GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 19, 2023

Deanna Turner
Bickford of Canton
5969 N Canton Center Rd
Canton, MI 48187

RE: License #: AH820395445
Investigation #: 2023A1027046
Bickford of Canton

Dear Ms. Turner:

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,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820395445
Investigation #:	2023A1027046
Complaint Receipt Date:	02/24/2023
Investigation Initiation Date:	02/27/2023
Report Due Date:	04/26/2023
Licensee Name:	Bickford of Canton, LLC
Licensee Address:	Suite 301 13795 S Mur-Len Rd. Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Chanda Pantano
Licensee Designee:	Deanna Turner
Name of Facility:	Bickford of Canton
Facility Address:	5969 N Canton Center Rd Canton, MI 48187
Facility Telephone #:	(734) 656-5580
Original Issuance Date:	04/02/2020
License Status:	REGULAR
Effective Date:	10/02/2022
Expiration Date:	10/01/2023
Capacity:	78
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A lacked care.	Yes
Resident A did not receive her prescribed medications.	No
The memory care was short staffed.	No
The memory care lacked human interaction and staff were sleeping. The memory care residents were provided drinks only during meals.	No
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

02/24/2023	Special Investigation Intake 2023A1027046
02/27/2023	Special Investigation Initiated - Letter Email sent to Ms. Pantano requesting a resident roster
02/27/2023	Contact - Document Received Email received from Ms. Pantano with requested documentation
03/14/2023	Inspection Completed On-site
03/17/2023	Contact - Document Sent Documentation requested at on-site inspection was to be emailed. Email sent to Ms. Pantano requesting documentation be emailed.
03/17/2023	Contact - Document Received Email received with requested documentation
03/17/2023	Inspection Completed-BCAL Sub. Compliance
03/20/2023	Contact - Document Sent Email sent to Ms. Pantano requesting Employee #1 and #2's training records
03/22/2023	Contact - Document Received

	Email from Ms. Pantano received with requested documentation
04/19/2023	Exit Conference Conducted by email with authorized representative Ms. Turner

ALLEGATION:

Resident A lacked care.

INVESTIGATION:

On 2/24/2023, the Department received a complaint forwarded from the Attorney General's office which read Resident A lacked care. The complaint read Resident A was sitting in her own "filth" and had developed a red, irritated bottom. The complaint read Resident A was not eating well due to lack of support from staff and had lost weight. The complaint read Resident A was not dressed in her own clothing.

On 3/14/2023, I conducted an on-site inspection at the facility. I interviewed administrator Chanda Pantano who stated Resident A's family had moved her out on 2/28/2023 for the reasons consistent with the complaint.

While on-site, I interviewed Employee #1 who cared for Resident A. Employee #1 stated Resident A's care was provided consistent with her service plan. Employee #1 stated Resident A had started to decline and received hospice services. Employee #1 stated Resident A utilized a wheelchair in which her movement was limited. Employee #1 stated Resident A wore briefs and her buttock was red in which she applied Calmoseptine lotion, however, she did not have open wounds on her buttock area. Employee #1 stated Resident A had complained of a sore bottom once while caring for her in which she took her to utilize the restroom and afterward she stated it felt better. Employee #1 stated Resident A usually ate well for her, however her appetite was "up and down."

While on-site, I interviewed Employee #2 who cared for Resident A and her statements were consistent with Employee #1. Employee #2 stated Resident A spoke Italian in which she could speak Italian with her. Employee #2 stated Resident A's hospice agency staff provided showers, however staff completed her showers in between hospice agency visits and as needed.

While on-site, I reviewed the memory care unit's (referred to as Mary B's) shower schedule dated 12/15/2022. The schedule read Resident A was to receive showers every Tuesday and Friday on afternoon shift. I reviewed Resident A's shower logs dated December 2022 and January 2023. The logs read Resident A received showers on the following dates: 12/7/2022, 12/12/2022, 12/15/2022, 12/21/2022, 12/28/2022, 1/4/2023, 1/11/2023, 1/16/2023, 1/19/2023, 1/23/2023 and 1/30/2023. The logs read on 1/19/2023, the "nurse" completed a shower. The logs read on

1/23/2023 and 1/30/2023, the Brighton hospice staff completed a shower. The shower log for February 2023 for Resident A was blank.

I reviewed Resident A's face sheet which read she moved into the facility on 8/31/2020. The face sheet read Relative A1 was her primary financial contact.

I reviewed Resident A's admission agreement dated 8/31/2020 and signed by Relative A1 which read in part residents received a standard two baths per week.

