GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 24, 2026

Cyle Pickett
Brother LL Brother Community Provider LLC
7439 Middlebelt Rd
Suite #2
West Bloomfield, MI 48322

RE: License #: AS630418349
Investigation #: 2026A0465033
The Troy-Modern Assisted Living

Dear Cyle Pickett:

Attached is the Special Investigation Report for the above-referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 (248) 972-9136.

Sincerely,

Stephanie Gonzalez

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place
3044 West Grand Boulevard
2nd Floor Annex, Suite 2-730
Detroit, MI 48202
Cell: 248-308-6012

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630418349
Investigation #:	2026A0465033
Complaint Receipt Date:	06/11/2026
Investigation Initiation Date:	06/15/2026
Report Due Date:	08/10/2026
Licensee Name:	Brother LL Brother Community Provider LLC
Licensee Address:	1052 Byron Dr. Troy, MI 48098
Licensee Telephone #:	(248) 986-4546
Administrator:	Cyle Pickett
Licensee Designee:	Cyle Pickett
Name of Facility:	The Troy-Modern Assisted Living
Facility Address:	1052 Byron Dr. Troy, MI 48098
Facility Telephone #:	(248) 986-4546
Original Issuance Date:	07/17/2025
License Status:	1ST PROVISIONAL
Effective Date:	05/22/2026
Expiration Date:	11/21/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff did not properly administer Resident E's antibiotic medication for treatment of a urinary tract infection.	No
Direct care staff did not adequately treat and care for Resident E's pressure wound.	No
Additional Findings	Yes

III. METHODOLOGY

06/11/2026	Special Investigation Intake 2026A0465033
06/15/2026	Special Investigation Initiated - Telephone I spoke to Complainant via telephone
06/15/2026	Contact – Telephone call made I spoke to Guardian E1 via telephone
06/16/2026	APS Referral Adult Protective Services Referral – Denied for investigation
06/18/2026	Inspection Completed On-site I conducted an unannounced onsite investigation at the facility. I completed a walk-through of the facility, observed residents, and interviewed direct care staff, Paulette Pacheco and Marjorie Henry
06/18/2026	Contact - Document Sent I sent an email to licensee designee and administrator, Cyle Pickett, requesting facility documents with a due date of 6/19/2026 by 4:00pm
06/18/2026	Contact - Document Received Email response received from Mr. Pickett regarding facility documents request
06/22/2026	Contact - Document Received Email received from Mr. Pickett requesting closure of license
06/22/2026	Contact - Telephone call received Telephone call received from Mr. Pickett
06/22/2026	Contact - Document Received

	Facility documents received from Mr. Pickett via email
06/22/2026	Contact - Telephone call received Telephone call received from AFC Licensing Consultant, Johnna Cade
06/22/2026	Contact - Document Received Email received from Mr. Pickett
06/23/2026	Contact - Document Received Document received from Mr. Pickett
07/01/2026	Contact - Document Received Email received from area manager, Kristen Donnay, confirming this investigation can proceed
07/24/2026	Contact - Telephone call made I conducted a zoom call with Mr. Pickett, Ms. Donnay, and AFC Licensing Consultant, Kristine Cilluffo
07/24/2026	Contact - Telephone call received Telephone call received from Mr. Pickett
07/24/2026	Contact – Document received Email received from Mr. Pickett
07/29/2026	Contact - Document Received Email document received from Mr. Pickett
07/30/2026	Contact - Document Received Email received from area manager, Kristen Donnay, confirming investigation can proceed
07/31/2026	Contact - Telephone call made I spoke to direct care staff, Salena Baldwin, via telephone
07/31/2026	Contact – Telephone call made I spoke to Ms. Pacheco via telephone
07/31/2026	Contact – Telephone call made I spoke to Guardian B1 via telephone
08/05/2026	Exit Conference I attempted to conduct an Exit Conference with licensee designee and administrator, Cyle Pickett, via telephone, however he declined and requested all communication be via email

ALLEGATION:

Direct care staff did not properly administer Resident E's antibiotic medication for treatment of a urinary tract infection.

INVESTIGATION:

On 6/11/2026, a complaint was received, alleging that direct care staff did not properly administer Resident E's antibiotic medication for treatment of a urinary tract infection (UTI). The complaint stated that Resident E was not provided with adequate fluids while at the facility, which led to development of a UTI. The complaint stated that Resident A was treated at the hospital for the UTI and sent home with an antibiotic for treatment. The complaint stated that direct care staff did not administer Resident E's antibiotic as prescribed. The complaint stated that Resident E no longer resides at the facility.

