GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 24, 2021

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

RE: License #: AH730279101
Investigation #: 2021A1019049
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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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 (248) 975-5053.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730279101
Investigation #:	2021A1019049
Complaint Receipt Date:	08/12/2021
Investigation Initiation Date:	08/16/2021
Report Due Date:	10/11/2021
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?
Inadequate supervision of Resident A	Yes
Emergency medical care was not sought for Resident A	Yes
Additional Findings	No

III. METHODOLOGY

08/12/2021	Special Investigation Intake 2021A1019049
08/16/2021	Special Investigation Initiated - Letter Notified APS of the allegations via email referral template
08/16/2021	APS Referral
08/18/2021	Inspection Completed On-site
08/18/2021	Inspection Completed-BCAL Sub. Compliance
08/24/2021	Exit Conference

ALLEGATION:

Inadequate supervision of Resident A

INVESTIGATION:

On 8/11/21, the department received a complaint regarding Resident A. The complaint read that on 7/29/21, Resident A fell while outside unattended. The complainant is unclear why the resident was not supervised.

Facility staff submitted an incident report to licensing staff Aaron Clum on 7/30/21 that read:

> [Resident A] has advancing dementia. [Resident A] ambulates independently with use of a walker. [Resident A] does require some prompting to use her walker. [Resident A] went into courtyard, BFM (Bickford family member) from AL heard alarm going off and came to check on [Resident A]. both BFMs came to courtyard door, opened the door and [Resident A] was sitting upright on the ground behind door.

Staff documented that this occurred on 7/29/21 at 4:40am. The incident report listed staff Ruby Peoples and Tamara Donald as witnesses.

On 8/18/21, I conducted an onsite inspection. I interviewed administrator Mark Sequin at the facility. Mr. Sequin stated that Resident A resides in the facility's member care unit (known as "Mary B's"). Mr. Sequin stated that Resident A does like to go outside but that Mary B's has a secured, enclosed courtyard that residents are permitted to access. Mr. Sequin stated that the doors going into the courtyard from inside the facility are not locked and residents are able to open the doors without staff assistance (no fob or key code needed). Mr. Sequin stated that Resident A wears a wander guard device that alerts staff when she goes outside. Mr. Sequin stated that the alert notification goes directly to staff pagers that they are supposed to carry on their person. Mr. Sequin stated that at the time of the incident, Mary B's had seven residents with one caregiver assigned in Mary B's. Mr. Sequin stated that during third shift, there is a float staff person who goes between the memory care and general assisted living units, with additional staff assigned strictly to assisted living. Mr. Sequin stated that the Mary B's caregiver (Ruby Peoples) did not accompany Resident A outside and did not respond to the alert when her wander guard went off. Mr. Sequin stated that med passing staff Tamara Donald came over from assisted living to respond to the wander guard alert and that is when Resident A was discovered on the ground outside. Mr. Sequin was unclear why Ms. Peoples did not respond to the alert but said it could have been the result of her not wearing her monitoring device and therefore not knowing that the alert had occurred. Mr. Sequin stated that Ms. Peoples' actions pertaining to this incident resulted in her termination.

Resident A's service plan was reviewed. The service plan dated 4/27/21 identified that Resident A has a history of wandering and exit seeking. The document read "When [Resident A] is noted to be out in Mary B's courtyard, BFM needs to be in the courtyard with her at all times."

A written statement from Ms. Peoples regarding the incident read:

> I came in the shift was going normal. [Resident A] was already outside when I came around 20 minutes after 7:45pm she came in and sat in a chair behind me for a couple hours. As she sat there she began to get very aggravated she hit on the type writer that was sitting next to her. I asked her would she like to go to bed she said no her son was coming. A couple hours later she went back outside. So Tamara came to the back and said the alarm went off and notice [sic] [Resident

> A] was outside so she helped her come back in. [Resident A] sat in the chair behind me for at least 20-25 minutes I felt her get up and she went out the side hall door. About 10 min and it was around about 4:25am. Tamara came back to Mary B's and said once again that the alarm went off and asked where was [Resident A] I looked to the chair and I said I figured she went outside so we both went to the door at the same time and she was sitting upright on the ground behind the door it was about 4:35am.

A written statement from Ms. Donald regarding the incident read:

> On July 29th I heard the alarm for the door go off in Mary B's I went back ask [sic] Ruby is she knew what the hall door was cause [sic] I figured it was the one by room 505 as I tried to push it open I couldn't I notice [Resident A] was on the ground behind the door. I called Angela right away @ 4:39am and told [her] what was going on she told me what was going to do to asset [sic] her. I got [Resident A] asset [sic] and got her off the ground. I asked [Resident A] did she have any pain she complained of neck and pain. Ruby cleaned her wound on her forehead. I called [Resident A's] family. I let [Resident A's] family know her vitals and asked if she would like to [have] [Resident A] sent out or to have Angela assest [sic] her. [Resident A] daughter stated to have Angela assest [sic] her and have her call when she does.

