GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 10, 2025

Cyle Pickett
Amor Memory Care Of Novi Inc.
405 W Greenlawn Ave
G11 1232
Lansing, MI 48910

RE: License #: AS630418307
Investigation #: 2026A0991002
Amor Novi

Dear Cyle Pickett:

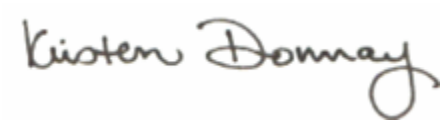
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 972-9136.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630418307
Investigation #:	2026A0991002
Complaint Receipt Date:	10/20/2025
Investigation Initiation Date:	10/22/2025
Report Due Date:	12/19/2025
LicenseeName:	Amor Memory Care Of Novi Inc.
Licensee Address:	405 W Greenlawn Ave G11 1232 Lansing, MI 48910
Licensee Telephone #:	(248) 536-2303
Administrator:	Cyle Pickett
Licensee Designee:	Cyle Pickett
Name of Facility:	Amor Novi
Facility Address:	41600 Borchart Dr. Novi, MI 48375
Facility Telephone #:	(248) 986-4546
Original Issuance Date:	03/18/2025
License Status:	REGULAR
Effective Date:	09/18/2025
Expiration Date:	09/17/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
A resident from Amor Novi was observed roaming the street and trying to enter a neighbor's home. Staff from the facility previously asked the neighbor's contractors to help lift a resident who had fallen.	Yes

III. METHODOLOGY

10/20/2025	Special Investigation Intake 2026A0991002
10/22/2025	Special Investigation Initiated - Letter Contacted complainant via email
10/22/2025	Contact - Document Received Email from complainant
10/22/2025	Contact - Document Received Videos from complainant's security cameras
10/22/2025	APS Referral Referred to Adult Protective Services (APS) Centralized Intake - not assigned for investigation
10/23/2025	Inspection Completed On-site Unannounced onsite inspection - interviewed staff and observed residents
10/23/2025	Contact - Telephone call made To licensee designee, Cyle Pickett
10/23/2025	Contact - Document Received Staff schedules, assessment plan, security camera screenshots
10/24/2025	Contact - Telephone call made To staff, Chanell Ruiz
10/24/2025	Contact - Telephone call made Left message for staff, Teeah Ezell
11/17/2025	Contact - Telephone call made Left message for staff, Teeah Ezell

12/04/2025	Contact - Telephone call made To former staff, Martha Hardmon
12/04/2025	Contact - Telephone call made Left message for staff, Teeah Ezell
12/04/2025	Contact - Telephone call made To staff, Sylvia Marshal- phone number out of service
12/08/2025	Exit Conference Via telephone with licensee designee, Cyle Pickett

ALLEGATION:

A resident from Amor Novi was observed roaming the street and trying to enter a neighbor's home. Staff from the facility previously asked the neighbor's contractors to help lift a resident who had fallen.

INVESTIGATION:

On 10/20/25, I received a complaint alleging that a resident from Amor Novi was observed to be roaming down the sidewalk unsupervised. The resident went to a neighbor's door and was attempting to enter the home. The complaint also stated that on 08/22/25, staff from the home asked contractors who were working on a neighbor's home to help pick up a resident who had fallen. On 10/22/25, I referred the allegations to Adult Protective Services (APS) centralized intake, but it was not assigned for investigation.

I initiated my investigation on 10/22/25 by contacting the complainant. The complainant shared video from a Ring video doorbell camera and from a security camera outside their home. The video shows an elderly woman walking down the sidewalk alone. There does not appear to be any staff accompanying the individual. The video from the doorbell camera shows the woman attempting to open the door of the home. The complainant stated that the video of the individual walking down the street was taken prior to her walking up to the front door. She shared a screenshot that shows a time stamp of 4:38pm. The video of the individual trying to open the door has a time stamp of 16:40-16:41 (4:40-4:41pm). The complainant stated that there was no video showing staff coming to get the individual. She stated that she confirmed it was a resident the following day when she went next door and asked the staff if the individual was a resident. The complainant stated that she did not have any videos from the incident on 08/22/25. She stated that the contractors were from Matheson Heating and Cooling.

