GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 11, 2022

Shahid Imran
Hampton Manor of Clinton, LLC
7560 River Road
Flushing, MI 48038

RE: License #: AH500401685
Investigation #: 2022A0585031
Hampton Manor of Clinton

Dear Mr. Imran:

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 responsible party 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) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500401685
Investigation #:	2022A0585031
Complaint Receipt Date:	02/01/2022
Investigation Initiation Date:	02/03/2022
Report Due Date:	04/03/2022
Licensee Name:	Hampton Manor of Clinton, LLC
Licensee Address:	18401 15 Mile Road Clinton Township, MI 48038
Licensee Telephone #:	(734) 673-3130
Authorized Representative/Administrator:	Shahid Imran
Name of Facility:	Hampton Manor of Clinton
Facility Address:	18401 15 Mile Road Clinton Twp., MI 48433
Facility Telephone #:	(734) 673-3130
Original Issuance Date:	10/12/2021
License Status:	TEMPORARY
Effective Date:	10/12/2021
Expiration Date:	04/11/2022
Capacity:	101
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was physically injured by staff causing her arm to be ripped out of socket and shoulder displaced.	Yes
Resident A was given medication that did not belong to her.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/01/2022	Special Investigation Intake 2022A0585031
02/03/2022	Special Investigation Initiated - Telephone Called the complainant to discuss the allegations and for additional information.
02/03/2022	APS Referral Emailed the allegations to Adult Protective Services (APS)
02/04/2022	Inspection Completed On-site Completed with observation, interview and record review.
02/04/2022	Inspection Completed – BCAL Sub. Compliance
02/04/2022	Contact - Telephone call made Attempted contact with Detective Mangan. A message was left to return this call.
02/07/2022	Contact - Telephone call received Receive telephone call from detective Michael Chirco regarding the investigation.
02/07/2022	Contact - Telephone call made Attempted contact with witness. A message was left to return call.
03/11/2022	Exit Conference Conducted with authorized representative Imran Shahid.

ALLEGATION:

Resident A was physically injured by staff causing her arm to be ripped out of socket and shoulder displaced.

INVESTIGATION:

On 2/1/2022, the department received the allegations from a complainant via the BCHS Online Complaint website.

On 2/3/2022, a referral was made to Adult Protective Services (APS).

On 2/3/2022, I interviewed the complainant by telephone. The complainant stated that Resident A said that staff was rough with her. He stated that a staff (Employee B) saw another staff (Employee A) grab Resident A's arm and threw her on the toilet. She stated that the staff reported it to the facility. The complainant stated that Resident A moved to the facility on 1/12/2022 after a prior fall at home which resulted in a broken arm. He stated that after physical therapy she was healing great. After the incident with Employee A, she was admitted to the hospital. He explained that it was discovered at the hospital, that Employee A had pulled Resident A by her broken arm. He stated that it was reported to him by the surgeon at the hospital that Resident A's arm was ripped out of the socket and the shoulder was displaced. He stated that the surgeon suggested surgery, but they felt that she could not handle the surgery and they opt to have a rod to be placed in her arm instead. He stated that her surgery was scheduled on 2/2/2022.

On 2/4/2022, I completed an onsite at the facility. I interviewed marketing director Jennifer Candela. She stated that administrator/authorized representative Imran Shahid was not in the building, and she is the next in charge until business manager Nayab Virk comes in. Ms. Candela stated that a witness (Employee B) saw Employee A being aggressive toward Resident A.

On 2/4/2022, I interviewed Ms. Virk at the facility. She stated that she received a call from Employee B. She stated that Employee B told her that Employee A was being aggressive, and she didn't know who to talk to. She stated that they reported it to the police department.

