GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 13, 2022

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

RE: License #: AH500401685
Investigation #: 2022A1027062
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) 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 #:	2022A1027062
Complaint Receipt Date:	05/20/2022
Investigation Initiation Date:	05/23/2022
Report Due Date:	07/19/2022
Licensee Name:	Hampton Manor of Clinton, LLC
Licensee Address:	18401 15 Mile Road Clinton Township, MI 48038
Licensee Telephone #:	(734) 673-3130
Administrator/Authorized Representative:	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:	04/12/2022
Expiration Date:	04/11/2023
Capacity:	101
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A had not received showers since March 2022.	Yes
Resident A had untreated wounds. Resident A did not receive two-hour checks at night.	No
Resident A's medications were not given as prescribed.	Yes
Resident A had a fall with injury.	Yes
Staff were not trained to use hoyer lifts or gait belts.	No
Additional Findings	Yes

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

III. METHODOLOGY

05/20/2022	Special Investigation Intake 2022A1027062
05/23/2022	Special Investigation Initiated - Letter Email sent to AR/Administrator Shahid Imran requesting a resident roster and employee list
06/01/2022	Inspection Completed On-site
06/07/2022	Contact - Document Sent Email sent to business office manager Nayab Virk regarding home care documentation requested at on-site inspection.
06/07/2022	Contact - Telephone call made Message left with facility receptionist for Nayab Virk
06/07/2022	Contact - Telephone call received Call received from Ms. Virk who plans email home care documentation today
06/07/2022	Contact - Document Received

	Email received from Ms. Virk with requested documentation
06/13/2022	Contact - Document Sent Email sent to Ms. Virk requesting home care nursing notes
06/14/2022	Contact – Telephone call made Telephone call made to Ms. Virk to request home care nursing notes
06/14/2022	Contact – Telephone call made Voicemail left with Employee #2
06/14/2022	Contact – Telephone call made Telephone interview conducted with Employee #3
06/14/2022	Contact – Telephone call received Telephone interview conducted with Employee #2
06/15/2022	Contact – Document Received Email received from Ms. Morris with requested documentation
06/16/2022	Contact – Telephone call made Telephone call conducted with director of compliance Sarah Gerrity at Optimal Home Care to request nursing documentation
06/16/2022	Contact – Document Sent Email sent to Ms. Gerrity to request nursing documentation
06/20/2022	Contact – Document Received Email received from Ms. Gerrity with requested nursing documentation
06/21/2022	Investigation Complete BCAL Sub Compliance
07/20/2022	Exit Conference Conducted with authorized representative Shahid Imran briefly by telephone then by email

ALLEGATION:

Resident A had not received showers since March 2022.

INVESTIGATION:

On 5/20/2022, the department was forwarded a complaint through the online complaint system which read Resident A had not received a shower since March 2022, after returning to the facility from the hospital.

On 6/1/2022, I conducted an on-site inspection at the facility. I interviewed business office manager Nayab Virk who stated Resident A's family had moved her out of the facility on 5/31/2022.

While on-site, I interviewed the resident care coordinator Employee #1 who stated Resident A had declined since she had moved into the facility. Employee #1 stated prior to moving out, Resident A had required three-person assist because she was not able to bear weight on her legs. Employee #1 stated the home care therapist recommended switching her from showers to bed baths for safety.

I reviewed Resident A's face sheet which read she admitted to the memory care unit and did not specify her move in date.

I reviewed Resident A's service plan which read Resident A required moderate assistance daily and required an assist to/from the shower.

I reviewed Resident A's April and May 2022 shower day skin assessments which read she had received bed baths on 4/13/2022, 4/15/2022, 4/19/2022, 4/21/2022, 5/1/2022, 5/4/2022, 5/7/2022, 5/10/2022, 5/16/2022.

I reviewed Resident A's activities of daily living (ADL) checklist which read she had received showers on the following additional days 4/14/2022, 4/17/2022, and 4/24/2022.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.

ANALYSIS:	Although review of facility documentation revealed Resident A had received showers, there was lack of documentation demonstrating compliance with this rule from 5/17/2022 through 5/31/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A had untreated wounds. Resident A did not receive two-hour checks at night.

INVESTIGATION:

On 5/20/2022, the department was forwarded a complaint through the online complaint system which read Resident A had “bed sores” and her family bought medication to be applied. The complaint read family was instructed by facility staff that the medication had to come from their pharmacy, and they never got it. Additionally, the complaint read night shift staff did not conduct two-hour checks at night.

On 6/1/2022, I conducted an on-site inspection at the facility. I interviewed the resident care coordinator Employee #1 who stated Resident A had returned from the hospital in April 2022 with a wound on sacral area about the size of a fifty-cent piece. Employee #1 stated Optimal Home Care was ordered at the hospital, then initiated services at the facility in which they educated staff on Resident A’s wound care. Employee #1 stated the home care team ordered for staff to conduct daily (and as needed if the dressing was soiled) wound care by washing the wound, drying it, applying Calmoseptine ointment, then a pad to cover it so it would stay clean, as well as dry. Employee #1 stated Resident A’s wound had not showed signs of infection and had decreased to about the size of dime upon her discharge from the facility. Additionally, Employee #1 stated all caregivers in both memory care and assisted living were to conduct two-hour rounds on every resident. Employee #1 stated there were five memory care residents in the facility in which all their rooms were near the nursing station.

