GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 20, 2023

Krystyna Badoni
Bickford of Canton
5969 N Canton Center Rd
Canton, MI 48187

RE: License #: AH820395445
Investigation #: 2023A0784069
Bickford of Canton

Dear Krystyna Badoni:

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 responsible party and a date.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820395445
Investigation #:	2023A0784069
Complaint Receipt Date:	06/21/2023
Investigation Initiation Date:	06/22/2023
Report Due Date:	08/20/2023
Licensee Name:	Bickford of Canton, LLC
Licensee Address:	13795 S Mur-Len Rd. Suite 301 Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Jeffrey Bowen
Authorized Representative:	Krystyna Badoni
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?
The facility did not provide adequate protection and supervision for Resident's A and B	Yes
Additional Findings	Yes

III. METHODOLOGY

06/21/2023	Special Investigation Intake 2023A0784069
06/22/2023	Special Investigation Initiated - On Site
06/22/2023	Inspection Completed On-site
08/01/2023	Exit Conference - Telephone Conducted with authorized representative Krystyna Badoni

ALLEGATION:

The facility did not provide adequate protection and supervision for Resident's A and B

INVESTIGATION:

On 6/21/2023, the department received this complaint from adult protective services (APS) centralized intake. Information provided within the complaint indicated APS denied the allegations for investigation.

According to the complaint, on 6/18/2023, Resident A was assaulted by Resident B. Resident B was taken to the hospital for evaluation while Resident A was not. Resident B was released from the hospital is back at the facility in his room which is across the hall from Resident A. It is unknown if Resident B has previously assaulted Resident A. After the assault, Resident A exhibited a change in behavior in that she was not eating, was minimally responsive and had complainant of vagina and rectal pain.

On 6/22/2023, I interviewed divisional director of resident services Deanna Turner by speaker phone. Present in person was Gretchin Mager, an administrator for another Bickford facility helping at the facility. Ms. Turner stated the incident involving Resident A and Resident B happened in the assisted living (AL) area of the building as they had both been placed there at the time. Ms. Turner stated Resident B has

since been moved to the memory care. Ms. Turner stated that prior the incident, Resident B had been a known wanderer, but had not been known to be physically aggressive. Ms. Turner stated Resident A had been at the facility for approximately three weeks prior to the incident. Ms. Turner stated that the incident happened early on 6/18/2023. Ms. Turner stated Associate 1 had reported that a resident from the same hallway as Resident A had reported that Resident A was in her wheelchair, in the hallway, crying. Ms. Turner stated Associate 1 reportedly checked on Resident A who stated her back hurt and that Resident B had pulled her out of her bed, put her in her wheelchair and pushed her into the hallway. Ms. Turner stated Resident B reportedly locked himself in Resident A's room, apparently thinking it was his room. Ms. Turner stated Associate 1 retrieved Associate 2 and that together they reported eventually being able to get Resident B out of the room. Ms. Turner stated that in the immediate aftermath of the incident, both residents were placed in their rooms with Associate 2 staying with Resident A to help her get calm. Ms. Turner stated Resident A's hospice nurse was contacted and directed staff to allow for hospice to come to the facility to evaluate her. Ms. Turner stated hospice did evaluated Resident A that day and no bruising was reported, but that Resident A reported to hospice she was afraid and her back hurt. Ms. Turner stated Resident B was sent to the hospital for a psychological evaluation. Ms. Turner stated Resident B did return to the facility on the evening of 6/18/2023 and was placed in the same room across the hall from Resident A. Ms. Turner stated Resident B was given increased monitoring in that staff were expected to check on him every 15 minutes. Ms. Turner stated she did not believe staff maintained any documentation of these 15 minutes checks and could not confirm if they have been completed. Ms. Turner stated Resident B was ultimately placed in the memory care (MC). Ms. Turner stated she personally evaluated Resident A on the morning of 6/19/2023 and that Resident A's behavior appeared normal at that time. Ms. Turner stated Resident A had not reported any vaginal or rectal pain to that point. Ms. Turner stated hospice evaluated Resident A later in the day on 6/19/2023 and that Resident A reportedly had a change in behavior and reported she had pain in her groin and rectum. Ms. Turner stated hospice had Resident A prescribed medication for treating a urinary tract infection (UTI).

I reviewed the facilities incident reporting regarding the incident on 6/18/2023, provided by Ms. Turner, which read consistently with Ms. Turners statements.

I reviewed handwritten notes from Resident A's hospice nurse dated 6/19/2023, provided by Ms. Turner, which read consistently with Ms. Turners statements regarding the hospice nurse's assessment.

