GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 8, 2026

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

RE: License #: AL250384167
Investigation #: 2026A0779007
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 #:	2026A0779007
Complaint Receipt Date:	11/18/2025
Investigation Initiation Date:	11/20/2025
Report Due Date:	01/17/2026
Licensee Name:	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?
Resident A was neglected and did not receive adequate supervision.	No
Additional Findings	Yes

III. METHODOLOGY

11/18/2025	Special Investigation Intake 2026A0779007
11/20/2025	Special Investigation Initiated - On Site
11/20/2025	Contact - Telephone call made Spoke to administrator.
12/01/2025	Contact - Telephone call made Spoke to staff person, Carly Carper.
12/03/2025	Contact - Telephone call made Spoke to staff person, Ellaween Douglas.
12/03/2025	Contact - Telephone call made Spoke to Genesee County Sheriff detective.
12/04/2025	Contact - Telephone call made Spoke to staff person, Jessica Woolworth.
12/05/2025	APS Referral Complaint was referred to APS centralized intake.
12/17/2025	Contact - Telephone call made Spoke to Resident A's POA.
12/17/2025	Contact - Telephone call made Spoke to administrator.
12/19/2025	Contact - Document Received Received paperwork via email from administrator.
12/30/2025	Contact - Document Received Received paperwork via email from administrator.

01/02/2026	Inspection Completed On-site
01/06/2026	Contact - Telephone call made Spoke to newly appointed administrator.
01/06/2026	Exit conference Held with newly appointed administrator, Dana Pikula

ALLEGATION:

Resident A was neglected and did not receive adequate supervision.

INVESTIGATION:

On 11/20/2025, an unannounced on-site inspection was conducted. Multiple residents were viewed to be clean, well-groomed and appeared to be doing well.

During the on-site inspection, home manager, Mary Anglebrandt, was interviewed. HM Anglebrandt stated that Resident A was admitted into this facility on 10/24/2025 and only lived there until 11/1/2025, when he had a fall and was transported to the hospital. Resident A passed away at the hospital. HM Anglebrandt stated that Resident A entered this facility as a fall risk, was non-mobile and utilized both a wheelchair and Hoyer lift. HM Anglebrandt reported that Resident A would try and get up and slide out of his bed and wheelchair. HM Anglebrandt stated that Resident A's family was having a hard time understanding the difference between 24-hour care, which is what this facility provides, and 1-on-1 staffing, which this facility does not provide. HM Anglebrandt stated that they were still in the process of properly assessing Resident A's needs. HM Anglebrandt stated that staff found Resident A on the floor on two separate occasions on 10/25/2025 and that during the second occasion, blood was observed on Resident A's forehead and he was sent out to the hospital. HM Anglebrandt stated that Resident A was found to have no significant injuries and was not admitted. Bed and Chair alarms were put into place for Resident A starting on 10/25/2025. HM Anglebrandt reported that staff also started keeping Resident A in the common areas during waking hours, so they could keep a closer eye on him. HM Anglebrandt stated that on 11/1/2025, Resident A had a significant fall out of his wheelchair, while in the dining room. HM Anglebrandt stated that Resident A was bleeding from his nose and mouth and did not have a pulse, so CPR was started and 911 was called. HM Anglebrandt stated that the EMTs had a pulse when they left the facility with Resident A and transported him to the hospital.

The facility provided copies of four separate *AFC Licensing Division Incident/Accident Reports* regarding Resident A's falls. The first IR was for an incident that took place during the morning of 10/25/2025. The IR stated that staff gave Resident A his medications, left briefly to use the bathroom, and upon returning to Resident A's room,

found Resident A on the floor next to his bed. Resident A said that he had crawled out of bed. Resident A was observed to have no known injuries at that time.

The second IR was completed when Resident A was found on the floor of his room during the afternoon of 10/25/20025. Resident A was observed to have blood on his forehead and was taken to the hospital. Bed and chair alarms were put into place for Resident A and staff were then keeping Resident A in the common area for closer supervision.

The third IR was completed when Resident A was leaning forward in his chair, but staff was able to catch him as he was sliding out of the chair. Resident A did not sustain any injuries from this incident and staff continued to try and provide closer supervision of Resident A in common areas.

