GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 30, 2026

Megan Fry
MCAP Holt Opco, LLC
Suite 115
21800 Haggerty Road
Northville, MI 48167

RE: License #: AL330404596
Investigation #: 2026A0007031
Prestige Way #1 (Cedar Cottage)

Dear Ms. Fry:

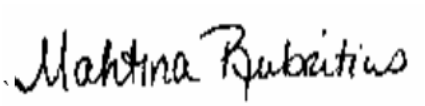
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9720.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330404596
Investigation #:	2026A0007031
Complaint Receipt Date:	05/12/2026
Investigation Initiation Date:	05/14/2026
Report Due Date:	07/11/2026
Licensee Name:	MCAP Holt Opco, LLC
Licensee Address:	Suite 115 21800 Haggerty Road Northville, MI 48167
Licensee Telephone #:	(517) 694-2020
Administrator:	Megan Fry
Licensee Designee:	Megan Fry
Name of Facility:	Prestige Way #1 (Cedar Cottage)
Facility Address:	4300 Keller Road Holt, MI 48842
Facility Telephone #:	(517) 694-2020
Original Issuance Date:	11/02/2020
License Status:	REGULAR
Effective Date:	05/02/2025
Expiration Date:	05/01/2027
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On Saturday, May 9, 2026, Resident A was yelled at by an unknown staff member because she pushed her call light too many times.	Yes
Resident A's basic needs are unmet. Resident A requires two direct care staff assistance with a Hoyer lift. The younger female staff members don't put her in bed correctly and she can't reach her pillow.	No

III. METHODOLOGY

05/12/2026	Special Investigation Intake - 2026A0007031
05/12/2026	APS Referral - Received.
05/14/2026	Special Investigation Initiated - On Site- Unannounced -Face to face contact with Carrie Berlin, Manager, Brittany Richardson-Klink, DCW, and Resident A.
06/26/2026	Contact - Telephone call made - Interview with Employee #1.
06/26/2026	Contact - Telephone call made - Interview with Resident B.
06/26/2026	Contact - Telephone call made to Relative A1. No answer, unable to leave a message.
06/26/2026	Contact - Telephone call made to the facility. I spoke with Carrie Berlin and Shelly Miller.
06/26/2026	Contact - Document Received - Email from and to Achal Patel, Owner.
06/29/2026	Contact - Document Sent - Email to Achal Patel, Owner. The Assessment Plan has not been received.
06/29/2026	Contact - Document Received - AFC Assessment Plan for Resident A.
06/30/2026	Contact - Telephone call made to Achal Patel, Owner. I left a message requesting a return phone call to conduct the exit conference.
06/30/2026	Exit Conference conducted with Achal Patel, Owner.

ALLEGATION: On Saturday, May 9, 2026, Resident A was yelled at by an unknown staff member because she pushed her call light too many times.

INVESTIGATION:
As a part of this investigation, I reviewed the written complaint, and the following information was noted:
Resident A "(96) is diagnosed with Alzheimer's, chronic kidney disease, dysphasia, anxiety and hyperlipidemia. [Resident A] lives in an assisted living facility. [Resident A's] daughter, [Relative A1] is her D.P.O.A. [Resident A's] food is often cold, or she is missing silverware. On Saturday (05/09/26) [Resident A] was yelled at by an unknown staff member because she pushed her call light too many times. [Resident A] pushed her call light because she didn't have silverware. [Resident A] is two-person assist with a Hoyer lift. The younger female staff members don't put her in bed correctly and she can't reach her pillow."

On May 14, 2026, I conducted an unannounced on-site investigation and for the purpose of this investigation, I made face to face contact with Carrie Berlin, who is on the management team, Brittany Richardson-Klink, direct care worker (DCW), and Resident A.

I interviewed Resident A. Resident A stated that her daughter (Relative A1) said she can't live alone anymore, which is why she is residing in the facility. Resident A stated that she goes out in the community on a regular basis with PACE. Resident A stated that she sometimes gets depressed, she cries and gets upset. She can contact her daughter or individuals at PACE to discuss her feelings and concerns.

