GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 31, 2025

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

RE: License #: AH500401685
Investigation #: 2025A0585027
Hampton Manor of Clinton

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,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500401685
Investigation #:	2025A0585027
Complaint Receipt Date:	01/21/2025
Investigation Initiation Date:	01/22/2025
Report Due Date:	03/20/2025
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?
Resident A eloped from the facility.	Yes
Additional Findings	No

III. METHODOLOGY

01/21/2025	Special Investigation Intake 2025A0585027
01/22/2025	Special Investigation Initiated - Telephone Contacted complainant for additional information.
01/22/2025	APS Referral Made a referral to Adult Protective Service (APS).
01/22/2025	Inspection Completed On-site Completed with observation, interview and record review.
01/22/2025	Inspection Completed-BCAL Sub. Compliance
01/31/2025	Exit Conference Conducted via email to authorized representative Shahid Imran.

ALLEGATION:

Resident A eloped from the facility.

INVESTIGATION:

On 1/21/2025, a complaint was received via BCHS complaint online. The complaint alleged that Resident A eloped from the facility in the middle of the night and staff never knew he was gone. The complaint alleged that Resident A was out of the facility for over 30 minute and fell. The complaint alleged that Resident A was found by public safety.

On 1/22/2025, a referral was made to Adult Protective Services (APS).

On 1/23/2025, an onsite was completed at the facility. I interviewed director Jane Goulette at the facility. The director stated that Resident A went out the front door.

She said that there is no alarm at the front door. She said that staff heard the door and when they went to see they saw another resident and assumed it was them. She said that she reviewed the camera, and the footage showed that Resident A walked up the hallway and left out the door at 4:09 a.m. She said the footage is no longer available for view because it is deleted already. She said the Frasier Police saw him in 15 minutes after he left out the door and by 4:30 the ambulance had come and took Resident A to the hospital.

I interviewed Employee #1 who stated that Resident A had memory issues, and he walked out the facility and was found by the police. Employee #1's statement was consistent with the director.

I interviewed Employee #2 who stated that she worked another shift over. She said that she did rounds and was at the desk when they heard something. She said that she jumped up and ran to the front. Employee #2 said that when she ran up front she saw another resident and assumed that she was the one open her door that she heard. She said that she walked around the building and didn't see anyone. She said by the time she got back to the front door, someone was knocking on the door and telling them that they think they had one of their residents. She said that Resident A fell. She said he wasn't out of the facility that long. She said that Resident A was confused, and he has a one-on-one sitter in the daytime. She said that there were two staff at the front of the building and two in the back when Resident A left the building. She said that all residents are on two-hour rounds. Employee #2 stated that she last saw Resident A at 3:00 a.m.

The Service plan for Resident A read, "Admitted to the facility on 8/12/2022. Requires staff assistance with mobility/ambulation. Use a 2 ww (wheel walker) cane. As needed every day. To safely move from place to place as desired with supervision from staff."

I reviewed the staffing schedule. The schedule was consistent to the director's statement regarding staffing.

Resident A was in the hospital at the time of the onsite.

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.

R 325.1901	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	The complaint alleged that Resident A eloped from the facility. Staff did not know Resident A had left the facility. The service plan does not adequately provide information as to how Resident A is monitored and how protection is provided to the resident. There is no update to the service plan as related to this incident. Therefore, this claim is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Brender L. Howard 01/31/2025

Brender Howard Date
Licensing Staff

Approved By:

Andrea L. Moore 01/31/2025

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