An email from Employee B to Nayab Virk read:

"Around 10:00 p.m., [Employee A] asked me to assist with [Resident A]. We went into the room and Employee A pushed Resident A's wheelchair into the bathroom, put her walker in front of her and told her to get up and get to the toilet. The resident told her she couldn't get up on her own. Employee A said, yes you can, you did it

the day before. When she wouldn't get up, we tried getting her on the toilet ourselves but when we would try to stand her up, she would slide right back down. I then suggested that we change her in the bed instead, Employee A yelled, no she's going to get on the toilet, and she grabbed her under her arms and threw her on the toilet, then Resident A started screaming in pain. Employee A hurt her back from tossing Resident A on the toilet which only made Employee A angrier. She yelled at her to stand up so that I can pull this brief up and said, I'm not doing this with you tonight! But the resident couldn't stand so she Employee A) said, well stay there for the rest of the night and stormed off leaving me in there by myself. So I tried to get her off the toilet myself and when I didn't feel it was safe for me to keep trying, I asked her to come back and help me. Employee A came in the bathroom yelling and threatening to throw Resident A out on the street with all of her things telling her that her son would have to pick her up off the curb while pointing her finger in her face. Resident A started begging and crying. We then got her off the toilet and she had a bm (bowel movement) all up her back and on her nightgown. Employee A said she is keeping the gown on. I said no she's not and begin taking it off her. The resident had no clean pjs (pajamas) so Employee A went in the dirty clothes basket and pulled out a wet shirt. When I realized it was wet, I said we can't let her wear that. Employee A said yes, she can. But I took it off her anyway and got a clean shirt from the closet. Employee A left the room again telling the resident (A) that she was going to call her son and let him know how she was behaving. I didn't want Employee A to hurt Resident A anymore, so I stood in front of her and said put your arms around me as if you were giving me a hug. Then I picked her up and put her in bed. She thanked me and said that other one really put me through the ringer. Employee A then called the son when she gave Resident A the phone. Employee A was slurring her words and shaking because she was scared her son, so he asked Employee A to call EMS. When they got there, they couldn't find nothing wrong with her, but the son didn't know why he couldn't understand her. I said she don't have to go out, she is just dehydrated, let me give her some water. I gave her the water and she started talking just fine. The EMS worker laughed, the one guy said I can't believe this problem was solved with just a drink of water. They took my name down, then they left. I suggested that she write up an incident report, she said that she didn't feel like it. So I wrote a small note in the communication book stating that we needed to start pushing fluids every two hours because she was very dehydrated. Employee A went back into Resident A's room, so I went in behind her. She opened the fridge and took a tea out of the fridge and asked me, girl do you want something. I said no. Resident A said that her son had just stocked the fridge. Employee A said good, you owe me this drink for all you put me through tonight my back hurt."

On 2/7/2022, I interviewed detective Michael Chirco by telephone. He stated that he is the assigned detective. He stated that the facility filed the report on 1/20/2022. He stated that he also got a statement from a witness (Employee B). He stated that the investigation is still open at this time. Detective Chirco shared a copy of the witness statement written by Employee B.

The witness statement reviewed was consistent with email statement from Employee B.

On 2/9/2022, I interviewed Employee B. Employee B stated that she had never seen anything like that before and she felt that she had to protect Resident A. She stated that Employee A was very mean to Resident A and she didn't want her to hurt Resident A anymore. She stated that she did not know who to report to at first and reached out the next morning to management. Employee B statement was consistent to her witness statement and email.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**

ANALYSIS:	Resident A was assaulted verbally and physically by Employee A. Resident A's arm that was healing was reinjured by Employee A. Therefore, this claim was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was given medication that did not belong to her.

INVESTIGATION:

The complainant stated that Resident A told him that Employee A gave her Norco on the night of 1/17/22 that she wasn't prescribed for.

Ms. Virk stated that Employee A was under investigation for her counts being off. She stated that it was not determined what Employee A did with the pill.

Detective Chirco stated that when he counted the medication (Norco) there was one missing from the pack with no explanation. He stated that he could not determine whether one was given to Resident A or if the employee took it for personal use.

