GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 30th, 2023

Krystyna Badoni
Bickford of W Lansing, LLC
13795 S Mur-Len Road
Olathe, KS 66062

RE: License #: AH230387590
Investigation #: 2024A1021002
Bickford of W Lansing

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 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

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 #:	AH230387590
Investigation #:	2024A1021002
Complaint Receipt Date:	10/05/2023
Investigation Initiation Date:	10/09/2023
Report Due Date:	12/04/2023
Licensee Name:	Bickford of W Lansing, LLC
Licensee Address:	Suite 301 13795 S Mur-Len Road Olathe, KS 66062
Licensee Telephone #:	Unknown
Administrator:	Fallon Williams
Authorized Representative:	Krystyna Badoni
Name of Facility:	Bickford of W Lansing
Facility Address:	6429 Earlington Ln Lansing, MI 48917
Facility Telephone #:	(517) 321-3391
Original Issuance Date:	06/09/2017
License Status:	REGULAR
Effective Date:	12/09/2022
Expiration Date:	12/08/2023
Capacity:	72
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Facility failed to provide Resident A with medications.	No
Additional Findings	Yes

III. METHODOLOGY

10/05/2023	Special Investigation Intake 2024A1021002
10/09/2023	Special Investigation Initiated - Telephone interviewed administrator
10/12/2023	Contact - Telephone call made interviewed regional nurse
10/16/2023	Contact - Document Received received Resident A's documents
10/18/2023	Contact - Telephone call made interviewed Pharmacist
11/30/2023	Exit Conference

ALLEGATION:

Facility failed to provide Resident A with medications.

INVESTIGATION:

On 10/05/2023, the Department received a complaint with allegations the facility failed to provide Resident A with medications. The complainant alleged that the facility pharmacy had a computer issue and Resident A's medications remained in discontinued status after Resident A returned to the facility from the hospital. The complainant alleged Resident A's family administered the medications, but Resident A is at health risk if Resident A does not receive the medications.

On 10/09/2023, I interviewed administrator Fallon Williams by telephone. Ms. Williams reported Resident A was in the hospital for approximately three days. Ms. Willaims reported when a resident is at the hospital for more than 24 hours, the resident is listed as "LOA" in the electronic medication administration record (EMAR). Ms. Williams reported the facility pharmacy, Serviam pharmacy, then

discontinues all medications. Ms. Williams reported when Resident A returned to the facility, a medication list was faxed to the pharmacy and all medications were active in the system. Ms. Williams reported on 09/15 in the morning, the facility was able to administer medications. Ms. Williams reported then the medication orders were not showing as active on the facility side and the facility was unable to administer medications. Ms. Williams reported Serviam pharmacy reported on their end the medications were active. Ms. Williams reported this occurred on a Friday and the pharmacy had limited resources to fix the issue. Ms. Williams reported Relative A1 came to the facility over the weekend to administer the medications. Ms. Williams reported staff members reported Relative A1 signed a medication log, but the facility can no longer locate the written medication log. Ms. Williams reported on 09/18, the pharmacy issue was resolved, the orders became active, and the facility was able to administer medications.

On 10/11/2023, I interviewed facility regional nurse Deanna Turner by telephone. Ms. Turner reported it is a Serviam pharmacy policy that medications are discontinued when a resident is in the hospital for more than 24 hours. Ms. Williams reported when Resident A returned to the facility on 09/15, Resident A's physician called in the medications to the pharmacy. Ms. Turner reported that for an unknown reason, the medications were still not listed as active. Ms. Turner reported Resident A's physician called in the medications again on 09/18 and the pharmacy issue was resolved. Ms. Turner reported if the family was not available to administer medications, the facility would have printed off a paper MAR to administer medications.

On 10/18/2023, I contacted Serviam pharmacy worker Denay Barber by telephone. Ms. Barber reported on 09/13, the pharmacy was notified Resident A was out of the facility. Ms. Barber reported on 09/14, the pharmacy received a discharge summary for Resident A. Ms. Barber reported on 09/14, the pharmacy received notice Resident A was back in the facility. Ms. Barber reported initially the medications were put on the EMAR and then was removed from the EMAR. Ms. Barber reported she could not confirm this was communicated to the facility. Ms. Barber reported on 09/15 the medication list received was dated 09/11 and the pharmacy needed an updated medication list to make the medications active. Ms. Barber reported a message was sent to the Branch that a new medication list was needed. Ms. Barber reported on 09/16 and 09/17, the facility contacted the pharmacy on-call worker, but the pharmacy has no documentation of those telephone calls. Ms. Barber reported on 09/18, Resident A's physician called in the medication orders and the issue was resolved. Ms. Barber reported it is a company policy to discontinue all medication orders when a resident is at the hospital for more than 24 hours.

I reviewed Resident A's medication administration record (MAR). The MAR revealed that Resident A was out of facility on 09/11-09/14. The MAR revealed morning medications on 09/15 were administered. Medications on 09/16-09/18 were not initialed of administrated. The MAR revealed most of the medication orders were written, discontinued, and then re-started.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Interviews conducted and review of documentation revealed upon Resident A's return to the facility there were problems getting medications re-started. With Relative A1's assistance, the facility ensured Resident A still received the required medications. While this error occurred, it was an isolated incident and not a systemic issue throughout the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

INVESTIGATION:

Review of Resident A's MAR revealed the medication technician did not initial the following medications were administered:

Atorvastatin Tab 80mg on 09/27
Donepezil Tab 10mg on 09/27.
Hydralazine Tab 10mg on 09/27 at 7:00pm.
Refresh tear drops on 09/27 at 7:00pm.
Systane Nighttime ointment on 09/27.

APPLICABLE RULE	
R 325.1932	**Resident Medications.**
	(3) Staff who supervise the administration of medication for residents who do not self administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the individual who administered the prescribed medication.**

ANALYSIS:	Review of Resident A's MAR for September 2023 revealed the facility failed to complete the medication log.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kimberly Horst 10/31/2023

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 11/30/2023

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