During the interview, Resident A stated, "That girl, she yelled at me." Resident A could not recall her name but stated she was a college girl in a blue uniform, with long hair. Resident A stated her voice was high and everyone could hear it. It made her feel embarrassed. Resident A recalled that on Saturday, (date not given), her food was cold, and she asked the staff member to take it back and warm it up. The meal that day was pancakes and sausage. Resident A stated that the syrup was missing and the sausage patty was cold. The staff, who was a young college girl in blue scrubs, said she couldn't warm up the food because she had other consumers (residents) to attend with. Then Resident A couldn't even eat the food because they did not bring her any silverware. Resident A stated that they (staff) eventually brought her silverware, and she stated she did not know why it took them so long. Resident A stated she was sitting there waiting for the silverware and she couldn't eat until they brought it back. While I was interviewing Resident A, Brittany Richardson-Klink, DCW, entered the room. She spoke loudly. After she left, Resident A stated she was not the staff that yelled at her. Regarding the staff responding to the call lights, Resident A confirmed that she was yelled at by staff for using the call light too much. No additional information was provided. Resident A

stated that she felt like the staff did not answer call lights and she was being ignored. She informed me that it sometimes takes them three to four minutes to answer the call light.

I spoke with Carrie Berlin, Manager. We discussed the allegations. During the interview, Carrie Berlin was concerned about the allegations of staff yelling at Resident A. She described Resident A as non-confrontational and the sweetest resident. We reviewed the schedule for May 9, 2026, and noted that Brittany Richardson-Klink and Employee #1, were on the schedule that day (first shift- when pancakes were served). Brittany Richardson-Klink was the only staff on the schedule (for both facilities), that had long hair. Carrie Berlin expressed concern, as she stated both were good staff, and she had not received any complaints regarding either direct care staff member.

I interviewed Brittany Richardson-Klink, DCW. She informed me that she has been employed as a direct caregiver and Med. Tech in the facility for three months. When asked about yelling at Resident A, she stated that she has never yelled at any residents, as there is no need to. She informed me that she has been working in health care and providing home help to her mother and grandparents; and described caregiving being to be an important role to her. She again denied yelling at any of the residents or observing other staff yelling at them. She also stated that she was used to working with people who had hearing difficulties, and that she speaks in a loud voice. She recalled saying good morning to one resident and then self-checking, as she realized that her voice was a little too loud, and she said sorry to them. She confirmed that she worked with Employee #1 on May 9, 2026. She described Employee #1 as having dark, shoulder length hair. She did not recall Resident A asking for silverware. She also stated that Resident A is not a resident that utilizes her call light a lot. She stated that once you get the hang of things, you kind of know what each of the residents need.

On June 26, 2026, I interviewed Employee #1 who confirmed that she worked with Brittany Richardson-Klink on May 9, 2026, and recalled it was a Saturday. Employee #1 stated that Brittany Richardson-Klink did yell at Resident A. According to Employee #1, Brittany Richardson-Klink said that Resident A was annoying. When her food was brought to her, Resident A asked Brittany Richardson-Klink to pull her up in bed, as she was slouched down. Resident A did not have any silverware, and Brittany Richardson-Klink told her she would have to wait. In the meantime, Resident A pulled the call light again and that is when Brittany Richardson-Klink yelled at her. Employee #1 stated she asked Brittany Richardson-Klink what happened, and Brittany Richardson-Klink stated that Resident A was being annoying (and then provided the information as noted above). According to Employee #1, Resident A started crying. After that, Brittany Richardson-Klink felt bad, then she said she didn't yell at Resident A. Employee #1 stated that she told her (Brittany Richardson-Klink) that she heard her. Employee #1 stated "I heard her yell, but I did not hear what she said."

Employee #1 stated that management spoke to Brittany Richardson-Klink after the incident occurred (date unknown). I inquired if any other staff or residents may have witnessed the incident and she stated that Resident B, who was across the hall, may have heard the incident. There were no other staff on duty. Employee #1 stated that this was the first time she had observed Brittany Richardson-Klink act in this matter. Employee #1 expressed concerns and stated she did not want any drama or issues at her place of employment.

On June 26, 2026, I interviewed Resident B via telephone. She stated that she was in her own room and had not observed any staff yelling at the residents. She reported to be treated “fine” by the staff and the staff respond and answer call lights in a timely manner.

On June 26, 2026, I spoke with Carrie Berlin and Shelly Miller, as I had some follow-up questions. Shelly Miller informed me that she heard about the allegations. Carrie Berlin and Shelly Miller also informed me that Resident A was hard of hearing, and she utilizes hearing aids. Carrie Berlin informed me that she spoke with Brittany Richardson-Klink about the allegations, and she (Brittany Richardson-Klink) stated that she did not yell at Resident A. Carrie Berlin also inquired if she should have written up a corrective action at that time, and I explained that a corrective action would not be necessary at that time, unless after conducting the internal investigation, she had reason to believe that the incident occurred. Carrie Berlin stated she did not.

