



STATE OF MICHIGAN  
 DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
 LANSING

GRETCHEN WHITMER  
 GOVERNOR

ORLENE HAWKS  
 DIRECTOR

January 26, 2022

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

RE: License #:	AH130278262
Investigation #:	2022A1021019
	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**

<b>License #:</b>	AH130278262
<b>Investigation #:</b>	2022A1021019
<b>Complaint Receipt Date:</b>	12/21/2021
<b>Investigation Initiation Date:</b>	12/22/2021
<b>Report Due Date:</b>	02/20/2022
<b>Licensee Name:</b>	Battle Creek Bickford Cottage, L.L.C.
<b>Licensee Address:</b>	Suite 301 13795 S. Mur-Len Road Olathe, KS 66062
<b>Licensee Telephone #:</b>	(913) 782-3200
<b>Administrator:</b>	Nicholas Fugate
<b>Authorized Representative:</b>	Justin Stein
<b>Name of Facility:</b>	Battle Creek Bickford Cottage
<b>Facility Address:</b>	3432 Capital Avenue Battle Creek, MI 49015
<b>Facility Telephone #:</b>	(269) 979-9600
<b>Original Issuance Date:</b>	12/29/2006
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	10/15/2020
<b>Expiration Date:</b>	10/14/2021
<b>Capacity:</b>	55
<b>Program Type:</b>	ALZHEIMERS AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Facility has insufficient staff.	Yes
Additional Findings	No

**III. METHODOLOGY**

12/21/2021	Special Investigation Intake 2022A1021019
12/22/2021	Special Investigation Initiated - Letter Referral sent to Adult Protective Services (APS)
12/29/2021	Inspection Completed On-site
12/29/2021	Contact - Telephone call made interviewed authorized representative by telephone
1/3/2022	Contact-Telephone call made Interviewed caregiver Greshena Howlett
1/3/2022	Contact-Telephone call made Interviewed caregiver Emily Rodriguez
1/5/2022	Contact-Telephone call made Interviewed caregiver Martin Rangel
1/26/2022	Exit Conference Exit Conference with authorized representative Justin Stein

**ALLEGATION:**

**Facility has insufficient staff.**

**INVESTIGATION:**

On 12/21/21, the licensing department received a complaint with allegations the facility has lack of staff. The complainant alleged the facility re-opened the memory care unit with insufficient staff to care for the residents.

On 12/22/21, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 12/29/21, I interviewed administrator Nicholas Fugate at the facility. Mr. Fugate reported the memory care unit opened on November 1<sup>st</sup> after it was remodeled. Mr. Fugate reported there are four residents in the unit. Mr. Fugate reported the staffing ratios are to have three caregivers for each shift with one caregiver in assisted living, one caregiver in memory care, and one caregiver that floats between the units. Mr. Fugate reported in the memory care unit there is one resident that is a two person assist. Mr. Fugate reported if there is a staff shortage, the facility will work with a staffing agency, have employees from other branches assist, or offer bonuses for caregivers. Mr. Fugate reported management will also work the floor, if needed.

On 12/29/21, I interviewed caregiver Courtney Engster at the facility. Ms. Engster reported she typically works first shift in the memory care unit. Ms. Engster reported there are four residents in the unit, and she is the sole caregiver. Ms. Engster reported it can be difficult to provide the required care to each resident but there is a floater caregiver that comes to assist her, when needed. Ms. Engster reported residents receive good care and there is significant staff when she works.

On 1/3/22, I interviewed caregiver Greshena Howlett by telephone. Ms. Howlett reported she typically works third shift. Ms. Howlett reported on third shift there are two caregivers in the building, with one in assisted living and one in memory care. Ms. Howlett reported if an issue arises in memory care, the caregiver will come to assist the unit. Ms. Howlett reported if an issue arises in assisted living, the caregiver cannot leave the secure memory care unit to assist. Ms. Howlett reported if there was an emergency in the facility, there would not be significant staff for the residents.

On 1/3/22, I interviewed caregiver Emily Rodriguez by telephone. Ms. Rodriguez reported she typically works first shift but will pick up additional shifts. Ms. Rodriguez reported on first shift there are three caregivers with one assigned to each unit and a caregiver that floats between the units. Ms. Rodriguez reported on third shift there are typically two caregivers with one caregiver in each unit. Ms. Rodriguez reported the memory care caregiver cannot leave their unit.

On 1/5/22, I interviewed caregiver Martin Rangel by telephone. Mr. Rangel reported he typically works third shift at the facility. Mr. Rangel reported on third shift there are to be three caregivers but at times there are only two caregivers. Mr. Rangel reported there is one caregiver in assisted living and one caregiver in memory care. Mr. Rangel reported the assisted living caregiver can leave the unit to check on the memory care, but memory care caregiver cannot leave the residents unattended.

Mr. Rangel reported if there was an emergency, such as a fall, there would be insufficient staff on duty.

I reviewed the staff schedule for 12/12-1/29. The schedule revealed there were only two caregivers that worked second shift on 12/26 and 12/27. The schedule revealed there were only two caregivers that worked third shift on 12/12, 12/14-12/23, and 12/26-12/27.

Mr. Fugate reported for second shift on 12/26, a caregiver was sent home early due to exhibiting Covid-19 symptoms. Mr. Fugate reported on second shift on 12/27 the facility nurse assisted with care. Mr. Fugate reported on third shift there are to be three caregivers but the facility has been working short.

I reviewed memory care Resident C's service plan. The service plan revealed Resident C was a two person assist.

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<b>(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.</b>
<b>ANALYSIS:</b>	Review of staff schedule revealed the facility was not staffed appropriately to their staffing ratios by having only two caregivers present on 12/12, 12/14-12/23, and 12/26-12/27 for third shift. Interviews with caregivers revealed having only two caregivers for the facility results in potential harm to the residents due to the lack of available staff.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 1/26/22, I conducted an exit conference with authorized representative Justin Stein by telephone.

**IV. RECOMMENDATION**

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

*Kimberly Horst*

1/7/22

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Kimberly Horst  
Licensing Staff

Date

Approved By:

*Andrea L. Moore*

01/21/2022

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Andrea L. Moore, Manager  
Long-Term-Care State Licensing Section

Date