GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 19, 2025

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

RE: License #: AL250384167
Investigation #: 2026A0576008
Cranberry Park 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,

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

License #:	AL250384167
Investigation #:	2026A0576008
Complaint Receipt Date:	11/06/2025
Investigation Initiation Date:	11/14/2025
Report Due Date:	01/05/2026
LicenseeName:	Clio Assisted Living, LLC
Licensee Address:	1354 W. Vienna Road Clio, MI 48420
Licensee Telephone #:	(810) 640-8357
Administrator:	Rachel Morgan
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:	05/14/2025
Expiration Date:	05/13/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Staff Carly Carper and Armonie Brown are mistreating residents during 3rd shift. Staff swear at residents and are verbally abusive.	Yes
Residents are not being changed properly and there have been unexplained bruises on some residents.	No

III. METHODOLOGY

11/06/2025	Special Investigation Intake 2026A0576008
11/06/2025	APS Referral Complaint was received from APS centralized intake.
11/14/2025	Special Investigation Initiated - Telephone Spoke to APS worker, Kyle Whitman.
11/20/2025	Inspection Completed On-site
12/01/2025	Contact - Telephone call made Spoke to Hospice nurse.
12/01/2025	Contact - Telephone call made Spoke to staff person, Carly Carper.
12/01/2025	Contact - Telephone call made Spoke to staff person, Armonie Brown.
12/03/2025	Contact - Telephone call made Spoke to staff person, Ellaween Douglas.
12/04/2025	Contact - Telephone call made Spoke to staff person, Jessica Woolworth.
12/04/2025	Contact - Telephone call made Spoke to Hospice nurse.
12/05/2025	Inspection Completed On-site
12/17/2025	Contact – Telephone call made Spoke to APS worker.

12/17/2025	Exit Conference Held with administrator, Rachel Morgan

ALLEGATION:

Staff Carly Carper and Armonie Brown are mistreating residents during 3rd shift. Staff swear at residents and are verbally abusive.

INVESTIGATION:

On 11/14/2025, a phone conversation took place with APS worker, Kyle Whitman, who confirmed that he was investigating the same allegations. APS Whitman stated that he had already been to this facility today and spoke to three residents. APS Whitman stated that all three residents stated that staff persons, Carly Carper and Armonie Brown, who work 3rd shift, are rude, disrespectful and have sworn at them and called them names. APS Whitman reported that Resident A told him that Staff Carper and Staff Brown pushed her once and frequently did not want to help her. APS Whitman stated that he spoke to both Staff Carper and Staff Brown, who denied that they have been rude, disrespectful or rough with any residents. APS Whitman reported that both staff have since been terminated and no longer work at this facility.

On 11/20/2025, an on-site inspection was conducted and three residents were interviewed regarding these allegations. Resident A stated that Staff Carper and Staff Brown were not nice to her at all. Resident A stated that they were very rude, would cuss at her and call her names, but she was not able to provide further details. Resident A claimed that Staff Carper and Staff Brown once pulled her out of her wheelchair onto the floor and stepped on her fingers. Resident A stated that she receives excellent care now that those two staff are gone and that all the other staff here are good and treat her well.

On 11/20/2025, Resident B and Resident C provided the same information. Both residents stated that Staff Carper and Staff Brown were quite rude, were disrespectful, would call them names and were sometimes rough while moving them. Neither resident could provide further detailed information. Resident B stated that she had anxiety every time those two staff worked. Resident B and Resident C reported that all other staff at this facility are good, do not verbally abuse them and are not rough when helping them.

During the on-site inspection on 11/20/2025, multiple other residents were spoken to and they all appeared to be doing well. They all reported that the current staff are nice to them and are always around when they need them.

