GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 2, 2025

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

RE: License #: AH630398529
Investigation #: 2025A1019023
American House Hampton Village

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 #:	AH630398529
Investigation #:	2025A1019023
Complaint Receipt Date:	12/19/2024
Investigation Initiation Date:	12/20/2024
Report Due Date:	02/18/2025
Licensee Name:	MCP Rochester Hills OpCo LLC
Licensee Address:	12377 Merit Drive, Suite 500 Dallas, TX 75251
Licensee Telephone #:	(214) 443-8300
Administrator and Authorized Representative:	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?
Timely medical treatment was not sought for Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

12/19/2024	Special Investigation Intake 2025A1019023
12/19/2024	Comment Complaint was forwarded to LARA from APS; APS is investigating the allegations.
12/20/2024	Special Investigation Initiated - Letter Requested documentation from the licensee.
12/23/2024	Contact - Document Sent Contacted APS worker for additional information/ status update.
12/27/2024	Inspection Completed BCAL Sub. Compliance

ALLEGATION:

Timely medical treatment was not sought for Resident A.

INVESTIGATION:

On 12/19/24, the department received a complaint alleging that Resident A was having difficulty breathing and staff waited two hours to call 911. The complaint alleged that staff also failed to give Resident A her breathing treatment during that timeframe. Due to the anonymous nature of the complaint, additional information could not be obtained.

In correspondence with Melanie Belfry, the administrator and authorized representative (AR), she confirmed that on 12/19/24 Resident A was sent to the hospital for breathing related issues and passed away on 12/20/24. The administrator/AR reported that Resident A was on hospice but was a full code status. The administrator/AR reported that Resident A was showing some changes in her baseline during second shift on 12/19/24, such as weakness and reported that

staff administered a breathing treatment to her around 5:00pm. The administrator/AR reported that the resident's daughter was present at the facility during second shift until around 9:00pm on 12/19/24, and there was no reason to seek medical attention at that time. The administrator/AR reported that during the third/midnight shift, Resident A began to experience respiratory distress which drove staff to call 911. The administer/AR reported that staff reported that Resident A declined very quickly and that staff sought medical attention appropriately.

The administrator/AR provided an incident report, progress note, physician's orders and medication administration records (MAR). The incident report read:

> *Resident started having a difficult time breathing on the afternoon shift. Upon the beginning of midnight shift, medication technician [Employee 2] was informed about the resident's condition and [Employee 2] advised to have her sent out to the hospital her vitals were taken and EMS was contacted. Resident was taken to the hospital. Hospice was contacted.*

The progress note read:

> *Resident started having a really difficult time breathing on the afternoon shift. Upon the beginning of midnight shift, I was informed about the resident's condition and advised to have her sent out. Her vitals were taken and EMS was contacted. Resident was taken to the hospital. [Nurse] was contacted, left voicemail. Resident's emergency contact was contacted. No response at first. Left a voicemail. He called back and I informed him about the incident. Hospice was contacted. I informed them about the incident as well.*

Resident A had a physician's order for ipratropium- albuterol and is instructed *"Inhale 1 vial via nebulizer into the lungs every 4 hours as needed*". Resident A's MAR was reviewed for the month of December 2024. Staff documented this medication was administered to Resident A once on 12/11/24 for the timeframe reviewed.

Employee 1 submitted a statement that read:

> *Around 4pm, [Resident A's] daughter and caregiver were assisting her and her daughter decided to put her mother to bed and skip her shower, due to her mother feeling weak. [Resident A] was given her 5pm breathing treatment and I took her vitals. Her daughter informed me that she would be staying with her mom until 9pm, and I told her to let me know if she needs anything. At the end of my shift I informed the on-coming med tech to keep a watch on resident because she was having a bad day*.

Employee 2 submitted a statement that read:

I started my shift at 11pm. I did my narcotic count sheet with the off-going med tech. during rounds, I was notified by a caregiver that [Resident A] needed some immediate attention. This was around 1:00am. she was having a really hard time breathing. I called 911 immediately. After i called EMS, I then proceeded to contact he emergency contact on file (son). I followed up by calling the hospice doctor. Neither answered. Called house nurse. No response. Moments [sic], son called back. We spoke. He was very calm and understanding. Also thankful. Hospice nurse returned my phone call. We spoke. Everything was fine. [Resident A's] breathing decline [sic], transpired very quickly. This entire event happened very quickly, in fact I called the EMS because I wanted to ensure her safety.

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: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	Resident A exhibited a change in condition to her baseline behavior during the afternoon shift on 12/19/24. At that time, staff were monitoring her but did not feel the observations warranted outside medical evaluation/treatment. During the following shift, staff attest that Resident A experienced a significant and rapid decline, prompting them to call 911.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Employee 1 attested that he administered a breathing treatment to Resident A on 12/19/24 at 5:00pm, however that treatment was not documented on Resident A's MAR. When Employee 1 was asked why the breathing treatment was not documented, he replied *"I just forgot*".

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(vii) A record of the reason for administration of a prescribed medication that is on an as-needed basis.**
ANALYSIS:	Staff failed to document the administration of a prescribed, as needed breathing treatment to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/02/2025

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

01/02/2025

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