On June 30, 2026, I conducted the exit conference with Achal Patel, Owner. I provided an overview of the investigation and my recommendations. We also spoke about ways to handle these matters, and he agreed to submit a written corrective action plan to address the established violations.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based upon my investigation, which consisted of an unannounced on-site investigation, interviews with staff, Resident A, Resident B, and management, it’s concluded that there is a preponderance of the evidence to support the allegations that Brittany Richardson-Klink raised her voice at Resident A, after she requested assistance regarding her food being cold, needing silverware, and utilizing her call light several times. Thus, Resident A was not treated with dignity and respect.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's basic needs are unmet. Resident A requires two direct care staff to assist with a Hoyer lift. The younger female staff members don't put her in bed correctly and she can't reach her pillow.

INVESTIGATION:
On May 14, 2026, I interviewed Resident A. I observed her to be neat, clean, and appropriately dressed. Regarding the staff answering the call lights, Resident A stated that the staff get busy and sometimes they don't answer the call lights. Resident A stated that she didn't like what they were serving for lunch that day (May 14, 2026) and she had asked for something different. The first staff member never came back; however, a different staff returned and said she would see about getting her something different. While I was at the facility, staff brought Resident A a peanut butter sandwich, because she did not like what they were serving for lunch. At approximately 1:43 p.m., staff gave Resident A the peanut butter sandwich, which was made from crust or the end pieces of the bread loaf. A photo was taken for the file. Resident A stated she did not like the crust. At approximately 1:50 p.m. staff were notified that she did not like the sandwich and another sandwich was requested. During the interview, Resident A also stated that she was left in the dining room and she couldn't sit in the chair too long. I observed a Hoyer Lift in Resident A's room. Resident A informed me that staff used the Hoyer Lift to assist her. I inquired about there being issues with them transferring her or her not being able to reach her pillow, and she stated that she had been placed in the facility previously, this was her third time there, and those were issues from the past placement. I also observed the back of Resident A's left hand to have bruising. She stated it was from the blood draws. She receives the blood draws at an agency outside of the facility.

According to Carrie Berlin, when Resident A returns from PACE, sometimes it may take staff longer to get Resident A back to her room. Carrie Berlin also recalled that she was informed that Resident A complained about the pizza being served one day, and staff said that she did not eat.

I interviewed Brittany Richardson-Klink, DCW. She reported to be fully trained to operate a Hoyer Lift and had no concerns about how the residents were transferred.

It was noted that at 2:05 p.m. and 2:15 p.m. Resident A still had not received her (replacement) sandwich.

After the interviews, I spoke with Carrie Berlin again, and she informed me that both staff have been trained to assist the residents and utilize the Hoyer Lift; and there have been no concerns regarding them not using it correctly. Carrie Berlin stated that Employee #1, especially, receives a lot of compliments.

At approximately 2:27 p.m. a staff member had the loaf of bread, and she was going to make Resident A's sandwich.

On June 26, 2026, during the interview with Employee #1, she confirmed that she was fully trained to operate the Hoyer Lift and had no concerns regarding operating it.

On June 26, 2026, Resident B reported the staff respond and answer call lights in a timely manner.

On June 26, 2026, I spoke with Carrie Berlin and Shelly Miller, as I had some follow-up questions. They informed me that lunch is usually served at 12:30 p.m. They also confirmed that Resident A is a two-person assist and staff utilize the Hoyer Lift to assist with transfers. I requested a copy of the *AFC Assessment Plan* for Resident A.

As a part of this investigation, I reviewed the written *AFC Assessment Plan* for Resident A, and it was noted that she is prescribed a regular diet. She also uses assistive devices including a Hoyer Lift, wheelchair, and hearing aids.

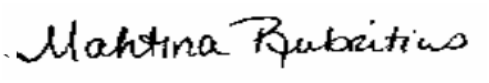
On June 30, 2026, I conducted the exit conference with Achal Patel, Owner. We discussed the investigation and my recommendations. I informed Achal Patel that while staff may be busy, they need to be mindful of the time it takes to bring the food (that is being substituted) to the resident, as Resident A requested another sandwich around 1:50 p.m. and at 2:27 p.m. she still did not have the sandwich. This was after they had brought her a sandwich made from crusts or the end pieces of the bread loaf. Lunch was served at 12:30 p.m. Achal Patel stated he would speak to the management staff regarding this matter.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include all of the following: **(a) The amount of personal care, supervision, and protection required by the resident that is available at the facility.**

ANALYSIS:	Based upon my investigation, which consisted of an unannounced on-site investigation, interviews with staff, management, Resident A and Resident B, it's concluded that there is not a preponderance of the evidence to support the allegations that amount of personal care and protection required by Resident A is not being provided.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.



6/30/2026

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Mahtina Rubritius — Date
Licensing Consultant

Approved By:

06/30/2026

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Dawn N. Timm — Date
Area Manager