STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

March 15, 2023

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

RE: License #: AH500401685
Investigation #: 2022A1022020
Hampton Manor of Clinton

Dear Shahid 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.
- 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.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500401685
Investigation #:	2022A1022020
Complaint Receipt Date:	08/16/2022
Investigation Initiation Date:	08/16/2022
Report Due Date:	10/15/2022
Licensee Name:	Hampton Manor of Clinton, LLC
Licensee Address:	18401 15 Mile Road Clinton Township, MI 48038
Licensee Telephone #:	(734) 673-3130
Administrator:	Nayab Virk
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

The complainant identified a number of concerns that are not related to or addressed in licensing rules and statutes for a home for the aged, including medical direction, and presence of licensed nurses in the facility. 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.

	Violation Established?
The facility did not provide the Resident of Concern (ROC) with reasonable actions to ensure her health and well-being as she was dropped during transfers, did not receive treatment for intestinal bleeding or for a fungal infection of her toe.	No
The facility did not have adequate staff to assist the residents.	Yes
The facility put “conditions” on releasing the ROC’s medications when the ROC was moved out of the facility.	No
Additional Finding	Yes

III. METHODOLOGY

08/16/2022	Special Investigation Intake 2022A1022020
08/16/2022	Special Investigation Initiated - Letter Email request for information sent to the facility
08/31/2022	Contact - Document Sent Complainant contacted by email.
08/31/2022	Inspection Completed On-site
09/08/2022	Contact - Telephone call made Spoke with the original complainant and two additional family members by phone.
01/04/2023	Contact - Document Received Received response to additional questions from the regional director
03/15/2023	Exit Conference

ALLEGATION:

The facility did not provide the Resident of Concern (ROC) with reasonable actions to ensure her health and well-being as she was dropped during transfers, did not receive treatment for intestinal bleeding or for a fungal infection of her toe.

INVESTIGATION:

On 8/12/2022, the Bureau of Community and Health Systems received a referral from Adult Protective Services (APS) that had initially been received from the family of the Resident of Concern (ROC); however, the only contact information supplied by the family was a phone number that did not work. APS "denied" the investigation.

According to the APS referral, "Staff members dropped [name of the Resident of Concern (ROC)] before. A week later, she was weak and stated that she could not walk. They did not hold onto her and she fell, causing her to hit her knee on the bedpost. On 7/19/22, [name of the ROC]'s husband, [family member #1], requested an x-ray for [name of the ROC]'s feet and ankle. Her left ankle was swollen, and it is fused together from a previous accident. [Name of the ROC] had a toe fungal infection, and her right foot was swollen. On 7/30/22, [name of the ROC] was bleeding from her rectum, as her colon had been perforated causing her to bleed. The staff called [name of the ROC]'s stepson, [name of complainant], at 2 AM and stated that [name of the ROC] had blood in her stool. They didn't know what was really going on."

On 8/31/2022, during the onsite visit, I interviewed the corporate regional director and the facility executive director. When asked about the ROC, the regional director described the ROC as needing physical assistance for many activities of daily living, but able to make decisions on her own. She went on to say the ROC was known to refuse care and had behavioral issues, including being aggressive with staff.

According to her assessment dated 1/20/2022 and amended 6/22/2022, the ROC needed the assistance of staff for ambulation on a regular basis due to physical needs or confusion, was at risk for falls, needed physical assistance for transfers on a regular basis, and was unable to stand more than 2 minutes at a time. Additionally, the ROC needed physical assistance for grooming; physical assistance for dressing; and physical assistance for continence management. She assessed as being able to being able to identify her own health/wellness needs and would receive monthly wellness checks only. However, her service plan reflected that she needed only moderate assistance for personal hygiene, required a care giver to assist to and from showers, that she required hands-on assist to get out of bed or into a chair; needed some hands-on assistance for occasional incontinence; and had no behavior problems. Further the ROC was at risk for falls and care staff had been instructed to check on her every 2 hours during rounds and to respond when she pressed the button on her pendant. The only medical condition noted in her service

plan was hypertension. According to the ROC's health record, she was seen for a by the resident care coordinator for wellness checks on both 6/16/2022 and 7/15/2022. At the time of the June wellness check, the ROC stated that she was in pain. The resident care coordinator documented that the ROC was "on scheduled medication for pain as well as antibiotic for ankle." There were no additional details in the wellness note. At the time of the July wellness check, the resident care coordinator documented "There is no change in resident condition…Resident is on schedule pain medication and antibiotic for current health conditions. Resident states that she is feeling well…"

