GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 7, 2022

Jeremiah Johnson
Lansing Bickford Cottage
3830 Okemos Road
Okemos, MI 48864

RE: License #: AH330278347
Investigation #: 2022A1021052
Lansing 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 #:	AH330278347
Investigation #:	2022A1021052
Complaint Receipt Date:	08/22/2022
Investigation Initiation Date:	08/22/2022
Report Due Date:	10/21/2022
Licensee Name:	Lansing Bickford Cottage L.L.C.
Licensee Address:	13795 S. Murlen Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	A'Lynne Dukes
Authorized Representative:	Jeremiah Johnson
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:	08/24/2022
Expiration Date:	08/23/2023
Capacity:	55
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from facility.	Yes
Facility has insufficient staff.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/22/2022	Special Investigation Intake 2022A1021052
08/22/2022	Special Investigation Initiated - Letter referral sent to APS
08/23/2022	Contact-Telephone call made Interviewed complainant
08/25/2022	Inspection Completed On-site
08/30/2022	Inspection Completed On-Site
09/07/2022	Exit conference Exit conference with authorized representative

ALLEGATION:

Resident A eloped from the facility.

INVESTIGATION:

On 8/22/22, the licensing department received a complaint with allegations Resident A continues to elope from the facility.

On 8/23/22, I interviewed the complainant by telephone. The complainant alleged Resident A continues to attempt to exit the facility.

On 8/25/2022, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident A does not want to reside at the facility and therefore continues to try to leave. SP1 reported Resident A will try to leave the facility every day and there is not sufficient staff at the facility to stop Resident A from leaving. SP1 reported once Resident A was able to exit the facility because a family member let him out. SP1

reported another time Resident A exited the building and the door alarm was activated. SP1 reported the medication technician on duty responded to the door alarm but could not reach Resident A before he exited the building. SP1 reported Resident A tries to leave daily and approximately 50% of the time a caregiver can reach him before he tries to leave. SP1 reported Resident A does have a wander guard placed on him so that caregivers are alerted to their pager and walkie-talkie when he does exit. SP1 reported Resident A's room is by an exit door which makes it easier for Resident A to exit. SP1 reported Resident A does need a 1:1 but there is not enough staff to provide this level of care.

On 8/25/2022, I interviewed SP2 at the building. SP2 reported Resident A tries to leave the building daily. SP2 reported she has caught Resident leaving the facility three times. SP2 reported Resident A has a wander guard placed on the back of his neck brace because he has a history of taking off the wander guard. SP2 reported when Resident A attempts to leave, caregivers are alerted on their pager, but the caregiver cannot respond in time because they are providing care to other residents. SP2 reported Resident A was to have a 1:1 caregiver but there is lack of staff to provide this care to Resident A.

At the facility I observed Resident A's room. Resident A's room was at the back of the facility and was not within eyesight of caregiver workstations. Resident A's room was located next to an alarmed exit door.

I reviewed the service plan for Resident A. The service plan read,

> *"(Resident A) has been wandering and exit seeking. (Resident A) wants to go and get more chewing tobacco. BFM's to take (Resident A) and show him where the chewing tobacco is in his apartment. (Resident A) is difficult to redirect and will get angry. BFM's to then leave him and keep eyes on him so he can calm down. Wander guard to be placed on the resident. (Resident A) does have a history of cutting his watch off when placed on. (Resident A) likes to watch TV in his apartment. BFM to walk with (Resident A) around the branch and take him through the courtyard and sit outside with him when he wants to go out the exit doors. If these interventions do not work BFM's to call Director/RNC for further direction."*

I reviewed incident reports for Resident A. The narrative of the incident report read.

> *"8/14/22: Med passer reported that she heard the front door alarm going off and asked a family member if someone had left or come in and was informed that a man, who didn't look like a resident, was waiting to be let out. She went to the resident's room a little bit later, but the resident was not in his room. The Med Passer did a search outside and found resident walking down the sidewalk on Okemos Rd. Family will provide the Director with a jar of organic chewing snuff to prevent him from attempting to walk to the store when he believes he is out,*

Wander Guard has been affixed to the resident's ankle and staff is on alert to keep eyes on him when is he out of his room.

8/16: A staff member was driving back to the branch and saw the resident walking down the sidewalk, heading south on Okemos Rd. Resident stated he was heading to the store to buy some chewing tobacco. Staff Member drove him back to the branch. Resident has been assigned a one-on-one staff member during wake hours."

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.**
	(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:	Resident A was known to voice the desire to leave the community and had history of leaving the facility. Resident A eloped from the facility on 8/14 and 8/16. Following the elopement on 8/16, the facility was to implement one-to-one supervision. Interviews with caregivers and review of Resident A's service plan revealed this was not implemented. Due to this insufficiently developed service plan and staff oversight, Resident A continues to exit seek and leave the facility. The facility lacks an organized program of supervision and reasonable protective measures to keep Resident A safe.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility has insufficient staff.

INVESTIGATION:

The complainant alleged there is insufficient staff at the facility. The complainant alleged on 8/21 on first shift, there was one medication technician and the activities director at the facility.

