GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 28, 2024

Shahid Imran
Hampton Manor of Brighton
1320 Rickett Road
Brighton, MI 48116

RE: License #: AH470412880
Investigation #: 2024A1028067
Hampton Manor of Brighton

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 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH470412880
Investigation #:	2024A1028067
Complaint Receipt Date:	07/11/2024
Investigation Initiation Date:	07/11/2024
Report Due Date:	09/10/2024
Licensee Name:	Brighton Comfort Care, LLC
Licensee Address:	2635 Lapeer Road Auburn Hills, MI 48326
Licensee Telephone #:	(989) 607-0001
Administrator/Authorized Representative:	Shahid Imran
Name of Facility:	Hampton Manor of Brighton
Facility Address:	1320 Rickett Road Brighton, MI 48116
Facility Telephone #:	(810) 247-8442
Original Issuance Date:	04/10/2023
License Status:	REGULAR
Effective Date:	10/10/2023
Expiration Date:	10/09/2024
Capacity:	93
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff do not provide medication administration in accordance with the service plan.	Yes
Additional Findings	No

III. METHODOLOGY

07/11/2024	Special Investigation Intake 2024A1028067
07/11/2024	Special Investigation Initiated - Letter
07/11/2024	APS Referral
07/23/2024	Contact - Face to Face Interviewed acting admin/Holly Kozma at the facility.
07/23/2024	Contact - Face to Face Interviewed Employee A at the facility.
07/23/2024	Contact - Face to Face Interviewed Employee B at the facility.
07/23/2024	Contact - Face to Face Interviewed Employee C at the facility.
07/23/2024	Contact - Face to Face Observed Resident A at the facility.
07/31/2024	Contact – Document Received Received requested documentation from acting admin/Holly Kozma via email.

This investigation will only address potential allegations pertaining to the rules and regulations of Homes for the Aged (HFA).

ALLEGATION:

Staff do not provide medication administration in accordance with the service plan.

INVESTIGATION:

On 7/11/2024, the Bureau received the allegations through the online complaint system.

On 7/11/2024, a referral was made anonymously to Homes for the Aged (HFA) through Centralized Intake.

On 7/23/2024, I interviewed acting facility administrator, Holly Kozma, at the facility who reported no knowledge of staff not administering medications appropriately or leaving medications unattended in resident rooms or the dining room during mealtimes. Ms. Kozma reported only medication technicians provide medication administration, and all are trained at orientation and annually to ensure competency and skills. Ms. Kozma reported some residents receive medications in the dining room during mealtimes, but medication technicians do not leave the medications unattended during administration. Ms. Kozma reported no knowledge of any medications being found in resident rooms unattended and reported that would not be tolerated at the facility. Ms. Kozma reported no knowledge of Resident A being administered the incorrect medication and if a medication administration error were to occur at the facility, it would be documented, and the staff member(s) involved would receive counseling, re-education, or re-training as needed. I requested documentation from Ms. Kozma, and it was reported it would be emailed to me due to her limited ability to access the documentation since she was filling in for the current administrator's leave of absence.

On 7/23/2024, I interviewed Employee A at the facility whose statement was consistent with Ms. Kozma's statement.

On 7/23/2024, I interviewed Employee B at the facility who reported no knowledge of any medication technician leaving medications unattended in the dining room or resident rooms. Employee B reported that would not be tolerated at the facility and could be subject to termination of employment if it were to occur. Employee B confirmed all medical technicians receive training and education at orientation and annually. Employee B reported there was a recent in-service training in July 2024 for medication technicians to ensure skills and competencies. Employee B reported if a medication administration error occurs, then it is documented, the physician is notified, and the staff member involved will receive counseling or re-training as needed. Employee B reported no knowledge of Resident A being administered a medication incorrectly.

On 7/23/2024, I interviewed Employee C at the facility whose statement was consistent with Ms. Kozma's statement, Employee A's statement, and Employee B's statement.

On 7/23/2024, I completed an on-site inspection due to this special investigation. I observed located medication carts and medication technicians administering medications appropriately. I also observed Resident A who was well groomed and content.

On 7/31/2024, I received the requested documentation from Ms. Kozma which revealed the following:

- Resident A requires assistance with bathing, dressing, and eating.
- Resident A requires cueing and reminders for activities of daily living.

The July 2024 Medication Administration Record (MAR) was reviewed which revealed the following:

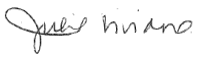
- Resident A is to take 1 tablet by mouth twice daily of busPIRone 15mg. On 7/30/2024, the 9:00 am administration time is blank in the record, and it cannot be determined if Resident A received or refused the medication.
- Resident A is to take 1 tablet of DONEPEZIL TAB 10mg by mouth daily at bedtime. On 7/3/2024, the 8:00 pm administration time is blank in the record, and it cannot be determined if Resident A received or refused the medication. It also cannot be determined if the medication did not arrive in time from the pharmacy to administer by bedtime because while the prescription was written on 7/3/2024, there is no documentation in the record as to why it was not administered to Resident A.
- Resident A is to take 1 tablet of MEMANTINE TAB HCL 10mg by mouth twice daily. The record is blank on 7/3/2024 and 7/30/2024. It cannot be determined if Resident A received or refused the medication due to the blank record.
- Resident A is to take 1 tablet of ROSUVASTATIN TAB 5mg by mouth once daily. On 7/30/2024, the 9:00 am administration time is blank in the record, and it cannot be determined if Resident A received or refused the medication.
- Resident A is to take 1 tablet of SERTRALINE TAB 100mg by mouth once daily. On 7/30/2024, the 9:00 am administration time is blank in the record, and it cannot be determined if Resident A received or refused the medication.
- Resident A may take 50 mg of SERTRALINE TAB 50mg by mouth once daily in addition to 100mg to total 150mg. On 7/30/2024, the 9:00 am administration time is blank in the record, and it cannot be determined if Resident A received or refused the medication.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.

ANALYSIS:	It was alleged that staff do not provide medication administration in accordance with the service plan. Interviews, on-site investigation, and review of documentation reveal there is no evidence to support that medications were left unattended during medication administration at the facility, or that Resident A received an incorrect medication. However, there is evidence that Resident A did not receive several medications in accordance with the physician orders. Resident A's medication administration record contains multiple blank entries, and it cannot be determined if Resident A received or refused the medications. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved correction action plan, I recommend the status of this license remain the same.



8/12/2024

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Julie Viviano Date
Licensing Staff

Approved By:

08/27/2024

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