STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

May 25, 2023

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

RE: License #: AH500401685
Investigation #: 2023A0585010
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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500401685
Investigation #:	2023A0585010
Complaint Receipt Date:	11/03/2022
Investigation Initiation Date:	11/07/2022
Report Due Date:	01/03/2023
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 #:	(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)

	Violation Established?
Resident A left the facility by herself without anyone knowing she was out of the facility.	Yes
Additional Findings	No

III. METHODOLOGY

11/03/2022	Special Investigation Intake 2023A0585010
11/03/2022	APS Referral Referral made to Adult Protective Services (APS).
11/07/2022	Special Investigation Initiated – On site.
11/07/2022	Inspection Completed On-site Completed with observation, interview and record review.
05/25/2023	Exit Emailed report with violation to authorized representative Shahid Imran.

ALLEGATION:

Resident A left the facility without anyone knowing she was out of the facility.

INVESTIGATION:

An incident report was received from the facility on 10/28/2022. The incident report read, “On 10/28/2022 at 7:15 p.m., as staff was on regular round, they noticed Resident [A] missing. As staff was looking for her, family came in and brought resident in. Family notified us that 911 called POA that someone found resident on the side path five minutes away from building.” The incident report read, “15-30-minute checks; process to move resident to memory care. Service plan updated. Resident will be put in memory care.”

On 11/7/2022, an onsite was completed at the facility. I interviewed business manager Nayab Virk at the facility. Ms. Virk stated that Resident A was checked on every hour. She stated that Resident A walks around the facility throughout the day. She stated that Resident A went out the main door at the front. She stated that a receptionist is not there at night and resident was able to walk out the front door. Ms. Virk explained that there are two staff in the morning, afternoon, and midnight shift. She stated that a nurse is also available to assist with residents' care.

During the onsite, I interviewed nurse Patricia Conner at the facility. Ms. Connor stated that Resident A has sundowners and they have asked the family to consider memory care. Ms. Connor stated that Resident A walks on her own and was able to leave out the door.

On 11/7/2022, I interviewed Relative A1 by telephone. Relative A1 stated that the police called him and said that Resident A was found a half mile down the road from the facility. He stated that Resident A apparently walked out of the door. He stated that facility don't have an alarm on the door and Resident A was able to just walk right out the door. He stated that he was told that a couple saw Resident A who had fallen, and they called the police. He stated that once he got to Resident A, he took her back to the facility where he was met with two attendants who was on their way to look for Resident A.

Attempts were made to contact the two staff on duty at the time of the incident. As of the date of this report, no return calls have been received and when I call back, the numbers were no longer in service. Therefore, no additional information was obtained.

The service plan for Resident A read, "Resident requires one person physically assistance for mobility due to weakness. Resident uses wheelchair and walker at times but is only able to ambulate approximately 15-20 feet before becoming fatigue. Resident is able to self-propel for short distances, uses feet while in wheelchair for moving. Resident requires frequent monitoring while in wheelchair. Requires physical assist with transfer due to weakness and unsteady gait. Fall risk."

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.

R 325.1901	**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 supervisor, 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.
	(21) “Service plan” means a written statement prepared by the home in cooperation with a resident and/or the resident’s authorized representative or agency responsible for a resident[s placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident’s physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Resident A was able to leave out the front door of the facility without supervision. Resident A was found a half mile from the facility by a passerby after she had fallen. The passerby contacted the police who called Resident A’s POA. The service plan did not adequately show how often Resident A should be monitored. The plan revealed that Resident A should have assistance when transferring and should have physical assistance when ambulating due to weakness. Resident A did not have assistance when ambulating as evidence of her leaving the facility. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/25/2023

Brender Howard Date
Licensing Staff

Approved By:

05/25/2023

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