GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 25, 2026

Shahid Imran
Hampton Manor of Dundee LLC
123 Waterstradt Commerce
Dundee, MI 48131

RE: License #: AL580396858
Investigation #: 2026A0116040
Hampton Manor of Dundee 2

Dear Mr. 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.

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.

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL580396858
Investigation #:	2026A0116040
Complaint Receipt Date:	07/14/2026
Investigation Initiation Date:	07/14/2026
Report Due Date:	09/12/2026
Licensee Name:	Hampton Manor of Dundee LLC
Licensee Address:	123 Waterstradt Commerce Dundee, MI 48131
Licensee Telephone #:	(734) 673-3130
Administrator:	Shahid Imran
Licensee Designee:	Shahid Imran
Name of Facility:	Hampton Manor of Dundee 2
Facility Address:	123 Waterstradt Commerce Dundee, MI 48131
Facility Telephone #:	(734) 826-9191
Original Issuance Date:	01/31/2020
License Status:	REGULAR
Effective Date:	07/31/2024
Expiration Date:	07/30/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her Plavix on 07/11/26 and 07/12/26. She also missed doses in March and May of this year. In January she did not receive her Synthroid for 10 days. This has been addressed with facility management to no avail.	Yes

III. METHODOLOGY

07/14/2026	Special Investigation Intake 2026A0116040
07/14/2026	Special Investigation Initiated - Telephone Complainant.
07/14/2026	APS Referral Made.
07/15/2026	Inspection Completed On-site Resident Care Coordinator (RCC), Jennifer Gibson, Resident A, and reviewed Resident A's medication administration records (MARs).
07/20/2026	Contact - Telephone call made Relative A1.
07/20/2026	Contact - Telephone call made Core Pharmacy Tech, Batool Syeda.
07/29/2026	Contact - Document Received Received additional information from complainant that Resident A was administered her pm dose of Atorvastatin in the am and no one at the facility was able to explain how the error occurred.
07/29/2026	Contact - Telephone call made Relative A1.
07/29/2026	Contact - Telephone call made RCC, Jennifer Gibson.
07/29/2026	Contact - Telephone call made

	Staff, Alexis Wickings.
08/04/2026	Contact - Document Received Additional information from the complainant.
08/13/2026	Contact - Telephone call made Staff, Bethann Duncan, left a message requesting a return call.
08/14/2026	Contact - Face to Face Spoke to Resident A.
08/17/2026	Contact - Telephone call made Core Pharmacy Tech, Batool Syeda.
08/17/2026	Contact - Telephone call made Complainant.
08/17/2026	Contact-Telephone call received. Staff, Bethann Duncan
08/17/2026	Inspection Completed-BCAL Sub. Compliance
08/19/2026	Exit Conference Licensee designee, Shahid Imran.

ALLEGATION:

Resident A did not receive her Plavix on 07/11/26 and 07/12/26. She also missed doses in March and May of this year. In January she did not receive her Synthroid for 10 days. This has been addressed with facility management to no avail.

INVESTIGATION:

On 07/14/26, I interviewed the complainant. Complainant reported that they have addressed the missed medication with some of the management team to no avail and they are blaming the pharmacy for the missed medications. Complainant reported that the management team is saying that the pharmacy is not delivering the medication as required. Complainant reported they plan to follow up with the pharmacy to see if the issue lies with them. Complainant reported that Resident A is

aware of the number of medications she takes and when she is missing a medication, she contacts them.

On 07/15/26, I conducted an unscheduled onsite inspection and interviewed resident care coordinator (RCC), Jennifer Gibson, Resident A and reviewed Resident A's January, March, May and July 2026 MARs. Ms. Gibson reported that they have been having issues with the pharmacy returning calls and delivering medications in a timely manner. Ms. Gibson reported that she does weekly cart audits and then notifies the pharmacy of what medications need to be refilled. Ms. Gibson reported that there have been repeated delays with the pharmacy filling and delivering medications and they are considering changing to a different pharmacy.

Ms. Gibson reported that Resident A did not miss 10 days of her Levothyroxine 88 mg tablet in January. Ms. Gibson and I reviewed Resident A's January 2026 MAR and observed that Resident A was not administered the medication 01/12/26 - 01/16/26. The note on the MAR documented that the medication was not available from the pharmacy. Ms. Gibson reviewed their record and showed me that the Levothyroxine was reordered from the pharmacy on 01/08/26, however, it was not delivered from the pharmacy until 01/16/26. Ms. Gibson recommended that I contact the pharmacy as they could provide more details regarding the delay in them receiving the medication. Ms. Gibson and I reviewed the March 2026 MAR. Resident A was out of the facility with her son from 03/16/26-03/19/26. The MAR reflects this. The medications were given to Resident A's son to administer while she was in his care. There were no other days in March where Resident A did not receive her medications. Ms. Gibson and I reviewed the May 2026 MAR and observed that from 05/10/26-05/14/26 Resident A did not receive her Clopidogrel 75 mg tablet. The notes on the MAR document that the medication was unavailable from the pharmacy. Ms. Gibson reported that the current prescription was expiring on 05/18/26. She reported that the pharmacy received the new order from Resident A's doctor and on 05/13/26 filled the prescription. The medication was delivered 05/13/26. Ms. Gibson was unable to look and see when the April 2026 medication was filled because with the new prescription order comes a new prescription number. Ms. Gibson was unable to say with any certainty why the medication was not administered from 05/10/26-05/13/26. Ms. Gibson and I reviewed the July 2026 MAR and observed that Resident A was not administered her Levothyroxine 88 mg tablets from 07/11/26-07/13/26. Ms. Gibson reported that the refill was submitted on 07/10/26 and the medication was delivered on the evening of 07/13/26. The note on the MAR documents that the medication was unavailable from the pharmacy. Ms. Gibson reported that the medication was ordered on 07/10/26 and admitted it was an oversight and should have been ordered sooner. Ms. Gibson reported that they normally order refills three to four days before they run out as that is normally the earliest insurance will allow for refills.

