GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 4, 2025

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

RE: License #: AH470412880
Investigation #: 2025A1035050
Hampton Manor of Brighton

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.
- Indicate 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.
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) 335-5985.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
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 #:	AH470412880
Investigation #:	2025A1035050
Complaint Receipt Date:	04/07/2025
Investigation Initiation Date:	04/10/2025
Report Due Date:	06/07/2025
Licensee Name:	Hampton Manor of Brighton LLC
Licensee Address:	1320 Rickett Rd Brighton, MI 48116
Licensee Telephone #:	Unknown
Administrator/ Authorized Representative:	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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's care needs had not been met. The family was not notified of incidents and accidents that occurred.	Yes
Resident A is not receiving medication as ordered.	Yes
The Facility is understaffed.	No
Additional Findings	No

III. METHODOLOGY

04/07/2025	Special Investigation Intake 2025A1035050
04/10/2025	Special Investigation Initiated - Telephone phone interview conducted with complainant.
04/24/2025	Contact - Face to Face
06/04/2025	Inspection Complete, BCAL Sub Compliance.
06/09/2025	Exit Conference.

ALLEGATION:

Resident A's care needs had not been met. The family was not notified of incidents and accidents that occurred.

INVESTIGATION:

On April 9, 2025, the Department received a complaint through the online complaint system which read:

> Family A would arrive at 630AM, and his brief was so saturated, and the back had feces. Resident A ended up getting a UTI which became sepsis and ended up killing him. He would sit in the same clothing due to being understaffed. He was having a seizure due to fever of 103. Overall concerns for lack of care to residents. Bruising on him, they would say were old bruises. No one would notify me; I would find these bruises. He went to the facility on 10/2024 and passed on 03/2025. He had morphine

and Ativan that were not documented that hospice had prescribed and they did not have in his chart it was in the office sitting.

On April 24, 2025, an onsite investigation was conducted while onsite I interviewed Staff Person (SP)1 who states Resident A had not lived in the community long. Resident A had multiple fall occurrences, required one person assistance, and was being seen by hospice. SP1 states when a fall occurs the resident is observed for injury, family is notified, and emergency services are contacted if needed.

While onsite I interviewed SP2 who states Resident A had multiple falls and was on every 30-minute checks. In the event a fall event occurs, the resident is checked for injury, vital signs are taken, and family is notified.

On April 24, 2025, a phone interview was conducted with complainant who states Resident A did not receive quality of care. There had been multiple times she had arrived at the facility to find Resident A's brief saturated with urine and dried feces. Complainant reports on several occasions Resident A was observed with new bruises without notification. Complainant states she was not notified of fall occurrences. Complaint provided several pictures of soiled briefs, Resident A with dark purple bruising to the right side of face and forehead, and a picture where a bolster is being used to keep Resident A in bed.

Through record review Resident A is independent with transfers and ambulation. Resident A's service plan states he has a history of falls and requires frequent 30-minute checks during wake hours and with every 60-minute checks during sleep hours of 10:00 PM to 07:00 AM. Resident A is dependent on staff assistance with routine medications and as needed medications. Resident A "will follow a toileting program designed for the resident. Assist Resident to restroom every 2 hours or as needed."

Through record review, Resident A had fall occurrences on 1/9/25 (family not notified),1/24/25 (family not notified), 1/25/2025 (family not notified), 1/26/25 (family notified), 1/27/2025 (family notified), 1/31/2025 (family not notified), 2/6/25 (family and physician notified),2/18/25 (family not notified), 3/1/25 (family not notified), 3/7/25 (family not notified), 3/8/25 (family not notified), 3/7/25 (family not notified 2nd fall)

Through record review of Facility Incident, Accident, and Elopement policy the home shall complete an incident and accident report. The incident and accident report should include name of person involved in incident or accident, date and time, effect of the accident, written documentation of individuals notified, corrective measures taken to prevent incident/ accident from occurring, name and time family and physician was notified.

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.**
ANALYSIS:	Through record review Resident A had multiple fall occurrences where family, physician, and hospice had not been notified. The service plan provided was dated 11/20/2024 without facility and family signatures. Additionally, there is no indication Resident A's service plan had been updated post fall occurrences with corrective measures to prevent further fall occurrences. Based on the information noted above, this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is not receiving medication as ordered.

INVESTIGATION:

On April 9, 2025, the Department received a complaint through the online complaint system which read:

> They were supposed to be giving him medicine and they were not keeping track correctly; He had morphine and Ativan that were not documented that hospice had prescribed and they did not have in his chart it was in the office sitting.

On April 24, 2025, an onsite investigation was conducted while onsite I interviewed Staff Person (SP)1 who states Resident A was being seen by hospice. Hospice managed medications. The facility did receive an emergency medication pack from hospice that was locked in the Wellness Directors office. Medications are to be given as ordered. In the event a medication is refused or not available it is signed as not given with an explanation.

While onsite, I interviewed SP3 who states Resident A did have a medication emergency pack delivered by hospice. This pack was double locked in the office until

medication orders for the drugs inside pack had been received and approved. There was an incident where Resident A needed a medication for anxiety but there was a delay in obtaining the order. SP3 states as soon as the order was received the medication was administered.

On April 24, 2025, a phone interview was conducted with the complainant who states Resident A did not receive medications as ordered. Complainant states hospice provided an “emergency pack” of medications that the Wellness Director locked in her office and staff were unable to access leading to a delay in care/ start of morphine and Ativan.

Through record review Resident A is dependent on staff assistance with routine medications and as needed medications. Review of medication administration record (MAR) there are five missed doses of Clozaril 25mg between the dates of February 21 through February 28, Multiple missed blood pressure documentation required for Midodrine HCL 10 mg three times a day, 15 missed doses of Midodrine HCL prior to discontinuing medication, 4 not given doses of Potassium and two doses not documented. Documented exceptions for missed medication include “med unavailable, resident refused, and medication out of order.”

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Through record review Resident A missed multiple consecutive medications related to medication not being available, resident refusal, and medication unavailable. Additionally, documentation revealed that there were several missed blood pressure readings, which are required prior to administering medication with blood pressure parameters. Based on the information noted above this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The Facility is understaffed.

INVESTIGATION:

On April 9, 2025, the Department received a complaint through the online complaint system which read:

"They are understaffed."

On April 24, 2025, an onsite investigation was conducted while onsite I interviewed Staff Person (SP)1 who states staffing goals are the facility staffs 5 care providers on days, 4 on afternoons, and 3-4 care providers on midnight shift for current census of 37.

While onsite, SP2 states staff work well together to meet the needs of the residents. This is the best staffing level we have had in years.

Through direct observation approximately 10 residents observed well-groomed and dressed appropriately.

Through direct observation facility is clean and free of clutter.

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:	Through record review of staff schedule and interview of facility staff, the facility is staffing according to their staffing goals. Facility is well maintained and free of clutter. Approximately 10 residents observed well-groomed and dressed appropriately. Based on the information noted above, this allegation has not been substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

06/03/2025

_____

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

Approved By:

06/04/2025

_____

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