GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 22, 2025

Krystyna Badoni
Battle Creek Bickford Cottage , L.L.C.
13795 S. Mur-Len Road Suite 301
Olathe, KS 66062

RE: License #: AH130278262
Investigation #: 2025A1010013
Battle Creek Bickford Cottage

Dear Licensee:

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) 241-1970.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH130278262
Investigation #:	2025A1010013
Complaint Receipt Date:	11/12/2024
Investigation Initiation Date:	11/13/2024
Report Due Date:	01/12/2024
Licensee Name:	Battle Creek Bickford Cottage , L.L.C.
Licensee Address:	Suite 301 13795 S. Mur-Len Road Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Brandy Aucunas
Authorized Representative:	Krystyna Badoni
Name of Facility:	Battle Creek Bickford Cottage
Facility Address:	3432 Capital Avenue Battle Creek, MI 49015
Facility Telephone #:	(269) 979-9600
Original Issuance Date:	12/29/2006
License Status:	REGULAR
Effective Date:	10/15/2024
Expiration Date:	07/31/2025
Capacity:	55
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was not checked on by staff for approximately four hours. She died on 8/8/24.	Yes
Resident A did not receive her medications as prescribed.	Yes

III. METHODOLOGY

11/12/2024	Special Investigation Intake 2025A1010013
11/13/2024	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
11/13/2024	APS Referral Intake
11/20/2024	Inspection Completed On-site
11/22/2024	Contact - Document Received Received resident service plan and physician orders via email from the admin
01/07/2025	Contact – Document Sent Emailed administrator and requested copies of all Resident A's MARs and incident reports from when she resided at the facility
01/09/2025	Contact – Telephone call made Interviewed the complainant by telephone
01/12/2025	Contact – Document received Received Resident A's ER report, ambulance report, and pharmacy orders via email from Relative A1
01/15/2025	Contact – Document received Email received from the administrator
01/22/2025	Exit Conference

ALLEGATION:

Resident A was not checked on by staff for approximately four hours. She died on 8/8/24.

INVESTIGATION:

On 11/12/24, the Bureau received the allegations from the online complaint system. The complaint read, “[Resident A] was found unresponsive 8/8/24 – EMS medics were told she was left unchecked at Bickford for approx [sic] 4 hours despite paying for highest level of care. [Resident A] ultimately had a massive stroke from aFib and died on 8/8/24.”

On 11/13/24, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 11/20/24, I interviewed the administrator at the facility. The administrator reported she started in the position in October 2024, therefore she did not know Resident A who died in August 2024. The administrator was unable to provide any information regarding Resident A, or Resident A’s care needs.

On 11/20/24, I interviewed the facility’s health and wellness director at the facility. The health and wellness director reported she also did not work at the facility when Resident A resided at the facility. The health and wellness director’s statements were consistent with the administrator.

On 11/20/24, I interviewed Staff Person 1 (SP1) at the facility. SP1 reported it is the facility’s policy and procedure to check on all residents every two hours during “rounds.” SP1 stated that to her knowledge, Resident A was also checked on every two hours. SP1 was unable to recall Resident A being found unresponsive on 8/8/24. SP1 denied knowledge regarding this incident and did not know whether an incident report was completed. SP1 said that to her knowledge, Resident A’s care needs were met consistent with her service plan.

SP1 reported most of the staff who were familiar with Resident A and assisted with her care no longer work at the facility.

On 11/20/24, I interviewed SP2 at the facility. SP2’s statements were consistent with SP1.

On 11/22/24, I received a copy of Resident A's service plan for my review via email from the administrator. The *TOILETING* section of the plan read, "Full assistance with all aspects of bathroom activity and hygiene. Assistance with morning toileting. Assistance with bedtime toileting. Assistance with nighttime toileting. Notes: [Resident A] is incontinent of bowel and bladder. She requires assistance with toileting in the mornings, between meals, before bed and twice through the night. She should not be left unattended in the bathroom." The *SPECIAL CARE NEEDS* section of the report read, "Safety checks – 4 times per shift."

On 1/7/25, I emailed the administrator and requested copies of all MARs and incident reports from when Resident A resided in the facility.

