GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 17th, 2021

Justin Stein
Battle Creek Bickford Cottage, L.L.C.
13795 S. Mur-Len Road
Olathe, KS 66062

RE: License #:	AH130278262
Investigation #:	2021A1021031
	Battle Creek Bickford Cottage

Dear Mr. Stein:

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 authorized representative 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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH130278262
Investigation #:	2021A1021031
Complaint Receipt Date:	05/12/2021
Investigation Initiation Date:	05/13/2021
Report Due Date:	07/11/2021
Licensee Name:	Battle Creek Bickford Cottage , L.L.C.
Licensee Address:	Suite 301 13795 S. Mur-Len Road Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator/ Authorized Representative:	Justin Stein
Name of Facility:	Battle Creek Bickford Cottage
Facility Address:	3432 Capital Avenue Battle Creek, MI 49015
Facility Telephone #:	(269) 979-9600
Original Issuance Date:	12/29/2006
License Status:	REGULAR
Effective Date:	10/15/2020
Expiration Date:	10/14/2021
Capacity:	55
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility.	Yes
Additional Findings	No

III. METHODOLOGY

05/12/2021	Special Investigation Intake 2021A1021031
05/17/2021	Contact - Telephone call made interviewed facility nurse Sandra Green
05/17/2021	Contact - Telephone call made interviewed caregiver Kayla
05/17/2021	Contact - Telephone call made interviewed caregiver Marilyn
05/17/2021	Contact - Document Received Received service plan and admission agreement
05/18/2021	Contact - Telephone call made Interviewed caregiver Alexa Brainard
06/21/2021	Exit Conference Exit Conference with authorized representative Justin Stein

ALLEGATION:

Resident A eloped from the facility.

INVESTIGATION:

On 5/9/21, the licensing department received an incident report that read,

"Staff contacted by (Relative A1) stating she had received a call from (Resident A) that he couldn't find his bed. Staff went to his room and he was not in his room. Staff started search immediately and noted side door alarm going off (300 Hall). Staff exited building through that door and started calling his name. Staff was flagged down by the police who were with him. Police had been contacted by a neighbor. (Resident A) was returned to the branch and evaluated. Vital

signs taken. Resident was wearing street clothes, socks and no shoes, he was ambulating with his cane."

Due to the Covid-19 pandemic, this investigation was completed remotely.

On 5/17/21, I interviewed facility nurse Sandra Green by telephone. Ms. Green reported Resident A admitted to the facility on 5/7. Ms. Green reported Resident A had no history of exit seeking. Ms. Green reported upon admission Resident A was to be checked every hour around the clock due to being a new admission. Ms. Green reported Resident B exited out of the side doors at 3:00am on 5/9. Ms. Green reported caregivers were alerted by Relative A1 that Resident A called her to tell her that he could not find his bed. Ms. Green reported caregivers went to check on Resident A and he was not in his room. Ms. Green reported caregivers then heard the door alarm going off. Ms. Green reported a caregiver went outside the facility and was able to locate Resident A. Ms. Green reported Resident A now wears a waunderguard. Ms. Green reported when a door is opened, the caregiver pager is to alert the caregiver that a door was opened.

On 5/17/21, I interviewed caregiver Cayla Molina by telephone. Ms. Molina reported on 5/9 she was contacted by Relative A1 reporting that Resident A called her because Resident A could not find his bed. Ms. Molina reported she went down to Resident A's room and Resident A was not in his bedroom. Ms. Molina reported she looked at the computer monitor and saw that the alert was going off that a door alarm was activated. Ms. Molina reported the door that Resident A exited out of was a double door so that it was difficult to hear the door alarm. Ms. Molina reported she ran outside and started to call Resident A's name. Ms. Molina reported she believes the neighbors saw Resident A and contacted 911. Ms. Molina reported herself and the police found Resident A and Resident A was brought back to the facility. Ms. Molina reported Resident A was outside no more than 10 minutes. Ms. Molina reported the door alarm should have went to her pager, but it did not. Ms. Molina reported the facility has placed a waunderguard system on Resident A and he is now checked on every thirty minutes at night and every hour during the day. Ms. Molina reported the pagers were checked and are now working properly.

On 5/17/21, I interviewed caregiver Marilyn Bennett by telephone. Ms. Bennett reported she provided care to Resident A prior to his elopement. Ms. Bennett reported Resident A was restless and said he wanted to get out and go home. Ms. Bennett reported she put Resident A back in bed and Resident A reported he did not need anything. Ms. Bennett reported she told Ms. Molina to keep an extra eye and increased checks on Resident A due to the statements he made. Ms. Bennett reported she was in the kitchen cleaning and her pager went off that Resident A pulled his pull cord. Ms. Bennett reported she went down to Resident A's room and Ms. Molina was in there and reported she could not find Resident A. Ms. Bennett reported Ms. Molina went outside to locate Resident A and she went room to room to locate Resident A. Ms. Bennett reported Resident A was located outside and was brought back to the facility. Ms. Bennett reported the door Resident A exited was the

fire door and was a double door. Ms. Bennett reported that alarm is not as loud due to the door being a double door. Ms. Bennett reported there was no page that the door had been opened.

On 5/18/21, I interviewed caregiver Alexa Brainard by telephone. Ms. Brainard reported she provided care to Resident A on 5/8. Ms. Brainard reported Resident A did not make any statements on exit seeking nor attempt to leave the facility. Ms. Brainard reported if a door is opened, the caregiver pager alerts the caregiver that a door is opened.

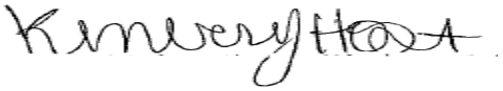
I reviewed Resident A's service plan that was in place at time of the elopement incident. There was no mention of nightly checks or exit seeking behaviors.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: 325.1901	**Definitions.**
	(22) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following: **(d) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.**
ANALYSIS:	Interviews with staff members revealed when a door is opened, a page is to go to the caregiver's pager. However, on 5/9 Resident A exited out of the facility and there was no page to the caregivers' s pager which resulted in Resident A outside the facility for approximately ten minutes. Due to the non-working pager, the facility was unable to properly supervise Resident A and therefore is in violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/21/21, I conducted an exit conference with authorized representative Justin Stein by telephone. Mr. Stein had no questions regarding the findings in this report.

IV. RECOMMENDATION

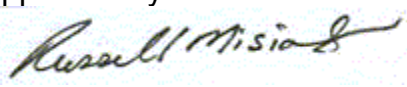
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



5/19/21

Kimberly Horst Date
Licensing Staff

Approved By:



6/16/21

Russell B. Misiak Date
Area Manager