GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 3, 2024

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

RE: License #: AH460406857
Investigation #: 2024A1027016
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 #:	2024A1027016
Complaint Receipt Date:	11/17/2023
Investigation Initiation Date:	11/20/2023
Report Due Date:	01/16/2024
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's medication orders were not implemented. Resident A's personal belongings were stolen.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/17/2023	Special Investigation Intake 2024A1027016
11/20/2023	Special Investigation Initiated - Letter Email sent to Reggie Parish and Shahid Imran requesting documentation for Resident A
11/20/2023	Contact - Document Received Email received with requested documentation
11/20/2023	Contact - Telephone call received Telephone interview conducted with Reggie Parish and Employee #1
11/22/2023	Contact - Document Received Additional and similar allegations received
11/22/2023	Contact - Document Sent Email sent to the complainant informing her the complaint submitted was opened for investigation
12/07/2023	Inspection Completed-BCAL Sub. Compliance
12/26/2023	Contact – Telephone Call Received Telephone interview conducted with Employee #1
12/28/2023	Contact – Telephone Call Made Telephone interview conducted with Employee #2
01/03/2024	Exit Conference Conducted by email with Shahid Imran

ALLEGATION:

Resident A's medication orders were not implemented. Resident A's personal belongings were stolen.

INVESTIGATION:

On 11/17/2023, the Department received a complaint which read Resident A was sent to the hospital on 11/7/23 for a low blood sugar of 28 because her hospital medication discharge orders from the previous week were not followed. The complaint read the emergency room staff stated Resident A was receiving the wrong dose of insulin.

The complaint read Resident A was sent to the emergency room with a low blood sugar in the 30s the previous week. The complaint read during that previous hospitalization Resident A's medications were changed which included discontinuing her Glucophage, reducing the Humalog sliding scale dose by half, and antibiotics were ordered for a urinary tract infection. The complaint alleged the medication changes were not continued or followed which caused undue distress, as well as harm and negligence to Resident A. The complaint read Resident A was receiving hospice services from Careline Hospice.

Additionally, the complaint alleged there was a police investigation for an employee at Hampton Manor for identity theft, forgery, and fraud for stealing a checkbook from Resident A, as well as her iPad was missing.

On 11/20/2023, I conducted a telephone interview with Employees #1 and #2. Employee #2 stated Resident A was transferred to the hospital on 10/29/2023 in which her medications were changed at the hospital but not by her primary care provider. Employee #2 stated she faxed the orders to Resident A's primary care provider's office even though the office received the orders electronically as well. Employee #2 stated Resident A was hospitalized again on 11/7/2023. Employee #2 stated Resident A's primary care provider visited her at the facility on 11/8/2023 and implemented the hospital's discharge orders.

On 11/22/2023, similar allegations were received from the complainant. The complaint read the initial hospital discharge orders were provided to the facility and staff were verbally informed of the medication order changes as well. The complaint alleged Resident A's family spoke with the wellness director in which the initial hospital discharge paperwork was not followed and resulted in an unnecessary hospitalization.

On 11/30/2023, I received email correspondence from the complainant which read in part Resident A was moved to another facility because her family no longer felt she was safe.

I reviewed Resident A's face sheet which read in part she admitted to the facility on 5/2/2022. The face sheet read in part Careline Hospice was Resident A's primary care provider. The face sheet read in part Relative A1 was her first emergency contact and power of attorney for healthcare.

I reviewed Resident A's admission contract dated 5/2/2022 and signed by Resident A. The contract read in part Resident A admitted to assisted living. The contract read in part:

> "*The Company makes no representations or guarantees that the Company is secure from theft or any other criminal act perpetrated by any other Resident or person; therefore, the Company recommends that valuables, including but not limited to, jewelry and large amounts of money, not be brought into the Facility. If the Resident chooses to bring in such valuables or large amounts of money, the Resident is doing so at their own risk and the Company will not be responsible for any theft or loss of these items.*
>
> *The Resident understand and agrees to assume the risks inherent in this Contract and further agrees to indemnify, defend and hold harmless the Company, and its officers, employees or agents from and against any damage (personal property or possessions), caused by the acts of the Resident, Resident's invitees or Guests or outside third party individuals or entities providing services to the Resident even if such outside third party individuals were referred to Resident by the Company. The Company's only liability for injury to the Resident's invitees or Guests shall be based only on a showing of Company's gross negligence and/or the failure to comply with a duty imposed by law. In no event shall the Company be liable for any damage to, loss of, lost, misplacement of, destroyed or theft of Resident's personal possessions and/or property for any reason (e.g. By way of example, but not limitation, Resident accidentally leaves a hearing aid in their pants pocket which subsequently gets washed by the Company and is damaged or destroyed). The Company reserves the right to recover from the Resident any loss incurred by fire, vandalism or any other acts caused by the Resident or Resident's invitees or Guests. The Company may assign such right to its insurance carrier."*

I reviewed Resident A's service plan updated on 3/16/2023 which read in part she resided in the memory care unit and her medications were administered by a medication technician. The plan read in part she had medical conditions of dementia and diabetes.

