GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 21, 2024

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

RE: License #: AL470402180
Investigation #: 2024A0466048
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

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 #:	2024A0466048
Complaint Receipt Date:	06/27/2024
Investigation Initiation Date:	07/01/2024
Report Due Date:	08/26/2024
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:	10/12/2023
Expiration Date:	10/11/2025
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATIONS:

	Violation Established?
Resident A fell, had a change in medical condition and did not receive timely medical treatment.	No
Resident A was admitted without the completion of admission paperwork.	Yes
Resident A is not being administered her medications as prescribed.	Yes
Resident A is not provided a shower at least weekly.	Yes

III. METHODOLOGY

06/27/2024	Special Investigation Intake 2024A0466048.
06/27/2024	Contact - Document Sent APS Sarah Barbee.
06/28/2024	Contact - Document Received 2nd Complaint received
07/01/2024	Special Investigation Initiated - On Site.
07/01/2024	Contact - Telephone call made to APS Sarah Barbee.
07/01/2024	Contact - Telephone call made; Complainant interviewed.
06/27/2027	APS Referral- APS Sarah Barbee assigned.
08/07/2024	Contact - Document Sent/Received to/from APS Sarah Barbee.
08/15/2024	Contact- telephone call made to Relative A1, interview.
08/21/2024	Contact- telephone call made to nurse Sheena Ross, interviewed.
08/21/2024	Exit Conference with licensee designee Shahid Imran, email sent.

ALLEGATION: Resident A fell, had a change in medical condition and did not receive timely medical treatment.

INVESTIGATION:
On 06/27/2024, Complainant reported that Resident A (81) who is diagnosed with coronary artery disease, kidney disease, heart failure, bipolar disorder, blindness, and increasingly altered mentation/confusion, has very limited mobility and is unable to complete her activity of daily living (ADL)s, had a fall on 06/05/2024. Complainant reported on 06/05/2024, facility staff contacted Relative A1 and informed her that Resident A had fallen around 1am but was not found until 7:30am and was covered in blood. Complainant reported that Relative A1 told staff that she would be at the facility after work around 5pm. Complainant reported that staff did not call an ambulance.

On 06/28/2024, Complainant reported on 06/05/2024, Resident A's nurse arrived at Resident A's room at 11am and also reached out to Relative A1 explaining the need for Resident A to go to the emergency room. Complainant reported that again, Relative A1 refused and facility direct care staff did not intervene and call 911 then either. Complainant reported Resident A had a significant eyeball injury that resulted in major surgery and now she could be blind. Complainant reported that Resident A was diagnosed with a globe rupture at the time she was finally evaluated over 16 hours after she was found lying on the ground covered in blood.

On 07/01/2021, Adult Protective Services (APS) staff Sarah Barbee reported that Resident A was not currently at the facility but was transferred from the hospital to a rehabilitation center. APS Barbee reported that the length of stay at the rehabilitation center is unknown at this time. APS Barbee reported that Resident A's current hospitalization and rehabilitation is not related to the fall on 06/05/2024.

On 07/01/2024, I conducted an unannounced investigation and I met with Julie Toering, licensed practical nurse (LPN), who reported that Resident A is a "fall risk" and does not ask for help when getting up from her bed at night which has caused her to fall. Nurse Toering reported that she was only aware of one fall on 6/11/2024 or 6/12/2024, (could not remember the date) when Resident A fell while reaching for the remote. Nurse Toering stated Resident A landed on her face and it was learned, after medical attention was obtained, that she required surgery on her eye. Nurse Toering reported Resident A's eye surgery was outpatient and Resident A returned to the facility the same day the eye surgery occurred. Nurse Toering reported the fall was not witnessed by any direct care staff and that the information gathered about the fall was from Resident A's self-report, including the time of the fall, and DCW Lillian Borek's observations. Nurse Toering reported emergency medical service (EMS) was not contacted at the time of the fall because they facility contacted Relative A1 and she wanted to take Resident A to the hospital after work. Nurse Toering reported Resident A had "an abrasion, bruising, carpet burn and a scrape around the eye" and she and direct care worker DCW Borek evaluated Resident A and determined medical care from a physician could wait until Relative

A1 came in after work. Nurse Toering reported that Resident A is not at the facility now and reported that she left on 6/25/2024.

Resident A was not able to be interviewed as she was not at the facility at the time of the unannounced investigation.

I reviewed Resident A's record which contained a *Resident Addresses Form* which documented that Resident A was admitted to the facility on 5/31/2024. Resident A's *Level of Care Assessment* documented that she was a "Level 2" which required staff assistance with ambulation due to "physical need or confusion, she is a fall risk, requires assistance with transfers on a regular basis and assistance with bathing." Additionally, it was documented that Resident A has "mild confusion, requires daily treatments/health services/support from nursing and has complex medication."

