GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 29, 2022

Shahid Imran
Hampton Manor of Dundee LLC
123 Waterstradt Commerce
Dundee, MI 48131

RE: License #: AL580396856
Investigation #: 2023A0116007
Hampton Manor of Dundee 1

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL580396856
Investigation #:	2023A0116007
Complaint Receipt Date:	11/10/2022
Investigation Initiation Date:	11/10/2022
Report Due Date:	01/09/2023
Licensee Name:	Hampton Manor of Dundee LLC
Licensee Address:	123 Waterstradt Commerce Dundee, MI 48131
Licensee Telephone #:	(734) 673-3130
Administrator:	Shahid Imran
Licensee Designee:	Shahid Imran
Name of Facility:	Hampton Manor of Dundee 1
Facility Address:	123 Waterstradt Commerce Dundee, MI 48131
Facility Telephone #:	(734) 826-9191
Original Issuance Date:	07/21/2020
License Status:	REGULAR
Effective Date:	01/21/2021
Expiration Date:	01/20/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 11/08/22, staff, Ann Cousino gave Resident A Resident B's 100mg Lyrica at 8:00 a.m. and 2:00 p.m. instead of her 300mg Gabapentin.	Yes

III. METHODOLOGY

11/10/2022	Special Investigation Intake 2023A0116007
11/10/2022	Special Investigation Initiated - Telephone Interviewed Jennifer Gibson, Resident Care Coordinator.
11/10/2022	Contact - Telephone call received Interviewed Marianna Taormina, Wellness Director, and facility nurse.
11/10/2022	Inspection Completed-BCAL Sub. Compliance No onsite required. Approved by Area Manager.
11/21/2022	Exit Conference With licensee designee, Shahid Imran.

ALLEGATION:

On 11/08/22, staff, Ann Cousino gave Resident A Resident B's 100mg Lyrica at 8:00 a.m. and 2:00 p.m. instead of her 300mg Gabapentin.

INVESTIGATION:

On 11/10/22, I interviewed Resident Care Coordinator, Jennifer Gibson, and she reported that during the 7:00 p.m. shift change it was discovered that staff, Ann Cousino, had administered Resident B's 100mg Lyrica to Resident A at 8:00 a.m. and 2:00 p.m. on 11/08/22. Ms. Gibson reported that Resident A was supposed to have received her 300mg Gabapentin which is to be given three times per day. Ms. Gibson reported that Resident A's primary care physician and her family was contacted and notified of what had occurred. Ms. Gibson reported that it is evident that Ms. Cousino did not follow their internal policy when it comes to medication administration, nor did she review the medication label to match it with the electronic medication administration record (E-MAR). Ms. Gibson reported that Resident A was fine and suffered no ill effects from the medication error. Ms. Gibson added at the

recommendation of Resident A's physician her evening dose of Gabapentin was held until the following day.

On 11/10/22, I received a call from Marianna Taormina, Wellness Director. Ms. Taormina confirmed the information previously provided to me by Ms. Gibson. Ms. Taormina added that while conducting the internal investigation as to how this error could have occurred, she discovered that Ms. Cousino failed to scan the barcode on the bubble pack, which is a required step in their electronic medication procedures. Ms. Taormina reported that had Ms. Cousino scanned the barcode the computer would have alerted her that this was the wrong medication for this resident. Further, had she followed the five rights of medication and reviewed the medication label and electronic medication administration Record (E-MAR) she would have known that she was administering Resident A her husband's medication instead of her own. Ms. Taormina reported that all staff are trained on the five rights of medication and on all the steps they are required to follow with their internal electronic medication program. Ms. Taormina reported that she was surprised that Ms. Cousino had the medication error as she is a Licensed Practical Nurse (LPN) practicing as a medication tech.

Ms. Taormina reported that she had a plan in place to remove Ms. Cousino from the medication cart, provide extensive medication re-training, and discipline her for the incident. Ms. Taormina reported that this morning (11/10/22), Ms. Cousino called and terminated her employment.

On 11/21/22, I conducted the exit conference with licensee designee, Shahid Imran, and informed him of the findings of the investigation. Mr. Imran reported an understanding of the rule violation. Mr. Imran inquired if there was some way that other facilities could be notified so that Ms. Cousino would not be able to go to another facility and do the same thing, especially because she quit prior to being retained on proper medication procedures. I informed Mr. Imran that no such system existed.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on the findings of the investigation, which included interviews of Ms. Gibson and Ms. Taormina, I am able to corroborate the allegations. Ms. Gibson and Ms. Taormina both reported that Ms. Cousino did not follow the proper medication procedures when administering Resident A's medication, resulting in her receiving Resident B's medication at 8:00 a.m. and 2:00 p.m. on 11/08/22. Ms. Taormina reported that Ms. Cousino did not follow their internal process that is in place to prevent medication errors, nor did she follow all of the five rights of medication or review the medication label as required by these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

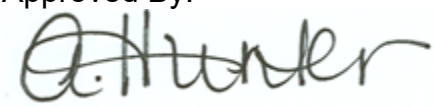
IV. RECOMMENDATION

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

11/28/22

Pandrea Robinson — Date
Licensing Consultant

Approved By:



11/29/22

Ardra Hunter — Date
Area Manager