On 6/15/2026, I spoke to Complainant via telephone. Complainant confirmed the information in the complaint is accurate.

On 6/15/2026, I spoke to Guardian E1 via telephone. Guardian E1 stated, "Resident E resided at the facility from 3/20/2026 – 5/19/2026. The staff did not administer [Resident E's] antibiotic for a UTI. [Resident E] went into the hospital in April for a UTI. She was sent back to the facility with a prescription for an antibiotic. A week later, I found out that the staff had never given her the medication by a home care nurse. A few weeks later, a new prescription for the antibiotic was prescribed for [Resident E], and it was again not administered. The staff were neglectful and should have given the antibiotic."

On 6/18/2026, I conducted an unannounced onsite investigation at the facility. The home specializes in caring for the Alzheimer's/aged, mentally ill and physically handicapped populations. At the time of my onsite investigation, there were four residents residing at the facility. I completed a walk-through of the facility, observed residents, and interviewed direct care staff, Paulette Pacheco and Marjorie Henry.

I reviewed Resident E's record. According to the complaint and signature dates on Resident E's paperwork, it is estimated that Resident E resided at the facility from March 2026 to May 2026. The *Health Care Appraisal* listed Resident E's medical diagnosis as dementia and stroke. The *Assessment Plan for AFC Residents* documented that Resident E's family takes her to outside appointments. Resident E has limited communication skills due to a prior stroke, requires assistance with all self-care tasks, and requires use of a Hoyer lift and wheelchair for mobility assistance. I reviewed the *Incident/Accident Reports*, which documented the following:

> 4/14/2026 at 6:00am; Completed by Destine Rogers: Checked [Resident E's] vitals and her heart rate was elevated, and she had a clammy feel to her skin. Vitals taken twice in one day. Contacted nurse Michelle and family. [Resident E] was sent to the hospital for further evaluation.

I reviewed the *Beaumont University Hospital Emergency After Visit Summaries*, which documented the following hospital visits:

> 4/14/2026: [Resident E] was diagnosed with a urinary tract infection and prescribed Cephalexin (Keflex) 500 mg capsule to be taken by mouth four times daily for 14 days.

I reviewed the *Medication Administration Record* (MAR) for Resident E, and it documented that Resident E was administered Cephalexin capsule 500mg four times daily, at 8:00am, 1:00pm, 5:00pm and 8:00pm. I did not observe any medication errors or discrepancies.

I spoke to direct care staff, Paulette Pacheco, who stated that she has worked at the facility for two weeks. Ms. Pacheco stated, "I was not working here when [Resident E] was here. There are four residents living here. We care for them and everything they need. We administer medication to everyone here." Ms. Pacheco denied knowledge of any medication concerns or issues.

I spoke to direct care staff, Marjorie Henry, who stated that she has worked at the facility for one week. Ms. Henry stated, "I have only been here a week. I don't know [Resident E]. We provide good care to the residents. We give medication to the residents every day. They always get their medication." Ms. Henry denied knowledge of any current medication concerns or issues.

On 7/31/2026, I spoke to former direct care staff, Salena Baldwin, via telephone. Ms. Baldwin stated that she worked at the facility during the time that Resident E was a resident. Ms. Baldwin could not recall her exact hire and end date of employment at the facility. Ms. Baldwin stated, "I remember [Resident E]. I really liked her a lot. She was a very nice person. She did have a UTI at one point and was prescribed an antibiotic. I gave her all the medications she was supposed to take. I gave her antibiotics. I don't recall any issues with her medications." Ms. Baldwin denied knowledge of this complaint being true.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	According to the MAR, direct care staff administered Resident E's Cephalexin 500mg, four times daily as prescribed during the months of April 2026 and May 2026. According to Ms. Baldwin, she administered Resident E's antibiotic as prescribed. Ms. Baldwin denied knowledge of this complaint being true. According to Ms. Pacheco and Ms. Henry, they administer all residents' medication as prescribed. Ms. Pacheco and Ms. Henry stated that they are not aware of any current medication errors or issues. Based on the information above, there is insufficient information to confirm that direct care staff failed to properly administer Resident E's medication, Cephalexin 500 mg antibiotic, as prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Direct care staff did not adequately treat and care for Resident E's pressure wound.

INVESTIGATION:

On 6/11/2026, a complaint was received, alleging that direct care staff did not adequately treat and care for Resident E's pressure wound. The complaint stated that direct care staff were given instructions on how to care for the wound; however, several weeks went by without this care being provided.

