GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 21, 2023

Josephine Halder and Albert Halder
8887 Meadow Lane
Berrien Springs, MI 49103

RE: License #: AF110415448
Investigation #: 2023A0579024
Josephine AFC Home

Dear Josephine Halder and Albert Halder:

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 (616) 356-0183.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AF110415448 |
| | |
| **Investigation #:** | 2023A0579024 |
| | |
| **Complaint Receipt Date:** | 02/28/2023 |
| | |
| **Investigation Initiation Date:** | 02/28/2023 |
| | |
| **Report Due Date:** | 04/29/2023 |
| | |
| **Licensee Name:** | Josephine Halder and Albert Halder |
| | |
| **Licensee Address:** | 8887 Meadow Lane<br>Berrien Springs, MI 49103 |
| | |
| **Licensee Telephone #:** | (269) 815-5030 |
| | |
| **Name of Facility:** | Josephine AFC Home |
| | |
| **Facility Address:** | 8887 Meadow Lane<br>Berrien Springs, MI 49103 |
| | |
| **Facility Telephone #:** | (269) 815-5030 |
| | |
| **Original Issuance Date:** | 02/22/2023 |
| | |
| **License Status:** | TEMPORARY |
| | |
| **Effective Date:** | 02/22/2023 |
| | |
| **Expiration Date:** | 08/21/2023 |
| | |
| **Capacity:** | 5 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A is not receiving appropriate supervision. | Yes |
| Additional finding | Yes |

## III. METHODOLOGY

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|---|---|
| 02/28/2023 | Special Investigation Intake<br>2023A0579024 |
| 02/28/2023 | APS Referral<br>Denied APS Referral |
| 02/28/2023 | Special Investigation Initiated - Letter<br>Albert Halder, Licensee |
| 03/14/2023 | Contact- Face to Face<br>Resident B, Resident C, Josephine Halder (Licensee), and Albert Halder (Licensee) |
| 03/15/2023 | Contact- Document received<br>Jacob Pehur (APS), Josephine Halder (Licensee), Albert Halder (Licensee) |
| 03/16/2023 | Contact- Document received<br>Albert Halder, Licensee |
| 04/10/2023 | Contact- Document sent<br>Jacob Pehur, APS |
| 04/10/2023 | Contact- Document sent<br>Albert Halder, Licensee |
| 04/10/2023 | Contact- Document sent<br>Darren Washington, APS |
| 04/27/2023 | Exit Conference<br>Albert Halder, Licensee<br>Josephine Halder, Licensee |

**ALLEGATION:**

**Resident A is not receiving appropriate supervision.**

**INVESTIGATION:**

On 2/28/23, I received this referral through the Bureau of Community Health Systems on-line complaint system. It alleged Resident A was brought to an appointment by licensee, Albert Halder. Mr. Halder asked the front desk for a piece of paper, wrote down the home's address on the paper, and put the paper in Resident A's pocket. Mr. Halder told Resident A to go to the grocery store after his appointment to eat and then walk home. Resident A is diagnosed with dementia and does not have the cognitive abilities to safely walk home unsupervised. Resident A could not remember how to use his zipper on the pocket with the home address on it. It is believed Resident A is not receiving adequate care at this home.

On 2/28/23, I received confirmation that the referral was denied by Adult Protective Services citing it was dismissed due to Resident A residing at an adult foster care home.

On 2/28/23, I sent an e-mail to Mr. Halder requesting Resident A's assessment plan. Mr. Halder responded that Resident A has been in his care since 1/12/23 under a different license. Resident A continued to remain at this home when the previous license closed, and Mr. Halder was made co-licensee on a new license that was issued on 2/22/23. He stated he can understand that "people are tired of [Resident A]" reporting that he and Ms. Halder are having a "very difficult time dealing with him." He expressed that Resident A leaves the home as soon as it is daylight, although he has severe dementia. He stated he has suggested to Guardian A that Resident A needs to be in a home with locked doors, so he does not wander but Guardian A is having a difficult time finding a new placement for him. He stated most church members in the community know Resident A and offer him rides home but he is "sure a lot of people are annoyed and it's not [Resident A's] fault" and neither is it his or Ms. Halder's.

On 2/28/23, I received and reviewed Resident A's *Assessment Plan for AFC Residents* which noted he can move independently within the community. It was completed and signed by Guardian A.

