GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

Zohaib Syed
Hampton Manor of Van Buren
43345 Tyler Rd
Van Buren Township, MI 48111

RE: License #: AH820412145
Investigation #: 2025A0628018
Hampton Manor of Van Buren

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 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,

Rebekah Looney

Rebekah Looney, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909

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

I. IDENTIFYING INFORMATION

License #:	AH820412145
Investigation #:	2025A0628018
Complaint Receipt Date:	08/19/2025
Investigation Initiation Date:	08/25/2025
Report Due Date:	10/18/2025
Licensee Name:	Hampton Manor of Van Buren LLC
Licensee Address:	43345 Tyler Rd Van Buren Township, MI 48111
Licensee Telephone #:	(989) 708-1878
Authorized Representative/Administrator:	Shahid Imran
Name of Facility:	Hampton Manor of Van Buren
Facility Address:	43345 Tyler Rd Van Buren Township, MI 48111
Facility Telephone #:	(989) 708-1878
Original Issuance Date:	05/20/2024
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	116
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility failed to keep the equipment in good repair.	Yes
Additional Findings	No

III. METHODOLOGY

08/19/2025	Special Investigation Intake 2025A0628018
08/25/2025	Special Investigation Initiated - On Site
08/27/2025	Contact - Document Sent email sent to administrator requesting additional documentation
08/27/2025	Contact - Document Received email received with requested documentation
09/30/2025	Exit Conference Conducted with Shahid Imran

ALLEGATION: The facility failed to keep the equipment in good repair.

INVESTIGATION: On 08/19/2025, the department received a complaint alleging that a grab bar, located in a resident's bathroom, came out of the wall and caused an injury to the resident.

On 08/25/2025, I interviewed the administrator at the facility. The administrator reported he was aware of the incident and provided an incident report. He reported that the process of reporting maintenance issues is as follows:

- Staff writes maintenance concern on form kept at the front desk
- Completed form is given to the front desk staff
- Front desk staff gives forms to maintenance personnel on the next day they work

The administrator reported that he was made aware on 08/15/2025 that the grab bar was loose from a staff member reporting it to him.

The administrator reported that he informed the facility's maintenance personnel of the concern on 08/15/2025 and that the grab bar was repaired on 08/18/2025, when the maintenance personnel returned to work. The administrator could not provide a completed work order for the repair as he reported it had been thrown out but

reported that the maintenance personnel told him on 08/18/2025 that the repair was completed.

The administrator showed me text messages between himself and the maintenance personnel on 08/15/2025. The administrator sent a text notifying the maintenance personnel that the grab bar in room 11 was loose. The maintenance personnel said they had just arrived home and asked if they should return to fix the grab bar right away. The administrator replied that the maintenance personnel could fix it "whenever you get to it".

While on-site, I interviewed Employee #1 at the facility. Employee #1 reported that on the morning of 08/15/2025 they informed the administrator of the loose grab bar in room 11. Employee #1 reported their usual method for reporting maintenance concerns is to tell the maintenance personnel and they write it down. Employee #1 reported that maintenance repairs things quickly.

While on-site, I observed the grab bar in room 11 and found it to be mounted firmly to the wall and not loose. Additionally, I reviewed the incident report for Resident A, who sustained an injury due to this loose grab bar. While Resident A was using the grab bar to transfer to the toilet, the grab bar dislodged from the wall and hit Resident A in the nose. This incident happened at 10:20pm on 08/15/2025. I also reviewed the facility's Policy for Reporting Maintenance Concerns. It was found that the actions of the staff were not consistent with the facility's policy.

- Employee #1 did not follow reporting procedures and complete a maintenance request form.
- The facility did not follow the response time set forth in the policy for urgent concerns (non-life threatening but disruptive) which requires action to be initiated within 24 hours.
- Additionally, the repair was not documented in the log as the administrator reported that the completed work order had been thrown out.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.

ANALYSIS:	Through staff interviews, visual inspection, and review of the incident report and the facility's Policy for Reporting Maintenance Concerns, it was determined that the facility did not follow their policy. The delay in fixing the grab bar resulted in an injury to Resident A. Therefore, this allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent on the receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Rebekah Looney 08/28/2025
Rebekah Looney Date
Licensing Staff

Approved By:

Andrea L. Moore 09/30/2025
Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section