GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 14, 2024

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

RE: License #: AH470412880
Investigation #: 2024A1019076

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.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH470412880
Investigation #:	2024A1019076
Complaint Receipt Date:	09/25/2024
Investigation Initiation Date:	09/25/2024
Report Due Date:	11/25/2024
Licensee Name:	Brighton Comfort Care, LLC
Licensee Address:	2635 Lapeer Road Auburn Hills, MI 48326
Licensee Telephone #:	(989) 607-0001
Administrator and Authorized Representative:	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:	10/10/2024
Expiration Date:	07/31/2025
Capacity:	93
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Improper bed rail use.	Yes
Staff are making multiple medication errors.	Yes
There is spoiled food in the kitchen.	No
The dish machine isn't functioning properly.	Yes
Additional Findings	No

III. METHODOLOGY

09/25/2024	Special Investigation Intake 2024A1019076
09/25/2024	Comment Complaint was forwarded to LARA from APS. APS denied the referral and is not investigating the allegations.
09/25/2024	Special Investigation Initiated - Letter Emailed licensee for additional information/ documentation.
10/02/2024	Inspection Completed On-site
10/02/2024	Inspection Completed-BCAL Sub. Compliance

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Improper bed rail use.

INVESTIGATION:

On 9/25/24, the department received a complaint alleging that Residents have bed rails that shouldn't. The complaint alleged that Residents A, B, C and D all have rails that are unauthorized. Due to the anonymous nature of the complaint, additional detail could not be obtained.

On 10/2/24, I conducted an onsite inspection. I interviewed Employee 1 at the facility. Employee 1 reported that the facility does not allow bedrails, however if a family insists on them, they must sign a consent form. Employee 1 reported that currently no residents at the facility have bed rails and no consent forms have been obtained. While onsite, I requested to go into Resident A, B, C, and D's apartments. Employee 1 reported that Resident A passed away last week, however his bed was still in his room. I observed Resident A's room to have a hospital bed with partial rails. In Resident B, C and D's apartments I observed a single rail that was attached to a board that slid underneath each mattress. The devices were not secured or affixed to the bed frames. At the time of inspection, there were no physician orders for the bedside assistive devices and the residents' service plans lacked information about the devices such as purpose of use, staff responsibility to ensure devices were safe, and ongoing maintenance schedules.

In follow up correspondence, Employee 1 reported that the bed rails were in place before the current licensee took over the facility in March 2024. Employee 1 reported that all the rails were removed except for Resident B, whom they obtained a verbal physician's order for on 10/3/24. Employee 1 also provided a copy of the licensee's bed rail policy that in part reads "*Bed Rails and Attached Bedside Mobility Devices except the specialty Halo Ring are not permitted with admission. Upon duration of tenure no attached assistance devices can be placed on the resident's bed or wall unless the specialty Halo Ring has been approved by the facility*." and a copy of the resident handbook that reads "*We are a no bed rail facility."*

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:	The licensee did not ensure the safe use of bedside assistive devices used within the facility. Staff interviewed initially reported that the facility does not allow bed rails and that no residents had the devices. Direct observation during the onsite inspection revealed bed rails in four separate apartments, where the facility lacked physicians' orders or service plan instruction on the devices. These observations are in direct contradiction with the licensee's policy to not have bed rails.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED**

ALLEGATION:

Staff are making multiple medication errors.

INVESTIGATION:

The complaint alleged that staff are failing to pass medications in some instances and are passing medications outside of their scheduled administration times. The compliant did not provide names of residents affected, medications that were not passed or passed outside of parameters nor list dates that the allegations occurred on. Due to the anonymous nature of the complaint, additional information could not be obtained.

While onsite, I randomly selected to review medication administration records (MAR) of six residents for the previous four weeks and the following observations were made:

- Resident D missed a dose of dicyclomine on 9/1/24. The MAR was left blank and staff failed to document a reason for the missed administration.

- Resident E missed a dose of Seroquel on 9/23/24. The MAR was left blank and staff failed to document a reason for the missed administration.

