GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 26, 2023

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

RE: License #: AL470402180
Investigation #: 2023A0466043
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 #:	2023A0466043
Complaint Receipt Date:	04/28/2023
Investigation Initiation Date:	05/04/2023
Report Due Date:	06/27/2023
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?
Residents are not being fed timely or served fully prepared meals.	No
Medications are being left with residents on tables in cups unattended.	Yes
Direct care workers are ignoring residents' call lights and telling residents that they push their call lights too much.	No

III. METHODOLOGY

04/28/2023	Special Investigation Intake- 2023A0466043.
05/04/2023	Special Investigation Initiated - On Site.
06/15/2023	APS Referral.
6/15/2023	Exit Conference with Shahid Imran, message left.

ALLEGATION: Residents are not being fed timely or served fully prepared meals.

INVESTIGATION:
On 04/282023, Anonymous Complaint reported that residents are not being fed timely or offered full meals prepared. Because Complainant was anonymous, no additional information or details regarding the allegation could be gathered from Complainant.

On 05/04/2023, I conducted an unannounced investigation and I interviewed Kelly Haddock, executive director who reported that the facility currently has 12 residents and that none of the residents require feeding assistance. Ms. Haddock reported that all residents are provided with three meals and snacks daily. Ms. Haddock reported that breakfast is typically served around 7 am, lunch at noon and dinner around 5pm.

I interviewed Resident A, Resident B, Resident C and Resident D and they all reported that they are provided three fully prepared meals a day and that alternative food options are available upon request. Resident A, Resident B, Resident C and Resident D all reported that all of the residents at the facility eat independently and that no one requires feeding assistance.

I interviewed direct care worker (DCW) Ashley Horton, DCW Erin Ware and DCW Amelia Self who all reported that none of the current residents require feeding assistance. DCW Horton, DCW Ware and DCW Self all reported residents are provided with three fully prepared meals and snacks daily, breakfast is typically served around 7 am, lunch at noon and dinner around 5pm.

I reviewed resident records for Resident A, Resident B, Resident C, Resident D, Resident E Resident F, Resident G, Resident H, Resident I, Resident J, Resident K and Resident L and none of the resident records documented that any of them required feeding assistance according to their written *Level of Care* assessment plans.

I was at the facility during lunchtime (approximately noon) and I observed the direct care workers on duty gathering the residents for lunch. I observed the residents eating a fully prepared lunch independently in the dining room.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Complaint reported that residents are not being fed timely or offered fully prepared meals however there was no evidence to support this allegation as all interviewed reported none of the resident require assistance with feeding and meals are fully cooked when served. Additionally, Resident A, Resident B, Resident C and Resident D and they all reported that they are provided three fully prepared meals a day and that alternative food options are available upon request.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Medications are being left with residents on tables in cups unattended.

INVESTIGATION:
On 04/282023, Anonymous Complaint reported that resident medications are being left on tables in cups unattended. Because Complainant was anonymous, no additional information or details regarding the allegation could be gathered from Complainant.

On 05/04/2023, I conducted an unannounced investigation and I interviewed Resident A who reported the direct care worker on duty that is passing medication

will leave his spouse's (Resident E's) medications in cups unsecured for him to administer if Resident E is asleep when they come to administer medication. At the time of the unannounced investigation there was Albuterol prescribed to Resident E in the bedroom and unsecured.

I interviewed Resident B who reported he cannot remember if the direct care worker on duty leaves medication in his room unattended, but he thinks the direct care worker watches him take the medications. I observed Resident B's room which did have an empty medication cup on his table by his rocking chair.

I interviewed Resident C and Resident D who reported the direct care worker on duty that passes medications does watch them take medications and the medication passer does not leave any medications in medication cups unattended.

I interviewed DCW Ashley Horton the direct care worker assigned to pass medication on 05/04/2023 who reported she does leave medication in medication cups unsecured for Resident E with Resident A because Resident E is typically asleep and her spouse Resident A administers medications to her when she wakes up. DCW Horton reported that she does go back to Resident E's room to make sure that Resident E has been administered her medications by her spouse Resident A if he gave the medications to her. DCW Horton reported that if any other resident is sleeping, she either wakes the resident up or takes the medication back to the medication room and tries to administer it later. DCW Horton stated she left two of Resident E's inhalers and Resident E's morning medications with Resident A today for administration.

