GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 28, 2022

Jeremiah Johnson
Bickford of Canton
5969 N Canton Center Rd
Canton, MI 48187

RE: License #: AH820395445
Investigation #: 2023A1027017
Bickford of Canton

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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820395445
Investigation #:	2023A1027017
Complaint Receipt Date:	11/17/2022
Investigation Initiation Date:	11/18/2022
Report Due Date:	01/17/2023
Licensee Name:	Bickford of Canton, LLC
Licensee Address:	Suite 301 13795 S Mur-Len Rd. Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Chanda Pantano
Authorized Representative:	Jeremiah Johnson
Name of Facility:	Bickford of Canton
Facility Address:	5969 N Canton Center Rd Canton, MI 48187
Facility Telephone #:	(734) 656-5580
Original Issuance Date:	04/02/2020
License Status:	REGULAR
Effective Date:	10/02/2022
Expiration Date:	10/01/2023
Capacity:	78
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A lacked emergency medical care.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/17/2022	Special Investigation Intake 2023A102701
11/18/2022	Special Investigation Initiated - Letter Email sent to administrator Denell Bruyere and AR Jeremiah Johnson requesting documentation pertaining to Resident A including a face sheet, service plan, IR, Sept 2022 nurse notes, contact information for staff working on 9/17/2022
11/18/2022	Contact - Document Sent Email sent to the complainant informing him the allegations were received and would be investigated.
12/20/2022	Inspection Completed On-site
12/23/2022	Contact - Document Received Email from Ms. Pantano with requested documentation received
12/29/2022	Contact - Document Sent Email sent to Ms. Pantano requesting additional documentation
12/30/2022	Contact – Document Received Email from Ms. Pantano with requested documentation received
01/03/2023	Inspection Completed – BCAL Sub. Compliance
01/26/2023	Exit Conference Conducted with authorized representative Mr. Johnson by voicemail

ALLEGATION:

Resident A lacked emergency medical care.

INVESTIGATION:

On 11/17/2022, the department received a complaint through the online complaint system. The complaint read the complainant received a telephone call from Resident A on 9/17/2022 stating she could not move her legs. The complaint read the complainant visited the facility later that morning in which Resident A complained of hip pain and had visible bruising on her face. The complaint read Resident A stated to facility staff that she did not fall. The complaint read Resident A had a diagnosis of Alzheimer's Dementia and walked with minimal assistance prior. The complaint read Resident A required a wheelchair for transportation to the hospital in which she admitted for a *pubic synthesis fracture*.

On 12/20/2022, I conducted an on-site inspection at the facility. I interviewed the newly appointed administrator Chanda Pantano who stated staff reported Resident A no longer resided at the facility and had discharged after her transfer to the hospital. Ms. Pantano stated records revealed Resident A had resided in the assisted living side of the facility.

While on-site, Ms. Pantano reviewed the staff schedule for 9/17/2022 which read Employee #1 was the second shift supervisor and Employee #2 was the medication technician on duty.

While on-site, I interviewed Employee #1 who stated it was reported to her Resident A had fallen on 9/17/2022.

On 12/22/2022, I conducted a telephone interview with Employee #2 who stated she worked dayshift on 9/17/2022. Employee #2 stated Resident A had pushed her call pendant and told the aide on duty that she wasn't feeling good, so the aide summoned Employee #2 for an assessment. Employee #2 stated she had observed Resident A was in pain and when she asked what happened, Resident A stated she did not fall. Employee #2 stated her, and the aide utilized a wheelchair to assist Resident A to the bathroom at that time. Employee #2 stated she sent a message to the on-call nurse who advised her to administer Resident A pain medications and monitor her. Employee #2 stated Relative A1 arrived at the facility in which Resident A had informed him that she fell, and he transported her to the hospital.

I reviewed Resident A's face sheet which read she admitted to the facility on 8/8/2022 and discharged on 9/30/2022. The face sheet read Relative A1 was Resident A's emergency contact.

I reviewed Resident A's service plan updated on 8/18/2022 which read in part she was independent with morning and night care, daily hygiene, grooming, transfers, and ambulation. The plan read in part Resident A did not want night checks and would call if she needed assistance. The plan read in part Resident A's medications were to be administered by staff. The plan read Resident A had forgetfulness in

which she needed daily reminding.

I reviewed Resident A's Medication Administration Records (MARs) for August and September 2022 which read she was prescribed the following medications: Amlodipine, Atorvastatin, Donepezil, Losartan, and Metoprolol.

I reviewed Resident A's nurse note dated 8/15/2022 which read in part Resident A was alert and orientated to person and place with short term memory loss. The note read Resident A was independent with care and would need reminders for showers, as well as meals.

I reviewed the Resident A's incident report dated 9/17/2022 13:00 [1:00 PM] completed by Employee #2 which read in part Resident A had complained of pain in her groin area to the medication technician around 6:30 AM. The report read in part Resident A denied falling when asked. The report read in part the medication technician notified the nurse that morning of the pain. The report read in part Resident was independent with transfers and mobility prior to complaints of pain. The report read in part the medication technician advised Resident A could bear weight and ambulate. The report read in part the nurse instructed the medication technician to monitor Resident A and give her Tylenol. The report read in part Resident A's physician was notified by fax on 9/20/2022.

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: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	Review of Resident A's medical records revealed she was independent with activities of daily however required reminders due to forgetfulness. Review of Resident A's service plan and MARs revealed she did not have a history of pain nor was she prescribed pain medications. Review of the incident report revealed Resident A reported pain in which was inconsistent with her plan and MARs and no action was taken. Based on this information, this violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's August MARs revealed the following dates were left blank for one or more doses of medication: 8/16/2022, 8/17/2022, and 8/18/2022.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Review of Resident A's service plan revealed staff were responsible for her medication administration. Review of Resident A's MARs revealed there were dates left blank in which it could not be determined if her medications were administered or not, thus there was violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Jessica Rogers 01/03/2023

Jessica Rogers Date
Licensing Staff

Approved By:

Andrea L. Moore 01/25/2023

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