On 11/20/2025, home manager, Mary Anglebrandt, confirmed that several residents have complained about how Staff Carper and Staff Brown have been treating them. HM Anglebrandt stated that Resident A had a fall out of her recliner chair and initially

refused to talk about the incident, but later said that either Staff Carper or Staff Brown stepped on her fingers and that they had been calling her names. Resident A would not be specific regarding the name calling. HM Anglebrandt reported that Resident A has a history of purposely sliding herself out of her recliner and has changed her story a few times about what happened with Staff Carper and Staff Brown, but Resident A did develop a bruise on her shoulder a day or so after the alleged incident. HM Anglebrandt stated that Resident A had no injuries to her fingers and that she had no proof that the staff had physically abused Resident A. HM Anglebrandt stated that Resident B and Resident C both claimed that Staff Carper and Staff Brown were being rude to them and often did not want to help them. HM Anglebrandt claimed that she has not received any complaints about any other staff or that other staff are verbally abusive. HM Anglebrandt confirmed that Staff Carper and Staff Brown were terminated and no longer work at this facility.

On 11/20/2025, staff person, Jenny Bell, stated that Resident A and Resident C have complained to her about Staff Carper and Staff Brown, but that she has not personally witnessed them swearing at or being rude or disrespectful to any residents. Staff Bell stated that she has not witnessed any staff verbally abuse any residents.

On 11/20/2025, staff person, Josef Wilber, stated that he has only briefly worked with Staff Carper and Staff Brown, and that he has not witnessed them having any issues with residents. Staff Wilber stated that he has not witnessed ay staff verbally abuse any residents.

On 11/20/2025, staff person, Latiesha Davis, stated that several residents have complained about Staff Carper and Staff Brown and that she has witnessed those two staff swear at, be rude and call residents names on more than one occasion. Staff Davis stated that on 10/7/2025, she could here Resident A yelling from her bedroom and then Staff Carper and Staff Brown asked for her assistance with Resident A. Staff Davis stated that when she arrived at Resident A’s bedroom, Resident A was already on the floor. Staff Davis reported that she did not see anyone step on Resident A’s fingers. Staff Davis stated that she has not witnessed any verbal abuse from any of the other staff at this facility.

The facility provided a copy of the *AFC Licensing Division Incident/Accident Report* (IR) regarding the incident involving Resident A on 10/7/2025. The IR stated that Staff Carper and Staff Brown went into Resident A’s room and observed Resident A on the floor. The IR stated that Resident A told staff that she slid out of her wheelchair. The IR stated that, while assisting Resident A off the floor, staff may have stepped on Resident A's fingers, but Resident A said she was fine and there were no visible injuries. The home manager and Hospice were called to report the incident. Corrective measures listed on the IR were to continue to follow doctor/Hospice orders.

On 12/1/2025, a phone interview was conducted with staff person, Carly Carper, who confirmed that she worked on 10/7/2025, when she found Resident A on the floor of her bedroom. Staff Carper claimed that Resident A was already on the floor when she

entered her room, that Resident A said that she had slid out her chair, and that she asked other staff for assistance with getting Resident A up off the floor. Staff Carper admitted that Resident A claims that someone stepped on her fingers, but she believes that she did not do this and that if she did, it definitely was not on purpose. Staff Carper stated that Resident A did not sustain any known injuries to her fingers. Staff Carper reported that Resident A and Resident B have been showing signs of confusion and increased levels of dementia recently and have been complaining in general a lot lately. Staff Carper stated that due to the decline, she might have had to be direct with them to complete daily tasks and/or care, but denies that she was ever intentionally rude, verbally abusive or rough with any residents. Staff Carper denied swearing at or calling any residents names.

On 12/1/205, a phone interview was conducted with staff person, Armonie Brown, who confirmed that she was involved in the care of Resident A on 10/7/2025. Staff Brown stated that Staff Carper asked for assistance with getting Resident A off the floor and that Resident A was already on the floor when she entered Resident A's room. Staff Brown stated that she does not know how Resident A got on the floor. Staff Brown stated that she is not aware of anyone stepping on Resident A's fingers. Staff Brown reported that Resident A and Resident B's dementia has gotten worse and that they have been declining more lately. Staff Brown reported that Resident B complained about all the staff. Staff Brown stated that you have to speak firmly and loud to Resident B for her to understand and follow instructions, but Staff Brown denied that she has ever been rude or disrespectful to any resident. Staff Brown denied swearing at or calling any residents names.

