GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 25, 2026

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

RE: License #: AH330278347
Investigation #: 2026A1021044
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 #:	2026A1021044
Complaint Receipt Date:	06/05/2026
Investigation Initiation Date:	06/09/2026
Report Due Date:	08/05/2026
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/05/2026	Special Investigation Intake 2026A1021044
06/09/2026	Special Investigation Initiated - On Site
06/11/2026	Contact-Telephone call made Interviewed SP3
06/11/2026	Contact-Telephone call made Interviewed SP4
06/12/2026	Contact - Document Received received resident docuements
06/25/2026	Exit Conference

ALLEGATION:

Resident A eloped from the facility.

INVESTIGATION:

On 06/05/2026, the licensing department received an anonymous complaint that on 05/16/2026, Resident A eloped from the facility.

On 06/09/2026, I interviewed the administrator Christopher Weber at the facility. The administrator reported that Resident A moved into the facility on 05/12/2026 and the facility had received limited information on Resident A. The administrator reported that Resident A has a wander guard and resides in the assisted living unit. The administrator reported that Resident A exited the facility out of the 300 hall exit door and was able to walk across the street. The administrator reported that the facility does have an alarm system. The administrator reported that around this time, the alarm system was mis-alarming that a door was opened when it was not. The administrator reported that on this day, the door alarm did alert and was sent to the caregivers' pager. The administrator reported that following the incident the facility

increased Resident A's Seroquel medication, a meeting is scheduled with Resident A's family on potentially moving Resident A back to the memory care unit for increased supervision, and there are signs throughout the facility to re-direct Resident A.

On 06/09/2026, I interviewed staff person 1 (SP1) at the facility. SP1 reported that she was working when Resident A eloped from the facility. SP1 reported that the elopement happened around 1:30pm when caregivers are busy with resident care. SP1 reported that the alarm did go off but she was busy with another resident and was unable to respond to the door alarm. SP1 reported that Resident A walked across the street.

On 06/09/2026, I interviewed SP2 at the facility. SP2 reported that she was working in the secure memory care unit when Resident A eloped. SP2 reported that someone came back to the unit to tell the medication technician that a resident was outside the facility.

While onsite I viewed the street that Resident A walked across. The street was a four-lane divided highway that was very busy.

On 06/11/2026, I interviewed SP3 by telephone. SP3 reported that she was working when Resident A eloped. SP3 reported that she was in the memory care unit. SP3 reported that a resident's family member came back to the unit and informed her that a resident was outside the facility. SP3 reported that she ran across the street and brought Resident A back to the facility. SP3 reported that the caregivers are responsible for the walkies and she did not hear a door alarm. SP3 reported that the elopement occurred when caregivers are busy with resident care.

On 06/11/2026, I interviewed SP4 by telephone. SP4 reported that she was working when Resident A eloped. SP4 reported that Resident A was a new admission and she was not aware that Resident A was an elopement risk. SP4 reported that when the elopement occurred there were two caregivers in the assisted living unit. SP4 reported that the caregivers were in a resident room providing two person assist care to the resident. SP4 reported that she received a call that Resident A had entered another resident's room. SP4 reported that when she went to this resident's room, Resident A was not in the room and that resident reported that Resident A had left her room. SP4 reported that then a door alarm alerted Resident B had exited the building. SP4 reported she went to Resident B's room and found Resident B in her room. SP4 reported that she then saw SP3 bringing Resident A back to the facility. SP4 reported that often the pagers will say the wrong door and/or resident name. SP4 reported that to know the correct door and resident room, the employee must go to the computer in the front office, which is not always feasible.

I reviewed Resident A's progress notes. The notes read,

“(Relative C1) came to Mary B’s while I was passing meds notified me that there is a elderly man across the street from us walking by himself. I saw an elderly man in front of Knobill apartment entrance and I ran to him and found out (Resident A) was sitting on the grass by the Knobhill apartment. He states that he was trying to find his buddy. Myself and a BFM escorted him back to Bickford safely. He eloped through the 300s exit door.”

I reviewed incident report following this elopement. The notes read,

“This nurse was notified by executive director that resident was across the street and had eloped. Resident per report was easily redirected back inside. Per report resident had no injury. Instructed to provide hourly checks x24 hours, escort to courtyard after meals weather permitting continue with wander guard.”

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:	Interviews conducted revealed Resident A was able to elope from the facility and cross a busy four lane divided highway. While the door alarm may have alerted, the message of who and where was not correct which resulted in delayed response time. In addition, due to staff responsibilities, there was no one immediately available to respond to the door alarm and begin elopement procedures. The facility lacked an organized program of supervision and reasonable protective measures to keep Resident A safe.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's incident report revealed Resident A was to be placed on hourly checks and escorted to the courtyard after meals.

I reviewed Resident A's service plan. The service plan read,

"BFM check on (Resident A) each shift for safety and comfort. BFM redirect (Resident A) away from exit doors. BFM ensure he is wearing the wander guard."

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 details on increased supervision and protection for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

SP1 reported that there are only two caregivers in the assisted living and the medication technician floats between both units. SP1 reported at times both caregivers can be in a resident room for a long period of time.

SP4 reported that there are only two caregivers assigned to the assisted living unit. SP4 reported that at the weekends there are no additional staff, such as management, that can assist when resident care needs are high. SP4 reported that there are many residents that require two person assist.

I reviewed a sample of resident service plans. Review of Resident D, E, F, and G's service plans revealed the residents required two person assist with transfers.

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:	Interviews with staff, consideration of care needs as identified in their plans of care, along with schedule review revealed the facility has lack of staff to provide care to the residents. There are four residents that require two staff persons to assist, yet there are only two caregivers in that unit, indicating other residents that require supervision or assistance are without it during that time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/15/2026

Kimberly Horst Date
Licensing Staff

Approved By:

06/25/2026

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