GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 18, 2026

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

RE: License #: AH330278347
Investigation #: 2026A1041011
Lansing Bickford Cottage

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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. 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,

Tammie Daniels

Tammie Daniels, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
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 #:	2026A1041011
Complaint Receipt Date:	06/18/2026
Investigation Initiation Date:	06/22/2026
Report Due Date:	08/18/2026
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:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	55
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was locked inside her apartment.	No
Resident A did not have furniture besides a bed in her apartment.	No
There was no table for Resident A's meal in her room.	Yes
Resident A's meal tray was on the floor next to her bed with food all over her, the bed, and the floor.	Yes
Additional Findings	No

III. METHODOLOGY

06/18/2026	Special Investigation Intake 2026A1041011
06/22/2026	Special Investigation Initiated - Telephone Phone Interview with Complainant
06/23/2026	Contact - Face to Face Onsite Visit
07/27/2026	Contact - Telephone call made Phone Interview with Administrator
07/29/2026	Contact – Telephone call made Phone Interview with Employee 3
07/30/2026	Contact – Telephone call made Phone Interview with Employee 4
08/04/2026	Contact – Documents Received Requested Information Received from Administrator
08/04/2026	Contact – Telephone call made Interview with Heartland Hospice Patient Care Manager
08/18/2026	Exit Conference

ALLEGATION:

Resident A was locked inside her apartment.

INVESTIGATION:

On 06/22/2026, I interviewed the complainant by phone. The complainant alleged that upon arriving at the facility on 06/10/2026, staff had to unlock Resident A's door, and she was in her room by herself. The complainant alleged that there was no way Resident A could have got out of her room on her own.

On 06/23/2026, I interviewed the Administrator, Chris Weber, at the facility. The Administrator reported that all apartment doors can be locked from the inside or the outside, however, they did not need to be unlocked for the residents to leave the apartment. The Administrator reported that even if the door was locked, residents simply needed to turn the doorknob, and the door would open to the hall. The Administrator reported that Resident A would never be locked in her room intentionally by staff. The Administrator reported that Resident A did fidget around and may have locked the door on her own but was unsure why the door would have been locked otherwise. The Administrator reported that although Resident A required assistance for transfers due to being unsteady, she did transfer herself and could walk. The Administrator reported that Resident A was being checked by staff every two hours for unattended transfers and behaviors. The Administrator reported that Resident A had transferred herself the morning of 06/10/2026 and recalled her coming into his office while pushing her own wheelchair. The Administrator reported that Resident A no longer resided at the facility.

On 06/23/2026, I toured the facility and entered three apartments, each in different halls. In each apartment, it was observed that when the hallway side of the door was locked, the door could still be opened from inside the apartment simply by turning the knob. Additionally, this was demonstrated in each room. I entered each of the three apartments and the Administrator locked the hallway side of the door (locking me in). I was able to open the apartment door easily from inside to get to the hall.

On 06/23/2026, I interviewed Employee 1 at the facility. Employee 1 reported that she was working with Resident A on 06/10/2026. Employee 1's statements were consistent with the Administrators.

On 07/21/2026, I reviewed Resident A's most recent service plan dated 04/23/2026. Review revealed the following transfer and mobility care needs:

- Transfer: "*One person assistance with resident participation*… provide assistance with all transfers…"

- Mobility: "*One person partial assist, hand hold…"*

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:	Observation and demonstration revealed that apartment doors are easily opened from inside the apartment even if the door is locked on the hall facing side of the door. Interviews revealed that although Resident A' needed assistance with transferring for safety, she would still transfer herself. Therefore, there is a lack of evidence to support a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A did not have furniture besides a bed in her apartment.

INVESTIGATION:

The complainant alleged that there was no furniture other than a bed in Resident A's apartment on 06/10/2026.

