GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 21, 2023

Shahid Imran
Hampton Manor of Dundee LLC
123 Waterstradt Commerce
Dundee, MI 48131

RE: License #: AL580396859
Investigation #: 2024A0116005
Hampton Manor of Dundee 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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL580396859
Investigation #:	2024A0116005
Complaint Receipt Date:	11/01/2023
Investigation Initiation Date:	11/01/2023
Report Due Date:	12/31/2023
Licensee Name:	Hampton Manor of Dundee LLC
Licensee Address:	123 Waterstradt Commerce Dundee, MI 48131
Licensee Telephone #:	(734) 673-3130
Administrator:	Shahid Imran
Licensee Designee:	Shahid Imran
Name of Facility:	Hampton Manor of Dundee 3
Facility Address:	123 Waterstradt Commerce Dundee, MI 48131
Facility Telephone #:	(734) 826-9191
Original Issuance Date:	01/31/2020
License Status:	REGULAR
Effective Date:	07/31/2022
Expiration Date:	07/30/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Complainant unsure if there is a trained cook at the facility as there are multiple staff throughout the facility assisting in the kitchen.	Yes
Resident A was given her medication at 7:00 a.m. and at 11:45 a.m. that same medication was still in the medication cup on Resident A's nightstand.	Yes

All allegations not addressed as they were not rule related

III. METHODOLOGY

11/01/2023	Special Investigation Intake 2024A0116005
11/01/2023	Special Investigation Initiated - Telephone Interviewed Complainant.
11/01/2023	Contact - Document Received Received picture of Resident A's medication in the medication cup on her nightstand.
11/03/2023	APS Referral Made
11/06/2023	Inspection Completed On-site Interviewed Resident Care Coordinator (RCC), Jennifer Gibson, Resident A and staff, Misti Allison. Reviewed staff, Brandy Sadjak, cook/kitchen manager, Ronald Lapointe and cook/assistant kitchen manager, Brandon Perales employee records.
11/06/2023	Inspection Completed-BCAL Sub. Compliance
11/15/2023	Contact - Telephone call made Interviewed, Mindy Fell, Executive Director.
11/20/2023	Exit Conference With licensee designee, Shahid Imran.

ALLEGATION:

Complainant unsure if there is a trained cook at the facility as there are multiple staff throughout the facility assisting in the kitchen.

INVESTIGATION:

On 11/01/23, I interviewed the complainant, and he reported being unsure if the facility had a cook as there have been times when he has observed, office staff, direct care staff and even the maintenance man assisting in the kitchen. Complainant reported that staff come and go so often he was not sure if there was an actual full-time cook employed at the facility.

On 11/06/23, I conducted an unscheduled onsite inspection and interviewed Resident Care Coordinator (RCC), Jennifer Gibson, reviewed cook/kitchen manager, Ronald LaPointe and cook/assistant kitchen manager, Brandon Perales employee records.

Ms. Gibson reported that the facility employs three cooks and reported that Mr. LaPointe is the kitchen manager/head cook. Ms. Gibson reported that at mealtimes all the staff chip in and assist with serving meals. She reported that at times staff will assist with some prep to ensure timely delivery of meals, under the supervision of Mr. LaPointe or the other trained cooks. Ms. Gibson reported that it is unlikely that the maintenance man would assist with any sort of meal prep or service and reported that she has never observed that, and no one has ever informed her of that happening.

I reviewed Mr. LaPointe's and assistant kitchen manger/cook, Brandon Perales, employee record. Neither record contained verification of training as required by these rules. Ms. Gibson reviewed the file of the third cook, Beverly Crater, and reported that her Serv Safe training was expired and had been at her time of hire. She reported not observing any additional training and confirmed that Mr. LaPointe is the fulltime head cook.

On 11/15/23, I interviewed executive director, Mindy Fell, and she reported that Mr. LaPointe is the head cook and she had been requesting his training since she hired him in September 2023. Ms. Fell reported that Mr. LaPointe told her he had training through his previous employer, but reported that the verification is not readily accessible to him. Ms. Fell reported that she had Mr. LaPointe complete Serv Safe/Food Handler training on 11/13/23 and reported that it is in his file. Ms. Fell also forwarded a copy of the certificate of completion. Ms. Fell added that she also had the other two cooks complete the Serv Safe training which is valid for three years.

Ms. Fell reported that the staff throughout the facility all chip in during meal times to assist with plating and serving meals. She reported she assists if needed also to

make sure timely meal service. Ms. Fell reported being unaware of the maintenance man assisting in the kitchen during meals times.

On 11/20/23, I conducted the exit conference with licensee designee, Shahid Imran, and informed him of the findings of the investigation. Mr. Imran reported an understanding of the rule violation.

APPLICABLE RULE	
R 400.15201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(14) A licensee shall employee at least 1 individual who is qualified by training, experience, and performance to be responsible for food preparation. Additional food service staff shall be employed as necessary to ensure regular and timely meals.
ANALYSIS:	This violation is established because at the time of the onsite inspection on 11/06/23, the head cook/kitchen manager, Ronald LaPointe, who is responsible for food preparation did not have verification of training contained in his file for consultant review.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was given her medication at 7:00 a.m. and at 11:45 a.m. that same medication was still in the medication cup on Resident A's nightstand.

