GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 21, 2021

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

RE: License #: AL470402157
Investigation #: 2021A0466037
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 #:	2021A0466037
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 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?
Facility is understaffed and not able to meet the needs of the residents.	No
Resident A's call light was going off for 83 minutes and no one was available to assist her.	No
Additional Findings	Yes

III. METHODOLOGY

07/27/2021	Special Investigation Intake-2021A0466037.
07/27/2021	Contact - Telephone call made to Complainant, left message.
07/28/2021	Inspection Completed On-site.
07/28/2021	Special Investigation Initiated - Face to Face.
07/28/2021	Contact – Telephone call received; Complainant interviewed.
9/15/2021	Inspection Completed On-site.
9/17/2021	Contact - Telephone call made to direct care staff member Anastasia Sheldon, interviewed.
9/17/2021	Contact - Telephone call made to direct care staff member Kerry Cesarz interviewed.
9/17/2021	Inspection Completed On-site.
9/21/2021	Exit Conference with Shahid Imran, message left.

ALLEGATION: Facility is understaffed and not able to meet the needs of the residents.

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 residents have walked out of the building without direct care staff members knowledge because the security system is not working.

On 07/28/2021, I interviewed Complainant who reported not knowing how many residents were in each licensed building.

On 07/28/2021, I walked through the facility and all residents were well groomed and free of any foul order.

On 07/28/2021, I interviewed Hillard Kelly, manager, who reported that most of the residents are independent with activities of daily living (ADL)s 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 direct care staff member is scheduled per shift. Ms. Pedawi reported that the facility has been short staffed and cross training everyone to work as a direct care staff member incase a direct care staff member calls in. Ms. Pedawi 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. 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 residents age in place they may eventually require additional staffing assistance but currently they do not have any resident that requires two person direct care staff assistance.

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

On 07/28/2021, I reviewed the *Resident Register* which documented that the facility had 14 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 direct care staff member was scheduled per shift.

On 09/17/2021,I interviewed direct care staff member Anastasia Sheldon who reported that there is always one direct care staff member assigned to work per shift. Direct care staff member Sheldon 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 interviewed direct care staff member Cesarz who reported that there is always one direct care staff member assigned to work per shift. Direct care staff member 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 two direct care staff members to assist with transfers or mobility or with 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:	Although Complainant reported that the facility was understaffed, direct care staff members Ms. Pedawi, Ms. Wideman, Ms. Malott, Ms. Sheldon, and Ms. Cesarz all reported that the facility is staffed with one direct care staff member per shift. I reviewed a *Staff Schedule*/*Building Assignment* log dated 06/26/2021 through 07/25/2021 which documented that one direct care staff member was scheduled per shift and according to the resident register there were 14 residents living at the facility at the time of the investigation. Additionally, Mr. Kelly, Ms. Pedawi, Ms. Wideman, Ms. Malott, Ms. Sheldon, and Ms. Cesarz all 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 therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A's call light was going off for 83 minutes and no one was available to assist her.

INVESTIGATION:
On 07/27/2021, Complainant reported that Resident A's call light was going off for 83 minutes and no one was available to assist her. Complainant reported someone from the kitchen finally went to help her.

On 07/28/2021, I interviewed direct care staff member Wideman who reported that some days get really busy with resident call lights. Direct care staff member Wideman reported typical response time to a call light is three to five minutes. Direct care staff member Wideman reported that the longest that she knows that a resident has waited after hitting the call light is 15 minutes. Direct care staff member Wideman is not aware of a time when Resident A's call light was going off for 83 minutes.

On 07/28/2021, I interviewed direct care staff member Malott who reported resident call lights are typically responded to within 10 minutes. Direct care staff member Malott reported that she is aware of one time that the call light went off for 40 minutes because although she had responded to it, she initially forgot to turn it off, then she had trouble turning it off as it would not deactivate. Direct care staff Mallott could not remember if Resident A's call button was the one that she had difficulty deactivating. Direct care staff member Mallott reported that she is not aware of any circumstance when Resident A waited 83 minutes for a direct care staff member to respond to her call light.