On 10/23/25, I conducted an unannounced onsite inspection at Amor Novi. I interviewed direct care worker, Ebony Blanding. Ms. Blanding stated that Resident A has dementia and staff go for walks with her around the neighborhood. She stated that Resident A never eloped from the facility or went for a walk alone as far as she knew. She stated that Resident A thinks she is in Detroit, and they have to take her for a walk in order to calm her down and show her that this is the neighborhood she lives in now. I showed Ms. Blanding the video from a neighbor's video doorbell. She verified that the individual in the video was Resident A and there did not appear to be any staff nearby. Ms. Blanding stated that she was not on shift on 10/13/25. Chantell and Teeah were the staff on shift that day. Ms. Blanding stated that Resident A often gets sundowners from 3:00-6:00pm and will become more aggravated during that time. She stated that there are alarms on the doors and windows. She stated that if a resident eloped from the facility, an incident report should be completed and staff should notify the licensee designee, Cyle Pickett. Ms. Blanding stated that there are always two direct care workers on shift. Two of the residents also have personal aides who are typically in the home for six hours during the daytime.

Ms. Blanding stated that she was not aware of any residents falling on or around 08/22/2025. She was not aware of anyone asking a neighbor or contractor in the neighborhood for assistance.

During the onsite inspection on 10/23/25, the licensee designee, Cyle Pickett, called the home. I spoke with Mr. Pickett via telephone. He stated that he was not aware of Resident A wandering from the home. He stated that Resident A is very active and staff do take her on walks through the neighborhood. She requires supervision at all times and is not able to walk through the neighborhood unsupervised. Mr. Pickett stated that Resident A recently had a medication change, which might contribute to her wandering. He stated that the home does have alarms on the doors. He did not receive an incident report regarding Resident A eloping from the facility. He stated that none of the neighbors notified him that Resident A came to their door.

On 10/23/25, I attempted to interview Resident A. Resident A has dementia and has limited cognitive abilities. She stated that she goes for walks once in a while and she has gone for a walk alone. Resident A then stated that she lives up north and only lives in this home some of the time.

On 10/23/25, I conducted a follow-up interview with the licensee designee, Cyle Pickett, via telephone. Mr. Pickett stated that on 10/13/25 they were celebrating the birthday of another resident who was turning 101 years old. He stated that there were family members and visitors in the home around lunchtime. He stated that he reviewed the surveillance video from the home, and it shows Resident A walking out of the front door at 15:38 (3:38pm). He stated that direct care worker, Chantell, was in the bathroom at

that time. The other direct care worker, Teeah, was assisting another resident. The video footage shows Chantell coming out of the bathroom at 15:41 (3:41pm) and running out the front door at 15:42 (3:42pm). Chantell returns to the home with Resident A at 15:43 (3:43pm). He stated that the front door was open when Chantell came out of the bathroom and the door alarm was chiming. Mr. Pickett stated that Resident A's Seroquel dosage was recently changed, which may be a factor in her wandering. He stated that she often wants to go see her husband. Mr. Pickett stated that staff did not notify him when this incident occurred and an incident report was not completed. He stated that he is already putting protective measures in place to ensure this will not happen again.

Mr. Pickett stated that he reviewed all of the staff communication logs and incident reports from 08/22/25 and there was no documentation regarding a resident falling. He provided a copy of the staff schedule, which shows that Chanell Ruiz, Sylvia Marshal, and Martha Hardmon were on shift.

