GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 23, 2024

Krystyna Badoni
Portage Bickford Cottage
4707 W. Milham Ave.
Portage, MI 49024

RE: License #: AH390278221
Investigation #: 2025A1028012
Portage Bickford Cottage

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 responsible party 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH390278221
Investigation #:	2025A1028012
Complaint Receipt Date:	11/19/2024
Investigation Initiation Date:	11/19/2024
Report Due Date:	01/19/2025
Licensee Name:	Portage Bickford Cottage LLC
Licensee Address:	Suite 301 13795 S. Mur-Len Road Olathe, KS 66062
Licensee Telephone #:	(810) 962-2445
Administrator:	Brandie McWethy
Authorized Representative:	Krystyna Badoni
Name of Facility:	Portage Bickford Cottage
Facility Address:	4707 W. Milham Ave. Portage, MI 49024
Facility Telephone #:	(269) 372-2100
Original Issuance Date:	03/05/2007
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	71
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A is violent towards staff and other residents and the facility did not appropriately address it.	Yes
The facility does not have a working staff schedule.	No
Additional Findings	Yes

III. METHODOLOGY

11/19/2024	Special Investigation Intake 2025A1028012
11/19/2024	Special Investigation Initiated - Letter
11/19/2024	APS Referral – No APS referral. Resident is deceased.
12/02/2024	Contact - Face to Face Interviewed the Administrator at the facility.
12/02/2024	Contact - Face to Face Interviewed Employee A at the facility.
12/02/2024	Contact - Face to Face Interviewed Employee B at the facility.
12/02/2024	Contact - Document Received Received requested documentation from the Administrator.

ALLEGATION:

Resident A is violent towards staff and other residents and the facility did not address it.

INVESTIGATION:

On 11/19/2024, the Bureau received the allegations through the online complaint system.

On 12/2/2024, I interviewed the administrator at the facility who reported Resident A was admitted to the facility in September 2024 and passed away 11/28/2024 with family and hospice services present. The administrator reported Resident A did exhibit combative behaviors. The administrator reported staff were trained to address Resident A's combative behaviors and methods to address Resident A's behaviors were documented in Resident A's service plan with the service being regularly reviewed by staff. The administrator reported due to the combative behaviors, Resident A's medications were assessed by the physician and hospice services were recommended. Resident A remained on hospice services until [their] passing in November 2024. The administrator reported the facility conferenced with Resident A's family, physician, and hospice services about the combative behaviors to ensure care and that the facility would call family to come sit with Resident A when demonstrating combative behaviors. The administrator provided me with the requested documentation.

On 12/2/2024, I interviewed Employee A at the facility who confirmed Resident A had combative behaviors and it could be "scary for us as staff sometimes because of [Resident A's] size." Employee A reported once [Resident A's] medications were changed by hospice services, behaviors decreased some, but Resident A continued to demonstrate behaviors. Employee A reported Resident A has hit, choked, pushed, and slapped staff and has also attacked other residents. Employee A reported strategies to address Resident A's behaviors were in the care plan for staff to utilize and that staff were provided instructions from management on approach and care techniques to prevent escalation of behaviors, but the techniques did not always work. Employee A reported knowledge of the staff calling the police due to Resident A's exhibited violent behaviors. Employee A confirmed Resident A received hospice services, and that Resident A recently passed away with family and hospice services present.

On 12/2/2024, I interviewed Employee B at the facility whose statement was consistent with the administrator's statement and Employee A's statement.

On 12/2/2024, I reviewed the requested documentation which revealed the following: Resident A's service plan -

- Resident A required assistance with showering, dressing, grooming, oral care, toileting, hearing aid care, and assistance with cutting food.
- The facility manages all medication, laundry, and housekeeping.
- Resident A was a fall risk and required 8 safety checks per shift.
- Resident A had advanced dementia, memory impairment, disorientation, poor safety awareness, and poor judgement.
- Required enhanced interventions and care coordination due to resistance to care services, combative behaviors, and to deescalate negative behaviors.
- History of aggressive behaviors at home with caregivers and family prior to admission at the facility due to advanced dementia.
- Requires ongoing assistance with communication to make needs known.
- Resident A is not exit-seeking.

