GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 18, 2023

Jeremiah Johnson
Saginaw Bickford Cottage
5275 Mackinaw Rd.
Saginaw, MI 48603

RE: License #: AH730279101
Investigation #: 2023A1027022
Saginaw 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by the authorized representative and dated.

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.

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 #:	AH730279101
Investigation #:	2023A1027022
Complaint Receipt Date:	12/07/2022
Investigation Initiation Date:	12/08/2022
Report Due Date:	02/06/2023
Licensee Name:	Saginaw Bickford Cottage, LLC
Licensee Address:	13795 S. Mur Len Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Suenae Blankenship
Authorized Representative:	Jeremiah Johnson
Name of Facility:	Saginaw Bickford Cottage
Facility Address:	5275 Mackinaw Rd. Saginaw, MI 48603
Facility Telephone #:	(989) 799-9600
Original Issuance Date:	02/08/2007
License Status:	REGULAR
Effective Date:	03/24/2022
Expiration Date:	03/23/2023
Capacity:	55
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was neglected.	No
The facility lacked kitchen staff.	No
Additional Findings	Yes

III. METHODOLOGY

12/07/2022	Special Investigation Intake 2023A1027022
12/08/2022	Special Investigation Initiated - Letter Email sent to administrator Ms. Blankenship and AR Mr. Johnson requesting a resident census and employee list including their name, title and phone number
01/12/2023	Inspection Completed On-site
01/12/2023	Contact - Document Received Employee #1 orientation training records received by email
01/18/2023	Inspection Completed – BCAL Sub. Compliance
02/02/2023	Exit Conference Conducted by voicemail with authorized representative Jeremiah Johnson

ALLEGATION:

Resident A was neglected.

INVESTIGATION:

The department received a complaint through the online complaint system forwarded from Adult Protective Services (APS) which read Resident A was neglected. The complaint read Resident A was paralyzed on the left side of her body. The complaint read Resident A was dropped on her wheelchair bars on an unknown date in which resulted in bruising on her left arm, and it was believed Employee #1 was involved. APS did not open an investigation pertaining to the allegations and their referral source was unknown.

On 1/12/2023, I conducted an on-site inspection at the facility. I interviewed administrator SueNae Blankenship who stated over one month prior a staff member assisted Resident A from her wheelchair to a chair in which her arm was caught. Ms. Blankenship stated Resident A had a skin tear on her arm. Ms. Blankenship stated she interviewed Employee #1 whose statements were consistent with her interview with Resident A regarding how she received the skin tear.

While on-site, I interviewed Employee #2 who stated Resident A had history of a stroke in which she had right sided weakness and transferred with a one person assist. Employee #2 stated there was not an incident report nor a progress note completed for Resident A's injury and bruising, however she had recently conducted in-services for staff regarding documentation.

While on-site, I interviewed Resident A who stated her right side was flaccid, however she could stand to pivot from her wheelchair. Resident A stated she was never "dropped" on her wheelchair bars. Resident A stated staff had assisted her in a transfer from the chair to her wheelchair in which she received a scratch and some bruises. Resident A stated could not remember which staff member specifically and thought it may have been the staff member's fingernail that caused the scratch on her right upper arm. Resident A stated she bruised easily. Resident A stated she had no concerns regarding that incident. Resident A stated the care was good at the facility and she was not harmed by staff. I observed Resident A's upper right arm which had standard size bandage covering an area and just below the bandage, was a half dollar sized yellowish-purple bruise. I observed Resident A's lower right and left arms, as well as her bilateral hands, in which there were also small bruises observed on each.

I reviewed Employee #1's file which read he was hired 1/20/2021. The records read Employee #1 electronically signed on 1/20/2021 receiving the Employee Handbook which included but was not limited to safety and work-related injuries and reporting resident abuse, neglect, or exploitation. The records read personal care training was completed 2/16/2021. The records read a Workforce Background Check was dated 3/16/2021.

I reviewed Resident A's face sheet which read she moved into the facility on 10/18/2022.

I reviewed Resident A's service plan updated on 12/21/2022 which read consistent with statements from Employee #2.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Review of Resident A's records revealed she had a history of a stroke with right sided weakness in which she required one person assist for personal care and transfers. Interviews with Resident A and staff, as well as observations, revealed an incident had occurred in which Resident A was injured however the details and staff involved were not documented. Although, it could not be determined if Employee #1 was involved with Resident A's incident or not, review of his files revealed no disciplinary actions involving Resident A nor other resident harm or abuse. Thus, there was insufficient evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility lacked kitchen staff.

