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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Krystyna Badoni
Saginaw Bickford Cottage
5275 Mackinaw Rd.
Saginaw, MI 48603

August 19, 2024

RE: License #: AH730279101
Investigation #: 2024A1022054
Saginaw Bickford Cottage

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.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730279101
Investigation #:	2024A1022054
Complaint Receipt Date:	06/13/2024
Investigation Initiation Date:	06/13/2024
Report Due Date:	08/13/2024
Licensee Name:	Saginaw Bickford Cottage, LLC
Licensee Address:	13795 S. Mur Len Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Melissa Kline
Authorized Representative:	Krystyna Badoni
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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	71
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents are not receiving appropriate care.	No
Food service sanitation standards are not being enforced.	Yes

III. METHODOLOGY

06/13/2024	Special Investigation Intake 2024A1022054
06/13/2024	Special Investigation Initiated - Telephone Phone call placed to complainant. Left message to return call.
06/13/2024	Contact - Telephone call received Complainant interviewed by phone.
07/02/2024	Inspection Completed On-site
08/19/2024	Exit Conference

ALLEGATION:

Residents are not receiving appropriate care.

INVESTIGATION:

On 06/13/2024, the Bureau of Community and Health Systems (BCHS) received a complaint that read, “Residents are not being cleaned, showered or changed enough and are being left in soil clothes for many hours.”

On 06/13/2024, I interviewed the complainant by phone. The complainant elaborated on the written complaint, explaining that in the memory care (MC) unit of the facility, she could see that residents were not provided timely incontinence care, were not assisted with personal hygiene, especially mouth care, and were not encouraged to drink enough to ensure they did not become dehydrated.

On 07/02/2024, at the time of the onsite visit, I interviewed the wellness director, as the administrator was off-site for the day. I made observations on 3 MC residents that were identified by the wellness director as requiring assistance to complete their activities of daily living (ADLs).

Resident A was seated in the common area of the MC unit. She responded to her name, but she was confused. When approached by caregiver #1, Resident A readily stood, and took caregiver #1's hand and allowed caregiver #1 to lead her to her room. However, when they reached Resident A's room, caregiver #1 realized that the air conditioning unit had been turned up and the room was very cold. Resident A said, "I'm not going in there! It's too cold." Caregiver #1 then took Resident A to the hallway toilet room. Caregiver #1 assisted Resident A to lower her pants and her incontinence brief. The brief was observed to be clean and dry. Resident A voided into the toilet and had a concurrent bowel movement. When Resident A said that she was finished, Caregiver #1 helped her to her feet, and wiped her clean using several lengths of toilet paper. Caregiver #1 then assisted Resident A in washing her hands and caregiver #1 did the same. Resident A was observed to be wearing clean clothing and her hair was neatly groomed. Because Resident A did not want to enter her room, I was not able to observe what oral hygiene implements were in the room. Caregiver #1 stated that Resident A allowed caregivers to help her brush her teeth. According to her service plan, Resident A was on a toileting schedule with caregivers offering assistance to the toilet about every two hours. Resident A was to receive assistance with oral hygiene with her morning and her evening care.

Resident B was still in his bed. The wellness director explained that Resident B stayed up late and consequently did not rise early. The wellness director further stated that Resident B was very confused and often resistant to care. Resident B required 2 caregivers for morning care, as he did not want to stand or be moved. As caregiver #1 explained to Resident B that she and caregiver #2 were going to get him changed, caregiver #2 removed his blanket and began to remove his incontinence brief. Resident B immediately began to strike out, but caregiver #1 was able to get him to calm down enough to proceed with incontinence care. Resident B's brief was wet but not saturated. After being changed into a clean incontinence brief, caregiver #1 looked through Resident B's dresser and closet for a clean pair of pants but was not able to find one. According to caregiver #1, Resident B's family had been notified that Resident B needed some additional clothing items as well as toothpaste, but no one from the family had been in since that notification. Caregiver #2 found a pair of clean pajama pants, so that was what was used. Caregiver #1 was able to coax Resident B into a seated position on the side of his bed and with the support of caregiver #2, helped Resident B briefly to his feet to pull up the pants before transferring him into his wheelchair. Caregiver #1 then wheeled Resident B into his bathroom, and with a wet washcloth, washed Resident B's face and hands, and gave him a glass of water to drink. Resident B was observed to be resistant to the efforts of both caregivers but was finally able to be coaxed into being more cooperative. The wellness director explained that Resident B frequently could be distracted when caregivers used his electric toothbrush on his teeth. Caregiver #1 found an unopened tube of toothpaste and assisted Resident B with oral hygiene, and he seemed somewhat calmer with this action. When he was dressed, caregiver #2 wheeled Resident B into the dining area, where she assisted him with his breakfast. According to his service plan, Resident B needed extensive assistance