I reviewed Resident A's October 2023 medication administration record (MAR) which read in part:

> Humalog, inject subcutaneously before meals and at bedtime meals and at bedtime per sliding scale: 200-250=0 units, 251-300=8 units, 301-350=12 units, 351 and above give 20 units and do have to call the medical doctor.

The MAR read in part staff initialed Resident A's Humalog as administered consistent with the order except on 10/10/2023 at 11:30 AM in which was left blank.

Additionally, the MAR read in part Resident A's Levothyroxine was left blank on 10/5/2023 and 10/14/2023.

I reviewed Resident A's November 2023 MAR which read in part:

The current Humalog medication order was stopped on 11/8/2023 at 4:00 PM and the new Humalog order read Humalog, inject subcutaneously before meals and at bedtime meals and at bedtime per sliding scale: 0-150= no insulin, 151-200=2 units, 201-250=4 units, 251-300=6 units, greater than 301= 8 units.

The MAR read in part staff initialed Resident A's Humalog as administered consistent with the order.

The MAR read in part Metformin was stopped on 11/8/2023.

Additionally, the MAR read in part Resident A's Acetaminophen was left blank on 11/6/2023.

I reviewed Resident A's physician orders which read consistent with the October and November 2023 MARs.

I reviewed Resident A's hospital documentation titled "*Community Referral Form*" and "*Summary of Inpatient Encounter*" dated 10/28/2023 which had a faxed stamp on it dated 10/29/2023.

I reviewed Resident A's hospital documentation titled "*ProMedica After Visit Summary"* dated 10/28/2023 to 10/29/2023 in which the discharge medications orders read consistent with the complaint. The discharge summary read in part to start taking Cefpodoxime (Vantin), change Insulin Lispro (Humalog), and stop taking Metformin. The summary read in part Cefpodoxime and Insulin Glargine were sent to Guardian Pharmacy of Michigan. Additionally, the summary had a faxed stamp on it dated 10/30/2023.

I reviewed Careline Physician Services Visit Note dated 11/8/2023 which read in part:

"*Pt seen for ER follow up, pt was sent out twice to the er for profound hypoglycemia and unresponsive. Pt initially went to hospital 10/28-10/29 for hypoglycemia. She was dc'ed back to facility with new orders, which were not implemented. Unknown reason at this time, though ER records did not make it to pcp office. Pt again had another hypoglycemic episode last evening and was sent to the hospital. She dc'ed back to assisted living and hospice continues.*

Care conference with facility administration and daughter in law by phone. I am amending the insulin and metformin orders per earlier suggestion and reaching to the hospice team regarding orders late October from ER stay."

On 12/7/2023, email correspondence with Employee #2 read the fax stamp dated 10/30/2023 was from the facility faxing the ProMedica After Visit Summary to Resident A's licensed healthcare provider. Additionally, the correspondence read the facility's pharmacy was Pioneer pharmacy, not Guardian pharmacy where the hospital faxed the medication prescriptions.

On 12/26/2023, this writer received a telephone call from Employee #1 who stated she identified Employee #3 had suspicious behaviors and observed her going through a resident's belongings. Employee #1 stated she walked Employee #3 out of the facility at that time pending investigation in which the police arrived the next day and informed her of an open investigation for theft. Employee #1 stated Employee #3's employment with the facility was immediately terminated on 10/13/2023.

On 12/28/2023, I conducted a telephone interview with Employee #2 who stated a Careline Hospice nurse evaluated Resident A after the first hospitalization, then her Careline licensed healthcare provider evaluated her that week in which the hospital recommendations were provided to both. Employee #2 stated she had not received written prescriptions from the first hospitalization; however, the ProMedica After Visit Summary was provided to Resident A's Careline health care provider and medication orders were faxed directly from the hospital to the incorrect pharmacy.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	R 325.1921 Governing bodies, administrators, and supervisors. **Rule 21. (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.** **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:	Review of Resident A's contract revealed the facility was not responsible for theft. Staff attestations revealed Employee #3 was terminated for theft and a police investigation was conducted; thus, these specific allegations could not be substantiated. Review of Resident A's medical records revealed on 10/28/2023 emergency medical services were sought for Resident A's change in condition in which the hospital's licensed healthcare professional faxed orders to a pharmacy for medication changes which were not implemented. Therefore, the facility lacked an organized program of protection to ensure Resident A's medications were implemented and changed as per the orders received from the hospital's licensed healthcare professional, thus a violation was established.
CONCLUSION:	**VIOLATION ESTABLISHED.**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's October and November 2023 MARs revealed there were one or more medications left blank in which it could not be determined if Resident A received her medications or not.

For Reference: **R 325.1932**	**Resident 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 MARs revealed she did not always receive her medications as prescribed by the licensed healthcare professional, thus there was a violation substantiated for this rule.
CONCLUSION:	**VIOLATION ESTABLISHED.**

IV. RECOMMENDATION

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

01/03/2024

_____

Jessica Rogers Date
Licensing Staff

Approved By:

01/03/2024

_____

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