GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 7, 2022

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

RE: License #: AH500401685
Investigation #: 2022A1027035
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by an authorized representative 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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500401685
Investigation #:	2022A1027035
Complaint Receipt Date:	02/11/2022
Investigation Initiation Date:	02/14/2022
Report Due Date:	04/13/2022
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 #:	(586) 649-3027
Original Issuance Date:	10/12/2021
License Status:	TEMPORARY
Effective Date:	10/12/2021
Expiration Date:	04/11/2022
Capacity:	101
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident's A, B, and C lacked care.	No
Residents lacked grooming.	No
Residents were not fed.	No
Resident D had falls. Resident E had falls in which her physician and family were not notified.	Yes
Resident E's toilet seat was broken.	No
Additional Findings	Yes

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

The complaint alleged the facility was short staffed which was investigated in Special Investigation Report (SIR) 2022A0585031.

III. METHODOLOGY

02/11/2022	Special Investigation Intake 2022A1027035
02/14/2022	Special Investigation Initiated - Letter Email sent to AR/Administrator Imran Shahid requesting a resident roster
02/16/2022	Contact - Document Received Email received from Mr. Shahid with the requested documentation
02/22/2022	Inspection Completed On-site
02/28/2022	Contact - Document Received Email received from Ms. Virk with documentation requested at on-site inspection
02/28/2022	Contact - Telephone call received

	Telephone interview conducted with adult protective services Christina Gregory
03/03/2022	Inspection Completed On-site
03/04/2022	Inspection Completed-BCAL Sub. Compliance
03/14/2022	Exit Conference Conducted with authorized representative Shahid Imran

ALLEGATION:

Resident's A, B, and C lacked care.

INVESTIGATION:

On 2/11/2022, the department received a complaint referred from Adult Protective Services (APS) which alleged Resident A and Resident B's feet were swollen and not cared for by facility staff. Resident C had swollen legs and were not cared for by staff.

On 2/22/2022, I conducted an on-site inspection at the facility. I interviewed business office manager Nayab Virk who stated residents are either evaluated by their own physician or the facility's physician. Ms. Virk stated the facility also has a visiting podiatrist in which residents can choose to receive his services. I interviewed Resident B who stated the podiatrist had visited her twice at the facility and the swelling in her feet had decreased. Resident B stated her feet did not need to be cared for by staff. I interviewed Resident C who stated she was evaluated by her primary care physician regularly and her last appointment was 2/14/2022. Resident C stated she received McLaren home care services. Resident C stated the swelling in her legs have decreased. Resident C stated there have been "hiccups" in her care, but staff have addressed all her concerns and are "very nice."

On 3/3/2022, I conducted an on-site inspection at the facility. I interviewed Resident A who stated she had "no complaints" regarding care at the facility and stated her legs are "always a little swollen."

I reviewed Resident A's service plan which read she ambulated and transferred independently while utilizing a walker. The plan read under medical conditions blood thinner, dementia, and pacemaker.

I reviewed Resident B's service which read she ambulated with a walker or wheelchair and required some hands-on assistance. The plan read under medical conditions hypertension.

I reviewed Resident C's service plan which read she ambulated with a walker independently and was left blank under medical conditions.

I reviewed Resident A, and B's physician orders which read their physicians ordered standard care orders and did not specify care for their feet. I reviewed Resident C's physician orders which read he reviewed and ordered her medications. Resident C's orders did not specify care for her legs.

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:	Staff and resident interviews along with review of facility documentation revealed Resident A, B and C received care consistent with their service plans. Review of physician orders did not reveal orders specifying care for resident's swollen feet or legs. Telephone interview with APS worker Christina Gregory revealed she had interviewed seven residents and did not identify lack of care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents lacked grooming.

INVESTIGATION:

On 2/11/2022, the department received a complaint referred from APS which alleged residents were not being properly groomed. The complaint read "residents fingernails are long and bleeding."