I interviewed DCW Erin Ware who reported that she does leave medication in medication cups unsecured for Resident E because she is typically asleep and her husband Resident A will administer her medications when she wakes up.

I interviewed DCW Self who denied that medication for Resident E is left unsecured with Resident A. DCW Self also reported that there is not a physician order for Resident A nor for Resident E to self-administer medications.

I reviewed resident records for Resident A and Resident E and neither contained written physician orders for self-administration of medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.

ANALYSIS:	Complainant reported resident medications are being left on tables in cups unattended. DCW Horton and DCW Ware both reported leaving Resident E's medications in medication cups unattended so that Resident E's spouse, Resident A, can administer the medication to her upon awakening. DCW Horton stated she left two of Resident E's inhalers and Resident E's morning medications on 5/04/2023 with Resident A unattended. There was no physician's order allowing Resident E to self-administer her own medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care workers are ignoring residents' call lights and telling the resident that they push their call lights too much.

INVESTIGATION:
On 04/282023, Anonymous Complaint reported direct care workers are ignoring resident call lights and telling residents they push their call lights too much. Because Complainant was anonymous, no additional information or details regarding the allegation could be gathered from Complainant.

On 05/04/2023, I conducted an unannounced investigation and I interviewed Resident A, Resident B, Resident C and Resident D who all reported resident call lights are responded to and are not ignored by direct care workers. Resident A, Resident B, Resident C and Resident D all reported that none of the other residents have ever reported to them that call lights are not responded to timely. Resident A, Resident B, Resident C and Resident D all reported that a direct care worker has never told them they push their call lights too much. Resident A, Resident B, Resident C and Resident D all reported that they have never heard any direct care worker tell another resident that they push their call light too much.

I interviewed Ms. Haddock who reported that the expectation is that call lights are responded to within 8 minutes. Ms. Haddock reported she conducts family nights with family members and she reported that no resident nor family member has ever reported to her direct care workers are ignoring resident call lights and/or telling residents that they push their call lights too much. Ms. Haddock reported call light logs can be pulled however the pendants that the residents wear around their neck are difficult to reset and sometimes that throws the data off. Ms. Haddock reported the call lights have a very small reset button on the pendant and that most direct care workers have to use the tip of a pen to reset it. Ms. Haddock reported that sometimes the direct care worker believes that the call light has been reset when it has not been and that is what makes the call light report inaccurate.

I interviewed DCW Horton, DCW Ware and DCW Self who all denied resident call lights are ignored or that any of them have ever told residents they push their call lights too much. DCW Horton, DCW Ware and DCW Self all reported they have

never heard another direct care worker tell a resident that they push their call light too much. DCW Horton, DCW Ware and DCW Self all reported that no resident or family member has ever reported to them that a direct care worker has ignored resident call lights and/or told residents that they push their call lights too much. DCW Horton, DCW Ware and DCW Self all reported the call lights have a very small reset button on the pendant and they have to use the tip of a pen to reset the call light. DCW Horton, DCW Ware and DCW Self all reported that if they do not have a pen with them resetting the pendant is delayed and sometimes, they believe that they have reset the pendant when it actually was not reset. DCW Horton, DCW Ware and DCW Self all reported that typically response times to call lights are pretty prompt unless all of the direct care workers are helping other residents and then it may take a little longer to respond. DCW Horton, DCW Ware and DCW Self reported that the longest they believe it may take to respond to a call light if they are helping another resident would be about 30 minutes.

I reviewed the April 2023 call light detail which documented that all call lights were responded to by direct care staff member with none being ignored. I also noted there was no one resident who overused the call light system. My review of the call light data confirmed the information provided by direct care staff members and executive director Haddock that response time varies widely.

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:	Based on interviews and review of the call light log, there is no evidence to support that direct care workers are ignoring resident call lights and telling residents that they push their call lights too much.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable correction action plan I recommend no change in license status.

06/15/2023

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Julie Elkins Date
Licensing Consultant

Approved By:

06/26/2023

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Dawn N. Timm Date
Area Manager