GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 31, 2026

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

RE: License #: AH330278347
Investigation #: 2026A1041013
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 #:	2026A1041013
Complaint Receipt Date:	06/30/2026
Investigation Initiation Date:	06/30/2026
Report Due Date:	08/31/2026
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?
The facility did not provide the level of care agreed upon, resulting in repeated falls and no follow-up emergency care.	No
The facility did not seek medical treatment for Resident A's wound.	No
The facility did not provide nutritious food.	No
The facility did not ensure the written admission contract was signed by Resident A.	Yes
The facility did not initiate a discharge for Resident A despite not having the resources to ensure her safety and health.	No
Additional Findings	No

III. METHODOLOGY

06/30/2026	Special Investigation Intake 2026A1041013
06/30/2026	Special Investigation Initiated - Telephone Interview with Complainant by phone
07/07/2026	Contact - Face to Face Onsite Investigation
07/31/2026	Contact- Email Additional Information received from Complainant
08/12/2026	Contact- Phone Interview Telephone Interview conducted with the Administrator
08/12/2026	Contact- Email Additional Information received from Administrator
08/31/2026	Exit Interview

Allegations made in this complaint regarding insufficient staffing levels have been investigated within the previous six months and were not reinvestigated in accordance with Michigan Administrative Rule 325.1918.

ALLEGATION:

The facility did not provide the level of care agreed upon, resulting in repeated falls and no follow-up emergency care.

INVESTIGATION:

The complainant alleged that the facility did not provide Resident A with adequate care, which resulted in five falls. The complainant alleged that the facility never initiated an emergency room visit or hospital transfer even when medically indicated.

On 07/07/2026, I interviewed the Administrator, Chris Weber, at the facility. The Administrator reported that Resident A no longer lives at the facility and moved out at the end of May 2026. The Administrator reported that Resident A needed assistance of one caregiver when she moved in during November 2025. The Administrator reported that although Resident A was alert, able to make her needs known, and able to use the call pendant, she would still occasionally attempt to transfer herself. The Administrator reported that Resident A began receiving occupational therapy (OT) services in December 2025 and physical therapy (PT) services in January 2026 because of a knee replacement done prior to moving in. The Administrator reported that both OT and PT services continued throughout Resident A's stay at the facility. The Administrator reported that Resident A had four falls which occurred on 03/31/2026; 04/06/2026; 04/20/2026; and 04/28/2026. The Administrator reported that Resident A's care needs increased during the last couple months of her stay at the facility. The Administrator reported that interventions and updates were documented in the progress notes and on Resident A's Care Summary which updated the service plan. The Administrator reported that the facility developed a new service plan on 05/13/2026 after Resident A's decline to reflect the increase in care services. The Administrator reported that Relative A1 wanted to have a conference about the increase in care and a conference was scheduled for 05/22/2026. The Administrator reported that prior to the conference, the Health & Wellness Director (HWD) left her position and the conference time needed to be adjusted. The Administrator reported that the care conference had not yet occurred and the new service plan was not signed by Resident A or Relative A1 prior to Resident A leaving the facility on 05/26/2026 and not returning.

On 07/07/2026, I interviewed Employee 2 at the facility. Employee 2 reported that when Resident A first came to live at the facility, she could pivot herself and needed one caregiver to help her with transfers. Employee 2 reported that Resident A had increased weakness in the last few months of her stay. Employee 2 reported that in the last few months, she needed two staff members for transferring and was monitored every two hours for safety. Employee 2 reported that Resident A did use her call pendant when she needed help.

On 07/07/2026, I interviewed Employee 3 and Employee 4 at the facility. Both Employee 3 and Employee 4's statements were consistent with Employee 2's statements.

On 08/10/2026, I reviewed Resident A's two most recent service plans. Review revealed the following care needs identified:

Service plan signed and dated 02/27/2026:

- "*Transfer Needs/Details*"; "*…one-person assist and requires standby assistance at all times for all transfers due to limited movement of her right leg and muscle deterioration."*

Service plan dated 05/13/2026:

- "*Transfer Needs/Details*"; "*Two person assistance with transferring… Non-weight bearing… require full assistance for ALL transfers with a gait belt*…"

On 08/10/2026, I reviewed the facility's progress notes for Resident A dated between 11/11/2025 through 06/02/2026. Review revealed the following:

