GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

June 26, 2024

RE: License #: AH580402179
Investigation #: 2024A1022049
Hampton Manor of Bedford

Dear Shahid 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.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara Zabitz, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 296-5731

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH580402179
Investigation #:	2024A1022049
Complaint Receipt Date:	05/23/2024
Investigation Initiation Date:	05/23/2024
Report Due Date:	07/22/2024
Licensee Name:	Hampton Manor of Bedford LLC
Licensee Address:	3099 W Sterns Rd Lambertville, MI 48182
Licensee Telephone #:	(989) 971-9610
Administrator/Authorized Rep:	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?
The Resident of Concern (ROC) did not receive her medication as prescribed by the physician.	Yes
When the ROC began to experience the symptoms of a stroke, it took more than 15 minutes for a caregiver to answer the emergency call bell and when the caregiver got to the room, she did not have a gait belt to transfer the ROC out of bed.	No

III. METHODOLOGY

05/23/2024	Special Investigation Intake 2024A1022049
05/23/2024	Special Investigation Initiated - Telephone Phone call placed to complainant. No answer. Left message to return call.
06/18/2024	Contact - Telephone call made. Investigation conducted remotely via videoconference.
06/26/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) did not receive her medication as prescribed by the physician.

INVESTIGATION:

On 05/23/2024, the Bureau of Community and Health Systems (BCHS) received a complaint that read in part, “On 2-23-2024 my mom (the Resident of Concern/ROC) suffered a double stroke due to the neglect of Hampton Manor. She had a hospital stay and was to resume taking her Xarelto (blood thinner) on 2-16-2024. She has AFIB (atrial fibrillation) so it is important that she take this medication. Hampton was verbally notified and given the discharge papers from the hospital stating that she was to resume her Xarelto on 2-16-2024. They did not resume her Xarelto, and she had a double stroke… Hampton Manor has a history of medication errors…”

On 05/23/2024, I interviewed the complainant by phone. The complainant explained that her mother, the ROC, had lived in the facility for more than a year, but needed to be hospitalized for gastrointestinal (GI) bleeding from 02/11/2024 through 02/14/2024. The complainant further explained that during the time she was in the hospital, the physician had temporarily stopped her Xarelto as it increases the tendency to bleed, but that the medication was to be reinitiated on 02/16/2024. However, according to the complainant, the medication was not restarted. The complainant stated that she had been provided a copy of the ROC's medication administration record (MAR) that documented for both 02/17/2024 and 02/18/2024, that the medication was not administered because the ROC was "physically unable" to take the medication. Review of the MAR revealed notations appended to the Xarelto order documented as "Suspended 14 Feb 2024 to 17 2024, per PCP (primary care provider)" and "Suspended 20 Feb 2024 to 23 Feb 2024, waiting for ok from GI doctor." The MAR further reflected that the Xarelto was not given 02/17/2024, 02/18/2024, and 02/19/2024.

On 02/20/2024, the wellness director sent an email to the complainant and the complainant's sister, the ROC's secondary emergency contact. The wellness director wrote, "I (wellness director) was wondering if you could remind me of [name of the ROC]'s follow up appointment with the GI doctor…We still have the Xarelto and Zoloft on hold." The complainant acknowledged that it was her sister who responded to the email, as the complainant was out-of-state, in a location with poor internet connections. Neither the complainant nor the complainant's sister realized that the ROC had not received her Xarelto since being hospitalized and that the facility did not intend to administer it to her until the ROC had seen the GI physician.

On 06/18/2024, I interviewed the director of operations and the wellness director, in a videoconference. When the wellness director was asked to explain the sequence of events, the wellness director stated that when the ROC returned from the hospital on 02/14/2024, she was accompanied by the complainant's sister. The complainant's sister told the wellness director that she was concerned that the med tech would administer the Xarelto to the ROC on 02/15/2024, so the wellness director suggested to the sister that she (the wellness director) place the Xarelto prescription in her office until 02/17/2024, so that it would be unavailable to the med tech. The wellness director acknowledged that she had misinterpreted the Xarelto restart date. The wellness director went on to explain that on 02/17/2024, the day the ROC was scheduled to re-start the Xarelto as entered into the MAR, she (the wellness director) had a family illness and did not report to work. She went on to say that the med tech did not contact her to ask where the medication was and simply marked it as being "physically unable" to be administered to the ROC. The wellness director further explained that when she returned to work, she again misread the paperwork that had come with the ROC from the hospital, interpreting an admission History and Physical, dated 02/11/2024 as being the discharge summary. The admission History and Physical did indicate that the Xarelto was to be held until the ROC was cleared by the GI service. The wellness director acknowledged that she did not look at the dates and did not read the entire document when she entered the

notation “waiting for ok from GI doctor (to restart Xarelto).” She further acknowledged that when she received the reply from the complainant’s sister which did not question the holding off of the Xarelto, she took it as confirmation that this was the right course of action.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	The directions for the administration of Xarelto were not correctly transcribed into the facility’s MAR which resulted in repeated errors in its administration.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

When the ROC began to experience the symptoms of a stroke, it took more than 15 minutes for a caregiver to answer the emergency call bell and when the caregiver got to the room, she did not have a gait belt to transfer the ROC out of bed.

INVESTIGATION:

According to the written complaint, “When she (the ROC) noticed she could not move her hand she pushed her call button for an aide to come and assist her…She (the caregiver) took 15.37 minutes to answer the call button. My mom had to use the restroom, so I (the complainant) asked the aide if she had a gait belt and she replied I do, but I don't know where it is so let's just get her up.”

When the director of operations was asked about the caregiver’s response to the emergency call, the director of operations said that she did not believe that the caregiver acted in an irresponsible manner. The ROC was independent for transfers, so the caregiver would not think a gait belt was needed. The director of operations further indicated that just over 15 minutes was not an unreasonable wait time.

According to her service plan, the ROC needed very little in assistance from caregivers to complete activities of daily living (ADLs). She was able to use the toilet independently, transfer independently, take care of her personal hygiene needs independently, needing only some hands-on assistance with bathing.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(e) A patient or resident is entitled to receive adequate and appropriate care**
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: R325.1901	**Definitions.**
	(16) "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:	There was no evidence that the ROC received inadequate care from the caregiver.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I reviewed the findings of this investigation with the director of operations on 06/26/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.

06/26/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

06/20/2024

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