GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 26, 2025

Shahid Imran
Hampton Manor of Commerce
100 Decker Rd.
Walled Lake, MI 48390

RE: License #: AH630414388
Investigation #: 2025A1035093
Hampton Manor of Commerce

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. 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 #:	AH630414388
Investigation #:	2025A1035093
Complaint Receipt Date:	09/16/2025
Investigation Initiation Date:	09/16/2025
Report Due Date:	11/16/2025
Licensee Name:	Hampton Manor of Commerce LLC
Licensee Address:	100 Decker Rd. Walled Lake, MI 48390
Licensee Telephone #:	(248) 896-1400
Administrator/ Authorized Representative:	Shahid Imran
Name of Facility:	Hampton Manor of Commerce
Facility Address:	100 Decker Rd. Walled Lake, MI 48390
Facility Telephone #:	(248) 896-1400
Original Issuance Date:	08/03/2023
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	80
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was unresponsive; staff did not initiate CPR.	Yes
Additional Findings	No

III. METHODOLOGY

09/16/2025	Special Investigation Intake 2025A1035093
09/16/2025	Special Investigation Initiated - Letter
09/17/2025	Contact - Face to Face
09/16/2026	APS Referral APS Denied
12/23/2025	Inspection Complete. BCAL Non-Compliance.
12/23/2025	Exit Conference.

ALLEGATION:

Resident A was unresponsive; staff did not initiate CPR.

INVESTIGATION:

On September 16, 2025, the Department received a complaint forwarded from Adult Protective Services (APS) which read:

> The morning of Saturday, 9/13/2025, about five unknown Hampton Manor staff found Resident A lying on the floor, laying on her left side. Resident A was not breathing and had a plastic bag over her head. Staff rolled Resident A over onto her back but did not remove the plastic bag. Staff called 911 but continued to refuse to remove the plastic bag or to attempt CPR. Staff failed to provide any aid to Resident A, instead just standing in the hallway and waiting for emergency services to arrive. Staff refused to explain their behavior or to identify specifically who first found Resident A and rolled her over. Resident A had bruises in various stages of healing all the way down her right side, including a large bruise on the side of her face near her jawline. Staff reported that Resident A falls a lot, but given the extent of the bruising and the staff's mishandling of Resident A being found with the plastic bag on her head, there is concern that the bruising could

have been abuse. Furthermore, Resident A signed a do-not-resuscitate (DNR) form on 9/12/2025, the day before she died, which is suspicious. However, the form was not signed by a physician. When emergency medical services arrived on Saturday, staff initially said that they did not know whether Resident A had signed a DNR form before eventually finding it.

On September 13, 2025, an onsite investigation was conducted. While onsite I interviewed staff person (SP)1 who states Resident A had signed new advance directives changing her code status to Do not resuscitate (DNR). The new advance directives had not been initiated related to not being signed by the physician. SP1 states all care staff are trained and certified in CPR. In the event of emergency requiring CPR, staff members are expected to initiate services until emergency services arrive.

While onsite, I interviewed SP2 who states she was the assigned Med Tech and was notified by the assigned caregiver that Resident A was observed on the floor. SP2 stated she called Resident A's name when she arrived to her room, Resident A did not respond. SP2 states she left the room to call 911 and check Resident A's code status. CPR had not been initiated at this time.

While onsite, I interviewed SP3 who states Resident A was lying on the floor with a plastic bag over her head when she arrived. The EMS dispatch operator instructed her to remove the bag and check for a pulse. SP3 states she did as instructed. SP3 states Resident A "did not have a pulse and was purple in color." SP3 states SP2 and SP4 returned to the room at this time and she left returning to her unit.

While onsite, I interviewed SP4 who states she received a call from SP2 to inform her Resident A was unresponsive, had a bag over her head and questioned her code status. SP4 promptly went to the facility to assist staff. Upon SP4 arrival to the facility, Family A arrived.

A phone interview was conducted with Deputy Reedy who states several staff members were noted outside Resident A's room, CPR was initiated by EMS personal, and there was suspicion with Resident A's death.

Through record review SP2, 3, and 4 have current CPR certifications.

Through record review of facility camera footage:

08:40 Resident A observed in dining room eating breakfast.
09:24 Resident A taken to her room
09:32 SP5 left Resident A room
09:34 SP5 reentered Resident A room
09:34 SP5 left Resident A room
09:52 SP2 in hall passing medication
09:53 SP2 in room across hall from Resident A room

09:55 SP2 observed exiting hall with med cart
11:12 SP5 entered/ exited Resident A's room then walked off unit (Resident A observed on floor with plastic bag over her head)
11:14 SP2 entered Resident A's room
11:14 SP5 entered room
11:15 Both SP2 and SP5 exited room
11:16 SP2 reenters room
11:15 SP3 enters room
11:17 Six staff member in hall looking at doorway
11:20 SP2 exits room talking on phone
11:22 Police observed entering room
11:24 Fire personnel arrived
11:25 Police/ EMT arrive
11:27 Additional EMS arrive
11:30 Fire/ Police exit
11:34 SP4 and additional staff member returned to room

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:	Through interview and record review, Resident A recently elected to have her resuscitation status changed to Do Not Resuscitate (DNR). DNR paperwork had not been completed with physician signatures therefore the DNR status had not been activated. Assigned staff members were uncertain of Resident A's resuscitation status causing a delay in care or response to the incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/16/2025

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

Approved By:

12/23/2025

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