- Comment entered on 11/11/2025 stated, "*I suggested she may need a new wheelchair as currently using a transfer wheelchair which is difficult to 'lock' and use on a daily level.*"
- Incident Note entered on 03/31/2026 stated "… *resident was on floor sitting in a chair style position… She says she slid out of bed… no visible injuries… vital signs within normal range*…"
- Incident Note entered on 04/06/2026 stated "*Phone call… says she is on floor for two minutes… I asked her if she is OK and she said yes… vitals… were in normal range… no visible injuries…* "
- Note entered on 04/07/2026 stated that Relative A1 "*reported resident had a fall two nights ago, landing on her knees, with no initial complaints. This morning, resident reported right knee pain and was noted to have left leg swelling. Resident was taken to* (Hospital)… *diagnosed with blood clot in the left leg…*"
- Note entered on 04/07/2026 stated *"Please pay attention to care tracker. Resident's care plan has been updated with a TWO person assist due to new injury to right knee and left leg swelling… Due to recurrent falls new right knee injury, writer recommended a hospital bed that can be lowered at night with elevation of the foot of the bed to assist with left leg swelling, as well as a fall mat for added safety*."
- Incident Note entered on 04/20/2026 stated "*Resident paged and was on the floor in the bathroom… Injuries N/A* (not applicable)".
- Note entered on 04/26/2026 stated that Relative A1*" took her to the Hospital; he did not disclose the reason why.*"
- Incident Note entered on 04/28/2026 at 4:20 PM stated "… *was observed on the floor this morning. She stated 'her wheelchair tipped and she fell out of it'… She was on her bad knee and the nurse said to not move her and call 911, so did her husband…*".
- Note entered on 04/28/2026 by Employee 6 stated "*Resident is a two person assist with transfers. Therapy will be here today. Service plan reviewed and was updated."*
- Note entered on 05/14/2026 by Employee 1 stated "*Spoke with* (Relative A1) *in regards to LOC* (Level of Care) *change, set up LOC care conference set for next Friday.*"

On 08/10/2026, I reviewed OT and PT notes dated between 03/31/2026 and 04/28/2026. Review revealed that OT made five visits and PT made eight visits to assist Resident A during the timeframe of the falls at the facility.

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:	Interviews and documentation revealed that the facility made recommendations to increase safety; staff followed Resident A's service plan; interventions were provided once becoming aware of medical complications; and updates were made to the service plan following changes in Resident A's status. There were no injuries reported at the time of the falls on 03/31/2026, 04/06/2026, and 04/20/2026. On 04/28/2026 when concern of injury was noted after the fall, the facility documented calling 911. Therefore, there is no documented evidence to support a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not seek medical treatment for Resident A's wound.

INVESTIGATION:

The complainant alleged that the facility caused a delay in care after Resident A developed a wound. The complainant alleged that Resident A had to be hospitalized and was found to have sepsis as a result.

Review of the facility's progress notes for Resident A dated 11/11/2025 through 06/02/2026 revealed the following regarding a wound:

- A Progress Note entered by Employee 4 dated 05/24/2026 stated "*STAT, NEEDS URGENT ATTENTION… bumps with pus inside… very red…opening start of wound… This is new, redness appeared late afternoon yesterday… Tylenol is taken regularly so no fever detected…*"
- An Emergency Room Visit Note was entered 05/25/2026 stated "*she have wounds… her husband called her dr.* (doctor) *an he told him to take her to the ER* (emergency room)" [sic].

On 08/10/2026, I reviewed the facility policy titled "*PP – 23950 – Skin Integrity*". Review revealed the following:

- The facility staff member will "*report skin changes to nurse or other caregiver…* (staff) *should complete an Incident Report in the resident chart… Once report is received, the HWD or designee should… Ensure completion and review incident report… Notify the physician/healthcare provider (HCP) and family of the skin concern as soon as possible… Apply dry dressing to wound until physician/HCP orders are received"*

On 08/12/2026, I interviewed the Administrator by phone. The Administrator reported that the progress note entered by Employee 4 on 05/24/2026 lacked appropriate follow-through based on the wound findings. The Administrator reported that Employee 4 should have notified leadership and completed proper documentation of the incident. The Administrator reported that after identifying this error, the facility provided written disciplinary action and counseled Employee 4 on facility policy for reporting incidents and proper documentation on 06/10/2026. The Administrator reported that in addition, all caregiver staff were re-educated on facility policy for documentation, reporting hierarchy, shift reporting and communication. The Administrator reported that Employee 1 is checking the electronic charting record daily to ensure care staff are documenting and following up properly. The Administrator reported that immediate coaching is done for any errors found.

On 08/12/2026, I reviewed Employee 4's disciplinary action completed on 06/10/2026, along with documentation of the staff re-education conducted the same day. The review confirmed that both tasks were completed as reported by the Administrator and included staff signatures.

