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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2026

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

RE: License #: AH580402179
Investigation #: 2026A1019018

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.

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 #:	AH580402179
Investigation #:	2026A1019018
Complaint Receipt Date:	02/18/2026
Investigation Initiation Date:	03/19/2026
Report Due Date:	03/20/2026
Licensee Name:	Hampton Manor of Bedford LLC
Licensee Address:	3099 W Sterns Rd Lambertville, MI 48182
LicenseeTelephone #:	(989) 971-9610
Administrator:	Carol Cancio
Authorized Representative:	Shahid Imran
Name of Facility:	Hampton Manor of Bedford
Facility Address:	3099 W Sterns Rd Lambertville, MI 48182
Facility Telephone #:	(734) 807-5800
Original Issuance Date:	04/09/2021
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	114
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility is understaffed.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/18/2026	Special Investigation Intake 2026A1019018
02/19/2026	Special Investigation Initiated - Telephone Called complainant to conduct phone interview, left voicemail requesting return phone call.
02/24/2026	Contact - Telephone call made Second attempt to reach complainant, voicemail left.
02/26/2026	Contact - Telephone call received Call received from Relative A, interview conducted.
02/26/2026	Inspection Completed On-site
02/26/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: The facility is understaffed.

INVESTIGATION:

On 2/18/26, the department received a complaint alleging that there is insufficient staff at the facility. The complaint read that there are times when there is one staff member to care for 40 residents. While the complainant did not return my phone call, a call was received from Relative A who reported that the complainant instructed that she speak to me on his behalf. Upon interview, Relative A reported that she does not believe the facility is sufficiently staffed, and stated that staffing is not at the levels she was promised when moving Resident A in. Licensing staff explained that state administrative rules governing homes for the aged do not require a specific staffing ratio to be met.

On 2/26/26, I conducted an onsite inspection. I interviewed the resident care coordinator [Employee 1] at the facility. Employee 1 reported that she does the scheduling at the facility. Employee 1 provided a resident roster that listed 56 residents at the facility (44 in general assisted living and 12 in memory care). Employee 1 reported that she schedules care givers and med passers on three shifts. At the current census and acuity level, Employee 1 reported that there should minimally be six staff (comprised of both care and med passing staff) on first shift, five staff on second shift and three staff on third shift to operate safely. Employee 1 reported that to combat unexpected staffing shortages such as a no call no show, there is a shift mandate assigned to each shift and bonuses are also offered when shifts are picked up. Employee 1 reported that most residents have call pendants to alert staff when assistance is needed, and that those alerts go to staff phones and a central monitor at the reception desk. Employee 1 was unsure if call response times were monitored and reported she did not have access to that data.

While onsite, I interviewed director of operations [Employee 2] at the facility. Employee 2 reported slightly different staffing levels as Employee 1, stating that there should minimally be five staff on first and second shift and three staff on third shift. Employee 2 reported that she does payroll based off of the schedules that Employee 1 creates, so she can confirm that the schedules are accurate. Additionally, Employee 2 reported that she personally monitors call response data on a monthly basis and that staff are trained to respond to call lights within 7 minutes.

While onsite, I obtained a copy of the schedule for the current and previous pay periods. Employee 1 attested that the schedules provided are updated to reflect who was present for each shift. I observed staffing at less than the minimum staffing levels attested to by Employee 2 on each day reviewed for all or part of the following shifts: 2/2/26 (all three shifts), 2/3/26 (1st and 3rd shift), 2/4/26 (2nd and 3rd shift), 2/5/26 (all three shifts), 2/6/26 (2nd shift), 2/7/26 (1st and 2nd shift), 2/8/26 (all three shifts), 2/9/26 (all three shifts), 2/10/26 (1st and 2nd shift), 2/11/26 (1st and 2nd shift), 2/12/26 (1st and 3rd shift), 2/13/26 (all three shifts), 2/14/26 (all three shifts), 2/15/26 (all three shifts), 2/16/26 (2nd and 3rd shift), 2/17/26 (1st and 3rd shift), 2/18/26 (2nd shift), 2/19/26 (all three shifts), 2/20/26 (all three shifts), 2/21/26 (3rd shift), 2/22/26 (2nd and 3rd shift), 2/23/26 (2nd and 3rd shift), 2/24/26 (2nd shift) and 2/25/26 (all three shifts). Some specific examples include 2/9/26 second shift only lists two staff for the entire shift when there should be five, 2/9/26 third shift lists only two staff for most of the shift when there should be three, 2/13/26 third shift only lists two staff for most of the shift when there should be three, 2/17/26 third shift only lists one staff for the whole shift when there should be three, 2/20/26 second shift only lists three staff for most of the shift when there should be five, 2/25/26 third shift only lists one staff for the entire shift when there should be three.

