GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 6, 2022

Shahid Imran
Hampton Manor of Woodhaven LLC
7560 River Rd
Flushing, MI 48433

RE: License #: AH820402181
Investigation #: 2022A1027088
Hampton Manor of Woodhaven

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 licensee 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 #:	AH820402181
Investigation #:	2022A1027088
Complaint Receipt Date:	08/29/2022
Investigation Initiation Date:	08/31/2022
Report Due Date:	10/28/2022
Licensee Name:	Hampton Manor of Woodhaven LLC
Licensee Address:	22125 Van Horn Woodhaven, MI 48183
Licensee Telephone #:	(734) 673-3130
Authorized Representative/ Administrator:	Shahid Imran
Name of Facility:	Hampton Manor of Woodhaven
Facility Address:	22125 Van Horn Woodhaven, MI 48183
Facility Telephone #:	(734) 673-3130
Original Issuance Date:	06/25/2021
License Status:	REGULAR
Effective Date:	12/25/2021
Expiration Date:	12/24/2022
Capacity:	113
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was neglected.	No
Additional Findings	Yes

III. METHODOLOGY

08/29/2022	Special Investigation Intake 2022A1027088
08/31/2022	Special Investigation Initiated - Letter Email sent to Mr. Imran requesting a resident census
08/31/2022	Contact - Document Received Email received with requested documentation
09/23/2022	Inspection Completed On-site
10/06/2022	Inspection Completed-BCAL Sub. Compliance
11/18/2022	Exit Conference Conducted with authorized representative Shahid Imran by voicemail

ALLEGATION:

Resident A was neglected.

INVESTIGATION:

On 8/29/2022, the department received a complaint referred from Adult Protective Services (APS) in which APS did not open an investigation for the allegations. The complaint read Resident A had resided at the facility for seven months and had dementia. The complaint read staff were not bathing Resident A and neglected her. The complaint read the facility contacted Resident A's family to help provide care.

On 9/23/2022, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated Resident A had moved into the assisted living at facility in the beginning of the year. Employee #1 stated Resident A had demonstrated behaviors such as blocking herself in her room and declining showers shortly after admission. Employee #1 stated Resident A transitioned to their Memory Care once

the behaviors were identified in which she continued to decline showers and medications, as well as became aggressive with staff and other residents. Employee #1 stated the facility and regional nurse met with Resident A's family regarding her behaviors. Employee #1 stated a 30-day discharge notice was provided to Resident A's family. Employee #1 stated Resident A's family moved her out of the facility last week.

While on-site, I interviewed Employee #2 whose statements were consistent with Employee #1. Employee #2 stated Resident A was combative when she initially moved into the assisted living in which her behaviors became worse, then she transitioned to memory care. Employee #2 stated Resident A's showers were supposed to be twice weekly on Wednesdays and Fridays, however Resident A would refuse her showers after multiple attempts from staff throughout the day and week. Employee #2 stated staff attempted various ways to have Resident A shower such as redirection, asking different times of the day, having different staff assist, offering her snacks/blankets afterward the shower and providing her reassurance. Employee #2 stated eventually Resident A became "smelly" and ultimately had to request assistance from her family. Additionally, Employee #2 stated Resident A had refused physician visits. Employee #2 stated Resident A had become combative as well, attempting to harm residents, her family, and staff. Employee #2 stated Resident A would wander into other residents' rooms, lay in their bed and/or become aggressive with them. Employee #2 stated other residents were fearful of Resident A in which one resident's family moved a resident out of the facility due to her fears of Resident A. Employee #2 stated staff had multiple meetings with Resident A's family to discuss her behaviors had increased and her needs could not be met.

While on-site, I interviewed Employee #3 whose statements were consistent with previous staff interviews. Employee #3 stated Resident A became physically aggressive when providing her medications. Employee #3 stated the physician wrote an order in which staff could administer her medications throughout the day such from 8:00 AM to 8:00 PM because they were unable to administer them. Employee #3 stated staff reached out to family for assistance with both administration of medications and showers, however Resident A would sometimes decline her family's assistance as well. Employee #3 stated staff conducted shift change meetings in which they would report if Resident A's showers were completed or not, so the next shift could attempt.