- Resident F missed one or more doses of Tylenol on 9/2/24, 9/5/24, 9/6/24, and 9/14/24. Resident F missed a dose of nystop on 9/26/24. Resident F missed a dose of oxygen on 9/5/24, 9/6/24, 9/9/24 and 9/23/24. Resident F missed a dose of tramadol on 9/23/24 and 9/25/24. For all the above-mentioned medications and dates, the MAR was left blank and staff failed to document a reason for the missed administrations.

- Resident G missed one or more doses of norco on 9/5/24, 9/9/24, 9/16/24, 9/17/24, 9/21/24 and 9/23/24. The MAR was left blank and staff failed to document a reason for the missed administrations.

In follow up correspondence, Employee 1 reported that medications should be passed within a two hour window- one hour before through one hour after the scheduled time. A copy of the licensee's medication administration policy was provided and confirmed this expectation, as it read *"Medications will be administered within one hour of the prescribed time for administration (60 minutes before or 60 minutes after the assigned time). Unless otherwise specified by the prescribed, routine medications will be administered according to the schedule*." In reviewing the MARs, I observed one or more medications passed outside of these parameters for the residents reviewed on the following dates:

- Resident D- 9/3/24, 9/6/24, 9/9/24, 9/10/24, 9/14/24, 9/19/24, 9/20/24, 9/23/24, 9/30/24, 10/1/24 and 10/2/24
- Resident E- 9/4/24, 9/8/24, 9/20/24, 9/22/24, 9/27/24 and 9/30/24
- Resident F- 9/4/24, 9/5/24, 9/6/24, 9/8/24, 9/15/24, 9/16/24, 9/22/24, 9/24/24, 9/26/24, 9/28/24, 9/29/24, 9/30/24, 10/1/24, 10/2/24 and 10/3/24
- Resident G- 9/12/24, 9/15/24, 9/22/24, 9/25/24, 9/26/24, 10/1/24 and 10/2/24
- Resident H- 9/8/24, 9/15/24, 9/16/24, 9/17/24, 9/18/24, 9/22/24, 9/23/24, 9/25/24, 9/28/24, 9/30/24 and 10/2/24
- Resident I- 9/15/24, 9/17/24, 9/22/24 and 9/26/24

APPLICABLE RULE	
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 randomly selected resident medication administration records reveals several instances of missed medications without proper documentation as well as staff administering medications outside of their designated parameters.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED**

ALLEGATION:

There is spoiled food in the kitchen.

INVESTIGATION:

The complaint alleged that there is old, spoiled food in the kitchen. The complaint did not provide examples of the food that is spoiled nor provide dates this is alleged to have occurred. Due to the anonymous nature of the complaint, additional information could not be obtained.

While onsite, I conducted an inspection of the commercial kitchen. I observed items in the walk in refrigerator and freezer. Items were observed to be labeled, dated and properly sealed and I did not observe any spoiled items as the complaint referenced.

APPLICABLE RULE	
R 325.1976	**Kitchen and dietary.**
	(6) Food and drink used in the home shall be clean and wholesome and shall be manufactured, handled, stored, prepared, transported, and served so as to be safe for human consumption.
ANALYSIS:	Direct observation of the commercial kitchen did not reveal any spoiled food.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The dish machine isn’t functioning properly.

INVESTIGATION:

The complaint alleged that there is something wrong with the dishwasher and the silverware is not getting cleaned. Due to the anonymous nature of the complaint, additional information could not be obtained.

Employee 1 reported that the facility’s dish machine is a time temperature dish machine. Employee 1 was not sure what temperatures the water needed to get to adequately sanitize the dishes but reported that the machine is functioning properly and has not had any issues. Employee 1 reported that they have ordered

temperature strips, but as of March 2024 when the current licensee took over the building they have not been taking or recording the temperatures of the dishes.

APPLICABLE RULE	
R 325.1976	**Kitchen and dietary.**
	(13) A multi-use utensil used in food storage, preparation, transport, or serving shall be thoroughly cleaned and sanitized after each use and shall be handled and stored in a manner which will protect it from contamination.
ANALYSIS:	The facility has no means of monitoring or recording temperatures of the commercial dish machine to ensure dishes are being sanitized per manufacturer's guidelines.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/09/2024

_____

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

10/14/2024

_____

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