GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 25, 2025

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

RE: License #: AL470402157
Investigation #: 2025A1029046
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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL470402157
Investigation #:	2025A1029046
Complaint Receipt Date:	07/09/2025
Investigation Initiation Date:	07/10/2025
Report Due Date:	09/07/2025
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:	05/20/2025
Expiration Date:	05/19/2027
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Wilma Baker improperly restrained Resident A because she put his Broda chair next to his bed so Resident A could not get out of bed.	Yes

III. METHODOLOGY

07/09/2025	Special Investigation Intake 2025A1029046
07/10/2025	Inspection Completed On-site -Special Investigation Initiated - Face to Face with Resident A, Caren Reyes, and Executive Director Altaf Veryamani at Hampton Manor of Hamburg 1
07/15/2025	APS Referral made to Centralized Intake
07/16/2025	Contact – Telephone call to direct care staff members Wilma Baker, Tiya Crowder, Alyssa O'Keefe, and email to Caren Reyes
07/17/2025	Contact – telephone call made to licensee designee Shahid Imran Left message, Shyanne Szarka
07/18/2025	Contact – telephone call made to direct care staff member Shyanne Szarka
07/24/2025	Contact – Telephone call to licensee designee Shahid Imran. Left message with Roz.
07/25/2025	Contact – Telephone call to licensee designee Shahid Imran, sent email, Dion Schoffner
07/25/2025	Exit conference with licensee designee Shahid Imran.

ALLEGATION: Direct care staff member Wilma Baker improperly restrained Resident A because she put his Broda chair next to his bed so he could not get out of bed.

INVESTIGATION:

On 07/09/2025 a complaint was received via Bureau of Community and Health Systems online complaint system with concerns that direct care staff member Wilma Baker improperly restrained Resident A after she put his Broda chair next to his bed so Resident A could not get out of bed. According to the complaint, these concerns were

brought to the attention of the Resident Care Manager however the concern was not addressed other than putting a message in the staff communication application called Band.

On 07/10/2025 I completed an unannounced on-site investigation at Hampton Manor of Hamburg 1 and interviewed Executive Director, Altaf Veryamani. Mr. Veryamani stated he did not have concerns that any of the direct care staff members restrained any residents by putting a chair in their way so the resident could not get out of bed. Mr. Veryamani stated Resident A does have an order through hospice for a Broda chair and denied there was a written policy regarding resident restraints. Mr. Veryamani stated Resident Care Manager Caren Reyes was responsible for direct care staff members and would have more knowledge.

On 07/10/2025 I interviewed direct care staff member, whose role is Resident Care Manager, Caren Reyes. Ms. Reyes stated there was a concern with a third shift direct care staff member Wilma Baker because she restrained Resident A with his Broda chair by placing the chair next to Resident A's bed so he could not get out of bed. Ms. Reyes stated Resident A receives hospice services and he has a Broda chair and wheelchair in his room. Ms. Reyes stated she received a report from another direct care staff member Ms. Crowder on 07/08/2025 that third shift direct care staff member, Ms. Baker was putting the Broda chair next to the bed so Resident A could not get out of bed during the night. Ms. Reyes stated she informed Ms. Baker she was not supposed to do this and gave her an informal verbal warning. Ms. Reyes stated when she spoke with Ms. Baker, she informed her Ms. Baker could not put the chair next to the bed again. Ms. Reyes denied this was reported to her more than once and stated she handled it when it was brought to her attention. Ms. Reyes stated Resident A was in bed and the Broda chair was put beside the bed so he was not able to fall out of the bed, however if he fell onto the chair, it could have caused more injuries. Ms. Reyes stated Resident A can walk a few steps however he leans forward and is a fall risk.

During the on-site investigation, I reviewed Resident A's resident record. According to Resident A's CorsoCare Hospice documentation he has a diagnosis of Parkinsons, depression, restlessness and agitation, pain, history of falling, urinary tract infections, and a need for assistance with personal care.

I interviewed Resident A who was resting in his recliner. Resident A stated he did not recall anyone putting anything against his bed while he was sleeping. Resident A stated sometimes he has a hard time getting out of the chair but he does not recall falling out of bed or the chair at any time. Resident A had a Broda chair, wheelchair, and recliner in his room. Resident A stated direct care staff members assist him when he needs to move to the bed or from the chair because he may fall. I observed the Broda chair to be next to the wall and not placed by his bed.