The Administrator reported that prior to leaving the facility on 06/10/2026, Resident A had been relocated within the facility due to concerns involving another resident in which she had been previously sharing a room. The Administrator reported that Resident A moved out of the original room on 04/22/2026. The Administrator reported that the facility does provide a bed and a bedside stand if needed for all residents. The Administrator reported that prior to moving out of her original apartment, Resident A had new behaviors which were followed by an inpatient stay at a healthcare institution. The Administrator reported that when Resident A returned to the facility, the behaviors were somewhat improved but still occurring. The Administrator reported that within a few days, Resident A was signed up to hospice services. The Administrator reported that Resident A had been supplied with a bedside stand by the facility following her move from the original apartment, but Resident A "*busted it*", and it was replaced after that but with a similar outcome. The Administrator reported that Resident A had also been pulling cupboards off the wall; ripping baseboards up; etc. The Administrator reported that during this time, the facility was working with hospice and the family to help with issues that may have

been causing the behavior of damaging things in her room. The Administrator reported that the latest broken bedside stand had been removed from Resident A's room about one and a half weeks prior to her leaving the facility on 06/10/2026. The Administrator reported that he had discussions with the family about possibly sharing some furniture from Resident A's original room. The Administrator reported that he was working to find another bedside stand from another location.

On 07/27/2026, I reviewed Resident A's progress notes from April 2026 to June 2026. The following was revealed:

- On 04/30/2026, "*tore up room; all items she owned was on the floor".*
- On 05/03/2026, "*calls to hospice-aggressive behavior-out to hospital*"
- On 05/06/2026, "*started on new med for behaviors per hospice*"
- On 05/21/2026, "*call to Heartland Hospice- pain not being managed, restless with agitation; tore the cupboard doors off in apartment*."
- On 06/07/2026, "*is breaking things in her room. Tore thermostat off the wall and pulled floor boards out with nails facing up*… hospice in to eval."

Employee 1 reported that Resident A had a "*coffee table*" removed from her room a coupled weeks earlier. Employee 1 reported that the table was removed because Resident A had damaged it. Employee 1 reported that she was unsure if the table had been replaced due to damage a second time. Employee 1 reported that Resident A would damage items in her room and that the facility was trying to work with hospice to help with the new behaviors.

On 07/30/2026, I interviewed Employee 4 by phone. Employee 4's statements were consistent with the Administrator and Employee 1.

APPLICABLE RULE	
R 325.1934	**Furniture.**
	(3) A bedside stand or its equivalent shall be available for a resident for the storage of small personal articles.

ANALYSIS:	Interviews reveal that the facility had provided Resident A with a bedside stand after moving out from her original apartment on 04/22/2026; that Resident A had been having behaviors; the facility had been working with the hospice to assist with behaviors; and that the bedside stand had been removed at least a week and a half prior to 06/10/2026. Review of Resident A's progress notes reveal that her behaviors included destruction to items in her room. Based on the above, there is insufficient evidence to conclude that the facility failed to provide the required furniture. Instead, the evidence indicates that Resident A repeatedly destroyed the furniture while the facility was attempting to manage those behaviors.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION(S):

There was no table for Resident A's meal in her room.

INVESTIGATION:

The complainant alleged that there was no table in Resident A's room for her meal to be placed so she could eat her meal without using the floor or the bed.

On 08/04/2026, I received information from the Administrator through email. The Administrator reported that the facility provided a freestanding tray for Resident A to place her meal trays on when receiving meals in her room.

Employee 1 reported that there was no furniture in Resident A's room besides a bed for a couple weeks, due to behavioral concerns, including any tables for her meal tray. Employee 1 reported that staff would hold on to Resident A's meal tray while sitting on the bed or on the floor.

Employee 4's statements were consistent with Employee 1. In addition, Employee 4 reported that the only other place in Resident A's room to put Resident A's meal tray other than the bed was on the kitchenette counter. Employee 4 reported that there were no tables for Resident A's room tray for "a while".

During review of Resident A's service plan dated 04/23/2026 and progress notes between April 2026 and June 2026, review revealed that there was no documentation indicating that a freestanding tray was provided or would need to be provided for Resident A's meals while in her room. There were no instructions for caregivers to provide Resident A's meals on a freestanding table when taking meals to her room (even if not stored in her room).

