GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 21, 2023

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

RE: License #: AH230387590
Investigation #: 2024A1021019
Bickford of W Lansing

Dear Mrs 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) 284-9730.

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 #:	2024A1021019
Complaint Receipt Date:	12/06/2023
Investigation Initiation Date:	12/08/2023
Report Due Date:	02/05/2024
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:	
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:	12/09/2022
Expiration Date:	12/08/2023
Capacity:	72
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident C not provided medical attention.	Yes
Resident C did not receive required laboratory testing.	No
Additional Findings	Yes

III. METHODOLOGY

12/06/2023	Special Investigation Intake 2024A1021019
12/08/2023	Special Investigation Initiated - On Site
12/12/2023	Contact - Telephone call made interviewed facility nurse
12/12/2023	Contact-Document Received Received additional intake with complaints
12/13/2023	Contact- Telephone call made Interviewed Greg Morrision, NP
	Exit Conference

ALLEGATION:

Resident C not provided medical attention.

INVESTIGATION:

On 12/06/2023, the licensing department received a complaint with allegations Resident C complained of a urinary tract infection (UTI) and it took days for medical attention to be provided. The complainant alleged that on 11/07/2023, Resident C complained of urinary issues and requested for a urinalysis to be completed. The complainant alleged it took seven days for a urinalysis test to be completed and then five days later for an antibiotic to be ordered.

On 12/08/2023, I interviewed administrator Fallon Williams at the facility. Ms. Williams reported on 11/08/2023, she received a text message from Resident C's family regarding the urinalysis test for Resident C. Ms. Williams reported she received the same text message on 11/09/2023. Ms. Williams reported she

responded that the facility was waiting for the order from the laboratory. Ms. Williams reported on 11/18/2023, the result from the laboratory came back and an order for the antibiotic was called in to Walgreens. Ms. Williams reported that she is not responsible for anything clinical at the facility and the licensee corporate health and wellness director, Kim Davis, manages the clinical needs of the residents. Ms. Williams reported she believes Ms. Davis was involved in the situation from 11/09/2023-11/18/2023.

On 12/12/2023, I interviewed Ms. Davis by telephone. Ms. Davis reported Resident C's family reached out to Ms. Williams on 11/09/2023. Ms. Davis reported she did not become involved until 11/13/2023 when she was back in the facility. Ms. Davis reported she was informed that Resident C needed a urinalysis ordered. Ms. Davis reported the urine was collected on 11/14/2023 and the preliminary results were obtained on 11/16/2023. Ms. Davis reported the results on 11/16/2023 showed a preliminary infection but that the physician wanted to wait until the urine culture came back to ensure the correct medication was prescribed. Ms. Davis reported on 11/17/2023, Resident C's family contacted Ms. Williams again and Ms. Williams reached out to Resident C's physician and an antibiotic was ordered at that time. Ms. Davis reported she is the one responsible for clinical issues with the residents and is available 24/7, however, she is often not informed of clinical issues. Ms. Davis reported she is working with Ms. Williams and the facility on ensuring she is made aware of clinical concerns.

On 12/13/2023, I interviewed Greg Morrison nurse practitioner by telephone. Mr. Morrison reported he prescribed an antibiotic for Resident C on 11/18/2023. Mr. Morrison reported he does not recall when and if the facility reached out to him regarding the order for the urinalysis test. Mr. Morrison reported this test is often prescribed by a verbal order so that there is no documentation of the order.

The facility had no documentation of communication with Resident C's physician nor Resident C's change in condition.

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.**
	(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 conducted revealed the facility was made aware of the request for a urinalysis test on 11/08/2023 but the request for the test was not communicated to the physician until 11/13/2023. In addition, there was no continued communication with the physician on the request for the results and for a medication to be started. The facility lacked an organized program of protection for the residents in regard to the clinical needs of Resident C.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident C did not receive required laboratory testing.

INVESTIGATION:

On 12/12/2023, the licensing department received a complaint with allegations Resident C did not receive required international normalized ratio (INR) laboratory testing while at the facility. The complainant alleged the facility reported they would be able to coordinate testing, however, Resident C did not have any testing completed while living at the facility for approximately 11 months.

On 12/13/2023, I reached out to Ms. Davis regarding the INR testing. Ms. Davis was able to obtain one INR test result from an emergency room visit on 04/18/2023. Ms. Davis and Ms. Williams were unable to locate any additional INR testing or orders for INR testing.

On 12/18/2023, I interviewed Mr. Morrison by telephone. Mr. Morrison reported typically INR testing is done every three months if the patient is stable. Mr. Morrison reported if Resident C required INR laboratory testing, there would have been a handwritten order provided to the facility nurse. Mr. Morrison reported there was turnover with facility nursing staff and the order could have been lost with the transition in nursing staff. Mr. Morrison reported that the physician office does not keep record of any handwritten orders, therefore, he cannot confirm nor deny that Resident C required INR testing. Mr. Morrison reported Resident C was asymptomatic and did not demonstrate any symptoms.

I reviewed the INR test result from 04/18/2023. The test results revealed the test was completed at a Sparrow Emergency Room.

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.**
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	(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 conducted and documents reviewed revealed Resident C was on warfarin medication which may have required INR testing. However, the facility and the physician's office were unable to locate any history of orders for INR laboratory testing. There is lack of evidence to support the allegation the facility did not coordinate INR testing to be completed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Davis reported the medication for Resident C was obtained at Walgreens and not through the facility pharmacy. Ms. Davis reported review of Resident C's medication administration record (MAR) revealed no record that the medication was ordered or administered because it was not obtained through their facility pharmacy.

Ms. Davis reported she was not made aware that Resident C was prescribed this medication until she heard of this complaint. Ms. Davis reported Resident C moved out of the facility on 11/20/2023.

I reviewed the MAR for November 2023 for Resident C. The MAR revealed no record of Keflex antibiotic administered from 11/18-11/20.

APPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(i) The name of the prescribed medication.** **(ii) The prescribed required dosage and the dosage that was administered.** **(iii) Label instructions for use of the prescribed medication or any intervening order.** **(iv) The time when the prescribed medication is to be administered and when the medication was administered.**
ANALYSIS:	Interviews conducted and review of documentation revealed Resident C was prescribed Keflex antibiotic on 11/18/2023. However, review of the MAR revealed no record that this medication was administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/18/2023

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Kimberly Horst — Date
Licensing Staff

Approved By:

12/20/2023

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