GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 7, 2021

Justin Stein
Lansing Bickford Cottage
3830 Okemos Road
Okemos, MI 48864

RE: License #: AH330278347
Investigation #: 2021A1028035
Lansing 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 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) 356-0100.

Sincerely,
Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH330278347
Investigation #:	2021A1028035
Complaint Receipt Date:	08/10/2021
Investigation Initiation Date:	08/10/2021
Report Due Date:	09/09/2021
Licensee Name:	Lansing Bickford Cottage L.L.C.
Licensee Address:	13795 S. Murlen Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Marie Jonzun
Authorized Representative:	Justin Stein
Name of Facility:	Lansing Bickford Cottage
Facility Address:	3830 Okemos Road Okemos, MI 48864
Facility Telephone #:	(517) 706-0300
Original Issuance Date:	09/08/2008
License Status:	REGULAR
Effective Date:	08/24/2020
Expiration Date:	08/23/2021
Capacity:	55
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility is understaffed to meet the needs of residents.	No
Residents did not bathe for four days due to an interruption of the facility hot water supply.	No
The facility did not have an appropriate hot water supply for four days.	No
Several resident rooms have bed bugs and the facility is not addressing it.	No

III. METHODOLOGY

08/10/2021	Special Investigation Intake 2021A1028035
08/10/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
08/10/2021	APS Referral APS referral emailed to Centralized Intake
08/25/2021	Inspection Completed On-site 2021A1028035
08/25/2021	Contact - Face to Face Interviewed Administrator, Marie Jonzen, and staff: Katie Johnson, Jenifer Martinsen, Alina Agha, Jin Pak, and Kelsey Gullick
08/25/2021	Contact - Face to Face Interviewed Resident A at the facility
08/25/2021	Contact – telephone call made Interviewed Dennis Moore of Moore plumbing by telephone

08/31/2021	Contact – Document received Received staff schedules and water temperature log from Marie Jonzun
09/01/2021	Contact – telephone call received Interviewed facility authorized representative, Justin Stein, by telephone
09/01/2021	Exit Interview

ALLEGATION:

The facility is understaffed to meet the needs of residents.

INVESTIGATION:

On 8/10/21, the Bureau received the allegations from the online complaint system. The complainant wished to remain anonymous, so I am unable to their verify concerns.

On 8/10/21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 7/1/21, I interviewed administrator Marie Jonzun at the facility. Ms. Jonzun reported the facility has been short staffed due to the pandemic, but there are procedures and policies in place to prevent shift shortages, so resident's needs are met appropriately. Ms. Jonzun reported agency staff is utilized as well. Ms. Jonzun reported the kitchen staff called in for few days in July due to illness, but other staff covered the shift shortage. Ms. Jonzun reported the facility also ordered one dinner meal from a local restaurant for all residents due to the kitchen staff shortage. Ms. Jonzun reported "all residents received their meals like normal despite the kitchen staff shortage." Ms, Jonzun reported there is a shift mandation policy in effect, bonuses for picking up shifts, and management also assists when there is a shift shortage. Ms. Jonzun reported the facility is actively hiring and is working with the local college to employ several students from the medical program there as well. Ms. Jonzun reported no shifts are left uncovered and that there are not a lot of call-ins. Ms. Jonzun provided me the working staff schedules, staff mandation policy and attendance policy for my review.

I interviewed care staff coordinator Jenifer Martinsen at the facility. Ms. Martinsen reported "getting and keeping good care staff has been an issue due to the pandemic, but the facility is doing a good job to prevent shift shortages and to

increase staffing". Ms. Martinsen statements about staff shift coverage, attendance policy, and shift mandation are consistent with Ms. Jonzun's statements.

I interviewed care staff person (CSP) Alina Agha at the facility. Ms. Agha reported the facility is short staffed but all shifts are covered through shift mandation, on-call or agency staff, and management assists as well. Ms. Agha reported the facility is hiring and training local college students to prevent shift shortages as well. Ms. Agha reported despite being short staffed overall, "none of the shifts go uncovered." Ms. Agha confirmed the kitchen staff called in few days in July, but other staff covered the shortage. Ms. Agha also reported the facility ordered one dinner meal from a local restaurant for residents during this time.

I interviewed CSP Kelsey Gullick at the facility. Ms. Gullick acknowledged the facility "is short staffed but is managing very well. All places are short staffed because of Covid." Ms. Gullick reported herself and other staff covered the recent kitchen staff shortage and the facility provided residents a dinner meal from a local restaurant during this time as well. Ms. Gullick was able to state the attendance and mandation policy and reported management assists as well to prevent shift shortages. Ms. Gullick reported the facility is actively hiring as well.

