GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 13, 2024

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

RE: License #: AH820395445
Investigation #: 2024A0585068
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.

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,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820395445
Investigation #:	2024A0585068
Complaint Receipt Date:	07/22/2024
Investigation Initiation Date:	07/23/2024
Report Due Date:	09/21/2024
Licensee Name:	Bickford of Canton, LLC
Licensee Address:	Suite 301 13795 S Mur-Len Rd. Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Krystyna Badoni
Authorized Representative:	Sandra Randall
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?
Resident A was observed with injuries to her lip, mouth, face and eyes.	No
Resident A's POA was not notified about her injuries.	Yes
Additional Findings	No

III. METHODOLOGY

07/22/2024	Special Investigation Intake 2024A0585068
07/23/2024	Special Investigation Initiated - Telephone Contacted the complainant by telephone to discuss allegations.
08/19/2024	Contact - Telephone call received Received phone call from detective Smiles regarding investigation.
07/25/2024	Inspection Completed On-site Completed with observation, interview and record review.
07/25/2024	Inspection Completed – BCAL Sub. Compliance
08/19/2024	Contact – Telephone call received. Received phone call from Detective Zachary Smilo regarding the investigation.
08/27/2024	Contact – Telephone call received. Received phone call from APS worker Megan Kinder.
11/13/2024	Exit Conference Conducted via email to authorized representative Krystyna Badoni.

ALLEGATION:

Resident A was observed with injuries to her and lip, mouth, face and eyes.

INVESTIGATION:

On 7/18/2024, the department received this complaint from Adult Protective Services (APS) through the BCAL online complaint system. The complaint alleged in part that

Resident A was found to have a fat lip, on top and bottom on the left side, bruising around the corner of her lip, down to the bottom of her mouth, and the white of her left eye had blood in it.

On 7/25/2024, an on-site was completed at the facility. I interviewed the administrator Sandra Randall who stated that they completed an investigation, and no one knew what happened to Resident A. She said that Resident A said a girl with a ponytail hit her but the only girl with a ponytail that works at the facility was not on the schedule that day. She said that caregiver was changing Resident A and she started screaming out. Ms. Randall said that when she spoke to Resident A, she was in good spirit. Ms. Randall said that she did not see any tension between residents and staff. Ms. Randall shared copies of written statements from herself and staff. She also gave me a copy of Resident A's chart notes.

During the onsite, I interviewed Resident B who stated that all is well, and she is not fearful of any staff. She said all the staff is nice to her and she does not have any issues.

I interviewed Resident C at the facility who stated that staff is excellent, and she is not fearful of anyone.

The chart note dated 7/15/2024 read, "At about 7:30 a.m. today, Employee #2 asked me to go to Resident A's room. Upon reaching there, I saw Employee #3 cleaning blood stain from the resident's mouth. Resident A kept yelling, "She hit me". I asked Employee #2 to step aside from the room. I called Employee #4 and told her about the situation." Signed by Employee #1

Hospice chart notes dated 7/17/2024, read, "observed resident today. Cooperative, up in am, area to lip, red and minimal swelling. No complaint of pain."

On 8/22/2024, I spoke with Witness #1 who stated they were called regarding Resident A bleeding from the mouth and they went and did an assessment. She said Resident A had a contusion to the lip, slightly swollen, and right eye lid was red. Witness #1 stated that they could not make a call as to what might have happened. Witness #1 stated that Resident A was unable to tell them what happened.

The written statement from Ms. Randall, "At 7:40 I received a text from Employee #4 which read, "I left the building and Employee #1 called me. She stated that Resident A was yelling, and Employee #3 was cleaning her up. Resident A stated she was hit. Can you get in and assess the situation? Thank you" I arrived at the building at approximately 7:55 a.m. I located Employee #4 in the med room. I asked Employee #4 what happened, and she stated that Resident A was bleeding, and that Employee #3 was in the room cleaning her up. I asked if she knew what happened she indicated she did not, but Employee #3 was in the room. I then went to Resident A's room; the door was closed, and I knocked and walked in. Employee #3 had Resident A in her wheelchair and was putting a clean shirt on her to take her to