INVESTIGATION:

The department received a complaint through the online complaint system forwarded from Adult Protective Services (APS) which read the facility lacked kitchen staff and the caregivers were making the resident's food. APS did not open an investigation pertaining to the allegations and their referral source was unknown.

On 1/12/2023, I conducted an on-site inspection at the facility. I interviewed administrator Ms. Blankenship who stated approximately one month ago the facility's kitchen's cooks left their positions. Ms. Blankenship stated herself and two other staff, Employee #3 and #4, worked in the kitchen during the timeframe in which new kitchen staff were being hired and trained. Ms. Blankenship stated Employees #3 and #4 were trained in other positions within the facility as well as the kitchen, however their other positions were not resident caregivers. Ms. Blankenship stated the corporate chef trained the facility's new chef who had been employed with the facility for approximately three weeks. Ms. Blankenship stated the kitchen was fully staffed now in which there was four cooks currently employed and completing their training. Ms. Blankenship stated residents received three meals per day consistently throughout the timeframe of their new cook's training and their menu items

continued to be made from scratch in which the recipes were provided by their corporate chef.

While on-site, I interviewed Employee #5 who stated he had worked at the facility for approximately three weeks and had observed only staff designated to kitchen work in there with him. Employee #5 stated he had not observed resident caregivers in the kitchen.

While on-site, I interviewed Employee #6 whose statements were consistent with Employee #5.

While on-site, I interviewed Resident A who stated she received three meals per day. Resident A stated she observed the staff assigned in the kitchen were not the staff same who provided her care.

While on-site, I observed the lunch food served which appeared appetizing and was consistent with menu posted.

I reviewed the facility's employee list which read consistent with statements from Ms. Blankenship.

I reviewed Employees #3 and #4 timesheets dated 11/20/2022 through 12/31/2022 which read they worked two positions within the facility. The timesheets read each employee worked one of their assigned positions each shift.

I reviewed the December 2022 kitchen staff schedule which read consistent with statements from Ms. Blankenship, as well as Employee #3 and #4's timesheets.

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:	Review of the facility's kitchen staffing schedule and employee timesheets revealed staff who were assigned other positions within the facility also had worked in the kitchen. Furthermore, review of the staffing schedule and employee list revealed staff assigned to the kitchen were not also providing resident care. Based on this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Staff attestations revealed an incident involving Resident A had occurred in which resulted in a skin tear and/or scratch on her upper right arm as well as bruising.

The facility's handbook read in part:

Safety and Work Related Injuries

Any incident occurring on Bickford premises that has resulted or may result in harm to a BFM, resident, or guest must be reported using an Incident Report form. Incident Report forms are available in the outer office and Core Forms section on the Core website. It is vitally important that Incident Reports are completed promptly and accurately. Failure to do so will lead to disciplinary action. Completed reports will be submitted to the Director as soon as possible. Directors will track incidents and post the necessary information.

I reviewed Resident A's medical records which lacked documentation of an incident.

I reviewed an employee meeting dated 12/23/2022 which read the agenda included discussing incident reports and progress notes.

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.**

For Reference: R 325.1901	**Definitions.**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	Review of Resident A's medical records as well as the facility's incident reports lacked documentation of an incident with injuries. Facility staff did not follow their own policy nor this rule on reporting incidents, thus there was a violation established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Employee #1's files revealed he was hired on 1/20/2021 and a Michigan Workforce Background Check dated 3/16/2021 was completed which read he was eligible for hire.

APPLICABLE RULE	
MCL 333.20173a	**Covered facility; employees or applicants for employment; prohibitions; criminal history check; procedure; conditional employment; knowingly providing false information as misdemeanor; prohibited use or dissemination of criminal history information as misdemeanor; review by licensing or regulatory department; conditions of continued employment; failure to conduct criminal history checks as misdemeanor; establishment of automated fingerprint identification system database; electronic web-based system; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (5), a covered facility shall not employ, independently contract with, or grant privileges to an individual who regularly has direct access to or provides direct services to patients or residents in the covered facility until the covered facility or staffing agency has a criminal history check conducted in compliance with this section or has received criminal history record information in compliance with subsections (3) and (10).

ANALYSIS:	Review of Employee #1's Michigan Workforce Background Check revealed it was not incompliance with the Public Health Code by allowing Employee #1 to provide direct services to residents prior to March 16, 2021, when the background check was completed, thus there was a violation established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/18/2023

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Jessica Rogers Date
Licensing Staff

Approved By:

02/02/2023

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