GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

July 31, 2024

RE: License #: AH580402179
Investigation #: 2024A1022056
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 #:	2024A1022056
Complaint Receipt Date:	06/17/2024
Investigation Initiation Date:	06/18/2024
Report Due Date:	08/17/2024
Licensee Name:	Hampton Manor of Bedford LLC
Licensee Address:	3099 W Sterns Rd Lambertville, MI 48182
Licensee Telephone #:	(989) 971-9610
Administrator/Authorized Rep	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:	10/09/2023
Expiration Date:	10/08/2024
Capacity:	114
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents do not get timely care because the facility does not have enough staff.	Yes

III. METHODOLOGY

06/17/2024	Special Investigation Intake 2024A1022056
06/18/2024	Special Investigation Initiated - Telephone
06/18/2024	Contact - Telephone call made. Investigation conducted remotely via videoconference.
07/18/2024	Contact - Document Received Email exchange with the wellness director.
07/31/2024	Exit Conference

ALLEGATION:

Residents do not get timely care because the facility does not have enough staff.

INVESTIGATION:

On 06/17/2024, the Bureau of Community and Health Systems (BCHS) received a referral from Adult Protective Services (APS) that read, "…there are 2 caregivers on the floor for 50-60 residents. The referral alleges that have their calls lights on for extended periods of time and have to wait 30-60 minutes for help…" APS did not include any information regarding their referral source.

On 06/18/2024, I interviewed the director of operations and the wellness director, remotely, in a videoconference. According to the director of operations, 8 employees including both caregivers and medication technicians (med techs) were scheduled for both the morning and the afternoon shifts, but only 4 for the overnight shift.

The facility provided their staffing schedule for the week 06/02/2024 through 06/08/2024. Review of these documents revealed that for the morning shift, the facility had either 7 or 8 employees providing care during that week. For the afternoon shift, the facility had 7 employees providing care, except for 06/07/2024, when there were 6 employees there for the entire shift and 1 employee there for part

of the shift. For the midnight shift, the facility was able to staff 4 employees for the week.

The facility also provided the pendent activation log for the same week, 06/02/2024 through 06/08/2024, which allowed me to identify multiple residents who waited an extended amount of time for their call lights to be answered. On 06/02/2024, the pendent activation log documented 12 such occasions; on 06/03/2024 there were 11 occasions; on 06/04/2024 there were 7 occasions; on 06/05/2024 there were 6 occasions; on 06/06/2024 there were11 occasions; on 06/07/2024 there were 12 occasions; and, on 06/08/2024 there were 7 occasions for a total of 66 times in that week.

Four of these residents who experienced longer wait times were as follows:

Resident A had extended wait times on 9 occasions during that week, including waiting more than 1 hour on 06/02/2024 at 5:01 pm and 52 minutes on 06/07/2024 at 6:30 am. According to her service plan, Resident A needed minimal physical assistance with most activities of daily living (ADLs) but required the physical assistance of 1 person to transfer. Once Resident A was in a standing position, she was able to use her walker to walk in her room. She was occasionally incontinence and needed some physical assistance to use the toilet and had been instructed to use her call light when assistance was needed.

Resident B had extended wait times on 3 occasions, including 1 hour on 06/02/2024 at 9:30 pm. According to her service plan, Resident B needed a moderate amount of physical assistance as well as verbal prompting to complete her ADLs. Resident B needed the physical assistance of 1 person for transfers, but once transferred into a wheelchair, she was able to propel herself from place to place. She was incontinent and caregivers were instructed to offer to take her to the toilet once every 2 hours while awake. Resident B also was at risk for falls as she had a history of falls.

Resident C had extended wait times on 10 occasions, including 1 hour and 44 minutes on 06/02/2024, at 9:32 pm, 45 minutes on 06/03/2024 at 3:33 pm, and 49 minutes on 06/06/2024 at 5:10 pm. According to her service plan, Resident C was mainly independent for the completion of her ADLs including toilet use, was able to transfer independently, ambulated using a walker but had been instructed to use her call light to call for assistance when needed.

Resident D had extended wait times on 5 occasions, including 32 minutes on 06/07/2024 at 3:59 pm. According to his service plan, Resident D was also mainly independent for his ADLs, but had some occasional incontinence. Resident D had an ostomy bag and required the caregiver’s assistance whenever the bag needed to be changed. He was a fall risk and had a history of falls. Resident D was instructed to “use call light for assistance.”

On 07/18/2024, via an email exchange with the wellness director, the facility was asked to explain the extended wait times for pendant responses. The wellness director replied, “The call pendant response times indicate when the button was pushed until the time it was reset. Once the call pendant has been pushed, the signal goes to a cell phone that the caregiver carries. The caregiver responds to the call and is supposed to reset the pendant. There are times that the caregivers answer the calls but fail to reset the call pendant. We know this because during the day, [name of the administrator] will remind the caregivers that a call pendant is going off and the staff respond that they forgot to reset the pendant.”

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: **(e) A patient or resident is entitled to receive adequate and appropriate care**
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.
For Reference: R325.1901	**Definitions.**
	(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:	The facility had 66 instances of extended wait times for response to resident call lights during the week evaluated. It does not seem likely that all of the extended wait times can be attributed to caregivers not deactivating the pendant and not to the caregivers' inability to respond to the signal.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the director of operations on 07/31/2024. 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.

07/31/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

07/25/2024

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