GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 7, 2022

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

RE: License #: AH500401685
Investigation #: 2022A1027038
Hampton Manor of Clinton

Dear Mr. Imran:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by the authorized representative and dated.

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. 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) 241-1970.

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) 241-1970
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500401685
Investigation #:	2022A1027038
Complaint Receipt Date:	02/23/2022
Investigation Initiation Date:	02/23/2022
Report Due Date:	04/25/2022
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 #:	(734) 673-3130
Original Issuance Date:	10/12/2021
License Status:	TEMPORARY
Effective Date:	10/12/2021
Expiration Date:	04/11/2022
Capacity:	101
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff were not background checked.	No
The facility lacked visiting hours.	No
Resident A did not receive her medications.	Yes
Residents were not offered protein with their meals.	No
Resident rooms were not cleaned regularly.	No
Additional Findings	No

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.

The complaint alleged the facility was short staffed and resident's lacked supervision at night which was investigated in Special Investigation Report (SIR) 2022A058503.

III. METHODOLOGY

02/23/2022	Special Investigation Intake 2022A1027038
02/23/2022	Special Investigation Initiated - Letter Email sent to AR/Administrator Shahid Imran requesting an employee list
02/23/2022	Contact - Document Received Email received from Mr. Imran with requested documentation
03/03/2022	Inspection Completed On-site
03/04/2022	Contact - Telephone call made Telephone interview conducted with medication technician Lashawanda Wiliams
03/04/2022	Inspection Completed-BCAL Sub. Compliance

03/14/2022	Exit Conference Conducted with authorized representative Shahid Imran

ALLEGATION:

Staff were not background checked.

INVESTIGATION:

On 2/23/2022, the department received a complaint which alleged staff were not background checked.

On 3/3/2022, I conducted an on-site inspection at the facility. I interviewed business office manager Nayab Virk. Ms. Virk stated all applicants are background checked prior to employment with the company by herself and her assistance Lauren Morris. While on-site, I reviewed copies of eligibility reports from the Michigan Workforce Background Check Department for three employees, a medication technician, a caregiver, and kitchen staff. The reports read consistent with statements from Ms. Virk.

APPLICABLE RULE	
MCL 333.20173a	**criminal history check**
	(2) Except as otherwise provided in this subsection or subsection (5), a covered facility shall not employ, independently contract with, or grant privileges to an individual who regularly has direct access to or provides direct services to patients or residents in the covered facility until the covered facility or staffing agency has a criminal history check conducted in compliance with this section or has received criminal history record information in compliance with subsections (3) and (10).
ANALYSIS:	Business office manager interview along with review of facility documentation revealed employees were background checked through the Michigan Workforce Background Check department during their hiring process, thus this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility lacked visiting hours.

INVESTIGATION:

On 2/23/2022, the department received a complaint which read visiting hours were from 9:00 AM to 5:00 PM Monday through Friday and alleged the facility closed at 5:00 PM. The complaint read there were no visiting hours on weekends.

On 3/3/2022, I conducted an on-site inspection at the facility. I interviewed business office manager Nayab Virk. Ms. Virk stated the facility offered visiting hours from 9:00 AM to 5:00 PM Monday through Friday and on weekends. Ms. Virk stated after 5:00 PM visiting hours were allowed if a family called the facility to arrange their visit. Ms. Virk stated families were informed of the facility's visiting policy in their admission contracts and by telephone. I interviewed receptionist Lauren Morris. Ms. Morris stated there was not a receptionist available after 5:00 PM on most days to greet families. Ms. Morris stated resident's families called her to arrange their visits after 5:00 PM in which she would stay after 5:00 PM or advise staff to accommodate the family. Ms. Morris stated once families arrived to visit, they would ring the doorbell at the front entrance vestibule. Ms. Morris stated the doorbell alert was sent to staff phones to let them know someone was at the door. I interviewed Resident A who stated her daughter visited occasionally but not after hours because she was tired from working. I interviewed Resident B who stated her family visited often at various times. I observed signs throughout the facility including in common areas and resident rooms which read

> "Hello Families,
>
> Visiting hours are Monday-Friday 9am-5pm and weekends 9 am-5pm only if you could not visit on weekdays. If you have any questions or concerns please see office. Thank you"

I reviewed Resident A's admission contract which was dated 1/6/2022, signed by the facility's sales staff and read "verbal consent given signature still needed she was sick with COVID." The contract read

> "Guests. The resident understands that as a resident, the Resident has a right to associate with friends and family ("Guests") during reasonable hours. Because the Company is a licensed facility, overnight guests are generally not permitted in a resident's room. Limited exceptions may be granted by the Administrator based on the Resident's health status or other pertinent factors. The Resident acknowledges and understands that the Resident's Guests are subject to the Company's rules and regulations, and if the Resident's Guests become disruptive to the operations of the Facility and/or are verbally or physically abusive to staff, residents or others, the Company may request that they leave

the Facility until their behavior is under control or may place limitations upon the location and time of their visitation. The Resident understands that, where circumstances warrant, the Company may exclude such individuals from the Facility."