I reviewed Resident A's service plan updated on 8/30/2022 which read Resident A followed a regular diet and would like her food cut-up prior to being served. The plan read Resident A really enjoyed bread and the kitchen was aware of her preference. The plan read to encourage fluids and offer her something to drink between mealtimes. The plan read Resident A had lost approximately nine pounds in the last six months. The plan read Resident A could feed herself and was known to mix her food all together. The plan read Resident A would sometimes try to pour her beverage on her plate and mix it with her food in which staff were to redirect her by correcting the way she drank and that they may have to get a new plate of food. The plan read staff were to provide verbal reminders at mealtimes and walk as a standby assist to and from meals. The plan read Resident A was one person assist for morning and evening care. The plan read staff were to offer Resident A two choices of clothing for the day and assist with dressing in which she would try to put her shoes on backwards, so staff were to demonstrate the correct way. The plan read at times Resident A refused to wear a brief but should wear one. The plan read if Resident A was unagreeable, to walk away and reattempt 15 minutes later. The plan read staff were to provide one person assist with undressing at night and changing into her pajamas as well as brush her teeth. The plan read there were times when Resident A preferred to sleep in her chair. The plan read Resident A was incontinent of both urine and bowel in which she was one person assist to change her briefs. The plan read to offer routine toileting every two to four hours which included upon waking, before and after meals, before bedtime and as needed. The plan read to have Resident A's brief remain clean and dry to avoid skin breakdown, as well as to perform peri care with each brief change. The plan read Resident A was a one person assist for showering/bathing in which she was unable to complete the tasks herself and staff were not to leave her unattended. The plan read her showers were Tuesday and Friday afternoons twice weekly and as needed. The plan read staff were to report any skin changes to the nurse. The plan read Resident A was a standby assist with mobility and utilized a walker in which she loved to walk. The plan read Resident A required coordination of health care with outside specialty services. The plan read staff were to check on Resident A at least once a night, but if asleep, to leave her sleeping. The plan read Resident A loved to participate in activities and was very social in which she loved to talk, go for walks, and play bingo.

I reviewed Resident A's weights from January 2022 through December 2022 which read in part on 1/2/2022 she was 140.9 pounds, on 6/2/2022 she was 151.4 pounds and on 12/2/2022 she was156 pounds.

I reviewed Resident A's charts notes dated from 8/31/2020 through 7/20/2022. Note dated 8/31/2020 read in part Resident A had moved into the assisted living unit at the facility. Note dated 1/18/2022 read Resident A had moved into the Mary B's unit.

I reviewed Brighton Hospice communication notes completed by the nurse. Note dated 1/13/2023 read in part Resident A's vital signs were within normal limits, staff reported she ate 100% of meals, she was no longer ambulatory, the high back wheelchair helped, and no wounds were reported. Note dated 1/16/2023 read in part staff reported Resident A denied pain, refused breakfast, and ate minimal lunch. Note dated 1/18/2023 read in part Resident A ate 100% of lunch, her vital signs were within normal limits, she complained of left lower extremity pain and staff were instructed to utilize Tylenol for leg pain. Note dated 1/26/2023 read in part staff reported Resident A fed herself breakfast and consumed 100%, participated in activities and was currently feeding herself lunch.

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: R 325.1901	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.

ANALYSIS:	Review of Resident A's records revealed she initially moved into an assisted living apartment then transitioned to the Mary B's unit in which she required one person assistance with her activities of daily living. Review of Resident A's service plan revealed she could eat independently, however required standby assistance and cueing during meals. The plan revealed she had history of weight loss in which review of records revealed the facility obtained monthly weights. Additionally, review of Resident A's service plan read consistent with facility's shower schedule and her admission agreement which revealed she was to receive showers twice weekly on Tuesdays and Fridays. However, the shower log sheets read Resident A had not always received showers twice weekly and sometimes they were completed once weekly. For example, from 12/16/2022 through 12/30/2022, the logs read Resident A received one shower each week, as well as from 12/30/2022 through 1/10/2023, and the February 2023 log sheet had no showers documented. Furthermore, Resident A's service plan read she received health care coordination; however, the plan lacked specific services requiring coordination. It was unknown when Resident A initiated hospice services, thus it could not be determined if the showers were missed by facility staff or provided by the hospice agency and not documented by staff on the logs. Although review of documentation could not substantiate her bottom was reddened from lack care nor that she was not dressed in her own clothing, based on the above information, this violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive her prescribed medications.

INVESTIGATION:

On 2/24/2023, the Department received a complaint forwarded from the Attorney General's office which read Resident A had glaucoma and required her to need eye drops every night to keep the pressure down. The complaint read Resident A had seen an eye doctor in which her eye pressure had increased which meant she had not received her eye drops at night.

I reviewed Resident A's December 2022, January 2023 through February 28, 2023 medication administration records (MARs). The MARs read staff initialed Resident

A's medications as administered per the licensed healthcare professional's orders. The MAR read Resident A was prescribed Lumigan 0.01%, instill one drop into each eye every night at bedtime in which staff initialed the medication as administered.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Review of the Resident A's MARs revealed staff were to administer her medications in which she was prescribed eye drops at bedtime. Resident A's MARs read staff initialed her medications as administered; however, the MARs could not be compared to the medications in the facility's medication cart since she had discharged on 2/28/2023. Thus, there was insufficient evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The memory care was short staffed.

