GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 15, 2024

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

RE: License #: AH230387590
Investigation #: 2024A1021073
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

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 #:	2024A1021073
Complaint Receipt Date:	07/17/2024
Investigation Initiation Date:	07/17/2024
Report Due Date:	09/16/2024
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident B left the facility unattended.	Yes
Additional Findings	No

III. METHODOLOGY

07/17/2024	Special Investigation Intake 2024A1021073
07/17/2024	Special Investigation Initiated - On Site
07/18/2024	APS Referral referral came from APS; APS denied the allegations
07/22/2024	Contact-Telephone call made Interviewed SP5
08/14/2024	Exit Conference

ALLEGATION:

Resident B left the facility unattended.

INVESTIGATION:

On 07/17/2024, the licensing department received a complaint from Adult Protective Services (APS) with allegations Resident B left the facility unattended. APS referral source alleged Resident B left the facility, went to the bank, and completed an electric job. APS did not open the case for investigation.

On 07/17/2024, I interviewed staff person 3 (SP3) at the facility. SP3 reported Resident B has been a resident at the facility for a few months. SP3 reported Relative B1 is his court appointed guardian. SP3 reported on 07/13/2024, Resident B reported to caregivers he was going to sit outside. SP3 reported Resident B can sit outside unattended. SP3 reported soon afterwards caregivers observed Resident B to have left the facility. SP3 reported Resident C, a friend of Resident B, reported Resident B told him he was leaving to do a job. SP3 reported the facility attempted to contact Resident B on his personal cell phone but the phone kept going to voicemail. SP3 reported the police were notified during this incident. SP3 reported a

few hours later, Resident B came back to the facility. SP3 reported Resident B reported that he can come and go as he pleases.

While onsite, I observed the patio of the facility. The patio of the facility was not secure and was located at the front of the building. The entire patio was not completely visible from the inside of the facility. The parking lot was connected to the patio.

On 07/22/2024, I interviewed SP4 by telephone. SP4 reported on 07/13/2024, she was in the main dining room at the facility. SP4 reported she observed a white SUV to be parked in the parking lot. SP4 reported she observed Resident B to be nicely dressed and walk through the common area. SP4 reported Resident B reported he was going to sit outside and enjoy the nice weather. SP4 reported she reported to Resident B to stay nearby as Resident B has left the facility unattended. SP4 reported a few minutes later she looked out the window and did not see Resident B sitting outside. SP4 reported she walked the entire outside perimeter of the facility and could not locate Resident B. SP4 reported she alerted other staff members, and they could not locate Resident B. SP4 reported Resident C was on the phone with Resident B and Resident B reported he was going to do a job and would be back at 5:00pm. SP4 reported Relative B1 and management came to the facility and the police department was notified all within 30 minutes of Resident B exiting the facility. SP4 reported caregivers attempted to contact Resident B but the phone kept going to voicemail. SP4 reported around 3:00pm Resident B was dropped off at the end of the road and came back to the facility. SP4 reported Resident B can sit outside unattended but caregivers are to keep an extra eye on him as he has been known to leave the facility unattended.

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

"Resident not to be left unattended outside the community. He is only to get to planned location and no where else unless (Relative B1) consent."

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 revealed on 07/13/2024, Resident B reported he was going outside to sit on the patio. Soon afterwards, Resident B was observed to leave the facility unattended and did not return for a few hours later. Review of Resident B's service plan revealed Resident B was not to be left unattended outside of the facility. The facility failed to ensure the protection of Resident B by not following the service plan and allowing Resident B to sit outside unattended.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend issuance of a corrective notice order.

Kimberly Horst 07/22/2024

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 08/13/2024

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