STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

May 21, 2026

Krystyna Badoni
Bickford of W Lansing, LLC
13795 S Mur-Len Road
Olathe, KS 66062

RE: License #: AH230387590
Investigation #: 2026A1021018
Bickford of W Lansing

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) 335-5985.

Sincerely,

Kimberly Horst

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH230387590
Investigation #:	2026A1021018
Complaint Receipt Date:	01/26/2026
Investigation Initiation Date:	01/28/2026
Report Due Date:	03/25/2026
Licensee Name:	Bickford of W Lansing, LLC
Licensee Address:	Suite 301 13795 S Mur-Len Road Olathe, KS 66062
Licensee Telephone #:	(517) 321-3391
Administrator:	Nora Lennox
Authorized Representative:	Krystyna Badoni
Name of Facility:	Bickford of W Lansing
Facility Address:	6429 Earlington Ln Lansing, MI 48917
Facility Telephone #:	(517) 321-3391
Original Issuance Date:	06/09/2017
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	72
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Medical records were not provided to Resident A.	No
Resident A was improperly discharged.	No
Resident A issued improper discharge notice.	Yes
Additional Findings	No

III. METHODOLOGY

01/26/2026	Special Investigation Intake 2026A1021018
01/28/2026	Special Investigation Initiated - Telephone interviewed administrator
01/28/2026	Contact - Telephone call made interviewed AR
01/28/2026	Contact - Document Received received documentation
01/28/2026	Contact-Telephone call made Interviewed Corporate Office
02/02/2026	Contact-Document Received Received Resident A's documents
05/21/2026	Exit Conference

ALLEGATION:

Medical records were not provided to Resident A.

INVESTIGATION:

On 01/26/2026, the licensing department received a complaint with allegations Resident A did not receive requested medical record. The complainant alleged Resident A's record was requested on 01/20/2026 and as of 01/22/2026, the records were not received.

On 01/28/2026, I interviewed the authorized representative Krystyna Badoni by telephone. The authorized representative reported that medical records requests are processed by the corporate office.

On 01/28/2026, I interviewed Donna Moss finance coordinator by telephone. The finance coordinator stated that on 01/21/2026, the corporate office was requested by Resident A’s attorney to provide the medical records. The finance coordinator reported that on 01/22/2026, all releases were obtained, and the gathering of documentation could begin. The finance coordinator reported this type of request usually takes approximately five to seven days. The finance coordinator reported that she contacted the attorney to inform them the process would begin to gather the documentation. The finance coordinator reported that on 01/23/2026, the attorney came to the facility requesting the documentation and the attorney was advised to contact the corporate office. The finance coordinator reported that on 01/26/2026 at 1:30pm all information was placed on an external flash drive and was shipped to the attorney office. The finance coordinator reported that on 01/27/2026, she spoke with the attorney, and the documentation was also provided via a secure portal.

I reviewed email correspondence between the finance coordinator and the attorney. The correspondence revealed the medical record request was granted on 01/22/2026 and documents were sent to the attorney on 01/26/2026.

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.**
	(3) The following additional requirements for the policy described in subsection (2) apply to licensees under parts 213 and 217. **(h) A nursing home patient or a person authorized by the patient in writing may inspect and copy the patient's personal and medical records. The records shall be made available for inspection and copying by the nursing home within a reasonable time, not exceeding 1 week, after the receipt of a written request.**
ANALYSIS:	Interviews conducted and review of documentation revealed the medical records were obtained within a reasonable time and did

	not exceed one week.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was improperly discharged.

INVESTIGATION:

The complainant alleged that Resident A's discharge was invalid.

The authorized representative reported that on 01/09/2026, she was notified by staff person 1 (SP1) that Resident A acted inappropriately with her on 12/26/2025. The authorized representative reported that this encounter was documented in Resident A's record and was also reported to the Health and Wellness Director (HWD). The authorized representative reported the HWD did not inform management of this nor complete an investigation. The authorized representative reported that the HWD was terminated due to the mishandling of information. The authorized representative reported that an internal investigation started that 01/09/2026 immediately after she was notified of the situation that had occurred. The authorized representative reported that it was found that Resident A was naked and pulled SP1 on top of him in hopes to engage in sexual activity with SP1. The authorized representative reported that it was also reported that Resident A offed SP1 money in hopes to make the "situation disappear." The authorized representative reported that other staff members reported that Resident A would often be naked in his room, ask staff members to engage in inappropriate activities with him, and would have explicit shows on his television. The authorized representative reported that it was also found that Resident A had a criminal sexual history. The authorized representative reported that it was determined Resident A posed a risk to staff members and Resident A was provided with a discharge notice due to these behaviors. The authorized representative reported that Resident A did admit to the encounter with SP1. The authorized representative reported that Resident A was issued a discharge notice on 01/12/2026 and discharged on 01/23/2026.

