GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 9, 2021

Justin Stein
Saginaw Bickford Cottage
5275 Mackinaw Rd.
Saginaw, MI 48603

RE: License #: AH730279101
Investigation #: 2021A1027035
Saginaw Bickford Cottage

Dear Mr. Stein:

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 licensee 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) 284-9727.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730279101
Investigation #:	2021A1027035
Complaint Receipt Date:	06/09/2021
Investigation Initiation Date:	06/09/2021
Report Due Date:	08/09/2021
Licensee Name:	Saginaw Bickford Cottage, LLC
Licensee Address:	13795 S. Mur Len Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Mark Sequin
Authorized Representative:	Justin Stein
Name of Facility:	Saginaw Bickford Cottage
Facility Address:	5275 Mackinaw Rd. Saginaw, MI 48603
Facility Telephone #:	(989) 799-9600
Original Issuance Date:	02/08/2007
License Status:	REGULAR
Effective Date:	03/24/2021
Expiration Date:	03/23/2022
Capacity:	55
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was injured by facility staff.	Yes
Additional Findings	No

III. METHODOLOGY

06/09/2021	Special Investigation Intake 2021A1027035
06/09/2021	Special Investigation Initiated - Letter Emailed administrator M. Sequin to request documentation pertaining to investigation
06/21/2021	Contact - Document Sent Emailed administrator M. Sequin to request documentation pertaining to investigation
06/24/2021	Contact - Document Received Requested documentation received from administrator M. Sequin
07/02/2021	Contact - Telephone call made Telephone interview conducted with Relative A1
07/02/2021	Contact - Telephone call made Telephone interview conducted with administrator M. Sequin
07/06/2021	Contact - Telephone call made Telephone interview conducted with facility nurse Deanna Turner
07/06/2021	Contact - Telephone call made Telephone interview conducted with facility caregiver Janelle Dudley
07/06/2021	Contact - Telephone call made Telephone interview conducted with facility staff Devontae Davis
07/09/2021	Exit Conference Conducted with licensee authorized representative Justin Stein

ALLEGATION:

Resident A was injured by facility staff.

INVESTIGATION:

On 6/9/21, the department received a complaint from Adult Protective Services (APS) alleging Resident A was injured by facility staff. The complaint read Resident has a history of advanced dementia with outbursts and is non-verbal. The complaint read on 6/7 facility staff assisted Resident A with care. The complaint read Resident A grabbed a staff member by her shirt and hair. The complaint read another staff member tried to release Resident A's hand by grabbing it, resulting in injury to Resident A's hand. The complaint read Resident A had kicked, scratched, and bit the staff member.

On 7/2/21, I conducted a telephone interview with Relative A1. Relative A1 stated she received a call on 6/8 from facility nurse Deanna Turner informing her that Resident A's left hand was injured. Relative A1 stated Ms. Turner stated Resident A was agitated the night prior with facility staff while putting on her pajamas in which she could have been injured. Relative A1 stated Ms. Turner had planned to obtain an x-ray of Resident A's hand as well re-educate the staff. Relative A1 stated Resident A is independent with ambulation but has dementia and difficulty with verbalization. Relative A1 stated Resident A has had increased agitation since moving into the facility one year ago and has had a few occurrences of behaviors. Relative A1 stated Resident A can answer questions and denied pulling the staff members hair. Relative A1 stated she could not envision Resident A attacking a staff member for no reason unless she felt rushed or something else happened.

On 7/2/21, I conducted a telephone interview with administrator Mark Sequin. Mr. Sequin stated both staff involved with the incident regarding Resident A were terminated in June.

On 7/6/21, I conducted a telephone interview with facility nurse Deanna Turner. Ms. Turner stated she received a call on the night of the incident from resident caregiver Cyrell Ball informing her Resident A may have bruising on her hand because Resident A had grabbed facility caregiver Sharave Ashworth's hair. Ms. Turner stated she evaluated Resident A's hand on 6/8 and noted it looked swollen, as well as bruised, so she notified Resident A's authorized representative then obtained an x-ray which showed a fracture. Ms. Turner stated Resident A's son obtained medical care for her hand and she received a split. Ms. Turner stated Mr. Sequin conducted an internal investigation and interviewed Ms. Ball and Ms. Ashworth. Ms. Turner stated in the interview with Ms. Ball, she stated she had given Resident A her medications and then Resident A came out of her room angry grabbing Ms. Ashworth's hair. Ms. Turner stated in the interview with Ms. Ball, she stated after Resident A released Ms. Ashworth's hair, both caregivers assisted Resident A with putting on her pajamas in which Ms. Ball had to hold Resident A's hand down. Ms.

