GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 21, 2023

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

RE: License #: AH580402179
Investigation #: 2024A1027007
Hampton Manor of Bedford

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, 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 #:	AH580402179
Investigation #:	2024A1027007
Complaint Receipt Date:	10/30/2023
Investigation Initiation Date:	10/31/2023
Report Due Date:	12/29/2023
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:	10/09/2023
Expiration Date:	10/08/2024
Capacity:	114
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A lacked protection.	Yes
Additional Findings	No

III. METHODOLOGY

10/30/2023	Special Investigation Intake 2024A1027007
10/31/2023	Special Investigation Initiated - Letter Referral to APS by email
10/31/2023	APS Referral by email
10/31/2023	Contact - Document Received Email received with requested documentation
11/13/2023	Contact - Document Received Email received with APS disposition letter. APS did not open the allegations for investigation.
11/27/2023	Inspection Completed-BCAL Sub. Compliance
12/21/2023	Exit Conference Conducted by email with Shahid Imran and Carol Cancio

ALLEGATION:

Resident A lacked protection.

INVESTIGATION:

On 10/30/2023, the Department received a complaint which alleged on 9/19/2023, Resident A was observed on the floor next to her bed, went to the emergency room and was admitted; however, it was uncertain if she was admitted from the fall or COVID.

Additionally, the complaint alleged on 10/12/2023, Resident A spilled tea on her lap in which facility staff did not express concern regarding an injury. The complaint

alleged Resident A had burns, and some 3rd degree burns, on both thighs, arm, and genitals in which she was admitted to the St. Vincent's hospital for ten days.

On 10/31/2023, the Department referred the allegations to Adult Protective Services (APS).

On 11/13/2023, the Department received a letter from APS which read in part the allegations were not opened for investigation.

I reviewed Resident A's face sheet which read in part she moved into the facility on 12/12/2022 and discharged on 10/31/2023. The face sheet read in part Relative A1 was her durable power of attorney and first emergency contact.

I reviewed Resident A's service plan dated 12/22/2022 which read in part Resident A required reminders of mealtimes and staff assistance to escort her to and from meals. The plan read in part Resident A required staff assistance with personal hygiene, dressing, bathing, and transferring. The plan read in part Resident A utilized a wheelchair for mobility and had difficulty pushing her own wheelchair. The plan read in part Resident A required a lid when drinking hot tea or coffee. The plan read in part Resident A's family provided a body pillow for extra safety from rolling out of bed.

I reviewed Resident A's incident reports as well as Employee #1's review of the incident reports titled "*Reviewing of Occurrence Reports and Behavior Logs*."

Report dated 9/15/2023 read in part Resident A was drinking hot tea in the dining room and spilled it on her left leg. The report read there were no signs of redness or burn. The report read Resident A's physician and Relative A1 were notified on 9/15/2023.

Employee #1's review of the report read Resident A was to have lids on her drinks.

Reported dated 9/19/2023 read in part caregivers conducted room checks and observed Resident A on the floor. The report read in part Resident A sustained a bruise on the bottom of her chin. The report read in part Resident A denied pain and staff offered Tylenol in which she declined. The report read Resident A's physician and Relative A1 were notified on 9/19/2023.

Employee #1's review of the report read staff were verbally educated to place a long pillow under the bed sheet, not on top, per Resident A's family.

Report dated 9/20/2023 read in part Resident A tested positive for COVID-19. The report read in part Resident A had a fever, was not eating or drinking nor able to take her medications. The report read in part Resident A was lethargic

and unable to answer questions. The report read Resident A's physician and Relative A1 were notified on 9/20/2023.

Employee #1's review of the report read the facility would follow discharge instructions from the emergency room.

Report dated 10/12/2023 at 8:19 AM read in part Resident A spilled hot tea on herself in the dining room in which redness was observed on her right forearm, right thigh, and pelvic area on the thigh. The report read Resident A's physician and Relative A1 were notified on 10/12/2023.

Employee #1's review of the report read an "*employee corrective*" was provided for not putting a lid on her drink.

Report dated 10/12/2023 at 10:00 PM read in part it was observed Resident A's burns were swelling and blistering. The report read in part Resident A was sent to the hospital to be evaluated. The report read Resident A's physician and Relative A1 were notified on 10/12/2023.

Employee #1's review of the report read to follow discharge instructions from the emergency room.

Report dated 10/13/2023 at 2:15 PM read in part Resident A's blisters from her burns were getting worse. The report read there were yellow serious fluid filled blisters on her abdomen, legs, and right arm. The report read in part Resident A's physician requested for her to be sent to St. Vincent's burn unit for treatment. The report read Resident A's physician informed Relative A1.

Employee #1's review of the report read to follow discharge instructions from the hospital and update her service plan accordingly.

I reviewed Resident A's progress notes.

Note dated 9/19/2023 and written by third shift staff read "*Reported by 2nd shift med tech of [Resident A] not feeling well and her symptoms and about her fall. Previously I learned another caregive (sp) tested positive for COVID. Tested [Resident A] @10:40 tested positive for COVID*."

Note dated 10/12/2023 and written by third shift staff read "*Resident was sent out to St. Anne's to have her evaluated for better treatment. She returned @ 2:30 AM*."

Note dated 10/25/2023 and written by first shift staff read "*Family here to move some of her stuff out*."

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.
For Reference: **R 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.
ANALYSIS:	Resident A's service plan was updated to reflect she required a lid on hot liquids and a long body pillow under her bed sheet at night as interventions for her protection and safety. Review of incident reports revealed staff did not always follow Resident A's service plan, therefore, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Jessica Rogers 11/27/2023

Jessica Rogers Date
Licensing Staff

Approved By:

12/19/2023

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