On 1/9/25, I interviewed the complainant by telephone. The complainant stated review of the responding Emergency Medical Services (EMS) staff written report from 8/8/24, revealed Resident A was left unchecked and unsupervised for four hours by staff at the facility. The complainant reported a copy of the EMS report will be provided to me via email for my review. The complainant stated Resident A was paying for and supposed to receive "the highest level of care" provided by staff. The complainant reported this included Resident A being "checked on" by staff multiple times throughout the day. The complainant explained management staff would not provide an answer as to what supervision and how often Resident A was supposed to be checked on.

On 1/12/25, I received a copy of Resident A's *Result Summary for ECG* hospital document dated 8/8/24 for my review via email from Relative A1. The document read, "Patient resides at assisted living facility in Battle Creek. Per EMS staff saw patient at breakfast this morning between 8a-9a. When they went to check on her she was found face down in her room."

Relative A1 also provided me with a copy of Resident A's emergency medical services (EMS) report for my review. The report read EMS staff were called at 12:49 pm and arrived at the facility at 12:55 pm on 8/8/24. The report read the last known time staff observed or checked on Resident A was 8:00 am on 8/8/24. Resident A's service plan read staff were to complete "safety checks" on Resident A "4 times per shift,"

therefore she should have been checked on every two hours during staff's eight-hour shifts.

On 1/15/25, the administrator reported there are no incidents reports in Resident A's record from the time she resided in the facility.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	The interview with the complainant, along with review of Resident A's EMS report and hospital report from 8/8/24 revealed staff at the facility observed Resident A between 8:00 am and 9:00 am on 8/8/24. Staff did not observe Resident A again on 8/8/24 until they found her "face down in her room" at approximately 12:49 pm. Resident A's service plan read she required "safety checks" four times during staff's eight-hour shifts. According to the EMS and hospital reports, Resident A went over four hours without staff checking on her and verifying her wellbeing on 8/8/24. This was not consistent with her service plan; therefore, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive her medications as prescribed.

INVESTIGATION:

On 11/12/24, the complaint read Resident A was diagnosed with atrial fibrillation (aFib) on 8/1/24 and was prescribed metoprolol succinate and aspirin. After Resident A died on 8/8/24, her prescribed metoprolol was not provided to her family. The facility will not provide Resident A's medication administration records (MARs) to confirm Resident A received her medications as prescribed.

On 11/20/24, the administrator had no information regarding Resident A's medications.

On 11/20/24, SP1 denied knowledge regarding Resident A not receiving her medications as prescribed.

SP1 provided me with a copy of Resident A's August 2024 MAR for my review. The MAR read Resident A was prescribed, "ACETAMINOPHEN 500MG TABLETS TAKE ONE TABLET BY MOUTH FOUR TIMES DAILY AS NEEDED FOR MILD PAIN *MAX 4GM APAP/24H*." This as needed medication was not administered at all in August 2024. Resident A's MAR did not have metoprolol listed as a prescribed medication, therefore it was not administered in August 2024. SP1 reported she did not have access to any other months of MARs for Resident A while she resided in the facility.

On 11/20/24, SP2's statements were consistent with SP1.

On 11/22/24, I received a copy of Resident A's facility medication list for my review. I observed metoprolol and aspirin were not listed as prescribed medications for Resident A.

On 1/9/25, the complainant questioned whether staff administered Resident A's prescribed metoprolol. The complainant explained Resident A's metoprolol was not provided to Resident A's family with her other prescribed medications after Resident A passed away. The complainant stated facility staff and corporate staff refuse to provide Resident A's MARs and medical documents to Resident A's family upon their request. The complainant reported corporate staff have been non-responsive to Resident A's family members when contact is attempted.

On 1/12/24, I received a copy of Resident A's *Connexus Pharmacy System* report for my review via email from Relative A1. The document read Resident A was prescribed, "ASPIRIN LOW EC 81MG TAB," METOPROLOL ER 25MG TAB, and QUEtiapine Fumarate 25 MG." These medications were filled by the Wal-Mart pharmacy in Battle Creek on 8/1/24. These medications were not listed on Resident A's August MAR, or her facility medication list.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.

ANALYSIS:	The interview with the complainant, along with review of Resident A's August MAR, facility medication list, and her *Connexus Pharmacy System* report revealed her prescribed metoprolol, aspirin, and quetiapine were not administered as prescribed. As a result, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with the licensee authorized representative on 1/22/25.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

01/15/2024

Lauren Wohlfert Date
Licensing Staff

Approved By:

01/21/2025

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