GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 24, 2023

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

RE: License #: AL470402157
Investigation #: 2023A0466028
Hampton Manor Of Hamburg 1

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 #:	AL470402157
Investigation #:	2023A0466028
Complaint Receipt Date:	02/23/2023
Investigation Initiation Date:	02/27/2023
Report Due Date:	04/24/2023
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 1
Facility Address:	7300 Village Center Dr. Whitmore Lake, MI 48189
Facility Telephone #:	(734) 673-3130
Original Issuance Date:	11/20/2020
License Status:	REGULAR
Effective Date:	05/20/2021
Expiration Date:	05/19/2023
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATIONS:

	Violation Established?
Direct care workers are sleeping on the job and disrespectful to residents.	No
Medications are not being administered as prescribed.	Yes
Residents are not being showered on a regular basis.	Yes
Linens are not being changed regularly.	Yes

III. METHODOLOGY

02/23/2023	Special Investigation Intake-2023A0466028.
02/27/2023	Special Investigation Initiated - On Site.
03/16/2023	APS Referral.
04/17/2023	Contact- Document sent -email to Kelly Haddock.
04/18/2023	Contact- Document received email from Kelly Haddock.
4/19/2023	Contact- Document received email from Kelly Haddock.
4/20/2023	Contact- Document received email from Kelly Haddock.
4/24/2023	Exit Conference with licensee designee Shahid Imran, email sent.

ALLEGATION: Direct care workers are sleeping on the job and are disrespectful to residents.

INVESTIGATION:
On 02/23/2023, anonymous Complainant reported direct care workers sleep on the job and are disrespectful to residents. Because Complainant was anonymous no additional information or details could be gathered to clarify the allegation.

On 02/27/2023, I conducted an unannounced investigation and I interviewed direct care worker (DCW) Perkita Sanders who reported she does not work third shift but has heard direct care workers sleep on the job but she could not report any names or at which licensed facility they worked. DCW Sanders stated she has never

witnessed any DCW disrespecting any resident nor has any resident complained to her that any DCW has disrespected them.

I interviewed DCW Malika Self who reported that a midnight staff was fired about two to three weeks ago. DCW Malika Self could not report the names of the DCWs that were terminated nor at which licensed facility they worked. DCW Malika Self reported she has not heard about any DCW sleeping on the job since then. DCW Malika Self stated she has never witnessed any DCW disrespecting any resident nor has any resident reported to her that any DCW has disrespected them.

I interviewed Resident A, Resident B, Resident C, Resident D, Resident E and Resident F who all reported that they have never observed a direct care worker sleeping while at work. Resident A did report that a few weeks ago, (she could not remember the day or the date) she did get up in the middle of the night and she could not find a direct care worker. Resident A reported that she then used her call button and a direct care worker still did not come to her room. Resident A, Resident B, Resident C, Resident D, Resident E and Resident F all reported that they have not been disrespected by a direct care worker nor have they witnessed any other residents be disrespected. Resident A and Resident B reported some direct care workers can be rude but neither reported any specific direct care worker names. Resident A reported that when she rings her bell some of the direct care workers will come into her room and say, “what do you want now?”

I interviewed executive director Kelly Haddock who reported that she had not observed nor had any of the residents or other direct care workers report to her that residents are being disrespected.

On 04/17/2023, Ms. Haddock reported that staffing for the facility is two DCWs for first shift, second shift two DCWs and third shift is just one DCW. Ms. Haddock reported that the property has four licensed facilities on the same campus and that all the buildings are connected even though they also have independent entrances and exits. Ms. Haddock reported that she does not give second chances with direct care workers who are caught sleeping on the job as sleeping is automatic termination. Ms. Haddock reported that she has not received reports of any direct care worker sleeping on the job recently. Ms. Haddock reported that two of the other licensed facilities on the same campus did have some issues with DCWs sleeping on the job earlier this year and those DCWs were immediately terminated on 01/04/2023.

