GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 4, 2025

Hemant Shah
Clio Memory Care, LLC
32685 Rockridge Lane
Farmington Hills, MI 48334

RE: License #: AL250384188
Investigation #: 2025A0779056
Cranberry Park Memory Of Clio

Dear Hement Shah:

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) 643-7960.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250384188
Investigation #:	2025A0779056
Complaint Receipt Date:	09/29/2025
Investigation Initiation Date:	09/29/2025
Report Due Date:	11/28/2025
Licensee Name:	Clio Memory Care, LLC
LicenseeAddress:	1346 W. Vienna Road Clio, MI 48420
Licensee Telephone #:	(810) 640-7783
Administrator:	Rachel Morgan
Licensee Designee:	Hemant Shah
Name of Facility:	Cranberry Park Memory Of Clio
Facility Address:	1346 W. Vienna Road Clio, MI 48420
Facility Telephone #:	(810) 640-7783
Original Issuance Date:	11/14/2016
License **Status:**	REGULAR
Effective Date:	05/14/2025
Expiration Date:	05/13/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was taken to the hospital and the facility refused to allow him to come back.	Yes
Residents are not being changed in a timely manner.	No
Home manager is rude and demeaning to residents and Resident B is verbally abused by staff.	No
Residents are missing meals because staff will not get them up or take meals to their rooms.	No
Narcotics have recently come up missing.	No

III. METHODOLOGY

09/29/2025	Special Investigation Intake 2025A0779056
09/29/2025	APS Referral Complaint was received from APS centralized intake.
09/29/2025	Special Investigation Initiated - Telephone Spoke to administrator, Rachel Morgan.
10/02/2025	Contact - Telephone call received Spoke to administrator.
10/08/2025	Inspection Completed On-site
10/15/2025	Contact - Telephone call made Spoke to staff person, Aubree Cook.
10/15/2025	Contact - Telephone call made Spoke to administrator.
10/17/2025	Contact - Telephone call made Spoke to Resident A's guardian.
10/17/2025	Contact - Telephone call made Spoke to staff person, Tomell Bridges.
10/17/2025	Contact - Telephone call made Spoke to Resident B's POA.
10/31/2025	Contact - Telephone call made Spoke to Resident A's guardian.

10/31/2025	Exit Conference Held with administrator, Rachel Morgan.

ALLEGATION:

Resident A was taken to the hospital and the facility refused to allow him to come back.

INVESTIGATION:

On 10/2/2025, a phone call was received from administrator, Rachel Morgan, who stated that Resident A had a few falls on 10/1/2025 and also physically assaulted a staff, so he was sent to the hospital. Admin Morgan stated that Resident A has established a pattern of being verbally and physically aggressive with staff and other residents and that they will be providing him with a 24-hour discharge notice. Admin Morgan stated that they have spoken to Resident A's guardian, who is understanding of the situation and that the home manager has made some calls, attempting to find Resident A with an alternative placement.

On 10/8/2025, an on-site inspection was conducted and home manager, Mary Anglebrant, was interviewed. HM Anglebrant stated that during her initial assessment of Resident A, she was told that Resident A's medications were regulated and that he was doing well. HM Anglebrant reported that Resident A came to this facility on 9/12/2025 and that he was doing fine for several days, but then he started displaying behaviors. HM Anglebrant stated that Hospice came to the facility, evaluated Resident A and felt that they could manage his medications. Hospice felt that Resident A would be appropriate to stay and kept making adjustments to Resident A's medication, but it was not working. HM Anglebrant stated that Resident A started being physically and verbally aggressive with staff and other residents and engaging in property destruction. HM Anglebrant stated that Resident A would try and get out of his wheelchair and fall, would put himself on the floor and crawl, and was once found to be in a female resident's room, possibly trying to touch her inappropriately, but staff intervened and nothing happened. HM Anglebrant reported that after Resident A tried to choke and physically assaulted a staff member on 10/1/2025, Hospice suggested to send Resident A to the hospital for a psych evaluation. HM Anglebrant stated that she spoke to Resident A's guardian on 10/2/2025 and told her that, due to Resident A's behaviors, he is considered a risk to other residents and staff, so he would not be allowed to return to this facility. HM Anglebrant stated that Guardian understood the situation and that a 24-hour discharge notice was mailed to Guardian. HM Anglebrant reported that Guardian is an elderly woman who does not have an email address to send the notice to.