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: (c) Assure the availability of emergency medical care required by a resident.
ANALYSIS:	Interview and documentation reveal that Employee 4 identified a wound on 05/24/2026 and did not report it according to facility policy. After discovering the issue, the facility provided disciplinary action to the direct employee involved; educated all care staff on documentation and the reporting hierarchy; and implemented documentation monitoring. Therefore, although not compliance with the rule when this incident occurred, the facility took appropriate corrective action prior to this investigation and has been monitoring to prevent future recurrence.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not provide nutritious food.

INVESTIGATION:

The complainant alleged that the facility did not provide nutritious food and instead delivered burnt foods; highly salted cured meats; and overcooked vegetables to Resident A during her stay.

The Administrator reported that a dietician comes to the facility and creates the menu every six months. The Administrator reported that the most recent visit from the dietician was in April 2026. The Administrator reported that the facility recently went through some changes with kitchen staff but that the facility menu is generated by the dietician and is followed by the facility each day. The Administrator reported that the facility offers alternate food choices when requested. The Administrator reported that any food that a resident does not like gets added to the resident's service plan, so staff are aware.

Review of Resident A's three service plans dated between 11/25/2025 and 05/13/2026 reveal that Resident A had a regular diet; was independent with meals throughout her stay at the facility; and did not want onions, banana, cucumbers, coffee, raisins, green peppers, liver, or ham.

On 07/07/2026, I interviewed Resident B at the facility. Resident B reported that the meals were good. Resident B reported that the food offered was nutritious in her opinion. Resident B reported that there were always alternate food options at each meal.

On 07/07/2026, I interviewed Resident C at the facility. Resident C's statements were consistent with Resident B.

On 08/19/2026, I reviewed the facility's weekly menus for four weeks between 04/26/2026 and 05/24/2026. Review revealed each weekly menu was signed by a dietician and included multiple choices for each meal.

On 08/19/2026, I reviewed the "*Assisted Living Kitchen Observation*" report completed on 04/23/2026 by the facility's Dining Manager Consultant. The report revealed that the facility met the following food standards for Assisted Living Facilities:

- Food purchased from approved sources
- Food code temperatures
- Dry food storage
- Cold food storage

- Hygiene
- Training of staff

APPLICABLE RULE	
R 325.1951	**Nutritional need of residents.**
	A home shall meet the food and nutritional needs of a resident in accordance with the recommended daily dietary allowances of the food and nutrition board of the national research council of the national academy of sciences, adjusted for age, gender, and activity, or other national authority acceptable to the department, except as ordered by a licensed health care professional.
ANALYSIS:	Review of documentation revealed that the food offered by the facility meets standards for Assisted Living Facilities and menus are reviewed and signed by a dietician. Therefore, there is not sufficient evidence to support a violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION(S):

The facility did not ensure the written admission contract was signed by Resident A.

INVESTIGATION:

The complainant alleged that Resident A was fully competent and capable of signing the admission contract with the facility, but it was instead signed by Relative A1.

On 08/1/2026, I received an email from the complainant. The email revealed the following statement made by Relative A1:

- "At the time of admission, the facility had me sign their admission agreement as the 'applicant' or 'legal representative.' The facility did this despite knowing I did not hold an active financial Power of Attorney (POA)."

On 08/10/2026, I reviewed Resident A's admission contract with the facility. Review revealed that it was electronically signed on 11/26/2025 by Relative A1.
On 08/10/2026, I reviewed Resident A's service plan signed on 11/26/2025 and progress notes between 11/10/2025 through 11/26/2025. Review revealed the following:

Service plan:

- "*Cognitive Needs/Details No significant cognitive decline; does not require assistance*"; "*Resident has no observable safety awareness deficits*"; "*MMSE* (Mini-Mental Status Examination) *29/30*"
- "*Communication Needs/Details*"; "*Independent, makes needs known*"
- There was no documented evidence for lack of ability to use her hands or fingers.

Progress notes:

- Note entered 11/10/2025 stated "*Pre-move-in… She is alert and oriented x4, able to communicate her needs.*"
- Note entered 11/25/2025 stated "*Resident moved in to apartment accompanied by daughter, spouse and sil… Plan of care reviewed with resident, spouse and daughter. Agree with level 3… Spouse leaving as assessment was completed and states to send service plan for signature through link*" [sic].

