



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

October 30, 2024

Shahid Imran  
Hampton Manor of Burton  
2105 Center Rd  
Burton, MI 48519

RE: License #: AH250410173  
Investigation #: 2024A0784094  
Hampton Manor of Burton

Dear Shahid 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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

A handwritten signature in cursive script that reads "Aaron L. Clum".

Aaron Clum, Licensing Staff  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(517) 230-2778

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AH250410173
<b>Investigation #:</b>	2024A0784094
<b>Complaint Receipt Date:</b>	09/19/2024
<b>Investigation Initiation Date:</b>	09/20/2024
<b>Report Due Date:</b>	11/18/2024
<b>Licensee Name:</b>	Hampton Manor of Burton LLC
<b>Licensee Address:</b>	2105 South Center Rd. Burton, MI 48519
<b>Licensee Telephone #:</b>	(989) 971-9610
<b>Administrator/Authorized Representative:</b>	Shahid Imran
<b>Name of Facility:</b>	Hampton Manor of Burton
<b>Facility Address:</b>	2105 Center Rd Burton, MI 48519
<b>Facility Telephone #:</b>	(989) 971-9610
<b>Original Issuance Date:</b>	05/18/2023
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	11/18/2024
<b>Expiration Date:</b>	07/31/2025
<b>Capacity:</b>	102
<b>Program Type:</b>	AGED ALZHEIMERS

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A was not administered prescribed medication	Yes
Additional Findings	No

**III. METHODOLOGY**

09/19/2024	Special Investigation Intake 2024A0784094
09/20/2024	Special Investigation Initiated - On Site
09/20/2024	Inspection Completed On-site
09/20/2024	Exit Conference Conducted with administrative assistant Jennifer West
09/30/2024	Contact - Telephone call made Interview with complainant

**ALLEGATION:**

**Resident A was not administered prescribed medication**

**INVESTIGATION:**

On 9/19/2024, the department received this online complaint.

According to the complaint, Resident A was prescribed medication for severe nerve pain and did not receive this medication from 9/14/2024 to 9/16/2024. When this was discovered on 9/16/2024, supervisors at the facility reported the medication had run out on 9/14/2024 and that the medication was not reordered until it ran out making it unavailable at the facility to administer to Resident A. Resident A no longer lives at the facility.

On 9/20/2024, I interviewed resident care coordinator Nichole Brooks at the facility. Administrative assistant Jennifer West was present for the interview. Ms. Brooks stated Resident A is prescribed a medication called pregabalin for nerve pain. Ms. Brooks stated this is not a new medication for Resident A as she has been taking it for a few months. Ms. Brooks confirmed that Resident A did not have this medication available to her between 9/14/2024 and 9/16/2024. Ms. Brooks stated the

medication ran out on the 9/13/2024 after Resident A's first dose for the day. Ms. Brooks stated Resident A is prescribed one morning and one evening dose. Ms. Brooks stated that on 9/16/2024, when Associate 1 was preparing to administer Resident A's medication, she discovered it had run out and ordered the medication at that time. Ms. Brooks stated Resident A's medications are reordered within the facilities computer system as the pharmacy has access to this system. Ms. Brooks stated that staff only need to click on a reorder option in the system to have the medication reordered. Ms. Brooks stated staff are instructed to reorder medications when only five days of medications are left. Ms. Brooks stated that upon investigation, it was discovered that Associates 2, 3 and 4 all worked on the medication cart Resident A's medications are stored in in the days leading up to 9/13/2024 and should have taken action to ensure the medication was reordered in time. Ms. Brooks stated she spoke to Associate 2 about the issue and that Associate 2 reported she had clicked on the reorder option in the system. Ms. Brooks stated there was no indication in the system that this attempt was made so she could not confirm this information. Ms. Brooks stated she had not yet spoken to Associates 3 and 4 regarding the issue. Ms. Brooks stated that ultimately, one of these staff should have either ensured that the medication was reordered, or at least followed up with supervision to make sure additional actions were taken to get Resident A her medication. Ms. Brooks stated that Resident A missed a total of five doses of her medication.

I reviewed Resident A's medication administration record (MAR) for September 2024, provided by Ms. Brooks. The MAR read consistently with Ms. Brooks statements. According to the MAR, Resident A was out of the pregabalin from the evening of 9/13/2024 until the evening of 9/16/2024.

<b>APPLICABLE RULE</b>	
<b>R 325.1932</b>	<b>Resident medications.</b>
	<b>(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.</b>
<b>ANALYSIS:</b>	The complaint alleged Resident A went without her prescribed pregabalin for several days. The investigation confirmed the allegations.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

*Aaron L. Clum*

10/23/2024

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Aaron Clum  
Licensing Staff

Date

Approved By:

*Andrea Moore*

10/30/2024

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Andrea L. Moore, Manager  
Long-Term-Care State Licensing Section

Date