GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 11, 2023

Shahid Imran
Hampton Manor of Adrian, LLC
7560 River Road
Flushing, MI 48433

RE: License #: AH460406857
Investigation #: 2023A1027097
Hampton Manor of Madison

Dear Licensee:

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 877-458-2757.

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 #:	AH460406857
Investigation #:	2023A1027097
Complaint Receipt Date:	09/28/2023
Investigation Initiation Date:	09/29/2023
Report Due Date:	11/27/2023
Licensee Name:	Hampton Manor of Adrian, LLC
Licensee Address:	7560 River Road Flushing, MI 48433
Licensee Telephone #:	(734) 673-3130
Authorized Representative/ Administrator:	Shahid Imran
Name of Facility:	Hampton Manor of Madison
Facility Address:	1491 E. US-223 Adrian, MI 49221
Facility Telephone #:	(517) 759-7799
Original Issuance Date:	12/10/2021
License Status:	REGULAR
Effective Date:	06/10/2023
Expiration Date:	06/09/2024
Capacity:	120
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's visitors were restricted from visiting and taking her out of the home. Resident A had bruises.	No
Additional Findings	Yes

III. METHODOLOGY

09/28/2023	Special Investigation Intake 2023A1027097
09/29/2023	APS referral The allegations were referred to APS by email.
09/29/2023	Special Investigation Initiated - Telephone Voicemail left with the complainant.
09/29/2023	Contact - Telephone call received. Telephone call conducted with complainant.
10/11/2023	Inspection Completed On-site
10/27/2023	Inspection Completed-BCAL Sub. Compliance
12/11/2023	Exit Conference Conducted with Shahid Imran by email

ALLEGATION:

Resident A's visitors were restricted from visiting and taking her out of the home. Resident A had bruises.

INVESTIGATION:

On 9/28/2023, the Department received allegations through the online complaint system which read Resident A's family was denied visitation initially; however, now the facility allowed family members to visit but would not allow Resident A to leave the facility with them. The allegations read Resident A had "bumps/bruises" and there was concern about her care.

On 9/29/2023, this licensing staff referred the allegations to Adult Protective Services (APS).

On 9/29/2023, I conducted a telephone interview with the complainant. The complainant stated Resident A resided in the memory care unit at the facility. The complainant stated family was not permitted to visit Resident A for the first few weeks after she moved into to the facility to allow her to become acclimated.

The complainant stated he received approval from Resident A's DPOA to take her out to a wedding; however, on 9/15/2023, he received a letter stating it was not in Resident A's best interest to take her out of the facility. The complainant stated the letter was signed by Resident A's nurse practitioner, Employee #1 and her DPOA.

On 10/11/2023, I conducted an on-site inspection at the facility. I interviewed Employees #1 who stated Resident A resided in memory care and had history of behaviors. Employee #1 stated Resident A received treatment at an outpatient mental health prior but was doing well now. Employee #1 stated Resident A had visitors including but not limited to her DPOA, sister, grandson, and friend. Employee #1 stated Resident A received visits from family members in which they discussed her finances which would upset her, so in those circumstances, the visitors were asked not to discuss those topics for her well-being. Employee #1 stated Resident A's nurse practitioner and DPOA discussed her leaving the facility for a family wedding in which they felt she could become more confused or have behaviors. Employee #1 stated the nurse practitioner wrote a letter advising that it was not in Resident A's best interest to the leave the facility.

While on-site, I interviewed Employee #2 whose statements were consistent with Employee #1. Employee #2 stated since Resident A's mental health treatment, her behaviors have been well managed with redirection and medications. Employee #2 stated the staff had not reported bruising observed on Resident A.

While on-site, I observed Resident A smiling and playing Bingo with other residents. I observed Resident A's face, neck, hands, lower arms, and lower legs lacked bruising.

While on-site, I interviewed Resident A's DPOA who stated there were not two physician statements enacting her Durable Power of Attorney. Resident A's DPOA stated the facility provided good care and had not observed bruises on her.

I reviewed Resident A's admission contract dated 11/2/2022 signed by her DPOA.

I reviewed Resident A's Durable Power of Attorney for Health Care document was signed by Resident A and dated 9/2/2020, and read consistent with her medical records.

I reviewed Resident A's face sheet which read she moved into the facility on 11/2/2022. The face sheet read Resident A's DPOA was her first emergency contact

and responsible party. The face sheet read Resident A's second emergency contact was her sister.

I reviewed Resident A's service plan updated on 4/27/2023 which read in part she had dementia, had occasional social and personal behaviors, and was easily re-directed. The plan read in part Resident A was independent with ambulation, transferring and toileting. The plan read in part Resident A required some hands-on assistance for her personal hygiene and bathing, as well as verbal prompting to change her clothes daily.

I reviewed a letter dated 9/15/2023 written by Resident A's nurse practitioner which read in part it would be more harm than benefit for Resident A to attend a family wedding, instead he recommended to host a small reception in the facility's café. The letter read the facility would provide cake to celebrate.

I reviewed a ProMedica hospital emergency room record dated 4/1/2023 which read consistent with Employees #1 and #2 interviews. The record read in part she was there for a mental health evaluation due to aggressive behavior.

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.**

ANALYSIS:	Interview with the complainant and staff attestations revealed Resident A's family was permitted to visit; however, Resident A could not leave the facility for a wedding. Review of the letter written by the licensed healthcare professional revealed he felt it was not in Resident A's best interest to leave the facility and offered another opportunity to celebrate. Observations and staff attestations revealed Resident A lacked bruising. The facility had a licensed healthcare professional's order to restrict her leaving the facility and there was lack of evidence Resident A had bruising, therefore this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Interview with Employee #1 and Resident A's DPOA revealed there was not a written statement from two physicians deeming Resident A incapable of making medical decisions.

Review of Resident A's admission contract dated 11/2/2022 revealed it was signed and dated by Resident A's DPOA on 11/1/2022.

Review of Resident A's Durable Power of Attorney for Health Care document dated 9/2/2020 read in part:

> "*My attending physician and one other physician of licensed psychologist, after examining me, shall determine whether I am able to participate in medical treatment decisions. Any determination that I am unable to do so must be in writing, made part of my medical record, and reviewed at least annually.*"
>
> Additionally, under the Witness Statement of the document, it was signed and dated 9/2/2020 by two witnesses, including Resident A's appointed agent, which read in part:
>
> "*I am not the person appointed as Agent or Patient Advocate by this document, nor am I the Patient's physician, an employee of the Patient's life or health*

insurance provider, or an employee of the health care facility or home for the aged where the Patient resides."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(1) A home shall have a written resident admission contract, program statement, admission and discharge policy and a resident's service plan for each resident.
ANALYSIS:	Review of Resident A's Durable Power of Attorney for Health Care documents revealed her appointed agented signed as a witness. Review of Resident A's medical records revealed it lacked two physician statements deeming her unable to participate in medical decisions. Thus, Resident A's Durable Power of Attorney paperwork was not completed correctly nor activated. Review of Resident A's admission contact revealed it was signed by Resident A's DPOA. Therefore, Resident A's admission contract was not valid as it was not appropriately signed nor were her Durable Power of Attorney for Health Care documents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/27/2023

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Jessica Rogers Date
Licensing Staff

Approved By:

12/11/2023

_____

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