GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 30, 2026

Krystyna Badoni
Battle Creek Bickford Cottage
3432 Capital Avenue
Battle Creek, MI 49015

RE: License #: AH130278262
Investigation #: 2026A1028047
Battle Creek Bickford Cottage

Dear Krystyna Badoni:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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

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

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH130278262
Investigation #:	2026A1028047
Complaint Receipt Date:	04/28/2026
Investigation Initiation Date:	04/30/2026
Report Due Date:	06/28/2026
Licensee Name:	Battle Creek Bickford Cottage , L.L.C.
Licensee Address:	Suite 301, 13795 S. Mur-Len Road, Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Laurel Space
Authorized Representative:	Krystyna Badoni
Name of Facility:	Battle Creek Bickford Cottage
Facility Address:	3432 Capital Avenue, Battle Creek, MI 49015
Facility Telephone #:	(269) 979-9600
Original Issuance Date:	12/29/2006
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 incurred an injury during an unwitnessed fall following an altercation with staff member 1.	No
Additional Findings	No

III. METHODOLOGY

04/28/2026	Special Investigation Intake 2026A1028047
04/30/2026	Special Investigation Initiated - Letter
04/30/2026	APS Referral
05/12/2026	Contact - Face to Face Interviewed the facility administrator at the facility.
05/12/2026	Contact - Document Received Received requested documentation from the facility administrator.

ALLEGATION:

Resident A incurred an injury during an unwitnessed fall following an altercation with staff member 1.

INVESTIGATION:

On 4/30/2026, the Bureau received the allegations through the online complaint system.

On 5/12/2026, I interviewed the administrator at the facility who confirmed that Resident A had an unwitnessed fall that resulted in injury, but it was not due to any staff altercation. The administrator reported Resident A resides in the memory care unit and often wanders into other resident's rooms, particularly the rooms located next to [theirs]. Resident A had wandered into the resident's room beside [theirs] with staff member 1 quickly redirecting Resident A away from the room. As Resident A was redirected away from the room, [they] demonstrated aggressive behavior towards staff member 1 in the hallway to include cursing and punching staff member.

Staff member 1 backed away to provide Resident A space and to not escalate the incident. Resident A was redirected to the dining room for the lunch time meal while staff member 1 went to assist another resident. Resident A then incurred an unwitnessed fall that resulted in injury a few minutes later. Due to the fall with injury and because Resident A punched staff member 1, a facility investigation was conducted immediately. All staff were interviewed and provided statements. It was (later) determined that Resident A had a severe urinary tract infection (UTI) that may have affected [their] balance and mood. It was also determined that staff member 1 did not engage with Resident A and did not harm Resident A when Resident A was redirected and punched [them]. Resident A was sent to the hospital for evaluation and treatment and is currently in a physical rehabilitation facility. The administrator provided me with the requested documentation for my review.

On 5/19/2026, I reviewed the requested documentation which revealed the following: Resident A's service plan:

- The service plan was last updated 2/18/2026.
- Resident A requires frequent help due to disorientation, memory loss, and has difficulty completing tasks.
- Resident A is disoriented to person/time/place, repeats information, and has memory impairment along with poor safety awareness.
- Resident A requires cueing or reminders if wandering.
- Resident A typically does not demonstrate behaviors and is cooperative, social, and demonstrates appropriate mood and affect.
- Resident A requires assistance with bathing and set-up and/or cueing for dressing, grooming, oral care, and toileting.
- (Prior to the fall,) Resident A was independent with transfers and mobility but could require escorts to meals due to cognition.
- The facility managed Resident A's meals, laundry, housekeeping, and medication administration.

Review of internal facility investigation:

- Summary: On 4/26/2036 around 11:30am, *[Staff member 1] saw [Resident A] coming out of another resident's room. [Staff member 1] told [Resident A] that the room did not belong to [them.] [Resident A] cursed at [staff member 1] and punched [staff member 1] in the chest. [Staff member 1] then cued [Resident A] to head to the dining room for lunch and [staff member 1] continued down the 400 hall and around the corner to get [another resident] ready for lunch. [Resident A] was witnessed on the ground a few minutes later. At some point, [Resident A] said something to the effect of "she pushed me down." We believe this was [Resident A] conflating the facts after [the] fall occurred shortly after [the] interaction with [staff member 1]. [Resident A] has severe dementia and the hospital indicated [Resident A] has a septic UTI, which might have affected [their] balance.*
- All staff member statements were consistent in that Resident A incurred an unwitnessed fall minutes after punching staff member 1 in the chest. Staff member 1 was assisting another resident on a different hallway when

Resident A fell. Staff member 1 and no other staff were present when Resident A incurred the unwitnessed fall. Staff member 1 has never demonstrated any harm or abuse towards any resident at the facility. Staff member 1 reported the incident in which Resident A punched [them] in the chest immediately to the shift supervisor, the facility administrator, and other staff working in the memory care unit that day.

- Resident A is a poor historian and reported different versions of the fall to different staff members. For example, Resident A reported, “I don’t even know how any of this happened”; “She wouldn’t let me up”; “I can’t get up”; and “She pushed me down”.
- Resident A complained of left arm pain and demonstrated a change in condition and speech after being found on the floor. Staff called emergency services immediately. Resident A initially refused to go to the emergency room for evaluation and treatment.
- Resident A’s family and physician were notified of the fall and transport to the hospital.

Hospital documentation:

- [Resident A] *reportedly had an unwitnessed fall [sic]. Circumstances unclear. The patient does not remember falling and cannot contribute to the history due to [their] dementia. [Patient] notes pain in right shoulder and right hip. [Sic] denies any headaches or neck pain. [Sic] denies any chest or abdominal pain. Detailed history is limited due to dementia.*
- *Family was notified and agreed to admission and plan of care.*
- [Resident A] *was alert but not oriented. Unclear mechanism of injury, there is concern patient was pushed by another resident just prior to fall per family at bedside. [Resident A] unreliable historian.*
- Resident A was diagnosed with *comminuted displaced fracture of right sacral ala., nondisplaced fracture in the right superior pubacetabular junction, displaced fracture of the right inferior pubic ramus, comminuted displaced fracture of the left pubic body and superior pubic ramus, urinary tract infection, leukocytosis, and hypertension with home medications to be reconciled.*
- [Resident A] *has a history of frequent UTIs.*
- [Resident A] to attend inpatient skilled rehabilitation for nursing and therapy services.

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.**

ANALYSIS:	It was alleged that Resident A incurred an injury during an unwitnessed fall following an altercation with staff member 1. Interview, onsite investigation, and review of documentation reveal there is no evidence to support this allegation. The facility demonstrated supervision, assistance, and protection to ensure Resident A's care and wellbeing when Resident A incurred an unwitnessed fall resulting in injury. Also, there is no evidence to support that staff member 1 caused Resident A's fall with injury or that staff member 1 harmed Resident A. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend the status of this license remains the same. No violation(s) found.

Julie Viviano

5/19/2026

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L Moore

07/30/2026

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