On 6/14/2022, I conducted a telephone interview with memory care medication technician Employee #2 whose statements were consistent with Employee #1. Employee #2 stated Resident A received two-hour checks minimally but often more frequently, as well as wound care minimally daily and as needed.

On 6/14/2022, I conducted a telephone interview with facility nurse Employee #3 who stated she had not assessed Resident A’s wound.

I reviewed Resident A's April and May 2022 medication administration records (MARs) which read Calmoseptine ointment, apply to affected area four times daily as needed.

I reviewed home care nursing note from Optimal Home Care staff dated 4/10/2022 and titled start of care which read Resident A had no changes to her skin integrity but was at risk for skin breakdown due to sedentary lifestyle and impaired mobility. The note read Resident A had no pressure ulcers/injuries. Nursing note dated 5/16/2022 read Resident A had a sacral pressure in which the onset date was 4/19/2022 and a new pressure injury noted to her left heel on 5/16/2022. The note read consistent with statements from Employee #1 regarding Resident A's sacral wound care. Additionally, the note read to wash the new left heel wound with soap and water, then apply skin prep to the entire heel. The note read facility staff were to complete the wound care daily between skilled nursing visits. The note dated 5/25/2022 read Resident A's wounds were improving.

I reviewed a handwritten home care note provided by Ms. Virk from Optimal Home Care staff dated 5/27/2022 which read wound care was completed, Resident A's daughter was present for the visit, there was improvement but plan to extend home care services for transition.

I reviewed the shower day skin assessments from May 2022 which read Resident A had a wound.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Review of facility documentation as well as staff attestations revealed the facility provided care consistent with her service plan. Review of Optimal home care notes revealed staff provided care and treatment of Resident A's wounds consistent with their orders, thus this allegation cannot be substantiated. Additionally, there was insufficient evidence to support lack of two-hour checks by facility staff.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's medications were not given as prescribed.

INVESTIGATION:
On 5/20/2022, the department was forwarded a complaint through the online complaint system which read Resident A had continued to receive her Seroquel after the hospital had stopped it.

On 6/1/2022, I conducted an on-site inspection at the facility. I interviewed business office manager Nayab Virk who stated Resident A had been hospitalized for two weeks at the end of March 2022.

While on-site, I interviewed resident care coordinator Employee #1 who stated upon Resident A's return to the facility from her hospitalization, her family kept her discharge paperwork. Employee #1 stated Resident A's family provided the medication changes on the discharge paperwork to her which read that her Seroquel had been discontinued. Employee #1 stated she provided their pharmacy the new medication orders in which the Seroquel was discontinued the same day they were informed of the change from Resident A's family.

I reviewed Resident A's hospital discharge documentation from Henry Ford Health System which read she was hospitalized from 3/28/2022 to 4/8/2022 and was consistent with complaint.

I reviewed Resident A's April 2022 MAR which read Quetiapine (equivalent to: Seroquel) tablet 25 mg, take one tablet by mouth twice a day. The MAR read Seroquel was ordered on 3/8/2022 and stopped on 4/16/2022.

Additionally, Resident A's April 2022 MAR read the following medication doses were not initialed as given on 4/15/2022: Amlodipine, Aspirin, Atorvastatin, Centrum, Cetirizine, Clopidogrel, Docusate, Fish oil, Furosemide, Memantine, Metoprolol, Polyethylene glycol powder, Potassium chloride, Quetiapine, Vitamin C, Vitamin D, and Zinc Chelate. Additionally, the MAR read the following medication doses were not initialed as given Amoxicillin/K Clavulanate and Doxycycline on 4/9/2022 at 8:00 PM, 4/10/2022 at 8:00 AM and 8:00 PM, 4/11/2022 at 8:00 AM, and 4/15/2022 at 8:00 AM.

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:	Review of Resident A's hospital documentation read consistent her MAR which revealed Seroquel was discontinued. There was insufficient evidence to support when the facility was notified of the medication change from Resident A's family. Additionally, review of the April 2022 MAR revealed Resident A 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, there it cannot be confirmed why the medication administration was not completed as scheduled.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Reference: Special Investigation Report (SIR) 2022A1027038 dated 3/7/2022 Corrective Action Plan (CAP) dated 3/21/2022]**

ALLEGATION:

Resident A had a fall with injury.

INVESTIGATION:

On 5/20/2022, the department was forwarded a complaint through the online complaint system which read one staff member lifted Resident A, then she fell on top of the staff member. The complaint read Resident was bruised. The complaint read an x-ray was not ordered for Resident A so her family to had to obtain one.

