



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 2, 2025

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

RE: License #: AH630408737
Investigation #: 2026A1019009

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,

A handwritten signature in blue ink, appearing to read "Elizabeth Gregory-Weil".

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 #:	AH630408737
Investigation #:	2026A1019009
Complaint Receipt Date:	11/13/2025
Investigation Initiation Date:	11/13/2025
Report Due Date:	01/13/2026
Licensee Name:	Hampton Manor of Bloomfield Hills 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 Bloomfield Hills
Facility Address:	2101 S. Opdyke Rd Bloomfield Township, MI 48301
Facility Telephone #:	(989) 971-9610
Original Issuance Date:	05/20/2024
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	82
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell and it wasn't reported.	Yes
Additional Findings	No

III. METHODOLOGY

11/13/2025	Special Investigation Intake 2026A1019009
11/13/2025	Comment Complaint was forwarded to LARA from APS. APS is investigating the allegations.
11/13/2025	Special Investigation Initiated - Letter Emailed APS worker for additional information.
11/24/2025	Inspection Completed On-site
11/24/2025	Inspection Completed BCAL Sub. Compliance

ALLEGATION: Resident A fell and it wasn't reported.

INVESTIGATION:

On 11/13/25, the department received a complaint alleging that on an unknown date, Resident A fell. The complaint alleged that Resident A fell while being transferred. The complaint listed Employees 1 and 2 as providing care to Resident A when the fall occurred. The complaint alleged that the staff were untrained and failed to report the fall. The referral source was not provided; therefore, additional information could not be obtained.

On 11/24/25, I conducted an onsite inspection. I interviewed executive director [Employee 1] at the facility. Employee 3 reported that the fall occurred during third shift in the early morning hours on 10/20/25. Employee 3 reported that the resident was attempting to transfer himself out of bed to grab his urinal when he fell onto the floor. Employee 3 reported that Resident A reported using his call pendant to summon staff but when no one responded in a timely manner, he called 911. Employee 3 reported that emergency medical personnel responded and got Resident A back into bed without issue. Employee 3 reported that Resident A is

capable of transferring himself in and out of bed but occasionally requires staff assistance and will use his call pendant in those instances. Employee 3 reported that Resident A ambulates independently with a walker and can appropriately verbalize his needs. Employee 3 reported that after the fall occurred, it was discovered that Resident A's call pendant was not working. Employee 3 reported that he personally tried using it and the alerts weren't registering even after changing out the batteries, and Resident A was issued a replacement. Employee 3 reported that Resident A stated he was on the floor for "*about an hour*". The facility has video surveillance footage throughout all common areas which Employee 3 said he reviewed but could not recall the specific time that Resident A was last checked on before the fall occurred. Employee 3 stated "*I watched to see that he was being checked on every two hours and he was, I just can't remember the time they were last in there*". I requested to review surveillance footage onsite, however the video storage only went back to 11/1/25. Employee 3 added that staff were not present when the fall occurred and Employees 1 and 2 were not working when it happened.

While onsite, I interviewed Resident A. Resident A's account of the events was consistent with Employee 3. Resident A stated that he got up in the middle of the night to use his urinal, and his knees buckled when getting out of bed and caused him to fall. Resident A stated that he did not hit his head and fell onto his bottom. Resident A stated that he used his call pendant and waited for staff to respond. When no one came, Resident A stated he grabbed his cell phone and called 911. Resident A stated EMS came and placed him back in bed without issue. Resident A stated that most of the time he is able to get himself out of bed and can take himself to the bathroom, however he often has urges that come on suddenly and he doesn't have much time to get there. Resident A denied any incidents where a fall occurred during a staff assisted transfer. Resident A answered my entire line of questioning appropriately and I found him to be a reliable historian.

During my onsite, I obtained incident report documentation, Resident A's service plan, call light response data and staff schedules. The incident report read:

I got a call over to MC that [Resident A] needed assistance getting up and EMS needed to be let in. When I walked over to AL they were in. They got [Resident A] in the bed in less than 5-10 mins. I checked on [Resident A] for any injuries and he said he didn't hit his head. He was comfortable & even went to sleep. He said he tumbled out the bed trying to get urinal.

The incident report indicated that Resident A's family was notified on 10/20/25 at 8:40am. Resident A's service plan read that he is independent with transferring and mobility. Resident call light response data was reviewed from 10/1/25- 11/24/25, the date of onsite investigation. I observed that during this timeframe, Resident A utilized his call pendant 332 times with an average staff response time of 10 minutes and 18 seconds. However, on the day of the fall, there were no pendant alerts recorded,

indicating that the pendant was not working. Staff schedules were reviewed, which confirmed that Employees 1 and 2 were not working when Resident A fell.

APPLICABLE RULE	
R 325.1921	Governing bodies, administrators, and supervisors.
	<p>(1) The owner, operator, and governing body of a home shall do all of the following:</p> <p style="padding-left: 40px;">(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.</p>
ANALYSIS:	Resident A had an unwitnessed fall on 10/20/25. Due to his faulty call pendant, Resident A was left on the floor for upwards of an hour and he called 911 for assistance because staff was unaware.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 325.1924	Reporting of incidents, quality review program.
	<p>(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.</p>
ANALYSIS:	Incident report documentation revealed that Resident A's authorized representative was notified of the fall on the day it occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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



11/25/2025

Elizabeth Gregory-Weil
Licensing Staff

Date

Approved By:



12/02/2025

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

Date