In review of the controlled substance, and disposition form, a Hydrocodone (Norco) was missing on 1/17. The last count was signed by Employee A on 1/17 to be 20 pills, and the next count was on 1/18 for 19 pills with no explanation. There was also a Lorazepam tablet missing from Resident C. The missing pills was from Resident B and not Resident A.

Resident B was prescribed Hydroco (Narco) tablet 10-325 mg ordered to take one tablet by mouth every six hours as needed for pain.

Resident C was prescribed Lorazepam tablet .5 mg, ordered to take one tablet by mouth twice a day as needed for anxiety.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.

ANALYSIS:	The complaint alleges that Resident A was given a Norco without a prescription. This claim could not be proven, however, pills were missing from the package with no explanation written on the log. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

During an onsite, I asked for an incident report of the alleged allegations. Ms. Virk stated that a report was not available. Ms. Virk stated that an incident report was not completed because they were still actively doing the investigation.

The missing pill was discovered on 1/18/2022 and a report was not completed.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. **The incident/accident report shall contain all of the following information:** **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**

ANALYSIS:	An incident on abuse and medication missing was not completed. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

There were two separate incidents that occurred at the facility. One incident involved Employee A being abusive to Resident A and the other incident involved a Norco not being recorded on the medication log as given making the count off. The facility did not report the incident to the department.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	The facility did not report incidents to the State department verbally or in writing.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Candela stated that there are 15 residents. She explained that two caregivers are supposed to be on each side of the facility. Ms. Candela stated that Employee A was training Employee B that night of the incident with Resident A. Ms. Candela stated that it was just Employee A and Employee B working that night.

Employee B stated that on 1/17/2022, it was just her and Employee A working that night. Employee B stated that was her first night working at the facility. She stated that she had did that kind of job before, but she didn't really know the residents that well. She stated that she worked one side of the facility and Employee A worked the other side of the facility.

A review of the staffing schedule showed that only Employee A and Employee B worked during that shift. Employee A was training Employee B.

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:	On 1/17/22 and 1/18/22, there was only one staff and one staff training working at night. The facility did not have adequate and sufficient staff on duty to care for the needs of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Virk stated that training was completed by the nurse who is no longer working at the facility.

In review of employees' files, there was no record of training completed and no one could tell me how the staff proved competency.

Employee B stated that she did not have any training before being put on the floor to work with the residents. She stated that she has worked as a caregiver at other facilities. She stated that they tried to get her to pass medication and she refused because she was not trained for it. She stated that she did not know any of the residents and their needs when she was put on the floor to work.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training pro- gram based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fi re prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**

ANALYSIS:	The facility was not able to show/verify claims of staff having training to adequate care for the needs of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite, facility was discovered to have a water leak in two unoccupied residents' rooms and in the hallway. There were vacuum sanctions throughout the rooms and the hallways.

Ms. Virk stated that the water leak just happened, and they did not know to send a report to the State department. Ms. Virk gave me copies of a work authorization from Midpoint Construction Company.

The work authorization form notes that work will be done for water damage, dated 2/2/2022. The form did not note the day that the work will be started.

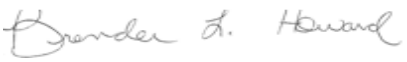
On 2/9/2022, I spoke with fire inspector Dan Dewatcher by telephone. He stated that the water leak was never reported to fire safety. He stated that it was reported to him by the Fire department.

APPLICABLE RULE	
R 325.1964	**Interiors.**
	(1) A building shall be of safe construction and shall be free from hazards to residents, personnel, and visitors.
ANALYSIS:	The facility had a water leak in the building. Although, it was isolated, it is still the responsibility of the facility to repair it in a timely manner and a report was not sent to the State department.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/11/2022, I conducted an exit conference with licensee authorized representative Imran Shahid by telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.



03/11/2022

Brender Howard Date
Licensing Staff

Approved By:

03/11/2022

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