On 07/15/26, I interviewed staff, Alyssa White, and she reported that they have been having issues with the pharmacy. She reported that Ms. Gibson does cart audits and will reorder medications that are due to be re-filled and sometimes it takes days for

the pharmacy to deliver them. Ms. White reported that when she sees errors or medications that are down to the last eight or nine pills, she will request refills or notify Ms. Gibson.

On 07/20/26 I interviewed Relative A1 and she reported that she has talked to multiple staff at the facility regarding the missed doses of Resident A's Levothyroxine 88 mg tablets. She reported that she wasn't getting answers from the staff, so she contacted the pharmacy directly on 07/13/26 and they delivered the medication the same evening. Relative A1 reported that she tried not to intervene, but she needed to be sure Resident A received that medication as it is a blood thinner. Relative A1 reported that this is the third time it's been an issue with Resident A not getting this medication.

On 07/20/26, I interviewed Core Pharmacy Technician, Batool Syeda. Ms. Syeda reported that the medication issue in January of 2026 was related to an insurance issue. She reported that on 01/08/26 when they ran the insurance for Resident A's Levothyroxine 88 mg tablets, insurance rejected it. She reported that they ran it through insurance again on 01/16/26 and a 15-day supply was approved and delivered that same evening. She reported that on 01/28/26 a 30-day supply was approved.

Ms. Syeda reported that the Clopidogrel 75mg tablets were refilled on 05/13/26 and a 30-day supply had been refilled and delivered in April of 2026. She reported she could not answer as to why the medications were not administered to Resident A from 05/10/26-05/13/26, as the facility should have still had pills left to administer.

Ms. Syeda reported that they received the refill request from the facility on 07/10/26, for Resident A's Clopidogrel 75mg tablets and delivered them to the facility on 07/13/26. Ms. Syeda reported that the facility can request refills up to four days before the medication is due for refill and insurance will approve. She reported that the facility staff did not do that and that is likely why they ran out of the medication. Ms. Syeda also reported that normally, based on how early the medication is refilled and delivered, the facility should still have a few pills leftover to administer before starting a new bubble pack. Although she is aware that if a medication is dropped on the floor and discarded, that takes away from any remaining or extra pills.

On 07/29/26, I received an email from the complainant with additional information. Complainant reported that on the morning of 07/29/26, Resident A was given six medications instead of the regular five. Resident A contacted Relative A1 and informed her of the matter. Relative A1 went to the facility and determined that the staff was administering Resident A's pm dose of Atorvastatin 20 mg tablet in the morning. Relative A1 spoke to facility staff about the matter and they reported that it was an internal MAR system error, but no one was able to explain how it happened.

On 07/29/26, I interviewed Relative A1 and she reported that she received a call from Resident A about having an extra pill with her am medications. Relative A1

went to the facility to see what was going on. She reported she was shown the MAR and saw that somehow the medication was showing to give in the morning and evening. Relative A1 reported that Atorvastatin is a p.m. medication. Relative A1 reported that the facility staff is working on getting the matter rectified.

On 07/29/26, I interviewed RCC, Jennifer Gibson, and she reported that on 07/21/26, Core Pharmacy put in the new order for the Atorvastatin to be given twice per day, an a.m. and p.m. dose. Ms. Gibson reported that she went into the electronic MAR system and corrected the order back to once per day. She reported that a few hours later Core pharmacy went back in and changed the order back to twice per day and updated the MAR to reflect a 7:00 a.m. dose and an 8:00 p.m. dose. Ms. Gibson reported that based on the updated MAR uploaded into the E-MAR system, they administered the medication twice per day from 07/21/26-07/28/26 and administered an a.m. dose on 07/29/26. Ms. Gibson reported that staff, Alexis Wickings, contacted the pharmacy on 07/29/26 and informed them again that the medication was previously ordered and administered once per day in the evenings and they were wondering why it was changed. Ms. Gibson reported that the pharmacy staff reported that they would look into the matter and update the MAR if needed. Ms. Gibson reported that the Pharmacist later updated the electronic MAR and changed it back to once per day in the evening. Ms. Gibson reported that Resident A has an outside doctor and so she sends the orders directly to the pharmacy, and they update the electronic MAR to reflect any changes in the medications. She reported they administered the medication based on the updates made by the pharmacy after receiving the orders from Resident A's doctor.