The fourth IR was completed when Resident A had his significant fall on 11/1/2025. The IR documents that Resident A was sitting at a dining room table when staff went to go get his medications. The staff heard a thud sound and turned around to see Resident A laying face down on the floor. Staff observed Resident A to be bleeding, turned him over to find that Resident A was not breathing and staff started CPR. 911 was called and CPR was provided until an ambulance arrived and EMT's took over care.

A review of medical discharge paperwork, that was received upon Resident A's admission to this facility, states that Resident A was 94 years old and suffered from a subdural hematoma and spinal stenosis. Review of Resident A's record indicates that Resident A was non-mobile and utilized a wheelchair, a Hoyer lift for all transfers and required full assistance from staff to complete all activities of daily living. There was no order in place for Resident A to receive one on one supervision and he was being checked on and/or changed at least every two hours. Facility was utilizing bed and chair alarms and keeping Resident A in common areas and close to staff for closer supervision. A formal autopsy has yet to be completed, but Resident A's death was informally deemed as a result of significant head trauma and advanced age.

The facility also provided a written statement written by another resident's family member, who was present during Resident A's fall on 11/1/2025. The statement documented that the family member was in the dining room with the other resident and with his back to Resident A, when he heard a loud thud noise. The family member turned around to see Resident A out of his chair and lying face down on the floor. The family member wrote that he called for help from staff person, Ellaween Douglas, who was preparing Resident A's medications. Staff Douglas and another staff came running, saw that Resident A was bleeding from the nose and started CPR. Family member wrote that staff feverishly worked on Resident A until medical staff arrived and took over.

On 11/20/2025, a phone call was made to administrator, Rachel morgan, who stated that after the initial falls on the second day Resident A was at this facility, bed and chair

alarms were put into place for Resident A. Admin Morgan stated that she also instructed staff to keep Resident A in common areas during waking hours for closer supervision. Admin Morgan stated that Resident A came to this facility from the hospital after already having spinal surgery and a history of a brain bleed and head trauma, but the family had hopes that he would get better and go back home. Admin Morgan reported that Resident A was assessed, while at this facility, for occupational and physical therapy, but that Resident A had the fall and passed away before the services could be put into place. Admin Morgan stated that they hoped that they had camera footage of Resident A's fall on 11/1/2025, but their cameras were only storing footage for 24 hours. Admin Morgan reported that a detective and medical examiner completed an investigation and had no concerns.

On 12/1/2025, a phone interview was conducted with staff person, Carly Carper, who stated that she was present at the facility on 11/1/2025, but did not see Resident A's fall. Staff Carper stated that they heard a family member yell for help and that she and two other staff came running. Staff Carper stated that it appeared that Resident A fell out of his wheelchair while sitting in the dining room. Staff Carper reported that Resident A was lying face down and that when they noticed he was not breathing, CPR was started. Staff Carper stated that Resident A would throw himself or slide out of his wheelchair and they were keeping him in the common areas to try and keep a closer eye on him.

On 12/3/2025, a phone interview was conducted with staff person, Ellaween Douglas, who stated that she was just with Resident A and had left him sitting in his wheelchair at the dining room table. Staff Douglas stated that she went to get Resident A's medications from the cart, which was close by and she heard a thud sound. Staff Douglas stated that she looked over to see Resident A lying face down on the floor, so she called for other staff to help. Staff Douglas reported that they saw blood coming from Resident A's face/mouth and turned him over and started to take his vitals. Staff Douglas stated that Resident A started to turn purple and they lost his pulse, so CPR was started and 911 was called. Staff Douglas stated that this was not the first time Resident A tried to get himself out of his wheelchair and fell to the floor and that they had put bed and wheelchair alarms in place and kept Resident A in the common areas to try and keep a closer eye on him.