On 8/25/22, I interviewed SP3 at the facility. SP3 reported there is lack of staff at the facility. SP3 reported she typically works in the secure memory care unit located at the back of the facility. SP3 reported there are six residents with advanced cognitive deficits. SP3 reported there are four residents that require two person assist, six residents that require assistance with dressing and bathing, six residents that require assistance with toileting, and five residents that require continued supervision. SP3 reported there should be two caregivers in the unit but at times on the weekends there are no staff present in the unit. SP3 reported the facility implemented a new schedule system, BookJane. SP3 reported with the new schedule system, there has been no mandation in place and insufficient staff scheduled. SP3 reported in the memory care unit, they are responsible for answering the branch telephone and addressing concerns in the assisted living unit which results in the caregiver leaving the unit and the residents are unattended. SP3 reported in the assisted living unit, the caregivers are responsible for kitchen duties, such as setting up the dining tables and washing dishes, because there is lack of kitchen staff to complete tasks.

SP1 reported there is lack of staff in the facility. SP1 reported in assisted living there are 38 residents. SP1 reported there are four residents that are a two person assist, two residents on oxygen, three residents with behavior difficulties, and one resident that has frequent falls. SP1 reported residents do not receive showers and medications on time due to the lack of staff in the building.

SP2 reported on first shift there are to be at least five caregivers scheduled. SP2 reported at times she has worked with only one caregiver on first shift. SP2 reported when there is lack of staff the caregivers are to contact the administrator to find replacement staff. SP2 reported when the schedule is developed, there are open shifts, and the facility does not try to fill the open shifts. SP2 reported care staff are responsible for resident care and dietary tasks. SP2 reported caregivers are to use walkie talkies to communicate between each other but at times the walkie talkies do not work or there are not enough for each caregiver to have one.

On 8/25/22, I interviewed Relative B1 at the facility. Relative B1 reported there is lack of staff at the facility. Relative B1 reported on 8/20, he came to the facility in the morning and there were no caregivers present in the memory care unit. Relative B1 reported Resident B was still in bed, covered in urine, and medications had not been administered. Resident B reported care staff at the facility reported there was only one caregiver for the entire facility.

On 8/25/22, I interviewed The Care Team nurse Amber Hester at the facility. Ms. Hester reported she has observed lack of staff at the facility. Ms. Hester reported it is

very chaotic at the facility due to lack of staff and management. Ms. Hester reported she has observed rooms to be very unclean and residents to be left soaked in urine. Ms. Hester reported she has observed caregivers reporting they are providing medications late.

On 8/30/22, I interviewed authorized representative Jeremiah Johnson at the facility. Mr. Johnson reported on 8/20 it was reported to him that there was a staffing shortage at the facility. Mr. Johnson reported he spoke with Bickford of W Lansing and a caregiver came from that facility on first shift to provide care. Mr. Johnson reported the administrator A'Lynne Dukes was also called into the building at 4:30am for assistance. Mr. Johnson reported when the facility implemented the new scheduling system, it was not implemented properly. Mr. Johnson reported he is now responsible for the staff schedule and staffing levels. Mr. Johnson reported the facility should have one medication technician with five caregivers on first and second shift. Mr. Johnson reported there should be one medication technician and two caregivers on third shift. Mr. Johnson reported in the memory care unit, there are to be two caregivers on first and second shift and one caregiver on third shift. Mr. Johnson reported the facility is now utilizing agency staff to fill staff shortages.

I reviewed detailed hour report for 8/21 and 8/22. The report revealed on 8/21 there was one medication technician for first shift, one medication technician and one caregiver for second and third shift. On 8/22, there was two medication technicians and one caregiver for first and second shift and two caregivers on third shift.

I observed the facility. The facility is licensed for 55 occupants and currently has 44 residents. The assisted living unit is at the front of the building and is a circle of rooms with the main living areas in the middle. The secure memory care unit is located at the back of the building.

I reviewed the service plans for the six residents in the memory care unit. The service plans revealed there is one resident that is a two person assist with transfers, five residents require assistance with dressing, three residents require assistance with toileting, three residents have a wander guard, one resident that requires total assist with feeding, two residents on frequent checks, two residents that require staff redirection, and one resident that requires a 1:1 as needed.

I reviewed four resident service plans for assisted living. The service plans revealed there is one resident that is exit seeking, 2 residents with a wanderguard, one resident that is incontinent, one resident that is a two person assist, and one resident that requires staff to manage behaviors.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(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.
ANALYSIS:	Interview with authorized representative revealed the facility is to have six employees on first and second shift and three employees on third shift. Review of staff schedule revealed on 8/20 and 8/21 these staff ratios were not met. Review of service plans for residents revealed there are multiple residents that are a two person assist, require assistance with dressing, and are an elopement risk. The residents are at potential risk of harm or injury because there is not enough staff available to safely meet the resident's needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident C's service plan revealed it was last updated on 2/3/2021.

Interviews with caregivers revealed Resident D and Resident E has a WanderGuard. Review of service plans revealed the use of the WanderGuard system was not in the resident service plans.

Interviews with caregivers revealed Resident F was recently sent out to the hospital for a psychiatric evaluation because Resident F was making suicidal statements. Review of Resident F's service plan revealed lack of detail on how staff are to manage these behaviors.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of multiple resident service plans revealed the service plans are not updated annually and lack detail pertaining to the specific care needs of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 8/25/2022, during my inspection of the facility, the medication room on the main hallway was discovered unlocked and unattended.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
ANALYSIS:	The medication room was found unlocked and unattended on the main hallway with no care staff present and easily accessible to anyone.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/7/22, I conducted an exit conference with authorized representative Jeremiah Johnson by telephone. Mr. Johnson reported management is actively involved in the facility and the facility is now able to meet their staffing ratios. Mr. Johnson reported the facility has corporate nurses updating service plans this week.

IV. RECOMMENDATION

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

Kimberly Horst 8/31/22

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 09/07/2022

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