I reviewed Resident A's record which contained a written *Assessment* that documented in the "social/behavioral" section that Resident A does not move in the community independently, she does not manage money, she does not control aggressive behavior, she does not get along with others and she does not participate in social activities. In the "self-care" section it documented she needs assistance with eating, toileting, bathing, grooming, dressing, personal hygiene and walking/mobility. In the "health care" assessment it stated, she takes medications. Under "comment" it stated, "has diagnosis of bipolar disorder. Has plural effusion. Needs lots of encouragement to drink and eat. Refuses most activities. Has history of insomnia and most nights is up all night. Also has major depressive disorder. Has history of dysphagia (problem swallowing)." Resident A's written assessment plan did not contain any supervision instructions nor any agreements as to how often Resident A would be checked on.

I reviewed an *Occurrence Report* that was authored by direct care worker (DCW) Lillian Borek who documented that Resident A had a fall. The document was dated "03/04/2024" at 8am however that date was prior to Resident A's admission. It also documented "Went into [Resident A's] room in the morning. She told me that in the night she fell reaching to unplug her tv. She has an abrasion on her face around her eye. She is okay other than the abrasion. She was given Tylenol 325 mg two time throughout the day."

I interviewed DCW Borek who reported that when she came to work (date unknown) the night staff reported to her "in passing" that Resident A had fallen and that she had a "nick" on her face. DCW Borek reported that when she checked Resident A, she observed that Resident A had an abrasion on her face but that "it wasn't that bad" and described it as a "gash by her right eye." DCW Borek reported she did not call EMS as she did not think that her injury warranted EMS care and gave Resident A Tylenol. DCW Borek reported that DCW Ruggles was the assigned medication passer that day. DCW Borek reported that she checked on Resident A every 1-2 hours throughout the day to assess Resident A's facial/eye injury. DCW Borek reported that Resident A was fine every time she checked on her and Resident A did

not report being in any pain. I showed DCW Borek the *Occurrence Report* and she verified writing it. DCW Borek reported that the date of the document was incorrect and thought maybe the fall occurred on 06/03/2024 or 06/04/2024 but was not certain and she had no explanation for the incorrect date on the report. DCW Borek reported that her shift ended prior to Relative A1 coming to the facility so she was not sure if Resident A was taken to the emergency room on the day of the injury occurred. DCW Borek reported that Resident A was taken to the hospital (date unknown) and Resident A came back to the facility that same day. DCW Borek reported that when Resident A had eye surgery (date unknown) she again came back to the facility the same day. DCW Borek reported that Resident is currently out of the facility for a reason unrelated to the fall discussed above.

I interviewed DCW Ruggles who reported Resident A has had one to two falls since moving into the facility on 05/31/2024. DCW Ruggles reported Resident A was never hospitalized for any of the falls. DCW Ruggles reported that she was not on duty when Resident A fell causing an abrasion on her face. DCW Ruggles reported Resident A was on 2-hour checks and when she worked Resident A's bedroom door was usually open, so it was easy to check on her while walking by her room. DCW Ruggles reported Resident A attempted to transfer without assistance which would cause her to fall. DCW Ruggles reported that Resident A typically slept during the day. DCW Ruggles reported that Resident A is in the hospital currently for a different medical issue and she was unaware of when Resident A was returning to the facility.

I interviewed DCW Victoria Corea who reported working the night shift and finding Resident A out of bed and on the floor often. DCW Corea reported that Resident A was falling/sliding out of bed a lot at night when she was trying to get to the bathroom without assistance. DCW Corea reported that Resident A refused care and assistance from the direct care workers often. DCW Corea was not sure of the date but reported that Resident A fell injuring face. DCW Corea reported that Relative A1 takes her to the hospital as needed. DCW Corea reported that Resident A is in the hospital now for an unrelated medical issue.

Resident A's record contained a *Health Care Appraisal* which was dated 5/30/2024 and documented in the "mental/physical status and limitation section, fall risk."

I reviewed an *After Visit Summary* dated 6/11/2024 Surgery Discharge Instructions which documented that Resident A had a ruptured global repair. I reviewed an *After Visit Summary* dated 6/12/2024 at 8am from the University of Michigan Heath Comprehensive Ophthalmology Clinic which documented that she was seen for post-op follow up.

On 08/07/2024, APS Barbee reported that she is going to substantiate her case. APS Barbee reported that the facility has no idea what happened to Resident A and there is no documentation in Resident A's record about her injuries. APS Barbee reported that she spoke to Mr. Veryanani who reported that Resident A is supposed to have checks every hour which were not being done. APS Barbee reported looking at documents at the hospital after Resident A was discharged and

she learned that Resident A fell two more times at the facility and did not receive medical attention timely even when injury was apparent.

