GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

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

June 7, 2023

RE: License #: AH580402179
Investigation #: 2022A1022032
Hampton Manor of Bedford

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 #:	AH580402179
Investigation #:	2022A1022032
Complaint Receipt Date:	09/15/2022
Investigation Initiation Date:	09/16/2022
Report Due Date:	11/15/2022
Licensee Name:	Hampton Manor of Bedford LLC
Licensee Address:	3099 W Sterns Rd Lambertville, MI 48182
Licensee Telephone #:	(989) 971-9610
Administrator:	Jennifer Booth
Authorized Representative:	Shahid Imran
Name of Facility:	Hampton Manor of Bedford
Facility Address:	3099 W Sterns Rd Lambertville, MI 48182
Facility Telephone #:	(734) 807-5800
Original Issuance Date:	04/09/2021
License **Status:**	REGULAR
Effective Date:	10/09/2021
Expiration Date:	10/08/2022
Capacity:	114
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The care staff do not respect the privacy of residents.	Yes
The care staff do not provide residents with good incontinence care resulting in skin redness and broken skin.	No
Care staff did not know the whereabouts of Resident B, who lived in the memory care unit.	No
Care staff do not identify whether or not residents have bowel movements.	No
The facility uses food service-grade gloves to provide resident care.	No
The facility has bed bugs.	No
The cushioned furniture pieces in the Memory Care (MC) unit are saturated with urine.	No
The care staff do not know how to use a mechanical lift.	No

III. METHODOLOGY

09/15/2022	Special Investigation Intake 2022A1022032
09/16/2022	Special Investigation Initiated - Telephone No answer. Left message for complainant to contact me. A second message sent by email.
09/20/2022	Contact - Telephone call made Spoke to complainant by phone
10/25/2022	APS Referral
10/25/2022	Inspection Completed On-site
06/07/2023	Exit Conference

ALLEGATION:

The care staff do not respect the privacy of residents.

INVESTIGATION:

On 9/13/2022, the Bureau of Community and Health Systems (BCHS) received a written complaint that in part read, “I (complainant) personally witnessed a female resident undressed & changed in a main living area while other residents were present, including male residents. 8/9/22. [Name of caregiver #1], Second shift supervisor, med tech, didn’t respect privacy of resident [name of Resident A].”

On 9/20/2022, I interviewed the complainant by phone. The complainant reiterated her written complaint and clarified that she had very briefly been employed as a caregiver at the facility.

On 10/25/2022, a referral was made to Adult Protective Services.

At the time of the onsite visit, 10/25/2022, I interviewed both the director of operations and the wellness director. The director of operations stated that this breach of Resident A’s privacy had been brought to her attention and had been addressed. The wellness director further explained that this incident had occurred at the change of shift and both caregiver #1 and caregiver #2 were involved with the decision to provide incontinence care to Resident A in the memory care common area, but that the facility only had written documentation that caregiver #2 had received counseling. The wellness director went on to say that caregiver #2 had displayed a number of problematic behaviors in carrying out her duties and the incident with Resident A was one of several that resulted in a demotion for caregiver #2. The wellness director provided a “Performance Improvement Plan,” dated 8/8/2022, for caregiver #2, in which “changing a resident in common area” was listed as a detail of the occurrence/reasons for her demotion as well as was “employee left cart unattended,” “did not count off narcs (narcotics),” “did not complete med (medication) pass.”

When asked about caregiver #1, the wellness director acknowledged that there was no written documentation that caregiver #1 was counseled, but stated, “We verbally educated her. We also discussed the situation at our monthly staff meeting with all staff.” The wellness director provided a staff meeting outline dated 8/31/2022, that contained the directive to staff, “You cannot change a resident’s brief in the common area of Memory Care.”

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(d) A patient or resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality.**
ANALYSIS:	Privacy rights of residents were not protected by care staff. Neither caregiver #1 nor caregiver #2, who had both been designated as shift supervisors, seemed to have misgivings about providing incontinence care in a common area. Caregiver #2 was demoted, but the demotion appears to be more closely linked to her failures passing medications. It remains unclear if the facility emphasized the responsibility to protect the privacy of all residents both to caregiver #1 as well as to all staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The care staff do not provide residents with good incontinence care resulting in skin redness and broken skin.

INVESTIGATION:

According to the written complaint, “Several residents have deteriorated skin or sores, especially on their bottoms, due to neglect of care.”

At the time of the onsite visit, accompanied by the wellness director, I made observations of incontinence care for Resident A, Resident B and Resident D. None of these residents showed signs of redness, wetness, or other indications of poor incontinence care. According to their respective service plans, all three of these

residents had total incontinence and needed to be provided checked at least every 2 hours and provided care as needed.

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.**
ANALYSIS:	Observations indicated residents receive appropriate incontinence care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Care staff did not know the whereabouts of Resident B, who lived in the memory care unit.

INVESTIGATION:

According to the written complaint, “Last week 9/9/22, a resident (Resident B) from the Memory Care Unit went missing, family was notified around 3am that staff couldn’t locate the resident. Resident was later found in another resident’s room, asleep in bed with the door locked. 2nd shift stated in report to 3rd shift that said resident was actually out of the facility, said resident hadn’t been checked or seen in over 10 hours!” When interviewed, the complainant stated that Resident B had not been checked on by the care staff for over 10 hours. She eventually was found asleep in another resident’s room.

