GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 5, 2022

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

RE: License #: AL250384188
Investigation #: 2022A0582022
Cranberry Park Memory Of Clio

Dear Mr. 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) 284-9727.

Sincerely,

Derrick Britton, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-9721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250384188
Investigation #:	2022A0582022
Complaint Receipt Date:	02/16/2022
Investigation Initiation Date:	02/16/2022
Report Due Date:	04/17/2022
Licensee Name:	Clio Memory Care, LLC
Licensee Address:	1346 W. Vienna Road Clio, MI 48420
Licensee Telephone #:	(810) 640-7783
Administrator:	Rene Parks
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:	05/14/2021
Expiration Date:	05/13/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATIONS

	Violation Established?
On 02/13/2022, the facility was short staffed and Direct Care Worker (DCW) Takeesha Moller worked alone. The facility has residents that require at least two staff for assistance with supervision and care.	Yes
Residents are lacking medications, as Administrator, Marcie Schulz, fails to order medications.	No
The residents are left laying in urine for days as their urine beds are not changed.	No

III. METHODOLOGY

02/16/2022	Special Investigation Intake 2022A0582022
02/16/2022	APS Referral Intake referred from APS
02/16/2022	Special Investigation Initiated - On Site
02/16/2022	Contact - Face to Face With Marcia Schulz, Administrator
02/16/2022	Contact - Face to Face With DCW Antonae Timmons
02/16/2022	Contact - Face to Face With DCW Mikalah Spanke
03/17/2022	Inspection Completed On-site
03/17/2022	Contact - Face to Face With Rene Parks, Administrator and Brianne King, Office Manager
03/17/2022	Contact - Face to Face With DCW Nariesha Whiteside
03/17/2022	Contact - Face to Face With Kristen Rife, Food Service Worker
03/17/2022	Contact - Telephone call made

	With DCW Takeesha Moller
04/01/2022	Inspection Completed-BCAL Sub. Compliance
04/01/2022	Exit Conference With Hemant Shah, Licensee Designee

ALLEGATION:

On 02/13/2022, the facility was short staffed and Direct Care Worker (DCW) Takeesha Moller worked alone. The facility has residents that require at least two staff for assistance with supervision and care.

INVESTIGATION:

I received this anonymous, denied Adult Protective Services referral on 02/16/2022. The referral documented that Administrator Marcie Schulz was made aware earlier in the day that a staff member would not be working their scheduled shift. As a result, Ms. Schulz offered to pay Direct Care Worker Takeesha Moller double time to work her scheduled shift alone. Ms. Schulz reportedly instructed Ms. Moller to contact another building staff adjacent to the facility for assistance if any troubles were to arise.

On 02/16/2022, I conducted an unannounced, onsite inspection the same day. I interviewed Marcia Schulz, Administrator. Ms. Schulz admitted that she asked DCW Takeesha Moller to work alone that weekend. Ms. Schulz stated that it was Super Bowl Sunday and there were four staff members who called off that day. Ms. Schulz stated that she could not find a replacement for one shift, so she asked Ms. Moller to work alone and contact the other facilities if needed. Ms. Schulz stated that this was not a normal practice and there are typically at least two staff members per shift. Ms. Schulz stated that normally she would have worked the shift but had plans for Super Bowl Sunday. Ms. Schulz stated that there are currently 11 residents at the facility, with one resident that requires a two-person assist.

On 03/17/2022, I conducted an unannounced, onsite inspection at the facility. I interviewed Rene Parks, new home manager. Ms. Parks stated that she was made aware of the complaint and had made changes to ensure that the facility has at least two staff per shift. Ms. Parks stated that there are currently 11 residents at the facility, with Resident A, Resident B, and Resident C requiring a Hoyer lift and/or two-person assist.