On 02/02/2026, I received Resident A's records. The records read,

"Interview with Resident A on 01/13/2025.
I grabbed (SP1) and wanted her to get close and wanted to see if she would, I wanted to see what she would do-what would happen.

Statement from Administrator:
"This writer and the Divisional Director of Health and Wellness, (SP2) went to (Resident A), knocked, asked permission to enter and speak with him. (Resident A) was agreeable. He was issued the 14 day move out notice and it was read to him.

When asked if (Resident A) had any questions, he replied, "it was only her over here, me and over here, I grabbed her, it was just playing, but I did let her go." (Resident A) then mention that he had spoken with the "guy, Director in charge of nursing." When asked if he meant (SP3), he mentioned, "yes, I told him to tell her that I would give her fifty-dollars if she would agree to say this didn't happen and make it all go away." This writer explained that offering money in this situation is inappropriate, please don't do that again and that the 14-day move-out notice stands. Both the Divisional Director of Health and Wellness and Executive Director exited (Resident A room) together."

Statement from SP4:
"On multiple occasions when I go into (Resident A)'s room he made sexual comments. When I gave him his meds a week or 2 ago he said that he does not bite unless I want to take my pants off and get into bed with him. He is always naked whenever I enter his room. I have reported this to management but not much was done. By the way this is all the time, every time I'm in his room he's exposing himself and talking sexual."

Statement from SP5:
(Resident A) offered to give me a massage and to play porn while I cleaned. Mentioned that being naked is ok in front of us."

Statement from SP6:
"Once while taking (Resident A) a meal he would open the door while being fully exposed. A different time I went into resident room he was again fully exposed and asked would I rub his back because other employee's have. I declined and told my co-worker I felt uncomfortable."

Statement from SP7:
"Yes, it is pretty much every time you go into the apartment; he pulls his covers back and exposes himself. I ask him to cover himself back up, he will then say come over here and sit with me, come by me. I have ask it again and then he will cover himself."

Statement from SP8:
"Yes, he exposes himself every time you go into the apartment. I have never had a time that I have not had him do it. It makes me uncomfortable."

Statement from SP9:
"Every day you see him he makes an inappropriate statement, like "I need a massage" followed by a laugh. He makes sure to fling his covers back and expose himself and does things to make you feel uncomfortable."

Statement from SP1:
"Upon entering the resident's room, I greeted him by saying, "Good morning." The resident responded with a groan and said, "Morning." I replied, "Well you don't sound

very jolly for Christmas Eve." At that time, the resident was facing away from me. He then rolled over and removed his blankets exposing himself and stated, "I would be more jolly if you got into bed with me." I informed the resident that such comments/actions were inappropriate. I proceeded with medication administration, and the resident initially complied by taking his medications. While I was gathering the medication and water cups, the resident grabbed both of my arms and began pulling me toward him, stating "Come on, get in bed with me." I instructed the resident to stop, but he continued pulling. I then raised my voice and told him to stop, as I felt fearful for my safety. While still holding my arms, the resident lunged backward onto the bed, causing me to begin falling with me. He then released one of my arms, which allowed me to catch myself. I was then able to remove his remaining hand from my arm and exited the room."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(15) A home may discharge a resident before the 30-day notice if the home has determined and documented that either, or both, of the following exist: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home.**
ANALYSIS:	Interviews conducted and review of documentation revealed Resident A posed a risk to the staff of the facility due to his behaviors. Therefore, a less than 30 days discharge notice was provided.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A issued improper discharge notice.

INVESTIGATION:

The complainant alleged that Resident A was issued an improper discharge. The complainant alleged the discharge notice did not include required information.

I reviewed the discharge notice that was provided to Resident A. The notice read, *"This letter serves to notify you that Bickford Assisted Living of West Lansing issuing a 14 day move out notice. Per section 2 of the Admission Agreement that you signed at the time of move-in, we may issue a move out notice if we feel the safety and well-being of other residents, visitors, staff.*

It is with great regret that due to the above, we are hereby issuing this 14-day involuntary discharge notice and (Resident A) must be vacated on or before January 26, 2026.

We have also notified our state licensing body of the discharge for behaviors in a sexual nature."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(16) A home that proposes to discharge a resident for any of the reasons listed in subrule (15) of this rule shall take all of the following steps before discharging the resident: **(a) The home shall notify the resident, the resident's authorized representative, if any, and the agency responsible for the resident's placement, if any, not less than 24 hours before discharge. The notice shall be verbal and issued in writing. The notice of discharge shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(iii) The location to which the resident will be discharged.** **(iv) The right of the resident to file a complaint with the department.**
ANALYSIS:	The discharge notice provided to Resident A did not have specific details on the specifics of the substantial risk to other residents, visitors, or staff of the home, the location to which Resident A would be discharged, and the right to file a complaint with the Department.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kimberly Horst 02/26/2026

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 05/21/2026

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