On 12/3/2025, a phone conversation took place with Genesee County Sheriff Detective, Nick Leonowicz, who confirmed that he responded to this facility regarding Resident A's fall on 11/1/2025. Detective Leonowicz stated that Resident A had a history of falls and that the staff at this facility appeared to act and/or respond to the situation appropriately. Detective Leonowicz stated that he found no evidence of abuse or neglect. Detective Leonowicz reported that he had spoken to the medical examiner, who also had no concerns and felt the incident was a result of significant head trauma and advanced age of 94-years. Detective Leonowicz stated that he had spoken to Resident A's son, whose only concern was that the facility initially stated there was a video of the fall, but then couldn't provide one.

On 12/4/2025, a phone interview was conducted with staff person, Jessica Woolworth, who stated that she had fed Resident A dinner at the dining room table and then left to go assist another resident and Staff Douglas went to get Resident A's medications. Staff Woolworth stated that she went to help when she heard calls for help and saw Resident A lying face down on the floor. Staff Woolworth reported that they started to take Resident A's vitals and noticed that he was bleeding badly from his mouth and nose, so they flipped him over and noticed that he was not breathing. Staff Woolworth stated that 911 was called and CPR was started until a police officer arrived and helped and then EMT's arrived and took over. Staff Woolworth stated that Resident A had been known to slide himself out of his chair onto the floor but never had any significant falls or injuries prior to this major incident. Staff Woolworth stated that staff were aware of this and tried to keep Resident A closer to them.

On 12/17/2025, a phone conversation took place with Resident A's power of attorney (POA), who stated that Resident A was only at this facility seven days, but had multiple falls. POA stated that prior to coming to this facility, Resident A was in rehab, then had surgery for a spinal injury, but the rehab center would not take Resident A back because he got a UTI while in the hospital. POA stated that Resident A lost use of his hands and legs after surgery, but use of his hands was starting to come back. POA reported that all the contact she had with Admin Morgan was via the phone and that Admin Morgan assured her that the facility could handle Resident A's care. POA stated that she wanted Resident A to have straps on his wheelchair, but that Admin Morgan told her that they were considered a restraint and they couldn't use them at this facility. POA stated that on the second day of Resident A being there, staff called to report that he had fallen out of his wheelchair, so she went to the facility to see him. POA stated that when she got there Resident A had fallen to the floor again and hit his head, so she took him to the hospital. POA reported that Resident A had a rug burn on his head but no significant injuries. POA confirmed that an RN came to the facility to assess Resident A for OT and PT, but the services could not be put into place before he fell again and passed away. POA stated that the RN mentioned that Resident A may need more help than this facility could provide and that they were starting to look for another place to move Resident A to.

On 12/17/2025, a phone call was made to Admin Morgan, who confirmed that she knew the family and was the one who convinced them to try this facility. Admin Morgan stated that the family thought Resident A was going to start walking and would be able to go back home. Admin Morgan stated that Resident A would say that he forgot that he couldn't walk. Admin Morgan reported that they were hoping that they could have gotten Resident A started with OT and PT, but they couldn't make that happen before that significant fall took place.

On 1/6/2026, an exit conference was held with newly appointed administrator, Dana Pikula. Admin Pikula was informed of the outcome of this investigation and that a written corrective action plan is required. Admin Pikula stated that extensive training will take place to ensure that a thorough and effective admission and assessment take place for any future resident admissions.

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 had three minor incidents/falls at this facility, prior to the significant fall which resulted in his death. After the first two falls, which took place during the same day, this facility put safety measures of bed and wheelchair alarms in place for Resident A. After Resident A started to display a pattern of trying to get up by himself and/or crawling out of his wheelchair and bed, staff started keeping Resident A in common areas, closer to staff, in attempts to keep a closer eye on him. During the third incident, staff were present and able catch Resident A sliding out of his wheelchair, preventing any injury from taking place. Resident A was assessed for PT and OT services that were in place to start soon. When the fall took place on 11/1/2025, staff acted appropriately, called 911 and performed CPR until medical services could arrive. A Sheriff detective and medical examiner found no proof that Resident A's death was a result of any neglect or abuse. There was insufficient evidence found to prove that this facility did not try to adequately protect and keep Resident A safe.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/20/2025, HM Anglebrandt stated that Admin Morgan was the one who did the initial assessment and admission of Resident A. HM Anglebrandt did not have a completed assessment plan for Resident A available to be reviewed.

