GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 24, 2024

Shahid Imran
Hampton Manor of Brighton
1320 Rickett Road
Brighton, MI 48116

RE: License #: AH470412880
Investigation #: 2024A1027045
Hampton Manor of Brighton

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 #:	AH470412880
Investigation #:	2024A1027045
Complaint Receipt Date:	04/04/2024
Investigation Initiation Date:	04/04/2024
Report Due Date:	06/03/2024
Licensee Name:	Brighton Comfort Care, LLC
Licensee Address:	2635 Lapeer Road Auburn Hills, MI 48326
Licensee Telephone #:	(989) 607-0001
Authorized Representative/ Administrator:	Shahid Imran
Name of Facility:	Hampton Manor of Brighton
Facility Address:	1320 Rickett Road Brighton, MI 48116
Facility Telephone #:	(810) 247-8442
Original Issuance Date:	04/10/2023
License Status:	REGULAR
Effective Date:	10/10/2023
Expiration Date:	10/09/2024
Capacity:	93
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility short staffed and there were no staff in the building.	Yes
Resident A was left on the floor. Residents were neglected.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/04/2024	Special Investigation Intake 2024A1027045
04/04/2024	Special Investigation Initiated – Letter Email sent to Shahid Imran
04/11/2024	Inspection Completed On-site
04/15/2024	Inspection Completed-BCAL Sub. Compliance
04/24/2024	Exit Conference Conducted by email with Shahid Imran

ALLEGATION:

The facility short staffed and there were no staff in the building.

INVESTIGATION:

On 4/4/2024, the Department received an anonymous complaint through the online complaint system which read there were no staff members in the building. The complaint read on 4/2/2024, there was on staff member on duty. The complaint read on 4/3/2024 from 5:00 AM to 7:00 AM there were no staff members in the building.

On 4/11/1024, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated the facility had adequate staffing and there were four staff assigned on day and afternoon shifts, and three staff assigned to night shift. I reviewed the facility's resident census with Employee #1 which there were 38 residents, six memory care and 32 assisted living residents. Employee #1 stated there were two residents in assisted living who required a Hoyer lift or sit to stand to transfer, and two-person assist. Employee #1 stated all memory care residents were one person assist. Employee #1 stated memory care staff would call the assisted living staff if additional assistance was required.

I interviewed Employee #3 whose statements were consistent with Employee #1.

I reviewed the April 2024 staff schedule, specifically 4/2/2024 and 4/3/2024.

On 4/2/2024, the schedule read there were three staff members on duty for dayshift and one staff member training. The schedule read there were three staff members on duty for the afternoon shift. The schedule read there were two staff members on duty for night shift.

On 4/3/2024, the schedule read there five staff members on duty for day shift and one staff member training. The schedule read there were four staff members on duty for afternoon shift. The schedule read there were three staff members on duty for night shift.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.

ANALYSIS:	Interview with staff revealed there were residents in the assisted living who required a lift and two-person assistance for care. Review of the staffing schedule revealed on 4/2/2024, there were two staff members on duty in which the memory care staff person would be required to leave the unit unattended to assist the staff member assigned to the assisted living unit; therefore, there were insufficient staff on duty to accommodate the needs residents and this allegation was substantiated.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[For Reference, see Special Investigation Report (SIR): 2023A0784084, CAP dated 10/11/2023,** **2023A0784062, CAP dated 8/2/2023,** **Licensing Study Report (LSR) dated 10/4/2023, CAP dated 10/17/2023]**

ALLEGATION:

Resident A was left on the floor. Residents were neglected.

INVESTIGATION:

On 4/4/2024, the Department received an anonymous complaint through the online complaint system which read on 4/3/2024 Resident A was found on the floor for an unknown number of hours. The complaint read Resident A fell and was found by dayshift staff at 7:05 AM, then sent to the hospital. The complaint alleged residents lacked incontinence care and there was concern for neglect.

On 4/11/2024, I conducted an on-site inspection at the facility. I reviewed the facility's resident census in which there were 38 residents, six memory care and 32 assisted living residents. The census read Resident A resided in the memory care unit.

I interviewed Employee #1 who stated memory care residents were check and changes every two hours. Employee #1 stated there were no residents who currently had wounds, sores, or breakdown on their buttock areas.

Employee #1 stated Resident A recently had several falls consecutively in a short timeframe in which her physician ordered her to be transferred to the hospital for evaluation. Employee #1 stated Resident A had been extremely weak. While on-site, Employee #1 asked the caregiver on duty in memory care how Resident A was doing in which she responded she was able to toilet and transfer her with one person.

While on-site, I reviewed the two-hour checks for safety charting for Resident A with Employee #1 on the computer. The charting read in part staff were to check Resident A every two hours for safety each shift from 12:00 AM to 6:00 AM. The chart lacked documentation of checks during the 12:00 AM to 6:00 AM timeframe on 04/03/2024.

I interviewed Employee #2 who stated she worked on 4/3/2024 and came on duty at 8:45 AM. Employee #2 stated Resident A's fall had just occurred and at that time the medication technician was assessing her, then emergency medical services were contacted.

I interviewed Employee #3 whose statements were consistent with Employee #1. Employee #3 stated she had not observed residents left in soiled briefs and residents were well cared for.

While on-site, I observed the five residents in the memory care unit who appeared to well-groomed and dressed in clean clothing. I observed ten assisted living residents who appeared well-groomed and dressed in clean clothing. The assisted living and memory care hallways lacked odors.

I reviewed Resident A's service plan updated on 8/30/2023 which read in part Resident A was able to verbalize her needs. The plan read in part Resident A was totally dependent on staff to "*provide assistance (total lift) transfer in case of a fall*" in which staff were to follow the fall prevention program. The plan read in part Resident A was a two person assist/lift. The plan read in part staff were to call 911 if she fell or was dropped during a transfer. The plan read in part for transfers, Resident A required one-person minimal assist with transfers, and she was able to stand and walk/pivot. The plan read in part Resident A received two-hour checks for safety 12 times per day.

I reviewed the incident report for Resident A dated 4/3/2024 at 6:00 AM which read in part Employee #4 transferred her from the bed to wheelchair and she slipped to the floor. The report read emergency medical services was called to pick her up and they took her vital signs. The report read Resident A was orientated and refused to go to the hospital. The report read Resident A's authorized representative was contacted at 7:00 AM.

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: R 325.1901	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Review of Resident A's service plan revealed it read she required two-person assistance to prevent falls and one person assistance for transfers. Staff attestations revealed she had increased falls recently. Review of the incident report revealed one staff member was assisting Resident A when she fell. Review of the charting notes revealed it lacked documentation of two-hour checks on night shift for 4/2/2024. Observations and staff attestations failed to provide sufficient evidence to support claims of inadequate incontinence care for residents. However, the facility was found to lack an organized program ensuring Resident A's service plan adequately addressed her needs for transfers, particularly considering her recent increase in falls. Additionally, there was lack documentation to support two-hour checks were completed on night shift for April 2, 2024. Therefore, this allegation was substantiated.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[For Reference, see LSR dated 10/4/2023, CAP dated 10/17/2023]**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of the April 2024 staff schedule revealed it lacked designation of supervisor of resident care during each shift.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(3) The home shall designate 1 person on each shift to be supervisor of resident care during that shift. The supervisor of resident care shall be fully dressed, awake, and on the premises when on duty.
ANALYSIS:	Review of the April 2024 staff schedule revealed it did not read consistent with this rule; therefore, a violation 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.

04/15/2024

Jessica Rogers Date
Licensing Staff

Approved By:

04/23/2024

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