On 2/22/2022, I conducted an on-site inspection at the facility. I interviewed business office manager Nayab Virk who stated the facility maintains shower logs in which staff document a shower skin assessment for each resident. Ms. Virk stated the podiatrist manages resident's toenails and visits every two weeks, as well as needed. I interviewed Resident B who stated she received showers twice a week and her nails were "fine." I interviewed Resident C who stated she had a shower that morning and received a shower twice a week. Resident C stated she did not require her nails be maintained by staff. At the entrance, I observed a sign which read the

podiatrist would be visiting on 2/22/2022. I observed 15 residents who appeared groomed, dressed in clean clothing while they attended lunch.

On 3/3/2022, I conducted a second on-site inspection at the facility. I interviewed Resident C who stated she had “no complaints” and was receiving her showers. I observed Resident C’s nails which were not lengthy. I interviewed F who stated staff are “very good” and received her shower this morning as well as regularly as scheduled.

I reviewed the facility’s shower log. The shower log read “All residents are scheduled a shower twice weekly, days may be increased if resident/family requests.” The log read “fingernails/cleaning should be done on shower days and as needed. If toenails need to be trimmed, add resident to Dr. Maki’s Podiatry Binder.” The shower day skin assessment read staff were to mark on a figure where residents have bruising, rashes, wounds, visible wax in ears, and redness under breasts, abdominal folds, or peri area. Additionally, the assessment read staff were to document if they cut and cleaned fingernails, noted the condition of toenails, and shaved women and men’s facial hair.”

Resident A’s shower logs read she received showers on 1/14/2022, 1/15/2022, 1/21/2022, 1/27/2022, 1/29/2022, 2/2/2022, 2/16/2022, 2/18/2022, and 2/21/2022. Resident A’s shower logs read she refused showers on 1/19/2022 and 1/26/2022 (bed bath given).

Resident B’s shower logs read she received showers on 2/9/2022 and 2/12/2022. The shower logs read Resident B refused showers on 2/14/2022 and 2/16/2022.

Resident C’s shower logs read she received showers on 1/20/2022, 1/26/2022, 1/29/2022, 2/9/2022, 2/12/2022, and 2/16/2022. The shower logs read Resident C refused showers on 2/2/2022 and 2/14/2022.

Resident D’s shower logs red he received showers on 2/2/2022, 2/9/2022, 2/12/2022, 2/16/2022

Resident E’s shower logs read she received showers on 1/13/2022, 1/19/2022, 1/27/2022, 2/3/2022, 2/10/2022, 2/17/2022, 2/14/2022, and 2/21/2022. The shower logs read Resident E refused showers on 1/31/2022.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before

	meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Staff and resident interviews along with review of facility documentation revealed residents were offered showers at least weekly, thus this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents were not fed.

INVESTIGATION:

On 2/11/2022, the department received a complaint referred from APS which alleged residents were not being fed on a regular basis.

On 2/22/2022, I conducted an on-site inspection at the facility. I interviewed business office manager Nayab Virk who stated residents are served three meals a day. Ms. Virk provided the facility's Gordon food supply receipts of food purchased which read the facility had purchased food in the month of February. I interviewed Resident B who stated the facility offers three meals per day, but she only attends two meals. I interviewed Resident C who stated she received three meals a day and snacks. I observed lunch served which was meatloaf, mashed potatoes, green beans, and a roll with dessert. I observed a juice machine in which residents have access to use at each meal. I observed fresh fruit offered as snack in the dining area.

On 3/2/2022, I conducted an on-site inspection at the facility. I interviewed Resident A who stated she received three meals per day. I interviewed Resident D who stated the facility offered three meals, but he does not usually eat all three meals. I interviewed Resident F who stated, "meals are very good" and she received three meals a day. I interviewed kitchen Donna Jarrard who stated the facility offers three meals per day with the resident's choice of beverages, as well as alternative menu. Ms. Jarrard stated she offers snacks in the dining area, such fresh fruit and individually wrapped homemade muffins then also has peanut butter and jelly sandwiches available for staff to provide if needed.

I reviewed the menus from 1/16/2022 through 3/12/2022 which read meals were offered at breakfast, lunch, and dinner times, as well as an alternative menu.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.
ANALYSIS:	Staff and resident interviews along with review of facility documentation revealed it was reasonable to assume residents received three meals per day along with snacks and beverages.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident D had falls. Resident E had falls in which her physician and family were not notified.