When the regional director and the executive director were asked about the ROC being "dropped" during a transfer, they offered the following Occurrence Reports:

- On 6/18/2022, the care giver documented "While showering resident she hit and screamed at staff. She made false accusations that staff hurt her. Her husband accompanied her for the shower… Resident care coordinator assessed residents no injuries or bruises."
- Also, on 6/18/2022, "Resident yelled and screamed while being showered. She expressed that she doesn't like to shower she is already clean. Resident made false accusations that staff hurt her doing the shower. Upon assessment, no injuries or bruises."
- On 7/23/2022, "While showering resident she was yelling and screaming. Calling staff names, showing inappropriate behavior. Resident stated false accusations that she hurt her leg. Upon assessment no injuries."
- On 7/26/2022, the care giver described the occurrence as "While putting [name of the ROC] on her bed after toileting her she fell back dramatically, and she hit her leg/knee. Husband was present during the issue."

When asked about the ROC "bleeding from her rectum," the regional director and the executive director provided an incident report dated 7/31/2023, that read, "During rounds staff notice resident is bleeding (illegible word) brief. Upon checking resident had bloody brief… Called EMS (emergency medical services)."

The facility further provided the ROC's "Hospital Stay Details," from the resulting hospitalization 7/31/2022 through 8/2/2022. According to this document, the reason for the hospital admission was "Blood in Stool," with additional diagnoses that included constipation and an ulcer of the toe of the right foot. During this hospitalization, the ROC was started on Senokot-S for constipation and was instructed to change how she was taking Miralax, also for constipation. Additionally, the ROC was started on two antibiotics, Ceftin and Flagyl. This document did not indicate if the antibiotics were prescribed only for the right toe ulceration or if they were used to treat other conditions as well.

According to the regional director, physician notes from the facility's physician were not available.

On 9/8/2022, I interviewed the complainant and two additional family members by phone. The complainant reiterated that the ROC had intestinal bleeding due to constipation. The complainant further alleged that the ROC had complained to staff that she was constipated and asked for treatment.

Because the ROC had been assessed to have the ability to self-administer her own medications neither the June nor the July medication administration records (MARs) had complete documentation, but they did indicate that the facility's physician had ordered a course of antibiotic from 6/10/2022 through 6/20/2022 and 6/28/2022 through 7/12/2022. Because the physician's notes were not available, it was not clear why the physician had ordered the medications. There was no evidence from the MARs if the ROC had been prescribed any medications for constipation.

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: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	There was no evidence that the facility did not take reasonable actions to ensure the ROC's health and safety. While the ROC did need assistance for transfers, there was no evidence that staff had "dropped" her. She was able to identify her own health/wellness needs but did not communicate concerns about her toe or of constipation to the resident care coordinator.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not have adequate staff to assist the residents.

INVESTIGATION:

According to the APS referral, “The caregivers there have multiple people to help, but they are always understaffed. There is one person behind a desk at night, one person on the floor throughout the entirety of the facility.”

At the time of the onsite visit, the regional director was asked to describe optimal staffing for the facility. According to the regional director, care staff employees worked 8-hour shifts with separate assignments for both the general assisted living unit and the memory care unit. At the time of the onsite visit, there were 21 residents living in the general assisted living unit and 6 residents in the memory care unit. For the AM and the PM shifts, staffing was usually 3 or 4 total caregivers with 1 caregiver assigned to the memory care unit and either 2 or 3 in the general assisted living unit. For the overnight shift, optimal staffing was described as 3 total, with 1 in the memory care unit and 2 in the general assisted living unit.