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(6) A home shall provide a table or individual freestanding tray of table height for a resident who does not go to a dining room.
ANALYSIS:	Interviews revealed conflicting witness statements regarding whether Resident A had a freestanding tray in her room during the relevant period. In contrast to the interview with the Administrator who reported that a freestanding tray was provided, Employee 1 and Employee 3 separately and independently reported their firsthand observations that there were no tables to set Resident A's meal tray on, which is consistent with the allegation. Due to the above findings, it is more likely than not that there was no freestanding tray for Resident A's meals to be placed when taking her meal in her room during the reviewed period, therefore, the facility is not compliant with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION(S):

Resident A's meal tray was on the floor next to her bed with food all over her, the bed, and the floor.

INVESTIGATION:

The complainant alleged that upon entering Resident A's room on 06/10/2026, a food tray was found lying on the floor next to the bed. The complainant alleged that food was scattered all over Resident A's bed and on the floor. The complainant alleged that Resident A was stepping and rolling around in her own food.

The Administrator reported that a food tray could have been in Resident A's room for breakfast on 06/10/2026 because she was a late riser in the morning and staff might have placed the tray in her room. The Administrator reported that Resident A was on a pureed diet and could feed herself with prompting from staff.

Employee 1 reported that Resident A required staff assistance to remain focused on eating. Employee 1 reported that if left alone with her tray, she would eat her pureed food with her fingers and get food on every surface. Employee 1 reported that staff usually stayed in the room to assist with breakfast but may have to leave if they receive a page for another resident. Employee 1 reported that she could not recall

delivering or picking up Resident A's breakfast tray on the morning of 06/10/2026 or the condition of the room.

On 07/29/2026, I interviewed Employee 3 by phone. Employee 3 reported that she assisted Resident A with toileting and dressing prior to her leaving on 06/10/2026. Employee 3's statements were consistent with Employee 1's. Additionally, Employee 3 reported that she could not recall delivering or picking up Resident A's breakfast tray that morning, or the condition of the room.

On 07/30/2026, I interviewed Employee 4 by phone. Employee 4 reported that she assisted Resident A prior to her leaving on 06/10/2026. Employee 4's statements were consistent with Employee 1 and Employee 3. Additionally, Employee 4 reported that if Resident A wasn't ready to eat when breakfast arrived, she would let Resident A know the tray was in the room, place the tray on the kitchenette counter, and leave to assist other residents. Employee 4 reported that Resident A needed staff assistance with meals. Employee 4 reported that she did not believe any staff would put the tray on the floor but reported that Resident A could get the tray and put the tray on the floor by her bed. Additionally, Employee 4 reported that she did not recall who delivered or picked up Resident A's tray on 06/10/2026 or the condition of the room.

I reviewed Resident A's most recent service plan dated 04/23/2026 which revealed the following:

- Meals and Nutrition: Resident A needed minimum assistance including "*Meal reminders or cueing to eat… will need cues to eat. Her focus is short and needs verbal cues… Support participating in the dining program daily at AM and PM*"
- Transfer: "*One person assistance with resident participation… provide assistance with all transfers… Notes… utilize wheel chair for ALL transfers due to very unsteady gait…*"
- Communication: Resident A "*is unaware of her need to drink fluids to stay hydrated*."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(3)(a) That the home shall provide room, board, protection, supervision, assistance, and supervised personal care consistent with the resident's service plan.
ANALYSIS:	Although it could not be confirmed whether Resident A's tray was on the floor or what condition the room was in on 06/10/2026, a review of Resident A's service plan indicated that she required reminders and cues during meals, as well as transfer assistance due to her unsteady gait. Employee interviews revealed that meal trays were occasionally left in Resident A's room, including on the kitchenette counter, without staff remaining to provide the reminders, supervision, and assistance outlined in her service plan. As a result, the facility was not compliant with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Tammie Daniels 08/07/2026

Tammie Daniels Date
Licensing Staff

Approved By:

Andrea L. Moore 08/18/2026

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