STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

May 28, 2024

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

RE: License #: AH820395445
Investigation #: 2024A0784046
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 #:	2024A0784046
Complaint Receipt Date:	04/12/2024
Investigation Initiation Date:	04/16/2024
Report Due Date:	06/11/2024
Licensee Name:	Bickford of Canton, LLC
Licensee Address:	13795 S Mur-Len Rd. Suite 301 Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Michelle Connell
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:	10/02/2023
Expiration Date:	10/01/2024
Capacity:	78
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Inadequate supervision of Resident A and provision of emergency medical care for Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/12/2024	Special Investigation Intake 2024A0784046
04/16/2024	Inspection Completed On-site
04/16/2024	Special Investigation Initiated - On Site
05/07/2024	Contact - Telephone call received Interview with Complainant
05/08/2024	Contact - Document Received Emails from Complainant with video footage from Resident A's room
05/28/2024	Exit - Email Report sent to authorized representative Krystyna Badoni

ALLEGATION:

Inadequate supervision of Resident A and provision of emergency medical care for Resident A.

INVESTIGATION:

On 4/12/2024, the department received this online complaint.

According to the complaint, on 3/14/2024, at approximately 8:30pm, family was visiting Resident A in her room and asked staff to put Resident A in bed as the family left the facility. Staff did not put Resident A in her bed or ensure that her walker was in front of her. Resident A proceeded to stand up from her wheelchair and fell in her room hitting her head. Resident A was observed, by camera located in Resident A’s room, yelling for help from her floor. Family called the facility several times for several minutes before reaching the facility to have staff go in and assist Resident A

at which time she was assisted to bed and left for the night. The next morning Resident A's physician evaluated her, and recommended Resident A be sent to the hospital due to a head injury sustained during her fall. Resident A was taken to St. Mary's hospital in Livonia for evaluation and discovered to have a brain bleed. Resident A passed away three days later.

On 4/16/2024, I interviewed administrator Sandy Randall at the facility. Ms. Randall stated she was only recently hired at the facility and was not present during the time of the incident. Ms. Randall stated Associate 1, the previous administrator, was here during that time. Ms. Randall stated authorized representative Krystyna Badoni was familiar with the incident.

On 4/16/2024, I interviewed authorized representative Krystyna Badoni by speaker phone from the facility. Ms. Randall was present during the interview. Ms. Badoni stated she interviewed associate 2, who was assigned to work with Resident A on the evening of 3/14/2024 and associate 3 who was the wellness director at the time of the incident, regarding the events surround the incident. Ms. Badoni stated associate 3 no longer works at the facility due to decisions made in relation to the incident with Resident A. Ms. Badoni stated that during her interview with associate 2, associate 2 reported the following: On the evening of 3/14/2024, Relative A1 had been visiting with Resident A. Prior to leaving that evening, Relative A1 asked associate 2 to put Resident A into bed. Associate 2 took Resident A to her bedroom, via her wheelchair. Resident A asked associate 2 to assist her to her reclining chair as she did not want to go to bed yet. Associate 2 assisted Resident A into her chair and turned-on Resident A's tv per request of Resident A and then left. Associate 2 returned to Resident A's room within approximately 15 minutes, as she had been asked by another staff to take ice to the room and associates 4 and 5 were already in the room with Resident A in bed. Associate 5 took the ice and applied it to Resident A's head and this was sometime after 7pm. Ms. Badoni stated the interview with associate 2 was conducted with associate 3 soon after the incident and prior to associate 3 being terminated. Ms. Badoni stated the interview questions and responses to those questions were documented. Ms. Badoni stated associates 4 and 5 went to check on Resident A after the facility received a call from Relative A1 asking for someone to conduct a well check. Ms. Badoni stated Resident A had a ring camera in her room, which she stated was known to the facility, and that he could hear Resident A yelling for help. Ms. Badoni stated Resident A did have a call pendent and knew how to use it, but that staff reported the call button was under her torso while she was on the floor and Resident A could not reach it. Ms. Badoni stated associate 3 was contacted by associate 5 and asked about having Resident A sent out to the hospital as she was unable to say whether or not she hit her head and was not presenting at baseline and was taking prescription blood thinners. Ms. Badoni stated associate 3 instructed staff not to have Resident A sent out. Ms. Badoni stated associate 3 should have contacted Resident A's physician upon being notified of the incident but did not do so until she arrived at the facility for work the next day at approximately 10am at which time Resident A's physician instructed staff to have Resident A sent to the hospital for examination. Ms. Badoni stated Resident

A was a known fall risk and that staff should have been aware that she needed her walker in front of her while in her chair as she was known to sometimes attempt to get up on her own even without her walker. Ms. Badoni stated that because the fall was unwitnessed while Resident A was on blood thinners, not at baseline and could not recall if she had hit her head, associate 3 should have automatically instructed staff to contact EMS. Ms. Badoni stated Resident A did have a camera in her room which would have most likely captured the circumstances described in the complaint and confirmed by staff interviews. Ms. Badoni stated the camera in Resident A's room was sanctioned in agreement with Resident A, Resident A's authorized representative and the facility. Ms. Badoni stated staff were aware of the camera and knew they were being recorded when they entered Resident A's room.

