GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 15, 2026

Shahid Imran
Hampton Manor of Burton
2105 Center Rd
Burton, MI 48519

RE: License #: AH250410173
Investigation #: 2026A1019042

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.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250410173
Investigation #:	2026A1019042
Complaint Receipt Date:	07/07/2026
Investigation Initiation Date:	07/09/2026
Report Due Date:	09/06/2026
Licensee Name:	Hampton Manor of Burton LLC
Licensee Address:	2105 South Center Rd. Burton, MI 48519
Licensee Telephone #:	(989) 971-9610
Administrator:	Carol Cancio
Authorized Representative:	Shahid Imran
Name of Facility:	Hampton Manor of Burton
Facility Address:	2105 Center Rd Burton, MI 48519
Facility Telephone #:	(810) 553-3355
Original Issuance Date:	05/18/2023
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	102
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/07/2026	Special Investigation Intake 2026A1019042
07/09/2026	Special Investigation Initiated - Face to Face
07/09/2026	Inspection Completed On-site
07/09/2026	Contact - Telephone call made Contacted Burton Police Department to request a copy of the police report, informed no report exists.
07/14/2026	Inspection Completed BCAL Sub. Compliance

ALLEGATION: Resident A eloped from the facility.

INVESTIGATION:

On 7/7/26, the department received a complaint alleging that Resident A had recently eloped from the facility. The complaint alleges that Resident A had tipped over into a ditch in her electric scooter, was found there by police and returned her to the facility. The complaint alleged that facility staff were unaware that she was gone until police showed up to the facility with the resident. Due to the anonymous nature of the complaint, additional information could not be obtained.

On 7/9/26, I conducted an onsite inspection. I interviewed Employees 1 and 2 onsite. Neither employee was present at the time of the incident but reported that it occurred on the evening of 7/4/26. Employee 2 reported that a staff member called to inform her of the elopement the evening it occurred. Employee 2 reported that after being returned to the facility, she was told that the resident did not have any injuries but as a precaution staff called 911 for medical evaluation, however Resident A and her daughter both refused to have her taken to the hospital. Employees 1 and 2 deny knowledge of Resident A being found in a ditch as the complaint alleges.

While onsite, an incident report was provided. The incident report, authored by Employee 3 read:

> *[Resident A] was saying she was hungry when I passed her medications. She said she didn't get dinner, but she did get dinner in the dining room. Staff still offered to make her something from the kitchen. [Resident A] was upset. [Resident A] rode her powerchair to the clubroom and watched out the window, the fireworks. She was sitting there for a while staff had to retrieve other call lights and pass others medications, and when staff came to check on [Resident A] we couldn't find her. Her daughter called the facility and said police are bringing her back and that she was down center road. [Resident A] was saying she didn't want to be here anymore and that she wants to go back home. She expressed she wants to kill herself, ambulance was called. [Resident A] said she escaped this dreadful place to go to her own home.*

In follow-up correspondence, Burton Police Department was contacted and a request for a copy of the police report was made, however the records department reported that a police report was never filed.

In follow up correspondence, Employee 4 confirmed via surveillance camera footage that Resident A left the facility on 7/4/26 at 9:38pm and was returned at 10:32pm.

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:	Resident A left the facility without staff knowledge on the evening of 7/4/26, placing her at significant risk of harm while unattended outside the facility. Therefore, this allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

While onsite, Resident A's service plan was reviewed. The service plan dated 6/6/26 read *"Resident has expressed anger towards family for putting her in the facility and states she wants to 'go home'. DO NOT LET OUTSIDE".*

APPLICABLE RULE	
R 325.1931	**Governing bodies, administrators, and supervisors.**
	(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.
ANALYSIS:	Resident A's service plan was not followed, as she was outside unattended without staff knowledge.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/14/2026

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

07/15/2026

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