I reviewed Resident A's face sheet which read she admitted to the facility on 1/17/2022 and discharged on 9/14/2022.

I reviewed Resident A's service plan dated 7/12/2022 which read Resident A's diagnosis' included Alzheimer's disease with early onset, anxiety disorder, unspecified Major Depressive Disorder, Unspecified Gastro-Esophageal Reflux Disease with Esophagitis, Essential (Primary) Hypertension. The plan read "Resident is non compliant [sp] with all ADLs, can become agitated with redirection."

The plan read “Resident continues with current plan of care, continues with aggressive behaviors. Continues to refuse care with redirection.”

I reviewed an incident report dated 8/12/2022 sent to the department which read

> *Staff was called to resident [sp] room. 508, observed resident from 501 was in bed with 508, 508 was upset crying. Staff attempted to get 501 to get out of bed and leave room. Resident became aggressive with staff and resident. Staff was able to remove resident from room.*

I reviewed Resident A’s Occurrence Reports dated from 6/25/2022 through 8/27/2022 which read consistent with staff interviews. The occurrence reports read in part Resident A had behavioral occurrences such as hitting while staff were trying to administer medications or provide showers.

I reviewed a letter addressed to the facility from Laura May Struble, NP from Michigan Medicine dated 7/7/2022 which read in part

> *If patient does not take morning medications please keep trying throughout the day, and do not stop trying.*
> *It is OK she has these medication [sp] close to evening medications of Tylenol and gabapentin*
> *-Risperdal 0.5 mg*
> *-Aricept (donepezil) 10 mg*
> *-Zoloft (sertraline) 150 mg*
> *-Gabapentin 100 mg*
> *-Tylenol 500 mg*

I reviewed Resident A’s shower/linen checklist dated 6/11/2022 through 9/14/2022 which read in part Resident A had refused showers on the following dates: 6/11/2022, 6/22/2022, 7/6/2022, 7/9/2022, 7/23/2022, 7/27/2022, 7/30/2022, 8/13/2022, 8/18/2022, 8/27/2022, 8/31/2022, 9/10/2022. The checklist read in part staff attempted three times for showering.

I reviewed Resident A’s skin monitoring forms dated 7/2/2022 through 9/14/2022 which read consistent with some dates on the shower/linen checklist. The forms read Resident A had refused showers on the following additional dates 7/2/2022, 7/10/2022, and 8/10/2022 The forms read staff had attempted three times for showering.

I reviewed Resident A’s July 2022 and August 2022 medication administration records (MARs) which read consistent with staff interviews.

I reviewed the 7/17/2022 through 8/20/2022 staff communication notes for Resident A which read consistent with staff interviews. Note dated 7/20/2022 read in part Resident A’s had refused her medications, however she took them after her son

visited. Note dated 7/22/2022 read Resident A took her medications and her husband was planning to try to assist with a shower and clean clothing.

I reviewed the discharge letter addressed to Resident A's family dated 5/17/2022 which read in part the reason for discharge was *refusal of all care/bathing, medication, combative behavior with staff and other residents*.

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:	Staff attestations and review of facility documentation revealed Resident A had behaviors in which she declined assistance with care and was combative. The records revealed staff attempted to provide protection and safety with transitioning to memory care, as well as provide care consistent with her service plan. Additionally, staff sought different methods to provide care to Resident A to ensure her needs were met. Based on this information, these allegations were not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's July and August 2022 MARs revealed Resident A missed one or more doses of scheduled medication following dates: 7/3/2022, 7/10/2022, 8/1/2022, and 8/6/2022.

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:	Review of the MARs revealed staff initialed Resident A's medications as administered or read reasons why the medications were not administered. The MARs were left blank for at least one medication/dose for the previously stated dates, and it could not be verified why the medications were not administered or missed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/06/2022

Jessica Rogers Date
Licensing Staff

Approved By:

11/17/2022

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