Melanie Belfry
American House Hampton Village
1775 S. Rochester Rd
Rochester Hills, MI 48307

September 24, 2024

RE: License #: AH630398529
Investigation #: 2024A1022069
American House Hampton Village

Dear Melanie Belfry:

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 P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630398529
Investigation #:	2024A1022069
Complaint Receipt Date:	07/18/2024
Investigation Initiation Date:	07/18/2024
Report Due Date:	09/17/2024
Licensee Name:	MCP Rochester Hills OpCo LLC
Licensee Address:	Suite 500 12377 Merit Drive Dallas, TX 75251
Licensee Telephone #:	(214) 443-8300
Administrator/Authorized Rep	Melanie Belfry
Name of Facility:	American House Hampton Village
Facility Address:	1775 S. Rochester Rd Rochester Hills, MI 48307
Facility Telephone #:	(248) 266-0356
Original Issuance Date:	05/13/2020
License **Status:**	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	105
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents of the memory care (MC) unit do not receive adequate and appropriate care.	No
Additional Findings	Yes

III. METHODOLOGY

07/18/2024	Special Investigation Intake 2024A1022069
07/18/2024	Special Investigation Initiated - Telephone Phone call placed to complainant. Left message to return call.
08/09/2024	Inspection Completed On-site
09/12/2024	Contact - Document Received Information exchanged with the facility via email.
09/24/2024	Exit Conference

ALLEGATION:

Residents of the memory care (MC) unit do not receive adequate and appropriate care.

INVESTIGATION:

On 07/18/2024, the Bureau of Community and Health Systems (BCHS) received a complaint alleging that residents living in the memory care (MC) unit were not receiving good incontinence care, were not being given assistance with eating, and did not have interventions for fall prevention. Fall prevention was recently investigated in investigation 2024A1022059 in which the facility was found to be compliant with the applicable rule, therefore fall prevention was not included in this investigation.

On 08/09/2024, at the time of the onsite visit, I interviewed the administrator/authorized representative (AR), the interim wellness director and the corporate operations specialist. They identified 3 residents who resided in the MC unit and needed the full assistance of staff to complete all activities of daily living (ADLs).

Resident A was seated in a high-backed wheelchair in the common area of the MC unit. Medication technician (med tech) #1 accompanied by caregiver #2 took Resident A to her room to provide incontinence care. According to med tech #1, Resident A was unable to participate any of her ADLs and was unable to stand and bear weight. Med tech #1 went on to say that Resident A could not feed herself and her family member came into the facility on a daily basis for both the noon and the evening meals so that he could feed her. A caregiver fed her at the breakfast meal. Med tech #1 stated that Resident A had her good days and her bad days when it came to food consumption. According to the wellness director, Resident A had just been admitted to hospice care. Med tech #1 and caregiver #2 transferred Resident A into her bed to provide incontinence care. As they removed her brief, which was slightly wet, it was apparent that Resident A had a prominent wound on her right coccyx, about the size of a fifty-cent piece, that was scabbed over in the center. The wellness director described the wound as a deep tissue injury, an unstageable pressure sore. Resident A also had a small amount of shearing of the skin lower down on her right buttock. Although there was no fecal matter on the brief, the wellness director cleaned off a small amount of feces that she discovered in the crease between Resident A's buttocks. According to documentation provided by the facility, Resident A had been hospitalized for pneumonia, from 07/23/2024 to 07/29/2024 and was seen by her nurse practitioner (NP) when she returned, on 07/30/2024. The NP documented, "Pressure injury of coccygeal region of back - Stage I to coccyx. Pressure injury precautions discussed. Continue calmoseptine (zinc oxide moisture barrier) to coccyx bid (twice daily) and prn (as needed)." According to her service plan, Resident A was totally dependent on a caregiver for the completion of activities of daily living (ADLs) and was unable to feed herself. A caregiver needed to feed Resident A finely chopped or soft foods. Resident A's service plan did not identify her as being at risk for falls.

Resident B was seated in a wheelchair in the MC unit common area. Med tech #1 and caregiver #2 took Resident B to her room for incontinence care. According to med tech #1, Resident B was unable to bear weight and required the assistance of 2 caregivers for transfer in and out of bed. Resident B also could not feed herself because she no longer had dexterity in her hands and fingers. Resident B was fed by a caregiver at all meals. Med tech #1 and caregiver #2 transferred Resident B into bed to provide incontinence care. When her brief was removed, the brief was observed to be mildly wet, and she had begun to stool, and feces was visible in the crease between Resident B's buttocks. Resident B had no visible skin impairments. According to her service plan, Resident B was totally dependent on a caregiver for the completion of ADLs and was unable to feed herself. A caregiver needed to feed Resident B finely chopped or soft foods. Resident B's service plan did not identify her as being at risk for falls.

Resident C was seated in a reclining geriatric chair in the common area of the MC unit. There was a Hoyer (mechanical) lift sling positioned underneath Resident C. Med tech #1 and caregiver #2 took Resident B to her room for incontinence care. Using a Hoyer lift, med tech #1 and caregiver #2, with the further assistance of the

wellness director, transferred Resident C into her bed. According to med tech #1, Resident C was receiving hospice care. Resident C's brief was clean and dry. There were no skin impairments to be seen. According to caregiver #2, Resident C was able to feed herself without any issues and her food intake was good. According to her service plan, Resident C was on occasion, resistive to care with verbally aggressive behaviors. She was totally dependent on a caregiver for the completion of ADLs, with the exception of eating. She was able to feed herself with occasional cuing from a caregiver. Resident C's service plan did not identify her as being at risk for falls.

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.**
ANALYSIS:	There was no evidence that the care provided to Resident A, Resident B, or Resident C was inappropriate or inadequate in any way.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time of the onsite visit, Resident A was observed to have a prominent wound on her right coccyx, about the size of a fifty-cent piece, that was scabbed over in the center. The wellness director described the wound as a deep tissue injury, an unstageable pressure sore. Resident A also had a small amount of shearing of the skin lower down on her right buttock.

According to the documentation provided by the facility, upon return from a hospital stay, Resident A had been evaluated by her NP. According to the NP's progress note, dated 07/30/2024, the pressure wound was described only as "Pressure injury of coccygeal region of back - Stage I to coccyx." Resident A's service plan was updated on 08/03/2024. According to her service plan, "Staff to observe the skin for any changes such as bruises, rashes, tears, and/open wounds, any/all changes should be reported to nurse immediately."

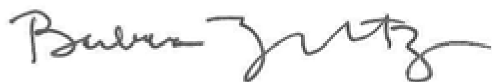
On 09/12/2024, via an email exchange with the interim wellness director, the interim wellness director was asked to provide documentation of observations of Resident A's wound that would have been made by caregivers when providing care to Resident A, that would describe the changes of the wound from a "stage I" as observed by the NP on 07/30/2024 to the deep tissue injury observed at the time of the onsite visit, 08/09/2024. The interim wellness director replied, "She (Resident A) signed on with Lily Hospice on 8/2/24, after which time hospice was completing her showers/bed baths and managing and documenting on any wounds or skin conditions."

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.**
	(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization.
ANALYSIS:	Although wound care was being provided by an outside agency, the facility could not identify through documentation when there was a change in skin condition for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 09/24/2024. 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.



09/24/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

09/19/2024

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