GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 06, 2025

Krystyna Badoni
Bickford of Shelby, LLC
Ste 301
13795 S. Mur-Len Rd
Olathe, KS 66062

RE: License #: AH500387432
Investigation #: 2025A1027045
Bickford of Shelby

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 #:** | AH500387432 |
| | |
| **Investigation #:** | 2025A1027045 |
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| **Complaint Receipt Date:** | 04/09/2025 |
| | |
| **Investigation Initiation Date:** | 04/09/2025 |
| | |
| **Report Due Date:** | 06/08/2025 |
| | |
| **Licensee Name:** | Bickford of Shelby, LLC |
| | |
| **Licensee Address:** | Ste 301<br>13795 S. Mur-Len Rd<br>Olathe, KS 66062 |
| | |
| **Licensee Telephone #:** | (913) 782-3200 |
| | |
| **Administrator:** | Gretchin Mager |
| | |
| **Authorized Representative:** | Krystyna Badoni |
| | |
| **Name of Facility:** | Bickford of Shelby |
| | |
| **Facility Address:** | 48251 Schoenherr Road<br>Shelby Township, MI 48316 |
| | |
| **Facility Telephone #:** | (586) 685-5800 |
| | |
| **Original Issuance Date:** | 12/10/2018 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/01/2024 |
| | |
| **Expiration Date:** | 07/31/2025 |
| | |
| **Capacity:** | 74 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A lacked protection and care consistent with her service plan. | No |
| Inadequate staffing in the memory care unit. | No |
| Resident A was not administered medications consistent with licensed health care professional orders. | Yes |
| Assisted living staff lacked Alzheimer's training. | No |
| Resident A's bathroom lacked cleaning. | No |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 04/09/2025 | Special Investigation Intake<br>2025A1027045 |
| 04/09/2025 | Special Investigation Initiated - Letter<br>Email sent to complainant to inform of Department's investigation process |
| 04/16/2025 | Inspection Completed On-site |
| 04/25/2025 | Inspection Completed-BCAL Sub. Compliance |
| 05/06/2025 | Exit Conference<br>Conducted by email with Krystyna Badoni and Gretchin Mager |

**ALLEGATION:**

**Resident A lacked protection and care consistent with her service plan.**

**INVESTIGATION:**

On 4/9/2025, the Department received a complaint alleging that Resident A had eloped four times, twice while residing in assisted living. The complaint also reported that she experienced two non-injurious falls and that her service plan did not reflect a documented need for twice-daily snacks. It was further alleged that Resident A did

not receive showers as outlined in her service plan (twice weekly), with specific deficiencies noted in November 2024, February 2025, and March 2025. The complaint claimed Resident A received only one shower over a three-week period.

On 4/16/2025, an on-site inspection was conducted, and staff were interviewed.

Administrator Gretchin Mager and Employee #1 reported that Resident A was initially admitted to assisted living at a level five care level and was later transitioned to the memory care unit after returning from a hospitalization. Staff noted she exhibited exit-seeking behavior in assisted living and, at times, aggressive behavior. Staff stated her daughter was sometimes asked to assist with showers due to these behaviors. Other concerns included Resident A flushing briefs and inappropriate toileting behaviors.

Employee #1 explained that Resident A's shower schedule was initially set for mornings, then temporarily changed to evenings based on family feedback to support better sleep. It was later reverted to mornings. Upon her return from hospitalization, Resident A was non-ambulatory and received bed baths; once she regained mobility, she began receiving showers again. Although the facility maintained a shower schedule, Employee #1 confirmed that shower logs were not kept, and documentation was only completed by exception when care was refused or could not be provided.

The administrator stated Resident A was hospitalized from 1/4/2025 to 1/7/2025, and again from 1/20/2024 to 2/3/2025. Upon her return, she was placed in memory care, and hospice services were initiated. Her family provided a 30-day discharge notice on March 20, 2025, and corporate staff waived remaining fees.

The administrator confirmed that all assisted living exit doors were alarmed, except for the center courtyard, which was locked at times. Doors sounded an alert after 15 seconds if opened.