I reviewed written statements from Associates 1 and 2, provided by Ms. Turner, which read consistently with the statements provided by Ms. Turner regarding the events of 6/18/2023.

On 6/22/2023, I observed Resident A in her bedroom. Resident A was sleeping at the time of the onsite and appeared comfortable. Resident A's authorized representative, Relative A1 was in her room visiting during this time.

On 6/22/2023, I interviewed Relative A1 at the facility. Relative A1 stated she visits Resident A often throughout the week. Relative A1 stated that on several occasions, Resident B had wandered into Resident A's room stating that he thought it was his room. Relative A1 stated that after the incident, staff initially placed Resident B back in the room across the hall from Resident A "even though he had just assaulted her, and she was afraid". Relative A1 stated Resident B had not been back in Resident A's room since he was moved to the MC.

On 6/18/2023, I observed Resident B actively wandering within the MC. He appeared to be calm at that time but was attempting to open each door as he passed by them.

On 6/22/2023, I interviewed Associate 3 at the facility who was working in the MC. Associate 3 stated Resident B consistently wanders in the MC and often attempts to enter other resident rooms as he does not appear to know the rooms are not his. Associate 3 stated Resident B gets aggressive with staff when staff attempt redirection. Associate 3 stated staff keep resident doors closed and locked so Resident B cannot enter their rooms. When asked if it was acceptable for all the residents to have to keep their doors closed, even if someone wanted it open, Associate 3 responded that it would not be possible to keep Resident B from entering other resident rooms under those circumstances as he attempts to do it so frequently. Associate 3 stated that staff would have to have staff with Resident B "almost constantly".

I reviewed Resident B's *H&P* (History and Physical Assessment), provided by Ms. Turner which she indicated was provided to the facility prior to his admission. The assessment was dated 5/12/2023 and completed at the *University of Michigan Health Geriatric Primary Care*. Within a summary section, the report read, in part, [Resident B] is a 86 y.o. male here with his wife and son. His cognition and behavior have declined in recent months he had C2 spinal fracture after a fall, recovered and then fell again. He was also found to have a spinal tumor, no treatment indicated. He has had at least 5 falls in last 6 months. He refuses to use a cane or walker. [Resident B and his wife] came back from Florida in late March. He was able to use lawn mower recently. Still has back and neck discomfort. He also couldn't do much while in Florida, including minimal bike riding. He hasn't fully recovered from neck injury. He has some posterior right chest pain per his wife that comes and goes. He tends to get more confused when he first returns to Michigan from his winter in Florida. Wife also has a new cancer diagnosis herself and feels it is too hard to take care of his needs as well, especially when he gets physically aggressive. His wife started to drive them back to Michigan and he became violent, hitting wife on return home as she drove. He also hit her another time, but not as angry at home in general".

I reviewed Resident B's new resident *ADMISSION ORDERS*, completed by Resident B's physician, provided by Ms. Turner. The report, dated 5/12/2023, indicated Resident B's *Primary Diagnosis* was "DEMENTIA" with a *Secondary Diagnosis* of "FREQUENT FALLS".

I reviewed Resident B's *FALL RISK ASSESSMENT* dated 5/16/2023, provided by Ms. Turner. According to the scall provided on the assessment, a "score of 15 or Above" equals a "High Risk for falls". Resident B's noted score was 18.

I reviewed Resident *B's Pre-Move in/Move in* service plan, provided by Ms. Turner. Under a section titled *Mobility/Escort*, the plan read, in part, "[Resident B is independent with ambulation". Under a section titled *Health Care Coordination*, the plan read, "HWC [health and wellness coordinator] to confer with Fox therapy for PT/OT for balance/strength/and endurance. [Resident B] is a full code. [Resident B has a history of chronic pain/HTN/Parkinson's/hypothyroidism and safety unawareness". Under a section titled *Safety*, with a subtitle of Resident's *Fall Risk Assessment Score 15+*, the plan read "[Resident B's] balance is very wobbly RT his Parkinson. [Resident B] has fallen numerous times due to his impaired balance and refusal to use a ambulatory [device]. BFM [Bickford Family Member/Staff] to make sure [Resident B] has non-slip footwear on/the bathroom light is on during night. [Resident B] does wear a wonder guard due to his impulsivity. BFM to take [Resident B] for a walk. BFM to use regular voice tone with specific instructions as to what task he is refusing to do. BFM to check daily to make sure wonder guard is in place. BFM to play classical music, offer to do word search, put on news CNN or offer to do word search with [Resident B]. [Resident B] has had numerous falls in past 6 months. PT/OT will be ordered for evaluation and treatment". Under a section titled *Other*, the report included a handwritten note which read "Altercations/wandering. 15 min" indicating Resident B should be checked on every 15 minutes. Ms. Turner was asked about this note and reported this was added after the incident on 6/18/2023 as an additional measure for supervision.

