STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

September 21, 2021

Shahid Imran
Hamburg Investors Holdings LLC
7560 River Rd
Flushing, MI 48433

RE: License #: AL470402182
Investigation #: 2021A0466039
Hampton Manor Of Hamburg 3

Dear Mr. Imran:

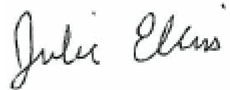
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9727.

Sincerely,



Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL470402182
Investigation #:	2021A0466039
Complaint Receipt Date:	07/27/2021
Investigation Initiation Date:	07/28/2021
Report Due Date:	09/25/2021
Licensee Name:	Hamburg Investors Holdings LLC
Licensee Address:	7244 E M36 Hamburg, MI 48139
Licensee Telephone #:	(313) 645-3595
Administrator:	Shahid Imran
Licensee Designee:	Shahid Imran
Name of Facility:	Hampton Manor Of Hamburg 3
Facility Address:	7300 Village Center Dr. Whitmore Lake, MI 48189
Facility Telephone #:	(734) 673-3130
Original Issuance Date:	04/12/2021
License Status:	TEMPORARY
Effective Date:	04/12/2021
Expiration Date:	10/11/2021
Capacity:	13
Program Type:	AGED ALZHEIMERS

II. ALLEGATIONS:

	Violation Established?
Facility is understaffed and not able to meet the needs of the residents.	No
One direct care worker (DCW) brought alcohol into the facility while she was on shift.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/27/2021	Special Investigation Intake- 2021A0466039.
07/27/2021	Contact - Telephone call made to Complainant, message left.
07/28/2021	Inspection Completed On-site.
07/28/2021	Special Investigation Initiated - Face to Face.
07/28/2021	Contact - Telephone call received from Complainant, interviewed.
09/15/2021	Inspection Completed On-site.
9/16/2021	Contact - Telephone call made to DCW Anastasia Sheldon, message left.
09/16/2021	Contact - Telephone call made to DCW Kerry Cesarz, message left.
9/16/2021	Contact - Telephone call made to Relative A1, message left.
9/17/2021	Contact - Telephone call received from Kerry Cesarz, interviewed.
9/17/2021	Inspection Completed On-site.
9/17/2021	Contact - Telephone call received from Anastasia Sheldon, interviewed.
9/17/2021	Contact - Telephone call received from Relative A1, interviewed.
9/21/2021	Exit Conference Shahid Imran, message left.

ALLEGATION: Facility is understaffed and residents are being neglected.

INVESTIGATION:
On 07/27/2021, Complainant reported concern the facility is short staffed and residents are being neglected. Complainant reported there were days where only one or two direct care staff members were available to care for 30 or more residents as all of the residents are spread out in different buildings that connect. Complainant reported that residents have walked out of the building without DCW knowledge because the security system is not working.

On 07/28/2021, I interviewed Complainant who reported not knowing how many residents were living in each licensed building. Complainant could not remember the exact dates but reported this concern to the licensee. Complainant reported being concerned as this is a memory care unit, so all of the residents have dementia. Complainant was not aware of any of the other needs of the residents.

On 07/28/2021, I conducted an unannounced investigation and I interviewed direct care worker (DCW) Ariel Diane who reported that she was working alone on 07/28/2021 and that there were five residents at the facility. DCW Diane reported that she is aware that the facility disables the delayed egress locks on the doors when a new resident is moving in. DCW Diane reported that one DCW to five residents is a reasonable ratio and that she is able to adequately supervise all five residents and meet their personal care needs. DCW Diane reported that she is not aware of any of the residents leaving the facility without supervision even when the delayed egress was unarmed. DCW Diane reported that the DCWs on shift keep a closer eye on the residents when the delayed egress is turned off for a new admission. DCW Diane reported that the delayed egress is turned off just for a short time while the family is bringing in the furniture and belongings. DCW Diane was not aware of any time that the delayed egress was broken. DCW Diane reported that most of the residents are independent with some of the activities of daily living (ADL)s and that none of the residents require two direct care staff members to assist with transfers and mobility.