On 10/24/25, I interviewed direct care staff, Chanell Ruiz, via telephone. Ms. Ruiz stated that she was working from 7:00am-7:00pm on 10/13/25. She stated that she went to use the bathroom and when she came out, she noticed Resident A was not there. She stated that she checked the rooms in the house and then went outside. The front door was open, and the door alarm was sounding. She stated that when she walked outside, Resident A was walking up the driveway. She estimated that it was about three and a half minutes from the time she went into the bathroom to the time Resident A was observed walking up the driveway. She stated that she heard the door alarm going off while she was in the bathroom, which is why she hurried up and went to look for Resident A. She stated that there was another staff, Teeah, on shift and she assumed Teeah was supervising Resident A while she was in the bathroom. Ms. Ruiz stated that she told Cyle Pickett that Resident A had walked off on 10/13/25. Ms. Ruiz stated that Resident A does have a history of wanting to walk outside. Staff are usually able to distract and redirect her. Resident A often wants to go outside to see her husband who is deceased. Ms. Ruiz stated that Resident A requires supervision when going outside. She stated that she did not speak to any of the neighbors following this incident, as she did not know that Resident A went up to a neighbor's home. She did not complete an incident report or make note of the elopement in the staff communication log.

Ms. Ruiz stated that she was not on shift when a resident fell on 08/22/25. She stated that if a resident fell, she would call the non-emergency number and request a lift and assist. The ambulance comes and paramedics will check on the resident to determine if they need to be sent out to the hospital or not. She stated that she would never ask a neighbor or contractor in the neighborhood for assistance. Ms. Ruiz stated that she believed Ebony and Teeah were working when this happened. She stated that there was some information shared in a group text message. Ebony or Teeah stated that

Resident B fell, and they had to ask a neighbor for assistance. Ms. Ruiz stated that she told them that this was not the proper protocol and that they should call for a lift and assist. She stated that this occurred in August. She was not aware of any incident reports or communication about the incident in the staff log. She was not sure if Cyle Pickett was included in the group text messages.

On 08/22/25, I interviewed direct care worker, Martha Hardmon. Ms. Hardmon stated that she worked at Amor Novi from May-August 2025, but she no longer works in the home. She stated that she was not aware of a time when a resident fell and staff asked a neighbor or contractor in the neighborhood for assistance. She stated that there was one occasion when Resident C fell out of bed when she was working at the home. She stated that they called a professional emergency responder for lift assistance. Nobody asked a neighbor or contractor for help lifting the resident. She stated that the licensee designee, Cyle Pickett, provided the emergency phone numbers and they were posted in the home. Ms. Hardmon stated that while she was working in the home, none of the residents, including Resident A, wandered out of the home. There was a door alarm on the door, so staff were always aware if anyone was going outside. Ms. Hardmon stated that Resident A did not have a history of wandering away when she was working at the home. Resident A would always stay close to staff and try to help with everything. Ms. Hardmon stated that she did not have any issues or concerns about the home or the safety of the residents.

I received and reviewed a copy of Resident A's assessment plan dated 04/03/25. The plan notes that Resident A cannot move independently in the community.

I received and reviewed the screenshots from Amor Novi's video camera system. The screenshots show Resident A walking out the door at 15:38:03 on 10/13/25. At 15:42:37, one staff person is standing in the doorway, and the other staff is walking towards the door. At 15:42:43, the outdoor camera shows staff walking down the driveway and Resident A walking on the sidewalk. At 15:43:15, Resident A can be seen reentering the home with the staff person.

On 12/08/25, I conducted an exit conference via telephone with the licensee designee, Cyle Pickett. Mr. Pickett stated that Resident A moved out of the facility and into a memory care unit. He stated that he would submit a corrective action plan to address the violation.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other

	advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A was not provided with supervision and protection in accordance with her assessment plan when she wandered away from Amor Novi on 10/13/25. Resident A's assessment plan states that she cannot move independently in the community. Resident A walked away from the home and was gone for five minutes without supervision, during which time she approached a neighbor's home and tried to enter through the front door. With regards to the allegation that staff asked a contractor working next door for assistance lifting a resident who had fallen, there was insufficient information to conclude that this happened. While direct care worker, Chanell Ruiz recalled information about this incident being shared in a group text message, she did not have documentation of it. None of the other staff who were interviewed had knowledge of this incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

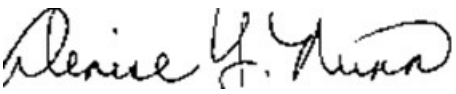
IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

12/08/2025

Kristen Donnay Date
Licensing Consultant

Approved By:



12/10/2025

Denise Y. Nunn Date
Area Manager