



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

January 29, 2026

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

RE: License #: AH630414388  
Investigation #: 2026A0627024  
Hampton Manor of Commerce

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.
- 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) 335-5985.

Sincerely,

A handwritten signature in black ink that reads "Rick Brummette".

Rick Brummette, Licensing Staff  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
Lansing, MI 48909



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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AH630414388
<b>Investigation #:</b>	2026A0627024
<b>Complaint Receipt Date:</b>	01/08/2026
<b>Investigation Initiation Date:</b>	01/08/2026
<b>Report Due Date:</b>	03/07/2026
<b>Licensee Name:</b>	Hampton Manor of Commerce LLC
<b>Licensee Address:</b>	100 Decker Rd. Walled Lake, MI 48390
<b>Licensee Telephone #:</b>	(248) 896-1400
<b>Administrator:</b>	Jordan Beltz
<b>Authorized Representative/</b>	Shahid Imran, Authorized Repr.
<b>Name of Facility:</b>	Hampton Manor of Commerce
<b>Facility Address:</b>	100 Decker Rd. Walled Lake, MI 48390
<b>Facility Telephone #:</b>	(248) 896-1400
<b>Original Issuance Date:</b>	08/03/2023
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	08/01/2025
<b>Expiration Date:</b>	07/31/2026
<b>Capacity:</b>	80
<b>Program Type:</b>	ALZHEIMERS AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
It was alleged that the facility's residents were being neglected.	Yes
It was alleged that 2 facility staff members were not in the building when EMS personnel arrived to assist with lifting a resident back into bed.	Yes
Additional Findings	No

**III. METHODOLOGY**

01/08/2026	Special Investigation Intake 2026A0627024
01/08/2026	Special Investigation Initiated - On Site Intake should be 12/9/25. Onsite should be 1/7/26
01/08/2026	Contact - Telephone call made ED & Corporate Nurse
01/08/2026	Contact - Document Received IR received

**ALLEGATION:** It was alleged that the facility's residents were being neglected.

**INVESTIGATION:**

On 12/9/2026 the Bureau of Community and Health Systems received a complaint alleging that the facility's residents were being neglected.

On 1/7/2026, I called to interview the complainant. Incident #1: The complainant stated that EMS was called twice on 11/27/25 at 4:40am for a medical issue call and again at 5:30am to assist staff with a large resident who had fallen out of bed. During the 4:30am call a family member told the EMS responder that he had waited outside the building for an hour trying to get someone's attention to let him in to see his

mother who was sitting in the lobby in view of the family member. The second call at 5:30am the complainant described that when the EMS crew was pulling into the facility parking lot, they followed a vehicle pulling in ahead of them and observed 2 people exit the vehicle and quickly moved towards the building to scan themselves in. The EMS crew saw the two employees in room 100 and the complainant reported that they smelled of marijuana. The complainant stated he believes the residents of the facility were left unattended between the family member found waiting outside at the 4:40am call and the 5:30am call. Incident #2: The complainant also reported an incident on 12/5/2025 where EMS was called to transport a resident to the hospital who had fallen a week prior and was taken to the hospital where it was discovered the resident had fractures in her lower vertebral spine.

On 1/7/26, I interviewed Jordan Beltz, Executive Director (ED) regarding the complaint. Hampton Manor is a 51 bed facility with a current census of 35, including 9 in the memory care unit. The ED reported that the minimum staffing levels of medication technicians (Med Tech) and care givers at the facility are 5 on day shift, 4 on afternoon shift and 4 on night shift.

I toured the facility with the ED. The residents in the common areas and in their personal rooms were clean and looked well cared for. I interviewed Resident A in the memory care unit who was alert oriented and pleasantly conversational. Resident A reports that she gets good care, receives good food and has her calls for assistance answered in a timely manner.

Resident B, subject of the complaint, lives on the assisted living side of the facility and has expressive aphasia. Resident B answers yes/no questions appropriately. He nods yes to questions revolving around whether he gets good care at the facility. He has a guitar in his room and shakes his head "No" to being a bass or drum player but nods yes to formerly being a lead guitarist.

Resident C is nonverbal, on hospice and was having a visit from her son and a hospice nurse. Resident C's son was very complimentary about the care his mother receives from caregivers and other staff at the facility stating she probably would not have lived this long if it were not for living at this facility.

During another interview on 1/7/2026 with the ED, an inquiry was made to review incident reports for the fall Resident B had on 11/27/25 at 5:30 am. ED stated that the corporate nurse keeps those and she could not locate the incident report. ED reported that that resident in incident #2 had fallen on 11/29/25 and that staff notified the resident's family of the fall and the resident and the family declined to have her transferred to the hospital for evaluation. The resident no longer resides at the

facility. ED reported that she will reach out to SP1 to search for those incident reports.

On 1/8/26 I spoke via telephone with ED and SP1, the Corporate Nurse who searched for the incident reports for incident #1 and incident #2. SP1 emailed me an incident report for issue #2. An incident report for issue #1 was not found.

<b>APPLICABLE RULE</b>	
<b>R 325.1924</b>	<b>Reporting of incidents, accidents, and elopement.</b>
	<b>(1) The home shall complete a report of all reportable incidents, accidents, and elopements.</b>
<b>ANALYSIS:</b>	Facility staff did not complete an incident report, incident #2, for the fall Resident B had on 11/27/2025 and the facility did not have incident reports available for timely review of either of the incidents referenced in the complaint; incidents 1 and 2.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:** It was alleged that 2 facility staff members were not in the building when EMS personnel arrived to assist with lifting a resident back into bed.

**INVESTIGATION:** On 1/7/2026, I asked ED if she was aware that 2 staff members were witnessed as not being in the facility on 11/27/25 when EMS arrived at 5:30am and also later noted by the complainant to be smelling of Marijuana. ED reported no awareness that that had happened and expressed disappointment that no one from the EMS crew had complained to her about the incident when it occurred so she could have dealt with the unacceptable issue promptly. While this is an unverified incident, ED gave me assurance that a serious incident such as this would not have passed without the responsible care givers being held accountable. ED presented the staffing levels on 11/27/25 and it was noted that there were 4 caregivers on the schedule. ED reports that the aide identified by the complainant as one of the staff seen going into the facility when EMS arrived, no longer works at the facility. ED also reports that the second caregiver in room 100 has turned in his resignation commencing next week.

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<b>(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable</b>

	<b>of providing for resident needs consistent with the resident service plans.</b>
<b>ANALYSIS:</b>	Two facility staff were witnessed not being in the facility upon arrival of EMS personnel to assist with lifting a large resident off the floor.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Upon receipt of an acceptable Corrective Action Plan (CAP) I recommend the status of the license remain unchanged.



1/16/2026

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Rick Brummette  
Licensing Staff

Date

Approved By:



01/30/2026

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

Date