breakfast. Resident A was in good spirits when I walked in, and I did not feel any tension between her and Employee #3. I helped Employee #3 put Resident A clean shirt on and kneeled in front of Resident A. I asked Resident A what happened to your lip, and she stated that a little girl in ponytails punched her. She lived down the hall and she was going to make her pay. I asked Employee #3 at that time what happened, and she stated she did not know. I let Resident A know that I would talk to the girl in ponytails…she said on good, I know you can get her. I then asked Resident A if she was ready for breakfast, she said yes and I pushed her to the dining room. While pushing her to the dining room she said that she hurt all over. I set her at her table and got Employee #1 to address her pain. She was brought back to her room shortly thereafter. I heard Resident A screaming out. I entered her room and Resident A had removed her brief. I told Resident A I would get a caregiver and be right back. Employee #3 went in and put a clean brief on. While providing care, Resident A was screaming that she was being hurt. I observed from the doorway and Employee #3 was providing care, she was not hurting Resident A. Resident A continued to scream. Resident A has days where she is agitated and screams out throughout the day. She can be aggressive toward staff. Resident A is not a good historian." Signed by Ms. Randall 7/15/2024

"At about 7:30 am today, Employee #2 asked me to go to Resident A's room. Upon reaching there, I saw Employee #3 cleaning Resident A's mouth with a wipe. There were blood stains and she said it was coming from her mouth. At that time, the resident was saying, "She hit me." The left lip was a little swollen. I asked Employee #3 to step aside from the room and come back later when she is calmed down. I called Employee #3 and told her about what happened." Signed by Employee #1 7/15/2024

"I was in another room, and I heard yelling. I stopped what I was doing. I went to Resident A's room when a care aide (Employee #3) was cleaning her up. She turned over and she was bleeding, and I went to get the med tech. Signed by: Employee #2 7/14/2024

"I went into Resident A's room. She had no clothes on, so I started to get her dressed and put her clothes on. I put her pants on, and she turned around and something on her face was bleeding. I put something on her face. Med tech came in the room. I told her she was bleeding on her face, and she wiped her face and then left the room, and she told me to leave out the room. I didn't get to put the rest of her clothes on but before that she was hitting me, and I tried to get her to be cool, but she did not want to. I left out the room for a little while then went back to get her dressed for the day." Signed by Employee #3

"Resident A was in bed upon arrival. No issues on my shift from start to end." Signed Employee #5

“I Employee #6 worked shift on July 14 10 p.m. – 6:00 a.m., set 2. I wasn’t assigned nor did I assist with care for Resident A on July 14. I didn’t hear no agitation behavior from Resident A’s room during the shift.” Signed Employee #6 7/16/2024”

“On Sunday, Resident A was fine. I had given her meds around 8. She was okay.” Signed by Employee #7 7/16/2024

On 8/27/2024, I received a call from APS worker Megan Kinder who stated that Resident A had passed away on 8/26/2024.

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 hoe maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
R325.1901	**Definitions.**
	(p) "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:	Resident A sustained injuries and staff did not know how they were sustained. Investigation was completed by the administrator and statements were provided by staff on duty who were providing care to Resident A. An assessment was completed, and actions were documented regarding steps that were taken to ensure the resident’s safety. The facility reasonably complied to this claim. Therefore, this claim was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION

Resident A's POA was not notified regarding her injuries.

INVESTIGATION:

The complaint alleged that Resident A's POA was not notified of the incident and only found out when she visited the facility.

Ms. Randall stated that they did not notify the POA at the time of the incident because they did not initially believe that there was an incident requiring such notification. She said that they assessed that Resident A had likely bumped her lip and was agitated. Ms. Randall said that since the POA was not contacted initially, there was no one who notified her at that time and when the POA arrived later to visit Resident A, she subsequently reported potential abuse. She said that after the POA's report, they conducted a full investigation and called Resident's A hospice nurse to assess the situation.

The facility occurrence report noted that on 7/15/2024, staff was changing Resident A. It notes that when staff turned her around and her mouth was bloody. The report notes that hospice was called.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review programs.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	The facility did not notify Resident A's POA regarding the incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

11/13/2024

Brender Howard Date
Licensing Staff

Approved By:

11/13/2024

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