I interviewed CSP Jin Pak at the facility. Ms. Pak's statements about the attendance and manadation policy, shift coverage, and staff coverage during the recent kitchen staff shortage are consistent with Ms. Jonzun's, Ms. Agha's, and Ms. Gullick's statements.

I interviewed Resident A at the facility. Resident A reported care staff "arrive very quickly when I call them. I do not see any problems with staffing." Resident A confirmed the facility was short kitchen staff in July, but other care staff covered the kitchen staff shortage. Resident A reported the facility "even ordered everyone a very nice meal one evening".

On 8/31/21, I reviewed the working staff schedules for the months of June 2021 to August 2021. The review revealed seven days in June 2021 across all shifts had shift shortages, but other care staff and management filled those vacancies. There were five days in July 2021 across all shifts with shift shortages, but other care staff and management filled those vacancies as well. No shift shortages were noted for the month of August.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(3) The home shall designate 1 person on each shift to be supervisor of resident care during that shift. The

	supervisor of resident care shall be fully dressed, awake, and on the premises when on duty.
ANALYSIS:	The facility outlined policy and procedures for facility staff attendance to include mandation and scheduling procedures to prevent staffing shortages and to appropriately meet the needs of the residents based on resident's care plans. The facility also demonstrates utilization of outside agencies to prevent staffing shortages. Interviews with the administrator, care staff managers, and other staff along with review of facility documentation demonstrate a normalization and manageable level of facility staff to meet the needs of residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents did not bathe for four days due to an interruption of the facility hot water supply.

INVESTIGATION:

Ms. Jonzun reported the facility incurred a hot water supply shortage for a portion of the building beginning in the late evening on 7/31. Ms. Jonzun reported care staff noted during resident showers the water was not staying warm and reported it to management immediately. Ms. Jonzun reported the water temperature was assessed in different parts of the building and it was determined the hot water supply was not working correctly. Ms. Jonzun contacted a plumber who came to the facility to address the issue as soon as possible. Ms. Jonzun reported a new part for the plumbing system needed to be ordered and due to this, the facility was without hot water from 7/31 until Monday 8/2 when the plumber was able to fix the issue. Ms. Jonzun reported there was still hot water available for resident use from the main facility outlet though. Ms. Jonzun reported to ensure residents bathing schedules were met, staff retrieved hot water from main facility outlet and provided hot/warm sponge bathes. Ms. Jonzun reported the facility addressed the hot water supply shortage immediately, but it ultimately took longer to fix than anticipated because a part needed to be overnighted to the plumber.

Ms. Martinsen reported the hot water supply stopped working late in the evening on 7/31. Ms. Martinsen reported care staff alerted management immediately. Ms. Martinsen reported due to it being a holiday weekend, it took longer than anticipated to locate a plumber, to overnight the part needed to fix the issue, but it was repaired. Ms. Martinsen reported the facility's hot water supply was working correctly by the

morning of 8/2. Ms. Martinsen reported most residents that were scheduled for showers during this time were provided hot/warm sponge bathes by care staff, while a few residents chose to wait until 8/2 to take showers once the hot water supply was fixed. Ms. Martinsen reported all residents were offered showers once the hot water supply shortage was corrected.

Ms. Agha reported the facility "lost hot water for two days, but those scheduled for showers were given sponge bathes. Some wanted to wait until the hot water came back on to bathe though." Ms. Agha reported no residents missed the opportunity to bathe. Ms. Agha reported the facility "had to wait on a part to arrive before the hot water could be fixed, but it was fixed pretty fast considering it was the weekend. The plumbing company was here pretty fast to fix it." Ms. Agha reported residents were later offered the opportunity to shower once the hot water supply shortage was corrected.

Ms. Gullick's statements are consistent with Ms. Jonzun's, Ms. Martinsen's, and Ms. Agha's statements. Ms. Gullick reported no residents missed the opportunity to bathe even though the hot water supply was not working appropriately.

Ms. Pak's statements are consistent with Ms. Ms. Jonzun's, Ms. Martinsen's, Ms. Agha's and Ms. Gullick's statements.

Resident A reported the facility was without water for two days, but that care staff still provided sponge baths. Resident A reported they chose to take a sponge bath and that "it was fine. After the hot water came back, they even offered me another shower, but I was Ok."

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.

ANALYSIS:	While the part of the facility was without a hot water supply for two days, the facility took immediate action to address and correct the issue. Residents were provided the opportunity to sponge bath and were later provided the opportunity to take showers once the hot water supply shortage was corrected. Staff took great measures to ensure no resident care routines were interrupted due to this issue.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not have an appropriate hot water supply for four days.

