GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 15th, 2024

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

RE: License #: AH230387590
Investigation #: 2024A1021072
Bickford of W Lansing

Dear Krystyna Badoni:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 #:	2024A1021072
Complaint Receipt Date:	07/12/2024
Investigation Initiation Date:	07/17/2024
Report Due Date:	09/11/2024
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 Williams
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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	72
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/12/2024	Special Investigation Intake 2024A1021072
07/17/2024	Special Investigation Initiated - On Site
07/18/2024	Contact-Telephone call made Interviewed Serviam Pharmacy
07/18/2024	Contact-Telephone call made Interviewed case manager Namoi Wells
07/18/2024	APS APS opened this investigation
07/19/2024	Contact-Document Received Received Jennifer Frey, NP documentation
07/22/2024	Contact-Telephone call made Interviewed Jennifer Frey, NP
08/14/2024	Exit Conference

ALLEGATION:

Resident A did not receive her medications.

INVESTIGATION:

On 07/12/2024, the licensing department received an intake with allegations Resident A did not receive Keppra and Vimpat medication.

On 07/16/2024, the licensing department received another complaint with the same allegations.

On 07/17/2024, I interviewed facility administer Fallon Williams at the facility. Ms. Williams reported Resident A admitted to the facility on 07/01/2024 from an outside health care facility. Ms. Williams reported Resident A admitted to the facility with medications. Ms. Williams reported on third shift on 07/09/2024, the medication technician called Serviam pharmacy for a stat refill order on the Keppra medication. Ms. Williams reported the medication was sent to the local Walgreens Pharmacy because Serviam pharmacy would take too long to deliver the medication. Ms. Williams reported the medication was to be picked up from Walgreens Pharmacy on 07/10/2024 but was not as Resident A was admitted to the hospital on 07/10/2024. Ms. Williams reported the medication technicians should have contacted the pharmacy sooner for the refill on the medication. Ms. Williams reported Resident A did not miss any doses of the Vimpat medication. Ms. Williams reported the Vimpat medication is a narcotic and was kept in the narcotic drawer. Ms. Wiliams reported the medication could not be scanned by the medication technicians as administered as there was no barcode on the medication bottle due to the medication was brought from home. Ms. Williams reported on the medication administration record (MAR) the medication technician made comments that the medication was administered. Ms. Williams reported Resident A administered her own medications until 07/03/2024.

On 07/18/2024, I interviewed Brianna Grant customer service technician at Serviam Pharmacy by telephone. Ms. Grant reported on 07/03/2024, a medication list was sent to the pharmacy, but the orders were not signed. Ms. Grant reported the physician then provided verbal orders, but the facility reported Resident A did not require medications as the facility had supply. Ms. Grant reported on 07/09/2024 at 10:09pm, the on-call worker was contacted for Keppra medication. Ms. Grant reported the medication was sent to West Lansing Central Pharmacy on 07/10/2024, but the medication could not be filled as the pharmacy had closed due to weather, and the medication was then sent to a local pharmacy. Ms. Grant reported on 07/10/2024, the facility requested all medications be sent to the facility.

On 07/18/2024, I interviewed Michigan Medicine Sparrow Hospital case manager Naomi Wells by telephone. Ms. Wells reported Resident A admitted to the emergency room on 07/10/2024. Ms. Wells reported Resident A's family was contacted on 07/10/2024 to report Resident A did not have medication. Ms. Wells reported when the family arrived, Resident A was vomiting, fatigued, and not at baseline. Ms. Wells reported the family decided to send Resident A to the emergency room. Ms. Wells reported Resident A has diagnosis of Parkinsons Disease and Resident A had significant tremors upon arrival. Ms. Wells reported she spoke with facility physician, Jennifer Frey, who reported the facility was to administer home medications until 07/07/2024 and then contact the pharmacy for additional medications. Ms. Wells reported this did not occur and Resident A did not have medications for multiple days. Ms. Wells reported she interviewed Resident A about medications at the facility. Ms. Wells reported Resident A reported the facility was to provide medications but each time the number of medications differed and at times she missed medications.

