GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 4, 2022

Bulu Halder
1637 Colfax Avenue
Benton Harbor, MI 49022

RE: License #: AF110380663
Investigation #: 2022A0579038
Seven Gables A.F.C. Home

Dear Bulu 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 was required. On 11/07/2022 , you submitted an acceptable written corrective action plan.

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

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

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

I. IDENTIFYING INFORMATION

License #:	AF110380663
Investigation #:	2022A0579038
Complaint Receipt Date:	09/15/2022
Investigation Initiation Date:	09/20/2022
Report Due Date:	11/14/2022
Licensee Name:	Bulu Halder
Licensee Address:	1637 Colfax Avenue Benton Harbor, MI 49022
Licensee Telephone #:	(269) 927-2680
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Seven Gables A.F.C. Home
Facility Address:	1637 Colfax Avenue Benton Harbor, MI 49022
Facility Telephone #:	(269) 927-2680
Original Issuance Date:	03/28/2016
License **Status:**	REGULAR
Effective Date:	09/28/2022
Expiration Date:	09/27/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A walked 10 miles unsupervised.	Yes
The AFC home did not report Resident A had eloped.	Yes

III. METHODOLOGY

09/15/2022	Special Investigation Intake 2022A0579038
09/19/2022	Special Investigation Initiated - Letter Bulu Halder, Licensee
09/27/2022	Contact - Face to Face Bulu Halder, Licensee
10/02/2022	Contact - Document Received Bulu Halder, Licensee
11/04/2022	Exit Conference Bulu Halder, Licensee

ALLEGATION:

Resident A walked 10 miles unsupervised.

INVESTIGATION:

On 9/15/22, I received this referral through the Bureau Information Tracking System. The referral alleged Relative A2, who lives in Watervliet, dropped Resident A off at an emergency department at 1:50 p.m. because Resident A walked ten miles to his home.

On 9/19/22, I received and reviewed an *Incident/Accident Report* dated 9/13/22 which stated on 9/11/22 Ms. Halder saw Resident A walking in her garden at 2:30 p.m. After 4:00 p.m., Resident A was not observed in or near the home and was missing. Ms. Halder contacted 911 and later spoke to Relative A2 who reported Resident A had walked to Relative A2's home in Watervliet.

On 9/27/22, I completed an unannounced onsite investigation. Ms. Halder reported Resident A discharged to a skilled nursing home and did not return to her home. I interviewed Ms. Halder privately.

Ms. Halder stated she admitted Resident A into the home when pressured by a case manager even though she was not certain she could meet the needs of a resident diagnosed with dementia. She stated she did not complete an assessment plan prior to him coming to the home. She stated she attempted to complete his assessment plan, but it was not signed by Resident A's designated representative or placing agency. She stated once Resident A was in her home, she learned he had intensive needs relating to his diagnosis of dementia. She stated he would have delusions, wander, and was paranoid that he was owed money or that someone was upset with him even though there was no reason for anyone to be upset with him. She stated he had eloped prior to this incident at 1:00 a.m., she notified law enforcement, and Resident A was returned to the home at 2:00 a.m. by law enforcement.

While onsite, I reviewed Resident A's *AFC-Resident Information and Identification Record* which noted he was admitted to the home on 8/22/22.

I inquired about Resident A's assessment plan, even though it did not have signatures, and Ms. Halder reported she could not locate it at this time.

On 10/2/22, Ms. Halder reported she located the copy of Resident A's *Assessment Plan for AFC Residents.* Relating to Resident A moving independently in the community, the box to select no was scribbled in, the area to describe resident needs had "He is" with a line through it. The box to select yes was checked. The assessment plan was signed by Ms. Halder on 9/1/22. There were no additional signatures on the form.