Mr. Halder also sent a letter dated 1/18/23 addressed to Guardian A which stated:

> *"It is very obvious now to us that [Resident A] can't be either controlled or monitored constantly. He barely remembers a thing and forgets any instructions in a next moment. He can't stay put in the house as soon as the morning light breaks through and neither can we stop him from doing so, he just prefers to walk away and wonder [sic] around until someone picks him up.*

*Having said that we want to let you know, as you are his Guardian [sic] that we cannot be held responsible should something bad happen to him as he keeps getting lost or wondering [sic] around during the day. Under these circumstances it is our belief that he should be with suitable agency like where he can be constantly monitored or be in a confined/gated areas [sic] where he can't just leave the premises easily."*

I responded advising that the letter to Guardian A was not an appropriate discharge notice. I directed Mr. Halder on how to complete an appropriate discharge notice and suggested that be done immediately since it has been known that Resident A's care needs could not be met at this home, yet he has remained in the home. I reminded Mr. Halder of a discussion I had with him and Ms. Halder on 2/21/23, about the importance of thoroughly assessing residents prior to admitting them to the home to ensure their needs could be met in the home. I advised Mr. Halder that he and Ms. Halder, not Guardian A, are responsible for Resident A's safety while he lives in this home, since they admitted him into the home, even if it is challenging to keep him safe.

Mr. Halder responded that he believes that Guardian A was already looking for placement but due to her own impairments, she is struggling and doing the best she can to help Resident A. He stated he knew Guardian A was struggling and "didn't want to pressure her" but now he and Ms. Halder believe a 30-day notice is necessary. He stated to ensure Resident A's safety, Resident A was registered with the local police department so they "don't give us a hard time every time they find him wondering [sic] around or at least they know where he lives." He stated he and Ms. Halder do their best to assess residents prior to moving them into the home but guardians and case workers do not give much information prior to moving a resident into the home so he and Ms. Halder typically learn about a resident after they move into the home.

I responded that Guardian A completed Resident A's assessment plan stating he moves independently in the community, which given what has been reported about the severity of his dementia by the complainant and Mr. Halder, this is not accurate. I advised the severity of Resident A's dementia, as reported, likely could have been assessed by meeting him prior to accepting him into the home. This could have determined his needs were not appropriate for this home, since they typically accept residents who move independently through the community and do not need staff to be awake at night.

Mr. Halder responded that I should schedule a time to meet with Guardian A so she could inform me of Resident A's needs herself. I advised that Mr. Halder should have completed a thorough assessment of Resident A prior to accepting him into the home so he could report Resident A's needs, I did not need to obtain that information from Guardian A now.

On 3/14/23, I completed an unannounced on-site investigation with Mr. Halder and Ms. Halder. They reported Resident A was independently in the community at the time I was at the home. I inquired why Resident A continued to be allowed in the community unsupervised even though it was known it was unsafe. Mr. Halder and Ms. Halder reported they could not keep him at the home. They reported Resident A should be safe as he has a routine where he walks to the supermarket, then later walks to his church, and he either returns home or someone brings him home later in the day. I discussed how the severity of his dementia could impact his routine and it was still unsafe. I advised if Resident A was harmed in the community, Mr. Halder and Ms. Halder would be held accountable for not appropriately supervising him. They expressed understanding and reported there was "nothing else" they could do.

I inquired about progress with Resident A being discharged from the home. Mr. Halder and Ms. Halder reported Guardian A reported she believes she found another home that can appropriately supervise Resident A and he should be moving soon.

On 3/16/23, I received an email from Mr. Halder requesting consultation on sharing Resident A's documents with his new placement and expressing that he believed Resident A had found, and would be moving to, a new placement.

| **APPLICABLE RULE** | |
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| **R 400.1407** | **Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physician's instructions; health care appraisal.** |
| | **(2) A licensee shall not accept or retain a resident for care unless and until a written assessment is made and it is determined that the resident is suitable pursuant to the following provisions:**<br><br>**(a) The amount of personal care, supervision, and protection required by the resident is available in the home.** |
| **ANALYSIS:** | Resident A's assessment plan noted Resident A moved independently in the community. The complainant and Mr. Halder confirmed due to Resident A's advanced dementia he was not safe unsupervised in the community. Mr. Halder expressed concern that Guardian A was not fit to appropriately complete and assessment plan for Resident A. Mr. Halder reported he and Ms. Halder typically assess resident care needs after they are admitted to the home, as was the case here, where it was determined Resident A was not suitable for the home. |

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| | Based on the interviews completed and documentation observed, there is sufficient evidence to support allegations Resident A was admitted prior to it being determined that the home could provide for his personal care, supervision, and protection needs and that he was suitable for this home. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDING:**

On 2/28/23, I exchanged emails with Mr. Halder who reported that Resident A has been under his care since 1/12/23 and on 1/18/23, he expressed in a letter to Guardian A that Resident A's needs could not be met in the home, but he did not issue a formal discharge notice. He expressed to me, and Resident A's assessment plan showed, concern that Guardian A's own impairments did not make her able find an appropriate placement for Resident A. Mr. Halder reported Guardian A was struggling to find a new placement for Resident A.

I advised Mr. Halder since Guardian A is having challenges finding a new placement and cannot accurately complete an assessment to find Resident A an appropriate placement, Mr. Halder should contact APS for assistance moving Resident A to an appropriate placement since he has direct knowledge of Resident A and Guardian A, and it appears additional assistance is needed to move Resident A from this placement. I provided Mr. Halder with contact information Central Intake to request APS assistance for Resident A.