On 07/29/26, I interviewed staff, Alexis Wickings, and she reported that she called the pharmacy to get clarity of why the Atorvastatin had been updated to twice per day when it has always been ordered once per day. Ms. Wickings reported that after the pharmacist reviewed their system, they saw that there were two orders from Resident A's doctor with different administration instructions. Ms. Wickings reported that the pharmacist immediately updated the electronic MAR to reflect that the medication be given once per day in the evenings as it had previously been.

On 08/04/26, I received additional information from the complainant. Complainant reported that on 08/03/24 Resident A was not given her 8:00 p.m. dose of Atorvastatin 20 mg tablet.

On 08/04/26, I interviewed RCC, Jennifer Gibson. Ms. Gibson reported that staff, Bethann Duncan, reported that while administering the evening medication on 08/03/26, Resident A's Atorvastatin was not in the bin with all her other medications and so the medication was not administered. Ms. Gibson reported that Ms. Duncan did not follow any of the internal procedures, including looking through the entire

medication cart, calling her and Resident A's daughter when a medication is missing.

Ms. Gibson reported that this morning she and staff, Alyssa White, looked through the entire medication cart and found the bubble back of medication in the slot before Resident A's. Ms. Gibson reported that Ms. Duncan will be written up. Ms. Gibson also reported that they have moved Resident A's medication within the cart, but in a separate divider.

On 08/14/26, I conducted an unscheduled onsite inspection and spoke with Resident A. Resident A reported things have been going well and that she has been getting all of her medications. She reported that she pays attention at each medication pass to ensure she is getting the correct number of pills. She reported that if she is missing pills or has too many, she calls Relative A1 before she takes anything.

On 08/17/26, I interviewed Pharmacy Technician, Batool Syeda, and she reported that they received an order on 07/21/26 from Resident A's doctor. She reported that the order was for Resident A's 20mg Atorvastatin. Ms. Syeda reported that the order was to give the medication twice per day. Ms. Syeda reported that she updated the electronic MAR and sent it over to the facility. She confirmed that Ms. Gibson went into the electronic MAR system and changed the MAR back to reflect once per day. She reported she changed it back to twice per day based on the order from Resident A's doctor. Ms. Syeda reported that the pharmacist caught what he believed was an error on the order, based on his knowledge that Atorvastatin is normally given at night. Ms. Syeda reported that they called Resident A's doctor's office and left a message regarding the order and never received a return call. She reported once they spoke to the facility staff, and had not heard back from Resident A's doctor, the pharmacist discontinued the Atorvastatin 20mg twice a day and updated the MAR based on the previous order from Resident A's doctor. Ms. Syeda reported that the staff administered the medication twice per day from 07/21/26-07/28/26 based on the order received from Resident A's doctor.

On 08/17/26, I interviewed staff, Bethann Duncan, and she reported that she worked from 7:00 p.m. to 7:00 a.m. on 08/03/26. She reported that she was responsible for passing medications. Ms. Duncan reported that she prepared Resident A's medication and noticed that the Atorvastatin was not there. She reported she looked in their electronic MAR system and saw that the medication had been recently filled and delivered, However, it was not in the with Resident A's other medications. Ms. Duncan reported that she did not look through the entire medication cart. She reported that she passed the other medication that was there and informed Resident A that the Atorvastatin was out. Ms. Duncan reported the following morning the a.m. staff found the medication in the slot in front of Resident A's, that was mistakenly placed there by another staff. Ms. Duncan reported that she was written up for the

incident and reported that it is a lesson learned. Ms. Duncan reported that she should have called Ms. Gibson to inform her and get instructions on next steps.

On 08/17/26, I spoke with the complainant and confirmed that Resident A was out of the facility and in his care 03/16/26-03/19/26. Complainant confirmed that she was.

On 08/19/26, I conducted the exit conference with licensee designee, Shahid Imran, and informed him of the findings of the investigation and the rule cited. Mr. Imran reported an understanding.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based on the findings of the investigation, which included interviews with the complainant, RCC, Jennifer Gibson, Resident A, staff, Alyssa White, pharmacy technician, Batool Syeda, Relative A1, staff, Alexis Wickings, staff Bethann Duncan and my review of Resident A's MARs, there is a preponderance of evidence to substantiate the allegations that Resident A's Clopidogrel 75 mg tablets and Atorvastatin 20mg tablets were not given as prescribed. Resident A did not receive her Clopidogrel 75 mg tablets from 05/10/26-05/13/26 and from 07/11/26-07/13/26. Additionally, she was not given her Atorvastatin 20mg tablet on 08/03/26.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/20/26

Pandrea Robinson — Date
Licensing Consultant

Approved By:

08/25/26

Ardra Hunter — Date
Area Manager