GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 30, 2024

Shahid Imran
Hampton Manor of Burton
2105 Center Rd
Burton, MI 48519

RE: License #: AH250410173
Investigation #: 2024A0585061
Hampton Manor of Burton

Dear Mr. 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 responsible party 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 (517) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250410173
Investigation #:	2024A0585061
Complaint Receipt Date:	06/27/2024
Investigation Initiation Date:	06/27/2024
Report Due Date:	08/27/2024
Licensee Name:	Hampton Manor of Burton LLC
Licensee Address:	2105 South Center Rd. Burton, MI 48519
Licensee Telephone #:	(989) 971-9610
Authorized Representative/Administrator:	Shahid Imran
Name of Facility:	Hampton Manor of Burton
Facility Address:	2105 Center Rd Burton, MI 48519
Facility Telephone #:	(989) 971-9610
Original Issuance Date:	05/18/2023
License Status:	REGULAR
Effective Date:	11/18/2023
Expiration Date:	11/17/2024
Capacity:	102
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident was discharged from the facility.	No
The staff is not trained to care for dementia residents.	No
Resident A was not given her agitation medication as prescribed.	No
Additional Findings	Yes

III. METHODOLOGY

06/27/2024	Special Investigation Intake 2024A0585061
06/27/2024	Special Investigation Initiated - Letter Emailed referral to Adult Protective Services (APS).
07/11/2024	Inspection Completed On-site Completed with observation, interview and record review.
07/31/2024	Exit Conference Conducted via email to authorized representative Shahid Imran.

ALLEGATION:

Resident was discharged from the facility.

INVESTIGATION:

On 6/25/2024, the department received a complaint through the BCAL online complaint system. The complaint alleged that they received a letter from the facility stating that they were discharging Resident A because of multiple physical altercations with staff and other residents. The complaint alleged that Resident A is triggered when she is afraid when somebody comes in her room. The complaint alleged that there have been three to four incidents.

Attempts were made to contact the complainant by telephone. As of the date of this report, no contact has been established.

On 6/27/2024, a referral was made to Adult Protective Services (APS).

On 7/11/2024, an onsite was completed at the facility. The administrator Shahid Imran was not present at that time. I interviewed director of operation [Employee #1] at the facility. Employee #1 stated that Resident A is no longer at the facility. Employee #1 stated that Resident A was discharged from the facility for fighting and showing aggressive behavior. He stated that Resident A's POA was contacted on all incidents but sometimes they were hard to contact. Employee #1 stated that Resident A got violent. He said that one of the other residents who is a wanderer walked in Resident A's room and before they could get her out, Resident A started attacking her. He stated that this was the third incident. He stated that two of the incidents happened in the common area and it was captured on video.

On 7/11/2024, I interviewed Employee #2 who stated that Resident A had behaviors. She stated that Resident A did not like to be bothered and didn't like anyone helping her. She stated that they learned to leave her alone and try a different approach depending on when she had behaviors.

On 7/11/2024, I interviewed Employee #4 at the facility. Employee #4 stated that although she got alone well with Resident A, she showed aggression toward other people. Employee #4 stated that Resident A was always arguing with other residents. She said that Resident A didn't like them showering her or changing her clothes and would get aggressive.

Employee #1 gave me a copy of the discharge letter for Resident A. The discharge letter read:

June 3, 2024

RE: Resident A

Please consider this a 30-day notice from Hampton Manor to terminate the residency of [Resident A] at Hampton Manor of Burton.

We have come to this decision due to [Resident A] being involved in multiple physical altercations with residents and staff which constitutes her being at risk for harm to herself or others.

Fee free to contact us for any assistance you may need to find new placement for [Resident A].

We anticipate [Resident A]'s departure July 3, 2024, or sooner. Her June or July fees will be prorated based on her move out date.

Please feel free to contact us for any additional information you may need.

