GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 9, 2023

Krystyna Badoni
Bickford of W Lansing, LLC
Suite 301
13795 S Mur-Len Road
Olathe, KS 66062

RE: License #: AH230387590
Investigation #: 2024A1028007
Bickford of W Lansing

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 #:** | AH230387590 |
| | |
| **Investigation #:** | 2024A1028007 |
| | |
| **Complaint Receipt Date:** | 10/18/2023 |
| | |
| **Investigation Initiation Date:** | 10/23/2023 |
| | |
| **Report Due Date:** | 12/17/2023 |
| | |
| **Licensee Name:** | Bickford of W Lansing, LLC |
| | |
| **Licensee Address:** | Suite 301<br>13795 S Mur-Len Road<br>Olathe, KS 66062 |
| | |
| **Licensee Telephone #:** | Unknown |
| | |
| **Administrator:** | Fallon Williams |
| | |
| **Authorized Representative:** | Krystyna Badoni |
| | |
| **Name of Facility:** | Bickford of W Lansing |
| | |
| **Facility Address:** | 6429 Earlington Ln<br>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:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A's bathroom was flooded resulting in mold. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 10/18/2023 | Special Investigation Intake<br>2024A1028007 |
| 10/23/2023 | Special Investigation Initiated - Letter |
| 10/23/2023 | APS Referral<br>APS referral made to Centralized Intake. |
| 11/13/2023 | Contact - Face to Face<br>Interviewed Admin/Fallon Williams at the facility. |
| 11/13/2023 | Contact - Face to Face<br>Interviewed Employee A at the facility. |
| 11/13/2023 | Contact - Face to Face<br>Interviewed Employee B at the facility. |
| 11/13/2023 | Contact - Face to Face<br>Interviewed Employee C at the facility. |
| 11/13/2023 | Contact - Face to Face<br>Interviewed Resident A at the facility. |

**ALLEGATION:**

Resident A's bathroom was flooded resulting in mold.

**INVESTIGATION:**

On 10/19/2023, the Bureau received the allegations through the online complaint system.

On 10/19/2023, an Adult Protective Services (APS) referral was made to Centralized Intake.

On 11/13/2023, I interviewed facility administrator, Fallon Williams, at the facility who confirmed that Resident A's bathroom was flooded on 8/22/2023 due to the resident in the unit above Resident A's apartment clogging the toilet. Ms. Williams reported Resident A was temporarily moved to another room while Resident A's room and bathroom were cleaned. Drywall was replaced in the bathroom, and it was repainted. A new light fixture was installed as well. However, there was a smell in the room with the facility re-assessing the room to ensure cleanliness and no mold development. No mold was found in the bathroom, the light fixture, and/or anywhere else in Resident A's apartment. Due to the odor in the room the carpet was removed and replaced as well. The carpet removal company staff reported the carpet had evidence of consistent cat urine and urine stains. The carpet removal company staff reported the smell was more than likely the result of the cat urine. Ms. Williams reported Resident A has a cat and completes care for the cat unassisted as listed in the service plan. Ms. Williams reported that Resident A and [their] authorized representative and family were communicated with regularly about the bathroom flooding incident, clean-up, and restoration of Resident A's room. Resident A is now back in [their] apartment and there have been no further issues or complaints from Resident A's authorized representative and family. Ms. Williams provided me Resident A's service plan for my review.

On 11/13/2023, I interviewed Employee A at the facility who reported Resident A's bathroom was flooded due to the resident in the unit above clogging the toilet. Employee A reported Resident A was temporarily moved to another room while the flooded bathroom and apartment was cleaned and restored. Employee A confirmed the bathroom had drywall replaced, a new light fixture, and paint. A mold assessment was completed, and no mold was detected. However, the carpet was replaced in Resident A's room due to the flooding incident and due to a continued odor. Employee A reported the carpet removal company informed the facility the carpet had cat urine and urine stains resulting in the continued odor in Resident A's room. Employee A confirmed the family was communicated with throughout the incident and process of restoring Resident A's room.

On 11/13/2023, I interviewed Employee B and Employee C at the facility whose statements were consistent with Ms. Williams statements and Employee A's statements.

On 11/13/2023, I completed an inspection of Resident A's room in which a detectable cat urine smell was observed. The litter was also observed scattered around the litter box on the floor of the bathroom.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1979** | **General maintenance and storage.** |
| | **(1) The building, equipment, and furniture shall be kept clean and in good repair.** |

| | |
|---|---|
| **ANALYSIS:** | It was alleged Resident A's bathroom flooded and there was evidence of mold growing in the bathroom. Interviews, on-site inspection, and review of documentation revealed there is no evidence of mold growing. The facility appropriately relocated Resident A to another room while Resident A's room was restored. New drywall, paint, and a light fixture were installed, and a mold assessment was completed with no evidence of mold being detected. The facility appropriately addressed and resolved the incident in a timely manner.<br><br>However, upon inspection of Resident A's room, there was detectable smell of cat urine in the bathroom and in the main living area of the room. Resident A's room cannot be considered clean due to the detectable odor of cat urine and due to the cat litter scattered around the litter box in the bathroom. The facility must ensure the resident's room is in good repair and clean, therefore the facility is in violation. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**Additional Findings**

**INVESTIGATION:**

On 11/13/2023, I reviewed Resident A's service plan which revealed Resident A has a cat and is *independent with the care of the cat, managing supplies, and/or vet visits.* The service plan was dated 10/17/2023.

On 11/13/2023, Employee B and Employee C confirmed Resident A receives assistance from care staff and housekeeping staff with cleaning of the litter, cleaning of the litter box, and removal of litter from Resident A's room. Both employees reported staff help because the cat litter can be too heavy at times for Resident A to move by [themselves].

On 11/13/2023, I completed an inspection of Resident A's room and observed the litter box on the floor of the bathroom with litter kicked out of the box. I also observed a detectable smell of cat urine in bathroom and the main living area of Resident A's apartment as well.

On 11/13/2023, I interviewed Resident A with Resident A stating [they] do all the care and clean-up for the cat.

| APPLICABLE RULE | |
|---|---|
| **325.1922** | **Admission and retention of residents.** |
| | **(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.** |
| **ANALYSIS:** | Interviews, on-site inspection, and review of documentation revealed Resident A's service plan was recently updated on 10/17/2023. Resident A is marked as being independent with the care of [their] cat. However, interviews with staff revealed Resident A has been receiving assistance from care staff and housekeeping staff to care for the cat. Resident A cannot be considered independent with pet care if [they] are receiving any form of assistance from facility staff. The service plan does not appropriately reflect Resident A's current level of function and therefore, the facility is in violation. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

11/16/2023

Julie Viviano Date
Licensing Staff

Approved By:

01/08/2024

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