INVESTIGATION:

On 8/25, Ms. Jonzun reported the facility was without a hot water supply from late evening 7/31 until early morning 8/2. Ms. Jonzun reported a local plumbing company responded as soon as possible to assess, address, and correct the issue. Ms. Jonzun reported “a part had to be overnighted to fix the issue, but it was fixed as soon as it could be, especially given it was a holiday weekend and a lot of places were closed.” Ms. Jonzun reported the main hot water outlet still worked though and the facility used this to continue to provide care for the residents and operate the facility.

Dennis Moore of Moore plumbing confirmed his company completed the necessary work to fix the hot water supply shortage at the facility and that it was fixed the morning of 8/2.

APPLICABLE RULE	
R 325.1970	**Water supply systems.**
	(7) The temperature of hot water at plumbing fixtures used by residents shall be regulated to provide tempered water at a range of 105 to 120 degrees Fahrenheit.

ANALYSIS:	The facility was without a hot water supply from 7/31 to 8/2 due to a broken part. The facility addressed the issue immediately, requiring an outside plumbing service to correct. The facility was able to use the hot water from the main outlet to continue to provide resident care appropriately and operate the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Several resident rooms have bed bugs and the facility is not addressing it.

INVESTIGATION:

On 8/25, Ms. Jonzun reported bed begs were discovered in Resident A's room by a care staff member. Ms. Jonzun reported Resident A's physician and authorized representative was notified immediately. A pest exterminator was called in immediately and it was discovered that rooms 101, 102, and 308 had bed begs also. The physicians and authorized representatives of these residents were notified as well. Ms. Jonzun reported the residents were moved to new rooms, several rounds of extermination treatment were performed on the rooms, and then dogs were also brought in after the first couple treatment rounds to sniff out any remaining or additional bed bugs. Ms. Jonzun reported the rooms are now clear of bed bugs and the facility is now on a routine insect and vermin control program to prevent any future occurrences. Ms. Jonzun reported no more outbreaks of bed bugs have occurred since and she is unsure where they originated from.

Ms. Johnson reported the residents in the affected rooms were treated for any infection once the bed bugs were discovered by care staff. Ms. Johnson reported the residents were moved to clean rooms while the other rooms were being treated. Ms. Johnson reported the physicians and authorized representatives of the affected residents were all notified immediately. Ms. Johnson reported exterminators and bed bug sniffing dogs were called to the facility to address the issue as well. Ms. Johnson confirmed the exterminators are now coming to the facility on a routine basis to continue to monitor and prevent the issue from occurring again.

Ms. Martinsen's statements are consistent with Ms. Jonzun's and Ms. Johnson's statements.

Ms. Agha reported bed bugs were found in Resident A's room and subsequently three other rooms. Ms. Agha reported the facility had an extermination service come out immediately and that "it seems to be taken care of. They even brought dogs in to

make sure there weren't anymore." Ms. Agha confirmed the extermination service is now routinely coming to the facility to prevent any more occurrences.

Ms. Gullick's statements are consistent with Ms. Jonzun's, Ms. Johnson's, Ms. Martinsen's and Ms. Agha's statements.

Ms. Pak's statements are consistent with Ms. Jonzun's, Ms. Johnson's, Ms. Martinsen's, Ms. Agha's and Ms, Gullick's statements.

Resident A reported the bed bugs were found in their room by care staff. Resident A is unsure of where they came from. Resident A reported their physician gave them an antibiotic due to the itching from the bed bugs and that their authorized representative was notified of the issue. Resident A reported being moved from their room to a new room during this incident. Resident A reported they felt the facility "did a good job handling the situation and making sure I was taken care of."

I was unable to interview Resident B, Resident C, and Resident D appropriately due to cognition.

APPLICABLE RULE	
R 325.1978	**Insect and vermin control.**
	(1) A home shall be kept free from insects and vermin.(2) Pest control procedures shall comply with MCL 324.8301 et seq.
ANALYSIS:	Bed bugs were discovered in Resident A's room and subsequently three other rooms in July 2021. The facility took immediate action to address the issue, exterminate and clean the rooms, and to continue to ensure good care was provided for the residents. The facility is also on a preventative extermination program to prevent any future occurrences.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend the status of this license remain unchanged.

Julie Viviano 9/1/21

Julie Viviano Date
Licensing Staff

Approved By:

Russell Misiak 9/3/21

Russell B. Misiak Date
Area Manager