On 08/15/2024, I interviewed Relative A1 who reported that Resident A fell on 6/04/2024. Relative A1 reported that within 24 hours of the fall, nurse Sheena Ross from Diamond Home Health Care saw Resident A and reported that she had “road rash” but otherwise looked okay. Relative A1 reported she took Resident A to the hospital on 06/06/2024 because Resident A reported that her eye hurt. Relative A1 reported that was when they learned that she required surgery for a ruptured global repair. Relative A1 reported that Resident A lost sight in that eye.

On 08/21/2024, I interviewed Nurse Ross who reported that she could not recall the date but reported that she did assess Resident A at the AFC facility the morning she fell and injured her face. Nurse Ross reported that she did not observe any “gross trauma” on Resident A. Nurse Ross reported that at the time Resident A did not have an assigned primary care physician (PCP) so she could not consult with a physician about her observations or Resident A’s condition. Nurse Ross reported that Resident A was not complaining of any pain, but she did offer to have her assessed at the hospital and both Resident A and Relative A1 declined medical treatment. Nurse Ross was aware that Resident A reported being in pain a couple of days later, was assessed at the ER and that Resident A had emergency surgery which did result in loss of vision in the eye. Nurse Ross reported that based on her observations and Resident A’s condition not changing until days later there was no way to know Resident A had an eye injury.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Resident A had an unwitnessed fall on 06/04/22024. Direct care worker Borek evaluated Resident A after Resident A informed of her injury and determined it was not necessary to call 911. DCW Borek continued to monitor Resident A every 1-2 hours throughout the day and reported Resident A's facial/eye injury was fine every time she checked on her and Resident A did not report being in any pain. Nurse Ross reported that she assessed Resident A at the AFC facility the same morning she fell and injured her face. Nurse Ross reported that she did not observe any "gross trauma" on Resident A. Nurse Ross reported that Resident A was not complaining of any pain, but she did offer to have her assessed at the hospital and both Resident A and Relative A1 declined medical treatment. Resident A was taken to the emergency department for evaluation on 06/06/2024 after Resident A's condition changed and she reported pain in her eye. Resident A received care after reporting the fall. Resident A was initially evaluated by direct care worker Borek and Nurse Ross before being taken to the emergency department by Relative A1 on 06/06/2024.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was admitted without the completion of admission paperwork.

INVESTIGATION:
On 06/28/2024, Complainant reported that facility does not have a contract/paperwork filled out on Resident A so Resident A is currently without appropriate documentation. Complainant reported that Resident A was admitted to facility on 5/31/24.

On 07/01/2024, I reviewed Resident A's resident record which contained:

- a written *Assessment Plan* completed by nurse Toering on 5/31/2024 but it was not signed by Relative A1 nor licensee designee Shahid Imran.
- a *Resident Care Agreement* dated 5/31/2024 and signed by Relative A1 on 6/29/2024 however this document was not signed by licensee designee Imran.
- a *Health Care Appraisal* dated 5/30/2024 and signed by medical personnel on 05/30/2024.

At the time of the unannounced investigation both Nurse Toering and Mr. Veryanani reported Resident A's resident record contained all available documents.

Renewal Licensing Study Report (LSR) dated 10/10/2023 documented violation of Rule 400.15301(4). At the time of the renewal inspection five resident records were reviewed and none of them contained evidence that the written assessment plans

were completed with the resident or the residents' designated representative. Licensee designee Imran submitted a corrective action plan (CAP) that stated the following: "A written assessment plan shall be completed with the resident, the resident's designated representative and the licensee. Assessment plans will be signed by the resident, the resident's designated representative and the licensee designee. Copies of assessment plans with signatures will be kept in the resident record. Compliance to be achieved by 10/31/2023."

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home. **(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following:** **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.** **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide dent as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.**

	(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost. **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.** **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.15315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.**
ANALYSIS:	At the time of the unannounced investigation Resident A's resident record contained a completed written *Assessment Plan* and a *Resident Care Agreement* however there was no documentation that both documents were completed with licensee designee Imran therefore a violation has been established.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE LSR dated 10/10/2023 and CAP 10/10/2023.]**

APPLICABLE RULE	
R 400.15301	**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.** **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.** **(c) The resident appears to be compatible with other residents and members of the household.** **(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.**
ANALYSIS:	At the time of the unannounced investigation Resident A's resident record contained a completed written *Assessment Plan* and a completed *Health Care Appraisal* therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A is not being administered her medications as prescribed.

