GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 5, 2024

Shahid Imran
Hampton Manor of Clinton, LLC
7560 River Road
Flushing, MI 48038

RE: License #: AH500401685
Investigation #: 2025A1027011
Hampton Manor of Clinton

Dear Licensee:

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 #:	AH500401685
Investigation #:	2025A1027011
Complaint Receipt Date:	11/18/2024
Investigation Initiation Date:	11/19/2024
Report Due Date:	01/17/2025
Licensee Name:	Hampton Manor of Clinton, LLC
Licensee Address:	18401 15 Mile Road Clinton Township, MI 48038
Licensee Telephone #:	(734) 673-3130
Authorized Representative/ Administrator:	Shahid Imran
Name of Facility:	Hampton Manor of Clinton
Facility Address:	18401 15 Mile Road Clinton Twp., MI 48433
Facility Telephone #:	(586) 649-3027
Original Issuance Date:	10/12/2021
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	101
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Medications were not administered per physician orders.	Yes
The facility was short staffed.	Yes
Residents had falls and were laying on the floor all night.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/18/2024	Special Investigation Intake 2025A1027011
11/19/2024	Special Investigation Initiated - Letter Email sent to Shahid Imran requesting documentation pertaining to allegations.
11/19/2024	Contact - Document Received Email received with additional allegations received from APS
11/19/2024	Contact - Document Received Email received with additional allegations received from APS
11/25/2024	Inspection Completed On-site
11/25/2024	Inspection Completed-BCAL Sub. Compliance
12/05/2024	Exit Conference Conducted by email with Shahid Imran

ALLEGATION:

Medications were not administered per physician orders.

INVESTIGATION:

On 11/19/2024, the Department received allegations from Adult Protective Services (APS) which read that the "ECP" system was not updated with the correct medications or the correct dates/times for medication administration.

On 11/25/2024, I conducted an on-site inspection at the facility and interviewed staff.

Employee #1 explained that the facility had switched to a new medication administration system called "ECP" two weeks ago, replacing the previous system, "PCC." She stated that staff had been trained on how to use the new system.

Employee #2 stated that the pharmacy entered all medications into the ECP system based on the physician's orders.

A review of the medication administration records (MARs) for Residents A and B for November 2024 revealed that the new system was implemented on 11/8/2024. Resident A had an order for Albuterol HFA 90 MCG, to inhale two puffs every 4 hours as needed. However, the medication was also scheduled at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM, making it unclear whether it was intended to be scheduled or as needed. Additionally, Resident A's MAR contained several blank dates from 11/8/2024 through 11/12/2024, 11/14/2024, 11/15/2024, and 11/22/2024 for all her prescribed medications. Similarly, Resident B's MAR showed blank dates from 11/8/2024 through 11/13/2024, making it unclear whether her prescribed medications Eliquis, and Hydroxyzine were administered.

Further, Resident B was prescribed Paxlovid for five days, starting on 11/8/2024, but some staff documented that the medication was unavailable, and only one dose was administered at 8:00 AM on 11/19/2024.

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.
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:
	(b) Complete an individual medication log that contains all of the following information: **(v) The initials of the individual who administered the prescribed medication.**

ANALYSIS:	While staff attestations indicated that the pharmacy staff entered residents' medications into the ECP system, the facility staff did not always initial or document reasons for missed medication doses. Additionally, the Resident A's MAR demonstrated uncertainty between PRN and prescribed medications; therefore, it is unclear whether the medications on the MARs were administered as prescribed by the physician. Therefore, a violation of this rule was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility was short staffed.

INVESTIGATION:

On 11/19/2024, the Department received allegations from APS which read that the facility was short-staffed from March to September 2024. The allegations indicated that the memory care unit was understaffed, with only one staff member working when there should have been two.

On 11/25/2024, I conducted an on-site inspection at the facility and interviewed staff.

Employee #1 explained that staffing levels were based on resident acuity and ratios. She reported that during the day and afternoon shifts, there were two staff assigned to memory care, three staff assigned to assisted living, and one medication technician. On the night shift, there were two staff assigned to memory care, two staff assigned to assisted living, and one medication technician. Employee #1 stated there were five memory care and 39 assisted living residents. Employee #1 also noted that one memory care resident required two-person assistance, and five assisted living residents required a Hoyer lift and two-person assistance.

Employee #3 stated that the workload was manageable, and staffing levels were adequate.

During the on-site visit, I reviewed the facility's staff schedule from 7/15/2024 to 10/27/2024. The schedules indicated that there were typically three staff members on duty during the night shift, including one or more medication technicians. However, on 10/21/2024, one staff member left for a medical emergency at 1:00 AM, leaving only two staff members on duty until 7:00 AM.