I reviewed the facilities sleeping policy which stated,

“Sleeping during a scheduled shift is not allowed by any Hampton Manor location. If a staff member is caught sleeping while on their scheduled shift it is at the discretion of their supervisor and Administrator on further disciplinary action up to and including termination.”

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Through the course of my investigation, I did not find any concrete evidence of direct care staff members sleeping while on shift at this facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	DCW Sanders, DCW Malika Self and Ms. Haddock all reported they had not observed nor had any of the residents or other direct care workers reported that residents were being disrespected. Resident A, Resident B, Resident C, Resident D, Resident E and Resident F all denied being disrespected by any direct care worker. Resident A, Resident B, Resident C, Resident D, Resident E and Resident F all reported that they have not witnessed other residents be disrespected either. .
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Medications are not being administered as prescribed.

INVESTIGATION:
On 02/23/2023, anonymous Complainant reported resident medications are not being administered correctly. Because Complainant was anonymous no additional information or details could be gathered to clarify the allegation.

On 02/27/2023, I conducted an unannounced investigation and I reviewed January 2023 and February 2023 medication administration records (MAR)s for Resident D, Resident E, Resident F, Resident G and Resident H. The findings are listed below.

- Resident D's January MAR documented that she was prescribed "Quinapril TAB 20MG, take 1 by mouth daily. The MAR documented the medication "order began 03/30/2022. Stop date 01/31/2023." The MAR documented in "exceptions" on 01/02/2023, 01/03/2023, 01/04/2023, 01/05/2023,01/06/2023, 01/07/2023, 01/082023, 01/09/2023, 01/12/203, 01/13/2023, 01/17/2023, 01/18/2023, 01/19/2023, 01/23/2023, 01/24/2023, 01/25/2023, 01/26/2023, 01/27/2023, 01/28/2023, 01/29/2023, 01/30/2023, 01/31/2023, medication "not in cart." Consequently, Resident D was not given this medication on the above dates.
- Resident E's record contained a letter from a physician documenting that he was able to self-administer his own medications. Resident E's MAR for both January 2023 and February 2023 were both completely blank. Resident E's record did not contain any documentation that the direct care workers were reminding a Resident E to maintain his medication schedule, as directed by the resident's physician.
- Resident F's January 2023 MAR documented that she was prescribed "Lidocaine PAD 5%, Apply 3 patches topically daily. Remove and discard patch within 12 hours or as directed by MD." This prescription was written on 01/05/2023 with no end date documented. The MAR documented in "exceptions" on 01/09/2023, 01/10/2023, 01/11/2023, and 01/16/2023 as medication "not in cart." Consequently, Resident F was not given this medication on the above dates.
- Resident G's January 2023 MAR documented that she is prescribed "Oxycodone Tab 5 MG, take 1 tablet by mouth twice a day, may crush. Order written 12/19/2022, stop date 02/07/2023. Resident G was out of the facility 01/06/2023-01/11/2023. The MAR documented in "exceptions" on 01/27/2023 at 8:20PM, 01/28/2023 at 9:52 am and 10:06PM, 01/29/2023 at 9:19 AM and 8:06 PM, 01/30/2023 at 9:59 AM and 7:07 PM, 1/31/2023 at 9:55 AM and 7:13PM medication "not in cart." Consequently, Resident G was not given this medication on the above dates.
- Resident G's February 2023 MAR documented that she was prescribed Oxycodone by two different physicians. The first was one "Oxycodone Tab 5 MG take 1 tablet by mouth twice a day may crush written by Adegeye, Charmine on 12/19/2023 with and end date of 02/07/2023." The second script on the MAR documented that Resident G was prescribed by "Oxycodone Tab 5 MG take 1 tablet by mouth twice a day for pain written by Abuya, Dominic on 02/06/2023, no stop date documented." "The MAR documented in "exceptions" on 02/01/2023 at 10:01AM and 9:55PM, 02/02/2023 at 9:14 AM and 8:35 PM, 02/03/2023 at 9:12 AM, 02/04/2023 at 9:34 AM and 9:03 PM, 02/05/2023 at 9:53 AM and 9:15 PM, 02/06/2023 at 9:20 AM and 8:29 PM and 02/07/2023 at 8:53 AM medication "not in cart." Consequently, Resident G was not given this medication on the above dates.

