GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 24, 2024

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

RE: License #: AH230387590
Investigation #: 2024A1021047
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 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) 284-9730.

Sincerely,

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 #:	2024A1021047
Complaint Receipt Date:	03/26/2024
Investigation Initiation Date:	03/27/2024
Report Due Date:	05/25/2024
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:	Fallon Wiliams
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:	12/09/2023
Expiration Date:	07/31/2024
Capacity:	72
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident B's privacy violated.	Yes
Resident A did not receive nightly checks.	Yes
Resident A received incorrect medications.	No
Resident A did not receive showers.	No
Resident A's sheets were not changed.	No
Additional Findings	Yes

III. METHODOLOGY

03/26/2024	Special Investigation Intake 2024A1021047
03/27/2024	Special Investigation Initiated - Telephone message left with complainant
04/01/2024	Inspection Completed On-site
04/01/2024	Contact-Telephone call made Interviewed SP2
04/01/2024	Contact-Telephone call made Interviewed SP3
04/01/2024	Contact-Telephone call made Interviewed SP4
04/02/2024	Contact-Telephone call made Interviewed SP6
04/04/2024	Contact-Telephone call made Interviewed SP5
04/24/2024	Exit Conference

ALLEGATION:

Resident B's privacy violated.

INVESTIGATION:

On 03/26/2024, the licensing department received a complaint with allegations Resident A received incorrect medications and, in the process, Relative A1 was shown Resident B's chart.

On 04/01/2024, I interviewed SP4 by telephone. SP4 reported she administered incorrect medications to Resident A. SP4 reported as she was administering medications to Resident A, Relative A1 stopped her and questioned about the medications. SP4 reported they went back to the medication room and SP4 showed Relative A1 Resident B's chart. SP4 reported it was then discovered the wrong medications were administered.

I reviewed SP4 employee training record. SP4 was trained on confidentiality during her initial training.

I reviewed facility *Medication Error Report*. The report read,

> *"(SP4) did not carry med bag with meds, No scanner, No laptop. Education, staff to carry med bag and meds, carry laptop and scanner."*

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(c) A patient or resident is entitled to confidential treatment of personal and medical records, and may refuse their release to a person outside the health facility or agency except as required because of a transfer to another health care facility, as required by law or third party payment contract, or as permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.**

ANALYSIS:	Interviews conducted and review of documentation revealed Resident B's privacy was violated when SP4 showed Resident B's medication administration record (MAR) to Relative A1.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive nightly checks.

INVESTIGATION:

The complainant alleged Resident A did not receive nightly checks as evidenced by the family's video monitoring system located in Resident A's room.

On 04/01/2024, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident A was initially care planned for minimal assistance. SP1 reported after one day at the facility, family requested additional assistance for Resident A. SP1 reported Resident A was to receive one nightly check.

On 04/01/2024, I interviewed administrator Fallon Williams at the facility. Ms. Williams reported the facility was aware Resident A's family had a video monitoring system in the room. Ms. Williams reported there was a sign posted on Resident A's door to inform staff. Ms. Williams reported the facility does not document if checks are completed.

On 04/01/2024, I interviewed SP2 by telephone. SP2 reported she works third shift. SP2 reported she only assisted Resident A once to the bathroom. SP2 reported Resident A did not require any nighttime assistance or checks.

On 04/01/2024, I interviewed SP3 by telephone. SP3 reported she works third shift. SP3 reported no knowledge that Resident A required a nightly check.

I reviewed Resident A's service plan. The service plan read,

"Please provide 1 night check, if resident is awake please offer toileting."

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:	Review of Resident A's service plan revealed Resident A was to be checked on nightly. However, interviews conducted with third shift workers revealed this was not completed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A received incorrect medications.

INVESTIGATION:

The complainant alleged Resident A received incorrect medications. The complainant alleged on 03/14/2024, Resident A received Resident B's medication. The complainant alleged Resident A did not receive as needed pain medication on 03/16/2024. The complainant alleged Resident A did not receive morning medication on 03/22/2024.

SP1 reported it was brought to her attention on 03/15/2024 that Resident A received one incorrect medication. SP1 reported SP4 administered incorrect medication to Resident A. SP1 reported SP4 was provided additional education and was written up.