While onsite, I obtained call light data for the previous four weeks. The average response times were above the seven-minute benchmark that Employee 2

referenced. During the previous week, the following excessive times (15+ minutes) were observed:

- 2/25/26- 15 minutes and 31 seconds, 17 minutes and 08 seconds, 30 minutes and 19 seconds, 18 minutes and 46 seconds, 34 minutes and 49 seconds, 15 minutes and 33 seconds, 20 minutes and 15 seconds, 46 minutes and 51 seconds, 41 minutes and 7 seconds, 16 minutes 19 seconds, 16 minutes and 12 seconds, 15 minutes and 12 seconds, 30 minutes and 20 seconds, one hour and 27 minutes one hour and 20 minutes,30 and 21 minutes and 32 seconds
- 2/24/26- 50 minutes and 27 seconds, 17 minutes and 20 seconds, 19 minutes and 25 seconds, 19 minutes and 54 seconds, 17 minutes 27 seconds, 51 minutes and 6 seconds, 17 minutes and 33 seconds, 19 minutes and 19 seconds, 44 minutes and 16 seconds, 51 minutes and 40 seconds, 15 minutes and 4 seconds, 16 minutes and 27 seconds, 23 minutes, 15 minutes and 40 seconds, 25 minutes and 11 seconds, 16 minutes and 49 seconds, 26 minutes and 4 seconds, 20 minutes and 1 second, 18 minutes and 59 seconds, and 24 minutes and 26 seconds and 16 minutes
- 2/23/26- 18 minutes and 8 seconds, 30 minutes and 55 seconds, 23 minutes and 59 seconds, 20 minutes and 56 seconds, 25 minutes and 33 seconds, 35 minutes and 35 seconds, 21 minutes and 36 seconds, 20 minutes and 6 seconds, 20 minutes and 20 seconds, 18 minutes and 11 seconds, 15 minutes and 27 seconds, 39 minutes and 10 seconds, 16 minutes and 23 seconds, 20 minutes and 45 seconds, 17 minutes and 21 seconds, 45 minutes and 2 seconds, 31 minutes and 57 seconds, 19 minutes and 27 seconds, 38 minutes, 37 minutes and 47 seconds, one hour and 10 minutes, 22 minutes and 23 seconds, and one hour and 35 minutes
- 2/22/26- 21 minutes and 17 seconds, 32 minutes and 48 seconds, 31 minutes and 5 seconds, 30 minutes and 5 seconds, 25 minutes and 55 seconds, 21 minutes and 26 seconds, 51 minutes and 35 seconds, 18 minutes and 2 seconds, 19 minutes and 7 seconds, 42 minutes and 51 seconds, 36 minutes and 26 seconds, 17 minutes and 48 seconds, 17 minutes and 36 seconds, 27 minutes and 12 seconds, 18 minutes and 30 seconds, 41 minutes and 26 seconds, 22 minutes and 50 seconds, 20 minutes and 13 seconds, 40 minutes and 29 seconds and 26 minutes and 54 seconds
- 2/21/26- 26 minutes and 40 seconds, one hour and 16 minutes, 18 minutes and 46 seconds, 23 minutes and 26 seconds, 21 minutes and 25 seconds, 55 minutes and 37 seconds, 20 minutes and 45 seconds, 16 minutes and 46 seconds, 25 minutes and 39 seconds, 17 minutes and 33 seconds, 36 minutes and 23 seconds, 18 minutes and 25 seconds, 16 minutes and 33 seconds, 35 minutes and 53 seconds, 15 minutes and 16 seconds, 26 minutes and 33 seconds, 15 minutes and 50 seconds, 31 minutes and 4 seconds, 27 minutes and 3 seconds, 22 minutes, 38

minutes and 3 seconds, 19 minutes and 5 seconds, 23 minutes and 11 seconds, 15 minutes and 36 seconds, and 24 minutes and 56 seconds

- 2/20/26- one hour and 25 minutes, 27 minutes and 2 seconds, 21 minutes and 30 seconds, 39 minutes and 41 seconds, 37 minute and 49 seconds, one hour and 15 minutes, 23 minutes and 21 seconds, 25 minutes and 3 seconds, 15 minutes and 43 seconds, 20 minutes, 16 minutes and 43 seconds, 30 minutes and 19 seconds, 20 minutes and 37 seconds, and 18 minutes and 24 seconds
- 2/19/26- 18 minutes and 7 seconds, 15 minutes and 52 seconds, 19 minutes and 40 seconds, 16 minutes and 13 seconds, 29 minutes and 52 seconds, 42 minutes and 55 seconds, 30 minutes and 7 seconds, 30 minutes and 22 seconds, 15 minutes and 2 seconds, 15 minutes and 58 seconds, 19 minutes and 49 seconds, 19 minutes and 56 seconds, 33 minutes and 15 seconds, 31 minutes and 14 seconds, and 39 minutes and 38 seconds

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Staff schedules revealed that staffing was consistently below minimum levels described by facility management throughout the entire timeframe reviewed. Additionally, call pendant response data reveals average response times above expected timeframes with frequent excessive times observed. Staffing below minimum standards set forth by the facility, coupled with repeated lengthy call pendant response times indicate that staffing is not sufficient to adequately meet residents' needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

While onsite, I observed that Resident A had a bedside assistive device with a support bar that slid underneath the mattress. The device was not adequately secured to the bed frame and could easily slide out. The device was not outlined in

Resident A's service plan, therefore the facility lacked instruction on how the resident is to be monitored regarding the use of the device.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Resident A had a bedside assistive device that was not secured, nor addressed in her service plan. The lack of a reasonably organized program of protection related to these devices place staff at a disadvantage when attempting to meet the safety needs of residents and does not reasonably protect residents from the possibility of unnecessary entrapment and/or entanglement injury or death associated with such devices.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

03/03/2026

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

03/11/2026

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