On 08/12/2026, I interviewed the Administrator by phone. The Administrator reported that Resident A was documented as being fully alert and capable of making her own decisions throughout her stay at the facility from November 2025 through June 2026. The Administrator reported that the facility had the power of attorney (POA) paperwork for Resident A. The Administrator reported that Relative A1 signed the admission contract and service plans. The Administrator reported that the facility did not have a written letter from Resident A authorizing Relative A1 to sign the admission contract, nor a physician order documenting that Resident A was incapable of making healthcare or financial decisions.

On 08/13/2026, I reviewed Resident A's POA paperwork supplied by Resident A to the facility. Review revealed that the document was titled "Durable Power of Attorney" and was signed by Resident A on 06/14/2004. The document stated that Relative A1 would be both healthcare and financial POA once in effect. On page 1., it stated the following:

- "*2. Effective Date This durable power of attorney shall become effective only in the event that I become incapacitated or disabled so that I am not able to manage my health care and financial affairs in which case it shall become effective as of the date of a written statement by two physicians*…"

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents. (3) At the time of an individual's admission, a home or the home's designee shall complete a written resident admission contract between the resident, the resident's authorized representative, or both, and the home.**
For Reference:	**R 325.1901 Definitions.** **(f) "Authorized representative" means that person or agency that has been granted written legal authority by a resident to act on behalf of the resident or is the legal guardian of a resident.**
ANALYSIS:	Although there is no evidence that Resident A disagreed with the admission contract terms or did not want Relative A1 to sign agreements for her, there is also no evidence that she was fully aware of the contract terms or requested Relative A1 to sign for her. There was only evidence to support that she was aware of and agreed to the service plan. Interview and review of Resident A's service plan and progress notes showed that she was alert and able to make decisions; had no physician order indicating she was incapable of making decisions to activate the POA; had no documented statement to allow Relative A1 to sign agreements on her behalf prior to activating the POA; did not have a noted deficit ability to sign; and did not sign the admission contract herself. Therefore, it cannot be determined that the facility completed a written admission contract with Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION(S):

The facility did not initiate a discharge for Resident A despite not having the resources to ensure her safety and health.

INVESTIGATION:
The complaint alleged that the facility did not initiate an emergency discharge for Resident A despite knowing they lacked the resources to ensure her health and safety.

During our phone interview, the Administrator reported that after Resident A went to the hospital on 05/25/2026, the facility expected Resident A would be coming back. The Administrator reported that Relative A1 sent him an email on 05/26/2026 to ask

if the facility would allow Resident A to have private caregivers to provide additional care when Resident A returned to the facility. The Administrator reported that he did not know that Resident A was not coming back until receiving another email from Relative A1 on 05/29/2026 that she would not be returning.

Review of the facility's progress notes for Resident A revealed the following:

- Note on 05/26/2026 stated "*HWD spoke with Case manager at hospital*. (Resident) *is now requiring daily wound care. CM will set up HHC* (Home Health Care) *willing to come daily*.
- Note on 06/02/2026 stated "*No longer lives here*"

Review of Resident A's admission contract revealed:

- On page 2., it stated "In the event the Resident requires transfer to a hospital or another level of care due to medical or behavioral reasons on a temporary basis, the Resident shall continue to pay the daily rate specified herein for room and board…"

On 08/13/2026, I reviewed the email that was sent to the Administrator from Relative A1 on 05/26/2026. Review revealed the following:

- "… *We are hoping to plan ahead for her return. If her medical team recommends it, we may like to temporarily hire one or two private caregivers… Could you let us know if* (the facility) *allows families to bring in supplemental, external care on a temporary basis*…"

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(10) A home shall not retain a resident who requires continuous nursing care services of any kind normally provided in a nursing home as specified in sections 21711(3) and 21715(2) of the act, MCL 333.21711 and 333.21715, unless the home meets the provisions of section 21325 of the act, MCL 333.21325, or the individual is enrolled in and receiving services from a licensed hospice program or a home health agency.

ANALYSIS:	Interview and documentation reveal that there is not enough evidence to determine whether the facility had information to know that they could not provide care according to Resident A's service plan dated 05/13/2026. The facility progress note dated 05/25/2026 revealed that there was an attempt to arrange an outside clinical resource capable of meeting Resident A's increased need for daily wound care. Review of the admission contract revealed that the facility identified that a resident could experience a medical event requiring temporary hospitalization or another level of care without that event automatically terminating the residency status. Therefore, there is not enough evidence to support a violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Tammie Daniels

08/21/2026

Tammie Daniels — Date
Licensing Staff

Approved By:

Andrea L. Moore

08/27/2026

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