INVESTIGATION:
On 06/28/2024, Complainant reported that Resident A received a new primary care provider (PCP) who made significant medication changes. Complainant reported that the updated medication list with dosages was provided to facility direct care staff members on 6/13/24. Complainant reported instead of going by the updated medication list, direct care staff combined Resident A's old medication list with the new medication list resulting in Resident A being on 25 medications and sleeping 20+ hours a day. Complainant reported Resident A was not only receiving the wrong medications but the wrong dosages of her medications. Complainant stated this was not discovered until 6/24/24.

On 07/01/2024, I conducted an unannounced investigation and I reviewed Resident A's medications in the medication cart in comparison with Resident A's June 2024

MAR. Based on the medications in the medication cart, physician ordered medications had been delivered for Resident A on 6/3/2024, 6/4/2024, 6/5/2024, 6/6/2024, 6/7/2024, 6/10/2024, 6/18/2024, 6/19/2024 and 6/21/2024. Additionally, after reviewing Resident A's June 2024 MAR, it documented that 18 medications has been discontinued throughout June 2024 and that Resident A was prescribed medications by at least four different physicians.

I reviewed the medication cart and Resident A's June 2024 MAR. Resident A's June 2024 MAR documented that Resident A's prescribed "Clonazepam 1 mg, take 1 tablet by mouth at bedtime for anxiety" that was prescribed by Christy Thallman on 06/05/2024 but the June MAR documented the medication was not available to be administered to Resident A from 06/05/2024-06/14/2024. Resident A's MAR documented Clonazepam medication was "not in cart." I observed Resident A's "Clonazepam 1 mg, take 1 tablet by mouth at bedtime for anxiety" in the medication cart on 07/01/2024. The medication documented a filled date of 06/15/2024 with 30 tabs.

On 08/15/2024, Relative A1 reported that Resident A went without her prescribed Clonazepam although it was prescribed. Relative A1 reported that once she was aware that Resident A was going without her prescribed Clonazepam she brought some that she had at home and provided it to the facility to administer to Resident A.

Special Investigation Report (SIR) #2023A0466024 dated 4/3/2023 documented that a resident was prescribed "Oxycod/Apap tab 5-325 mg, take 1 tablet by mouth every 6 hours scheduled for pain. The medication administration record documented this medication was not administered as prescribed to the resident multiple times during February 2023. Licensee designee Imran submitted a corrective action plan dated 4/17/2024 which documented that "an automatic reminder has been set up in Quick Mar to notify the Resident Care Coordinator (RCC) when any medication has only a 7 day supply remaining. The system alert will notify the RCC if the medication can be reordered or if a new prescription is required. RCC will then either reorder or obtain a new Rx and then reorder. The CAP documented that this was implemented. April 17, 2023 and compliance will be maintained by the health and wellness director conducting audits of the Quick Mar system alerts weekly.

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

	Resident A's Clonazepam prescribed on 06/05/2024 was not available to be administered to Resident A from 06/05/2024-06/14/2024. Resident A's MAR documented that the medication was "not in cart." Resident A was not being administered medications as prescribed for nine days therefore a violation is established.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR 2023A0466024 dated 04/03/2023, CAP 04/18/2023.]**

ALLEGATION: Resident A is not provided a shower at least weekly.

INVESTIGATION:
On 06/28/2024, Complainant reported that Resident A is assisted with bathing/hygiene on Tuesday and Fridays. Complainant reported that upon arrival to ED on 06/28/2024, while obtaining a urine sample it was found Resident A had not been washed (specifically in her genitals) for what appeared to be a very long time.

I conducted an unannounced investigation on 07/01/2024 and I reviewed Resident A's record which documented that she was admitted to the facility on 05/31/2024. I reviewed Resident A's June MAR which documented that Resident A received a shower on 6/14/2024, 6/18/2024 and 6/21/2024.

On 07/01/2024, I interviewed DCW Borek who reported that she never assisted Resident A with a shower. DCW Borek reported that Resident A did not like water and she did not like to shower, so direct care staff member gave her a bed bath. DCW Borek reported that Resident A was clean.

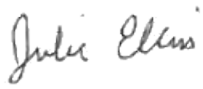
On 07/01/2024, DCW Victoria Corea reported that Sara (last name unknown) gave Resident A showers, but she was not sure of the dates.

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:	Resident A's record documents that she received showers at the facility on 6/14/2024, 6/18/2024 and 6/21/2024. There was at least a 13-day laps from 6/1/2024-6/14/2024 when Resident A did not receive a shower therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend no change in license status contingent upon receipt of an acceptable corrective action plan.



08/21/2024

_____

Julie Elkins Date
Licensing Consultant

Approved By:

08/21/2024

_____

Dawn N. Timm Date
Area Manager