GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 24, 2024

Shahid Imran
Hampton Manor of Trenton LLC
7560 River Road
Flushing, MI 48433

RE: License #: AH820401687
Investigation #: 2024A1027041
Hampton Manor of Trenton

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 authorized representative 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 877-458-2757.

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 #:	AH820401687
Investigation #:	2024A1027041
Complaint Receipt Date:	03/22/2024
Investigation Initiation Date:	03/22/2024
Report Due Date:	05/21/2024
Licensee Name:	Hampton Manor of Trenton LLC
Licensee Address:	5999 Fort Street Trenton, MI 48183
Licensee Telephone #:	(734) 673-3130
Authorized Representative/ Administrator:	Shahid Imran
Name of Facility:	Hampton Manor of Trenton
Facility Address:	5999 Fort Street Trenton, MI 48183
Facility Telephone #:	(734) 673-3130
Original Issuance Date:	03/09/2023
License Status:	REGULAR
Effective Date:	09/09/2023
Expiration Date:	09/08/2024
Capacity:	120
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

Allegation	**Violation Established?**
Resident A lacked care.	Yes
Resident A did not receive his medications per the licensed healthcare professional's orders.	Yes
Additional Findings	Yes

III. METHODOLOGY

Date	Activity
03/22/2024	Special Investigation Intake 2024A1027041
03/22/2024	Special Investigation Initiated - Letter Email sent to Shahid Imran and Azher Farooq requesting documentation for Resident A
03/29/2024	Contact - Document Received Email received from Azher Farooq with requested documentation
04/02/2024	Contact - Document Sent Emails sent to Azher Farooq requesting the service plan be rescanned and emailed, as well as requested additional documentation
04/05/2024	Contact - Document Received Email received from Azher Farooq with requested documentation
04/09/2024	Inspection Completed-BCAL Sub. Compliance
04/24/2024	Exit Conference Conducted by email with authorized representative Shahid Imran and Azher Farooq

ALLEGATION:

Resident A lacked care.

INVESTIGATION:

On 3/22/2024, the Department received a complaint which read Resident A resided at the facility from October 2023 until his death on January 17, 2024. The complaint read Resident A had dementia and sometimes would not agree to get out of bed. The complaint alleged Resident A had fallen in November 2023 resulting in a femur fracture and developing a stage 2 pressure ulcer. The complaint alleged staff refused to get him out of bed after his family attempted to counsel staff on how to word their request and the pressure ulcer worsened to stage 4.

The complaint read a ring camera installed in Resident A’s room in which it was observed staff checked on Resident A one or two times during a 7 to 8 hour period.

I reviewed Resident A’s admission contract dated 10/18/2023 which was signed and dated by Relative A.

I reviewed Resident A’s level of care assessment dated 10/18/2023 which read in part he admitted to the memory care and required physical assistance for transfers, bathing, grooming, and toileting. The assessment read in part Resident A could eat independently and was setup only. The assessment read in part Resident A had mild confusion but was generally cooperative. The assessment read in part Resident A required basic level medication assistance, requiring oral medication and administration up to twice daily or nine or less medications.

I reviewed Resident A’s updated level of care assessment dated 11/29/2023 which read in part he required staff assistance regularly due to physical needs or confusion and required staff monitoring for falls daily. The assessment read in part Resident A required staff assist for transfers on a regular basis or required assistance of two staff members. The assessment read in part staff assisted Resident A with bathing, dressing, continence management needs every 1-2 hours, and he resisted care. The assessment read in part Resident A required physical assist with meals. The assessment read in part Resident A had moderate confusion and may have unpredictable behaviors or require moderate emotional support. The assessment read in part Resident A required daily treatments and wound care. The assessment read in part Resident A required complex medication assistance.

I reviewed Resident A’s service plan dated 10/18/2023 which read consistent with the consecutive level of care assessment. The plan read in part resident A received a regular diet. The plan read in part for all staff to ensure that frequent checks were conducted and encourage Resident A to get up for meals. The plan read in part Resident A was a one person assist for transfers and utilized a wheelchair for mobility.

I reviewed Resident A’s service plan dated 11/29/2023 which read in part Resident A required his food to be cut up. The plan read in part to encourage Resident A to get out of bed daily. The plan read in part Resident A required moderate assistance with dressing, personal hygiene, bathing/showering, toileting, incontinence care, and two-person assist to transfer.

