GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 18, 2024

Krystyna Badoni
Saginaw Bickford Cottage
5275 Mackinaw Rd.
Saginaw, MI 48603

RE: License #: AH730279101
Investigation #: 2024A1019057

Dear Licensee:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730279101
Investigation #:	2024A1019057
Complaint Receipt Date:	05/17/2024
Investigation Initiation Date:	05/20/2024
Report Due Date:	07/16/2024
Licensee Name:	Saginaw Bickford Cottage, LLC
Licensee Address:	13795 S. Mur Len Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Krystyna Badoni
Authorized Representative:	Melissa Kline
Name of Facility:	Saginaw Bickford Cottage
Facility Address:	5275 Mackinaw Rd. Saginaw, MI 48603
Facility Telephone #:	(989) 799-9600
Original Issuance Date:	02/08/2007
License Status:	REGULAR
Effective Date:	03/24/2024
Expiration Date:	07/31/2024
Capacity:	71
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/17/2024	Special Investigation Intake 2024A1019057
05/20/2024	Special Investigation Initiated - Letter Emailed admin/AR for resident roster.
05/21/2024	Contact- Document Sent Emailed admin/AR requesting supporting documentation.
05/20/2024	APS Referral
05/30/2024	Contact - Document Received Documentation submitted by licensee.
06/05/2024	Contact - Document Received Staff statements submitted by facility administrator.
06/10/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A eloped.

INVESTIGATION:

On 5/17/24, the department received a complaint alleging that on 12/4/22, Resident A left the facility without staff knowledge. The complaint alleged that Resident A was later found outside in a ditch and was subsequently hospitalized for several days.

On 5/21/24, licensing staff requested that licensee review Resident A's file to locate supporting documentation pertaining to the allegations. Due to the length of time that

had passed, facility administrator Melissa Kline and authorized representative Krystyna Badoni initially were unable to confirm if the event took place. On 5/30/24, Ms. Kline submitted Resident A's entire chart, which included an *unusual occurrence report* dated 12/4/22 and hospital discharge paperwork dated 12/8/22. The occurrence report read "*Went to check on Resident, not in room, did unit check, unable to find resident. Checked new addition and outside of facility without finding resident. Called CMA, called Director, called 911*." The occurrence report identified that the incident took place in the memory care courtyard and classified the incident as an "elopement unknown- security system failure". The occurrence report did not identify when or how Resident A was found or any additional detail surrounding the incident; no corrective measures were noted on the report. The occurrence report indicated that Resident A did not have any apparent injuries but went on to read that Resident A was sent out to the hospital.

Ms. Kline reported that two current staff members were present at the time of the elopement and submitted statements from both. Employee 1 attested the following:

> *Sometime after supper a staff member notified me that [Resident A] was missing. I instituted a whole facility check along with an outside check. In the meantime I notified the Director, Nurse and her family. When the director arrived we had searched multiple times inside and around the building, including the new construction that was happening at the time. She [the director] asked us to wait and search longer. At that time I stated that we had waited to [sic] long and needed to call 911. When the police and ambulance arrived they searched along the road and found [Resident A] in a ditch next to the road right next to the facility. Once she was found the [sic] rescued her and transported [her] to the hospital by ambulance.*

Employee 2 attested the following:

> *It was after supper we had just finished changing a resident. [Employee 3] went into change [Resident A] she was not in her room. We checked every room in Mary B's. I then went out the east outer door to look around because the back gates were taken down so the court yard was open & the door alarm was not working. I then ran up front told [Employee 1] we can not find [Resident A] so we did a search in AL she was not located. [Employee 1] then called 911 and [Employee 4]. [Employee 1] and I went out to check all the grounds could not find [Resident A]. I got in my car to check the street next to Bickford & subdivisions on the way back the cop was flashing a light in the ditch. I pulled over and grabbed a blanket [Resident A] was in the ditch on the west side of Mackinaw. She was placed in the cop car to get warm and then into MMR to be checked out.*

Resident A's discharge paperwork from Covenant Hospital was reviewed. Resident A was hospitalized from 12/4/22-12/8/22. Hospital staff recommended Resident A follow up with a colonoscopy and her primary care provided within one week. A

hospice referral was also ordered. Resident A's discharge diagnoses were listed as AKI (acute kidney injury), anemia, gastrointestinal hemorrhage and cold exposure.

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	**(p) "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.** **(u) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following:** **(iv) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.**
ANALYSIS:	Facility staff failed to adequately supervise Resident A as evidenced by her leaving the secured memory care unit without staff knowledge. Resident A was found outside of facility ground in a ditch by local police, placing Resident A at significant risk of harm while unattended outside the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(5) Records must be maintained that demonstrate incident reporting to the team, analyses, outcomes, corrective action taken, and evaluation to ensure that the expected outcome is achieved. These records must be maintained for 2 years.
ANALYSIS:	The licensee failed to demonstrate that all the above measures were taken pertaining to Resident A's elopement event on 12/4/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon approval of an acceptable corrective action plan, I recommend no changes to the status of the license.

06/14/2024

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

06/18/2024

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