On 12/4/2025, a phone call was made to staff person, Jessica Woolworth, who confirmed that Resident A, Resident B, and Resident C had been complaining a lot about Staff Carper and Staff Brown being rude and disrespectful. Staff Woolworth denied that she is verbally abusive to any resident and stated that she has not witnessed any staff doing so or being disrespectful toward residents. Staff Woolworth stated that she would definitely report it if she ever witnessed any abuse or disrespect.

On 12/4/2025, a phone conversation took place with Hospice nurse, Jamie Marzi, from Swan Hospice. Nurse Marzi stated that Swan Hospice currently provides care to four residents at this facility. Nurse Marzi reported that Resident A, Resident B, and Resident C have told her that two 3rd shift staff are rude, disrespectful, and are rough with them during personal care. Nurse Marzi stated that Resident A has claimed that Staff Carper and Staff Brown have thrown her down into her chair before and pushed down on her head/hair. Nurse Marzi stated that Resident B and Resident C claimed that those two staff have cussed at them but could not provide any further detailed information. Nurse Marzi stated that the residents have not complained about any other staff at this facility and appear to be getting good care, now that Staff Carper and Staff Brown are no longer employed there.

On 12/17/2025, an exit conference was held with administrator, Rachel Morgan, who was informed of the outcome of this investigation and that a written corrective action

plan is required. Admin Morgan confirmed that Staff Carper and Staff Brown have been terminated and are no longer employed at this facility.

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:	Resident A, Resident B, and Resident C stated that staff persons, Carly Carper and Antonie Brown, have been very rude, disrespectful, swear at them and call them names. These three residents have made these complaints to other staff repeatedly and also to APS worker and their Hospice nurse. One other staff person claims to have witnessed Staff Carper and Staff Brown swear at, be rude and call residents names on more than one occasion. There was sufficient evidence found to prove that residents were not treated with dignity and respect.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are not being changed properly and there have been unexplained bruises on some residents.

INVESTIGATION:

On 11/14/2025, APS worker, Kyle Whitman stated that he was at this facility recently and spoke to three separate residents. APS Whitman stated that all three residents were clean, well-groomed and appeared to be doing well.

On 11/20/2025, an unannounced on-site inspection was conducted. Multiple residents sitting in the living room area of the facility were spoken to. They all reported that staff take good care of them and are always around when they need them. The residents were viewed to be clean, well-groomed, and free from any visible bruising.

On 11/20/2025, a more detailed interview was conducted with Resident A, Resident B and Resident C. Resident A stated that she has a catheter and does not need to be changed. Resident A stated that now that the two 3rd shift staff are no longer working there, she is getting excellent care here. Resident A stated that all the other staff are good, treat her well, and are always there when she needs assistance.

Resident B and Resident C stated that they are happy now that the 3rd shift staff they were having trouble with are gone. They stated that they both wear adult briefs and can

tell staff when they have to use the bathroom but will have occasional accidents. Resident B and Resident C stated that they are never left in wet or soiled briefs for long and that all the current staff at this facility treat them well.

During the on-site inspection on 11/20/2025, a conversation took place with Family Member 1(FM1) regarding Resident D and Family Member 2(FM2) for Resident E. Both FM1 and FM2 stated that they visit the facility often, that staff at this facility seem good and that Resident D and Resident E are always clean, well-groomed and appear well cared for at this facility.

On 11/20/2025, HM Anglebrandt stated that almost all the residents at this facility wear briefs but many are fairly independent and can use the bathroom on their own. HM Anglebrandt stated that only three of the residents require full assistance to complete all activities of daily living (ADL's). HM Anglebrandt reported that residents are checked often and briefs are changed at least every two hours, or sooner if needed. HM Anglebrandt stated that staff document on each resident's medication administration record (MAR) that every two hour check/change is being completed. HM Anglebrandt stated that she is not aware of any complaints from any residents or family members about residents not being changed. HM Anglebrandt stated that no current residents have any skin breakdown related to lack of personal care. HM Anglebrandt reported that she is not aware of any residents having unexplained bruising. HM Anglebrandt stated that Resident A had some bruising on her upper shoulder area, but that was a result of her sliding out of her chair.