Employee #1 showed me the video footage of Resident A and other residents. A review of the video showed a resident standing up walking in the direction of Resident A who was sitting down. Resident A stood up, pushed the other resident to the floor and proceeded to get on top of her. Staff immediately came to get her off the other resident as she was swinging.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(11) In accordance with section 20201(3) of the code, MCL 333.20201(3) (e), a home's discharge policy shall specify that a home for the aged resident may be transferred or discharged for any of the following reasons: **(a) Medical reasons.** **(b) His or her welfare or that of other residents.** **(c) For nonpayment of his or her stay.** **(d) Transfer or discharge sought by resident or authorized representative.**
ANALYSIS:	Resident A was given a discharge notice based on aggression toward staff and residents. Therefore, the facility reasonably complied with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The staff is not trained to care for dementia residents.

INVESTIGATION:

The complaint alleged that the staff is not trained to deal with dementia patients, and some have never worked in memory care or with dementia patients.

Employee #1 stated that all staff are trained before working with the residents and that they all do in-service throughout the year. He said they try to do in-service at least once a month and as needed.

Employee #2 stated that she has been working at the facility for a year and she had training before working with the residents. She said that her training included dementia care, resident rights, reporting and abuse.

Employee #3 stated that she has been working at the facility for two months and she completed her training before providing care to the residents. She said that she had computer training, and she shadowed another care staff prior to working with the

residents. Employee #3's statement was consistent with Employee #2 regarding her training.

Training documents were consistent with Employee #2 and Employee #3's statements.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	There is no evidence to support this claim that staff were not trained in caring for dementia residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was not given her agitation medication as prescribed.

INVESTIGATION:

The complaint alleged that the facility has not filled Resident A's agitation medication since April and the facility has falsely documented that they have given her all prescribed medication, which the facility is responsible for, per the nurse it stated that she had been receiving Lorazepam two times daily.

Employee #1 stated that the doctor did not prescribe any different medication and felt that Resident A would not benefit from giving new medication. Employee #1 stated that all medication was given as prescribed.

Employee #2 stated that Resident A has an as needed (PRN) for aggression, but would go weeks and she be fine, then she would just "snap". She said they had to

protect other residents. She said they would watch Resident A lots more to ensure that she doesn't bother the other residents.

Employee #3 stated that Resident A had a PRN and would usually take it on the second or third shift. She said they did not have to give it to Resident A every day.

Physician orders show that Resident A was prescribed Lorazepam 0.5 mg to be given one tablet by mouth twice daily as needed for agitation.

On 7/17/2024, I interviewed Witness #1 by telephone. Witness #1 stated that Resident A was very aggressive. Witness #1 stated Resident A was prescribed a PRN for agitation. Witness #1 stated that she spoke with Resident A's doctor who said that they cannot give her any more medication and they would have to send her to a neurologist. She said that she spoke to Resident A's POA and told them that they can't just give the resident the medication anytime, but it can only be given when she displays the behaviors twice a day.

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:	According to physician order, Resident A was prescribed agitation medication to be given as needed. It is not known when and how often she needed it. Therefore, this claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

A review of Resident A's service plan read, "Admitted to the facility 10/06/2023 with diagnoses of unspecified dementia, moderate with agitation, hypertension, and anxiety disorder. Occasional verbal direction; appropriate social and personal behavior. No history of aggression per family, has been aggressive multiple times since move in. Medication: Mech tech administered."

Employee #1, Employee #2, Employee #3 and Witness #1 stated that Resident A is aggressive toward staff and other residents. Their statements were consistent regarding Resident A having a PRN.

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.
ANALYSIS:	Employee #1, Employee #2 and Employee #3 all have made the statements regarding Resident A having behaviors. Resident A is prescribed a PRN for agitation. There is nothing in the service plan to reflect excessive behaviors and aggression toward staff and other residents. The service plan does not adequately describe care to be given for Resident A's excessive behaviors. There is nothing in the service plan that references the PRN.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/30/2024

Brender Howard Date
Licensing Staff

Approved By:

07/30/2024

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