GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 31, 2025

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

RE: License #: AH250410173
Investigation #: 2025A0784057
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 #:	2025A0784057
Complaint Receipt Date:	06/09/2025
Investigation Initiation Date:	06/10/2025
Report Due Date:	08/08/2025
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate plan for Resident A's supervision	Yes
Additional Findings	No

III. METHODOLOGY

06/09/2025	Special Investigation Intake 2025A0784057
06/10/2025	Special Investigation Initiated - On Site
06/10/2025	Inspection Completed On-site
7/31/2025	Exit – Email Report sent

ALLEGATION:

Inadequate plan for Resident A's supervision

INVESTIGATION:

On 6/09/2025, the department received this complaint from adult protective services. The information provided within the complaint indicated there are no alleged perpetrators, no date of incident, no witnesses or other information in relation to the complaint.

According to the complaint, Resident fell from her bed a second time and has suffered a broken hip from one of the falls. Resident A is a person with dementia and poor mobility. There are concerns that Resident A does not have an adequate plan for her safety.

On 6/10/2025, I interviewed staff 1 at the facility. Staff 1 stated she was familiar with Resident A as she has provided care for her regularly. Staff 1 stated Resident A did have a fall during the last week of April 2025 which resulted in a break to her hip. Staff 1 stated she and staff 2 were providing care for Resident on the morning that Resident A had a fall resulting in a break to her hip. Staff 1 stated she and staff 2 had gone to Resident A's room to assist her with getting up for breakfast. Staff 1 stated they first had to get Resident A's breakfast set up in the dining area. Staff 1 stated she and staff 2 left so one person could get Resident A's breakfast set up and

one person could bring coffee back to Resident A's room. Staff 1 stated that by the time she returned to Resident A's room, Resident A had attempted to get out of bed and fell. Staff 1 stated Resident A was sent to the hospital by emergency Medical services (EMS) because Resident A had reported hitting her head and that her right hip hurt. Staff 1 stated it was later reported Resident A had broken her hip and would be in the hospital for a while. Staff 1 stated Resident A returned from the hospital on 5/27/2025. Staff 1 stated she was not aware of Resident A having any falls previous to this one. Staff 1 stated she had been concerned that Resident A might have a fall. Staff 1 stated Resident A was a person who had poor balance and was supposed to have staff assistance for transfers. Staff 1 stated Resident A would often try to get out of bed and transfer on her own. Staff 1 stated Resident A was a person with low safety awareness as she did not seem to understand she should be getting staff to assist her. Staff 1 stated that Resident A is not very mobile since she returned from the hospital.

On 6/10/2025, I interviewed staff 3 at the facility. Staff 3 stated Resident A moved to the facility in December of 2024. Staff 3 stated that prior to the fall in April 2025, Resident A was independent with transfers though Resident A did have a history of falls prior to coming to the facility. Staff 3 stated an initial assessment was completed for Resident A prior to moving to the facility identifying her as a fall risk.

I reviewed facility incident reports for Resident A titled *INCIDENT OBSERVATION SHEET,* provided by staff 3, dated 4/29/2025 and 6/04/2025. The report dated 4/29/2025 read consistently with statements provided by staff 1. Report dated 6/04/2025 indicated Resident A was found by her bed laying on the floor and reported she "slid out of bed and hit her head on the side table". According to this report, Resident A suffered a laceration to the head and was sent to the hospital for treatment.

I reviewed written staff Daily Progress Notes for Resident A, provided by staff 3. dated between May 2025 and June 2025. Notes dated 5/31/2025 at 3:58pm read, in part, Resident A "was found in the bathroom on the floor by [staff]. She tried to take herself to the bathroom and her wheelchair flipped over. The bathroom light was not on, and she told staff that she didn't want to bother us so she took herself to the bathroom and she doesn't remember telling staff telling her to call for help".

I reviewed Resident A's initial assessment, provided by staff 3. Under a sectioned titled *Ambulation,* the assessment read, "Walks/wheels self with minimal assist; needs verbal cues and/or reminders". Under a section titled *Fall Risk*, the assessment read "fall risk review includes 2 or more". Under a section titled *Transfer Ability,* the assessment read, "Transfers with minimal assist; needs verbal cues and/or reminders".

I reviewed Resident A's service plan, provided by staff 3, and dated 5/27/2025. Under section titled *Transfer and Mobility*, the plan read, in part, "Requires one person assist to transfer. Recovering from fractured right hip, staff are to provide full

physical assistance during all transfers. Wheelchair for ambulation". Under section titled Fall Risk, the plan read, in part, Yes. History of falls, one hour safety checks. Recently fractured right hip due to fall".

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.**
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	The complaint alleged Resident A is a person with poor mobility who has fallen more than once and sustained a broken hip from one of the falls. The investigation confirmed Resident A had a fall, on 4/29/2025 after which she did not return to the facility for approximately one month. It was also revealed that after returning from the hospital, Resident A had two more falls with one of those falls resulting in a head injury and a visit to the hospital. Staff 1 reported having concerns about Resident A's mobility prior to her first fall indicating Resident A was a high fall risk person with poor safety awareness. Review of Resident A's documentation, as well as the noted falls, supported these statements. Review of Resident A's initial assessment, as well as statements from staff 3, revealed Resident A was a fall risk when she moved to the facility with the evidence indicating this propensity only became worse. While Resident A had two additional falls after returning to the facility on 5/27/2025, no additional measures were included in her service plan to address Resident A's poor safety awareness. Based on the findings, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

7/22/2025

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Aaron Clum Date
Licensing Staff

Approved By:

07/31/2025

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