GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 13, 2024

Shahid Imran
Hampton Manor of Clinton, LLC
7560 River Road
Flushing, MI 48038

RE: License #: AH500401685
Investigation #: 2025A1027015
Hampton Manor of Clinton

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 #:	AH500401685
Investigation #:	2025A1027015
Complaint Receipt Date:	12/02/2024
Investigation Initiation Date:	12/02/2024
Report Due Date:	02/01/2025
Licensee Name:	Hampton Manor of Clinton, LLC
Licensee Address:	18401 15 Mile Road Clinton Township, MI 48038
Licensee Telephone #:	(734) 673-3130
Authorized Representative/ Administrator:	Shahid Imran
Name of Facility:	Hampton Manor of Clinton
Facility Address:	18401 15 Mile Road Clinton Twp., MI 48433
Facility Telephone #:	(586) 649-3027
Original Issuance Date:	10/12/2021
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	101
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had bruising, and it was not reported.	Yes
Additional Findings	No

III. METHODOLOGY

12/02/2024	Special Investigation Intake 2025A1027015
12/02/2024	Special Investigation Initiated - Letter Email sent to administrator Jane Goulette to request documentation
12/02/2024	Contact - Document Received Email received with requested documentation
12/10/2024	Inspection Completed On-site
12/13/2024	Exit conference Conducted by email with Shahid Imran and Employee #1

ALLEGATION:

Resident A had bruising, and it was not reported.

INVESTIGATION:

On 12/2/2024, the Department received a complaint through the online system reporting an incident on 11/24/2024 at approximately 3:00 PM, where bruising was noticed on the left side of Resident A's jaw, face, and eye. The complaint read that on 11/23/2024, Resident A had visitors and there were no signs of bruising at that time. According to the complaint, the visitor informed staff of the bruising, prompting an investigation. Additionally, the complaint mentioned that on 11/26/2024, Resident A's left pinky finger was broken, and the night shift employee on duty on 11/24/2024 was terminated.

On 12/4/2024, additional information was received from Adult Protective Services (APS), who did not open an investigation. The camera footage showed Resident A falling on 11/23/2024 at 1:04 AM. Resident A has a history of falls and was found to have healing bruising on the right side of her face. The hospice nurse conducted an exam on 11/24/2024 and noted the bruising. Additionally, it was observed that

Resident A's left pinky was bruised and painful to touch, and she was guarding her right arm and shoulder. The hospice nurse wrapped her hand and is providing pain medication. There are overall concerns that no staff at Hampton Manor noticed or reported the incident.

On 12/10/2024, I conducted an on-site inspection at the facility and interviewed staff.

In a telephone interview, Employee #1 revealed that Resident A had an unwitnessed fall in her apartment. Employee #1 reviewed the facility's camera footage, which showed Employee #2 entering Resident A's room. After interviewing Employee #2, it was revealed that Resident A had fallen out of bed, and Employee #2 had placed her back in bed. Employee #1 stated that Employee #2 was terminated for failing to follow the facility's fall policy.

Employee #3 mentioned that Resident A had started receiving hospice services from Accent Care a few weeks prior and that the hospice agency, along with Resident A's authorized representative, should be contacted for any incidents.

During my visit, I observed Resident A walking down the memory care hallway with a staff member. She did not appear to be in pain or guarding her right arm.

Resident A's face sheet indicated that she moved into the facility on 3/19/2024, with Relative A1 designated as her healthcare durable power of attorney. Her service plan, also dated 3/19/2024, stated that she was at risk for falls and required hourly checks for safety.

An occurrence report dated 11/23/2024 at 2:00 AM noted that Employee #2 was in and out of Resident A's apartment at 1:04 AM, 1:09 AM, and 1:49 AM. It was recorded that Employee #2 left the memory care unit at 2:15 AM and returned at 3:11 AM. The report indicated that Employee #2 did not report the fall or complete an incident report. After reviewing the camera footage, Employee #2 admitted to placing Resident A back in bed after she fell. The report further stated that Resident A's family noticed a black eye and red marks on her face the following day. The report was completed by Employee #1 on 11/26/2024, and Relative A1 was notified at 11:10 AM, followed by notification to the hospice agency at 11:15 AM.

A review of the facility's fall policy revealed that staff were required to contact the hospice agency to send a nurse to the facility if a resident on hospice services experienced a fall. The policy also instructed staff to immediately call the family and leave a message if there was no answer.

Employee #2's file revealed that he was hired on 7/11/2024, and his Workforce Background Check dated 7/10/2024 indicated he was eligible for hire. Employee #2's training records dated 7/11/2024 read he was trained on employee policies and procedures, as well as accident prevention/incident reporting. An investigation letter dated 11/26/2024, written by Employee #1, was maintained in his file, which reiterated the details of the incident. The letter also noted that on 11/25/2024,

Resident A's hospice nurse and family reported multiple bruises on her face and neck, as well as a right black eye. The letter further indicated that Employee #2 was removed from the schedule pending investigation and was later terminated on 11/26/2024 for leaving the memory care unit unattended.

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.** **Rule 1. As used in these rules:**
	(p) "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:	Based on the investigation, it was determined that Resident A sustained bruising and possibly an injury to her left pinky. Employee #2 did not follow the proper protocol for reporting the fall or notifying the required parties, including the hospice agency and Resident A's family. As a result, Employee #2 was terminated. However, other staff members who provided care to Resident A between 11/23/2024 and 11/25/2024 also did not report her injuries to her family or the hospice team. Therefore, this allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/12/2024

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Jessica Rogers Date
Licensing Staff

Approved By:

12/12/2024

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