On 07/28/2021, I walked through the facility and all of the residents were well groomed and free of any foul order. The delayed egress was armed, working and I did not find any alcohol in the refrigerator.

On 07/28/2021, I interviewed Hillard Kelly, manager, who reported that the delayed egress was not working for a few hours the previous weekend. Mr. Kelly reported the delayed egress was fixed by the regional maintenance director who discovered that it was a blown fuse. Mr. Kelly reported none of the residents left the facility when the delayed egress was not working. Mr. Kelly reported that most of the residents are independent with ADLs and that none of the residents require two direct care staff members to assist with transfers or mobility.

On 07/28/2021, I interviewed Razanne Pedawi, administrative executive who reported that one DCW is scheduled per shift. Ms. Pedawi reported that she was not aware of anytime that the delayed egress was broken or not working in the facility. Ms. Pedawi denied that the delayed egress is turned off when a resident is moving in/out. Ms. Pedawi reported that the facility has been short staffed so direct care staff members are being cross trained in the event of call-ins. Ms. Pedawi reported that most of the residents are independent with ADLs and none of the residents require two direct care staff members to assist with transfer or mobility. Ms. Pedawi reported that the facility accepts only residents that require one direct care staff member to assist with transfers/mobility at admission. Ms. Pedawi reported that as their residents age in place they may eventually require additional staffing assistance but currently there are no residents that require two direct care staff members to assist with transfers or mobility.

On 07/28/2021, I interviewed direct care staff member Jessica Wideman who reported that she works in all of the licensed AFC facilities located on the Hamburg campus as needed. Direct care staff member Wideman reported there is one direct care staff member assigned to this facility per shift. Direct care staff member Wideman reported direct care staff members do call in but that is why she was cross trained as a direct care staff member even though she was hired for another position. Direct care staff member Wideman reported that most of the residents are independent with ADLs and that none of the residents require a two person assist/transfer.

On 07/28/2021, I interviewed DCW Caroline Malott who reported that the facility always has one DCW on shift and there is a “float” that helps all of the facilities on the property as needed. DCW Malott reported that the delayed egress was not working about a week and half ago after the facility lost power briefly after a storm. DCW Malott reported that the maintenance director re-set the delayed egress after it was not working for two days. DCW Malott reported that she was not aware of any residents leaving the facility when the delayed egress was not working. DCW Malott reported that most of the residents are independent with ADLs and that none of the residents require two direct care staff members to assist with transfer or mobility.

On 07/28/2021, I reviewed the *Resident Register* which documented that the facility had six residents.

On 07/28/2021, I reviewed a *Staff Schedule*/*Building Assignment* log dated 06/26/2021 through 07/25/2021 which documented that one DCW was scheduled per shift.

On 09/17/2021, I interviewed DCW Anastasia Sheldon and DCW Cesarz who reported that there is always one DCW assigned to work per shift. DCW Sheldon and DCW Cesarz reported that most of the residents are independent with ADLs

and that none of the residents require two direct care staff members to assist with transfers or mobility.

On 09/17/2021, I reviewed all of the residents written *Service Plans* and none of the service plans documented that any resident required a two person assistance with mobility or personal care needs.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	At the time of the investigation, there were six residents living at the facility with one direct care staff member working per shift. I verified this via review of the staff schedule and multiple interviews with direct care staff members and administration. None of the residents require two direct care staff members to assist with transfers, mobility, or personal care needs. Therefore, there is no evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: A DCW brought alcohol into the facility while they were on shift.

INVESTIGATION:
Complainant reported that there was a recent situation where a DCW brought alcohol into the facility and one of the residents had some. Complainant reported that the DCW was not terminated or reprimanded because the facility needs direct care staff due to minimal staffing.

On 07/28/2021, I interviewed Complainant who reported DCW Kerry Cesarz brought alcohol into the facility. Complainant reported DCW Cesarz brought the alcohol into work to drink while working over the fourth of July holiday weekend. Complainant did not see the alcohol but was told about it. Complainant reported that Resident A likes to go into the refrigerator and Complainant heard that that a DCW (name unknown) caught Resident A with a can of seltzer that contained alcohol and Resident A was drinking it. Complainant reported that it is unknown how much Resident A drank. Complainant reported that he did not hear that Resident A had any adverse side effects to drinking the alcohol.