While there were no documented discussions regarding provision of twice-daily snacks, staff reported that Resident A's family regularly supplied snacks and water, which were offered to her. Additionally, snacks were available to residents at any time.

During the on-site visit, all exit doors were observed to have locking mechanisms, alert systems, and keypad access.

Resident A's service plan, updated on 2/7/2025 and signed by Relative A2, and had moved into the home on 9/12/2024. The plan read she required one-person assistance with bathing, received showers twice weekly, mobility support in the shower, and use of a shower chair. The plan read the Care Team also supported with her bathing needs. It further noted she needed maximum assistance with dressing, grooming, hygiene, and transfers. The plan documented her high fall risk and specified safety checks once per shift, plus nighttime checks at 11:00 PM, 2:00

AM, and 5:00 AM. The plan read Resident A required ongoing assistance with care due to advanced dementia with speech, functional, and behavioral impairments. The plan indicated she required redirection for exit-seeking behavior and was equipped with a wander guard device.

Physician orders instructed staff to confirm the wander guard was on Resident A at 8:00 AM, 3:00 PM, and 11:00 PM each day written on 1/14/2025.

Review of progress notes from 9/12/2024 through 3/28/2025, reflected Resident A's exit seeking and wandering, as well as shower preference:

9/17/2024: Resident observed roaming halls looking for her spouse.

9/23/2024: Family requested showers be scheduled in the morning.

9/27/2024: Resident wandering, confused, and was redirected to the sitting area.

12/24/2024, 12/31/2024 and 1/1/2025: Resident noted to be wandering.

1/14/2025: Resident exited to courtyard, redirected without incident; wander guard implemented. Resident A's family agreed to her being placed on the memory care waiting list.

1/17/2025: Resident pulled the fire alarm twice while exit-seeking.

1/20/2025: Agitation and entry into other apartments led to hospitalization.

2/3/2025: Resident returned to the home and to her new room in memory care. Resident A's physician notified regarding return and planned to visit 2/11/2025.

2/4/2025: Resident was observed outside of her room sitting on the floor with small rash on the left side of her forehead. Relative A1 and her physician were notified and intended to see her on 2/11/2025. Her service plan was updated to reflect staff to encourage her to use her wheelchair for ambulation, remove foot pedals and encourage her to self-propel. Orientation to new environment related to her move to memory care.

2/12/2025: Resident attempted to kick at a balloon that was being tossed around, lost her balance and fell to the floor in which no injuries were found. Relative A1 and her physician were notified.

2/19/2025: Resident was exit seeking during the night.

Several entries documented Resident A refusing showers, followed by eventual compliance and completion of the task.

On 4/30/2025, email correspondence from Employee #1 indicated that Resident A weighed 139 pounds in both December 2024 and January 2025. She was out of the facility during February 2025, and in March 2025, following a hospitalization and transfer to the memory care unit, her weight was recorded at 127 pounds.

| 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.** |
| **ANALYSIS:** | The home took measures to protect Resident A, including the use of a wander guard, transitioning her to memory care, and providing ongoing monitoring with interventions regarding her falls. While records show that Resident A occasionally refused showers, there were also instances where she accepted them, with progress notes reflecting staff reports. However, as the home was not required to maintain documentation regarding shower provision, this specific allegation could not be substantiated. Additionally, weight records showed a decrease; however, Resident A was hospitalized twice in January 2025 and returned to the facility in February 2025 under hospice care. As a result, it cannot be determined whether the weight loss was due to hospitalization, decline associated with hospice care, or factors related to the care provided by the home. As a result, the overall allegation that Resident A was not provided protection and care in accordance with her service plan could not be substantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Inadequate staffing in the memory care unit.**

**INVESTIGATION:**

On 4/9/2025, the Department received a complaint which alleged on the evening shift of 3/1/2025, only one staff member was assigned to the memory care unit.

On 4/16/2025, an on-site inspection was conducted, and staff were interviewed.

