



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 2, 2025

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

RE: License #: AL470402180
Investigation #: 2025A0466039
Hampton Manor Of Hamburg 2

Dear Mr. Imran:

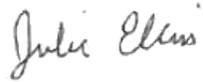
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "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 #:	2025A0466039
Complaint Receipt Date:	06/03/2025
Investigation Initiation Date:	06/03/2025
Report Due Date:	08/02/2025
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 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:	AGED ALZHEIMERS

II. ALLEGATIONS:

	Violation Established?
There is one direct care worker scheduled to work even though there are three residents who require two direct care workers to assist with personal care and/or transferring.	Yes
Resident A is being restrained in bed.	See Report #2025A1029048
Executive director (ED) Altaf Veryamai moved a non-elderly person into room 106.	Yes
Additional Finding	Yes

III. METHODOLOGY

06/03/2025	Special Investigation Intake 2025A0466039.
06/03/2025	Special Investigation Initiated – Telephone Complainant interviewed.
06/17/2025	Inspection Completed On-site.
09/02/2025	Exit Conference with licensee designee Shahid Imran.

ALLEGATION: There is one direct care worker scheduled to work even though there are three residents who require two direct care workers to assist with personal care and/or transferring.

INVESTIGATION:

On 06/03/2025, Complainant reported that the facility is chronically understaffed, and management consistently fails to provide support during critical shortages. Complainant reported that there is only one direct care worker (DCW) scheduled to work starting at 5pm and throughout the night. Complainant reported that Resident A, Resident B, Resident C all require the assistance of two DCWs for transferring. Complainant reported that Resident A requires the use of a sit to stand and the company policy is that this assistive device requires two DCWs when in use. Complainant reported that Resident B requires two-person assistance for toileting and showering. Complainant reported that when staff raise concerns about being overworked or experiencing burnout, they are frequently ignored or, in some cases,

terminated for speaking up. Complainant reported that this culture of fear and retaliation prevents necessary issues from being addressed. Furthermore, Complainant reported that the administrator routinely walks the building to monitor staff and assigns housekeeping tasks during downtime, including dusting and vacuuming, despite staff already being overextended with care responsibilities. Complainant reported that staff are underpaid, underappreciated, and forced to take on additional responsibilities when others fail to perform their duties with no compensation or acknowledgment. Complainant reported that repeated concerns brought to management about unfair workloads and inadequate staff performance are dismissed or ignored. Complainant reported that the current working conditions are unsustainable and directly affect both the quality of resident care and staff well-being.

On 06/17/2025, I conducted an unannounced investigation and I reviewed the *building census* provided by executive director (ED) Veryamani who confirmed that the facility has 16 residents. ED Veryamani reported that the facility utilizes two DCWs when a sit to stand device is being used.

I interviewed Caren Reyes, Residential Care Manager/Scheduler who reported that the facility operates with several different shifts: 7am-7pm, 7am-3:30pm, 7am-5:30p, 7am-3pm, 3pm-11pm and 7pm-7am or 11pm-7am. Ms. Reyes reported that it is difficult to hire staff and sometimes she has to schedule the DCW for the hours that they are willing to work even if it does not fall within the “ideal” staffing shifts. Ms. Reyes reported there are four individually licensed facilities that are all connected and at night each building has one DCW that is trained in medication administration assigned to each facility. Ms. Reyes reported that there is a fifth DCW on the schedule working as a “float” to assist all DCWs on duty as needed to meet the needs of the residents that require two-person assistance. Ms. Reyes reported that sometimes she documents the “float” on the lines in-between facilities on the list or the “float” is the second DCW on duty in Hampton Manor of Hamburg #3. Ms. Reyes reported that the DCWs have complained to her that there are not enough DCWs each shift however she reported that administration “follows the state requirements as much as possible” regarding ratios.