On 07/28/2021, I conducted an unannounced investigation and I interviewed DCW Diane who reported that Resident A does wander around the facility, and he does frequently try to get into the refrigerator. DCW Diane reported that Resident A has dementia but she was not aware, nor did she hear that any DCW brought alcohol into the facility. DCW Diane reported that currently there was no alcohol in the refrigerator. DCW Diane reported that she has worked with DCW Cesarz and reported that the first time she worked with DCW Cesarz she was emotional but that she never smelled of alcohol nor did she appear to be under the influence of drugs or alcohol. DCW Diane reported that DCW Cesarz was "twitchy" and reported that DCW Cesarz told her that she takes psychotropic medications and that is to what she attributed the twitching. DCW Diane reported that DCW Cesarz was very sensitive and often emotional. DCW Diane reported that DCW Cesarz quit and has not worked at the facility since 07/24/2021 when she left around 3pm and did not let anyone know.

On 07/28/2021, I attempted to interview Resident A but he was sleeping and declined to be interviewed.

On 07/28/2021, I interviewed Ms. Pedawi who reported that it was brought to her attention that there was alcohol in the refrigerator but that when she went to look in the refrigerator there was no alcohol in there. Ms. Pedawi reported that other DCWs reported that DCW Cesarz threw the alcohol away. Ms. Pedawi reported confronting DCW Cesarz about having the alcohol while on shift and reported that she denied it. Ms. Pedawi reported that this was reported to her three weeks after when it allegedly occurred and that the cameras in the building do not go back that far. Ms. Padawi reported that this situation would have been easier for her to investigate if it had been reported timelier. Ms. Pedawi reported that DCW Cesarz never smelled of alcohol nor did she appear to be under the influence of alcohol while on shift.

On 07/28/2021, I interviewed DCW Malott who reported that on 07/04/2021, DCW Cesarz brought in Truly and Coors seltzers that contained alcohol. DCW Malott is not sure but she heard that Resident A got a hold of one of the alcoholic beverages and that his family member that was visiting at the time took it away from him. DCW Malott reported that Resident A did not have any adverse side effects from the alcohol. DCW Mallott reported that DCW Cesarz never smelled of alcohol nor did she appeared to be under the influence of alcohol while on shift.

On 07/28/2021, I reviewed DCW Cesarz's personal record which did contain a Michigan Workforce Background Check that was dated 04/21/2021 and documented that she is eligible to work in an adult foster care facility.

On 07/28/2021 and again on 09/15/25021, I reviewed Resident A's record. Resident A's record did not contain a physician order stating that based on the medications that Resident A was prescribed that it was safe for him to consume alcohol.

On 09/15/2021, I reviewed Resident A's written *Resident Service Plan* did not contain any documentation or instruction as to if Resident A could or could not consume alcohol.

On 09/17/2021, I interviewed DCW Sheldon who reported that she had heard that DCW Cesarz had alcohol at work but that she did not witness this personally. DCW Sheldon reported that the facility has cameras, but the cameras overwrite what has been saved after 48 hours. DCW Sheldon did report that she heard that Resident A did get into alcohol that DCW Cesarz brought into work, but she did not hear anything else nor did she observe Resident A with the alcohol. DCW Sheldon reported that DCW Cesarz never smelled of alcohol nor did she appear to be under the influence of alcohol while on shift.

On 09/17/2021, I interviewed DCW Cesarz who admitted that she had brought beer into the facility on 07/04/2021 to have a fourth of July celebration with the residents. DCW Cesarz reported that she obtained permission from kitchen staff member Elisabeth Decker to bring in the alcohol. DCW Cesarz reported that Ms. Decker is the one that stores the alcohol for the "happy hours" that the facility had and that is why she asked her for permission. DCW Cesarz reported that she did not consume any alcohol at work while on shift. DCW Cesarz reported that she did give Resident A a beer which he drank. DCW Cesarz reported that she later learned that she was not supposed to provide alcohol to residents who did not have a physician's order allowing the alcohol. DCW Cesarz reported that she just wanted to do something nice for the residents since memory care is not typically included in facility "happy hour." DCW Cesarz reported that she just brought in a couple of beers that she had at home. DCW Cesarz reported that she did not bring in an alcoholic seltzer. DCW Cesarz reported that she has never been under the influence of drugs or alcohol while on shift.