On 07/16/2025 I interviewed direct care staff member Wilma Baker. Ms. Baker stated she had a conversation with Ms. Reyes regarding a restraint by the bed, however she denied she put the Broda chair next to Resident A's bed. Ms. Baker stated she learned

she was not supposed to put the chair next to the bed because it is a restraint. Ms. Baker stated she did not know who placed the chair there. Ms. Baker stated she has worked in direct care for a long time, is a certified nursing assistant, and knows not to do this. Ms. Baker stated she does not know who put the chair next to the bed. Ms. Baker stated there was another direct care staff member, Alyssa O'Keefe who went in and moved the chair. Ms. Baker stated she had a conversation about it with Ms. Reyes but she was not written up. Ms. Baker stated someone else moved the chair next to the bed because if she had walked in and seen the chair there, she would have moved it because she knew that it was a restraint. Ms. Baker stated he also has a pad that will cushion his fall in case he falls out of bed. Ms. Baker stated sometimes Resident A will try to get out of bed but typically does not fall out of bed. Ms. Baker stated she does her rounds to check on Resident A every two hours and at 7 PM and 9 PM the chair was in its place against the wall across from the bed but not pushed up next to the bed. Ms. Baker stated Ms. O'Keefe is the one that came in before midnight and saw the chair was next to the bed.

On 07/16/2025 I interviewed direct care staff member Alyssa O'Keefe who stated she was aware of Ms. Baker putting a chair next to Resident A's bed to keep him from getting up or falling out of bed. Ms. O'Keefe stated she did make a comment about it to Ms. Baker because she is the midnight supervisor and she wanted to let her know this was not allowed. Ms. O'Keefe stated Ms. Reyes put it in the communications application BAND about a month ago however but she does not know if she brought it up to Ms. Baker. Ms. O'Keefe stated this was still occurring even after they put the message in the application. Ms. O'Keefe stated she moves the chair once she sees them so Resident A has not been injured. Ms. O'Keefe stated she does not know what is going on the other nights that she is not working. Ms. O'Keefe stated this has been occurring for the five months that she has worked there. Ms. O'Keefe has been a supervisor for two months and she stated she has reminded the other direct care staff members it was state law for them not to restrain a resident. Ms. O'Keefe stated there was one night she had to reposition Resident A because his foot was on the chair but he had never fallen onto it.

On 07/16/2025 I interviewed direct care staff member Tiya Crowder. Ms. Crowder stated that she has seen third shift direct care staff member Ms. Baker put the Broda chair in front of Resident A's bed because she claims that he tries to get out of bed. Ms. Crowder stated she saw this occur on an unknown date within the last couple weeks. Ms. Crowder stated she reported her concerns to Ms. Reyes and she posted in the BAND application that they are not allowed to put anything in front of Resident A's bed because it's a restraint and it could cause more harm. Ms. Crowder stated she did not speak to Ms. Baker about this because Ms. Baker can be confrontational with other direct care staff members so she just went straight to Ms. Reyes. Ms. Crowder stated she has a picture of the chair being in front of Resident A's bed.

I was able to review a picture that was sent by text message with the chair next to the bed. It appears to be light outside in the picture but it did not have a timestamp or date on it. I also reviewed the BAND message which was sent on 07/03/2025 from Ms. Reyes which stated the following message:

"Attention staff – please do not put wheelchairs, Geri-chairs, and side tables beside the residents bed because that is considered a restraint and may cause more harm to our residents. Please follow your every two hour checks or more often than that if you have residents that are fall risks or anxious. Thank you"

On 07/18/2025 I interviewed direct care staff member Shyanne Szarka. Ms. Szarka stated she has seen Broda chairs pushed up against Resident A's bed multiple times. Ms. Szarka stated she has notified Ms. Reyes and she sent a message this is not acceptable. Ms. Szarka stated she had noticed the chair placed by the bed at night in Resident A's bedroom but she does not know who placed it there but it was likely Ms. Baker because she was working then. Ms. Szarka has talked to direct care staff multiple times and nothing has changed. Ms. Szarka stated there are no written policies about what is considered a resident restraint.

On 07/25/2025 I interviewed licensee designee Shahid Imran. Mr. Imran stated that he has not been informed of this occurring during third shift but he will investigate the concerns further and prepare a corrective action plan to address these concerns.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**
ANALYSIS:	Based on the interviews with direct care staff members Ms. Reyes, Ms. Baker, Ms. Crowder, Ms. O'Keefe, and Ms. Szarka a chair was placed next to Resident A's bed with the purpose of stopping Resident A from getting out of bed. This happened on more than one occasion. The Broda chair has wheels and could have caused an injury to Resident A if he had fallen on top of the chair, instead of out of bed. Ms. Reyes put a message in the staff member communication application, BAND, informing direct care staff members not to put the chairs next to the bed because it is considered a restraint. According to Executive Director Mr. Veryamani there is no written policy regarding resident restraints.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon completion of an approved corrective action plan, I recommend no change in the license status.

_____07/25/2025_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

07/25/2025

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Dawn N. Timm
Area Manager

Date