A review of facility staffing for the week 8/14/2022 through 8/27/2022 revealed that for the AM shift on Monday, 8/15/2022, there were only 2 caregivers present in the building, 1 on the general assisted living unit and 1 on the memory care unit. For the remainder of the week, there were 3 caregivers present for the AM shift. For the PM shift, there were at least 3 caregivers present each day of the week. On 2 days, there was an additional caregiver who worked the second half of the shift. For the overnight shift, there were only 2 caregivers present in the building on Sunday, 8/14/2022, on Monday, 8/15/2022, and on Saturday, 8/20/2022. On those days with only 2 caregivers, the schedule indicated that the resident care coordinator was “on-call.” For the overnight shift for all other dates, there were 3 caregivers present.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.

ANALYSIS:	During the week that was randomly chosen for staffing review, for approximately 27 residents, there were only 2 caregivers in the building for 4 total shifts. This did not meet the facility's stated optimal staffing level. For the AM shift on Monday, 8/15/2022, this appeared to be due to an employee "call-off" and not concerning because it occurred during business hours and there would be plenty of managers and staff who were not caregivers in the building, but for the overnight shifts, with only 2 employees in the building, it is questionable that an emergency situation could be properly handled.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility put "conditions" on releasing the ROC's medications when the ROC was moved out of the facility.

INVESTIGATION:

According to the APS referral, "[Name of the ROC]'s family moved her into a new facility on 8/11/22. Hampton Manor would not release her medication when she was moved."

At the time of the onsite visit, the regional director explained that if a resident leaves the facility, any remaining medications are available for the resident or resident family member to take with them; if medications are not picked up within a reasonable time, the medications go back to the pharmacy. When asked specifically about the ROC, the regional director provided the facility's In House Notes with documentation dated 8/11/2022, written by the facility's resident care coordinator that read "[Name of ROC] family came in the morning and took [name of the ROC] things out of the facility. Family did not notify staff or managers they are taking her out of the facility. Family requested [name of the ROC]'s medication and I (resident care coordinator) told them I will have it ready. Family told me they will return back within 1 hr (hour) to pick up the medication and never showed up. I called them and still no show."

On 9/8/2022, when the complainant was interviewed by phone, the complainant clarified this initial allegation. After the family decided to move the ROC out of the facility and began packing up her belongings from her room, they asked for her medications. The complainant went on to say that they were told that the facility needed to complete their medication inventory and the medications would be ready for pick-up. They waited at least 10 minutes, but the medications were not ready, and the family requested that the facility call one of them when they were ready. The complainant then stated after calling several times, the corporate regional director

"gave a bunch of conditions" for the release of the medications including the settlement of the ROC's bill as well as signing a statement that the family would not file a complaint with the State of Michigan.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(4) If a resident requires medication while out of the home, then the home shall assure that the resident, or the person who assumes responsibility for the resident, has all of the appropriate information, medication, and instructions.
ANALYSIS:	There is no evidence that that the facility would not release the ROC's medications after her family moved her out of the building.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

According to the APS referral, "The in-house doctor at Hampton Manor is Dr. [name of physician #1], MD. There is a concern that Dr. [name of physician #1] and the staff members at Hampton Manor neglected [name of the ROC]." The referral made clear that the ROC's family had not chosen physician #1 to be the ROC's health care provider and that this was the option offered to the family by the facility.

When the regional director was asked to provide physician #1's notes on the ROC, the regional director via email replied, "Dr. [name of physician #1] is 3rd party, we do not have her documentation. Family has to get it from the doctor directly."

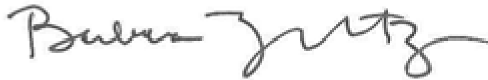
APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.**
	(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations

	made, treatments provided, and in the case of a hospital, the purpose of hospitalization.
ANALYSIS:	Physician #1 was the option offered to the family for the medical care of the ROC. The facility did not keep the record of Physician #1's examinations and observations.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the corporate regional director on 03/15/2023. When asked if there were any comments or concerns with the investigation, the corporate regional director stated that there were none.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.


03/15/2023

Barbara Zabitz　　　　Date
Licensing Staff

Approved By:

03/09/2023

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