HM Anglebrant provided copies of multiple incident reports documenting Resident A's aggressive behaviors. The IR's documented that Resident A would put himself on the

floor multiple times, a few times where he physically assaulted staff and two other residents, and one occasion where he engaged in property destruction.

Resident A's *Assessment Plan For AFC Residents* was reviewed. The plan indicates that Resident A utilizes a wheelchair but will get on the floor and crawl. The plan states that Resident A has issues with getting along with others and controlling aggressive behavior. Resident A requires assistance from staff to complete all his activities of daily living.

On 10/8/2025, staff persons, Reagan Valentine and Antonae Timmons, were interviewed. Both staff stated that Resident A was verbally and physically combative with staff and other residents. Both staff reported that Resident A would put himself on the floor and crawl around. Staff Timmons stated that Resident A would spit, destroy things in his room, go into other residents' rooms and go through their things or just stand there and awkwardly stare at them, making other residents scared of him.

On 10/8/2025, staff person, Jessica Goodman, stated that Resident A was very physically and verbally aggressive. Staff Goodman stated that Resident A has hit and kicked her, would throw water at staff and dump large amounts of water on the floor on purpose.

On 10/15/2025, a phone interview was conducted with staff person, Aubree Cook, who confirmed that Resident A was verbally and physically aggressive with staff and other residents and that other residents were scared of him. Staff Cook stated that Resident A was destructive to property and broke furniture and windows. Staff Cook reported that she once walked into a female residents room and found Resident A next to her bed with his hand near her private area. Staff Cook stated that she redirected Resident A out of the other residents room and that the female resident did not wake up.

On 10/15/2025, Admin Morgan confirmed that the 24-hour discharge was made to Guardian by phone on 10/2/2025 and the written notice was mailed to Guardian the same day. Admin Morgan stated that they would have taken Resident A back from the hospital, but they were scared that he would hurt someone. Admin Morgan reported that they never heard back from another AFC provider that they contacted about accepting Resident A and that she has not heard anything further from the hospital.

On 10/17/2025, a phone call was made to Guardian, who stated that Resident A is still in the hospital and they are continuing to look for another home for him to move to. Guardian stated that she was aware of the 24-hour discharge, understands this facility's situation and agrees that he was not a good fit for this facility. Guardian reported that Resident A is Bi-polar, that he was previously in a psych placement and did well there, so she would like him to go to one again.

On 10/31/2025, a second phone call was made to Guardian, who confirmed that Resident A is still in the hospital. Guardian stated that with Resident A's Bi-polar and

dementia, they are continuing to struggle and monitor his medications. Guardian reported that Resident A seems quite confused but is doing okay physically.

On 10/31/2025, an exit conference was held with administrator, Rachel Morgan. Admin Morgan was informed of this violation, due to the discharge taking place without another appropriate placement for Resident A being found. Admin Morgan stated that phone calls were made to one other AFC provider, but no placements were arranged. Admin Morgan reported that she will be working with the home manager regarding doing more extensive initial assessments of potential residents.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.**
ANALYSIS:	Due to his continued verbal and physical aggression toward staff and other residents, Resident A was sent to the hospital on 10/1/2025. Although a 24-hour discharge notice was provided to Resident A's guardian, this facility officially discharged Resident A before another appropriate setting was found. The hospital is not deemed as an appropriate long-term setting.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are not being changed in a timely manner.

INVESTIGATION:

On 10/8/2025, an unannounced on-site inspection was conducted and fourteen residents were all viewed to be clean, well-groomed and appeared to be doing well. Multiple resident rooms were viewed to be appropriately clean and no strong odors of urine were noticed.