I reviewed Resident A’s service plan dated 12/26/2023 in which read consistent with the plan dated 11/29/2023.

I reviewed Resident A’s incident reports:

Report dated 10/25/2023 at 12:15 AM read in part Resident A fell in his room getting up from bed and scraped his right arm. The report read in part staff assisted Resident A off the floor and cleansed and bandaged his wound. The report read in part staff contacted Resident A’s family and they would provide a fall mat.

Report dated 11/1/2023 at 10:10 AM read in part staff were rounding and observed Resident A on the floor. The report read Resident A stated he fell getting out of bed and was trying to go the bathroom. The report read Resident A stated he was in pain and staff called 911. The report read Resident A’s daughter was notified and had obtained an alarm for his bed, as well as ordered a fall mat for next to his bed.

Report dated 12/5/2024 read in part Resident A was in pain from his broken thigh bone, so the medication technician administered an as needed medication for pain; however, he remained in pain and his family wanted him to get up. The report read Resident A declined to get up and the caregiver respected his rights.

Report dated 12/10/2023 read in part staff attempted to wake Resident A up for breakfast, but he refused and exhibited rude behavior towards to staff when they persisted. The report read Resident A’s family expressed concerns to staff regarding Resident A not getting up for breakfast. The report read in part staff discussed the matter with Resident A’s family and they would do the following: document the incident and the family’s concerns in Resident A’s file, monitor Resident A’s behavior and willingness to participate in daily routines, keep open communication with the family ad update them, and review and assess the approach to encouraging resident to attend meals and consider any necessary adjustments.

I reviewed a sign which read:

Attention staff

Please ensure that we are assisting [Resident A] in waking up for breakfast every morning. If he refuses, kindly give him some time and then return to his room to remind him again. If he refuses a second time, a different staff member should approach him with another reminder. If [Resident A] refuses three times, please make sure to call his [Relative A1], and if she is unavailable, then call his, [Relative A2]. Their phone numbers are posted in [Resident A’s] room for your reference. Thank you for your cooperation.

I reviewed Resident A’s October 2023 through January 2024 medication administration records (MARs). The October 2023 through January 2024 MARs read

in part Triad Wound Paste, apply one application topically three times daily. The December 2023 and January 2024 MARs read in part Metronidazole, crush one tablet and sprinkle powder in wounds daily with wound care (start date 12/26/2023) in which staff initialed the medication as administered or documented the reason why it was not administered.

I reviewed the facility’s chart notes from October 2024 through January 2024.

Note dated 10/19/2023 read in part Resident A needed a “bottom dressing.”

Note dated 10/20/2023 read in part Resident A did not want to eat breakfast or wake up.

Note dated 10/23/2023 read in part Resident A had been sleeping all day and staff tried to get him up but he was tired. The note read in part he did not eat breakfast or lunch.

Note dated 10/24/2023 read consistent with Resident A’s incident report dated 10/25/2023.

Note dated 10/28/2023 read in part Resident A fell after coming back from the hospital.

Note dated 12/25/2023 read in part staff informed Resident A’s family his sore was getting worse and might be infected.

Note dated 12/29/2023 read in part Resident A’s nurse visited for his 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.
R 325.1901	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the 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:	Review of Resident A's records revealed he had declined and required more assistance with activities of daily living. The records read Resident A received hospice services. Although review of facility chart notes revealed staff checked on Resident A, review of Resident A's service plans revealed staff were to conduct frequent checks; however, they lacked specification on how often staff were to conduct checks. Additionally, review of Resident A's assessment revealed he required daily treatments and wound care in which was not reflected in his service plan. The service plans lacked specific instructions for staff to provide Resident A's wound care and maintenance nor did the plan specify if the wound care was maintained by his hospice nurse, as well as when to notify hospice nurse if there were changes or concerns. Furthermore, the MAR lacked specific instructions indicating where to apply the Triad Wound Paste. Therefore, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive his medications per the licensed healthcare professional's orders.

INVESTIGATION:

On 3/22/2024, the Department received a complaint which alleged staff did not provide his scheduled doses of pain medication overnight and as needed. The complaint alleged Resident A demonstrated non-verbal signs of pain such as grunting, groaning, grimacing, and tension in his hands and arms. The complaint read Resident A had a ring camera installed in his room in which it was observed he went nights without his pain medication.