On 07/18/2024, I received correspondence from Adult Protective Services (APS) worker Carol Stahl. Ms. Stahl reported APS was also investigating the medication issues with Resident A. Ms. Stahl reported a blood test came back on Resident A. The blood test revealed Resident A was at a level two and normal range for people with Keppra in their system is between 10 and 40.

On 07/22/2024, I interviewed Curanna Heath nurse practitioner Jennifer Frey by telephone. Ms. Frey reported her first interaction with Resident A was on 07/03/2024 at the facility. Ms. Frey reported she completed her initial evaluation with Resident A. Ms. Frey reported on this day, she was given a medication sheet that appeared from a prior facility. Ms. Frey reported this medication sheet had no signature and appeared incomplete. Ms. Frey reported throughout the day she contacted the previous facility and Relative A1. Ms. Frey reported Relative A1 was very knowledgeable on Resident A's medications and assisted in completing the correct medication list. Ms. Frey reported she contacted Serviam pharmacy by telephone and went over each medication. Ms. Frey reported the medications were profiled in the pharmacy system but were not ordered. Ms. Frey reported the medication technician or management at the facility would have to push the order through to receive new medications. Ms. Frey reported staff at the facility reported Resident A admitted to the facility with medications and the medications were in the locked medication cart. Ms. Frey reported she does not have access to this medication cart. Ms. Frey reported at the end of the day, she spoke with Ms. Williams and explained they would need to count the medications and then re-order the medications soon to ensure Resident A had medications. Ms. Frey reported she also emailed Ms. Williams and SP1. Ms. Frey reported she did not have any contact regarding Resident A until 07/10/2024 when she came back to the facility for her weekly visit.

I reviewed the email Ms. Frey sent to Ms. Williams and SP1. The email was dated 07/03/2024 and read,

> *"I figured out through many phone calls her medication list. I verified it with pharmacy. It will be available on your Maher. (SP1) please verify your med count and order any med that you need refilled especially if you only have a week left."*

I reviewed Resident A's July 2024 MAR. The MAR revealed Resident A was prescribed Levetiraceta Tab 1000mg with instruction to take one tablet by mouth twice daily for epilepsy. On 07/09/2024 at 9:38am and 6:19pm, the medication technician noted there was no supply of this medication, and the nurse was notified.

Resident A's MAR revealed Resident A was prescribed Lacosamide Tab 200mg with instruction to administer one tablet by mouth twice daily for epilepsy. The MAR revealed medication technicians documented on 07/04/2024 at 6:55pm and on 07/06/2024 there was no supply of this medication.

I reviewed Resident A's documentation from Jennifer Frey, NP. The documentation revealed Jennifer Frey visited Resident A at the facility on 07/03/2024 to complete the initial evaluation. Jennifer Frey, NP completed the medication review with Relative A1 to ensure medications were correct. There was documentation that read,

> "*Occurrence today, patient sent to ED at Sparrow. (Resident A) I saw for initial visit on 7/3/24. No medications were verified before move in and patient missed 1-2 days of meds per patient. No one contacted me or emailed me from the facility prior to initial contact 7/3/24. Patient has bottles of meds in med cart from home. She has hepatic encephalopathy, Parkinson's, and epilepsy. She can not miss meds. I saw her within 2-3 days of move in, verified all meds with POA and called Serviam 7/3/24 and went over meds one by one, they were all profiled and ready when nursing was ready to order. I told (SP2) via email 7/3/24 all meds are ready and available at pharmacy, asked her to verify cart count and order the meds that are needed. She verbalized understanding and agreed. (Resident A) had enough meds until 7/8/24, Med passers and Nursing never ordered refills per Serviam pharmacy as of today. A med passer called the on call pharmacist last night for missing Lacosamide and Keppra. They were all sent to all night pharmacy, due to rain pharmacy flooded and closed. Again, no one communicated to me all week since I was here 7/3/24. I walked in today to find this all out from med passers because no director or nurse is in the building today or for the next 2-3 days per care staff. The patient missed 3 doses of each epilepsy med, is very sick and sent to out to Sparrow Hospital. I verified all medications with pharmacy and they were available to the facility 7 days ago. The patients family stated they do not feel safe returning (Resident A) here and they are upset they have hospital costs as well (Resident A) having missed medications."*

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Interviews conducted and review of documentation revealed Resident A did not receive medications are prescribed by the prescribing licensed health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

SP3 reported the facility policy is when a resident is to administer their own medications, the physician must agree to it and the facility is to complete a test to ensure competency with medication administration. SP3 reported to her knowledge these steps to ensure medication administration competency was not done.