Ms. Reyes reported that Resident A does not require the assistance of two DCWs to be transferred as he uses a lift chair and sit to stand. Ms. Reyes confirmed that two DCWs are utilized with a sit to stand device. Ms. Reyes reported that Resident A does not need the sit to stand at night when he is sleeping and reported that there is always a “float” to help if he does need to transfer. Ms. Reyes reported that Resident B requires one direct care worker assistance, however she reported Resident B is declining. Ms. Reyes reported that Resident C had a stroke and she cannot use her left side. Ms. Reyes reported that Resident C cannot bear weight and requires two direct care workers to assist with personal care and transfers.

I reviewed Resident A’s record which contained an *Assessment* which was dated 01/23/2025. This document is signed by facility nurse Julie Toering and in the

“comment” section it states, “Uses sit to stand. Needs to be fed. Is independent with ADLs. Is incontinent of both bowel and bladder. Has diagnosis of Parkinsons. Leans forward in sitting position. Need to use recliner chair.” In the “self care skill assessment” it stated that Resident A requires assistance with eating, toileting, bathing, grooming, dressing and personal hygiene.”

I reviewed Resident A’s *Health Care Appraisal* dated 01/17/2025 and documented that he weights “185 pounds.” It documented in the “diagnosis” section of the report it stated, “Parkinsons, disease and depression.” In the “mobility” section it documented the use of a “walker and wheelchair.” Additionally, it noted, “Tremors in upper extremities. Weakness in lower extremities, Poor trunk control/kyphosis.”

I reviewed Resident B’s *Assessment* which was dated 05/31/2024. This document is signed by facility nurse Julie Toering and in the “comment” section it states, “Has diagnosis of bipolar disorder. Has plural effusion. Needs a lot of encouragement to drink and eat. Refuses most activities. Has a history of having insomnia and most nights she is up all night. Also has major depressive disorder. Has a history of dysphagia (problems swallowing.)” In the “self-care skill assessment” it stated that Resident B requires assistance with eating, toileting, bathing, grooming, dressing, personal hygiene and walking/mobility.”

I reviewed Resident B’s *Health Care Appraisal* dated 05/30/2024. In the “diagnosis” section of the report it stated, “Pleural effusion.” The “mobility” section was blank. Additionally, it noted, “high fall risk.”

I reviewed Resident C’s *Assessment* which was dated 06/14/2024. This document is signed by facility nurse Julie Toering.” In the “self care skill assessment” it stated that Resident C requires assistance with eating, toileting, bathing, grooming, dressing, personal hygiene and walking/mobility.”

I reviewed Resident C’s *Health Care Appraisal* dated 06/12/2024 that documented that she weighs 170 pounds. In the “mental/physical status” section of the report it documented, “hemi-walker, wheelchair.” In the “mobility” section both walker and wheelchair were checked. Resident C’s record contained Progress Notes for WellBridge of Pinckney dated 5/11/2024 which stated that Resident A is 85 years, wheelchair bound and obese.

I reviewed the Hampton Manor Shift assignments or staff schedule dated 4/28/2025 through 6/17/2025. I noted that on 05/09/2025, 05/18/2025 and 06/03/2025, there were not two DCWs working during waking hours which list the approximate time frames and the census report documented more than 15 residents admitted on those dates.

I further reviewed the Hampton Manor Shift assignments dated 4/28/2025 through 6/16/2025 and specifically reviewed the sleeping hours shifts (7pm-7am) as the executive director and multiple DCWs stated two DCWs are needed to utilize a sit-

to-stand with any resident. As stated above Resident A utilizes a sit-to-stand so two DCWs are needed to meet Resident A's transfer needs per facility policy. I noted on the following dates between the hours of 7pm-7am two direct care workers were not scheduled: 04/28/2025, 04/29/2025, 04/30/2025, 05/01/2025, 05/03/2025, 05/04/2025, 05/05/2025, 05/06/2025, 05/07/2025, 05/08/2025, 05/10/2025, 05/11/2025, 05/12/2025, 05/14/2025, 05/15/2025, 05/18/2025, 05/19/2025, 05/20/2025, 05/21/2025, 05/22/2025, 05/23/2025, 05/24/2025, 05/26/2025, 05/27/2025, 05/28/2025, 05/29/2025, 05/30/2025, 05/31/2025, 06/01/2025, 06/02/2025, 06/03/2025, 06/05/2025, 06/06/2025, 06/07/2025, 06/08/2025, 06/09/2025, 06/11/2025, 06/12/2025, 06/13/2025, 06/14/2025, 06/15/2025 and 06/16/2025. On 05/16/2025, 05/17/2025, 05/25/2025, 06/10/2025, a second DCW worked until 11pm. After 11pm one DCW was the only DCW on the schedule.