- Resident H's January 2023 MAR documented that she was prescribed "Simethicone CHW 80 MG, Take 1 by mouth three times daily." This prescription was written on 01/05/2023 with a 01/20/2023 end date. The MAR documented in "exceptions" on 01/08/2023 at 5:52 AM, 01/19/2023 at 6:00 AM, 1:11 PM and 8:13 PM, 01/20/2023 at 5:06 AM, 1:15 PM and 10:07 PM, medication "not in cart." Consequently, Resident H was not given this medication on the above dates.
- Resident H's January 2023 MAR documented that she was prescribed "Simethicone CHW 80 MG, Take 1 by mouth three times daily." This prescription was written on 01/20/2023 with no end date documented. On 01/28/2023 1:53 PM medication "not in cart." Consequently, Resident H was not given this medication on the above dates.
- Resident H's January 2023 MAR documented that she was prescribed "Acetamin Tab 500 MG, take 2 tablets by mouth every 8 hours." The MAR documented in "exceptions" on 01/12/2023 at 6:50 AM, 01/14/2023 at 5:47 AM, 1:10 PM and 9:20 PM, 01/15/2023 at 5:42 AM,1:12 PM, and 5:38 PM, 01/16/2023 at 5:38 AM, 9:48 AM,1:56 PM, 01/17/2023 at 5:46 AM, 01/18/2023 at 5:40 AM, 1:11 PM, 01/19/2023 at 1:11 PM, 8:13 PM, 01/20/2023 at 5:05 AM, 1:15 PM and 01/28/2023 at 1:53 PM medication "not in cart." Consequently, Resident H was not given this medication on the above dates. On 1/21/2023 at 5:49 AM,9:13 PM, 1/22/2023, 1:43 PM, 9:18 PM,1/23/2023, 5:33 AM, 1:03 PM, 9:04 PM, 1/24/2023 at 5:15 AM, 1:21 PM, 1/25/2023 at 5:30 AM, 1:58 AM,1/26/2023 at 5;37 AM,9:01 PM, 01/27/2023 at 5:32 AM, 9:16 PM, 01/28/2023 at 5:07 AM MAR documented "resident refused."
- Resident H's February 2023 MAR documented that she was prescribed "Simethicone CHW 80 MG, Take 1 by mouth three times daily." The MAR documented in "exceptions" on 02/09/2023 at 1:24 PM and 9:45 PM, "Resident Refused." The MAR documented in "exceptions" on 02/10/2023 at 6:23 AM, 02/11/2023 at 6:23 AM, 02/12/2023 5:51 AM and 3:03 PM, 02/13/2023 at 5:31 AM medication "not in cart." Consequently, Resident H was not given this medication on the above dates.

On 02/27/2023, I reviewed the medications in the medication cart for Resident D, Resident E, Resident F, and Resident G and determined all prescribed medications were available for administration per each physician's orders as of 02/27/2023. The medication cart contained Resident D's Quinapril in the medication cart, and it was available to be administered. The facility did not have any medication in the medication cart for Resident E because he self-administers. The medication cart contained Resident F's Acetamin, Simethicone and Resident G's Oxycodone were available to be administered however Resident G's Acetamin was not available. Resident G's Acetamin is prescribed as a pro re nata (PRN), "Take 2 tablets (650 MG) by mouth every 4 hours as needed for pain/fever above 100 degrees."

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the residents' medication administration records for January 2023 there is evidence to support that Resident D, Resident F, Resident G and Resident H's physician prescribed medications were not administered as prescribed. Resident D, Resident F, Resident G and Resident H all missed multiple dosages of medications because the medication was "not in cart."
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are not being showered on a regular basis.

INVESTIGATION:
On 02/23/2023, anonymous Complainant reported residents are not being showered on a regular basis. Because Complainant was anonymous no additional information or details could be gathered to clarify the allegation.