INVESTIGATION:

On 11/01/23, I interviewed the complainant. The complainant reported that there was an incident in September concerning Resident A’s medication that is an issue for him. The complainant reported that his brother went to visit Resident A and while in her room observed her a.m. medications sitting on her nightstand still in the medication cup. Complainant reported that his brother took a picture of the medications and sent it to him. He reported that the am medications are given usually around 7:00 a.m. and it was around 11:45 a.m. when his brother went to visit and observed them. Complainant reported that he addressed his concerns with management at the facility and they reported that they were going to address it with staff and re-iterate that they should be watching Resident A to make sure she takes

her medication prior to them leaving out of her bedroom. Complainant reported concern of the documentation issues as well, stating that the staff are initialing medication as given, and in actuality they have not watched or confirmed that the medication had been taken. Complainant reported also being in the facility at times and observing different staff give residents their medications and walk away without ensuring that the residents ingested the medication.

I asked the complainant to forward a copy of the picture taken by his brother. He reported that he would send it.

On 11/01/23, I received the picture of Resident A's medications in a medication cup on what appeared to be a nightstand. I counted seven pills and three capsules in the medication cup.

On 11/06/23, I conducted an unscheduled onsite inspection and interviewed RCC, Jennifer Gibson. Ms. Gibson reported that she was aware of the incident that occurred on the morning of September 9, 2023, and stated that she and Executive Director, Mindy Fell, observed the medications on Resident A's nightstand when they went to check on Resident A. They reported she had recently been diagnosed with Covid 19 and was complaining about being nauseous and just not feeling well. Ms. Gibson reported that the Nurse Practitioner was in the building seeing residents the same day and she informed her of the incident. Ms. Gibson reported that the nurse practitioner reported that Resident A could go ahead and take her a.m. medications even though they were supposed to be taken at 7:00 a.m. Ms. Gibson reported that she and the nurse practitioner reviewed all of Resident A's 7:00 a.m. prescribed medications and the medications she was scheduled to take that evening. Ms. Gibson reported that after reviewing the medications the nurse practitioner gave authorization for them to give Resident A's next dose of evening medication as scheduled.

Ms.Gibson reported that she then spoke to the staff, Brandy Sadjak, who passed the a.m. medication the morning of September 9, 2023. Ms. Gibson reported that Ms. Sadjak reported that Resident A was complaining that she wasn't feeling well and was nauseous and would take her medications a little later. Ms. Gibson reported that Ms. Sadjak reported that she said ok and left the medication cup on Resident A's nightstand. Ms. Gibson reported that she explained to Ms. Sadjak that that was unacceptable and that the rules and their training mandate staff watch residents ingest the medication and by initialing, that signifies that they have confirmed that the resident has taken the medication. Ms. Gibson further reported that she explained to Ms. Sadjack that if Resident A refused the medication and did want to take it, that she should have taken it out of the room and documented the refusal on the medication administration record (MAR). Ms. Gibson reported that Ms. Sadjak was immediately re-educated on proper medication administration procedures.

Ms. Gibson reported that Ms. Sadjack quit this morning at 6:45 a.m. and is no longer employed at the facility.

I reviewed staff Brandy Sadjack's training and confirmed that she completed medication training prior to assumption of duties as required by the rule. I also reviewed the additional in-depth medication training that was provided to Ms. Sadjak by Ms. Gibson.

I interviewed Resident A and she reported that she likes living at the facility and reported that the staff treat her nice and are very helpful. Resident A was unable to recall this incident where her medication was left on her nightstand, but she reported that the staff do not always watch her take her medication. Resident A reported that most of the staff do, but not all of them. She reported that some of the staff give her the medication cup and walk right out of her room. Resident A was unaware of the requirement for staff to watch every resident take their medication before leaving out of their room.

I interviewed staff, Misti Alison, and she reported that the medication training at the facility is extensive and reported that everyone is trained to make sure before they leave a resident's bedroom or their presence that they must confirm that they have taken/swallowed the medication. She reported once they have confirmed that, then the MAR is initialed. Ms. Alison reported that it is sad that people don't do what they are trained and supposed to do.

On 11/20/23, I conducted the exit conference with licensee designee, Shahid Imran, and informed him of the findings of the investigation. Mr. Imran reported an understanding of the rule violation.

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: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

ANALYSIS:	This violation is established, as former staff, Brandy Sadjak, prepared Resident A's 7:00 a.m. medication, took it to her bedroom, failed to watch her take the medication, and initialed the MAR signifying Resident A had taken it. Later that morning around 11:45 a.m. Resident A's medication was observed in the medication cup on her nightstand.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Pandrea Robinson
Licensing Consultant

11/20/23
Date

Approved By:

11/21/23

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Ardra Hunter
Area Manager

Date