On 08/28/2025, ED Veryamani confirmed that between 4/28/2025 through 6/16/2025 were 16 residents in Hampton Manor #2. ED Veryamani reported that the admission date for Resident A was 01/23/2025.

APPLICABLE RULE	
R 400.15206	Staffing requirements.
	<p>(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.</p> <p>(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.</p>

<p>ANALYSIS:</p>	<p>On 06/17/2025, the facility had a census of 16 residents which requires two DCWs working in that facility during waking hours. I reviewed the Hampton Manor Shift assignments dated 4/28/2025 through 6/17/2025 and on 05/09/2025, 05/18/2025 and 06/03/2025, the facility did not have two DCWs working during waking hours. ED Veryamani confirmed that between 4/28/2025 through 6/16/2025 were 16 residents in Hampton Manor #2. Additionally I noted that on the following dates between the hours of 7pm-7am two direct care workers were not scheduled: 04/28/2025, 04/29/2025, 04/30/2025, 05/01/2025, 05/03/2025, 05/04/2025, 05/05/2025, 05/06/2025, 05/07/2025, 05/08/2025, 05/10/2025, 05/11/2025, 05/12/2025, 05/14/2025, 05/15/2025, 05/18/2025, 05/19/2025, 05/20/2025, 05/21/2025, 05/22/2025, 05/23/2025, 05/24/2025, 05/26/2025, 05/27/2025, 05/28/2025, 05/29/2025, 05/30/2025, 05/31/2025, 06/01/2025, 06/02/2025, 06/03/2025, 06/05/2025, 06/06/2025, 06/07/2025, 06/08/2025, 06/09/2025, 06/11/2025, 06/12/2025, 06/13/2025, 06/14/2025, 06/15/2025 and 06/16/2025. These dates are noted because not all residents were sleeping by 7PM so therefore a second DCW is required during those hours. Because there was not a second DCW during waking hours, this violation has been cited.</p> <p>ED Veryamani and Ms. Reyes reported that when using a sit to stand the use of two DCWs is required per facility policy. Resident A's <i>Assessment Plan</i> documented that he uses a sit to stand and per facility policy there should be two DCWs available at all times to assist him. Ms. Reyes reported that there is a fifth DCW on the schedule working as a "float" to assist all DCWs on duty as needed to meet the needs of the residents that require two-person assistance. Because a "float" DCW cannot be in every facility at the same time, the float DCW cannot be counted into the staffing ratio. Ms. Reyes reported that administration "follows the state requirements as much as possible" regarding ratios. Additionally Ms. Reyes reported that Resident C requires two-person assistance.</p> <p>I reviewed the <i>Hampton Manor Shift Assignments</i> or staff schedules from 4/28/2025 through 6/16/2025 and found multiple dates during the nighttime hours when two direct care workers were not scheduled to work so residents requiring the assistance of two direct care workers did not have that assistance available therefore a violation has been established.</p>
<p>CONCLUSION:</p>	<p>VIOLATION ESTABLISHED</p>

ALLEGATION: Resident A is being restrained in bed.

INVESTIGATION:

This allegation was investigated under Special Investigation Report #2025A1029048 completed on 7/25/2025 by AFC Licensing Consultant Jennifer Browning. A violation was established during this investigation.

ALLEGATION: Executive director (ED) Altaf Veryamani moved a non-elderly family member into room 106.

INVESTIGATION:

On 06/03/2025, Complainant reported that the ED has allowed his non-elderly family member to reside in Room 106, which raises concerns about compliance with residency requirements.