On 11/20/2025, Admin Morgan confirmed that she was the one who conducted the initial assessment of Resident A and deemed that he was appropriate for this facility. Admin Morgan stated that she would provide Resident A's assessment plan. During a phone call on 12/17/2025, Admin Morgan confirmed that she knew the family and was the one who convinced them to try this facility. Admin Morgan again stated that she would provide a copy of Resident A's assessment plan.

On 12/17/2025, Resident A's POA stated that the only contact she had with Admin Morgan, prior to Resident A's admission into this facility on 10/24/2025, was by phone. POA stated that Admin Morgan assured her that this facility could handle Resident A's care.

On 12/30/2025, Admin Morgan provided a copy of an assessment for Resident A, via email. The assessment plan was signed by HM Anglebrandt and contained information that was put into place days after Resident A's admission into this facility. The assessment plan was not signed by Resident A or his POA.

On 1/2/2026, HM Anglebrandt confirmed that Admin Morgan was the one to do Resident A's initial assessment and admission paperwork. HM Anglebrandt stated that she completed the actual assessment form for Resident A with information provided to her by Admin Morgan. HM Anglebrandt reported that she was not aware of any other admission paperwork that was done for Resident A.

On 1/6/2026, a phone call was made to newly appointed administrator, Dana Pikula. Admin Pikula stated that she had spoken to HM Anglebrandt and Admin Morgan and has determined that Resident A's assessment was not completed prior to or at the time of Resident A's admission and only completed at a later date, once it was asked for. LD Pikula stated that neither HM Anglebrandt nor Admin Morgan could produce a completed resident care agreement for Resident A.

On 1/6/2026, an exit conference was held with newly appointed administrator, Dana Pikula. Admin Pikula was informed of the outcome of this investigation and that a written corrective action plan is required. Admin Pikula stated that extensive training will take place to ensure that a thorough and effective admission and assessment take place for any future resident admissions.

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.** **(b) The services, skills, and physical accommodations required by the resident that are available at the facility.**

ANALYSIS:	This facility accepted Resident A as a resident and started providing care for him without first completing a written assessment plan. They had no written documentation to prove that this facility could adequately provide the personal care, supervision and protection that Resident A required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	On 12/17/2025, Resident A's power of attorney stated that the only contact she had with administrator Rachel Morgan, prior to Resident A's admission into this facility, was done by phone. Admin Morgan provided a copy of Resident A's written assessment plan that was signed by home manger, Mary Anglebrandt, but that did not have Resident A's or his POA's signature.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(6) A licensee shall complete a written resident care agreement at the time of a resident's admission that includes all of the following: **(a) A statement that the facility is licensed to provide foster care to adults.**

	(b) The services to be provided and the fee for those services. **(c) Any additional costs in addition to the basic fee that is charged.** **(d) A resident's rights policy.** **(e) A discharge policy.** **(f) Transportation services provided for a basic fee and services that are provided at an extra cost.** **(g) A refund policy.** **(h) A resident's funds and valuables policy.** **(i) An agreement by the licensee to provide care, supervision, and protection to the resident and to ensure transportation services as indicated in the resident's assessment plan and resident care agreement.** **(j) An agreement by the licensee to respect and safeguard the resident's rights.** **(k) An agreement by the licensee and resident or the resident's designated representative to follow the facility's discharge policy.** **(l) An agreement by the resident, resident's designated representative, or responsible agency to provide necessary intake information, including health-related information, at the time of admission.** **(m) An agreement by the resident or the resident's designated representative to provide a current health care appraisal.** **(n) An agreement by the resident to follow written house rules if any.**
ANALYSIS:	This facility was not able to provide a completed and/or signed copy of a resident care agreement for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

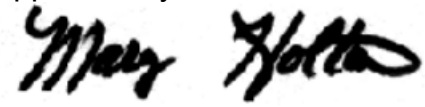
IV. RECOMMENDATION

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

1/8/2026

Christopher Holvey Date
Licensing Consultant

Approved By:



1/8/2026

Mary E. Holton Date
Area Manager