I also observed four residents in memory care and ten assisted living, all of whom appeared clean and well-groomed.

APPLICABLE RULE	
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.
ANALYSIS:	Staff interviews did not fully align with the staffing schedule for the night shifts. Frequently the staff schedules read there three staff members were on duty; however, staff attestations revealed two staff were assigned to memory care, two to assisted living and a floating medication technician were on duty to accommodate residents requiring two-person assistance or a Hoyer lift. Furthermore, on 10/21/2024, from 1:00 AM to 7:00 AM, only two staff members were on duty. The facility did not adhere to its own staffing guidelines, and there were not always enough staff on duty to meet the needs of both memory care and assisted living residents requiring Hoyer lifts.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents had falls and were laying on the floor all night.

INVESTIGATION:

On 11/19/2024, the Department received allegations from APS which read that residents were falling and lying on the floor overnight. The allegations specified that Resident A fell on 11/11/2024 and she was on hospice services. It claimed Resident A was not transferred to the hospital, as staff must contact hospice before sending residents to the hospital. Additionally, the allegations read that Resident B fell during the first week of November 2024 around midnight and was found by staff at 7:00 AM with an injury to the right side of the face, after which she received medical treatment.

On 11/25/2024, I conducted an on-site inspection at the facility and interviewed staff.

Employee #1 confirmed that both Resident A and Resident B had falls. Employee #1 stated that Resident A was receiving hospice services, and it was the facility's policy to contact the hospice agency before sending a resident to the hospital. Employee #1 explained that, per the facility's fall protocol, staff should contact the resident's family and physician if an injury occurred. If an injury was

sustained, the resident was to be sent to the hospital for evaluation. If no injury occurred, a 24-hour watch was to be implemented. Employee #1 also stated that the APS worker had investigated and spoken with the families of both residents, with no findings.

Employee #2's statements were consistent with Employee #1 adding that if a resident was on a blood thinner medication, they were automatically sent to the hospital.

Employee #3's statements were consistent with previous employee attestations noting that if a resident also injured their head, they would be sent to the hospital. Additionally, if there was injury anywhere, then staff were to contact emergency medical services (EMS) for evaluation. Employee #3 stated staff were to notify the director of health and wellness and resident care coordinator.
Employee #3 stated Resident B did not require assistance to the bathroom or two-hour checks, so staff were unaware she was on the floor.

On 12/2/2024, telephone interview with Employee #4 revealed she observed Resident B on the bathroom floor on 11/3/2024 during her rounds. Employee #4 stated it was unknown how long Resident B was on the floor since she did not require two-hour checks at that time; however, she does require two-hour checks and assistance with the toileting now.

Resident A's service plan, dated 2/6/2024, identified her as a fall risk, requiring hourly rounding for safety and standby assistance for bathroom use. The incident report for 11/14/2024 at 10:10 PM read that Resident A was found on the floor attempting to put her pants on during staff rounds. No injuries were noted, and both her hospice agency and family were notified.

Resident B's service plan, dated 10/23/2023, indicated that she required standby assistance for safety due to an unsteady gait. She ambulated with a walker for short distances and used a wheelchair for long distances. The plan read that staff were to offer toileting assistance and monitor for safety, as she was a fall risk with a history of falls. Resident B was also on blood thinners, and staff were to remind her of safety measures. The incident report for 11/3/2024 at 6:10 AM read that during final rounds, staff found Resident B on the floor with a bruised face and a skin tear on her left hand. The report noted that her family and physician were notified.

I reviewed the facility's fall prevention program, which outlined the policy, defined a fall, and detailed the procedures for fall prevention for the resident care director and healthcare aides. The policy specified that healthcare aides were to implement the interventions outlined in the service plan.

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.**
For Reference: **R 325.1901**	**Definitions.** **Rule 1. As used in these rules:**
	(p) "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:	Staff interviews confirmed that they are required to contact a resident's hospice agency following a fall. Additionally, it was confirmed that a fall prevention policy was in place, along with a procedure for completing an incident report. However, Resident B's service plan indicated that she occasionally had an unsteady gait, required standby assistance for safety, was at risk for falls, and that staff were to offer toileting, although staff stated she was able to toilet herself. As a result, a violation was substantiated, as the actions taken by staff did not align with Resident B's service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

A review of Resident B's service plan, dated 10/23/2023, revealed that it had not been updated as required by this rule.

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:	Resident B's service plan was dated 10/23/2023; therefore, this violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/05/2024

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Jessica Rogers Date
Licensing Staff

Approved By:

12/05/2024

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