I reviewed the staff documentation record which revealed:

- On 9/9/2024, Resident A was exit-seeking and yelling.
- On 9/10/2024, Resident A refused care multiple times, was exit-seeking, and was verbally aggressive with other residents.
- On 9/11/2024, Resident A grabbed a knife out of the sink and lunged towards a staff member, threatening to kill the staff member. Shift supervisor was notified and was able to calm Resident A.
- On 9/13/2024, Resident A argued with other residents and demonstrated increased agitation and combative behaviors despite staff attempts to redirect.
- On 9/13/2024 on third shift, Resident A was very agitated and combative during shift. Resident A entered another resident's room and was redirected out, however, after exiting Resident A pushed staff member against wall causing staff member to hit [their] head. Resident A held staff member against the wall while other staff tried to intervene. Resident A tried to hit other staff members that tried to intervene and deescalate the situation. Staff member was able to talk Resident A into letting [them] go, but Resident A continued to yell. Staff called Resident A's family to notify them that Resident A continued to demonstrate behaviors despite staff's several attempts to calm Resident A. Family arrived at the facility later and sat with Resident A until Resident A fell asleep.
- On 9/14/2024, Resident A attempted to push another resident in [their] wheelchair with staff asking Resident A not to. Resident A became combative when staff intervened, hitting staff. Staff member notified shift supervisor with Resident A following staff and attempting to enter another resident's room. Staff told Resident A it was not their room, but Resident A pushed at the door to enter.
- On 9/16/2024, Resident A attempting to enter other resident's rooms.
- On 9/16/2024, the facility requested a medication review from Resident A's physician due to Resident A's demonstrated aggression, agitation, combative behaviors, restlessness, wandering, and exit seeking behaviors.
- On 9/17/2024, Resident A was very agitated during first shift and was aggressive with staff.
- On 9/17/2024, Resident A refused nighttime care.
- On 9/17/2024, staff made 911 call on second shift due to Resident A's aggressive and violent behaviors. Resident A entered another resident's room during second shift with staff asking Resident A to leave. He followed a staff member out of the room, chased the staff member down the hallway, and used verbally aggressive language. Resident A then diverted to another hallway and charged towards a second staff member who was in the medication room. Resident A balled [their] fists at the staff member, threatening the staff member. "[Resident A] had to be restrained to stop all physical violence, and the police were then called."
- On 9/22/2024, Resident A was found in another resident's room with partial clothing on during second shift. Staff attempted to redirect Resident A to dress and to get Resident A out of the room with Resident A becoming combative

with staff. Resident A's family was called with the family member arriving and assisting staff to redirect Resident A to [their] own room.

- On 9/23/2024 on third shift, Resident A refused to get changed out of wet clothing despite reapproach multiple times from staff.
- On 9/23/2024 during second shift, Resident A flooded [their] sink which leaked into hallway and room next door.
- On 9/24/2024, a staff member on second shift entered the bathroom and found Resident A on the floor of the bathroom asleep without clothes and soiled. The staff alerted other staff members who reported Resident A was last seen sleeping in [their] bed. The staff member also alerted the shift supervisor.
- On 9/26/2024, Resident A was up all night and combative.
- On 9/26/2024, Resident A was in common area bathroom digging through the garbage during third shift. Staff approached to redirect with Resident A forcefully grabbing staff member's hand and twisting it. Resident A would not let go and staff member reported [they] felt a snap in [their] hand. Resident A let go with the staff member walking away deciding to reapproach again in a short time. Resident A was agitated on second approach with the staff member keeping their distance and following Resident A around the area cleaning up after Resident A. The staff member was unable to get the trash bag away from Resident A.
- On 9/27/2024, Resident A was exit seeking during first shift. Resident A exited through the front door into the small lobby area setting off the alarm went off, but staff got in front of Resident A to prevent Resident A from exiting the building with Resident A choking the staff member and grabbing the staff member's arm. Staff asked Resident A to stop and Resident A released the staff member. Staff called family to notify them of exit seeking behaviors with a family member arriving later to sit with Resident A.
- On 10/13/2024 during third shift, Resident A was found in another resident's room on top of the resident attempting to hit the resident. Emergency services and the family were called.
- On 10/25/2024, Resident A was very agitated and verbally aggressive with staff and visiting family members. During second shift, Resident A grabbed a garbage can from staff member and attempted to punch staff member.
- On 10/28/2024, Resident A was agitated.
- On 10/30/2024, Resident A hit a third shift staff member.
- On 11/2/2024, Resident A was found in another resident's room attacking the resident. Staff intervened with Resident A throwing the wheelchair at staff and the other resident twice.
- On 11/4/2024, Resident A refused all medication and morning care despite multiple reapproaches from staff.
- On 11/7/2024, Resident A went into an empty resident room and became physically aggressive when staff redirected Resident A. Resident A forcefully grabbed the staff member and attempted to punch staff member in the face.
- On 11/7/2024 during second shift, Resident A was aggressive, tried to exit the building, and refused breakfast and lunch.

