GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 3, 2026

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

RE: License #: AL250384188
Investigation #: 2026A0779019
Cranberry Park Memory Of Clio

Dear Hemant 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 #:	AL250384188
Investigation #:	2026A0779019
Complaint Receipt Date:	03/09/2026
Investigation Initiation Date:	03/09/2026
Report Due Date:	05/08/2026
Licensee Name:	Clio Memory Care, LLC
Licensee Address:	1346 W. Vienna Road Clio, MI 48420
Licensee Telephone #:	(810) 640-7783
Administrator:	Dana Pikula
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:	05/14/2025
Expiration Date:	05/13/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Facility purchased a heating pad for Resident A, without prior physician approval, which resulted in a severe burn.	Yes

III. METHODOLOGY

03/09/2026	Special Investigation Intake 2026A0779019
03/09/2026	Special Investigation Initiated - Telephone Received phone call from Administrator.
03/12/2026	APS Referral Confirmed that APS is investigating the same allegations.
03/12/2026	Contact - Telephone call made Spoke to APS worker.
03/13/2026	Inspection Completed On-site
03/17/2026	Contact - Telephone call made Spoke to Hospice nurse.
03/19/2026	Contact - Telephone call made Spoke to staff person, Brooke Williams.
04/02/2026	Exit Conference Held with administrator, Dana Pikula.

ALLEGATION:

Facility purchased a heating pad for Resident A, without prior physician approval, which resulted in a severe burn.

INVESTIGATION:

On 3/9/2026, a call was received from administrator, Dana Pikula, who stated that she wanted to report an incident involving Resident A. Admin Pikula stated that Resident A suffers from chronic pain, was complaining of bad hip pain and asked for a heating pad.

Admin Pikula reported that the facility purchased a heating pad and staff placed Resident A on the heating pad, while in her recliner chair, on 2/26/2026. Admin Pikula stated that Resident A was left on the heating pad for approximately one hour that day and that the heating pad was not used again. Admin Pikula stated that on the morning of 2/27/2026, staff observed a blister had formed on Resident A's left hip area and Hospice was called. Admin Pikula reported that a few days later on 3/3/2026, a dime size wound appeared on Resident A's buttock area and that multiple wounds have appeared since. Admin Pikula stated that Hospice started treatment for the wounds immediately and the heating pad has not been used since that one initial time. Admin Pikula admitted that the facility did not get prior approval from Resident A's PCP or Hospice for the use of the heating pad.

On 3/12/2026, a phone call was made to APS worker, Melanie Gallego, who confirmed that she was investigating the same allegations and had already visited Resident A at the facility. APS Gallego stated that staff have reported that the heating pad was on the low setting and that Resident A was placed on the pad for one hour and on only one occasion. APS Gallego stated that Resident A confirmed that she asked for the heating pad but claimed that she told staff that the heating pad was too hot and they left her on it anyway. APS Gallego reported that staff person, Shelby Cruz, denied that Resident A said anything about the heating pad being too hot and stated that the heating pad was only used once for one hour. APS Gallego stated that the facility staff appeared to have good intentions when using the heating pad and that she will not be substantiating any abuse or neglect took place.

On 3/13/2026, an on-site inspection was conducted and Resident A was interviewed. Resident A stated that she had used heating pads in the past, before coming to this facility, and confirmed that she asked staff for one. Resident A stated that staff placed her in her recliner chair on top of the heating pad. Resident A claimed that the heating pad was very hot and that she asked to be taken off of it, but staff did not move her. Resident A stated that she only used the heating pad on that one occasion. Resident A reported that staff started treating the burn right away and that the burns are getting better.

A review of Resident A's *Assessment Plan For AFC Residents* was completed. The plan states that Resident is non-mobile, utilizes a wheelchair and requires full assistance from staff in order to complete all her activities of daily living.