Administrator Gretchin Mager and Employee #1 confirmed that the facility operates on three shifts: 6:00 AM–2:00 PM, 2:00 PM–10:00 PM, and 10:00 PM–6:00 AM. At the time of inspection, there were 14 residents in the memory care unit. The administrator stated that three staff members are typically assigned to the unit for both the first and second shifts, while one staff member is assigned during the night shift. During the night shift hours, two staff members are

assigned to assisted living, and one is designated to assist memory care if needed. It was noted that one memory care resident required a Hoyer lift and two-person assistance. The administrator stated that all staff received training on Alzheimer's and dementia, regardless of their assigned work area within the home.

Review of the staffing schedule for 3/1/2025 confirmed that staffing levels in the memory care unit were consistent with staff reports. Staff interviews also aligned with the documented schedule.

| **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:** | Based on staffing records and staff attestations, the allegation of inadequate staffing in the memory care unit on the evening of 3/1/2025, could not be substantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Resident A was not administered medications consistent with licensed health care professional orders.**

**INVESTIGATION:**

On 4/9/2025, the Department received a complaint alleging that Resident A was not administered her thyroid medication from 9/11/2024, to 12/6/2024, despite the medication being provided to the home. The complaint further alleged that staff failed to routinely administer as-needed (PRN) medications such as Tylenol and Motrin. Additionally, it was alleged that Resident A did not receive her prescribed Remeron for three nights and Robaxin for seven days, both ordered to address sleep and pain, respectively.

On 4/16/2025, an on-site inspection was conducted, and staff were interviewed.

Employee #1 explained that Resident A's physician was an external provider, which sometimes caused delays in obtaining orders. Additionally, Resident A's medications were supplied by the Veterans Administration (VA) and delivered by her family, rather than the home's contracted pharmacy. As a result, these

medications could not be scanned into the facility's electronic medication system. Employee #1 also noted that Resident A experienced changes in her Synthroid dosage. Some medications, she added, were only ordered to be administered for three to five days following her hospitalization.

A review of Resident A's MARs from September 2024 through March 2025 showed the following:

- Levothyroxine (Synthroid):
    - 75 mcg: Started 10/10/2024, discontinued 12/12/2024 – documented as administered.
    - 100 mcg: Started 12/13/2024, discontinued 1/7/2025 – documented as administered.
    - 150 mcg: Started 1/8/2025, discontinued 4/2/2025 – documented as administered, except during hospitalization (1/22/2025–2/3/2025).
- Acetaminophen (Tylenol) and Ibuprofen (Advil):
    - Acetaminophen 325 mg was prescribed as needed and scheduled doses – documented as administered.
    - Ibuprofen was prescribed both as a routine and PRN medication. The February and March MARs showed inconsistent documentation, including entries noting the medication was "unavailable and reordered" on 3/21/2025, 3/25/2025, and 3/26/2025, followed by entries showing it as administered.
- Methocarbamol (Robaxin):
    - Ordered as needed or prn for up to 7 days starting 2/3/2025 – documented as administered on two occasions (2/3/2025 and 2/6/2025).
- Mirtazapine (Remeron):
    - Ordered as needed or prn for sleep for up to 3 nights beginning 2/3/2025 – documented as administered on 2/6/2025.

Review of Resident A's progress notes from 2/12/2024 through 3/28/2025 indicated that on 2/4/2025, she complained of pain, and staff documented that Ibuprofen was administered twice.

| **APPLICABLE RULE** | |
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| **R 325.1932** | **Resident medications.** |
| | **(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions,** |

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|---|---|
| | **orders and by the prescribing licensed health care professional.** |
| **ANALYSIS:** | Review of the MARs indicated that staff consistently documented the administration of Resident A's Levothyroxine (thyroid) medication. Robaxin and Remeron were prescribed as needed, and therefore, not required to be administered unless the resident requested or demonstrated need. However, documentation regarding Ibuprofen was inconsistent, and in some instances, it was unclear whether the medication was administered or not due to availability issues. Therefore, the portion of the allegation regarding inconsistent administration of Ibuprofen was substantiated. The remaining allegations could not be substantiated. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Assisted living staff lacked Alzheimer's training.**

**INVESTIGATION:**

On 4/9/2025, the Department received a complaint alleging that assisted living staff were not adequately trained to care for residents with Alzheimer's disease.

