GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 3, 2022

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

RE: License #:	AH130278262
Investigation #:	2022A1021042
	Battle Creek Bickford Cottage

Dear Mr. Johnson:

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 #:	2022A1021042
Complaint Receipt Date:	04/08/2022
Investigation Initiation Date:	04/08/2022
Report Due Date:	06/08/2022
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:	Nicholas Fugate
Authorized Representative:	Jeremiah Johnson
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:	10/15/2021
Expiration Date:	10/14/2022
Capacity:	55
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident F suffered injuries at the facility.	No
Additional Findings	Yes

III. METHODOLOGY

04/08/2022	Special Investigation Intake 2022A1021042
04/08/2022	Special Investigation Initiated - Letter allegations sent to centralized intake at APS
04/11/2022	Inspection Completed On-site
04/20/2022	Contact-Telephone call made Interviewed SP1
04/20/2022	Contact-Telephone call made Interviewed SP2
05/03/2022	Exit Conference

ALLEGATION:

Resident F suffered injuries at the facility.

INVESTIGATION:

On 4/8/22, the licensing unit received an intake with allegations Resident F suffered injuries at the facility. The complainant alleged Resident F was brought to the hospital with unexplained bruising. The complainant alleged the facility reported Resident F fell, but the bruising is not consistent with a fall.

On 4/11/22, I interviewed nursing coordinator Ashlee Rivera at the facility. Ms. Rivera reported one week prior to this incident occurring, the facility observed a bruise on Resident F's right side. Ms. Rivera reported the facility notified hospice and hospice advised the facility to monitor. Ms. Rivera reported the bruise started to spread down Resident F's body. Ms. Rivera reported a few days later, she received a telephone call from a third shift caregiver reporting additional bruising down the left side of Resident F's body. Ms. Rivera reported the facility contacted hospice and hospice advised the facility to monitor the bruising. Ms. Rivera reported the following

morning, the hospice company came out to evaluate Resident F and sent Resident F to the hospital for a trauma assessment due to the amount of bruising. Ms. Rivera reported the hospital completed testing and no broken bones or internal injuries were found. Ms. Rivera reported the hospital discontinued Resident F's Aspirin and Plavix medication because they believed it could be the cause of the bruising. Ms. Rivera reported the facility started an internal investigation and no abuse or neglect has been reported. Ms. Rivera reported at times Resident F does slide down in her wheelchair and requires re-positioning and this could have caused some bruising. Ms. Rivera reported Resident F is now a Hoyer lift transfer. Ms. Rivera reported there has been no reports of a fall with Resident F. Ms. Rivera reported no other residents have unexplained bruising. Ms. Rivera reported due to Resident F's cognitive status, she is unable to provide any details. Ms. Rivera reported Resident F has been at baseline and has not acted scared to be with any caregivers. Ms. Rivera reported Resident F is very pleasant and is receptive to care. Ms. Rivera reported she has no concerns about staff and their interactions with Resident F. Ms. Rivera reported hospice does believe the bruising could be contributed to medications. Ms. Rivera reported she has no concerns with the care Resident F receives at the facility.

On 4/11/22, I interviewed administrator Nicholas Fugate at the facility. Mr. Fugate's statements were consistent with those made by Ms. Rivera.

On 4/11/22, I observed Resident F at the facility. I observed Resident F to have bruising on the right and left side of her body. The bruises appeared to be healing and were not recent bruises. I did not observe any fingerprint bruises that would be the result of someone grabbing Resident F.

On 4/13/22, I interviewed Centrica Care Navigator home hospice nurse Lisa Gilman by telephone. Ms. Gilman reported her agency received a telephone call from the facility on 4/6 requesting a nurse visit due to bruising on Resident F. Ms. Gilman reported there was no known origin for the bruising. Ms. Gilman reported on 4/7, Resident F was sent out to the hospital for an assessment due to the amount of bruising. Ms. Gilman reported the hospital recommended discontinuing Aspirin and Plavix due to the amount of bruising and these medications have been discontinued. Ms. Gilman reported she has never had any concerns with the care Resident F receives nor any caregivers at the facility. Ms. Gilman reported she does believe Resident F receives good care at the facility.

On 4/20/22, I interviewed staff person 1 (SP1) by telephone. SP1 reported a few days prior to Resident F's hospital visit, she observed a small bruise on Resident F. SP1 reported on 4/6, she provided care to Resident F on the second shift. SP1 reported Resident F spent most the day in bed. SP1 reported around 4:30-5:00pm she got Resident F up to her wheelchair for the dinner meal. SP1 reported while she was getting Resident F ready for bed, she observed significant bruising. SP1 reported she contacted Ms. Rivera who advised for her to contact the hospice company. SP1 reported she contacted the hospice company who was advised by

the physician to monitor Resident F. SP1 reported the following day Resident F was sent to the hospital. SP1 reported Resident F did not fall on her shift and she did not receive any shift report of Resident F falling. SP1 reported she does not believe the bruising is from a caregiver or an employee.

On 4/20/22, I interviewed SP2 by telephone. SP2 statements were consistent with those made by SP1.

I reviewed written staff statement by SP3. The statement read,

> *"On Thursday March 31st. I was working with (SP4) getting (Resident F) up for the day we noticed bruising on her side. SP4 notified the nurse. On Friday when hospice came for her shower they called (SP4) in to see something. (SP4) told me it looked bad but I didn't go in and see for myself. Over the weekend I noticed bruising. It was worse on her side arm. On the 7th 3rd shift stressed how bad it was. So I went in to check her out that is when I noticed. Chest side breast left shoulder/neck dark bruising. We informed Nick. Called hospice they came in and checked her out and sent her out."*

I reviewed progress notes for Resident F. The progress notes read,

> *"4/7/22: Notified overnight by CNA that resident had bruising to left side of chest and towards neck. No falls or injuries were noted, and staff could not account for the bruising. Hospice notified and came for PRN visit. Hospice physician instructed to continue monitoring and not sent to ER at that time.*
> *4/7/22: Notified by hospice that resident would be sent to ED for trauma evaluation. Resident sent to BBC ED.*
> *4/7/22: Resident returned to Bickford via EMS.*
> *4/8/22: Resident observed in bed stated she is not in pain. No other complaints at this time. Hospice will be coming today to see. Family coming for care conference as well."*

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 R 325.1901	**Definitions.**

	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Interviews conducted and documents reviewed revealed Resident F did have unexplained bruising at the facility. However, there is lack of evidence to support the allegation Resident F was abused at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Rivera and Mr. Fugate reported there was no incident report completed for Resident F's emergency room visit.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**

ANALYSIS:	Resident F was treated in the emergency room on 4/7/22 due to unexplained bruising. An incident or accident that results in a sudden adverse change in a resident's condition requiring treatment in a hospital emergency room is reportable event that is to be reported to the licensing department, authorized representative, and physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/3/22, I conducted an exit conference with authorized representative Jeremiah Johnson by telephone. Mr. Johnson 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.

Kimberly Horst 4/21/22

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 05/02/2022

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