- On 11/8/2024, upon return from hospital, Resident A was found on first shift with no undergarments on but allowed staff to assist with dressing.
- On 11/8/2024, Resident A tried exit the building during dinner and refused care on second shift.
- On 11/9/2024, Resident A was up all night. Staff had difficulty changing Resident A's clothes after becoming soiled and tried to punch, kick and hit staff who were assisting and spouse who was also present. Resident A pinched, scratched and bruised a staff member's arm, and punched and kicked another staff member. Resident A pushed a third staff member into a wall. Resident A's spouse called hospice requesting an evaluation.
- On 11/11/2024, Resident A demonstrating very aggressive behaviors during second shift. Hospice notified.
- On 11/12/2024, Resident A was found laying on the floor in the common area during second shift with staff attempting to assist Resident A from the floor. Resident kicked and punched staff, but staff were able to assist Resident A from floor and back to room.
- On 11/12/2024, Resident A restless and wandering into other resident rooms with Resident A demonstrating aggressive behaviors. Family notified by facility with facility conferencing with family on recommendation of psych evaluation.
- On 11/13/2024, Resident A was found on floor next to bathroom during second shift. Staff assisted up.
- On 11/14/2024, Resident A entered common area without pants and was agitated during third shift. Staff were able to provide meds and redress Resident A.
- On 11/15/2024, Resident A was observed on knees in dining room at 5:30 am. Staff attempted to assist up with Resident A demonstrating agitation and hitting staff.
- On 11/15/2024, Resident A was combative when hospice was providing shower during first shift.
- On 11/16/2024, Resident A seen by hospice during first shift due to fall and Resident A receiving new medication.
- On 11/16/2024, Resident A was observed crawling out of room at 5:00 am and refused to let staff help [them] up. Resident A continued to refuse and provided Resident A pillow and blanket and let him lay on the floor.
- On 11/16/2024, Resident A was observed standing in the hallway at 7:00 am and kitchen area and fell. Resident A possibly lost balance and no known injuries. Staff assisted Resident A from floor and back to bed.
- On 11/19/2024, Resident A was found on floor of room and while staff was assisting Resident A off floor, Resident A hit, punched, and kicked staff.
- On 11/19/2024 during third shift, Resident A found crawling on floor and rubbing head into carpet causing rug burn and bleeding. Resident A also observed with rug burn to the knees and forehead due to behaviors and was combative when staff attempted to assist Resident A from the floor. Resident A was taken to hospital earlier by family member and returned to the facility.

Resident A balling fists as family member as well and was combative with staff all night upon return from hospital.

