



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 2, 2025

Krystyna Badoni
Lansing Bickford Cottage
3830 Okemos Road
Okemos, MI 48864

RE: License #: AH330278347
Investigation #: 2026A1021005
Lansing 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

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 #:	AH330278347
Investigation #:	2026A1021005
Complaint Receipt Date:	11/04/2025
Investigation Initiation Date:	11/05/2025
Report Due Date:	1/04/2025
Licensee Name:	Lansing Bickford Cottage L.L.C.
Licensee Address:	13795 S. Murlen Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Christopher Weber
Authorized Representative:	Krystyna Badoni
Name of Facility:	Lansing Bickford Cottage
Facility Address:	3830 Okemos Road Okemos, MI 48864
Facility Telephone #:	(517) 706-0300
Original Issuance Date:	09/08/2008
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	55
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's care needs were not met.	Yes
Resident A's room was dirty.	No
Additional Findings	No

III. METHODOLOGY

11/04/2025	Special Investigation Intake 2026A1021005
11/05/2025	Special Investigation Initiated - Letter email sent to complainant for additional information
11/06/2205	Inspection Completed On-site
12/02/2025	Exit Conference

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Resident A's care needs were not met.

INVESTIGATION:

On 11/04/2025, the licensing department received a complaint with allegations Resident A's care needs were not met. The complainant alleged that Resident A has been found to be sitting in urine and feces for a substantial amount of time.

On 11/06/2025, I interviewed staff person 1 (SP1) at the facility. SP1 reported that Resident A resided in memory care and moved out of the facility on 11/03/2025. SP1 reported that Resident A was combative and would often refuse care. SP1 reported that Resident A was active with The Care Team hospice company.

On 11/06/2025 I interviewed SP2 at the facility. SP2 reported that Resident A was very resistant to care and would refuse care. SP2 reported that sometimes Resident A could be coaxed into receiving care by offering him cookies or coffee. SP2

reported that Resident A was incontinent, and his briefs would almost always be full. SP2 reported that caregivers would tear a brief to make it into a pad to place added protection into Resident A's briefs. SP2 reported caregivers were told this was not allowed and this practice stopped. SP2 reported that Resident A was not on a toileting schedule, and caregivers were to follow the care plan.

On 11/06/2025, I interviewed The Care Team hospice aid at the facility. The aid reported that she observed briefs made into a pad and placed into Resident A's brief due to the amount of urination Resident A had. The aid reported typically Resident A's brief was full. The aid reported that Resident A was very resistant to care and would often refuse care.

I reviewed Resident A's care summary. The summary read,

"Help with bathroom activities and hygiene. (Resident A) is to be taken to the restroom sometime between 5-6 am daily and then after meals, and bedtime."

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:	Review of Resident A's service plan revealed lack of detail regarding his specific needs. Interviews with direct care staff revealed Resident A's brief was often found soaked and that caregivers had started to place a pad for additional protection. Resident A's care plan simply stated that Resident A only required toileting assistance four times daily which was not sufficient to meet Resident A's toileting needs.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident A's room is not clean.

INVESTIGATION:

The complainant alleged that Resident A's room was not kept clean. The complainant alleged that the facility is in complete disarray and a mess. The complainant alleged that on several occasions, several of Resident A's pills were found to be sitting on a nightstand next to Resident A's bed. The complainant alleged the facility constantly reeks of urine and the floors have not been vacuumed in weeks as evidenced by trash is in the same spot for weeks.

SP1 reported that a few of these concerns were brought to the facility's attention. SP1 reported that the light was not working properly in Resident A's room and that the light was fixed. SP1 reported caregivers were to clean residents' rooms in memory care but now the housekeeper is responsible for these tasks. SP1 reported that Resident A's bathroom sink was cluttered and that it was immediately cleaned. SP1 reported Resident A had a history of taking his brief off and placing it on the floor. SP1 reported no knowledge of pills found in Resident A's room.

SP2 reported that Resident A would often take off his brief and place it on the floor. SP2 reported that Resident A would often move things around in his room and place them in different spots, such as the floor. SP2 reported that Resident A's room was to be cleaned on second shift, and this did not always occur. SP2 reported that she did tidy up Resident A's room when she could. SP2 reported that she has not seen pills left unattended at the facility.

The Care Team aid reported she never observed pills left in Resident A's room. The Care Team aid reported that she observed briefs left in Resident A's room because he would take them off.

While I was onsite, Resident A had moved out of the facility, and I was unable to view Resident A's room. However, I did walk the memory care unit at the facility. I did not smell urine or observe dirty floors.

APPLICABLE RULE	
R 325.1979	General maintenance and storage.
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Interviews conducted revealed there may have been occurrences when Resident A's room was not cleaned. However, the facility acted timely by changing the cleaning responsibilities and fixing maintenance issues. While these events may have occurred, it was an isolated incident and not a systemic issue at the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

Kimberly Horst

11/07/2025

Kimberly Horst
Licensing Staff

Date

Approved By:

Andrea L. Moore

12/02/2025

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

Date