On 06/17/2025, I conducted an unannounced investigation and I interviewed Ms. Reyes who denied that ED Veryamani allowed a non-elderly family member to live in room #106. Ms. Reyes reported that room #106 is occupied with an AFC resident.

I interviewed ED Veryamani who denied that he moved a non-elderly family member into room #106. ED Veryamani denied that anyone was living in room #106.

I reviewed the Building 2 census which was provided by ED Veryamani which documented that room #106 is vacant.

I went into room #106 with ED Veryamani upon entering room #106, I observed a man changing in the bathroom. When I walked into the bedroom area the closet doors were open and men's clothes were hanging in the closet. There were shirts and sweaters folded in the closet on a shelf with binders and papers on the shelf also. There were men's shoes in the bottom of the closet. Additionally, there were two suitcases and a backpack in the closet. There were dirty socks on the floor by two additional bags that were located on the floor. In the kitchen area there was food in the room refrigerator, freezer and pantry. In the freezer there was two large containers of soup, one that was half eaten. There was another large zip lock bag that looked to have some from tacos or enchiladas. The refrigerator contained yogurt and two carry out containers which appeared to be half eaten. In the cupboard there was a case of bottled water, some pop, napkins and medications that were set up in daily pill containers. The bed was made with a sheet and a pillow and there was a television on the nightstand. There were clothes hanging over the back of a chair.

The gentleman in the room identified himself as Muwaqar Jamalvi and reported that he is not a resident at the facility. Mr. Jamalvi reported that he lives out of town and when he comes to visit relatives he stays at the facility. Mr. Jamalvi reported that he stays at the facility 1-2 times a month for an unknown length of time. Mr. Jamalvi did not provide any details about his stay at the facility including who he was visiting. Mr. Jamalvi reported that his brother is employed by the facility and that is how he is

able to stay at the facility. Mr. Jamalvi reported that he is 63 years and reported that he just arrived at the facility a few hours ago.

On 08/28/2025, ED Veryamani reported that Mr. Jamalvi has stayed 1-2 times per month for the last two months.

APPLICABLE RULE	
R 400.15103	Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.
	(5) An applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license, including any changes in the household and in personnel-related information, within 5 business days after the change occurs.
ANALYSIS:	Muwaqar Jamalvi, who is not a resident nor documented as living on the premises on the Building #2 census report, was observed to be living in the facility on 06/17/2025. Mr. Jamalvi admitted to staying at the facility 1-2 times per month when he comes into town to visit with family. ED Veryamani reported that Mr. Jamalvi has stayed in this resident bedroom 1-2 times per month for last two months after reporting resident bedroom #106 was empty.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.15105	Licensed capacity.
	(2) Any occupant of a home, other than the licensee or persons who are related to the licensee, live-in staff or the live-in staff's spouse and minor children, or a person related to a resident who is not in need of foster care, shall be considered a resident and be counted as a part of the licensed capacity.

ANALYSIS:	Muwaqar Jamalvi, who is not a resident nor documented as living on the premises on the Building #2 census report ,was observed to be living in the facility on 06/17/2025. Mr. Jamalvi admitted to staying at the facility for unknown periods of time because he has a relative who works for the licensee. Based on the information provided, Mr. Jamalvi will be considered a resident and count toward the licensed capacity.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION:

On 06/17/2025, I conducted an unannounced investigation and I reviewed Resident B's and Resident C's *Health Care Appraisals* that were dated 05/30/2024 and 06/12/2024 respectively. Resident B was admitted to the facility on 5/31/2024 and Resident C was admitted to the facility on 6/14/2024. Resident B and Resident C were compliant with admission physicals however updated annual *Health Care Appraisals* were not available for review at the time of the unannounced investigation.

APPLICABLE RULE	
R 400.15301	Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.
	(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 inspection, Resident B and Resident C's records did not contain <i>Health Care Appraisals</i> that were updated annually as required, therefore a violation has been established.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change to the status of the license.

Julie Elkins

09/02/2025

Julie Elkins
Licensing Consultant

Date

Approved By:

Dawn Timm

09/02/2025

Dawn N. Timm
Area Manager

Date