GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 27, 2025

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

RE: License #: AH250410173
Investigation #: 2025A0784050
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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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) 335-5985.

Sincerely,

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

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

I. IDENTIFYING INFORMATION

License #:	AH250410173
Investigation #:	2025A0784050
Complaint Receipt Date:	05/05/2025
Investigation Initiation Date:	05/05/2025
Report Due Date:	07/04/2025
Licensee Name:	Hampton Manor of Burton LLC
Licensee Address:	2105 South Center Rd. Burton, MI 48519
Licensee Telephone #:	(989) 971-9610
Administrator/Authorized Representative:	Shahid Imran
Name of Facility:	Hampton Manor of Burton
Facility Address:	2105 Center Rd Burton, MI 48519
Facility Telephone #:	(810) 553-3355
Original Issuance Date:	05/18/2023
License Status:	REGULAR
Effective Date:	11/18/2024
Expiration Date:	07/31/2025
Capacity:	102
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Misadministration of medication.	Yes
Additional Findings	No

III. METHODOLOGY

05/05/2025	Special Investigation Intake 2025A0784050
05/05/2025	Special Investigation Initiated - Telephone
05/06/2025	Inspection Completed On-site
05/06/2025	Exit Conference Conducted with staff 1

ALLEGATION:

Misadministration of medications

INVESTIGATION:

On 5/05/2025, the department received this online complaint.

According to the complaint, Resident A was not administered her medications. Staff attempted to administer Resident A the incorrect medications. Resident A no longer lives at the facility.

On 5/05/2025, I interviewed complainant and Relative A by telephone. The interview was initiated with the complainant who ultimately had Relative A get on the phone. The complaint stated staff at the facility have either not administered medications to Resident A she was supposed to receive or administered medications to her at the wrong time. The complaint stated staff administered medications around approximately 9pm on several occasions even though she was not supposed to receive medications that late in the evening. Relative A stated that around the morning of 4/23/2025, Resident A was acting outside of her baseline, so the facility had her tested for a urinary tract infection (UTI). Relative A stated Resident A was found to be positive for a UTI. Relative A stated Resident A's physician was notified and prescribed her an antibiotic that day. Relative A stated the facility did not get the antibiotic to the facility until the next evening, on 4/24/2025, when it was available on

4/23/2025, leaving Resident A to have unnecessary pain from urination for several hours.

On 5/06/2025, I interviewed staff 1, a supervisor, at the facility. Staff 1 confirmed Resident A was tested for a UTI on 4/23/2025. Staff 1 stated the test was done a "dipstick" UTI test around approximately 1:30pm on 4/23/2025. Staff 1 stated that upon being shown the test result, Staff 1 took a picture of the result and sent it to Resident A's nurse practitioner (NP) who she stated sent an order to the pharmacy for ciprofloxacin (a medication used to treat bacterial infections). Staff 1 stated that the pharmacy, located in Farmington Hills, delivered the antibiotic the next morning, the morning of 4/24/2025. Staff 1 stated Resident A was removed from the facility by the family that same day so the medication was taken by the family. Staff 1 stated this is why Resident A was not administered that medication by the facility. Staff 1 stated Resident A's other medications already in the cart were administered that day until the point she left the facility.

I reviewed the text message conversation between staff 1 and the NP, which read consistently with statements provided by staff 1. The conversation was dated 4/23/2025. The picture of the positive test sent to the NP was time stamped 1:33pm.

I reviewed Resident A's physicians orders which read consistently with staff 1's statements that the order was written on 4/23/2025 with an "original" date of 4/24/2025 for the prescription. The prescription indicated the medication should be administered at 8am and 8pm.

I reviewed the facilities April 2025 *Med Variance* record for Resident A showing prescriptions for Resident A administered outside of the acceptable timeframe for administration. Reviewing of the record revealed the following prescriptions were administered late with no explanation other than "LATE":

- BUMETANIDE, prescribed for 8pm administration and administered at 10:16pm on 4/24/2025
- CEPHALEXIN, prescribed for 8pm administration and administered at 9:11pm on 4/19/2025 and 9:07pm on 4/21/2025.
- ENSURE, prescribed for 1pm administration and administered at 2:29pm on 4/04/2025, 3:08pm on 4/18/2025, 4/19/2025 and 2:07pm on 4/20/2025.

It should be noted that the record indicated that the previously mentioned medications as well as several other medications were administered late, however the notes from staff provide additional explanation such as "internet was lagging" or simply "on time" suggesting the medications were administered on time but entered late.

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:	The complaint alleged Resident A was not administered an antibiotic medication on 4/23/2025 that was available on that day. The investigation revealed the medication was ordered on 4/23/2025 but was not delivered to the facility until 4/24/2025. Evidence reviewed did not support the allegation. Additionally, the complaint alleged Resident A was administered medications at 9pm when she was not supposed to be administered medications that late in the evening. While review of the facility Med Variance record did show medications scheduled for 8pm, which can be administered until 9pm, the record also showed medications were administered outside of the allowable one-hour time frame for administration. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Aaron L Clum 6/11/2025

Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 06/27/2025

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