On 09/17/2021, I interviewed Ms. Decker who denied giving DCW Cesarz permission to bring in alcohol to work. Ms. Decker reported that she has nothing to do with the "happy hour" that the facility has, just that some of the alcohol had been stored in the kitchen. Ms. Decker reported that since the fourth of July, she no longer stores any of the alcohol for the "happy hour." Ms. Decker reported that is all done by the activity director now. Ms. Decker reported that she was not aware if DCW Cesarz was consuming alcohol at work or not as she did not see DCW Cesarz with alcohol nor has she observed DCW Cesarz to be under the influence of alcohol while on shift. Ms. Decker reported having little interaction with DCW Cesarz as she works in the kitchen and DCW Cesarz works in a different building.

On 09/17/2021, I interviewed Relative A1 who reported that she was not aware of anytime that Resident A was provided alcohol by the facility. Relative A1 reported that she was not aware of any physician order giving permission for Resident A to consume alcohol at the facility.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	DCW Cesarz admitted bringing beer into the facility for a fourth of July party with the residents. DCW Cesarz denied consuming alcohol while at the facility and on shift. DCW Cesarz denied ever being under the influence of drugs and or alcohol while on shift. Ms. Pedawi, DCW Wideman, DCW Malott, DCW Sheldon all reported hearing about the incident but none of them observed the alcohol in the facility nor did they observe DCW Cesarz consuming it, therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	DCW Cesarz admitted that she brought beer to the facility on 07/04202, she gave Resident A a beer and he drank it. DCW Cesarz reported that she later learned that she was not supposed to provide alcohol to residents who did not have a physician's order allowing the consumption alcohol as it could have a negative impact on their prescribed medications. Resident A does not have a physician's order allowing him to drink alcohol. A violation has been established as Resident A should not have been provided with an alcoholic beverage from the facility without written physician approval.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 07/28/2021, I conducted an unannounced investigation and asked to review DCW Diane's employee record. Mr. Kelly and Ms. Pedawi both reported that they did not have fingerprints for DCW Diane because she was a temporary agency staff. At the time of the unannounced investigation, the facility did not have documentation that DCW Diane had been fingerprinted prior to assuming her duties as the only DCW at the facility on shift on 07/28/2021.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(5) Upon receipt of the written consent to conduct a criminal history check and identification required under subsection (3), if the individual has applied for employment either as an employee or as an independent contractor with an adult foster care facility or staffing agency, the adult foster care facility or staffing agency that has made a good faith offer of employment or independent contract shall comply with subsection (4) and shall make a request to the department of state police to forward the individual's fingerprints to the federal bureau of investigation. The department of state police shall request the federal bureau of investigation to make a determination of the existence of any national criminal history pertaining to the individual. An individual described in this subsection shall provide the department of state police with a set of fingerprints. The department of state police shall complete the criminal history check under subsection (4) and, except as otherwise provided in this subsection, provide the results of its determination under subsection (4) and the results of the federal bureau of investigation determination to the department within 30 days after the request is made. If the requesting adult foster care facility or staffing agency is not a state department or agency and if criminal history record information is disclosed on the written report of the criminal history check or the federal bureau of investigation determination that resulted in a conviction, the department shall notify the adult foster care facility or staffing agency

