GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 30, 2025

Krystyna Badoni
Midland Bickford Cottage
101 Joseph Dr
Midland, MI 48642

RE: License #: AH560278460
Investigation #: 2025A1019057

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 responsible party and a date.

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) 335-5985.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
[THIS REPORT CONTAINS GRAPHIC CONTENT]

I. IDENTIFYING INFORMATION

License #:	AH560278460
Investigation #:	2025A1019057
Complaint Receipt Date:	05/23/2025
Investigation Initiation Date:	05/27/2025
Report Due Date:	07/22/2025
Licensee Name:	Midland Bickford Cottage, LLC
Licensee Address:	13795 S Murlen Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Jamie Stratton
Authorized Representative:	Krystyna Badoni
Name of Facility:	Midland Bickford Cottage
Facility Address:	101 Joseph Dr Midland, MI 48642
Facility Telephone #:	(989) 835-5300
Original Issuance Date:	11/22/2006
License Status:	REGULAR
Effective Date:	08/21/2024
Expiration Date:	07/31/2025
Capacity:	71
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A sexually assaulted Resident B.	No
Additional Findings	Yes

III. METHODOLOGY

05/23/2025	Special Investigation Intake 2025A1019057
05/27/2025	Comment Complaint was forwarded to LARA from APS. APS denied the referral and is not investigating the allegations.
05/27/2025	Special Investigation Initiated - Letter Emailed licensee requesting information/documentation.
05/28/2025	Inspection Completed On-site
05/30/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A sexually assaulted Resident B.

INVESTIGATION:

On 5/23/25, the department received an anonymous complaint forwarded from Adult Protective Services (APS) that Resident A had sexually assaulted Resident B. The complaint alleged that Resident A had “violated” Resident B on three occasions over the past few weeks. The complaint alleged that on two occasions, Resident A was observed with his penis in Resident B’s mouth.

On 5/28/25, I conducted an onsite inspection. I interviewed administrator Jamie Stratton at the facility. The administrator confirmed that there was a recent incident involving Residents A and B that took place on 5/19/25. The administrator reported that staff walked into Resident A’s bathroom and observed him to have his penis in Resident B’s mouth. The administrator reported that staff removed Resident A from Resident B’s room and assessed her following the incident. The administrator reported that Resident B did not appear to be in distress and did not appear fearful or hurt in any way. The administrator reported that due to cognitive limitations of both residents, it is unclear exactly what happened, and she is only able to rely on

staff's direct observations. The administrator reported that Resident B is a known wanderer, and a similar incident occurred on 5/13/25 where she entered Resident A's apartment while he was using the bathroom. The administrator reported that it is believed that Resident B was the instigator of both encounters. The administrator also reported that Resident B was diagnosed with a urinary tract infection (UTI) the following day and is being treated for that infection.

While onsite, progress note documentation was obtained. A progress note dated 5/14/25 read: "*late entry 5/13 received call resident [Resident B] had wandered into another male residents apartment and was in his bathroom sitting on a chair with the male resident standing and with his private area exposed. Resident per report was assisted out of the room*." A progress note dated 5/19/25 that read:

> *Received call that resident [Resident B] was in another male resident room sitting on a chair in bathroom and the male resident had his penis in resident mouth. Resident was removed immediately. Divisional nurse notified, executive director notified and spouse [Relative B] notified. Discussed with spouse about discussion with PCP regarding medication adjustment and recent change in pattern of wandering spouse agreed. Instructed staff to keep in view of resident hallway to know when coming out of room.*

While onsite, I interviewed Relative B. Relative B reported that Resident B has resided at the facility for 1 year. Relative B reported that he visits the facility daily and stated that the facility staff are "*wonderful, compassionate, caring and knowledgeable".* Relative B reported that he was notified promptly when the incidents occurred and confirmed that Resident B was not in distress following the events. Relative B reported that due to her cognitive decline, Resident B is unaware that the incidents took place. Relative B acknowledged that Resident B has had an increase in her wandering behaviors and believes the facility is making efforts to provide more monitoring for her. Relative B stated "*I cant think of anything more they could be doing for my wife."*

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting; 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:

	(*l*) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician, by a physician's assistant with whom the physician has a practice agreement, or by an advanced practice registered nurse, for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician, physician's assistant, or advanced practice registered nurse who authorized the restraint. In case of a chemical restraint, the physician, or the advanced practice registered nurse who authorized the restraint, shall be consulted within 24 hours after the commencement of the chemical restraint.
ANALYSIS:	Staff attested that on two recent occasions, Resident B wandered into Resident A's apartment. There is no evidence that Resident A forced himself sexually onto Resident B, as these events were only witnessed by staff after the fact. Staff attestations reveal that neither Resident appeared to be harmed and neither remembers the events taking place. Additionally, Resident B was diagnosed with a UTI following the 5/19/25 incident, which could contribute to her recent increase in wandering and overall confusion. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The administrator reported that following the 5/19/25 incident, staff were expected to increase their monitoring of Resident B, and an audible chiming device was placed on her door, so staff were aware when her door opens.

While onsite, I reviewed Resident B's service plan. The service plan was not dated, however the administrator reported that her last service plan update took place in October 2024 and the plan I was provided was signed by Relative B on 1/2/25. The service plan was not updated to include the increase monitoring, redirection of

Resident B away from Resident A and made no mention of the door chime or how staff are to react and monitor/observe Resident B when the chime sounds.

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:	Resident B's service plan was not updated to include pertinent information pertaining to her increased wandering behavior.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon completion of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

06/09/2025

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

06/30/2025

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