On 4/16/2025, an on-site inspection was conducted, and staff were interviewed.

> Administrator Gretchin Mager reported that staff receive Alzheimer's and dementia-related training through Relias at the time of hire, as well as ongoing monthly training. In addition to Relias modules, the home also conducts "Daily Roots" meetings where training is discussed and regular in-service sessions. The administrator stated that all staff received training on Alzheimer's and dementia, regardless of their assigned work area within the home.

A random review of Employee #2's Relias training records confirmed completion of multiple Alzheimer's and dementia care modules during both orientation and ongoing training. These included, but were not limited to:

- *Bickford Dementia – Naomi Feil and Validation Therapy Videos*
- *Communication and People with Dementia*
- *Dementia Care: Activities for People with Memory Problems*
- *Dementia Care: Art and Music Interventions*

- *CMS Hand in Hand Modules 1–4 (Understanding Dementia, Communication, Actions & Reactions, Making a Difference)*
- *Effective Communication in Dementia Care*
- *Managing Challenging Behaviors*
- *Self-Study: Dementia Programming*
- *Sexuality and Persons with Dementia*
- Multiple trainings by Teepa Snow, including:
    - *Hand-Under-Hand Technique*
    - *Positive Physical Approach*
    - *Meaningful Activities*
    - *PAC Skills*
    - *Seeing It from the Other Side*

| **APPLICABLE RULE** | |
|---|---|
| **MCL 333.20178** | **Nursing home, home for the aged, or county medical care facility; description of services to patients or residents with Alzheimer's disease; contents; represents to the public defined.** |
| | **(1) Beginning not more than 90 days after the effective date of the amendatory act that added this section, a health facility or agency that is a nursing home, home for the aged, or county medical care facility that represents to the public that it provides inpatient care or services or residential care or services, or both, to persons with Alzheimer's disease or a related condition shall provide to each prospective patient, resident, or surrogate decision maker a written description of the services provided by the health facility or agency to patients or residents with Alzheimer's disease or a related condition. A written description shall include, but not be limited to, all of the following:**<br><br>**(d) Staff training and continuing education practices.** |

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| **ANALYSIS:** | Based on staff interviews and documentation, the facility provides training related to Alzheimer's and dementia care. Therefore, the allegation that assisted living staff lacked training in caring for residents with Alzheimer's disease could not be substantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Resident A's bathroom lacked cleaning.**

**INVESTIGATION:**

On 4/9/2025, the Department received a complaint alleging that Resident A's bathroom was not properly cleaned while she resided in the assisted living unit. The complaint also stated that staff did not have access to necessary cleaning supplies.

On 4/16/2025, an on-site inspection was conducted, and staff were interviewed.

Administrator Gretchin Mager stated that housekeeping services were provided weekly, with staff assisting with daily trash removal. She noted that while staff had access to cleaning supplies when needed, residents and their families were responsible for supplying items necessary to maintain the apartment, including cleaning supplies, personal care products and trash can liners for daily use.

During the inspection, multiple resident bathrooms were observed and appeared clean. Residents were seen maintaining personal hygiene supplies, including wipes, gloves, paper towels, and soap. The housekeeping closet was also reviewed and was well-stocked with trash can liners and general cleaning supplies such as sprays, brooms, and mops.

Resident A's admission agreement dated September 11, 2024, and signed by Relative A1, indicated that the resident or responsible party was to supply all personal items, clothing, and linens unless otherwise arranged at an additional cost. Her service plan, updated 2/7/2025, read that she required weekly assistance with housekeeping and laundry.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1979** | **General maintenance and storage.** |
| | **(1) The building, equipment, and furniture shall be kept clean and in good repair.** |

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| **ANALYSIS:** | Based on staff interviews, documentation, and direct observations, the allegation that resident's bathrooms were not cleaned and that staff lacked access to cleaning supplies 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.

04/25/2025

_____

Jessica Rogers Date
Licensing Staff

Approved By:

05/06/2025

_____

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