GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 11, 2025

Shahid Imran
Hampton Manor of Holly
14480 N. Holly Rd.
Holly, MI 48442

RE: License #: AH630410280
Investigation #: 2025A1035041
Hampton Manor of Holly

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.
- 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.

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) 284-9730.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
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 #:	AH630410280
Investigation #:	2025A1035041
Complaint Receipt Date:	03/18/2025
Investigation Initiation Date:	03/18/2025
Report Due Date:	05/17/2025
Licensee Name:	Hampton Manor of Holly LLC
Licensee Address:	14480 N. Holly Rd. Holly, MI 48442
Licensee Telephone #:	(734) 673-3130
Administrator/ Authorized Representative:	Shahid Imran
Name of Facility:	Hampton Manor of Holly
Facility Address:	14480 N. Holly Rd. Holly, MI 48442
Facility Telephone #:	(989) 971-9610
Original Issuance Date:	10/13/2023
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	104
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility had a disorganized disaster plan. There was no guidance or support during a power outage.	Yes
Additional Findings	No

III. METHODOLOGY

03/18/2025	Special Investigation Intake 2025A1035041
03/18/2025	Special Investigation Initiated - Telephone
03/18/2025	Contact - Telephone call made contacted complainant
03/19/2025	Contact - Face to Face
04/10/2025	Inspection Complete. BCAL Sub Compliance.
04/11/2025	Exit Conference.

ALLEGATION:

Facility had a disorganized disaster plan. There was no guidance or support during a power outage.

INVESTIGATION:

On March 18, 2025, the Department received a complaint through the online complaint system which read:

> "Power outage at approx. 1:45pm 3/15/25 and is still the case at 1:58 am 3/16. No management onsite or reachable by phone to help, resident on oxygen & spouse couldn't find power outlet that worked in unit. He called 911. Firemen told maintenance, the only staff member that responded, there needs to be one working outlet in each unit. No one on premises was aware of this, including maintenance. Outlets still weren't marked. residents weren't notified of this outlet. All units on the south half of the building did not have ANY working lights, but north half had overhead lights & bathroom fixtures on. This left each resident in a south unit completely in the dark. I personally made certain there was a lamp plugged in each unit. used lamps from common areas in some units. A few

residents were offered glow sticks with no instructions. Kitchen couldn't properly prepare dinner. And will not have power for a proper breakfast. Safety alert buttons not working. Residents confused and anxious."

On March 19, 2025, an onsite investigation was conducted. While onsite, I interviewed Staff Person (SP)1 who states he was notified at approximately 14:01 p.m. on March 15, 2025, that the facility had lost power. SP1 reported to the facility to get generators up and running. At this time, it was noted the generator running the 400 hall was running at 20% capacity which would normally run at 60% capacity. It was noted that emergency outlets had not been identified. SP1 went room to room locating and marking emergency outlets with red marker. SP1 contacted Total Energy Systems, LLC for further guidance and assistance. SP1 states he remained at the building approximately 1.5 hours. SP1 states he felt the facility had things under control prior to leaving.

While onsite, I interviewed SP2 who states she is unaware of the emergency plan in the event of a power outage. SP2 was unable to identify emergency electrical outlets.

While onsite, I interviewed SP3 who states she was unaware of the location of the emergency plug outlets nor the emergency plan. SP3 states during the power outage no one knew how to change a portable oxygen tank. The call lights had not worked during this time and she was unable to find emergency outlets.

While onsite, I interviewed Resident A who states she is oxygen dependent. Resident A raised a pulse ox from around her neck stating I use this device to monitor my oxygen level, and it was down to 73% during the outage related to my concentrator not being plugged into an emergency outlet. Resident A family member contacted 911 related to low oxygen level secondary to not having power to run oxygen concentrator. SP1 assisted Resident A's family member in locating an emergency outlet and plugging her oxygen concentrator into the emergency plug. Resident A remained at the facility.

While onsite, I interviewed Resident B who states it was "very scary" as the staff had no idea of what to do, they were not rounding on residents, residents were very anxious. Resident B states her family member had brought in extension cords to plug in lights, assisted with plugging in lights so residents were not left in the dark. Resident B states there were family members and staff attempting to reach management without response or support provided.

While onsite, I interviewed Resident C who states he was not served dinner and was left in the dark.

On March 26, 2025, a phone interview was conducted with the complainant. The complainant stated there were a couple families at the building. Multiple family members attempted to contact management with one manager stating they will be in

and not showing and another stating “I’m six hours away and will not be coming in.” Complainant states SP1 helped identify emergency outlets in each unit and marked them with a red check. Approximately an hour later SP1 left. Staff members and residents at the facility were left without guidance and support. Complainant, another family member, and one staff member assisted with plugging in lights and passing out glow sticks.

On March 31, 2025, a phone interview was conducted with SP4 who states the power went out around 14:00 p.m. and that the staff ensured everyone was safe. SP4 states she needed to get assistance from another staff member to assist with setting up oxygen tanks. SP4 states she used her hot spot on her phone to get internet on the laptop to pass medications. SP4 states no one knew where the emergency plugs were located.

On March 31, 2025, a phone interview was conducted with SP5 who states the power went out around 15:00 p.m. and returned around 03:00 a.m. SP5 states it was confusing at first but SP1 assisted in locating emergency outlets and passing out glow sticks, flashlights, and whistles. SP5 states one staff member used their hotspot to run the computer, and she chose to use the “med book” to pass medications.

While onsite SP1 toured the writer showing red check marks on outlets, fire extinguishers box holds glow sticks, flashlights, and whistles. Most of the emergency supply boxes noted were untouched in fire extinguisher boxes except one. One emergency box located in the 400-hall nursing station had emergency supplies missing.

APPLICABLE RULE	
R 325.1981	**Disaster plans.**
	(1) A home shall have a written plan and procedure to be followed in case of fire, explosion, loss of heat, loss of power, loss of water, or other emergency. **(2) A disaster plan shall be available to all employees working in the home.** **(3) Personnel shall be trained to perform assigned tasks in accordance with the disaster plan.**

ANALYSIS:	Through interviews, staff and residents state that the power outage was very confusing with little support and direction. All staff members interviewed stated they were unaware of the emergency plan and the procedures that should have been followed. Complainant states the emergency plan was nonexistent, staff and residents were left without support or guidance. Based on the information noted above, this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

04/07/2025

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

Approved By:

04/10/2025

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