GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

November 7, 2024

RE: License #: AH470412880
Investigation #: 2024A1022084
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 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
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH470412880
Investigation #:	2024A1022084
Complaint Receipt Date:	09/11/2024
Investigation Initiation Date:	09/11/2024
Report Due Date:	11/11/2024
Licensee Name:	Brighton Comfort Care, LLC
Licensee Address:	2635 Lapeer Road Auburn Hills, MI 48326
Licensee Telephone #:	(989) 607-0001
Administrator/Authorized Rep	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:	10/10/2024
Expiration Date:	07/31/2025
Capacity:	93
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents do not receive appropriate and adequate care.	Yes
Facility caregivers take incontinence supplies that has been provided by the hospice for specific hospice residents and are using them for residents other than the resident the supplies were intended for.	No

III. METHODOLOGY

09/11/2024	Special Investigation Intake 2024A1022084
09/11/2024	Special Investigation Initiated - Telephone Complainant interviewed by phone.
09/17/2024	Inspection Completed On-site
11/07/2024	Exit Conference

ALLEGATION:

Residents do not receive appropriate and adequate care.

INVESTIGATION:

On 09/11/2024, the Bureau of Community and Health Systems (BCHS) received a complaint that read in part, “I am a (hospice agency employee), assigned to visit Ms. [name of Resident A] and a few other residents at the Hampton Manor of Brighton facility twice a week… I have asked on several occasions how they are going through all the wipes within a week or less. One of the staff members notified me that staff are using wipes to give patients baths instead of using a towel with soap and water. Families have complained that the patients are not being bathed. I discussed this several times with staff. The lack of using soap/water has caused several of my female patients to experience foul vaginal/body smells and/or itching. When I first started servicing the facility, staff was instructed not to bathe patients because hospice should be doing that… On occasion during my visits, I have had to request patients receive a shower from staff immediately because of body odor or physical signs of uncleanliness.”

On 09/11/2024, I interviewed the complainant by phone. According to the complainant, the hospice she worked for was based in a distant geographical area and did not send hospice care aides to the facility due to the distance involved. She did not believe that any of the residents who were clients of her hospice agency were receiving showers or baths from facility caregivers.

The complainant went on to say that she further believed that facility caregivers were careless when they transferred residents with a mechanical lift and alleged that Resident B had sustained skin tears due to improper transfer technique. The complainant clarified that Resident B was not currently on her case load.

On 09/17/2024, at the time of the onsite visit, I interviewed the administrator and the regional nurse, who was serving as the facility's interim wellness director. The facility identified 3 residents who were clients of the complainant's hospice: Resident A, Resident C, and Resident D. When I asked about bathing of the residents, the regional nurse stated that the facility was bathing all three residents. According to the regional nurse, the caregivers did not use incontinence wipes for bed baths. I asked both caregiver #1 and caregiver #2 about the bathing of these three residents, and, according to these caregivers these residents were on the facility's bathing schedule and were their responsibility. Wash clothes or towels were used for washing and rinsing when a resident was being given a bed bath. Observations of these residents at the time of the onsite visit did not reveal any resident with body odor.

According to her service plan, Resident A needed the assistance of 1 caregiver to complete her activities of daily living (ADLs) including to transfer in and out of bed and chair. Bathing was not addressed on her service plan. According to the facility's shower/bathing schedule, Resident A received bathing assistance from caregivers on Tuesdays and Fridays during the second shift.

According to her service plan, Resident C needed also needed the assistance of 1 caregiver to complete her ADLs with the exception of assistance with transfers in and out of bed and chair, when she needed the assistance of two caregivers. Resident C was to be bathed twice weekly. Resident C was known to refuse baths and caregivers were to reapproach her if she said no to her shower or bath. According to the facility's shower/bathing schedule, Resident C received bathing assistance from caregivers on the first shift Mondays and Thursdays.

According to her service plan, Resident D, like Resident A and Resident C, needed the assistance of 1 caregiver to complete her ADLs with the exception of assistance with transfers in and out of bed and chair. Resident C was also to be bathed twice weekly. According to the facility's shower/bathing schedule, Resident D received bathing assistance from caregivers on the first shift on Mondays and the second shift on Thursdays.

The facility further identified Resident B and Resident E as residents who needed to be transferred by mechanical lift. Resident B was in a reclining wheelchair in the room that she shared with her husband, Resident F. When I asked if Resident B had any skin tears or other skin impairments, Resident F pointed to a bandage on Resident B's upper left arm and stated that he (Resident F) had placed the bandage there when he noticed that her skin had been scratched. Resident F stated that he did not know how Resident B had sustained the injury. Resident B was observed to be sitting on a Hoyer lift sling. Caregiver #1 and caregiver #2 positioned the Hoyer lift over Resident B and hoisted her out of her wheelchair and on to her bed for incontinence care. While Resident B was heard to moan with every touch, the caregivers kept Resident B from hitting the wheelchair, the wall or other obstacles between her wheelchair and her bed. Caregiver #1 removed Resident B's incontinence brief and observed that it was mildly wet. Once a clean incontinence brief had been placed on Resident B, the two caregivers again hoisted her with the lift from her bed back into her wheelchair. Although further observation of Resident B did not result in the identification of skin tears or other skin impairment other that the impairment covered with the bandage, it did reveal that Resident B's fingernails were coated with a dark brown or black substance, which may have been fecal matter. When I asked the caregivers who was responsible for Resident B's nail care, they stated that Resident B was a hospice resident, and that the hospice aide assigned to her had been in to give her a bed bath on the prior day. According to her service plan, Resident B needed the assistance of 2 caregivers using a Hoyer mechanical lift to transfer in and out of bed and chair. Resident B was to receive a shower or a bed bath twice weekly. A caregiver was needed to "perform all grooming and personal hygiene tasks…"