Turner stated Ms. Ashworth's statements were consistent with Ms. Ball however Ms. Ashworth stated Resident A was upset while trying to assist her with her pajamas. Ms. Turner stated both employees were terminated from employment with the facility after the internal investigation. Ms. Turner stated neither Ms. Ball nor Ms. Ashworth had a prior history of harming or becoming physical with residents. Ms. Turner stated Resident A has history of behaviors of physical aggression with staff and other residents. Ms. Turner stated an all-staff education was conducted immediately to discuss ways to redirect and de-escalate situations with residents specifically with behaviors and dementia. Ms. Turner stated she is planning further education in July with the concepts on dementia. Ms. Turner stated Resident A is not currently taking any oral medications for her behaviors and has requested family have her evaluated by a geriatric psychiatrist.

On 7/6/21, I conducted a telephone interview with certified nursing assistant Janelle Dudley. Ms. Dudley's statements were consistent with Ms. Turner's. Ms. Dudley stated Resident A has had behaviors of acting violent towards staff or other residents intermittently. Ms. Dudley stated staff manage Resident A's behaviors by allowing Resident A to walk away to calm down or de-escalating the situation by encouraging Resident A to talk about something she likes or perform an activity. Ms. Dudley stated Resident A also has a male friend in the facility in which they enjoy each other's company. Ms. Dudley stated she has not witnessed any staff harming or becoming physical with Resident A or any other residents.

On 7/6/21, I conducted a telephone interview with nursing assistant Devontae Davis. Ms. Davis' statements were consistent with Ms. Turner and Ms. Dudley's. Ms. Davis stated she gives Resident A space when she has behaviors of acting physical aggressive and allows her time to calm down before trying to provide care.

I reviewed the incident report submitted to the department regarding the injury to Resident A. The incident report read consistent with statements from Ms. Turner.

I reviewed Resident A's service plan. Resident A's service plan read consistent with statements from Relative A1 and staff interviews. Resident A's service plan read facility staff are to encourage, remind and assist Resident A with activities of daily living (ADLs). Resident A's service plan read Resident A is noted to have some aggressiveness at times with ADLs. Resident A's service plan read staff should keep instructions simple and not to rush. Resident A's service plan read to include Resident A in tasks to encourage independence. Resident A's service plan read if Resident A becomes agitated, for staff to come back 10-15 minutes later to attempt the task or obtain another staff member to try. Resident A's service plan read Resident A prefers only one staff member assist at time, otherwise she may feel threatened with two staff members.

I reviewed Resident A's progress notes. The progress note from 6/7/21 read Resident A grabbed Ms. Ashworth's hair and shirt, then Ms. Ball attempted to pry Resident A's

hand from Ms. Ashworth's hair leaving a bruise on Resident A's left hand. The progress notes on 6/8 read consistent with statements from Ms. Turner.

I reviewed Resident A's medication administration records (MARs) which read consistent with statements from Ms. Turner.

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.
For Reference: R325.1901	**Definitions.**
	(16) "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:	Interviews with Relative A1 and facility staff, along with review of facility documentation revealed that Resident A posed behavioral challenges that were not handled appropriately by staff. While the employees involved were terminated from employment with the facility there is evidence to suggest the methods staff utilized were not adequate to deescalate the situation and maintain the safety of the resident and others.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/9/2021, I shared the findings of this investigation with licensee authorized representative Justin Stein. Mr. Stein verbalized understanding of the citation.

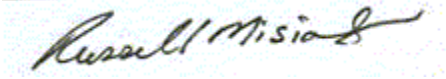
IV. RECOMMENDATION

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

7/9/21

Jessica Rogers Date
Licensing Staff

Approved By:



7/9/21

Russell B. Misiak Date
Area Manager