Multiple resident's records were reviewed, including the part of the MAR documenting personal care being completed. It was confirmed that there are various levels of care needed at this home and only three residents require full care for ADL's. The staff appear to do well with documenting that two-hour checks are being completed for all residents.

On 11/20/2025, staff person, Jenny Bell, stated that all residents are checked/changed every two-hours, if not sooner, and as needed when accidents happen. Staff Bell stated that many of the residents will tell staff when they have to use the restroom or have had an accident. Staff Bell stated that no residents are sitting in wet or soiled briefs and that she is not aware of any residents with skin breakdown issues. Staff Bell is not aware of any residents having any unexplained bruising.

On 11/20/2025, staff person, Josef Wilber, stated that all residents are checked/changed at least every two-hours. Staff Wilber stated that he will check residents that are known to be heavy wetter's more often and that no residents are left sitting in wet briefs. Staff Wilber reported that no residents have any skin breakdown related to lack of care. Staff Wilber stated that some of the residents bruise easily from common daily events, but that he is not aware of any residents with any significant and/or unexplained bruising. Staff Wilber feels that the current staff that he works with are good and that they are providing good care.

Phone interviews were conducted with an additional four staff. All four staff confirm that two-hour checks and changes of briefs are taking place and that no residents are sitting in wet or soiled briefs for long periods of time. They all stated that changing of residents' briefs are taking place as needed and often before the two-hour requirement. None of the staff claim they are aware of any skin breakdown or any unexplained bruising on any residents.

On 12/1/2025, a call was made to Hospice nurse, Sasha Pate, from Residential Hospice. Nurse Pate stated that she has had multiple patients at this facility in the past but currently only sees Resident F. Nurse Pate stated that Resident F is always clean and appears well cared for. Nurse Pate stated that she has never seen any signs of neglect at this facility or any unexplained bruising on residents. Nurse Pate reported that she has no concerns regarding the care this facility provides.

On 12/4/2025, a phone conversation took place with Hospice nurse, Jamie Marzi, from Swan Hospice. Nurse Marzi stated that Swan Hospice currently provides care to four residents at this facility and that those residents seem to be getting good care. Nurse Marzi stated that the residents are always clean and well groomed, with no signs of neglect. Nurse Marzi stated that none of those residents have any unexplained bruising. Nurse Marzi reported that she has no concerns with the care this facility provides.

On 12/5/2025, a second unannounced on-site inspection was conducted. Multiple residents were viewed to be clean, well-groomed, and free from any significant bruising.

On 12/17/2025, a phone call was made to APS worker, Kyle Whitman, who stated that he was at this facility on 12/8/2025 to specifically speak to Resident A. APS Whitman stated that Resident A was clean, well-groomed and reported that everything was going well.

On 12/17/2025, an exit conference was held with administrator, Rachel Morgan, who was informed of the outcome of this investigation and that a written corrective action plan is required. Admin Morgan confirmed that Staff Carper and Staff Brown have been terminated and are no longer employed at this facility.

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:	Two unannounced on-site inspections were conducted at this facility and multiple residents were viewed to be clean, well-groomed and free from any significant visible bruising. All the residents interviewed stated that staff take good care of them and are always there when they need them. Family members for two separate residents stated that they visit this facility often and that their loved ones are always clean, well-groomed and appear to be well cared for. Seven total staff persons reported that residents are checked and/or changed at least every two hours or sooner and do not sit in wet briefs for long periods. All staff interviewed stated that they are not aware of any residents having any unexplained bruising. Staff appear to be appropriately documenting that two-hour checks and changes are taking place for each resident. Two nurses from two separate Hospice companies stated that the patients they see at this facility appear well cared for and have never had any known unexplained bruising. There was insufficient evidence found to prove that residents at this facility are not being provided with adequate supervision, protection and personal care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Christopher A. Holvey

12/18/2025

Christopher Holvey — Date
Licensing Consultant

Approved By:

Mary Holton

12/19/2025

Mary E. Holton — Date
Area Manager