INVESTIGATION:

On 2/11/2022, the department received a complaint referred from APS which alleged Resident D had a fall. The complaint read Resident E had a fall 1/31/2022 in which her physician nor family were notified.

On 2/22/22022, I conducted an on-site inspection at the facility. While on-site, business office manager Ms. Virk provided a “behavior form” and an incident report for Resident D, as well as a “behavior form” for Resident E. I attempted to interview Resident D and E, but both were not available for interview.

On 2/28/2022, I conducted a telephone interview with licensing staff Brender Howard who stated she had not received incident reports from the facility recently.

On 3/3/2022, I interviewed Resident D who stated he had a few falls at the facility because his right leg was weak and buckles. Resident D stated he “didn’t get hurt bad.” I attempted to interview Resident E but she was at the hair salon.

I reviewed the behavior forms and incident report provided by Ms. Virk at the time of inspection. Resident D’s incident report dated 2/17/2022 read “He notified Relinda he fell few days ago, if Relinda can clean up the wound and put bandaid. She cleaned up and put bandaid.” The report read corrective measures taken were Optimal home care. The report was left blank for notifying Resident D’s physician, authorized representative, and the department. Resident D’s “behavior form” read Resident D was on the floor and staff assisted him back to his chair. The form was signed by staff member “Denise” and dated 2/3/2022. The form was left blank in reporting the incident to Resident D’s authorized representative, did not have an

option for staff to mark notification of Resident D's physician, and there was not annotation of notification of either party. Resident E's "behavior form" dated 2/20/2022 read "Answered push button found resident on bathroom floor face down alert no visible injury resident states she is fine no pain to record." The report read Resident E's daughter was notified and did not want her to go the hospital, so the daughter stayed overnight to observe her. The report did not have an option for staff mark to notification of Resident E's physician and there was not annotation of notification.

I reviewed the facility's file which read there were two incident reports submitted to the department on 11/15/2021 and 11/17/2021.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(2) 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:	Review of documentation revealed facility staff did not always notify Resident D and E's physician or authorized representative when an incident/accident occurred, thus the facility was not incompliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident E's toilet seat was broken.

INVESTIGATION:

On 2/11/2022, the department received a complaint referred from APS which alleged Resident E had a broken toilet seat and fell on 1/31/2022.

On 2/22/2022, I conducted an on-site inspection at the facility. I interviewed administrator Nayab Virk who stated Resident E's toilet seat was fixed when staff were notified it was broken. I attempted to interview Resident E but she was sleeping. I observed Resident E's toilet seat which was secured to the toilet and not broken.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Staff interview and observations revealed Resident E's toilet seat was not broken and secured to the toilet. Based on this information, this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 2/22/2022, Ms. Virk stated Resident D had an admission assessment completed in which service plans were derived from but did not have a service plan.

I reviewed Resident D's "Resident Services – Level of Care Program Review" which read unknown staff member placed a check mark next to each score for functional areas and determined he required level two services. The assessment was left blank in the functional area of medication administration as well as communication with Resident D or his authorized representative.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(2) The admission policy shall specify all of the following: **(c) That the individual seeking admission and his or her authorized representative, if any, shall participate in the development of the individual's service plan.**
ANALYSIS:	Staff interview and review of facility documentation revealed the facility completed Resident D's assessment but lacked development of an individual service plan and participation from the Resident D and/or his authorized representative. Based on this information, the facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 2/22/2022, interview with Ms. Virk revealed the facility did not maintain a meal census.

APPLICABLE RULE	
R 325.1954	**Meal and food records.**
	The home shall maintain a record of the meal census, to include residents, personnel, and visitors, and a record of the kind and amount of food used for the preceding 3-month period.
ANALYSIS:	Staff interview revealed the facility did not maintain a meal census and thus were not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/14/2022, I shared the findings of this report with authorized representative Shahid Imran. Mr. Imran verbalized understanding of the findings.

IV. RECOMMENDATION

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

3/7/2022

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Jessica Rogers Date
Licensing Staff

Approved By:

03/09/2022

_____

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