Ms. Williams reported when Resident A admitted to the facility, the family refused to provide medications in bottles and tried to provide the facility with a pill organizer. Ms. Williams reported education was provided to Resident A's family that medication must be in bottles to ensure correct medication is administered. Ms. Williams reported there was a medication error on 03/14/2024 with SP4. Ms. Williams reported the staff member did not bring the computer to Resident A's room to ensure the correct medication was administered. Ms. Williams reported SP4 received discipline and additional training. Ms. Williams reported no knowledge of Resident A not receiving medications on 03/22/2024.

On 04/01/2024, I interviewed SP4 by telephone. SP4 reported she did administer the incorrect medication to Resident A. SP4 reported she was in the medication room and there was a resident upset about medications and a family member upset. SP4 reported she was confused with Resident A's medications as the medications were in a pill bottle and not in a bubble pack. SP4 reported she went into Resident A's room and administered Resident B's medication. SP4 reported Resident A's family questioned the medications and that is when it was discovered the incorrect medications were administered. SP4 reported she was taken off the medication cart for two days and was provided additional training.

On 04/02/2024, I interviewed SP6 by telephone. SP6 reported she administered pain medication per family request. SP6 reported Resident A had PRN pain medication orders for Ibuprofen and Acetaminophen.

On 04/04/2024, I interviewed SP5 by telephone. SP5 reported Resident A's family would take photos of care staff providing care to Resident A. SP5 reported staff members would typically administer medications as Resident A was leaving the dining room in the medication room.

I reviewed documentation *Medication Error Report.* The narrative of the report read,

> *"Wrong medication was given. (SP4) did not carry med bag with meds, no scanner, no laptop. Family noticed there were to many pills. (SP4) did not notify PCP or HWD. Education, staff to carry med bag and meds, carry laptop and scanner."*

I reviewed Resident A's MAR for 2024. The MAR revealed staff initialed on 03/22/2024 that Resident A received his morning medications. The MAR revealed on 03/16/2024 at 1:15pm and 7:09pm Resident A received Ibuprofen Tab 400mg for pain/fever and the medication was effective.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Interviews conducted and review of March MAR revealed Resident A did receive PRN pain medications on 03/16/2024 and did receive medications on 03/22/2024. While Resident A did receive incorrect medication on 03/14/2024, the facility acted appropriately by providing education and discipline to the staff member.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A did not receive showers.

INVESTIGATION:

The complainant alleged Resident A did not receive showers.

Ms. Williams reported Resident A's family often visited Resident A and would provide a shower to Resident A. Ms. Williams reported Resident A was to receive one or two showers a week on Tuesdays and Fridays. Ms. Williams reported Resident A resided at the facility 03/11/2024-03/22/2024 and would have received at least two showers.

I reviewed facility *Skin Monitoring: Comprehensive CNA Shower Review* for Resident A. The documents revealed Resident A received a shower on 03/12/2024 and 03/19/2024.

I reviewed Resident A's service plan. The service plan read,

> *"staff to provide queuing and step by step instructions, (Resident A) can wash himself but does need queuing. 1-2 times a week."*

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Interviews conducted and review of documentation revealed Resident A resided at the facility 03/11-03/22. Resident A was to receive one shower a week and review of documentation revealed this did occur.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident sheets were not changed.

INVESTIGATION:

The complainant alleged resident sheets were not changed.

Ms. Williams reported no knowledge of concerns with laundry. Ms. Williams reported second shift completes laundry and first shift puts away laundry.

SP5 reported she took care of Resident A's laundry. SP5 reported Resident A's sheets were washed and his bed had clean bedding.

Resident A no longer resided at the facility, and I was unable to view his bedding. However, I viewed other resident's bedding and did not observe any cleanliness issues.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(1) Bedding shall be washable, in good condition, and clean, and shall be changed at least weekly or more often as required.
ANALYSIS:	Interviews conducted and observations made revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's MAR revealed staff initialed that medications were administered on 03/26/2024.

APPLICABLE RULE	
R 325.1932	**Resident 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:** **(v) The initials of the individual who administered the prescribed medication.**
ANALYSIS:	Resident A discharged from the facility on 03/22/2024, however, staff incorrectly documented that medications were administered to Resident A on 03/26/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

04/10/2024

Kimberly Horst — Date
Licensing Staff

Approved By:

04/23/2024

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