GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 21, 2025

Tyler May
American House Hampton Village
1775 S. Rochester Rd
Rochester Hills, MI 48307

RE: License #: AH630398529
Investigation #: 2025A1019073

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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) 335-5985.

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 #:	2025A1019073
Complaint Receipt Date:	07/10/2025
Investigation Initiation Date:	07/11/2025
Report Due Date:	09/09/2025
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:	Tyler May
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	105
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's arm was broken after being pushed by staff.	Yes
Additional Findings	No

III. METHODOLOGY

07/10/2025	Special Investigation Intake 2025A1019073
07/11/2025	Comment Licensee previously notified the department of the incident on 6/28/25. APS and law enforcement were also notified at that time.
07/11/2025	Special Investigation Initiated - Letter Email correspondence with licensee; requested additional information and documentation.
07/15/2025	Inspection Completed BCAL Sub. Compliance

ALLEGATION: Resident A's arm was broken after being pushed by staff.

INVESTIGATION:

On 7/10/25, the department received a complaint alleging that on 6/28/25, Resident A was pushed to the ground by Employee 1, resulting in a broken arm.

The licensee had previously notified the department of this incident. An email from the administrator and authorized representative (AR) Tyler May from 6/28/25 read:

> *At approximately 8:55am this morning, a memory care resident was reported to have been carrying a napkin with fecal matter. The caregiver attempted to remove the napkin from the resident, once it was removed the caregiver walked away. The resident made physical contact with the back of the caregiver. The caregiver then turned around and made physical contact with the resident who fell to the floor. It was witnessed by 2 caregivers and the shift supervisor. The caregiver was immediately asked to vacate the building by the shift supervisor. The resident expressed pain in the left arm and was sent to the hospital for further evaluation at 9:07am, where it was confirmed the resident did injure the left wrist. It was reported to me at 8:59am. We notified the family and physician*

along with the Rochester Hills police department, they are currently investigating and pursing [sic] legal action against the caregiver. Adult Protective Services was notified as well. The staff member has been suspended pending this investigation and will be relieved of duties.

In follow-up correspondence, the AR provided a collective written statement from the three staff who directly witnessed the events. Employees 2, 3, and 4 wrote:

[Employee 1] was cleaning up after breakfast and [Resident A] had a napkin on the table and it had BM in the napkin. [Employee 1] was trying to get the napkin from [Resident A], [Employee 1] then turned her back to do something else and [Resident A] then got up and slapped [Employee 1] and her reaction was to push [Resident A] then she [Resident A] fell to the ground.

Resident A's hospital discharge paperwork was reviewed. The documentation from Ascension Providence Rochester hospital confirmed that Resident A sustained a left radial fracture.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(*l*) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician, by a physician's assistant with whom the physician has a practice agreement, or by an advanced practice registered nurse, for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician, physician's assistant, or advanced practice registered nurse who authorized the restraint. In case of a chemical restraint, the physician, or the advanced practice registered nurse who authorized the restraint, shall be consulted within 24 hours after the commencement of the chemical restraint.**

ANALYSIS:	Resident A was pushed to the ground by Employee 1, causing her arm to be fractured. This event was witnessed by Employees 2, 3 and 4. This unnecessary and wrongful application of force is inconsistent with the provision of care outlined in this statute.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/15/2025

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

07/21/2025

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