GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 16, 2022

Shahid Imran
Hampton Manor of Bedford LLC
7560 River Rd
Flushing, MI 48433

RE: License #: AH580402179
Investigation #: 2022A0784047
Hampton Manor of Bedford

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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH580402179
Investigation #:	2022A0784047
Complaint Receipt Date:	04/20/2022
Investigation Initiation Date:	04/20/2022
Report Due Date:	06/19/2022
Licensee Name:	Hampton Manor of Bedford LLC
Licensee Address:	3099 W Sterns Rd Lambertville, MI 48182
Licensee Telephone #:	(989) 971-9610
Administrator:	Carol Cancio
Authorized Representative:	Shahid Imran
Name of Facility:	Hampton Manor of Bedford
Facility Address:	3099 W Sterns Rd Lambertville, MI 48182
Facility Telephone #:	(734) 807-5800
Original Issuance Date:	04/09/2021
License Status:	REGULAR
Effective Date:	10/09/2021
Expiration Date:	10/08/2022
Capacity:	114
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has an inadequate plan for her supervision	Yes
Additional Findings	No

III. METHODOLOGY

04/20/2022	Special Investigation Intake 2022A0784047
04/20/2022	APS Referral
04/20/2022	Special Investigation Initiated - Letter APS Referral
04/20/2022	Contact - Telephone call made Interview conducted with Complainant
04/26/2022	Inspection Completed On-site
04/27/2022	Contact - Telephone call made Interview with Complainant
04/28/2022	Contact - Document Sent Document request made via email
04/28/2022	Contact - Document Received Information received from facility nurse via email
06/16/2022	Exit Conference – Telephone Conducted with authorized representative Shahid Imran

ALLEGATION:

Resident A has an inadequate plan for her supervision

INVESTIGATION:

On 4/20/2022, the department received this online complaint. A referral was made to adult protective services (APS).

According to the complaint, on 4/15/2022, Resident A opened the fire extinguisher case and the fire extinguisher fell on her foot. On 4/16/2022, staff did not wake

Resident up in the morning for breakfast and did not ensure she was provided lunch. On 4/17/2022, staff was unable to locate Resident A. on 4/18/2022, Residents A walked into Resident C's room and was assaulted. Resident A sustained a cut on her forehead with blood running down her face. Resident B also entered Resident C's room with Resident A, at the same time, and was discovered laying on the floor with a swollen eye, cut on the back of her head and a bruise on her leg.

Review of the facility licensing file revealed a timely report was submitted which read consistently with the complaint regarding the incident involving Residents A, B and C.

On 4/20/2022, I interviewed Complainant by telephone. Complainant stated attempts have been made to communicate with administrative staff regarding the concerns noted in the complaint which have been unaddressed. Complainant stated her belief that staff are not able to provide adequate supervision for Resident A especially with the increase in residents overall in the past few weeks. Complainant stated the on 4/16/2022, she visited the facility at 3:15pm and Resident A has not eaten breakfast or lunch and was still in her pajamas. Complainant stated staff reported Resident A was offered breakfast and lunch but would not get out of bed and chose not to eat and chose not to get dressed. Complainant stated the memory care has several residents who wander and appear to not have adequate supervision making it more difficult for staff to keep track of residents.

On 4/26/2022, I conducted an onsite inspection at the facility. Resident A calmly eating breakfast in the dining area of the MC. Resident A appeared well groomed and comfortable. I observed multiple residents sitting in the living room area watching tv and a few residents working directly with staff at the facility.

On 4/26/2022, I Interviewed the facility nurse (FN) at the facility. FN stated the facility has had an increase in resident in the past few weeks, since prior to easter. FN stated the MC does have several residents who are prone to wandering. FN named Residents A, C, D, E, F, G and H as residents prone to wander. FN stated staff are instructed to use each resident's service plan to ensure they receive the supervision necessary for their supervision. FN stated Resident A tends to wander more frequently than other residents when she is up and out of her room. FN stated Resident A generally wanders more frequently in the evening time. FN stated Resident A does usually get up in the morning for breakfast, however sometimes she will receive her morning medications, go back to bed and not want to get up for breakfast and not want to change out of the clothes she sleeps in. FN stated the named wandering residents do not tend to do so through the night except for Resident A.

On 4/26/2022, I interviewed director of operations Jennifer Booth and resident care coordinator Heather Sadowski at the facility who provided statements consistent with those of FN.

I reviewed Resident A's service plan, provided by Ms. Booth. Under a section titled *PSYCHO/SOCIAL STATUS* the plan provided two pre-filled options with one open checked which read "Occasional verbal direction appropriate social and personal behavior". Under a section titled *ADDITIONAL INSTRUCTIONS*, the plan read "30 min visual checks". Review of the entire plan revealed no additional information regarding Resident A's described wandering or specific instructions on how to supervise and work with Resident A to mitigate her wandering and provide increased supervision.

I reviewed service plans for Residents C, D, E, F, G and H which read consistently with Resident A's service plan in that they did not provide information or instructions relative to the increased supervision they need, especially specific to wandering behaviors.

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.**
For Reference: R 325.1901	**Definitions**
	(22) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following: **(d) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.** **(e) Supporting a resident's personal and social skills.**
R 325.1922	**Admission and retention of residents**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
For Reference: R 325.1901	**Definitions**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible

	for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	According to the complaint, Resident A, as well as other residents in the MC, are not provided adequate supervision relative to their needs. Interviews with FN, the director of operations and the resident care director revealed staff are instructed to provide care for Residents based on their service plans. When interviewed FN indicated Residents A, C, D E, F, G and H as individuals who tend to wander. Review of service plans for Resident A, C, D, E, F, G and H revealed substantially inadequate information and instructions needed for their care and supervision, especially specific to these residents' propensity to wander. Based on the findings, the facility is not in compliance 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.

Aaron L Clum 6/10/2022

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Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 06/15/2022

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