GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 22, 2025

Shahid Imran
Hampton Manor of Trenton LLC
7560 River Road
Flushing, MI 48433

RE: License #: AH820401687
Investigation #: 2025A1027024
Hampton Manor of Trenton

Dear Licensee:

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 authorized representative 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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820401687
Investigation #:	2025A1027024
Complaint Receipt Date:	01/03/2025
Investigation Initiation Date:	01/03/2025
Report Due Date:	03/02/2025
Licensee Name:	Hampton Manor of Trenton LLC
Licensee Address:	5999 Fort Street Trenton, MI 48183
Licensee Telephone #:	(734) 673-3130
Authorized Representative/ Administrator:	Shahid Imran
Name of Facility:	Hampton Manor of Trenton
Facility Address:	5999 Fort Street Trenton, MI 48183
Facility Telephone #:	(734) 673-3130
Original Issuance Date:	03/09/2023
License Status:	REGULAR
Effective Date:	09/09/2024
Expiration Date:	07/31/2025
Capacity:	120
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Medications were not administered on time.	Yes
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

Allegations related to ants were investigated in Special Investigation Report (SIR) 2025A0585014 and allegations related to short staffing were investigated in SIR 2025A1035009.

III. METHODOLOGY

01/03/2025	Special Investigation Intake 2025A1027024
01/03/2025	Special Investigation Initiated - Letter Email sent to Shahid Imran and Azher Farooq requesting medication administration policies
01/03/2025	Contact - Document Received Email received from Employee #1 with requested documentation
01/07/2025	Inspection Completed On-site
01/14/2025	Contact - Document Received Documentation requested at the on-site received
01/14/2025	Inspection Completed-BCAL Sub. Compliance
01/22/2025	Exit Conference Conducted by email with Shahid Imran

ALLEGATION:

Medications were not administered on time.

INVESTIGATION:

On 1/3/2025, the Department received anonymous allegations through the online complaint system which read medications were not administered on time. Due to the anonymous nature of the complaint, additional information could not be gathered.

On 1/8/2025, I conducted an on-site inspection at the facility and interviewed staff.

Employee #1 reported there were 56 residents in the home and stated there were no concerns about residents receiving their medications on time.

Employee #2 explained that most medications were administered at 9:00 AM, with a window of one hour before or after the scheduled time. Employee #2 further stated that medications were administered one resident at a time, and staff would note if a resident refused or if there was a delay. She also mentioned that medications may be administered late due to resident care needs.

A random audit of the Medication Administration Records (MARs) for three memory care residents and two assisted living residents from November and December 2024 revealed instances where medications were left blank. Specifically, Resident A's MAR on 11/24/2024, 12/1/2024, and 12/8/2024 showed one or more medications were left blank, and Resident B's MAR on 11/9/2024 and 11/21/2024 also showed blank entries for one or more medications. It could not be determined if the medications were administered or not.

A review of the medication administration history report for Residents A, B, C, D, and E revealed instances where medications were administered outside the designated timeframe. In these cases, staff noted "*prioritizing care*." However, for Residents D and E on 1/1/2025, both had medications scheduled for 9:00 PM. Employee #3 documented that these medications were administered at 5:55 PM and 5:57 PM, respectively, with the note "*on time, prioritizing care*." The reason for administering these medications approximately three hours earlier than scheduled could not be confirmed.

The facility's medication administration policy read that medications should be given within one hour before or after the prescribed time unless otherwise specified by the physician. The policy also requires staff to initial the medication sheet in the appropriate time slot for each medication administered. The policy read to note any missed or refused medications, along with an explanation, on the back of the medication sheet.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(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.

ANALYSIS:	Review of the residents' medication administration records revealed they had blank spaces; therefore, they were inconsistent with the facility's policy for initialing medications at the time they were administered. Additionally, the medication administration history reports for Residents D and E indicated that some medications were administered up to three hours before their scheduled time. As a result, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/15/2025

Jessica Rogers Date
Licensing Staff

Approved By:

01/21/2025

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