GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 15, 2024

Shahid Imran
Hampton Manor of Holly
14480 N. Holly Rd.
Holly, MI 48442

RE: License #: AH630410280
Investigation #: 2025A1035007
Hampton Manor of Holly

Dear Mr. 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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630410280
Investigation #:	2025A1035007
Complaint Receipt Date:	10/27/2024
Investigation Initiation Date:	10/29/2024
Report Due Date:	12/29/2024
Licensee Name:	Hampton Manor of Holly LLC
Licensee Address:	14480 N. Holly Rd. Holly, MI 48442
Licensee Telephone #:	(734) 673-3130
Administrator:	Jeff West
Authorized Representative:	Shahid Imran
Name of Facility:	Hampton Manor of Holly
Facility Address:	14480 N. Holly Rd. Holly, MI 48442
Facility Telephone #:	(989) 971-9610
Original Issuance Date:	10/13/2023
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	104
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A received poor quality of care.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/27/2024	Special Investigation Intake 2025A1035007
10/29/2024	Special Investigation Initiated - Letter
12/18/2024	Onsite Inspection.
12/20/2024	Additional Information Received from Attorney General
12/20/2024	Contact: Phone Interview with Complainant.
01/7/2025	Additional Information provided from Administrator.
01/08/2025	Contact: Phone Message Left with Complainant.
01/15/2025	Inspection Complete BCAL Sub-Compliant.
01/15/2025	Exit Conference.

ALLEGATION:

Resident A received poor quality of care.

INVESTIGATION:

On October 28, 2024, the department received a complaint forwarded from Adult Protective Services (APS) which read:

"Resident A has severe dementia, high blood pressure, is hard of hearing and has poor vision. Staff were abusing Resident A. They would throw her around like a ragdoll on the bed, tossing her violently back and forth. There was an incident where Staff Person A was putting Resident A in her wheelchair. Resident A was screaming because she wasn't picked up properly and SP1 dropped her on the wheelchair. The wheelchair was not locked and was rolling during the incident. Resident A had cuts and bruising. SP2 was not feeding Resident A proper amounts of food. Resident A

was in the facility for under a year and she lost 50 pounds. There was not a medical reason for Resident A to lose that amount of weight. Staff would tell Resident A she can feed herself and would leave her in the room all weekend and just bring her soup and oatmeal occasionally. Staff would make excuses on why they weren't giving her proper portions. On 9/29, Resident A ended up at the hospital and stayed for 2 weeks. Resident A had a UTI and bruising that coincided with abuse."

APS did not open an investigation pertaining to the allegations.

On December 20, 2024, the Department received an additional complaint referred by the Attorney General which read:

"Resident A lived at the Hampton of Manor of Holly from approximately September 2023 to September 29th, 2024. The family and I started noticing burses, bedsores and deep cuts on my Resident A in the early fall (who is completely wheelchair bound). Family A inquired about these issues and was given excuses that she accidently scratched her leg etc. One wound was tightly wrapped in gauze which we did not see the severity of it until after she left the facility (I have photos as it was a very deep cut). We also noticed her losing a lot of weight. On September 20th, 2024, we installed a camera in the room to ensure she is getting fed and taken out of the room when appropriate. We immediately witness the staff never taking her out of the room, feeding her 2-3 spoonsful of food per meal (sometimes only 2 times a day) Then on Tuesday 9/24 we witnessed on the camera Staff Person (SP)2 the caregiver tossing around my grandmother violently like a ragdoll and yelling at her. Then SP2 and another caregiver (this part we have this recorded) picking up my grandmother incorrectly one had each arm and then they dropped her against the wheelchair as my grandmother was yelling help, help. They were rude and disrespectful during this episode of abuse. That is when we notified the police (we were out of town at the time). The officer did a wellness check. We contacted the management regarding this issue and their resolution was to simply turn our camera away or unplug it throughout the day so we couldn't see anything going on. On Sunday 9/29 we were notified by Hampton Manor that they were sending her to the hospital as she was shaking uncontrollably. They had the camera unplugged for the day, so we didn't know what went on. Once at the hospital we saw the severity of the wounds. The doctor agreed there were signs of abuse. Other than a mild UTI all her blood work was normal, and she doesn't have any critical illnesses other than dehydration at that time and signs of starvation."

