GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 21, 2023

Krystyna Badoni
Portage Bickford Cottage
4707 W. Milham Ave.
Portage, MI 49024

RE: License #: AH390278221
Investigation #: 2023A1028062
Portage Bickford Cottage

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH390278221
Investigation #:	2023A1028062
Complaint Receipt Date:	06/27/2023
Investigation Initiation Date:	06/28/2023
Report Due Date:	08/27/2023
Licensee Name:	Portage Bickford Cottage LLC
Licensee Address:	Suite 301, 13795 S. Mur-Len Road Olathe, KS 66062
Licensee Telephone #:	(810) 962-2445
Administrator:	Angela Rafferty
Authorized Representative:	Krystyna Badoni
Name of Facility:	Portage Bickford Cottage
Facility Address:	4707 W. Milham Ave., Portage, MI 49024
Facility Telephone #:	(269) 372-2100
Original Issuance Date:	03/05/2007
License **Status:**	REGULAR
Effective Date:	06/28/2023
Expiration Date:	06/27/2024
Capacity:	71
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff did not provide care in accordance with Resident A's service plan.	Yes
Additional Findings	No

III. METHODOLOGY

06/27/2023	Special Investigation Intake 2023A1028062
06/28/2023	Special Investigation Initiated - Letter
06/28/2023	APS Referral APS referral made to Centralized Intake
06/28/2023	Contact - Face to Face Interviewed Admin/Angela Rafferty at the facility.
06/28/2023	Contact - Face to Face Interviewed Employee A at the facility.
06/28/2023	Contact - Face to Face Interviewed Employee B at the facility.
06/28/2023	Contact - Document Received Received Resident A's record from Admin/Angela Rafferty.
06/28/2023	Contact - Telephone call made Interviewed the complainant by telephone.

This special investigation will only address potential violations pertaining to the rules and regulations of Homes for the Aged (HFA).

ALLEGATION:

Staff did not provide care in accordance with Resident A's service plan.

INVESTIGATION:

On 6/27/2023, the Bureau received the allegations through the online complaint system.

On 6/28/2033, an APS referral was made through Centralized Intake.

On 6/28/2023, I interviewed the facility administrator, Angela Rafferty, at the facility who reported Resident A was admitted to the facility in March 2023. Resident A required one to two person assist, cuing, and set-up with most care. Resident A also had a nephrostomy tube that home health nursing monitored weekly. However, facility staff were trained to cue Resident A to not sit on the tube, to keep the tube below the bladder, and to monitor the tube and skin integrity for signs of infection, pain, or discomfort. Ms. Rafferty explained to Resident A's authorized representative that facility staff would monitor the tube and ensure cleanliness, but that home health would ultimately be caring for the tube since it required a license skilled person to complete that type of care. Ms. Rafferty reported this was also noted in Resident A's service plan with Resident A and [their] authorized representative in agreement. Ms. Rafferty reported Resident A's home health was set up by the Veterans Administration and while the facility requested increased visits due to Resident A's fluctuating condition throughout [their] stay at the facility, the home health company would not increase nursing visits to more than one time per week. Resident A was an increased fall risk as well and interventions were put into place to help prevent falls, but Resident A incurred two falls at the facility and was sent to the hospital for further evaluation. Ms. Rafferty reported Resident A's health continued to fluctuate while at the facility with Resident A requiring multiple hospitals stays due to decline. Ms. Rafferty reported Resident A demonstrated behaviors during care routines and would not follow staff direction or wait for staff to assist. Resident A often tried to self-transfer despite staff direction not to which resulted in falls. Ms. Rafferty reported Resident A was sent to the hospital again in May 2023 due to a change in condition and was unable to return to the facility due to the required level of care needed. Ms. Rafferty reported Resident A now required admittance to a skilled facility, but [their] authorized representative had difficulty understanding why Resident A could not return to the facility with increased home services. Ms. Rafferty reported the home health services were in agreement that Resident A required skilled care and [they] would not be able to provide those services at the facility. Ms. Rafferty reported Resident A was discharged from the facility on 6/6/2023 with Resident A's authorized representative removing Resident A's personal belongings from the facility then. Ms. Rafferty reported the facility keep consistent communication with Resident A's authorized representative, physician, and home health company while Resident A was at the facility. Ms. Rafferty reported after the last hospital stay, "[Resident A] was beyond the level of care we and home health could provide". Ms. Rafferty provided me Resident A's record for my review.