Ms. Peoples also documented the following on an *Unusual Occurrence Report*:

> [Resident A] said some girl was outside so she went out there to talk to them. She was sitting in the chair behind me she got up to go outside she went out the side door. Tamara said the alarm went off so we went and checked on her and she was behind the door on the ground…[Resident A's] wound was clean [sic] and first aid was given.

The *Quantum Safety and Security* event report was reviewed, which detects when staff enter/exit the memory care unit by means of their key fob system and also detects when the door magnets secure and release. The report read that Ms. Donald entered Mary B's on 7/29/21 at 4:37am. Mr. Sequin stated that time corresponds to when Ms. Donald responded to Resident A's wander guard alert. Prior to 4:37am, the report listed other alerts that occurred at 4:36am, 4:22am and 4:05am. Mr. Sequin stated that the facility does not have any video surveillance inside or outside of the facility. Given that the memory care courtyard doors do not require a code or fob to open, it cannot be determined what exact time Resident A exited or how long she was outside unattended. Ms. Peoples statement read that she observed Resident A go outside around 4:25am, which could correspond with the alert at 4:22am, but Mr. Sequin stated that he does not feel Ms. Peoples was being truthful in her attestation.

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.**
For Reference R 325.1901	**Definitions.**
	(22) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following: **(d) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.**
ANALYSIS:	Resident A requires supervision while outside in the courtyard. Memory care staff did not ensure adequate supervision of Resident A by allowing her to go outside unattended. It is reasonable to assume that the lack of proper supervision could be a contributing factor to her falling.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Resident A was found outside by facility staff in the early morning hours on 7/29/21. Resident A's service plan clearly instructed that she required supervision when in the courtyard. Ms. Peoples attested that she observed Resident A go outside and made no attempts to accompany her, thus not ensuring that her service plan was followed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Emergency medical care was not sought for Resident A

INVESTIGATION:

The complainant alleged that Resident A sustained injury after her fall on 7/29/21 that included severe bruising, a cut above her nose, had worsening confusion and expressed having pain in her neck. The complainant expressed concerns that the facility didn't seek medical attention in a timely manner.

On 8/18/21, I interviewed facility nurse Angela Gustavison at the facility. Ms. Gustavison stated that she was contacted by med passer Tamara Donald notifying her of the fall. Ms. Gustavison stated that she was informed that it was apparent Resident A hit her head, as Ms. Donald described an abrasion to her forehead and a cut in between her eyes. Ms. Gustavison stated it was relayed to her by Ms. Donald that Resident A's vitals were within normal limits and she denied being in pain. Ms. Gustavison stated that normal protocol when someone hits their head is to send out to the hospital, however because pain was not reported she did not advise staff to call emergency medical services (EMS). Ms. Gustavison stated that she was told by Ms. Donald that Relative A was already contacted and advised that she did not want Resident A to go to the hospital. Ms. Gustavison stated that Ms. Donald reported to her that Relative A requested to have the facility monitor her and keep her updated. Ms. Gustavison stated that she came into work early that morning and evaluated Resident A. Ms. Gustavison stated that Resident A did not report any pain to her during her evaluation. Ms. Gustavison stated that she contacted Relative A after her assessment of Resident A and was also informed to continue to monitor her. Ms. Gustavison stated Resident A was not exhibiting signs of pain until Relative A came up to the facility later that morning when they decided to send her out for x-rays.

While Ms. Donald's written attestation identifies that Resident A expressed pain in her neck and head following the fall, Ms. Gustavison stated that this was not reported to her or she would have advised staff to send her to the hospital. Per the facility's incident report, EMS was contacted on 7/29/21 at 4:00pm.

Covenant Hospital documentation was reviewed and noted the following:

> The patient is a 92 y female who was admitted on 7/29/2021 because of a fall at her Bickford Assisted Living Center. It occurred about 5:00am. she is alert to self at baseline. She fell on the concrete and was noted at scattered ecchymoses over her face. She was brought to the emergency room where she was found to have acute nondisplaced bilateral fracture of the anterior arch of C1, acute hairline nondisplaced fracture of the posterior arches C4 vertebrae, mildly concave appearance of the superior endplate of T3.

Resident A also returned to the facility receiving hospice services.

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: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	Resident A sustained a fall with significant injury on 7/29/21. Conflicting reports from staff were obtained, however at least one staff member reports that Resident A expressed pain in her head and neck following the fall. Facility staff also expressed protocol of sending residents out to the hospital for medical evaluation whenever a resident hits their head, but this did not occur until nearly twelve hours later. Based on this information, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/24/21, I shared the findings of this report with authorized representative Justin Stein. Mr. Stein verbalized understanding of the citations however stated he would contact licensing staff with any questions following the review of this report.

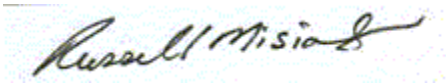
IV. RECOMMENDATION

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

8/24/21

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:



8/20/21

Russell B. Misiak Date
Area Manager