GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 11, 2023

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

RE: License #: AH500401685
Investigation #: 2023A1027048
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 authorized representative 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) 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) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500401685
Investigation #:	2023A1027048
Complaint Receipt Date:	03/03/2023
Investigation Initiation Date:	03/03/2023
Report Due Date:	05/02/2023
Licensee Name:	Hampton Manor of Clinton, LLC
Licensee Address:	18401 15 Mile Road Clinton Township, MI 48038
Licensee Telephone #:	(734) 673-3130
Administrator/ Authorized Representative:	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:	REGULAR
Effective Date:	04/12/2022
Expiration Date:	04/11/2023
Capacity:	101
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A lacked administration of medications. Residents lacked supervision.	Yes
Additional Findings	No

III. METHODOLOGY

03/03/2023	Special Investigation Intake 2023A1027048
03/03/2023	Special Investigation Initiated - Letter Email sent to Mr. Imran and Ms. Virk requesting documentation pertaining to Resident A
03/13/2023	Contact - Document Received Email received from Ms. Virk with requested documentation
04/07/2023	Contact - Document Sent Email sent to Ms. Virk requesting additional documentation
04/11/2023	Contact - Telephone call made Telephone call made to Ms. Virk to confirm receipt of email with requested documentation. Ms. Virk stated she would provide the requested documentation today or tomorrow.
04/13/2023	Contact - Document Sent Email sent to Ms. Virk inquiring about requested documentation
04/13/2023	Contact – Document Received Email received from Ms. Virk with requested information/documentation
04/14/2023	Inspection Completed -BCAL Sub. Compliance
04/27/2023	Exit Conference Conducted with authorized representative Mr. Imran by telephone

ALLEGATION:

Resident A lacked administration of medications. Residents lacked supervision.

INVESTIGATION:

On 3/3/2023, the Department received a complaint which read Resident A did not receive his medications as prescribed leading to his death. The complaint read Resident A admitted to the facility on 10/3/2022 in which the facility informed his family that they would have his medications on 10/4/2022. The complaint read the rehabilitation facility sent Resident A with one day of medications which were provided to the facility, except Latanoprost. The complaint read Pioneer Pharmacy Services, LLC invoice showed that Latanoprost was not sent at all and Xarelto was sent 10/4/2022. The complaint read Resident A did not receive his prescribed Xarelto until 10/14/2022. The complaint read Resident A's family was not notified that the facility had not received all his medications. The complaint read on 10/14/2022 Resident A passed away from heart failure, atrial fibrillation and sick sinus syndrome as listed on the death certificate. Additionally, the complaint read the complainant witnessed other residents lacked supervision while at the facility. The complaint read on 10/9/2022 the complainant witnessed one resident sleeping and another resident pulled the sleeping resident out of the chair. The complaint read the complainant asked the resident to stop pulling on the other resident in which an employee stopped the altercation, however the employee had been in another resident's room.

I reviewed Resident A's face sheet which read consistent with the complaint.

I reviewed Resident A's service plan updated on 10/12/2022 which read in part the medication technician was responsible for medication administration. The plan read in part Resident A required some hands-on assistance and moderate assistance daily with activities of daily living.

I reviewed the facility's admission contract which read in part:

> "*Daily Living means activities associated with eating, toileting, bathing, grooming, dressing, transferring, mobility, and medication management.*"

I reviewed Resident A's physician orders dated 10/3/2022 which the following medications were prescribed: Alphagan, Atorvastatin, Donepezil, Ferosul, Glimepiride, Latanoprost, Memantine, Metformin, Metoprolol, Quetiapine, and Xarelto. The orders read the following as needed medications were prescribed: Acetaminophen, Anti-diarrheal, Docusate, Mucinex, Mylanta, Nitroglycerin, SM Tussin.

I reviewed Resident A's October 2022 medication administration records (MARs). The MARs read on the following dates one or more doses of his medications were left blank: 10/8/2022 and 10/12/2022. The MARs read Xarelto, take one tablet by mouth daily and the original order date was 10/3/2022. For Xarelto, the MAR read staff documented the medication as not given from 10/5/2022 through 10/10/2022, 10/13/2022 and 10/14/2022 for the following reasons "medication unavailable from pharmacy" or "out of facility." For Xarelto, the MAR read staffed initialed the medication as administered on 10/11/2022 and was left blank on 10/12/2022. The MAR read Latanoprost solution 0.005%, instill one drop in both eyes daily and the original order date was 10/4/2022. The MAR read staff initialed the Latanoprost as administered on 10/5/2022 through 10/7/2022 and 10/11/2022. For Latanoprost, the MAR read staff documented from 10/8/2022 through 10/10/2022 and on 10/13/2022 the medication was not administered for the following reason "out of facility."

I reviewed the Pioneer Pharmacy Services, LLC invoice dated 10/31/2022 in which read consistent with the complaint. The invoice read medications were dated as follows:

10/3/2022: Alphagan, Atorvastatin, Ferosul, Glimepiride, Memantine, Metformin, Metoprolol, Quetiapine
10/4/2022: Nitroglycerin
10/6/2022: Atorvastatin, Ferosul, Glimepiride, Memantine, Metformin, Metoprolol, Quetiapine
10/11/1022: Donepezil
10/14/2022: Xarelto

I reviewed Resident A's death certificate dated 10/14/2022 which read consistent with complaint. The death certificate read the manner of death was natural.

Email correspondence with Employee #1 on 4/13/2023 read there were eight residents in the memory care unit in the first two weeks of October 2022. I reviewed the facility's staff schedule dated 10/2/2022 through 10/15/2022 which read in part there were one or two staff who worked in the memory care unit for each shift, then one or two staff who worked in the assisted living unit.

I reviewed the facility's memory care program statement which read in part:

"The independent area of Hampton Manor Memory Care offers residents diagnosed with dementia and Alzheimer's or with cognitive impairment and memory issues, a safe homelike setting with specialized care. Our residents have experienced many changes and our mission is to provide a positive emotional, intellectual, physical, and social environment. Features of Hampton Manor Memory Care include a comfortable large common area, secure with enclosed courtyard, full assistance 24 hours a day, housekeeping services, individual and group activities, three meals a day, laundry."

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: 325.1901	**Definitions.** **Rule 1. As used in these rules:**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.

For Reference: 325.1932(2)	**Resident's medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Review of Resident A's records revealed he resided in the memory care unit in which he required staff assistance with activities of daily living, as well as medication administration. Review of the facility's October 2022 staffing schedule revealed it read consistent with the facility's program statement in which there was insufficient evidence to support residents lacked supervision. Review of Resident A's physician orders revealed his medications were prescribed on 10/3/2022. Review of Resident A's pharmacy invoice revealed medications Nitroglycerin, Donepezil, and Xarelto were sent to the facility after 10/3/2022 and Latanoprost was not delivered as ordered. Review of Resident A's MARs revealed staff initialed medications as administered in which read inconsistent with the pharmacy invoice. For example, medications Latanoprost and Xarelto were documented as administered on some dates in which the pharmacy invoice read, they had not been delivered. Review of the MARs revealed inconsistent documentation in reasons for not administering medications. For example, the MAR read staff documented the reason for not administering Xarelto as "out of facility" which would imply the resident was out of the facility for that medication administration however records revealed he had not left the facility. Additionally, the MARs read some medication doses were left blank in which it could not be determined if Resident A's medications were administered or not. The facility lacked an organized program to ensure Resident A's medications were ordered, delivered, and administered as prescribed by his licensed health care professional. Based on this information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

04/14/2023

Jessica Rogers Date
Licensing Staff

Approved By:

04/26/2023

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