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents**
	(3) The following additional requirements for the policy described in subsection (2) apply to licensees under parts 213 and 217: **(b) Each nursing home patient may associate and communicate privately with persons of his or her choice. Reasonable, regular visiting hours, which shall be not less than 8 hours per day, and which shall take into consideration the special circumstances of each visitor, shall be established for patients to receive visitors. A patient may be visited by the patient's attorney or by representatives of the departments named in section 20156, during other than established visiting hours. Reasonable privacy shall be afforded for visitation of a patient who shares a room with another patient. Each patient shall have reasonable access to a telephone. A married nursing home patient or home for the aged resident is entitled to meet privately with his or her spouse in a room that assures privacy. If both spouses are residents in the same facility, they are entitled to share a room unless medically contraindicated and documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.**
ANALYSIS:	Staff and resident interviews along with review of facility documentation revealed the facility had specified visiting hours however families could visit any time after those hours if it was prearranged.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A did not receive her medications.

INVESTIGATION:

On 2/23/2022, the department received a complaint which alleged Resident A had not received her medications at correct times, medications were being skipped and the facility had not refilled her prescriptions.

On 3/3/2022, I conducted an on-site inspection at the facility. I interviewed Resident A, B and C who stated they received her medications and received them on time.

On 3/4/2022, I conducted a telephone interview with medication technician Lashawanda Williams who stated staff work eight-hour shifts and conduct narcotic medication counts at shift change. Ms. Williams stated resident medication administration is conducted electronically in which staff provide residents their medications and sign they were provided in the computer. Ms. Williams stated the computer prompts staff when medications are missed or administered early or administered late. Ms. Williams stated the electronic system allows staff to reorder medications easily in the system and the pharmacy notifies the facility if a medication cannot be reordered for reasons such as it was too soon to reorder, or a new prescription was needed.

I reviewed Resident A's facesheet which read she admitted to the facility on 1/6/2022.

I reviewed Resident A's medication administration records (MAR) for January, February, and March 2022. Resident A's MAR read the original medication orders were entered on 1/6/2022 which read consistent with her facesheet.

The MAR read the following medications were not marked as administered in January 2022: Alendronate on 1/9/2022, Aspirin from 1/6/2022 through 1/11/2022, 1/13/2022, 1/18/2022, 1/19/2022, 1/21/2022, 1/24/2022, 1/25/2022, Atorvastatin from 1/6/2022 through 1/9/2022, 1/12/2022, 1/14/2022, 1/17/2022, Azithromycin on 1/29/2022, Azithromycin from 1/30/2022 through 1/31/2022, Carvedilol twice daily from 1/6/2022 through 1/9/2022, 8:00 AM dose on 1/10/2022 and 1/11/2022, 8:00 PM dose on 1/12/2022, 8:00 AM dose on 8/13/2022, 8:00 PM dose on 1/14/2022 and 1/17/2022, 8:00 AM dose on 1/18/2022, 1/19/2022, 1/21/2022, 1/24/2022, 1/25/2022, 1/30/2022, 1/31/2022, Donepezil from 1/6/2022 through 1/9/2022, 1/12/2022, 1/14/2022, 1/17/2022, Lantanoprost eye drops from 1/6/2022 through 1/9/2022, 1/12/2022, 1/14/2022, 1/17/2022, Levothyroxin from 1/6/2022 through 1/11/2022, 1/13/2022, 1/16/2022, 1/22/2022, 1/25/2022, 1/29/2022 through 1/31/2022, Multivitamin from 1/6/2022 through 1/11/2022, 1/13/2022, 1/18/2022,

1/19/2022, 1/21/2022, 1/24/2022, 1/25/2022, Penicilln VK from 1/24/2022 through 1/31/2022, Spironolact from 1/6/2022 through 1/11/2022, 1/13/2022, 1/18/2022, 1/19/2022, 1/21/2022, 1/24/2022, 1/25/2022, 1/30/2022, Vitamin D3 from 1/6/2022 through 1/11/2022, 1/13/2022, 1/18/2022, 1/19/2022, 1/21/2022, 1/24/2022, 1/25/2022, Triamcinolon cream twice daily from 1/6/2022 through 1/9/2022, 8:00 AM dose on 1/10/2022 and 1/11/2022, 8:00 PM dose 1/12/2022, 8:00 AM dose on 1/13/2022, 8:00 PM dose on 1/14/2022, 8:00 AM and 8:00 PM doses on 1/16/2022, 8:00 PM dose on 1/17/2022, 8:00 AM and 8:00 PM doses on 1/18/2022, 8:00 AM dose on 1/19/2022.