All the residents of this facility have some degree of dementia. Four of those residents were able to communicate regarding the care they are receiving and reported that they have no complaints. Resident C stated that the care is exceptional and that he loves living here. Resident D stated that staff are good and that she would speak up if things were bad.

On 10/8/2025, home manager, Mary Anglebrant, stated that they have four residents who are either bed bound or fall risks, who are checked on every hour, and all the other residents are checked on at least every two hours or earlier. HM Anglebrant stated that no residents are left in wet or soiled briefs for long periods of time and that no current residents have any bedsores as a result of neglect. HM Anglebrant reported that she has not received any complaints from residents, family members or Hospice regarding resident personal care being an issue.

On 10/8/2025, three separate staff on shift were interviewed. They all stated that they try to check on the residents every hour, but that they are definitely checked and changed at least every two hours. The staff stated that no one is left in wet and/or soiled briefs for long and confirmed that no residents have any current bedsores.

On 10/8/2025, a face-to-face meeting took place with All American Hospice nurse, Felicia Richards. Nurse Richards stated that she has seven current patients at this facility and that she spends time in this facility 3-4 times a week. Nurse Richards reported that all seven residents she sees all wear briefs, that she has never witnessed them sitting in saturated briefs and that none of them have skin issues, as a result of neglect. Nurse Richards stated that she has no concerns regarding the care that this home provides for their residents and that she has not witnessed any signs of neglect at this facility.

On 10/17/2025, a phone call was made to Resident B’s power of attorney (POA), who stated that Resident B seems quite happy at this facility and appears to be receiving decent care here. POA stated that Resident B has a tendency to refuse care and does not like to shower at times, but that staff seem to do a good job of keeping him clean.

APPLICABLE RULE	
R 400.15305	**Resident protection**
	(3) A resident shall be treated with dignity and his or her personal needs , including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 10/8/2025, an unannounced on-site inspection was conducted and fourteen residents were all viewed to be clean, well-groomed and appeared to be doing well. Four residents were able to communicate that staff are good and that they have no complaints regarding the care they are receiving. Multiple staff report that all residents are checked and changed at least every 2 hours and many of them more often than that. A Hospice nurse, who serves seven of the current residents, stated that those residents are receiving good care and that she has not witnessed any signs of neglect at this facility. There was insufficient evidence found to prove that the residents of this facility are not being provided with adequate personal care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Home manager is rude and demeaning to residents and Resident B is verbally abused by staff.

INVESTIGATION:

On 10/8/2025, Resident B stated that he likes living here. Resident B stated that HM Anglebrant and all the staff are nice to him. Resident B was observed to respond quite friendly and positively during interactions with HM Anglebrant and staff working that day.

On 10/8/2025, several residents confirmed that they like HM Anglebrant and that she is never rude or demeaning. HM Anglebrant was observed to have a quite positive relationship with multiple residents.

On 10/8/2025, home manager, Mary Anglebrant, denied that she has ever been rude or demeaning to any residents. HM Anglebrant stated that she would never accept that behavior from any of her staff and would never display it herself. When asked about Resident B, HM Anglebrant stated that Resident B can be difficult at times by refusing care, but the staff seem to like Resident B and have good patience with him. HM

Anglebrant stated that she has never received any complaints from Resident B, his POA or from staff regarding Resident B being verbally abused.

On 10/8/2025, staff person, Reagan Valentine, stated that she has never seen HM Anglebrant be inappropriate with any residents. Staff Valentine stated that all the residents are very comfortable with HM Anglebrant. Staff Valentine confirmed that Resident B will refuse care, but that he can eventually be talked into cooperating, you just have to be patient with him. Staff Valentine reported that Resident B gets along with everyone and that she has never seen any staff verbally abuse him.

On 10/8/2025, staff person, Antonae Timmons, stated that HM Anglebrant loves the residents and that the residents love her back. Staff Timmons stated that there are definitely no issues there. Staff Timmons stated that you might have to try a few times with Resident B, but he always gives in and cooperates. Staff Timmons stated that Resident B is a nice guy, so there is no reason to ever verbally abuse him and that she has never seen any staff do so.