On 07/28/2021, I interviewed Ms. Pedawi who reported that she is not aware of any time where it took any direct care staff member 83 minutes to respond to Resident A's call light. Ms. Pedawi did report that some direct care staff members were having trouble turning the call lights off. Ms. Pedawi explained that if a DIRECT CARE STAFF MEMBER thought they turned the call light off, they would not realize that the call light was not turned off until they went back into the nursing station where the call light station is. Ms. Pedawi agreed to look into if she could obtain a report from the call button agency about response times for Resident A's call button.

On 07/28/2021 and 9/15/2021, I reviewed Resident A's record which contained a written *Resident Service Plan* that documented that Resident A is a wheelchair user that requires some assistance to propel herself at times. Resident A's *Resident Service Plan* documented that Resident A requires assistance with transferring and occasional incontinence assistance. Resident A's *Resident Service Plan* did not document that Resident A is required to have any checks, additional personal care assistance or supervision.

On 09/15/2021, Ms. Pedawi provided me with a report from Tek-CARE dated 08/02/2021 for Resident A's call button from 07/01/2021 through 08/01/2021. The report documented that Resident A had pushed her button 89 times with a "min response 10 seconds" and a "max response of 1 hour 23 minutes." The report documented an "average response of 9 minutes, 17 seconds."

On 09/17/2021, I interviewed Resident A who reported direct care staff members at the facility take good care of her. Resident A reported that she uses her call button when she needs assistance and direct care staff members help her as needed. Resident A stated some days she had to wait longer than others, but she did not recall a time when she waited 83 minutes for a direct care staff member to respond.

On 09/17/2021, I interviewed Resident B, Resident C and Resident D who all reported that they received good care from direct care staff members at the facility. Resident B reported he uses his call button all of the time and direct care staff members respond to assist him. Resident B could not tell me how long it took for direct care staff members to respond, however he thought direct care staff members responded fairly quickly and within a reasonable about of time. Resident C and Resident D reported that they are still independent and they do not need to utilize their call button yet.

APPLICABLE RULE	
R 400.15303	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written

	assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**
ANALYSIS:	Direct care staff members interviewed denied purposefully allowing Resident A's resident call light to go off for an extended period of time rather direct care staff members reported responding timely to Resident A's call light but at times experiencing challenges deactivating the light. There is no evidence Resident A required additional personal care assistance or supervision per her written *Resident Service Plan.* Consequently, there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

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 direct care staff member available to pass medication to residents on 20 shifts during that one-month time frame. The following days/times are when a medication passer was not assigned to this facility/not available to pass medication to the residents as needed:

- 6/26/2021, 3rd shift
- 6/27/2021, 2nd
- 7/04/2021, 3rd shift
- 7/05/2021, 2nd
- 7/07/2021, 1st shift
- 7/08/2021, 3rd shift
- 7/09/2021, 2nd shift
- 7/10/2021, 1st
- 7/11/2021, 3rd shift
- 7/12/2021, 3rd shift
- 7/14/2021, 3rd shift
- 7/17/2021, 1st and 2nd shifts
- 7/18/2021, 2nd shift
- 7/19/2021, 2nd shift
- 7/20/2021, 1st and 2nd shifts
- 7/21/2021, 1st shift
- 7/23/2021, 1st and 2nd shifts
- 7/24/2021, 2nd shift

- 7/25/2021, 2nd shift

On 09/16/2021, I interviewed Ms. Pedawi, who reported that when a trained medication passer is not assigned to the facility, a nurse as well as management staff, who are all trained in medication passing, are available to pass medication.

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 resident July 2021 medication administration records (MAR)s and all 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, 20 shifts did not have an available direct care staff member trained in medication passing working in the AFC facility. Five, 1st shifts, nine, second shifts and six, 3rd shifts did not have a direct care staff member available that was trained in the proper handling and administration of medications therefore a violation has been established.
CONCLUSION:	**VIOLATION NOT 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:

09/21/2021

Dawn N. Timm Date
Area Manager