The MAR read the following medications were not marked as administered in February 2022: Azithromycin from 2/1/2022 through 2/2/2022, Carvedilol 8:00 AM dose on 2/5/2022, Levothyroxin from 2/1/2022 through 2/3/2022, 2/5/2022, 2/7/2022, 2/8/2022, 2/13/2022 through 2/15/2022, 2/18/2022, 2/22/2022, 2/27/2022, 2/28/2022, Penicilln VK from 2/1/2022 through 2/3/2022.

The MAR read the following medications were not marked as administered in March 2022: Levothyroxin on 3/1/2022 and 3/2/2022.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Resident and staff interviews, along with review of Resident A's MARs revealed she did not always receive her medications as prescribed. Facility staff failed to mark any reason for the missed doses and the MARs were left blank, therefore it cannot be confirmed why the medication administration was not completed as scheduled.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents were not offered protein with their meals.

INVESTIGATION:

On 2/23/2022, the department received a complaint which alleged residents are not offered protein at some dinner meals.

On 3/3/2022, I conducted an on-site inspection at the facility. I interviewed business office manager Nayab Virk who stated the kitchen manager entered a proposed menu in the online system Grove Assisted Living Menus in which they are approved by a dietician prior to serving the meals to residents. I interviewed kitchen manager Donna Jarrard whose statements were consistent with Ms. Virk. Ms. Jarrard stated the facility offered protein with most meals and on the alternative menu, as well as in some snacks, such as peanut butter and jelly sandwiches. I interviewed Resident A who stated, “meals are very good” and she was offered protein. I interviewed Resident B who stated she had “no complaints” regarding the meals served. I interviewed Resident C who stated he thought the facility offered protein at meals.

I reviewed the facility’s menus from 1/16/2022 through 3/12/022 which read consistent with Ms. Jarrard’s interview. The menus read most meals offered a source of protein. For example, the menu on 1/16/2022 read breakfast was scrambled egg, hash browns, bacon, 100% juice and muffin, lunch was chicken broccoli stir-fry, fried rice, fresh coconut cream pie, dinner was homestyle sloppy joes, soup du jour, onion rings, chocolate chip brownie and milk were offered at every meal.

APPLICABLE RULE	
R 325.1951	**Nutritional need of residents.**
	A home shall meet the food and nutritional needs of a resident in accordance with the recommended daily dietary allowances of the food and nutrition board of the national research council of the national academy of sciences, adjusted for age, gender, and activity, or other national authority acceptable to the department, except as ordered by a licensed health care professional.
ANALYSIS:	Staff and resident interviews along with review of facility documentation revealed protein was offered at most meals and the facility’s menus were reviewed by a dietician prior to serving to ensure they met the nutritional needs of residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident rooms were not cleaned regularly.

INVESTIGATION:

On 2/23/2022, the department received a complaint which alleged resident rooms were not being cleaned regularly.

On 3/3/2022, I conducted an on-site inspection at the facility. I interviewed business office manager Nayab Virk who stated she had one full time housekeeper and was in the process of hiring a part-time housekeeper. Ms. Virk stated housekeeping staff were to focus on one area of the building daily, but resident rooms were priority. Mr. Virk stated for example, housekeeping would clean resident rooms on one day then on the following day clean common areas. Ms. Virk stated if a resident's room required cleaning during a day in which the common area was being cleaned then housekeeping would provide services as need to that room. I interviewed housekeeper Marshae Slappy whose statements were consistent with Ms. Virk. I interviewed Resident A who stated she occasionally observed housekeeping cleaning the bathroom and thought cleaning could be done more often. I interviewed Resident B who stated her room was cleaned. I interviewed Resident C who stated housekeeping regularly cleaned his room. I observed 10 resident rooms which appeared clean including the floor area, kitchen areas, bathrooms and resident beds were made.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Staff and resident interviews along with observations revealed it was reasonable to assume residents' rooms were cleaned regularly, thus this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 3/14/2022, I shared the findings of this report with authorized representative Shahid Imran. Mr. Imran verbalized understanding of the findings.

IV. RECOMMENDATION

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

3/7/2022

Jessica Rogers Date
Licensing Staff

Approved By:

03/09/2022

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