Resident E was seated in her room, waiting for assistance to use the toilet. According to caregiver #2, Resident E was transferred using a sit-to-stand mechanical lift. Once in the room, the two caregivers located the sit-to-stand sling and applied the sling around Resident E. Resident E assisted the two caregivers in positioning the sling where it would give her the best support. Once the sling was in place, the caregivers used the lift to get Resident E into a standing position and moved the lift into the bathroom, where they lowered Resident E onto the toilet. Resident E stated that she had no skin tears, scratches, or other skin impairments. According to her service plan, for mobility, Resident E used a motorized scooter or a standard wheelchair if the motorized scooter needed charging. She needed the assistance of 2 caregivers for transfer in and out of bed or chair. She was to receive assistance with bathing twice weekly.

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 325.1921	**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.**
For Reference: R325.1901	**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 supervision 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.
ANALYSIS:	Observation of Resident B indicated that she was not being provided nail care as outlined in the service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility caregivers take incontinence supplies that has been provided by the hospice for specific hospice residents and are using them for residents other than the resident the supplies were intended for.

INVESTIGATION:

According to the written complaint, “As a hospice provider we are responsible for supplying our patients with supplies such as briefs and wipes. When I (the complainant) first started seeing patients at this facility, (another hospice employee) notified me that (facility) staff was opening packages addressed to him and using those supplies for other people in the facility. The facility was notified and denied that the supplies were being used… When I took over there was a surplus of briefs located in the closet of that room. I place a brief and wipes order every other week and have the briefs delivered to the facility. When I visit the facility, if packages have been delivered, I restock patients as needed and place what I don't use in the closet space with the other surplus supplies. If by chance one of my patients needs extra or I admit a new patient, I can pull from my surplus. When I restock a patient's supplies, I provide 3-4 packs of briefs to last for the week and 2-3 packs of wipes to last for 2 weeks. During my visits, I noticed that briefs and wipes are disappearing from patient rooms faster than they should. Once again staff denied taking briefs out of (name of the hospice) patient rooms to use on other patients. I also had patients and their families notify me that staff is "stealing" their supplies. On August 14, 2024, I entered the locked room where I kept my supplies and saw several empty boxes brief boxes tossed aside in the room and most of the briefs I was keeping in that closet were gone…”

At the time of the onsite visit, I asked the administrator and the regional nurse about incontinence supplies for residents. According to the regional nurse, resident families were all responsible for the incontinence supplies needed by residents. When caregivers noticed that the supply of incontinence briefs or the personal hygiene wipes for any given resident was getting low, the caregiver could either call the resident family themselves or they could inform the facility resident care coordinator, who would alert the family. The regional nurse went on to say that if a resident completely ran out of incontinence products, the facility had extra supplies that were given in donation by families after their resident had passed away or otherwise no longer needed the products. There were several locations in the building where these extra incontinence supplies were stored: in the storage closet behind each unit medication room and a closet located next to the laundry room. Further, according to the regional nurse, because of the facility had these extra supplies, there was no reason for any caregiver to take supplies from one resident to use on another.

When asked specifically about incontinence supplies for the 3 residents who were enrolled with the complainant’s hospice agency, the regional nurse stated that the

hospice nurse order the supplies with the delivery coinciding with the nurse's visit dates. The hospice nurse would then put the supplies in the rooms of patients.

At the time of the onsite visit, observation revealed the presence of incontinence briefs in all of the storage areas. While the facility had an overabundance of extra supply incontinence briefs, there were no extra personal hygiene wipes. Observation in the rooms of the identified clients of the complainant's hospice agency, Resident A, Resident C, and Resident D revealed that all 3 residents had incontinence supplies, briefs and personal hygiene wipes, to last a minimum of 10 days.

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.**
	(3) The following additional requirements for the policy described in subsection (2) apply to licensees under parts 213 and 217: **(c) A nursing home patient or home for the aged resident is entitled to retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other patients or residents, or unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse. Each nursing home patient or home for the aged resident shall be provided with reasonable space.**
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(2) 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.
For Reference: R325.1901	**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 supervision 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.
ANALYSIS:	There was no evidence that incontinence supplies that had been bought for one resident was being used for other residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I reviewed the findings of this investigation with the administrator on 11/07/2024. When asked if there were any comments or concerns with the investigation, the administrator stated that there were none.

II. RECOMMENDATION

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

11/07/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

11/04/2024

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