On 03/17/2022, I interviewed DCW Takeesha Moller. Ms. Moller admitted that she was asked to work alone on third shift on 02/13/2022. Ms. Moller stated that she agreed and was fine working by herself. Ms. Moller stated that there are three

residents that require a two-person assist, but on third shift they are typically asleep and have a Hoyer lift that she can operate alone. Ms. Moller stated that this was not a normal occurrence and she usually works with another staff member.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on interviews with Ms. Schulz, Ms. Parks, and Ms. Moller, there is at least one resident that requires a two-person assist. As the Administrator, Ms. Schulz admitted to allowing Ms. Moller to work alone on the 02/13/2022, leaving the facility short staffed. Ms. Moller stated she typically would work when the facility is short staffed, but she had plans for Super Bowl Sunday. Ms. Schulz's solution was to pay Ms. Moller overtime to work alone that evening and contact staff at the adjacent facilities in case of emergency.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are lacking medications, as Administrator, Marcie Schulz, fails to order medications.

INVESTIGATION:

I received this anonymous, denied Adult Protective Services referral on 02/16/2022, and conducted an unannounced, onsite inspection the same day. I inspected the medication cart and reviewed the medications for four random residents, comparing them to their Medication Administration Record (MAR). Medications identified on the MAR all coincided with medications on hand. I interviewed Home Manager Marcie Schulz and discussed the process of the facility receiving medications. Ms. Schulz denied that the residents are lacking medications and stated that medications are ordered in a timely manner.

I interviewed Direct Care Workers Antonae Timmons and Mikalah Spanke, who both report no issues with residents lacking medications.

On 03/17/2022, I conducted an unannounced, onsite inspection at the facility. I interviewed Rene Parks, new Administrator, and Brianne King, Office Manager, who both report no issues with residents lacking medications. I inspected the medication cart and medications for two random residents, comparing with their MAR. There were no discrepancies noted.

I interviewed DCW Nariesha Whiteside and Kristen Rife, who stated that they have not observed issues with residents lacking medications.

On 03/17/2022, I interviewed DCW Takeesha Moller, who stated that she has not observed any issues with residents lacking medications.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.** **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Based on staff interviews and my observations of the MAR and medications on 02/16/2022 and 03/17/2022, there is no information to suggest that residents are lacking ordered medications.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The residents are left laying in urine for days as their urine beds are not changed.

INVESTIGATION:

I received this anonymous, denied Adult Protective Services referral on 02/16/2022 and conducted an unannounced, onsite inspection the same day. I observed seven residents who were in their rooms or in the common area watching television. I checked four random staff beds, which were found to be clean. All residents

observed appeared to be receiving proper care and supervision. There was no indication that that the residents or their bedrooms smelled of urine.

I interviewed Home Manager Marcie Schulz, DCW Antonae Timmons and DCW Mikalah Spanke, who all denied that residents are being neglected and with changing and cleanliness.

On 03/17/2022, I conducted an unannounced, onsite inspection at the facility. I observed eight residents in the common area, dining area, and in their bedrooms. All residents appeared to be receiving proper care and supervision. I interviewed DCW Nariesha Whiteside and Kristen Rife, who reported no concerns about residents being left in urine.

On 03/17/2022, I interviewed DCW Takeesha Moller. Ms. Moller stated that she works third shift and has never noticed concerns with residents being left in urine-soaked clothes or beds.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on staff interviews and my observations on 02/16/2022 and 03/17/2022, there is no information to suggest that residents are left laying in urine or that their beds are urine soaked.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 04/01/2022, I conducted an Exit Conference with Hemant Shah, Licensee Designee. Mr. Shah stated that he hired a new Administrator since the complaint was made, and she has been making positive changes. Mr. Shah agreed with the findings and will submit a corrective action plan.

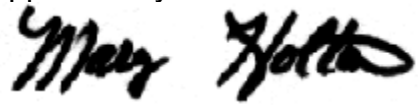
IV. RECOMMENDATION

Contingent on an acceptable corrective action plan, I recommend no change in the license status.

04/04/2022

Derrick Britton Date
Licensing Consultant

Approved By:



04/05/2022

Mary E Holton Date
Area Manager