GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 13, 2025

Shahid Imran
Hampton Manor of Woodhaven LLC
7560 River Rd
Flushing, MI 48433

RE: License #: AH820402181
Investigation #: 2025A0585054
Hampton Manor of Woodhaven

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) 335-5985.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820402181
Investigation #:	2025A0585054
Complaint Receipt Date:	05/02/2025
Investigation Initiation Date:	05/02/2025
Report Due Date:	07/01/2025
Licensee Name:	Hampton Manor of Woodhaven LLC
Licensee Address:	22125 Van Horn Woodhaven, MI 48183
Licensee Telephone #:	(734) 673-3130
Authorized Representative/Administrator:	Shahid Imran
Name of Facility:	Hampton Manor of Woodhaven
Facility Address:	22125 Van Horn Woodhaven, MI 48183
Facility Telephone #:	(734) 673-3130
Original Issuance Date:	06/25/2021
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	113
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had a pressure wound stage 3-4 on his buttocks, staff put him in the wheelchair, leaves him there all day and staff don't change him when he uses the bathroom.	No
Additional Findings	Yes

III. METHODOLOGY

05/02/2025	Special Investigation Intake 2025A0585054
05/02/2025	Special Investigation Initiated - Telephone Call the witness for additional information. Left message to return this call.
05/06/2025	Contact – Telephone call made Call the witness again to discuss allegations and to get additional information.
05/06/2025	Inspection Completed On-site Completed with observation, interview and record review.
05/06/2025	Inspection Completed-BCAL Sub. Compliance
05/09/2025	Contact – Telephone call made Call the wound nurse from Better Homecare Health to discuss allegations and to get additional information.
05/13/2025	Exit Conference Conducted via email to authorized representative Shahid Imran.

ALLEGATION:

Resident A had a pressure wound stage 3-4 on his buttocks, staff put him in the wheelchair, leaves him there all day and staff don't change him when he uses the bathroom.

INVESTIGATION:

On 05/02/2025, the licensing department received a complaint from Adult Protective Services (APS) via BCHS online complaint. The complaint alleged that Resident A

had a pressure wound stage 3-4 on his buttocks. The complainant alleged that staff put Resident A into a wheelchair and leaves him there all day. The complaint alleged that staff are not changing Resident A when he uses the bathroom.

On 05/06/2025, I spoke to Witness #1 whose statement was consistent with what was reported in the written complaint. Witness #1 stated that Resident A did not come to the facility with pressure wounds and that he got those during his stay at the facility. She stated that Resident A stays in his wheelchair all the time. Witness #1 stated that staff don't change Resident A as they should.

On 05/06/2025, onsite visit was completed at the facility. The administrator was not on site at that time. I interviewed Employee #1 who stated that when a wound goes beyond stage 2 it is their policy to send residents out to the hospital. She said that there are 59 residents at the facility, with 16 of those residents in memory care. She said the staff consists of 7-9 on the morning and afternoon shift. She said there are 5-6 care staff on the midnight shift.

I interviewed Employee #2 at the facility. Employee #2 stated that Resident A uses is wheelchair to get around. She stated that Resident A had a wound for a couple of weeks that developed to stage 2. She said once it was at stage 2, they had to send Resident out. She said that the wound was being treated by Homecare Health.

I interviewed Employee #3 at the facility. Employee #3 statements were consistent to Employee #1 and Employee #2 regarding wound stages that are beyond two. Employee #3 stated that Resident A had a companion that sat with him, and he had a urinal when he was up on his own.

During the onsite, I interviewed Employee #4 and Employee #5 who both stated that they have changed Resident A and the expected response time to call lights are around 5-10 minutes.

On 5/9/2025, I spoke with Witness #1 who stated that she tends to Resident A's wound, and it was at stage 2. Witness #1 stated that she sent Resident A to the hospital. She said that Resident A already had the wound when she started taking care of him. She said that prior to sending him to the hospital the week before, the wound had increased in redness with scab over. She said that she watched it week by week and it got bigger. She said that staff were instructed by her not to do anything to the wound. She said that whenever she went to the facility, Resident A was always in his wheelchair, but he was never wet. Witness #1 said the dressing that she put on him was always intact with no issues noted. Witness #1 said when she put the package/bandage on the wound, she always dated it and included a note not to touch it.

A review of Resident A's service plan read, "requires one person assist to transfer, walk with resident, use mobility devices: wheelchair and total incontinence."

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	There is no evidence to support the claim of Resident A being in his chair all day without being changed. Resident A's wound was staged at 2. Witness #1 is responsible for all of Resident A's wound care. Therefore, this claim cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

Employee #2 stated that staff put the wrong information in the MAR and the pharmacy was supposed to discontinue the medication. Employee #2 stated that if a resident refuse medication, they contact the family and the pharmacy to have it discontinued.

I reviewed Resident A's medication administration record (MAR). Resident A was prescribed Nitrofurantoin mono prescribed to take one capsule by mouth two times daily. The MAR shows that Resident A refused his medication at times and there were times when medication was not always available. For example, Nitrofurantoin mono was not given on 4/1- 4/3, 4/5, 4/6, 4/7, 4/8, 4/9, 4/11, 4/12, 4/13, 4/14, 4/15, 4/18, 4/19, 4/20, 4/21, 4/22, 4/23, 4/24, 4/25 and 4/28 with the reason as meds not available, meds not on cart; Finasteride 5 mg tablet not available, med not on cart on 4/22; clopidogrel was not available, not on cart on 4/22, 4/23, 4/25, 4/28 and 4/29. There was also a lot of medication marked as resident refused on 4/6, 4/7, 4/8, 4/9, 4/10, 4/11, 4/12, 4/13, 4/14, 4/19, 4/20, 4/23, 4/24, 4/26, 4/28 and 4/29.

APPLICABLE RULE	
R 325.1932	**Resident's medication.**
	(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:	Based on review of Resident A's MAR, resident did not always get medication as prescribed. Medication was marked as not on cart, or medication not available. Resident A was marked as refusing medication at least 15 times. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon completion of an acceptable corrective action plan, I recommend no changes to the status of the license at this time

Brender L. Howard 05/13/2025

Brender Howard Date
Licensing Staff

Approved By:

Andrea L. Moore 05/13/2025

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