GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 30, 2025

Shahid Imran
Hampton Manor of Madison
1491 E. US-223
Adrian, MI 49221

RE: License #: AH460406857
Investigation #: 2025A1019064
Hampton Manor of Madison

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH460406857
Investigation #:	2025A1019064
Complaint Receipt Date:	06/20/2025
Investigation Initiation Date:	06/23/2025
Report Due Date:	08/20/2025
Licensee Name:	Hampton Manor of Adrian, LLC
Licensee Address:	7560 River Road Flushing, MI 48433
Licensee Telephone #:	(734) 673-3130
Administrator and Authorized Representative:	Shahid Imran
Name of Facility:	Hampton Manor of Madison
Facility Address:	1491 E. US-223 Adrian, MI 49221
Facility Telephone #:	(517) 759-7799
Original Issuance Date:	12/10/2021
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	120
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is not receiving her medications as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/20/2025	Special Investigation Intake 2025A1019064
06/23/2025	Special Investigation Initiated - Telephone Telephone interview conducted with the complainant.
06/23/2025	APS Referral
06/24/2025	Contact - Document Sent Emailed licensee requesting documentation.
06/25/2025	Contact - Document Received Requested documentation received from licensee.
06/25/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A is not receiving her medications as prescribed.

INVESTIGATION:

On 6/20/25, the department received a complaint regarding concerns over Resident A's medication administration. The complaint read that Resident A's medications are not given correctly by facility staff.

On 6/23/25, I interviewed the complainant by telephone. The complainant reported that staff are not giving Resident A her "*iron pill*" but are documenting on her medication administration record (MAR) that it was refused. The complaint denies that the resident is refusing the medication. The complainant also reported that Resident A recently ran out of her "*blood pressure medication*" and hadn't received it for three days on or around 6/20/25. The complainant was unsure of the names of the medications in question.

In follow up correspondence with the licensee, I requested Resident A's physician's orders and medication administration records for the previous seven weeks. I observed that Resident A had an order for Tab-A-Vite iron tablet and is instructed to "*take 1 tablet by mouth every morning*" and had an order for Amlodipine (per the Cleveland Clinic, this medication is prescribed to treat high blood pressure) and is instructed to "*take 1 tablet by mouth daily*".

Review of Resident A's May MAR reveals that staff documented she refused the Tab-A-Vite every singe day of the month, with the exception of when she was documented as being out of the facility from 5/21-5/24. Review of Resident A's June MAR reveals that staff documented she refused the medication on 6/1, 6/2, 6/4-6/9, and 6/15-6/23. Staff documented on 6/3 that Resident A was "*physically unable to take*" and noted "*none in cart*". Staff documented on 6/9 that Resident A was "*physically unable to take*" and noted "*None in cart or med room. Med was reordered yesterday*. *Waiting on pharmacy to fill med."* Staff documented that the medication was administered as prescribed from 6/11-6/14. Employee 1 confirmed that Resident A ran out of her Tab-A-Vite and it was not available at the facility to administer from 6/3-6/9. Employee 1 reported that she personally reordered the medication on 6/9 and provided delivery receipts confirming the medication arrived at the facility on 6/10.

Regarding Resident A's Amlodipine, review of Resident A's June MAR reveals that staff documented on 6/18 that Resident A was "*physically unable to take*" and noted "*needs new rx*" and documented on 6/19 that Resident A was "*physically unable to take*" and noted "*not in cart*". Employee 1 confirmed that the Amlodipine was reordered on 6/18 and was delivered to the facility on 6/19. Employee 1 reported that per facility policy, medications should be reordered when five doses remain but stated "*This is sometimes difficult because most medications in the building are on cycle fill automatically."*

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:	Resident A has not been receiving her Tab-A-Vite iron tablet as prescribed. Facility staff claim the medication is being refused by Resident A, while the complainant alleges that she does not refuse it. What can be confirmed is that the facility ran out of the medication and did not proactively reorder it before the medication became unavailable. Additionally, staff documented that the resident refused the medication during a period of time when it was not in the building to be administered, which is considered a documentation error. Facility staff also failed to proactively reorder Resident A's Amlodipine, resulting in her missing two doses. Based on this information, the allegation is substantified.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 6/23/25, the licensee issued a 30-day discharge notice to Resident A. The discharge notice read:

> *Please consider this a 30 day notice from Hampton Manor to terminate your residency of [Resident A] at Hampton Manor of Adrian. We have come to this decision based on our inability to meet your care needs. Feel free to contact us for any assistance you may need to find new placement. We anticipate your departure date by July 31, 2025 or sooner. Your July fees will be prorated based on your move out date. you can contact me for any additional information you may need.*

The discharge notice did not specify how they could no longer meet Resident A's needs and failed to indicate which of the four reasons outlined in the administrative rules that the discharge fell under (medical reasons, welfare of Resident A or other residents, nonpayment of stay or voluntary transfer by the resident). The discharge notice also failed to inform the reader of their right to file a complaint with the department as regulations require.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(11) In accordance with section 20201(3) of the code, MCL 333.20201(3) (e), a home's discharge policy shall specify

	that a home for the aged resident may be transferred or discharged for any of the following reasons: **(a) Medical reasons.** **(b) His or her welfare or that of other residents.** **(c) For nonpayment of his or her stay.** **(d) Transfer or discharge sought by resident or authorized representative.** **(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following:** **(a) The reasons for discharge.** **(b) The effective date of the discharge.** **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**
ANALYSIS:	Resident A's discharged notice issued by the licensee was missing mandatory information required by this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/27/2025

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

06/30/2025

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