GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 14, 2024

Krystyna Badoni
Bickford of Canton
5969 N Canton Center Rd
Canton, MI 48187

RE: License #: AH820395445
Investigation #: 2024A1027095
Bickford of Canton

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. 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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820395445
Investigation #:	2024A1027095
Complaint Receipt Date:	09/20/2024
Investigation Initiation Date:	09/23/2024
Report Due Date:	11/19/2024
Licensee Name:	Bickford of Canton, LLC
Licensee Address:	Suite 301 13795 S Mur-Len Rd. Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Sandra Randall
Authorized Representative:	Krystyna Badoni
Name of Facility:	Bickford of Canton
Facility Address:	5969 N Canton Center Rd Canton, MI 48187
Facility Telephone #:	(734) 656-5580
Original Issuance Date:	04/02/2020
License Status:	REGULAR
Effective Date:	10/02/2024
Expiration Date:	07/31/2025
Capacity:	78
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A lacked protection and care.	Yes
The facility was short staffed.	No
Additional Findings	No

III. METHODOLOGY

09/20/2024	Special Investigation Intake 2024A1027095
09/23/2024	Special Investigation Initiated - Letter Email sent to complainant informing that an investigation was opened
09/23/2024	Contact - Document Received Additional information received by complainant
10/01/2024	Inspection Completed On-site
10/09/2024	Inspection Completed-BCAL Sub. Compliance
10/14/2024	Exit Conference Conducted by email with Krystyna Badoni and Sandra Randall

ALLEGATION:

Resident A lacked protection and care.

INVESTIGATION:

On 9/20/2024, the Department received allegations regarding an incident that occurred on 8/11/2024. The allegations read Resident A exited the facility, triggering the alarm, which was turned off eight minutes later. It was noted that the police were contacted, and searches were initiated. Approximately four to five hours later, Resident A was found by an unknown citizen over a mile away, exhibiting signs of distress, including broken glasses, back pain, and being cold. She was subsequently taken to the hospital, where she was diagnosed with bruises, swollen hands, and a fractured wrist. Following her hospital stay, Resident A was transferred to memory care. The report also mentioned that one and a half weeks prior, Resident A had previously exited the facility through the same door and walked to the front entrance.

On 9/23/2024, further allegations were reported, indicating that Resident A lacked proper care, and that facility staff were unaware of cuts on her legs due to her wander guard.

On 10/1/2024, I conducted an on-site inspection at the home and interviewed staff.

Administrator Sandra Randall's statements aligned with the allegations. She reported that Resident A had exited the facility once before, with staff involvement, and had been tested for a urinary tract infection. Regarding the August 11, 2024, elopement, Ms. Randall stated that staff responded to Resident A's exit by conducting an internal and external search, notifying the nurse, police, and her family. She characterized Resident A as independent in ambulation.

Employee #1 confirmed that Resident A was treated for a urinary tract infection following her first exit. Employee #1's account of the August 11 incident was consistent with Ms. Randall's, noting that upon her arrival to search for Resident A, she observed two other staff members searching outside.

Employee #1 also mentioned that after the incident, Resident A had small, intact scratches on her skin. Employee #1 stated that staff were required to inform the medication technician and herself of any concerns related to residents' skin, and then document their observations in the online charting system. She explained that either she or her counterpart would review the reported skin concerns, and if follow-up was necessary, the residents' physician would be contacted. Employee #1 noted that staff charted by exception.

A review of Resident A's records indicated she moved into the home on December 1, 2023, and that Relative A1 was designated as her responsible person, as well as having medical and financial power of attorney. Her service plan noted that she was not considered an elopement risk.

The incident reports dated 8/12/2024, documented that Resident A had eloped through the 100-door exit at 11:19 PM, with the alarm sounding. The police found her at 5:30 AM with injuries that included bruising, a wrist fracture, and a knot on her other hand. The reports read Resident A had a wander guard on, and the recommended intervention was to move her to memory care. Both her physician and family were notified.

Written statements from Employees #2, #3, and #4, dated 8/11/2024, were consistent with the incident reports.

A timeline from Employee #1 detailed events surrounding the elopement, noting she was notified by phone at 11:43 PM on 8/11/2024, that the administrator was alerted at 11:47 PM, the police were contacted at 12:02 PM on 8/12/2024, and Relative A1 was notified at 12:08 PM. The police informed the facility at 5:10 AM that Resident A had been found.

The alarm system log indicated that Resident A exited the 100 Hall exit at 11:19 PM on 8/11/2024 and ended at 11:27 PM.

Reviewing Resident A's chart notes from August and September 2024 confirmed staff statements and the incident report. Notably, a July 28, 2024, note indicated that Resident A wandered at 2:15 AM and triggered the 100-hall door. An August 30, 2024, note documented several scabbed areas on her left lower leg, which appeared old and healing, but the cause was unknown. Resident A was unable to provide a history and denied pain or discomfort. Relative A1 was present and informed, with no treatment deemed necessary. A note from September 18, 2024, indicated that the areas had resolved and were small and scabbed.

Review of the facility's Missing Resident policy read upon becoming aware of a missing resident, staff should immediately summon assistance of other employees on duty, search inside and outside of the facility, call the director, notify the police if the resident is not found during the search, and notify the residents' designated agent.

The facility's Missing Resident policy requires staff to immediately summon assistance, search the premises, notify the director, and alert the police if the resident is not found.

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.
For Reference: R 325.1924	**Reporting of incidents, quality review program.**
	(8) If an elopement occurs, staff shall conduct a search to locate the resident. If the resident is not located within 30 minutes after the elopement occurred, staff shall comply with subrule (7) of this rule and contact the local police authority.

ANALYSIS:	The actions taken by staff in response to Resident A's elopement on August 11, 2024, were consistent with the facility's policy. Review of staff documentation revealed Resident A's history of wandering and skin abrasions; however, her service plan lacked specific details to inform staff of her wandering history and risk for elopement. Additionally, the facility did not contact the local police authority within 30 minutes. Therefore, these aspects of the allegation were substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility was short staffed.

INVESTIGATION:

On 9/20/2024, the Department received allegations which read the facility was short staffed.

On 10/1/2024, I conducted an on-site inspection at the home and interviewed staff.

Administrator Sandra Randall reported that there are typically four to six staff members on morning and afternoon shifts, with a minimum of four. She indicated that the midnight shift generally has three to four staff members, with a minimum of three.

Employee #1 mentioned that there were two residents in assisted living who required two-person assistance and a Hoyer lift, while residents in memory care needed only one-person assistance.

A review of the resident census dated August 12, 2024, showed there were 43 residents in assisted living and seven in memory care. I also examined the August 2024 staff schedule and assignment sheets, which aligned with staff statements. Specifically, the schedules for August 11 and 12, 2024, were consistent with what staff reported.

While on-site, I observed six memory care and ten assisted living residents who appeared well groomed.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Given that the staffing schedule and resident census matched staff accounts, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

10/09/2024

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Jessica Rogers Date
Licensing Staff

Approved By:

10/14/2024

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