I reviewed Resident B's updated Change of Condition service plan dated 6/20/2023, provided by Ms. Turner. Mr. Turner reported this service plan was adjusted after the incident on 6/18/2023. Review of the updated plan revealed all sections previously noted were the same except for the section titled *Safety*, with a subtitle of Resident's *Fall Risk Assessment Score 15+.* The updated plan under this section read "[Resident B's] balance is very wobbly RT his Parkinson. [Resident B] has fallen numerous times due to his impaired balance and refusal to use a ambulatory [device]. BFM to attempt redirect/and diversional activities due to his impulsiveness, unaware of safety and intermittent outburst of anger. BFM to make sure [Resident B] has nonslip footwear on/the bathroom light is on during night. [Resident B] does wear a wander guard due to his wandering and impulsivity. BFM to take [Resident B] for a walk. BFM to use regular voice tone with specific instructions as to what task he is refusing to do. BFM to check daily to make sure wander guard is in place. BFM to play classical music, offer to do word search, put on news CNN or offer to do word

search with [Resident B]. [Resident B has had numerous falls the past 6 months. [Resident B] has had some aggressiveness noted and wanders throughout the branch. BFM's to walk with [Resident B] around the branch, talk to him about his occupation, sit down and do a [word] search with him, talk about his golfing, classical music (play) to redirect the behavior. If these interventions do not work, call the HWD or ED for further instructions. BFM's to check on [Resident B] every 15 minutes to make sure he is not wandering in other resident apartments and keep busy with activities. Encourage him to come out and sit in family/dining area".

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:	According to the complaint, on 6/18/2023 Resident A was assaulted by Resident B. The investigation confirmed Resident B entered Resident A's room, thinking it was his room, place her in her wheelchair after pulling her out of bed an pushed her into the hallway while initially locking himself in her room before were eventually able to escort him out of the room. While Resident B was ultimately moved to the MC, as both Residents were AL residents at the time, Resident B was initially allowed to come back to his room across the hall from Resident A, after returning from the hospital the same evening where he had a psychological evaluation. While divisional director of resident services Deanna Turner reported she instructed staff to at least check on Resident B every 15 minutes as added supervision upon his return, the facility was unable to provide any documentation to show this added measure was ever completed. Given that Resident B was directly across the hall from Resident A, even if the facility could provide evidence that the 15 min checks were completed, it is not reasonable to assume Resident B, a known wanderer, would not be able to repeat the same behavior again within a 15-minute time period. It is also notable that while Ms. Turner reported Resident B was not known to be aggressive prior to this incident, his pre-move in medical assessment contradicted this statement indicating he had displayed aggression prior to moving in. Additionally, review of Resident B's pre-move in medical assessments and facility completed service plan revealed that not only was Resident B a known wanderer, but he was also assessed as a high fall risk person with low safety awareness. The service plan also noted Resident B as being "independent with ambulation" despite his fall risk, low safety awareness, propensity to wander and noted refusal to use an ambulatory device. During the investigation, Resident B was observed walking the halls, independently, attempting to open every resident door. When interviewed, Associate 3 reported Resident B does this so much that they keep all resident doors in the MC locked, regardless of if they want their doors locked, and that it was not possible for staff to provide the kind of constant supervision necessary as they would have to be with him almost all the time. Associate 3 also reported that when staff do try to re-direct him, he can become aggressive. Based on the findings, the facility is not in compliance with this rule as inadequate protection was provided for Resident A and other residents, due to the facility not having an adequate

	supervision plan for Resident B based on the information available to them. Additionally, the facility also provided an inadequate plan for Resident B's supervision as it pertains to his lack of safety awareness, propensity to wander, and high risk for falls.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

When interviewed, Ms. Mager stated that she was helping the facility out in the administrator position as Chanda Patano did not work there anymore. Ms. Mager stated a new administrator is supposed to be starting soon and that Ms. Patano had resigned on 5/10/2023.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; general provisions.**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.
ANALYSIS:	During the investigation, it was revealed that the facilities previous administrator had resigned on approximately 5/10/2023 and no new administrator had been appointed as of the date of the onsite, 6/22/2023. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable correction action plan, it is recommended that the status of the license remain unchanged.

8/01/2023

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Aaron Clum Date
Licensing Staff

Approved By:

08/17/2023

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