Review of facility documents revealed this facility process was not completed for Resident A.

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.**
	(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.
ANALYSIS:	Interviews conducted and review of facility documentation revealed the facility did not ensure the safety and protection of Resident A by allowing her to administer her own medications and not ensuring the competency of Resident A to do so.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Williams reported when a resident admits to the facility, they should have medication orders upon admission. Ms. Williams reported Resident A did not have medication orders until 07/03/2024. Ms. Williams reported she is not certain why orders were not obtained at admission.

I reviewed Resident A's records. The records revealed the physician orders list that was written on 07/03/2024 by Jennifer Frey, NP. There was no documentation from a licensed health care professional prior to Resident A's admission.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(6) A home shall require an individual who, at the time of admission, is under the care of a licensed health care professional for ongoing treatments or prescription medications that require the home's intervention or oversight, to provide a written statement from that licensed health care professional completed within the 90-day period before the individual's admission to the home. The statement shall list those treatments or medications for the purpose of developing and implementing the resident's service plan. If this statement is not available at the time of an emergency admission, then the home shall require that the statement be obtained not later than 30 days after admission.
ANALYSIS:	Interviews conducted and review of documentation revealed the facility did not have the appropriate documentation at time of Resident A's admission.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Williams reported Resident A moved into the facility on 07/01/2024. Ms. Williams reported initially Resident A was administering her own medications in her room. Ms. Williams reported when the orders were received, the facility began to administer medications.

On 07/18/2024, I interviewed SP4 at the facility. SP4 reported when Resident A admitted to the facility Resident A was administering medications in her room. SP4 reported after a few days, the medication technicians began to administer medications.

Resident A's service plan read,

> *"Med aid to administer medications in apartment as delegated by HWD and ad prescribed by PCP."*

I reviewed Resident A's July 2024 MAR. The MAR revealed no medications were administered by the facility 07/01-07/03.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) A service plan must identify prescribed medication to be self-administered or managed by the home.
ANALYSIS:	Interviews conducted and review of service plan revealed the facility was not following Resident A's service plan by allowing her to administer her medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

SP4 reported she worked the morning of 07/10/2024 when Resident A was transferred to the emergency room. SP4 reported she administered morning medications and did not document it as Resident A was sent to the emergency room before she could document that medications were administered. SP4 reported when she went back to document, Resident A was taken out of the medication administration system.

Review of Resident A's MAR revealed morning medications on 07/10/2024 were not documented as administered.

Review of Resident A's July 2024 MAR revealed Resident A was prescribed Pantoprazole Tab 40mg with instruction to administer one tablet by mouth on an empty stomach. There was no documentation that this medication was administered 07/06-07/08.

Review of Resident A's July 2024 MAR revealed Resident A was prescribed Levothyroxine Tab with instruction to administer one tablet by mouth every day 30-60 minutes before other meds and food. Review of the MAR revealed medication technicians did not document that this medication was administered 07/07 and 07/08.

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:	Review of Resident A's MAR revealed staff did not document that medications were administered as prescribed. **REPEAT VIOLATION:** **SIR 2024A1021002 corrective action plan date 12/18/2023** **SIR 2024A1021019 corrective action plan dated 01/12/2024** **SIR 2024A1021047 corrective action plan 05/10/2024**
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Frey, nurse practitioner reported she was not notified that Resident A missed any medications. Ms. Frey reported as she was walking into the facility on 07/10/2024, EMS was arriving at the facility to transport Resident A to the emergency room. Ms. Frey was unaware that Resident A had missed medications.

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: **(c) Contact the appropriate licensed health care professional when the prescribed medication has not been administered in accordance with the label instruction, an order from a health care professional, medication log, or a service plan.**
ANALYSIS:	Interviews conducted revealed the facility did not appropriately contact the licensed health care professional when Resident A did not receive her prescribed medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend issuance of a corrective notice order.

07/22/2024

Kimberly Horst — Date
Licensing Staff

Approved By:

08/12/2024

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