On 6/28/2023, I interviewed Employee A at the facility who reported Resident A entered the facility in March 2023 and was discharged in June 2023 due to

exceeding the level of care the facility could provide. Employee A confirmed Resident A entered the facility requiring one to two person assistance with most care. Employee A reported staff were trained to monitor Resident A's nephrostomy tube which included cuing Resident A to not sit on the tube, to keep the tube below the bladder, and to monitor the tube and skin integrity for signs of infection, pain, or discomfort. Employee A reported a home health company saw Resident A one time per week due to the nephrostomy tube. The facility requested increased nursing visits from home health, but the home health company declined. Employee A reported it was explained to Resident A's authorized representative that facility staff would monitor the nephrostomy tube for infection, pain, discomfort and to ensure cleanliness, but the home health would ultimately be caring for the tube since it required a license skilled person to provide that kind of care. Employee A reported Resident A's authorized representative had difficulty understanding the separation of care between the facility and the home health company, but it was documented in the service plan accordingly. Employee A reported Resident A had falls at the facility due to not waiting for staff to assist, for self-transferring despite being told not to, and for not using the call-light consistently. Resident A could be defiant and demonstrate behaviors during care routines. Resident A was sent to the hospital multiple times due to changes in condition with the last hospital visit occurring in late May 2023. Employee A reported Resident A was unable to return to the facility due exceeding the level of care the facility and the home health company could provide. Resident A required a skilled setting after the last hospital stay with Resident A being discharged from the facility on 6/6/2023. The authorized representative removed Resident A's personal belongings from the facility after the discharge. Employee A reported the facility followed physician orders and communicated consistently with Resident A's authorized representative, physician, and home health company while Resident A was at the facility.

On 6/28/2023, I interviewed Employee B at the facility whose statements are consistent with Ms. Rafferty's statements and Employee A's statements.

On 6/28/2023, I interviewed the complainant by telephone who reported the facility should not have accepted Resident A if the facility could not provide appropriate care. The complainant reported the home health company should have provided more visits and that facility staff did not ensure good care for Resident A's nephrostomy tube. The complainant also provided me pictures of Resident A and the nephrostomy tube bag from the last hospital visit in May 2023.

On 7/12/2023, I reviewed Resident A's service plan which revealed the following:

- Resident A required total assist with morning care to include assistance with upper and lower body dressing, bathing, hygiene, grooming, and peri care.
- Required *complete nephrostomy care during a.m. cares. Notify HWD if nephrostomy tubing is compromised, or drainage bag is leaking.*
- Required total assist with nightly care to include oral care, upper and lower body dressing, and peri care.

- *[Resident A] has left nephrostomy tube that will drain urine into collection bag. BFM to ensure that nephrostomy tubing is secured. Please ensure urine collection bag is secure and sits below the bladder.*
- Required two person assist with use of Hoyer lift with all transfers.
- Required assistance with wheelchair ambulation.
- Evidence of detailed procedure for staff to follow for nephrostomy care.
- Evidence that Resident A is a documented increased fall risk with interventions in place.
- Evidence staff initialed the service plan due in understanding of Resident A's prescribed plan of care.
- No evidence Resident A or their authorized representative signed the service plan in agreement of services.

I reviewed the record notes which revealed the following:

- Evidence of falls on 4/7/2023, 4/9/2023, and 4/10/2023.
- Evidence of the facility monitoring Resident A's nephrostomy tube with communication to physician when change of condition noted.

I reviewed the home health record notes which revealed the following:

- Evidence of nephrostomy tube care completed by home health company.
- Evidence pf physical therapy assessment and planned treatment.
- Evidence Resident A returned from the hospital with the wrong connecting bag for nephrostomy tube.
- Evidence of issues with nephrostomy tube kinking and tubing found underneath Resident A.

On 7/12/2023, I requested a signed copy of Resident A's service plan from Ms. Rafferty. Ms. Rafferty provided the same unsigned copy of the service plan I had obtained previously during the on-site investigation. Ms. Rafferty stated in the return email, "*The Service plan I have that has signatures are that of myself and my RNC. The initials at the bottom of the service plan you have a copy of are those staff members who reviewed it while it was in our communication book."*

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:	It was alleged the facility did not provide care in accordance with Resident A's service plan. Interview, on-site investigation, and review of documentation the facility had detailed service plan and plan of care in place for Resident A's nephrostomy tube. Facility management and staff signed the service plan and plan of care, but it was not signed by Resident A and/or Resident's authorized representative. It cannot be determined if Resident A or Resident A's authorized representative were in agreement with the service plan and nephrostomy tube plan of care. Also, further review of the record revealed there is evidence that Resident A's nephrostomy tube was found kinked and that the tubing was found underneath Resident A which violated the facility nephrostomy tube plan of care.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Viviano

7/17/2023

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

08/21/2023

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