On 10/8/2025, staff person, Jessica Goodman, stated that HM Anglebrant is very gentle and sweet to the residents and that she has never seen her be rude or demeaning. Staff Goodman stated that she has no issues with Resident B and that she has never seen anyone verbally abuse him.

On 10/15/2025, staff person, Aubree Cook stated that HM Anglebrant is really good with the residents and that she has never seen her to be rude or demeaning. Staff Cook stated that Resident B will refuse care at times, but that he is mean about it and that there is no need to ever verbally abuse him. Staff Goodman stated that she has never witnessed any staff verbally abuse Resident B.

On 10/17/2025, Resident B's POA stated that she is not aware of any staff verbally abusing Resident B. POA stated that Resident B has not told her about staff verbally abusing him and she has never witnessed it. POA reported that it is Resident B who is rude to the staff at times.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(ii) Verbal abuse.**

ANALYSIS:	Resident B stated that home manager, Mary Anglebrant, and all the staff are nice to him and was observed to interact with HM Anglebrant and other staff quite positively. HM Anglebrant denies ever being rude or demeaning to any resident. Several staff confirm that HM Anglebrant is good with the residents and that they have never seen her be rude or demeaning. Staff deny ever verbally abusing Resident B or witnessing any other staff doing so. Resident B's POA stated that Resident B has never mentioned being verbally abused by staff and that she has never witnessed it. There was insufficient evidence found to prove that Resident B or any other resident at this facility is being verbally abused.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are missing meals because staff will not get them up or take meals to their rooms.

INVESTIGATION:

On 10/8/2025, HM Anglebrant stated that all residents are provided three meals a day. HM Anglebrant stated that staff are required to put a meal in front of all residents, whether they eat it or not, and food is taken into resident rooms for those that choose not to come to the dining room. HM Anglebrant reported that the cook has a check list in the kitchen where staff check off that each resident was given a plate of food at each meal.

During the on-site inspection on 10/8/2025, lunch at this facility was observed. Ten residents were observed to eat lunch in the dining area, three residents were served lunch in their rooms and one resident ate lunch while sitting in a recliner in the living room area. Four residents were able to report that they are provided with three meals daily and that the food is good.

On 10/8/2025, Resident E confirmed that she is bedridden and chooses not to be taken down to the dining room to eat meals. Resident E stated that staff bring her meals to her in her room and that she is provided with three meals daily.

This facility has a food intake log where staff document how much food each resident eats at each meal. Multiple residents' logs were reviewed and no significant and/or recent changes were noted. Multiple resident weight records were also reviewed. No

significant changes in weight were observed. The facility's menu was reviewed and appeared to be appropriate.

On 10/8/2025, facility cook, Gary Nedull, was interviewed. Cook Nedull stated that he communicates with staff to make sure every resident is served a meal. Cook Nedull showed the check list, located in the kitchen, where staff document that each resident was provided a meal. Cook Nedull stated that no resident should be missing any meals, unless they choose not to eat, and that there are multiple options available if residents do not want what is on the menu.

On 10/8/2025, three staff were interviewed separately regarding this issue and they all reported the same information. All three staff confirmed that they are required to place a meal in front of all the residents at each meal (3x daily), including those that choose to eat in their rooms. They reported that some residents will refuse to eat at times or eat very little, but that all residents are provided with three meals daily.

On 10/8/2025, Hospice nurse, Felicia Richards, stated that she has observed meals at this facility and that it appears all residents are served, including those in their rooms. Nurse Richards stated that one of her patients here, Resident B, will occasionally eat in his room. Nurse Richards stated that she is not aware of any issues regarding meals for any of the seven residents she provides services to here or any issues regarding those residents losing significant weight, due to neglect.

On 10/15/2025, staff person Aubree Cook stated that residents are encouraged to go to the dining room to eat, but are not required to and are served food in their rooms if they choose not to. Staff Cook stated that three meals daily are placed in front of every resident and they decide whether they eat or not.

