GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 3, 2023

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

RE: License #: AL470402180
Investigation #: 2023A0466024
Hampton Manor Of Hamburg 2

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 #:	AL470402180
Investigation #:	2023A0466024
Complaint Receipt Date:	02/07/2023
Investigation Initiation Date:	02/09/2023
Report Due Date:	04/08/2023
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 2
Facility Address:	7300 Village Center Dr. Whitmore Lake, MI 48189
Facility Telephone #:	(734) 648-5002
Original Issuance Date:	04/12/2021
License Status:	REGULAR
Effective Date:	10/12/2021
Expiration Date:	10/11/2023
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION:

	Violation Established?
Resident A is prescribed pain medication three times a day however the medication was not administered as prescribed.	Yes

III. METHODOLOGY

02/07/2023	Special Investigation Intake 2023A0466024.
02/09/2023	Special Investigation Initiated - Face to Face.
03/30/2023	APS Referral.
3/30/2023	Contact telephone call to DCW Zakirah Beauford, interviewed.
3/30/2023	Exit Conference with licensee designee Shahid Imran.

ALLEGATION: Resident A is prescribed pain medication three times a day however the medication was not administered as prescribed.

INVESTIGATION:
On 02/07/2023, anonymous Complainant reported that Resident A receives pain medication three times daily but the facility ran out of her prescribed medications. Complainant reported the family happened to be visiting and asked to have pain medication administered to Resident A but told there was none at the facility. Complainant reported a family member went home to get Resident A the needed medication and brought it back to the facility. Complainant reported being concerned facility administration did not know in advance that Resident A was out of medication. Complainant was also concerned because it was unclear how long Resident A had been without the medication or when it would be refilled. Because Complainant was anonymous no additional information or details could be gathered to clarify the allegation.

On 02/09/2023, I conducted an unannounced investigation and I interviewed Amelia Self, Resident Care Coordinator, who reported that on 02/06/2023 Resident A ran out of her prescribed Oxycodone during the afternoon shift. Ms. Self reported Relative A1 brought some of Resident A's Oxycodone medication that she had for Resident A at home to the facility so that she could be administered it. Ms. Self reported that the medication was refilled by Resident A's physician and received from the pharmacy on 02/07/2023. Ms. Self-reported that Oxycodone must be called into the pharmacy by hospice every 15 days and somehow that was missed.

On 02/09/2023, I reviewed Resident A's February medication administration record (MAR) which documented that Resident A was prescribed:

- "Oxycod/Apap tab 5-325 mg, take 1 tablet by mouth every 6 hours scheduled for pain.
- Oxycodone Please give her PRN med every bedtime by 6pm. Please record as PRN."

Resident A's MAR documented the following exceptions:

- 02/05/2023 12:01 PM Oxycod/Apap tab 5-325 mg, not in cart.
- 02/05/2023 5:26 PM Oxycod/Apap tab 5-325 mg, out of facility.
- 02/05/2023 11:10 PM Oxycod/Apap tab 5-325 mg not in cart.
- 02/06/2023 5:02 AM Oxycod/Apap tab 5-325 mg not in cart.
- 02/06/2023 11:13 AM Oxycod/Apap tab 5-325 mg, out of facility.
- 02/06/2023 4:06 PM Oxycodone not in cart.
- 02/06/2023 5:22 PM Oxycod/Apap tab 5-325 mg not in cart.
- 02/07/2023 5:15 PM Oxycod/Apap tab 5-325 mg not in cart.
- 02/08/2023 5:48 AM Oxycod/Apap tab 5-325 mg not in cart.
- 02/08/2023 5:59 AM Oxycod/Apap tab 5-325 mg not in cart.
- 02/08/2023 11:11 AM Oxycod/Apap tab 5-325 mg not in cart.

On 03/30/2023, I interviewed direct care worker (DCW) Zakirah Beauford who reported she was on shift on 02/06/2023 when Resident A was out of her pain medication Oxycodone. DCW Beauford reported that 02/06/2023 was Resident A's birthday so Relative A1 was at the facility with her. DCW Beauford reported she told Relative A1 that Resident A was out of Oxycodone so Relative A1 went home to get the Oxycodone pills that she had for Resident A there. DCW Beauford reported Relative A1 brought in 5 pills in a pharmacy prescribed pill container. DCW Beauford reported that she administered her one pill and gave the four other pills in the pharmacy container to DCW Deana Dang, whose role is shift supervisor.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Resident A is prescribed "Oxycod/Apap tab 5-325 mg, take 1 tablet by mouth every 6 hours scheduled for pain so she is prescribed this medication four times a day. Resident A's medication administration record documented that Resident A was not administered her prescribed medication twice on 02/05/2023, three times on 02/06/2023, once on 02/07/2023 and three times on 02/08/2023. DCW Zakirah Beauford reported she was on shift on 02/06/2023 and noted Resident A was out of her pain medication Oxycodone. DCW Beauford reported Relative A1 was at the facility and went home to get Oxycodone that she had for Resident A. DCW Beauford reported Relative A1 brought in five pills in a pharmacy prescribed container. DCW Beauford reported she administered Resident A one pill and gave the four other pills in the pharmacy container to DCW Deana Dang. According to Resident A's medication administration record, Resident A was not administered ten prescribed doses of her mediation between 02/05/2023 and 02/07/2023 therefore a violation has been established as her medication was not being administered as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan I recommend that the current license status remain.

3/30/2023

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Julie Elkins Date
Licensing Consultant

Approved By:

04/03/2023

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Dawn N. Timm Date
Area Manager