Mr. Halder responded that he would like me to schedule a time to meet with Guardian A to explain to her the need for Resident A to move and the reason for APS involvement.

I responded that based on what was reported, it sounds like Resident A and Guardian A would benefit from Resident A having the support of a caseworker which is why I recommended APS, as I cannot act in the role of caseworker. I advised Mr. Halder should have acquired the necessary information regarding Resident A, prior to placement and be able to relay that to me, so I did not need to meet with Guardian A to get information regarding Resident A myself now.

On 3/14/23, I inquired about Mr. Halder contacting APS to get their support for Resident A and Guardian A as requested. He stated he told Guardian A to contact APS and he believes she did. I inquired if, as he reported, Guardian A was unable to act in the best interest of Resident A due to her own impairments, he believed she could appropriately communicate her and Resident A's needs and request

assistance for Resident A to APS. He advised he did not understand why I could not just contact APS myself if I wanted APS involved. I advised his role as licensee is to ensure the safety of Resident A and Resident A is currently unsafe in his home. I advised since he reported Resident A's guardian is not fit to appropriately place Resident A, as licensee, to help ensure Resident A's safety, and because he had direct knowledge of the circumstances and Resident A's needs, he was advised to and should have contacted APS, instead of requesting Guardian A or me to do so on his behalf. He and Ms. Halder stated they would reach out to Jacob Pehur from APS regarding Resident A. I requested to be included in the e-mail contact with Mr. Pehur to ensure it was sent.

On 3/15/23, I received an email sent to Mr. Pehur where Mr. Halder requested APS assistance with finding Resident A a new placement as he has severe dementia.

On 4/10/23, I contacted Mr. Pehur inquiring if Resident A was receiving APS services. Mr. Pehur reported he received the email from Mr. Halder on 3/15/23 and believes he spoke to Mr. Halder on the phone regarding Resident A. He stated he advised Mr. Halder to contact Centralized Intake since Resident A was not receiving APS services and an intake would have to be completed to have Resident A be connected to APS services.

On 4/10/23, I sent an email to Mr. Halder inquiring if he had contacted Centralized Intake as both me and Mr. Pehur had advised. I also inquired if Resident A had moved to his new placement. Mr. Halder responded that Mr. Pehur never responded to his email on 3/15/23, Mr. Pehur had never called him, and Mr. Pehur did not also advise him to contact Central Intake. He reported Resident A moved from the home on 3/22/23.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.1404** | **Licensee, responsible person, and member of the household; qualifications.** |
| | **(3) A licensee or responsible person shall possess all of the following qualifications:**<br><br>**(c) Be capable of appropriately handling emergency situations.** |
| **ANALYSIS:** | Mr. Halder reported it was known Resident A was not safe in the home, but efforts were not made to appropriately discharge him until I advised a 30-day discharge was necessary. This occurred nearly six weeks after Mr. Halder wrote to Guardian A that Resident A was not suitable for this home. Although Mr. Halder and Ms. Halder knew Resident A needed supervision and was not safe moving independently in the community, Resident A was still allowed to move independently in the community daily. |

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| | Mr. Halder expressed concern that Guardian A could not find Resident A an appropriate placement. I expressed concern, after reviewing Resident A's assessment plan, that Guardian A was not able to complete an assessment plan that accurately noted Resident A's needs. I advised Mr. Halder to contact APS through Centralized Intake, due to his direct knowledge of the concerns for Guardian A and Resident A, and to seek assistance moving Resident A from the home to a more appropriate placement. Mr. Halder reported he did not contact APS, rather he told Guardian A to contact APS on his behalf. He then advised I should contact APS on his behalf.<br><br>Mr. Halder and Ms. Halder agreed to contact Mr. Pehur from APS. Mr. Pehur reported he also advised Mr. Halder to contact APS through Centralized Intake to complete an intake for services for Resident A. Mr. Halder reported he did not contact Centralized Intake.<br><br>Based on the interviews completed and documentation observed, there is sufficient evidence to support allegations that Mr. Halder and Ms. Halder are not capable of appropriately handling emergency situations. They did not take appropriate action to discharge Resident A from the home when they knew he was not suitable for their home and was unsafe unsupervised in the community. They continued to allow Resident A to go into the community unsupervised daily, although it was known it was unsafe. They did not follow through with contacting Centralized Intake to connect Resident A to APS support to assist him with moving from the home to an appropriate placement. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 4/27/23, I completed an exit conference with Ms. Halder and Mr. Halder who disputed my findings stating they had done nothing wrong and disputed my recommendations, requesting I cite guardians and case managers for not appropriately completing assessment plans. They continued to take no accountability for the actions leading to the violations within this report.

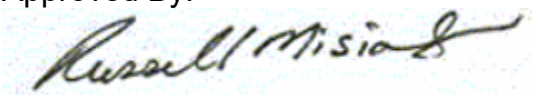
## IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

4/21/23

Cassandra Duursma Date
Licensing Consultant

Approved By:



4/27/23

Russell B. Misiak Date
Area Manager