with all activities of daily living. Resident B's hospice care provider completed showers with him twice weekly.

Resident C was also a late sleeper, but she had got out of bed on her own and was walking in the hallway. Caregiver #3 took her hand and led her back to her room for morning care. Caregiver #3 helped Resident C with her clothing and Resident C sat on the toilet where she voided. Resident C's incontinence brief was wet, but not saturated. Resident C had not received incontinence care since the end of the overnight shift. The wellness director explained that Resident C frequently hid her clothing and personal care items, such as her hairbrush and her toothbrush. Although Resident C's hairbrush was on the countertop in the bathroom, her toothbrush could not be found. Caregiver #3 stated that sometimes she used a mouth swab with Resident C, as it was easier to get her to accept it. As Resident C sat on the toilet, caregiver #1 and caregiver #3 brought clean clothes into the bathroom and assisted Resident C to put them on. When she was done, Resident C used the assist bar by the toilet to stand, and caregiver #3 assisted her by pulling up her clean incontinence brief and her pants. Caregiver #1 gave Resident C a washcloth and assisted her to wipe her face and wash her hands. Resident C then walked into the dining area where caregiver #3 gave her breakfast. According to her service plan, Resident C was on occasions, resistive to care, and frequently needed the assistance of 2 caregivers due to this resistance.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(e) A patient or resident is entitled to receive adequate and appropriate care**
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: R325.1901	**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:	Based on observation, there was no evidence that the care provided to residents in the facility's memory care unit was either inadequate or inappropriate.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Food service sanitation standards are not being enforced.

INVESTIGATION:

According to the written complaint, "The (memory care unit) kitchen at the facility is dirty with food sitting out." The complainant stated that this was based on her personal observations at the facility.

At the time of the onsite visit, I made observations in the facility's MC unit. The MC unit opened into its large common space that included the dining area and a serving kitchen. All of the breakfast items had been cleared away, the buffet serving holders had been cleaned out and the countertops were clean. Caregiver #2 was seen bringing clean dishes from the main kitchen area into the MC unit on a 3-shelf service cart. According to the wellness director, after meals, the MC unit caregivers would pre-rinse plates, utensils, and serving pieces in the MC kitchen and then return them to the main kitchen, where the items were placed in the main dish machine to be washed and sanitized for the next meal. The clean dishes were then placed onto the service cart and one of the caregivers would retrieve them from the main kitchen to take back into the MC unit for the next meal. While the dishes were

clean, the service cart was not. The service cart shelving was observed to be encrusted with food debris. Caregiver #1 attempted to clean the food debris off the service cart, but some of the food debris had dried and caregiver #1 needed to use a butter knife to scrape the food off the cart.

According to the wellness director, the food service manager was responsible for ensuring that food service equipment was clean and sanitary.

The facility provided their monthly, quarterly, and semi-annual cleaning schedules, as well as the Kitchen Daily Task Guide. Cleaning of the service cart was not included on any of the schedules or the Daily Task Guide.

APPLICABLE RULE	
R 325.1976	**Kitchen and dietary.**
	(12) Food service equipment and work surfaces shall be installed in such a manner as to facilitate cleaning and be maintained in a clean and sanitary condition, and in good repair.
ANALYSIS:	Based on observation, not all food service equipment and surfaces were kept in a clean and sanitary condition.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 08/19/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

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

08/19/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

08/14/2024

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