I reviewed Resident A's service plan, provided by Ms. Badoni. The plan read consistently with Ms. Badoni's statements regarding Resident A's safety noting that "[Resident A] is at high risk for falls".

I reviewed the documented interview with associate 2, provided by Ms. Badoni. The interview read consistently with statements provided by Ms. Badoni. Under the question *When did you last provide care for [Resident A] before her fall*, the response read "At 6:48pm, I took her to her room and put her in her chair. She was in the sitting room/TV room before that". Under the question *What prompted you to take her to her room at that time*, the response read "[Relative A1 asked me to take her to her room and put her to bed, but when I got there in her room, she said she didn't want to sleep anymore, she wanted to watch TV". Under the question *When did you see her next*, the response read "When I went back to the room, [associate 4 and 5] were already in her room. It was about 10-15 minutes after I had left her in her room in the recliner. I was in the kitchen doing dishes and [Gabby] told me to take some ice with me to [Resident A's room] because she had fallen".

I reviewed a *Disciplinary/Counseling Report* for associate 3, provided the Ms. Badoni. Under a section titled Details of issue/incident/statements of the problem/behavior: the report read "The resident sustained a fall on 3/14/24, which you were informed about minutes after the fall by the Medication Technician. The resident was observed on the floor face first with her head on the floor. The resident was unable to state if they hit their head and were on prescription blood thinners, however you failed to instruct the staff to send the resident to the hospital for evaluation. [Associate 3] you indicated you arrived at the branch on 3/15/24 by 10:00am however did not go down and observe or assess the resident. The resident's physician arrived to the branch around 10am and you let them know of the fall, they did an assessment and sent res out".

On 5/07/2024, I interviewed Complainant by telephone. Complainant stated that after Resident A fell on the evening of 3/14/2024, she laid on the floor for 45 minutes yelling out for help. Complainant stated this was observed and recorded by the camera in Resident A's room. Complainant stated upon observing Resident A laying on the ground, several calls were made to the facility before staff answered the

phone. Complainant stated staff were not aware that Resident A was on her floor yelling out for help until receiving the phone call and being notified and finally checking on her.

On 5/08/2024, I received an email from Complainant which included a timeline breakdown of the events of 3/14/2024 as interpreted from videos taken with the camera located in Resident A's bedroom. According to Complainant, associate 2 left Resident A's room at 7:55pm after putting her in her recliner with video showing that at 8:25, Resident A was no longer in view of the camera and was yelling for help. Complainant indicated that video footage showed a staff member was observed in the room at 8:43pm while another staff member arrived at 8:44pm.

I reviewed the video footage provided by Complainant. The video as described by Complainant regarding staff leaving Resident A's room at 7:55pm was consistent with Complainants statements. The video showing Resident A was no longer in view of the camera at 8:25pm, of which I could audibly hear Resident A yelling "Hey, Hey", was consistent with Complainants statements. On the video showing associates 4 and 5 coming into Resident A's room, I could not confirm the times of 8:43pm and 8:44pm as noted by Complainant. The time was difficult to read on the video, as, for me, it appeared to read "8:55pm" and "8:56" pm, respectively.

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.** **(c) Assure the availability of emergency medical care required by a resident.**

ANALYSIS:	The complaint alleged inadequate supervision of Resident A when was left in her recliner by staff without her walker in front of her and she fell on 3/14/2024. Statements from Ms. Badoni as well as video footage and documentation reviewed support a lack of adequate supervision was provided to Resident A leading to the fall on 3/14/2024. It should be noted that evidence also shows a discrepancy between the amount of time associate 2 reported returning to Resident A's room after having left and when staff came back to the room only after having been contacted at the facility by telephone with a request to check on Resident A. Additionally, Resident A was discovered to have hit her head when she fell. Ms. Badoni reported that because Resident A's fall was unwitnessed while Resident A could not recall if she hit her head, was not behaviorally baseline and was taking blood thinners, EMS should have been contacted to take her to the hospital for evaluation. Based on the findings, the facility is not in compliance with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

When interviewed, Ms. Badoni stated Resident A was supposed to have her walker placed in front of her when she was sitting in her chair as noted in the complaint. Ms. Badoni stated Resident A was a person who was a high risk for falls and had low safety awareness. Ms. Badoni stated Resident A would attempt to get up on her own and that she was able to use her walker to balance herself.

I reviewed Resident A's service plan, provided by Ms. Randall. Under a section titled Safety, the plan read, "[Resident A] is at high risk for falls. BFMs [Bickford Family Members/Staff] will encourage her to use her walker for ambulation and transfers and will encourage her to signal her call light for assistance when needed. Assist her to keep her frequently used items within reach, and to wear proper footwear". Ms. Badoni stated Associate 3 was responsible for updating service plans while she was working and that she did not update Resident A's service plan.

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:	The complaint indicated Resident A was supposed to have her walker placed in front of her when sitting in her chair in order to mitigate her potential for falling. When interviewed, Ms. Badoni confirmed this provision was necessary for Resident A. Although having Resident A's walker placed in front of her while she was sitting was a known need, this need was not identified in her service plan. Based on the findings the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan. It is recommended that the status of the license remain unchanged.

Aaron L. Clum 5/09/2024

Aaron Clum Date
Licensing Staff

Approved By:

Andrea L. Moore 05/28/2024

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