I reviewed Resident A's October, November and December 2023 medication administration records (MARs), as well as the January 2024 MAR. The MARs read staff initialed Resident A's medications as administered per the licensed health care professional's orders or documented reasons medications were not administered, such as the resident refused or was physically unable to take the medication, except in the following instances:

The October 2023 MAR read Triad Wound Paste, apply one application topically three times a day at 9:00 AM, 1:00 PM and 9:00 PM, which started on 10/20/2023; however, the MAR was left blank from 10/21/2023 to 10/23/2023 and staff documented it as administered starting on 10/24/2023 at 9:00 AM. Additionally, on 10/24/2023, the Triad Wound Paste was left blank for the 9:00 PM dose.

The November 2023 MAR read Resident A was out of the facility from 11/2/2023 to 11/3/2023 and from 11/14/2023 to 11/29/2023. The MAR read on 11/6/2023 at 1:00 PM, the dose for Triad Wound Paste was left blank.

> The MAR read Oxycodone, give 5 mL by mouth every 6 hours as needed for severe pain for 3 days (date written 11/3/2023 and stop date 11/6/2023) in which staff initialed the medication as administered twice on 11/4/2023, once on 11/5/2023 and twice on 11/6/2023.

The December 2023 MAR read there were blank spaces for the 1:00 PM doses of Triad Wound Paste on 12/29/2023 and 12/31/2023. The MAR read there were two orders for Acetaminophen 325 mg, take 2 tablets by mouth every 6 hours as needed for mild or moderate pain or take 2 tablets by mouth every 4 hours as needed for pain or fever above 100 degrees. The MAR read there were two doses of as needed Acetaminophen administered for pain on 12/14/2023 and 12/22/2023.

> The MAR read there were two as needed orders written for Oxycodone, give 0.25 mL (5 mg) by mouth every 4 hours or take one tablet (5 mg) by mouth every 4 hours. The MAR read Resident A received one dose of as needed Oxycodone 0.25 mL on 12/31/2023.

The January 2024 MAR read consistent with the December 2023 in which there were two as needed Acetaminophen medication orders, as well as four as needed Oxycodone medication orders in which some of the start and stop dates overlapped.

> The MAR read in part Oxycodone, 0.25 mL (5 mg) by mouth every 6 hours was scheduled from 1/2/2024 through 1/10/2024, then Oxycodone, give 0.25 mL by mouth every 4 hours was scheduled starting 1/10/2024.
>
> The MAR read in part as needed Oxycodone was administered on 1/2/2024, 1/5/2024, 1/6/2024, twice on 1/7/2024, three times on 1/8/2024 and 1/9/2024, and once on 1/10/2024.

I reviewed Resident A’s incident reports:

Report dated 12/26/2023 read in part Resident A had prescribed Oxycodone for pain management, with scheduled doses every six hours and as needed

Oxycodone for breakthrough pain. The report read Resident A's family requested he receive the as needed Oxycodone at a scheduled time each day. The report read staff explained to his family that as needed medications were intended to use when needed and Resident A was unable to communicate his needs, so the team would only administer the as needed Oxycodone if he showed signs of distress or discomfort. The report read staff informed Resident A's family they would need to consult with Resident A's hospice team to change the as needed prescription. The report read staff reached out to Resident A's hospice team to discuss the request and they agreed.

A handwritten note by a staff member dated 1/10/2024 read in part Resident A's family was concerned staff were not administering the as needed Oxycodone. The note read in part Resident A had taken the scheduled Oxycodone every 6 hours; however, his family requested he receive the as needed Oxycodone every 4 hours as well. The note read in part Resident A was sleeping and had not required the as needed medication.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Resident A's MARs read consistent with the complaint in which Oxycodone was prescribed as a scheduled medication in January 2024 and as needed from November 2023 to January 2024. Review of the Resident A's MARs revealed there were various dates in which were left blank in which lacked documentation Triad Wound Paste was administered. Additionally, the MARs lacked specific instructions for the Triad Wound Paste. Furthermore, the MARs lacked specific instructions for administration of as needed pain medications Acetaminophen and Oxycodone. Therefore, a violation was established for this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

Review of Resident A’s assessments and service plans revealed they were updated on 11/29/2023. Additionally, the service plan dated 12/26/2023. The plans lacked evidence that the changes were communicated with his authorized representative.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of Resident A’s updated assessments and service plans revealed they lacked communication of changes with his authorized representative; therefore, a violation was established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

04/09/2024

Jessica Rogers Date
Licensing Staff

Approved By:

04/23/2024

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