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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 23, 2024

Krystyna Badoni
Portage Bickford Cottage
4707 W. Milham Ave.
Portage, MI 49024

RE: License #: AH390278221
Investigation #: 2025A1028015
Portage 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 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH390278221
Investigation #:	2025A1028015
Complaint Receipt Date:	11/27/2024
Investigation Initiation Date:	12/02/2024
Report Due Date:	01/27/2025
Licensee Name:	Portage Bickford Cottage LLC
Licensee Address:	Suite 301 13795 S. Mur-Len Road Olathe, KS 66062
Licensee Telephone #:	(810) 962-2445
Administrator:	Brandie McWethy
Authorized Representative:	Krystyna Badoni
Name of Facility:	Portage Bickford Cottage
Facility Address:	4707 W. Milham Ave. Portage, MI 49024
Facility Telephone #:	(269) 372-2100
Original Issuance Date:	03/05/2007
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	71
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was observed with bruising on 10/30/2024.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/27/2024	Special Investigation Intake 2025A1028015
12/02/2024	Special Investigation Initiated - Letter
12/02/2024	APS Referral APS made referral to HFA.
12/02/2024	Contact - Face to Face Interviewed the administrator at the facility.
12/02/2024	Contact - Face to Face Interviewed Employee A at the facility.
12/02/2024	Contact - Face to Face Interviewed Employee B at the facility.
12/02/2024	Contact - Document Received Received requested documentation from the administrator.

ALLEGATION:

Resident A was observed with bruising on 10/30/2024.

INVESTIGATION:

On 11/19/2024, the Bureau received the allegations through the online complaint system.

On 12/2/2024, I interviewed the administrator at the facility who reported Resident A has fragile skin due age and is currently receiving hospice services. Resident A requires assistance with all care and is wheelchair bound. The administrator reported knowledge of Resident A incurring a fall on 10/17/2024 with staff finding Resident A on the floor of [their] room. Staff transferred Resident A back to bed and at that time Resident A did not demonstrate any skin tear, bruising, or pain. When asked about

the method of transfer by staff, the administrator reported staff were physically picking up Resident A in a carry position to transfer but due to concerns about Resident A's fragile skin, a Hoyer lift was requested by the facility. Hospice services were hesitant at first to order because Resident A does not necessarily meet the medical requirements to prescribe a Hoyer lift, but a Hoyer lift was ordered and is currently being used to provide further protection of Resident A's fragile skin during transfers. The administrator reported hospice later reported bruising to Resident A's hand a few days after Resident A's fall. The administrator also reported staff were trained by a healthcare professional such as a physical therapist or occupational therapist on how to transfer Resident A. The administrator provided the requested documentation for my review.

On 12/2/2024, I interviewed Employee A at the facility who confirmed Resident A is receiving hospice services and that Resident A has very fragile skin, so staff were transferring Resident A using a two-arm carry position. Employee A confirmed Resident A fell on 10/17/2024 and a bruise related to the fall was later demonstrated. Employee A reported staff know to be careful when transferring Resident A but sometimes staff are not careful. Employee A reported Resident A will sometimes incur bruising from the foot pedal when staff transfer Resident A to their Broda chair. Employee A reported staff are supposed to use a Hoyer lift with Resident A but sometimes staff do not and will physically transfer Resident A. Employee A also reported Resident A can demonstrate impulsiveness at times and attempt to get out of [their] chair or bed unassisted and that staff must monitor Resident A to prevent falls and any injury. Employee A reported staff are trained by other staff to transfer residents and that to their knowledge, staff have not been trained by any healthcare professional on transfers. Employee A reported [they] were trained by other facility staff on transfer techniques including using a Hoyer lift.

On 12/2/2024, I interviewed Employee B whose statement was consistent with Employee A's statement. Employee B reported some staff require reminders to use the Hoyer lift with Resident A and to not physically transfer Resident A. Employee B also reported staff are trained by other staff on how to transfer residents, that staff are not trained by a healthcare professional. Employee B confirmed [they] were trained by other facility staff on transfer techniques including using a Hoyer lift.

On 12/2/2024, I observed Resident A in the dining room who was clean, well-groomed, and content. I did not observe any bruising to the hands, arms, or lower leg. However, please note bruising may have been concealed by clothing or healed due to the amount of time elapsed between the incident date of 10/17/2024 and when the department received this allegation.

On 12/2/2024, I reviewed the requested documentation which revealed the following:

- Resident requires assistance with dressing, grooming, oral care, toileting, transfers, mobility, and for safety.
- Hospice provides showers twice weekly.
- Requires two-person assistance with transferring and is wheelchair bound.

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.**
ANALYSIS:	It was alleged that Resident A was observed with bruising on 10/30/2024. Interviews, on-site investigation, and review of documentation revealed the following: • Resident A incurred a fall to the floor in [their] room and bruising was observed later by hospice. • Due to the limited documentation, it cannot be determined the date hospice reported the bruising to facility management or the location of the bruising on Resident A or what measures were taken by the facility once the bruising was discovered. • Staff interviews and documentation conflicted about how Resident A is transferred and about who has trained staff to safely transfer Resident A to prevent skin tear(s) and injury. • Staff interviews revealed staff are not consistent with transfer methods for Resident A and this may also potentially contribute to Resident A's bruising due to Resident A's fragile skin. • Bruising was not observed on Resident A's hands, upper arms, or legs at the time of the on-site investigation. The facility does not demonstrate an organized program to provide protection, supervision, assistance, and/or supervised personal care for Resident A to prevent falls and/or injury from falls. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On 12/2/2024, review of the service plan revealed that Resident A's service plan was not updated to reflect that Resident A required assistance with bathing. Resident is marked as independent with bathing needs on the service plan, but the details section of the service plan reads that hospice provides showers twice weekly. Also, the service plan shows Resident A requires two-person assist, but there is no evidence in the service plan that a Hoyer lift is used with Resident A during transfers, despite staff and on-site investigation confirming a Hoyer lift is used when transferring Resident A.

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:	Interviews, on-site investigation, and review of documentation reveal that Resident A's service plan was not updated to reflect current provision of care or care levels. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On 12/2/2024, I requested the incident report documentation pertaining to Resident A's fall on 10/17/2024 that allegedly resulted in injury and while a note was placed in the record, it did not follow the incident reporting rule guidelines.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(5) Records must be maintained that demonstrate incident reporting to the team, analyses, outcomes, corrective action taken, and evaluation to ensure that the expected outcome is achieved. These records must be maintained for 2 years.

ANALYSIS:	Incident reporting pertaining to Resident A's fall on 10/17/2024 was documented in the record but it did not follow the reporting of incidents' guidelines and did not include outcomes, corrective action taken, and/or the evaluation to ensure that the expected outcome is achieved. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend the status of this license remain the same.

12/11/2024

Julie Viviano Date
Licensing Staff

Approved By:

12/19/2024

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