On December 18, 2024, and onsite investigation was conducted. While onsite I interviewed Executive Director Jeff West who states the facility attempted to work with Resident A's family to meet their needs. Jeff states families can utilize cameras in resident room. Family A was informed they could not have cameras on while personal care was being provided such as showers and incontinent care. Jeff states an incident and accident report was initiated post Resident A being lowered to floor when the wheelchair rolled away during a transfer from bed. Verbal education was provided to

staff members involved in the incident. Jeff states the facility does not have an employee by one of the names provided in the complaint. Jeff states the family contacted the local police department to complete a “well” check, no police report initiated.

While onsite I interviewed Staff Person (SP)1 who states all staff are currently educated during orientation on transfer training. All-American Home Health provides transfer training to new staff members. SP1 was unable to provide documentation SP2 and SP3 received transfer training.

While onsite I interviewed SP2 who states when she was in the process of transferring Resident A and the wheelchair rolled away, therefore Resident A was lowered to floor. SP2 states she provided care as indicated per service plan. Resident A would refuse to get up at times and “she has the right to do that.” SP2 denies physical and verbal abuse occurring.

Through record review Resident A’s initial weight was not obtained during the initial assessment and move in date of November 8, 2023. First recorded weight was 163.1 lbs. recorded on 7/1/2024 last weight documented 172.3 lbs. recorded on 8/10/2024, during this time weekly weights had been obtained.

On December 23, 2024, a phone interview was conducted with Family A who states she had noticed a significant weight loss since Resident A was had moved into Hampton Manor of Holly. Family A did not know Resident A’s base weight. Family A states cameras were placed in Resident A’s room to monitor care being provided. Camera footage was obtained during transfer by SP2 in which Family A states it was an improper transfer where SP2 was “yelling” at Resident A and Resident A fell to the floor as the wheelchair rolled back. Family A stated she would email video footage and photos as evidence of her accusations.

On January 7, 2025, Jeff emailed additional requested information related facility Incident and Accident policy and procedure, SP2 and SP3 skills competency check off, Resident A’s medication administration record (MAR) for the month of September and point of care charting.

Through record review SP2 and SP3 do not have documented transfer training. SP2 and SP3 did receive training related to resident service plans and safety with manager verification. Resident A’s service plan indicates she was a one person transfer assist.

Through record review of facility Incident and Accident policy states *“the home shall complete a report of all changes in skin, incidents, accidents and elopements. The incident/ accident report shall contain date, place, and narrative description of the facts about the incident, effect of accident or incident on person involved, written documentation of the individuals notified, and the corrective measure taken to prevent further incidents/ accidents from occurring.”*

On January 8, 2025, Family A provided multiple pictures of Resident A with bruising in various stages of healing on right arm and wound on right lower extremity.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan. **(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following:** **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f)Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	Unable to substantiate allegations related to Resident A not being fed appropriate amounts of food, loosing significant weight, and receiving poor care. Through record review, the facility did not follow Incident and Accident policy and fill out all components of report. Effect of incident on Resident A, written documentation of the individuals notified, vital signs, and the corrective measure taken to prevent further incidents/ accidents from occurring had not been documented. Through record review, SP2 and SP3 did not receive transfer training. Based on information noted above this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

Resident A did not receive medications as ordered.

INVESTIGATION:

Through record review Resident A missed thirteen morning doses and seven evening does of scheduled does of Albuterol related to “medication not available on cart” in the month of September. Multiple missed documentation noted in the month of September related to “check and rotate” “rotate position and assure brief is clean and dry, apply barrier cream to sore on rear end.”

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.
ANALYSIS:	Through record review multiple doses of scheduled Albuterol had been missed related to “medication not being available.” No documentation noted as to steps facility took to obtain medication or address missed doses. Through record review multiple missed documented “check and rotate” missed without explanation. Based on information noted above violation established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/11/2024

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Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

01/14/2025

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