GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 31, 2026

Carol Cancio
Hampton Manor of Trenton LLC
7560 River Road
Flushing, MI 48433

RE: License #: AH820401687
Investigation #: 2026A1035047
Hampton Manor of Trenton

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,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820401687
Investigation #:	2026A1035047
Complaint Receipt Date:	06/23/2026
Investigation Initiation Date:	06/24/2026
Report Due Date:	08/23/2026
Licensee Name:	Hampton Manor of Trenton LLC
Licensee Address:	5999 Fort Street Trenton, MI 48183
Licensee Telephone #:	(734) 673-3130
Administrator:	Carol Cancio
Authorized Representative:	Shahid Imran
Name of Facility:	Hampton Manor of Trenton
Facility Address:	5999 Fort Street Trenton, MI 48183
Facility Telephone #:	(734) 673-3130
Original Issuance Date:	03/09/2023
License Status:	REGULAR
Effective Date:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	120
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A, B, and C are not receiving care in accordance with their service plan. The facility is unable to maintain a safe environment for their residents.	Yes
The home does not maintain a safe environment that is free from hazards, Resident B's room has a large hole in the wall.	Yes
The facility is serving uncooked food to their residents.	No
Medication is not being administered as ordered.	Yes
Additional Findings	No

III. METHODOLOGY

06/23/2026	Special Investigation Intake 2026A1035047
06/24/2026	Special Investigation Initiated - Letter
07/08/2026	Contact - Face to Face
08/31/2026	Inspection Complete. BCAL Sub Compliance.
08/31/2026	Exit Conference.

ALLEGATION:

Resident A, B, and C are not receiving care in accordance with their service plan. The facility is unable to maintain a safe environment for their residents.

INVESTIGATION:

On June 24, 2026, the Department received a complaint forwarded from Adult Protective Services (APS) which alleged Resident A fell and fractured her hip. Safety was not maintained for Resident A. Approximately two weeks ago the facility did not maintain a secure environment. Residents were eloping from the facility related to unlocked doors. Staff are not providing quality of care to the residents. The facility smells of urine and feces. Medications are not being passed in accordance with the resident's services plans.

On June 30, 2026, the Department received an additional complaint forwarded from Adult Protective Services (APS) which alleged Resident B fell causing a “knot on her forehead, a knot on her back, and a black eye.” Resident B’s care needs were not met. Resident B was discharged from the facility.

On June 30, 2026, the Department received an additional complaint forwarded from Adult Protective Services (APS) which alleged Resident C is being neglected, his care needs are not being met.

On July 8, 2026, an onsite investigation was conducted. While onsite, I interviewed Staff Person (SP)1 who states staff provide high quality of care. SP1 is unaware of any care concerns. SP1 states the facility had a recent power outage that lasted a few days. During the power outage the generators maintained a safe and secure environment.

While onsite, I interviewed SP2 who stated there was one staff member that did not provide good care, that staff member has been let go. SP2 states the staff work well together and meet the needs of the residents. SP2 states the facility lost power a few weeks ago. SP2 is unaware of residents eloping from the facility, the doors remained locked.

Through record review, Resident A had an unwitnessed fall on 6/14/2026. Facility completed an incident and accident form, notified hospice, and family. Resident A was sent to the emergency room for further evaluation. Resident A’s care records indicate Resident A received care in accordance with her service plan. Resident A was discharged from the facility 6/16/2026.

Through record review, Resident B had received care in accordance with her service plan. Resident B was discharged from the facility on 4/27/2026.

Through direct observation, Resident C was in the dining area being fed by another resident. At this time, facility staff were not monitoring Resident C.

Through record review Resident C eats independently, has an alternative diet of mechanical soft foods and thickened.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan. **(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:	Through record review Resident A and Resident B received care in accordance with their service plans. Resident C was observed in dining area being fed by another resident. No staff were present in dining area maintaining safety of the residents during meals.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The home does not maintain a safe environment that is free from hazards, Resident B's room has a large hole in the wall.

INVESTIGATION:

On June 24, 2026, the Department received a complaint forwarded from Adult Protective Services (APS) which alleged the facility does not maintain a hazard free environment. Resident B's room has a large hole in his wall by the window. The hole has been for approximately seven months.

Through direct observation, a large hole was observed in Resident B's wall. No safety measures were implemented to protect Resident B from the hole in wall.

APPLICABLE RULE	
R 325.1964	**Interiors.**
	(1) A building must be of safe construction and be free from hazards to residents, personnel, and visitors.
ANALYSIS:	Through direct observation there was a large gaping hole observed in wall next to Resident B's bed. Facility stated they will promptly fix the hole in wall, but no specific plans were identified.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is serving uncooked food to their residents.

INVESTIGATION:

On June 24, 2026, the Department received a complaint forwarded from Adult Protective Services (APS) which alleged staff are giving residents uncooked food.

While onsite, lunch service was observed. Through record review, the facility maintains food temperature logs. Each food item temperature was taken prior to serving.

APPLICABLE RULE	
R 325.1976	**Kitchen and dietary.**
	(5) The kitchen and dietary area, as well as all food being stored, prepared, served, or transported, shall be protected against potential contamination from dust, flies, insects, vermin, overhead sewer lines, and other sources.
ANALYSIS:	The facility maintains food temperature logs. Observed food well presented. Resident observed appeared to enjoy food being served.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medication is not being administered as ordered.

INVESTIGATION:

On June 24, 2026, the Department received a complaint forwarded from Adult Protective Services (APS) which alleged medications are not being passed in accordance with the resident's services plans.

Through record review of Resident A's medication administration record (MAR) for the month of May 2026, Resident A did not receive prescribed medications in the afternoon on May 27, 2026.

Through record review of Resident B's MAR for the month of June 2026, Resident B did not receive the following medications:

- Aspirin 81mg 6/5/2026 at 8 a.m.
- Famotidine 40 mg 6/5/2026 at 8 a.m.
- Lisinopril 20mg 6/5/2026 at 8 a.m.
- Memantine HCL 5mg 6/5/2026 at 8 a.m.
- Tamsulosin HCL 0.4 mg 6/5/2026 at 8 a.m.

Through record review of Resident C for the month of April 2026, Resident C did not receive the following medications:

- Amlodipine 5mg missed 4/6, 4/7, 4/10, and 4/14.
- Atorvastatin 10mg missed 36 doses
- Atorvastatin 10mg at bedtime indicates “stop date” March 4, 2026, eight doses signed as given post discontinuation of medication.
- Carbidopa-Levodopa 23-100mg three times a day missed 20 doses.
- Cranberry Extract 500mg daily missed 8 doses.
- Carvedilol 6.25mg missed 4 doses as not charted, 6 doses charted as not given.
- Fluoxetine 40mg once daily missed 4 doses as not charted, 2 doses charted as not given.

APPLICABLE RULE	
R 325.1932	**Resident Medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Resident A did not receive all medication as ordered in the month of May 2026. Resident B did not receive medications as ordered in the month of June 2026. Resident C did not receive medications as ordered in the month of April 2026. Through record review, this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/12/2026

Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

08/31/2026

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