAR
Effective Date:	06/20/2023
Expiration Date:	06/19/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION:

	Violation Established?
On more than one occasion, residents have been locked out of the facility.	No
Additional Findings	Yes

III. METHODOLOGY

01/19/2024	Special Investigation Intake 2024A0466025.
01/22/2024	Special Investigation Initiated – Letter to assigned licensing consultant Jana Lipps.
01/22/2024	APS Referral.
01/25/2024	Inspection Completed On-site.
01/25/2024	Exit conference with co-licensee Beshah and co-licensee Mengistu about additional findings.
03/05/2024	Exit conference with co-licensee Beshah and co-licensee Mengistu regarding full investigation.

ALLEGATION: On more than one occasion, residents have been locked out of the facility.

INVESTIGATION:
On 01/19/2024, anonymous Complainant reported this facility's online *Original Licensing Study Report* stated that 24-hour care will be provided to the residents of this facility. Complainant reported that on more than one occasion a resident has been locked out of the facility night and police were involved to get them inside and warm. Complainant reported that as a resident in the neighborhood, Complainant is concerned residents are not being cared for properly because Complainant does not see staff vehicles at the facility. Complainant was anonymous, so no additional information or details regarding the allegation could be gathered.

On 01/25/2024, I conducted an unannounced onsite investigation and I interviewed co-licensee Asnakech Mengistu who reported there are six residents currently living at the facility and that all shifts 24 hours a day seven days a week are being covered by her and the co-licensee Ketema Beshah. Co-licensee Mengistu reported that they serve residents who quite independent and freely leave the facility throughout the day. Co-licensee Mengistu reported that the police have been to the facility twice. Co-licensee Mengistu reported the first time the police were out on

12/20/2023 when Resident A left the facility without signing out and had not returned by 9pm, so local police were contacted as they were worried about Resident A's whereabouts. Co-licensee Mengistu reported learning later that Resident A was with Relative A1 and he later returned to the facility. Co-licensee Mengistu reported she could not recall the date the second time the police were out but it was during terribly cold weather with significantly low windchills that closed all of the schools. Co-licensee Mengistu reported that Resident A wanted to go out to smoke late at night once the sun was down the temperature was below zero. Co-licensee Mengistu did not think that was a safe idea so she tried to talk him out of going outside due to the extreme weather conditions. Co-licensee Mengistu reported Resident A ended up going outside to smoke and at the same time Resident A called the police who did come to the facility. Co-licensee Mengistu denied ever locking Resident A or any resident out of the facility.

At the time of the unannounced investigation Resident A, Resident B, Resident C and Resident D were home and able to be interviewed. Resident A, Resident B, Resident C and Resident D all reported that there is always a staff member at the facility. All stated the staff member is typically co-licensee Beshah or co-licensee Mengistu who provide care and supervision 24 hours a day seven days a week. Resident A, Resident B, Resident C and Resident D all reported that they are always supervised and that they have never been left home alone for any amount of time. Additionally, Resident A, Resident B, Resident C and Resident D reported that they have never been locked out of the facility at any time.

I interviewed co-licensee Ketema Beshah who reported that he or co-licensee Mengistu are covering all shifts 24 hours a day seven days a week. Co-licensee Beshah recalled that the police had been to the facility however it was when he was not on shift and he does not remember the circumstances around their involvement. Co-licensee Beshah denied ever locking Resident A or any resident out of the facility.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.

ANALYSIS:	Co-licensee Beshah, co-licensee Mengistu, Resident A, Resident B, Resident C and Resident D all reported that there is always a staff member, typically co-licensee Beshah or co-licensee Mengistu, in the facility to provide care and supervision 24 hours a day seven days a week. Resident A, Resident B, Resident C and Resident D all reported that they are always supervised and that they have never been left unsupervised.
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:	Co-licensee Beshah, co-licensee Mengistu denied ever locking Resident A or any resident out of the facility. Resident A, Resident B, Resident C and Resident D all reported that they have never been locked out of the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 01/25/2024, I conducted an unannounced investigation and when I entered Resident B's bedroom, I observed the following medications unsecured on her nightstand:

- Triamcinolone Acetonide Ointment USP, 0.196.
- Tylenol, extra strength, 225 caplets, 500 mg each.
- I observed what appeared to be two lose Tylenol pills on the nightstand.
- Halls cough drops, 30 drops.

I interviewed Resident B who reported that she needs to take Tylenol for pain and that she applies the cream as prescribed.

I interviewed co-licensee Beshah & co-licensee Mengistu who reported that Guardian B1 provided Resident B with the Tylenol and Halls Cough drops that were in her bedroom. Co-licensee Beshah & co-licensee Mengistu reported that because they were over the counter medications they did not realize that a physician prescription was required. Co-licensee Beshah & co-licensee Mengistu reported that they have allowed Resident B to apply and keep in her possession the Triamcinolone Acetonide Ointment so she can administer it as needed. Co-licensee Beshah & co-licensee Mengistu reported Resident B does not have a physician

order for Tylenol nor does Resident B have a physician order to self-administer any medication.

I reviewed Resident B's record which contained an *Assessment Plan for AFC Residents* (written assessment plan) dated 12/3/2023 and signed by Guardian B1. In the "taking medication" section of it the written assessment plan, it stated Resident B needs assistance taking medications. It also documented that she "knows her medications very well." There was no written documentation from a physician stating that Resident B could self-administer any medication without direct care staff member supervision.

Resident Bs' record contained a January 2024 medication administration record (MAR) which documented that Resident A was prescribed:

- Triamcinolone Acetonide Ointment USP, 0.196. "Apply topically to affected area of hands and behind ears daily 5 days a week or less."

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being §333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required. **(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.**

ANALYSIS:	I conducted an unannounced investigation on 01/25/2024 and I observed Triamcinolone Acetonide Ointment USP, 0.196, Tylenol, extra strength, 225 caplets, 500 mg each, two lo**o**se Tylenol pills on the nightstand and Halls cough drops, 30 drops on Resident B's nightstand. Not only were these medications not secured, Resident B, co-licensee Beshah & co-licensee Mengistu reported that Resident B was self-administering these medication**s** without a physician order**.** Resident B's resident record did not contain a physician order for Tylenol 500mg each for pain and cough drops.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Elkins 03/07/2024

Julie Elkins Date
Licensing Consultant

Approved By:

Dawn Timm 03/07/2024

Dawn N. Timm Date
Area Manager