The director of operations and the wellness director were asked to provide evidence of Resident B’s whereabouts on 9/9/2022. According to Resident B’s ADL records, she was provided incontinence care at 9:45 am, 1:17 pm, 9:25 pm and 2:53 am. Resident B was marked for both the breakfast and the noon meal, at 9:45 am and at 1:17 pm. There was no ADL record for the evening meal. In Resident B’s health record progress notes, for 9/9/2023, all three shifts, first, second and third, caregivers had documented “good day.” According to the medication administration record, Resident B had two scheduled medications on the morning of 9/9/2023 and

both were documented as having been administered. When the director of operations was asked if there was any possibility that Resident B had “been missing” for the alleged time period in September 2022, she said that there was no possibility to her knowledge.

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.**
ANALYSIS:	Documentation indicates that Resident B was monitored on the day she was alleged to be “missing.”
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Care staff do not identify whether or not residents have bowel movements.

INVESTIGATION:

According to the written complaint, “there are fecal-impacted residents.” When interviewed, the complainant alleged that Resident C had a documented fecal impaction and that a second resident, who was not able to be identified “was constipated.”

The facility submitted Resident C’s Activity of Daily Living (ADL) record for September 2022. According to this record, Resident C was monitored for bowel movements at least once daily. The facility also submitted ADL records for Resident A, Resident B and Resident D. There was bowel monitoring for these residents as well.

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.
ANALYSIS:	Documentation indicates that care staff did document bowel movements.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility uses food service-grade gloves to provide resident care.

INVESTIGATION:

According to the written complaint, “The facility is using gloves from Gordon Food Services (dietary and housekeeping supply vendor) to do care on residents. (The complainant) didn’t feel comfortable, (the gloves) not medical grade.” When interviewed, the complainant stated that this practice in her opinion was very poor infection control.

At the time of the onsite visit, the director of operations stated that the vendor, Gordon Food Services was the vendor for all of their housekeeping supplies. The director of operations stated that this issue had been brought to her attention and she had asked the vendor to change the facility’s order so that all the gloves used were “Medical Exam” grade gloves. Observation of the glove supply revealed that the boxes on the shelf were marked “Medical Exam.”

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.**

ANALYSIS:	Observation indicated that gloves in the supply room were appropriate.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility has bed bugs.

INVESTIGATION:

According to the written complaint, the facility "currently has bed bugs specifically located in its Memory Care Unit." When interviewed, the complainant was alarmed that a vendor had used "bed bug sniffing dogs" as a tool to determine bug infestation locations.

At the time of the onsite visit, the director of operations stated that the facility had contracted with a licensed bed bug exterminator, which included the use of "canine inspection." The facility had an infestation of bed bugs in the middle of September 2022, and they "isolated" the affected furniture until the vendor could address the infestation. The director of operations provided invoices dated 9/7/2022, 9/12/2022, 10/3/2022, 10/4/2022, and 10/10/2022 to verify services provided by the vendor.

APPLICABLE RULE	
R 325.1978	**Insect and vermin control.**
	(1) A home shall be kept free from insects and vermin.(2) Pest control procedures shall comply with MCL 324.8301 et seq.
ANALYSIS:	Documentation indicates that the facility took measures to rid the facility of the bugs.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The cushioned furniture pieces in the Memory Care (MC) unit are saturated with urine.

INVESTIGATION:

According to the written complaint, “Residents (who are incontinent) are left sitting in furniture for extended periods of time and go unchanged. The furniture is then soaked with urine and the caregivers spray it with Spray N Shout, change the slipcover and put the cushions back on to be sat on by anyone.” The complainant stated that the cushions of the upholstered furniture in the memory care common area were saturated with urine and visitors, or residents could not sit down without being overwhelmed by the odor.

At the time of the onsite visit, accompanied by the director of wellness, observation of the upholstered furniture in the common area of the memory indicated they were without odor or signs of wetness.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Observation indicates that the furniture was clean and in good condition.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The care staff do not know how to use a mechanical lift.

INVESTIGATION:

According to the written complaint, “No one knows how to use the mechanical lift.” When interviewed, the complainant alleged that there was a hospice resident on the memory care unit who they could not move because no one knew how to transfer him.

At the time of the onsite visit, the director of wellness stated that there was only one resident in the facility who used a mechanical lift, Resident D, and that currently, he was weight-bearing and was not using a lift for transfers. The director of wellness went on to say that the lift was brought in by Resident D’s hospice provider and in-service training on the use of the lift was given on 6/17/2022. The training outline was verified by the physical therapist who provided the training.

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:	Documentation indicates that the facility provided training when Resident D needed to use a mechanical lift.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I reviewed the findings of this investigation with the director of operations on 06/07/2023. When asked if there were any comments or concerns with the investigation, the director of operations stated that there were none.

IV. RECOMMENDATION

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

06/07/2023

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

05/18/2023

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