



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 3, 2023

Hemant Shah
Clio Assisted Living, LLC
32685 Rockridge Lane
Farmington Hills, MI 48420

RE: License #: AL250384167
Investigation #: 2023A0582056
Cranberry Park of Clio

Dear Hemant Shah:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If 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 "Derrick L. Britton".

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 #:	AL250384167
Investigation #:	2023A0582056
Complaint Receipt Date:	06/05/2023
Investigation Initiation Date:	06/09/2023
Report Due Date:	08/04/2023
Licensee Name:	Clio Assisted Living, LLC
Licensee Address:	1354 W. Vienna Road Clio, MI 48420
Licensee Telephone #:	(810) 640-8357
Administrator:	Rene Parks
Licensee Designee:	Hemant Shah
Name of Facility:	Cranberry Park of Clio
Facility Address:	1354 W. Vienna Road Clio, MI 48420
Facility Telephone #:	(810) 640-8357
Original Issuance Date:	11/14/2016
License Status:	REGULAR
Effective Date:	05/14/2023
Expiration Date:	05/13/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATIONS

	Violation Established?
Employees are stealing narcotics and lying about giving residents their medication.	No
Direct Care Worker Vicki Whitaker is verbally and physically abusive to Resident A.	No
Staff are not changing resident when needed.	No

III. METHODOLOGY

06/05/2023	Special Investigation Intake 2023A0582056
06/09/2023	APS Referral
06/09/2023	Special Investigation Initiated - On Site Interviews with Kaitlyn Doyle, Resident Care Coordinator, DCW Robilee Cook, DCW Patricia Csirke, DCW Fiona Uhrig, Resident A, Resident D, Resident E
07/03/2023	Contact - Telephone call made With DCW Vicki Whitaker
07/03/2023	Exit Conference With Rene Parks, Administrator

ALLEGATION:

Direct Care Worker Vicki Whitaker is verbally and physically abusive to Resident A.

INVESTIGATION:

I received this complaint on 06/05/2023. On 06/09/2023, I conducted an unannounced, onsite inspection at the facility. I reviewed documentation for the narcotic counts in the facility, which were in a separate locked container inside the medication carts. There was no discrepancy in the count, which had written

documentation for each day and shift from when the counts were conducted. I reviewed the narcotics prescribed to Resident A, which documented that he is prescribed Oxycodone ½ tab and Oxycontin 1 tab 15 mg. The counts of both medications matched what was in the medication cart. I reviewed narcotics prescribed to Resident B, which documented he is prescribed Gabapentin Cap 300mg. The count for this medication matched what was in the medication cart. I reviewed the narcotics prescribed to Resident C, which documented he is prescribed Lorazepam 0.25mg tab. The count for this medication matched what was in the medication cart.

I interviewed Resident A, who stated that he receives and takes his medication regularly.

I interviewed Resident D, who stated that he receives and takes his medication regularly.

I interviewed Resident E, who stated that he receives and takes his medication regularly.

I interviewed Direct Care Worker Robilee Cook, who expressed no concerns about stolen narcotics. I interviewed Direct Care Worker Patricia Csirke, who expressed no concerns about stolen narcotics. I interviewed Direct Care Worker Fiona Uhrig, who expressed no concerns about stolen narcotics. I interviewed Kaitlyn Doyle, Resident Care Coordinator. Kaitlyn Doyle expressed no concerns about stolen narcotics.

On 07/03/2023, I interviewed Direct Care Worker Vicki Whitaker, who expressed no concerns about stolen medications.

APPLICABLE RULE	
R 400.15312	Resident medications.
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on interviews and observations during the unannounced, onsite inspection, there is no evidence to suggest that staff are stealing narcotics from residents. All counts completed during the inspection were accurate. Staff interviewed denied any issues with administering narcotics appropriately. Residents interviewed denied issues with regularly receiving medications.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Direct Care Worker Vicki Whitaker is verbally and physically abusive to Resident A.

INVESTIGATION:

I received this complaint on 06/05/2023. On 06/09/2023, I conducted an unannounced, onsite inspection at the facility. I interviewed Resident A, who stated that Direct Care Worker Vicki Whitaker is “a nice lady.” Resident A emphatically denied that DCW Whitaker was verbally or physically abusive to him and stated that someone is lying about that.

I interviewed Direct Care Worker Robilee Cook, who denied that Resident A was being verbally or physically abused. I interviewed Direct Care Worker Patricia Csirke, who denied that Resident A was being verbally or physically abused. I interviewed Direct Care Worker Fiona Uhrig, who denied that Resident A was being verbally or physically abused. I interviewed Resident Care Coordinator Kaitlyn Doyle, who denied that Resident A was being verbally or physically abused.

On 07/03/2023, I interviewed Direct Care Worker Vicki Whitaker. Ms. Whitaker denied being verbally or physically abusive towards Resident A.

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:	Based on interviews with Resident A and DCW Vicki Whitaker, there is no evidence to suggest that DCW Whitaker is verbally or physically abusive towards Resident A. Both Resident A and DCW Whitaker denied the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff are not changing resident when needed.

INVESTIGATION:

I received this complaint on 06/05/2023. On 06/09/2023, I conducted an unannounced, onsite inspection at the facility. I interviewed Kaitlyn Doyle, Resident Care Coordinator. Kaitlyn Doyle identified Resident D and Resident E as residents who wear briefs, require changing by staff, and could answer questions.

I interviewed Direct Care Worker Robilee Cook, who expressed no concerns about residents not being changed when needed. I interviewed Direct Care Worker Patricia Csirke, who expressed no concerns about residents not being changed when needed. I interviewed Direct Care Worker Fiona Uhrig, who expressed no concerns about residents not being changed when needed. I interviewed Resident Care Coordinator Kaitlyn Doyle, who expressed no concerns about residents not being changed when needed.

I interviewed Resident D, who stated that staff treat him very well and respond to him in a timely manner. Resident D stated that he has never had to wait for an extended period to have his brief changed.

I interviewed Resident E, who stated that he has no concerns with staff. Resident D stated that staff regularly check on him and change him when needed.

On 07/03/2023, I interviewed Direct Care Worker Vicki Whitaker, who expressed no concerns about residents not being changed when needed.

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 interviews with staff and residents, there is no evidence to suggest that staff are not changing residents when needed. Staff denied the allegation. Resident D and Resident E, who require staff assistance with changing briefs, both denied issues with being changed in a timely manner.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 07/03/2023, I conducted an Exit Conference with Rene Parks, Administrator. I informed Rene Parks of the findings from the investigation.

IV. RECOMMENDATION

I recommend no change in the license status.



07/03/2023

Derrick Britton
Licensing Consultant

Date

Approved By:



07/03/2023

Mary E. Holton
Area Manager

Date