	and the individual in writing of the type of crime disclosed on the written report of the criminal history check or the federal bureau of investigation determination without disclosing the details of the crime. The notification shall inform the adult foster care facility or staffing agency and the applicant regarding the appeal process in section 34c and shall include a statement that the individual has a right to appeal the information relied upon by the adult foster care facility or staffing agency in making its decision regarding his or her employment eligibility based on the criminal history check. Any charges imposed by the department of state police or the federal bureau of investigation for conducting a criminal history check or making a determination under this subsection shall be paid in the manner required under subsection (4).
ANALYSIS:	All DCWs, including those utilized though a private staffing agency are required to be fingerprinted by the Michigan Workforce Background Clearance prior to their assumption of duties. Additionally, the facility is required to maintain a copy of the Michigan Workforce Background Clearance in the employee's record. The facility did not have an employee record available for review at the time of the unannounced investigation that contained a Workforce Background Clearance for DCW Diane therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 07/28/2021, I conducted an unannounced investigation and asked to review DCW Diane's employee record. Mr. Kelly and Ms. Pedawi both reported that they did not have an employee record for DCW Diane because she was an agency staff. At the time of the unannounced investigation, the facility did not have documentation that DCW Diane had been trained or was component in the required areas prior to assuming her duties as the only DCW at the facility on 07/28/2021.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.**

	(d) Personal care, supervision, and protection. **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	The facility is required to maintain an employee record for all DCWs, including those utilized though a private staffing agency. The facility did not have an employee record available for review on 07/28/2021 for DCW Diane therefore a violation has been established as there was no documentation available for review at the time of the unannounced investigation that DCW Diane was competent in the required areas prior to performing any duties and assigned tasks.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 07/28/2021, I reviewed the *Staff Schedule*/*Building Assignment* log dated 06/26/2021 through 07/25/2021, which documented that the facility did not have any trained DCW available to pass medication to the residents on 22 shifts during that one-month time frame. The following days/times did not have a direct care staff member trained in medication passaging assigned to this facility/available to pass medication to the residents as needed:

- 6/28/2021, 1st shift
- 6/30/2021, 1st and 3rd shifts
- 7/01/2021, 1st shift
- 7/02/2021, 2nd and 3rd shifts
- 7/03/2021, 1st shift
- 7/05/2021, 1st shift
- 7/07/2021, 3rd shift
- 7/09/2021. 3rd shift
- 7/10/2021, 3rd shift
- 7/13/2021, 2nd shift
- 7/15/2021, 1st and 3rd shifts
- 7/16/2021, 3rd shift
- 7/20/2021, 3rd shift
- 7/22/2021, 2nd and 3rd shifts
- 7/23/2021, 3rd shift
- 7/24/2021, 3rd shift
- 7/25/2021, 3rd shift

On 09/16/2021, I interviewed Ms. Pedawi, who reported that when a trained medication passer is not assigned to the facility that they have a nurse as well as the management, who are all medication passers certified, passing the medications.

On 09/17/2021, I interviewed direct care staff member Sheldon and direct care staff member Cesarz who both reported being trained as a medication passers and both reported being responsible for two medications carts at one time while on shift. Direct care staff member Sheldon reported working third shift and stated that there were not a lot of medications to administer during third shift. Direct care staff member Cesarz reported working first shift. Direct care staff members Sheldon and Cesarz reported that if they had to go to another building on the property to administer medications, a direct care staff member from another building would come to their building to supervise the residents. Both direct care staff members reported all resident medications are administered to the residents timely. Direct care staff members Sheldon and Cesarz reported there were not any “floaters” or anyone from management available to assist with medication passing. Direct care staff member Sheldon reported that the nurse and other managers were not available during third shift. Both direct care staff members Sheldon and Cesarz reported resident medications were administered by a trained medication passer who was assigned to administer medications in more than one building per shift.

On 09/17/2021, I reviewed all of the residents July 2021 medication administration records (MAR)s and all of the resident MARs documented that all of the residents are being administered medications as prescribed.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	The *staff schedule/Building Assignment* log documented that between 06/26/2021 through 07/25/2021, 22 shifts did not have direct care staff member available that was trained in medication passing. Six, 1st shifts, three, second shifts and 13, 3rd shifts did not have a DCW available that was trained in the proper handling and administration of medications therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

09/21/2021

Julie Elkins — Date
Licensing Consultant

Approved By:

9/21/2021

Dawn N. Timm — Date
Area Manager