- On 11/20/2024, Resident A being treated for urinary tract infection and had medication adjustment at hospital.
- On 11/20/2024, Resident A was sent back to the hospital during third shift due to rug burn and bleeding.
- On 11/20/2024 at 9:49 am, Resident A continues on hospice services and medications were adjusted to address behaviors. Staff instructed to let [Resident A] be when demonstrating combative behaviors and reapproach when calmed down.
- On 11/21/2024 during first shift, Resident A observed with restlessness and unsteadiness. Staff were able to encourage Resident A to sit in recliner where [they] slept for tow hours before placing [their self] on the floor. Staff and family attempted to help Resident A from floor, but Resident A was combative.
- On 11/21/2024, Resident A observed putting self on floor during third shift.
- On 11/22/2024, Resident A was sitting in the dining room eating lunch at 12:45 pm and fell out of the chair onto right side. Resident A assessed and injuries or pain.
- On 11/22/2024, Resident A was sitting in dining room at 6:10 pm and attempted to get up and lot balance, falling onto right side. Staff assisted up from floor, but within 30 minutes, Resident A was found on the floor 3 more times. Hospice present and recommended 1:1 care for Resident A.
- On 11/23/2024, Resident A refused dinner.
- On 11/26/2024 at 8:29 pm, Resident A is incoherent and cannot swallow medications. Resident A demonstrating very little output.
- On 11/26/2024, Resident A was repositioned throughout the night and incontinent of urine one time. Pain and discomfort managed by routine comfort medications. Resident A’s spouse present whole night. No behaviors exhibited.
- On 11/27/2024 at 8:07 pm, Resident A received bed bath from hospice, was repositioned, and still not eating.
- On 11/28/2024, Resident A passed away.

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.**
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:	It was alleged that Resident A is violent towards staff and other residents and the facility did not appropriately address it. Interviews, on-site investigation, and review of documentation reveal Resident A exhibited numerous incidents of aggressive and violent behaviors towards staff, other residents, and family from September 2024 to November 2024. While there are directives for staff in Resident A's service plan for staff to utilize when Resident A demonstrated aggressive and violent behaviors, the directives did not work; and there was no further evidence in the documentation that staff received advanced directives and/or additional education and training to deescalate the incidents as Resident A's aggressive and violent behaviors continued and increased from September 2024 to November 2024. Also, per the service plan, Resident A was to receive 8 safety checks per shift, however, Resident A demonstrated numerous aggressive and violent behaviors multiple times throughout first, second, and third shifts from September 2024 to November 2024, which resulted in staff injury, resident injury, and self-injury to Resident A. The facility did not maintain an organized program to provide protection, supervision, assistance, or supervised personal care for Resident A within the home. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility does not have a working staff schedule.

INVESTIGATION:

On 12/2/2024, the administrator reported the facility has working staff schedules and provided evidence of the preceding three months of working staff schedules. The

administrator reported the schedule may change due to call-ins or other events, but the schedule is posted along with daily assignment sheets and that all staff have access to the schedule.

On 12/2/2024, Employee A's and Employee B's statements were consistent with the administrator's statement.

On 12/2/2024, I reviewed the working staff schedule and had no concerns.

APPLICABLE RULE	
R 325.1944	**Employee records and work schedules.**
	(3) The home shall retain the work schedules for the preceding 3 months.
ANALYSIS:	It was alleged that the facility does not have a working staff schedule. Interviews, on-site investigation, and review of documentation reveal there is no evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

On 12/2/2024, review of the service plan and comparison of record notes reveal that Resident A's service plan was not updated to reflect preventative measures to prevent exit-seeking behaviors. Resident A demonstrated exit-seeking behaviors on 9/9/2024, 9/10/2024, 9/16/2024, 9/27/2024, 11/7/2024, and 11/8/2024.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

ANALYSIS:	Interviews, on-site investigation, and review of documentation reveal that Resident A's service plan was not updated to reflect preventative measures to prevent exit-seeking behaviors, as Resident A demonstrated exit-seeking behaviors on 9/9/2024, 9/10/2024, 9/16/2024, 9/27/2024, 11/7/2024, and 11/8/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

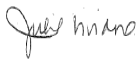
ADDITIONAL FINDINGS:

On 12/2/2024, when asked for incident reports of Resident A's aggressive and violent incidents along with Resident A's hospital visits on 11/8/2024, 11/19/2024, and 11/20/2024, the administrator reported the incidents were recorded within the record, but review of the record revealed incidents were not documented in accordance with the rule.

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:	Incidents pertaining to Resident A's aggressive and violent behavior were documented in the record but did not follow the reporting of incidents' guidelines and did not include outcomes, corrective action taken, and/or the evaluation to ensure that the expected outcome is achieved. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend the status of this license remain the same.



12/11/2024

Julie Viviano Date
Licensing Staff

Approved By:

12/19/2024

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