On 02/27/2023, I conducted an unannounced investigation and I interviewed Resident A who reported that she is independent and that she showers every other day. Resident A reported she takes the sheets off her bed once a week and DCWs on duty will wash them. Resident B reported she is provided a shower a couple of times a month and that the sheets are changed when she showers. Resident C reported that he is independent so he showers a couple of times a week. Resident C reported DCWs do not wash his bedding rather his daughter does. Resident D and Resident F both reported that they shower at least weekly. Resident E reported that she is provided a shower a couple of times a month. Resident A, Resident B, Resident C, Resident D, Resident E and Resident F were all observed in clean clothing and lacked any foul odor.

I interviewed DCW Sanders and DCW Malika Self who reported that some of the resident's shower independently and some are provided assistance. DCW Sanders and DCW Malika Self reported that all residents have good hygiene, are in clean clothing daily and are assisted with showers more than once per week. DCW Sanders and DCW Malika Self reported that *Shower/Linen Checklists* are kept for some of the residents but not all of them. DCW Sanders and DCW Malika Self both reported that some residents receive showers through hospice and some residents refuse showers. DCW Sanders and DCW Malika Self reported that there is a shower schedule. DCW Malika Self reported Resident G regularly refuses showers. DCW Sanders and DCW Malika Self reported that when residents refuse showers, they try to offer them a different shower time and different DCWs to see if the resident is more willing to shower with a particular DCW or at a different time.

I reviewed *Shower/Linen Checklist* for Resident C, Resident D, Resident E Resident F. Ms. Haddock reported that shower records are not kept on Resident G. According to the *Shower/Linen Checklist* residents were showered on the following days:

- Resident C-2/23/2023 showered. Resident C reported that he showers independently.
- Resident D- 1/31/2023 shower refused, 2/13/2023 shower refused, 2/20/2023 shower refused and 2/23/2023 shower given.
- Resident E-2/16/2023 showered and 2/23/2023 showered.
- Resident F- 1/31/2023 showered,02/03/2023 showered and 02/14/2023, showered.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based on the documentation provided by the facility, Resident D went at least 23 consecutive days without bathing and therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Linens are not being changed regularly.

INVESTIGATION:
On 02/23/2023, anonymous Complainant reported bedding isn't being changed regularly. Because Complainant was anonymous no additional information or details could be gathered to clarify the allegation.

On 02/27/2023, I conducted an unannounced investigation and I interviewed Resident A who reported that she takes the sheets off her bed once a week and the DCWs on duty will wash them. Resident B reported that the sheets are changed when she showers. Resident C reported that the DCWs do not wash his bedding, his daughter does.

I interviewed DCW Sanders and DCW Malika Self who reported that *Shower/Linen Checklists* are kept for some of the residents but not all of them. DCW Sanders and DCW Malika reported that bedding is changed it soiled. DCW Sanders and DCW Malika reported that at minimum bedding is changed when the resident showers.

I reviewed *Shower/Linen Checklist* for Resident C, Resident D, Resident E Resident F. According to the *Shower/Linen Checklist* residents were showered on the following days:

- Resident C-2/23/2023 linens not changed.
- Resident D- 1/31/2023 linen change refused, 2/13/2023 linen change refused, 2/20/2023 linen change refused, 2/23/2023 linen change.
- Resident E-2/16/2023 linen changed and 2/23/2023 linen changed.
- Resident F- 1/31/2023 linen changed,02/03/2023 linen changed and 02/14/2023 linen changed.

APPLICABLE RULE	
R 400.15411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillow case, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.
ANALYSIS:	Based on the documentation provided by the facility, Resident D's and Resident F's linens were not changed at least weekly. Resident D's linens were not changed for at least 23 consecutive days.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend no change in license status.

04/24/2023

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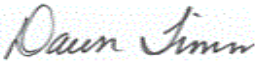
Julie Elkins Date
Licensing Consultant

Approved By:



04/24/2023

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Dawn N. Timm Date
Area Manager