



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

February 25, 2026

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

RE: License #: AL250384188  
Investigation #: 2026A0779014  
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,

A handwritten signature in cursive script that reads "Christopher A. Holvey".

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**

<b>License #:</b>	AL250384188
<b>Investigation #:</b>	2026A0779014
<b>Complaint Receipt Date:</b>	01/21/2026
<b>Investigation Initiation Date:</b>	01/22/2026
<b>Report Due Date:</b>	03/22/2026
<b>Licensee Name:</b>	Clio Memory Care, LLC
<b>Licensee Address:</b>	1346 W. Vienna Road Clio, MI 48420
<b>Licensee Telephone #:</b>	(810) 640-7783
<b>Administrator:</b>	Dana Pikula
<b>Licensee Designee:</b>	Hemant Shah
<b>Name of Facility:</b>	Cranberry Park Memory Of Clio
<b>Facility Address:</b>	1346 W. Vienna Road Clio, MI 48420
<b>Facility Telephone #:</b>	(810) 640-7783
<b>Original Issuance Date:</b>	11/14/2016
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	05/14/2025
<b>Expiration Date:</b>	05/13/2027
<b>Capacity:</b>	20
<b>Program Type:</b>	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Staff Makensie Eidson has allowed her children into Resident A's bedroom during care, causing Resident A emotional distress and discomfort.	No
On 1/12/2026, Staff Makenzie Eidson verbally degraded Resident A during a brief change by making offensive comments about a rash.	Yes

**III. METHODOLOGY**

01/21/2026	Special Investigation Intake 2026A0779014
01/22/2026	Special Investigation Initiated - Telephone Complaint was referred to APS.
01/22/2026	APS Referral Complaint was referred to APS centralized intake.
01/23/2026	Inspection Completed On-site
01/23/2026	Contact - Telephone call made Spoke to staff person, Josef Wilber.
01/23/2026	Contact - Telephone call made Spoke to staff person, Kate Bradford.
01/23/2026	Exit Conference Held with administrator, Dana Pikula.

**ALLEGATION:**

**Staff Makensie Eidson has allowed her children into Resident A's bedroom during care, causing Resident A emotional distress and discomfort.**

**INVESTIGATION:**

On 1/23/2026, an on-site inspection was conducted and Resident A was interviewed. Resident A acknowledged that she knew who staff person, Makensie Eidson was. Resident A stated that during one occasion, when Staff Eidson was changing her brief, Staff Eidson's children came into her bedroom. Resident A reported that Staff Eidson stopped the children from coming all the way into the room and made them leave right

away. Resident A stated that she is not sure if the children saw much of her or not, but that it was not a big deal and did not cause her any emotional distress. Resident A reported that there was no one else in the room to witness the incident and that she does not remember reporting it to anyone.

On 1/23/2026, Staff Eidson denied that her children have ever been inside Resident A's bedroom. Staff Eidson claimed that her children have only been at this facility 2-3 times, with the last time being about one month ago. Staff Eidson stated that her children stayed in the staff breakroom or, on one occasion, watched a movie with another resident in the living room.

On 1/23/2026, home manager, Mary Anglebandt, stated that Staff Eidson has had her children at the facility a few times at the end of her shift. HM Anglebrandt stated that she is not aware of the children ever being in Resident A's or any other resident's bedrooms. HM Anglebrandt reported that Resident A has never told her that this has happened and no other staff have reported witnessing that happen.

On 1/23/26, staff person, Jared Hinijosa, stated that he has seen Staff Eidson's children at the facility on maybe two occasions. Staff Hinijosa stated that on both occasions it was during the last 10 or so minutes of Staff Eidson's shift and that the children never left the living room.

On 1/23/2026, staff person, Josef Wilber, confirmed that he works with Staff Eidson frequently. Staff Wilber stated that he has never seen Staff Eidson's children at the facility.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(3) A licensee and staff shall respect and safeguard all of the following resident rights to:</b> <b>(p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.</b>
<b>ANALYSIS:</b>	Staff person, Makensie Eidson, denies that her children have ever been in Resident A's room. Multiple staff reported that they have seen Staff Eidson's children at the facility for a few minutes at the end of her shifts, but never inside any resident's bedrooms. Resident A claims that the children did enter her room on one occasion, but that Staff Eidson stopped them from coming all the way into the room and made them leave right away. Resident A stated that the incident did not cause her any emotional distress. There was lack of sufficient evidence to

	prove that the incident in question impacted Resident A in a negative way.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**On 1/12/2026, Staff Makenzie Eidson verbally degraded Resident A during a brief change by making offensive comments about a rash.**

**INVESTIGATION:**

A review of Resident A’s record took place. It was confirmed that, by her own choice, Resident A is bed bound and is a one-person assist for all her activities of daily living.

On 1/23/2026, Resident A confirmed that she had a rash under her brief and on her bottom area and that it is not uncommon for her. Resident A stated that while recently changing her brief, Staff Eidson made a comment about her rash, joking that she has a disease. Resident A could not provide any more detailed information as to what Staff Eidson said, but stated that she remembers feeling that it was a rude statement for Staff Eidson to make.

On 1/23/2026, Staff Eidson stated that she has a good relationship with Resident A and that she is the only staff that Resident A wants to give her a shower. Staff Eidson denied that she has ever joked about Resident A having a disease or made any rude comments to Resident A. Staff Eidson claimed that the only comments she has made about Resident A’s rash is that they might want to start using a powder instead of a cream to treat it.

On 1/23/2026, Staff Hinijosa confirmed that he worked with Staff Eidson on 1/23/2026. Staff Hinijosa stated that Resident A is a one-person assist for her brief changes, so Staff Eidson would have probably been in the room with Resident A alone. Staff Hinijosa stated that Resident A has not told him anything about Staff Eidson making any inappropriate comments to her.

On 1/23/2026, a conversation took place with Hospice nurse, Felica Richards, who confirmed that she provides services to Resident A. Nurse Richards stated that it is not uncommon for Resident A to have issues with yeast infections on her bottom. Nurse Richards stated that Resident A’s infection seems to have cleared up after oral medications were given. Nurse Richards reported that Resident A has not told her about any staff making rude or inappropriate comments about her rash.

On 1/23/2026, a phone call was made to staff person, Kate Bradford, who stated that she is a new staff at this facility. Staff Bradford stated that she worked on 1/12/2026 and was being trained by Staff Eidson. Staff Bradford reported that Staff Eidson was training her on how to change Resident A's brief and that she did witness Staff Eidson make an inappropriate comment to Resident A. Staff Bradford stated that, while changing Resident A's brief, Staff Eidson said to Resident A, "This is gross, what you got the herpes." Staff Bradford stated that Staff Eidson laughed and thought the comment was funny.

On 1/23/2026, an exit conference was held with administrator, Dana Pikula. Admin Pikula stated that Staff Eidson has been placed on suspension and her employment will likely be terminated. Admin Pikula was informed of the outcome of this investigation and that a written corrective action plan is required.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.</b>
<b>ANALYSIS:</b>	Resident A stated that while changing her brief, staff person, Makensie Eidson, made a comment about her rash and joking that she had a disease. Resident A felt that it was a rude statement for Staff Eidson to make. Staff person, Kate Bradford, stated that she was present at the incident in question and witnessed Staff Eidson make an inappropriate comment related to Resident A having a rash. There was sufficient evidence found to prove that Resident A was not treated with dignity or respect.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

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



2/25/2026

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Christopher Holvey  
Licensing Consultant

Date

Approved By:



2/25/2026

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Mary E. Holton  
Area Manager

Date