GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 6, 2025

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

RE: License #: AH390278221
Investigation #: 2025A1021050
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 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 (517) 335-5985.

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 #:	AH390278221
Investigation #:	2025A1021050
Complaint Receipt Date:	04/15/2025
Investigation Initiation Date:	04/15/2025
Report Due Date:	06/15/2025
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's mental health is untreated.	Yes
Additional Findings	No

III. METHODOLOGY

04/15/2025	Special Investigation Intake 2025A1021050
04/15/2025	Special Investigation Initiated - Telephone message left for complainant
04/16/2025	Contact - Telephone call made interviewed complainant
04/23/2025	Inspection Completed On-site
04/25/2025	Contact-Telephone call made Interviewed Administrator
05/06/2025	Exit Conference

ALLEGATION:

Resident A's mental health is untreated.

INVESTIGATION:

On 04/15/2025, the licensing department received a complaint with allegations Resident A's mental health is untreated.

On 04/16/2025, I interviewed the complainant by telephone. The complainant alleged Resident A admitted to the facility on 03/07/2025. The complainant alleged Resident A was brought to the emergency department on 04/12/2025 due to aggression and leaving the facility. The complainant alleged Resident A had no medical provider at the facility and would not establish care with a provider for another week. The complainant alleged Resident A's behavior was not managed at the facility.

On 04/23/2025, I interviewed staff member 1 (SP1) at the facility. SP1 reported Resident A is aggressive with staff and is exit seeking. SP1 reported Resident A will

push carts into employees and will refuse care. SP1 reported Resident A will push on the doors until they open, and then she attempts to exit the facility. SP1 reported the facility has not found any successful strategies to manage Resident A's behavior.

On 04/25/2025, I interviewed administrator Brandie McWethy by telephone. The administrator reported Resident A was admitted to the facility from her home in the upper peninsula. The administrator reported Resident A had a family physician in her community, but did need to establish care with a local provider. The administrator reported Resident A has an active durable power of attorney (DPOA) but the facility had a difficult time getting the DPOA to sign the visiting physician agreement form. The administrator reported Resident A did have behaviors such as aggression and exit seeking. The administrator reported Resident A has a wander guard and is on frequent checks. The administrator reported that when Resident A has exited the facility, there has always been an employee with her. The administrator reported Resident A's DPOA did sign the visiting physician agreement and Resident A is now active with a provider through Curana.

I read Resident A's facility notes. The notes read,
"03/10: Awake all night packing in the common area. Pulled the fire alarm several times stating she didn't want staff to touch her she wanted her husband and she wanted to leave.
03/12: Resident was exit seeking around 4pm got outside while BFMs following her. BFMs tried to redirect resident but the resident was not redirectable, Director and nurse were also notified, both assisted to redirect and got the resident back in the building, resident complaining of having pain R hip. Alarms on doors were being worked on at this time. Staff was aware resident was on 15 minute checks. Staff observed resident walking out the door and the entire time she was out of the building staff were with her.
03/14: Sleeping at the beginning of the shift woke up around midnight pacing in the common areas and going into residents rooms.
03/19: Resident was exit seeking at beginning of night breaching both the entrance and employee exit doors. Staff were able to redirect resident and bring her to a common area before she was able to open the door she was only able to set the door alarm off.
03/30: Resident was showing exit seeking behavior, she was able to get through the Mary B's interior entrance and out the employee entrance before staff were able to catch up with her. Staff was able to redirect back into the building through the main Mary B's entrance.
04/12: Resident was observed by a BFM in the parking lot walking towards the round about. 2 BFM's attempted to redirect the resident back to the community but she was unwilling. The med tech called 911 and joined in to help and we followed the resident down 12th street towards the elementary school while continuing our attempts to redirect her but she was physically and verbally combative. Resident tried to walk in front of a car twice, stated that she "would be better off dead" and "I should just kill myself." PPD met us near Pinefield and also attempted to assist her

and was successful after several tries. EMS arrived and was also able to get her onto the stretcher after several more attempts. Resident ahs been transported to Bronson for evaluation. BFM followed ambulance to the hospital to fill out a petition for mental health treatment.
04/13: Resident placed on 15 minute checks once she returned from the hospital. No exit seeking behaviors noted.
04/14/2025: Bronson AVS reviewed. While resident was in the ER she was given Versed and Zyprexa at 3:34pm AND 6:49pm. However, hospital stated that she did not meet inpatient psych criteria. She was returned to the facility with prescription for Seroquel 25mg tablet with a total quantity of 3 tablets. Resident will not be able to start this medication until 4/15/25 due to it being ordered from Serviam.
04/15/2025: Confirmation from Curana that resident will be seen by NP on Friday April 18 to establish care.

04/15: Resident was seeking exits again. Redirection was successful, had her go to the courtyard instead.

I reviewed physician order for 04/12/2025 from Bronson Emergency Department. The prescription read,
"Quetiapine 25mg: Take one tablet by mouth at bedtime. Quantity 3."

I reviewed physician order from Resident A's primary care physician that was dated 04/15/2025. The order read,
"Seroquel 25mg by mouth every HS. May increase to 50mg by mouth every HS after 1 week if tolerable."

I read physician communication to facility that was dated 04/15/2025. The communication read,
"Called (SP2) after reviewing chart. For agitation do recommend Seroquel 25mg by mouth nightly, may increase to 50mg at bedtime if needed for agitation and if tolerating well after 1 week. Can also use Zyprexa 2.5mg by mouth once daily as needed for agitation. I did caution that she needs to be monitored for prolonged QT and if any concerns with this will be need to be stopped. Also did enforce that (Resident A) does need to establish care with a local provider as I am unable to manage her care from a distance. I am assured that she will be seeing a primary care provider tomorrow. Her new primary care provider's recommendations should supersede my orders as the time of her assessment."

Resident A's service plan read,
"Safety checks- 4 times per shift. (Resident A) resides in a locked memory care unit. (Resident A) cannot be out of the facility without supervision at all times.

I reviewed Resident A's medication administration record (MAR). The MAR revealed Resident A was prescribed Quetiapine Tab 25mg and this was administered on 04/15-04/17. A new order was obtained and was administered 04/18-04/22.

Resident A was also prescribed Olanzapine Tab 2.5mg with instruction to take one tablet by mouth every day as needed for agitation.

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:	Review of Resident A's documentation revealed Resident A admitted to the facility on 03/10/2025 and Resident A exhibited aggressive and exit seeking behaviors from the day of admission. The facility did not communicate with a licensed medical professional until 04/13/2025 for medical intervention in managing Resident A's behaviors. The facility failed to ensure the safety and protection of Resident A by waiting an extended time to communicate with a provider on medical intervention to manage the behaviors of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

05/01/2025

Kimberly Horst Date
Licensing Staff

Approved By:

05/06/2025

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