APPLICABLE RULE	
R 400. 1407	**Resident assessment plan;**
	(2) A licensee shall not accept or retain a resident for care unless and until a resident assessment plan is made and it is determined that the resident is suitable pursuant to the following provisions: **(a) The amount of personal care, supervision, and protection required by the resident is available in the home.**

ANALYSIS:	Resident A's *AFC-Resident Information and Identification Record* noted he was admitted to the home on 8/22/22. Resident A's assessment plan was not available when I was at the home on 9/27/22. The copy of Resident A's assessment plan I received 10/2/22, signed by Ms. Halder on 9/1/22, did not have the signatures of Resident A's designated representative or placing agency and the section regarding his movement in the community was modified from no to yes. Based on the interview completed and documentation observed, there is sufficient evidence to support allegations that Ms. Halder accepted Resident A without completing an assessment plan to ensure he was suitable for the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The AFC home did not report Resident A had eloped.

INVESTIGATION:

On 9/15/22, I reviewed the referral which alleged Relative A1 reported Resident A's AFC home had not called him, nor had they filed a missing person police report, at the time that Resident A was admitted to the hospital at 1:50 p.m on 9/12/22.

On 9/19/22, I reviewed the *Incident/Accident Report*, which was noted as completed on 9/13/22, and I received on 9/19/22, which noted at 6:00 p.m. on 9/11/22, Ms. Halder called 911 to report Resident A missing. At 8:00 p.m., Relative A2 reported Resident A had walked to his home in Watervliet. On 9/12/22, Relative A2 reported he had taken Resident A to the hospital and Resident A was admitted. Relative A1 was listed at Resident A's designated representative on the *Incident/Accident Report*.

On 9/27/22, Ms. Halder stated on 9/11/22, she had observed Resident A coming in and out of the home and standing in her yard throughout the day. She stated at approximately 3:00 p.m., she last saw Resident A standing in the yard outside. She stated when Resident A did not come in for dinner, she became concerned. She stated after dinner, she and other residents went into the community searching for Resident A and did not find him. She stated she returned to the home and at approximately 6:00 p.m. she called 911 to report Resident A missing. She stated she

gave law enforcement the contact information for Resident A's relatives and intended to email Relative A1, Relative A2, and Relative A3, who are all involved in Resident A's care, regarding his elopement. She stated at 8:00 p.m., she received a phone call from Relative A2 stating Resident A had walked to his home and he would keep Resident A at his home overnight. She stated at 9:00 a.m. on 9/12/22, Relative A2 called her to state Resident A did not appear well and he was going to take Resident A to the emergency room that day. She stated that afternoon, she was contacted by law enforcement who reported Resident A was in the hospital and no longer missing. She stated she believed Relative A2 and law enforcement would tell the other relatives what was occurring which is why she did not immediately.

While onsite, I reviewed Resident A's *Resident Care Agreement* which was signed by Resident A, Relative A1 listed as "Agent POA", and Ms. Halder.

I also reviewed Resident A's *AFC- Resident Information and Identification Record* which listed Relative A1 as Resident A's payee.

I observed an untitled form completed by a case manager which noted Relative A1 as Resident A's Power of Attorney.

APPLICABLE RULE	
R 400.1417	**Absence without notice.**
	3) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.
ANALYSIS:	The *Incident/Accident Report* noted the incident occurred on 9/11/22. The form was noted as completed on 9/13/22. Relative A1 was listed as Resident A's designated representative on the form. Relative A1 was listed as Resident A's "Agent POA", Power of Attorney, and payee. He also signed Resident A's *Resident Care Agreement* as his designated representative. Ms. Halder reported looking for Resident A in the community and calling 911 to report Resident A missing. However, she reported she gave law enforcement contact information for Resident A's relatives and did not immediately contact them. She stated when Relative A2 reported Resident A was with him, she assumed Relative A2 would inform the other relatives.

	Based on the interview completed and documentation reviewed, there is sufficient evidence to support allegations that reasonable attempts were not made to contact Relative A1, who is Resident A's designated representative, and the written report was not submitted to Relative A within 24 hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/4/22, I completed an exit conference with Ms. Halder who did not dispute my findings or recommendations and provided a plan of corrective action.

IV. RECOMMENDATION

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

Cassandra Duursma 11/4/22

Cassandra Duursma Date
Licensing Consultant

Approved By:

Russell Misiak 11/4/22

Russell B. Misiak Date
Area Manager