On 6/1/2022, I conducted an on-site inspection at the facility. I interviewed resident care coordinator Employee #1 who stated she could not recall Resident A having a fall with injury or bruising.

On 6/14/2022, I conducted a telephone interview with memory care medication technician Employee #2 who stated Resident A did not have a fall or a fall with injury.

On 6/14/2022, I conducted a telephone interview with facility nurse Employee #3 whose statements were consistent with Employee #2.

I reviewed an occurrence report dated 4/24/2022 which read Resident A "tilted back in her wheelchair." The report read staff tried to pull put Resident A's legs up and she tilted back in the wheelchair. The report read another staff member assisted to pull Resident A back forward in her seat. The report read there was no injury and Resident A's physician was to evaluate her on 4/26/2022.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(2) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	Review of facility documentation revealed there insufficient evidence to support Resident A had a fall with injury, however review of Resident A's hospital discharge documentation from Henry Ford Health System read she was hospitalized from 3/28/2022 to 4/8/2022 for a diagnosis of an Empyema. Review of the facility's file revealed the department was not notified of Resident A's hospitalization, thus was not in compliance with this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Reference: SIR 2022A1027035 dated 3/7/2022 CAP dated 3/21/2022; SIR 2022A585031 dated 3/11/2022 CAP dated 3/21/2022]**

ALLEGATION:

Staff were not trained to use hoyer lifts or gait belts.

INVESTIGATION:

On 5/20/2022, the department was forwarded a complaint through the online complaint system which read staff were not trained to use hoyer lifts or gait belts.

On 6/1/2022, I conducted an on-site inspection at the facility. I interviewed business office manager Nayab Virk who stated the facility did not currently have any residents requiring a hoyer lift or gait belt for transfers. Ms. Virk stated Resident A had declined since her hospitalization in which her home care physical therapist recommended transfers by hoyer lift in May 2022, but they had not received a physician order nor the equipment. Ms. Virk stated Resident A would be the first resident in the facility to require a hoyer lift and gait belt, so staff would require training to utilize that equipment, however Resident A's family moved her out of the facility prior to discussing the therapy recommendations with her family as well as the need for staff training. Ms. Virk stated if the equipment was ordered by her licensed health care professional, then Resident A's home care agency would provide staff education and training for use of a hoyer lift and gait belt.

While on-site, I interviewed resident care coordinator Employee #1 who statements were consistent with Ms. Virk. Employee #1 stated Resident A had required one person assist prior to her hospitalization in March 2022, however she had declined and prior to her discharge required two to three staff for a stand and pivot transfer to the wheelchair and/or commode.

On 6/14/2022, I conducted a telephone interview with memory care medication technician Employee #2 whose statements were consistent with Employee #1 and staff did not utilize a gait belt or hoyer lift. Employee #2 stated Resident A was no longer able to walk.

On 6/14/2022, I conducted a telephone interview with facility nurse Employee #3 who statements were consistent with Employee #1 and #2.

I reviewed Optimal home care notes which read Resident A started their services on 4/10/2022. Physical therapy note dated 5/6/2022 and titled discharge summary read Resident A had showed some progress with current functional status, however, her goals were only partially met due to continuing decline in patient's overall physical and mental health.

I reviewed Resident A's Optimal Home Care Occupational therapy note dated 5/2/2022 which read approximately six weeks prior, Resident A was able to complete toilet and shower transfers with minimal assist, as well as dressing and grooming. The therapy note read Resident A required a moderate assist for bathing task prior as well. Additionally, the therapy note read Resident A was able to follow one step commands with increased time for decreased following due to decreased processing as well as confusion. Occupation therapy note dated 5/19/2022 read a hoyer lift was recommended to ensure the safety of Resident A and facility staff during transfers. The note read Resident A's daughter agreed and awaiting approval from the facility. The note read due to Resident A's cognitive decline, she was unable to progress further in treatment and her daughter agreed with discharge from therapy.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.**

	(f) Containment of infectious disease and standard precautions. **(g) Medication administration, if applicable.**
ANALYSIS:	Review of Optimal Home Care documentation, as well as facility staff attestations revealed Resident A had declined since her hospitalization in which a hoyer lift and gait belt were recommended, however, Resident A discharged from the facility. Thus, this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A's face sheet lacked her date of admission, date of discharge, reason for discharge and place of discharge, if known, as well as her licensed health care professional's address and telephone number.

APPLICABLE RULE	
R 325.1942	**Resident records.**
	(3) The resident record shall include at least all of the following: **(d) Date of admission.** **(e) Date of discharge, reason for discharge, and place to which resident was discharged, if known.** **(g) Name, address, and telephone number of resident's licensed health care professional.**
ANALYSIS:	Review of Resident A's records revealed the facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/20/2022, I shared the findings of this report with authorized representative Shahid Imran briefly by telephone then by email.

IV. RECOMMENDATION

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

6/22/2022

Jessica Rogers Date
Licensing Staff

Approved By:

07/20/2022

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