INVESTIGATION:

On 2/24/2023, the Department received a complaint forwarded from the Attorney General's office which read the memory care was short staffed.

On 3/14/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Pantano who stated the Mary B's unit currently had six residents. Ms. Pantano stated the Mary B's unit was staffed with one caregiver and one medication technician for each shift in which there were three shifts. Ms. Pantano stated one memory care resident required a two-person assist. Ms. Pantano stated the facility had utilized a staffing agency.

While on-site, I interviewed Employee #1 and #2 who statements were consistent with Ms. Pantano.

While on-site, I observed three staff assigned to the Mary B's unit, as well as Employee #3 assisting a resident with her meal.

While on-site, I reviewed the resident roster which read consistent with statements from Ms. Pantano.

I reviewed the facility's daily staffing sheets from February 1, 2022, through March 14, 2023, in which read a medication technician and caregiver were to be scheduled for each shift in Mary B's. The schedule read there were three shifts: days, afternoons, and midnights. Some daily staffing sheets read "posted in book Jane" next to a blank space for the medication technician or caregiver.

On 3/17/2023, per email correspondence with Ms. Pantano, "posted in book Jane" is when the facility posts open shifts for caregivers to pick up. Ms. Pantano stated if there was one caregiver or medication technician in Mary B's, then the staff would walkie/call for another staff member from the assisted living for assistance.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Interview with Ms. Pantano revealed the Mary B's unit was to be scheduled with one medication technician and one caregiver. Review of the staffing schedule revealed there was not always one medication technician and caregiver in the Mary B's unit. Review of the staffing schedule revealed the assisted living unit staffed both medication technicians and caregivers who could be summoned for assistance if needed. Although the facility had not always staffed the Mary B's unit per their policy, the facility met this rule requirement. Based on that information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The memory care lacked human interaction and staff were sleeping. The memory care residents were provided drinks only during meals.

INVESTIGATION:

On 2/24/2023, the Department received a complaint forwarded from the Attorney General's office which read there was no human interaction in the memory care and staff were sleeping at work. The complaint read residents were only provided drinks during meals.

On 3/14/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Pantano who stated since February 2023 the facility had transitioned Employee #3 from working full time at the front desk to the activities department. Ms. Pantano stated Employee #4 was recently hired as the nurse coordinator for the Mary B's unit in which she provided oversight for activities on the unit. Ms. Pantano stated she was not apprised of staff sleeping and would follow the facility's disciplinary policy if that occurred.

While on-site, I interviewed Employee #3 who stated she worked previously at the front reception desk, however, now was working full-time conducting activities with residents. Employee #3 stated she worked Monday through Friday, 8:30 AM to 4:30 PM, then every other weekend at the front desk. Employee #3 stated a majority of her time was in the Mary B's unit in which her activities consisted of but was not limited to: listening to music of the residents' generation, playing balloon toss, walking, coloring, counting, flash cards, reading out loud, working with pipe cleaners, crafts, and watching movies such as Little House on the Prairie, Andy Griffith, and I love Lucy after lunch. Employee #3 stated memory care residents were offered snacks and water around 10:30 AM. Employee #3 stated *Tender Hearts,* an outside agency, also provided an activity every week at no cost to the residents. Employee #3 denied observing staff sleep while working.

While on-site, I interviewed Employee #4 who provided an example of a monthly activities calendar created in which read there were planned activities throughout each day for the Mary B's unit. Employee #4 denied observing staff sleep while working. Employee #4 stated snacks and drinks were available and offered between meals for residents.

While on-site, I observed Employee #3 with six memory care residents sitting around a table listening to music and playing balloon toss prior to their lunch meal being served. I observed three staff assisting residents during their lunch meals.

I reviewed Resident A's admission contract dated 8/31/2020 which read that the facility had a Mary B's Neighborhood. The contract read under the addendum that Mary B's was specifically designed to accommodate the special needs of individuals with Alzheimer's disease, dementia and other conditions that require more individualized services. The contract read Mary B's small sized unit assisted in managing confusion and agitation. The contract read Mary B's had increased staffing levels and specialty programming provided to encourage quality care.

I reviewed Employee #1 and #2 training records dated 10/24/2022 and 10/11/2022 consecutively which read in part staff received training on the following physical and mental care needs of residents, dementia, resident rights and responsibilities, and resident abuse and neglect.

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 325.1952**	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.
ANALYSIS:	Staff attestations and observations revealed the facility had implemented daily activities with the Mary B's residents. There was lack of evidence to support staff were sleeping while working or that drinks and beverages were not provided. Based on this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Jessica Rogers 03/24/2023

Jessica Rogers Date
Licensing Staff

Approved By:

Andrea L. Moore 04/18/2023

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