On 10/17/2025, Resident B's POA stated that she has observed Resident B to be served meals in his room. POA stated that Resident B has never said anything about him missing any meals and that Resident B does not appear to be having any issues regarding his weight.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	Through interviews with residents, staff, a Hospice nurse and a family member, it was confirmed that all residents are served three meals daily. It was confirmed that some residents are provided with meals in their rooms, if they choose not to go to the dining room. Resident weight records, food intake logs, and the facility's menu were reviewed and no issues were found. There was no evidence found to prove that any residents are not being provided with three meals daily.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Narcotics have recently come up missing.

INVESTIGATION:

On 9/29/2025, a phone call was received from administrator, Rachel Morgan. Admin Morgan stated that they are internally investigating an allegation that some narcotic medication may have come up missing. Admin Morgan stated that staff person, Tomell Bridges has been placed on a suspension, pending the outcome of the investigation.

On 10/8/2025, HM Anglebrant confirmed that she conducted an internal investigation regarding this issue and that her and Admin Morgan watched camera footage for the day in question. HM Anglebrant stated that medications were delivered to the facility on 9/19/2025 and were signed for by staff person, Tomell Bridges. HM Anglebrant reported that the cameras showed that Staff Bridges only took one med pack out of the bag that was delivered, discarded the bag and that the medication was not a narcotic. HM Anglebrant stated that the pharmacy claimed that a few packs of narcotics were delivered, but that they are fairly certain that there were no narcotics included in the delivery on 9/19/2025 and that Staff Bridges is adamant that the delivery only consisted of one pack of meds. HM Anglebrant reported that they have had these issues with this pharmacy in the past, where the pharmacy claims that medications were delivered and they were not. HM Anglebrant stated that the facility paid for new narcotic medications to be filled. HM Anglebrant reported that she will have discussions with staff about the importance of checking all delivery's from the pharmacy for accuracy before the delivery person leaves the facility.

Several residents' medication administration records (MARs), for those taking narcotic medications were reviewed. This included documentation where staff count narcotic medications on each shift. The MARs showed that residents are receiving their narcotic medications as prescribed and it does appear that any narcotic medications were missing.

On 10/15/2025, Admin Morgan stated that they never found any proof that narcotics were actually delivered to the facility on 9/19/2025. Admin Morgan stated that cameras showed that Staff Bridges only pulled one med pack from the delivery bag, which is what Staff Bridges is reporting. Admin Morgan confirmed that they have had issues in the past with this pharmacy not sending medications that they claim they have and that they will be changing pharmacy providers.

On 10/17/2025, a phone interview was conducted with staff person, Tomell Bridges. Staff Bridges denies that he took any residents narcotic medication and that any narcotics were included in the pharmacy delivery on 9/19/2025. Staff Bridges stated that he signed for the medication but admitted that he did not pay attention to what medications he was signing for, and that there was only one med pack in the bag from the pharmacy, which was not a narcotic.

APPLICABLE RULE	
R 400.15312	**Resident medications**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Staff person, Tomell Bridges, who was the staff that signed for the pharmacy delivery on 9/19/2025, claimed that the delivery only consisted of one med pack, which was not a narcotic. Staff Bridges denied that he has ever taken any residents narcotic medication. Home manager, Mary Anglebrant, and administrator, Rachel Morgan, stated that cameras show that Staff Bridges only removed one med pack from the pharmacy delivery bag and then discarded the bag. Documentation was reviewed and all residents who prescribed narcotic medications appear to have received them as prescribed. No evidence was found to prove that any narcotic medications are missing.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/31/2025, an exit conference was held with administrator, Rachel Morgan. Admin Morgan was informed of the outcome of this investigation and that a written corrective action plan is required.

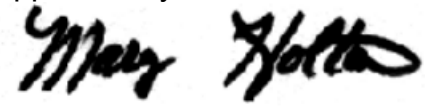
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

11/4/2025

Christopher Holvey Date
Licensing Consultant

Approved By:



11/4/2025

Mary E. Holton Date
Area Manager