GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 12, 2024

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

RE: License #: AH820402181
Investigation #: 2025A1027014
Hampton Manor of Woodhaven

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 #:	AH820402181
Investigation #:	2025A1027014
Complaint Receipt Date:	12/02/2024
Investigation Initiation Date:	12/02/2024
Report Due Date:	02/01/2025
Licensee Name:	Hampton Manor of Woodhaven LLC
Licensee Address:	22125 Van Horn Woodhaven, MI 48183
Licensee Telephone #:	(734) 673-3130
Authorized Representative/ Administrator:	Shahid Imran
Name of Facility:	Hampton Manor of Woodhaven
Facility Address:	22125 Van Horn Woodhaven, MI 48183
Facility Telephone #:	(734) 673-3130
Original Issuance Date:	06/25/2021
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	113
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A experienced a fall that was not documented. There were no gloves or personal protective equipment (PPE) provided, and feces was left in trash outside residents' rooms.	Yes
Additional Findings	No

III. METHODOLOGY

12/02/2024	Special Investigation Intake 2025A1027014
12/02/2024	Special Investigation Initiated - Letter Email sent to Carol Cancio to request documentation.
12/02/2024	Contact - Document Received Email received with requested documentation
12/10/2024	Inspection Completed On-site
12/11/2024	Inspection Completed-BCAL Sub. Compliance
12/12/2024	Exit Conference Conducted by email with Shahid Imran and Azher Farooq

ALLEGATION:

Resident A experienced a fall that was not documented. There were no gloves or personal protective equipment (PPE) provided, and feces was left in trash outside residents' rooms.

INVESTIGATION:

On 12/2/2024, the Department received allegations indicating that fall incidents were not being documented or filed. One specific case involved Resident A, who had a fall while three staff members were present, but no action was taken. The facility was reported to be lacking medical gloves and PPE for staff, and feces was allegedly left outside residents' rooms.

On 12/2/2024, the resident census confirmed there were 65 residents in care.

On 12/10/2024, an on-site inspection was conducted, and staff were interviewed.

Employee #1 stated that falls were documented in "*PCC*" and that two or three cases of gloves were delivered every Tuesday through Cintas. Employee #1 also confirmed that the facility did not run out of gloves, and additional gloves could be ordered through Amazon if needed. Regarding trash management, Employee #1 explained that residents' trash was emptied every shift, and small trash bags were placed in large trash cans inside soiled linen rooms before being taken outside to the dumpster. If necessary, a trash bag may be temporarily placed outside a resident's room while staff attended to care, but it was always taken to the larger trash can afterward.

Employee #2 provided similar statements and confirmed that Resident A had an unwitnessed fall. An incident report was completed, and Resident A's emergency contact and physician were notified. Employee #2 denied running out of gloves and stated extra boxes were kept in the manager's office. PPE supplies were stored in a closet on the 100 hallway.

Employee #3's statements aligned with the previous staff interviews. Employee #3 noted that gloves were sometimes stolen, so they were stored in a locked office accessible by the resident care coordinator. Gloves were also placed at nurses' stations, medication carts, and the kitchen maintained extra gloves for staff use as well.

During the on-site visit, I observed a box of gloves at each nurses' station, on the medication cart, in the laundry cart, and outside the kitchen. I observed several boxes of gloves located in the manager's office. I also observed the PPE supply room, which contained two large boxes of gowns and two boxes of different type masks, each containing several individual boxes. No trash was observed outside any resident rooms in the assisted living area.

A review of Cintas account statements dated 9/30/2024, 10/31/2024, and 11/30/2024 was consistent with the staff interviews.

Resident A's face sheet revealed he moved into the home on 3/2/2024, with Relative A1 listed as his emergency contact. His service plan dated 3/1/2024 and level of care evaluation dated 11/11/2024, indicated that Resident A transferred independently but was a fall risk. Resident A's progress note dated 11/8/2024 read that he reported to staff around 7:45 AM – 8:00 AM that he had fallen and had been on the ground for about an hour. The note read that he did not press his call pendant. The incident report note dated 11/8/2024 at 7:29 AM indicated that Resident A fell out of bed, stated he was okay, and had carpet burn. Staff cleaned him up and helped him get ready for the day.

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 325.1924**	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	Staff attestations, observations, and a review of facility records found no evidence to support the claims of inadequate gloves or PPE, or trash being left outside residents' rooms. Resident A's records confirmed he had a fall on 11/8/2024; however, the incident report did not include confirmation that his authorized representative and physician were notified. As a result, a violation was substantiated for this aspect of the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/11/2024

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Jessica Rogers Date
Licensing Staff

Approved By:

12/12/2024

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