On 3/13/2026, staff person, Shelby Cruz, was interviewed and confirmed that she was the staff that placed Resident A on the heating pad on 2/26/2026. Staff Cruz stated that she put the heating pad on the low setting, put it in Resident A's recliner chair and placed Resident A on top of it. Staff Cruz stated that she put Resident A on the heating pad sometime between 11:30am and 12:00pm, but that she was not the staff that removed Resident A from the recliner and the pad. Staff Cruz stated that no guidance or instructions were provided to staff regarding what setting to use or for how long to use the heating pad. Staff Cruz reported that she noticed a blister on Resident A's left

hip area the next morning and Hospice was contacted. Staff Cruz stated that Resident A never said anything about the pad being too hot and did not ask to be taken off of it. On 3/13/2026, manager, Shantelle Zarko, stated that after the blister was observed on 2/27/2026, an internal investigation was started regarding the use of the heating pad. Manager Zarko stated that it appears that staff person, Brooke Williams, took Resident A off the heating pad after approximately one hour of use and that Resident A was not put back on the heating pad the remainer of that day. Manager Zarko stated that 2nd and 3rd shift staff on 2/26/2026, did not notice any blister, mark or burn on Resident A and that the blister was not observed until the morning of 2/27/2026. Manager Zarko reported that multiple other wounds did not show up until a few days later and that Hospice prescribed cream for the burns. Manager Zarko stated that Resident A's PCP saw her on 3/9/2026 and reported that the burns seem to be healing well.

On 3/17/2026, a phone call was made to Hospice nurse, Felicia Richards, who confirmed that she was not contacted prior to the use of the heating pad and that she is not aware of any medical authorization given for the use of the heating pad. Nurse Richards stated that she was contacted by the facility about Resident A's blister on 2/27/2026 and that visited Resident A later that day and prescribed a cream to be used as soon as the blister popped. Nurse Richards stated that she saw Resident A again on 3/2/2026, that the blister had popped and revealed a 2nd degree burn on Resident A's hip area. Nurse Richards reported that Resident A had no other burns or marks at that time, but that more burns were present on Resident A's buttock when she saw Resident A on 3/4/2026. Nurse Richards stated that she spoke to the physician, who confirmed that some burns can wait to appear a few days after contact. Nurse Richards stated that she feels that the facility staff were just trying to help Resident A with her chronic hip pain and that there was no ill intent involved. Nurse Richards confirmed that Resident A's burns are healing nicely.

On 3/19/2026, a phone call was made to staff person, Brooke Williams, who confirmed that she was the staff who took Resident A off the heating pad on 2/26/2026. Staff Williams stated that she cannot remember the exact time she moved Resident A from her recliner and off the heating pad, but said that it was not long after lunch was served at 12:30pm. Staff Williams stated that Resident A never said anything about the heating pad being too hot and did not complain about her hip hurting her the rest of that shift. Staff Williams reported that the blister was observed the next morning, Hospice was contacted and a cream was prescribed. Staff Willaims stated that the other burns did not appear on Resident A's tailbone area until a few days later. Staff Williams stated that the heating pad was only used that one time.

On 4/2/2026, an exit conference was held with administrator, Dana Pikula. Admin Pikula stated that they had good intentions with using the heating pad, but that prior medical authorization will be sought before using any assistive device moving forward. Admin Pikula was informed of the outcome of this investigation and that a written corrective action plan is required.

APPLICABLE RULE	
R 400.673	**Use of assistive devices, therapeutic support.**
	(2) An assistive device or therapeutic support must be authorized in writing by an appropriately licensed health care professional and the authorization must state the reason for and the term of the authorization.
ANALYSIS:	Resident A requested the use of a heating pad for her hip pain and facility staff purchased one for her, but unfortunately the use of the heating pad resulted in Resident A obtaining multiple burns. It was confirmed that facility staff did not obtain authorization, from a licensed health care professional, prior to using the heating pad, which is considered an assistive device.
CONCLUSION:	**VIOLATION 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.

4/3/02026

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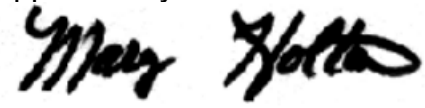
Christopher Holvey Date
Licensing Consultant

Approved By:



4/3/2026

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Mary E. Holton Date
Area Manager