On 6/15/2026, I spoke to Guardian E1 via telephone. Guardian E1 stated, "In April, [Resident E] had a pressure wound on her heel. The staff were given instructions on how to care for the wound several times by a home care agency. It was never treated by staff."

I reviewed Resident E's record and was unable to locate any documentation related to the care and treatment of a pressure wound.

I spoke to direct care staff, Ms. Pacheco, who stated that she has worked at the facility for two weeks. Ms. Pacheco stated, "I was not working here when [Resident E] was here. There are four residents living here. We care for them and everything they need. We provide good care. We follow all doctor's orders." Ms. Pacheco denied knowledge of any medication concerns or issues.

I spoke to direct care staff, Ms. Henry, who stated that she has worked at the facility for one week. Ms. Henry stated, “I have only been here a week. I don’t know [Resident E]. We provide good care to the residents. We treat wounds. We make sure everyone is well taken care of.” Ms. Henry denied knowledge of any current medication concerns or issues.

On 7/31/2026, I spoke to former direct care staff, Salena Baldwin, via telephone. Ms. Baldwin stated, “I remember that [Resident E] had a pressure wound on her foot. We used to bandage it and place a pad and wrap it. We did everything we needed to take care of the wound. I don’t remember specific details. It has been a long time since then.” Ms. Baldwin denied knowledge of this complaint being true.

On 8/5/2026, I attempted to conduct an Exit Conference with licensee designee and administrator, Cyle Pickett, via telephone, however he declined and requested all communication be via email. On 8/6/2026, I sent Mr. Pickett an email, informing him that this special investigation is now complete, the recommendation of revocation, and that he will receive a copy of the report via postal mail in the next few weeks.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	According to Ms. Baldwin, she provided adequate care to Resident E to treat the pressure wound on her foot. Ms. Baldwin denied knowledge of this complaint being true. According to Ms. Pacheco and Ms. Henry, they administer all residents’ medication as prescribed. Ms. Pacheco and Ms. Henry stated that they are not aware of any current medication errors or issues. Based on the information above, there is insufficient information to confirm that direct care staff failed to properly follow the instructions and recommendations of Resident E’s physician or other designated health care professional.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 6/18/2026, I conducted an onsite investigation at the facility. At the time of my onsite investigation, I interviewed the two direct care staff on duty, Ms. Pacheco and Ms. Henry. Upon my arrival at the facility, I provided Ms. Pacheco and Ms. Henry with a copy of my business card and informed them that I was there to investigate a complaint.

I spoke to Ms. Pacheco, who stated, “I am new. I have only been working here for two weeks.” At this point, I informed Ms. Pacheco that she could call the licensee designee/administrator, Cyle Pickett, to request guidance and to notify him of my presence at the facility. In response, Ms. Pacheco stated, “Who is Cyle? I call Sunshine [Calamayan], Jen [Hiller], or Lijo [Antony]. We call Lijo or Jen if something important is needed.” At that time, I asked Ms. Pacheco to tell me about the interactions she has had with Mr. Antony. Ms. Pacheco replied, “Lijo is the one that hired me. He interviewed me and Marjorie [Henry] for this job. We interviewed with Lijo on June 8th, a few weeks ago. He stopped by here [the facility] last week, Friday, to check on how we are doing.” I asked Ms. Pacheco if she had contact information or a staff list that I could review. Ms. Pacheco proceeded to open her cell phone and showed me an app called ConnectTeam, which she stated is the primary tool used for all staff communications and updates. Ms. Pacheco opened the app, and I observed a message dated 6/9/2026, which stated the following:

6/9/2026; Message was from Lijo Antony, titled, “Updates,” and stated the following:

> “Dear team, I am excited to announce some significant changes within our organization aimed at enhancing operational efficiency and ensuring smoother management across our communities. After thorough consideration, we have decided to rebuild the company structure and delegate responsibilities more effectively to make management more manageable and responsive. Effective June 8, 2026, we are promoting two outstanding team members, Nyeiko Hylton and Sunshine Ramos, to the roles of Community Managers. Please join me in congratulating them on their new appointments. As they transition into these roles, I kindly ask everyone to allow them the necessary time to adjust, complete their training, and provide them with your full support to succeed. Below are the details regarding the new community assignments: - Nyeiko Hylton will oversee Meadows Mt. Clemens. - Sunshine Calamayan will manage Meadows of Troy, Troy House, Bloomfield, and Franklin. - Jen Hiller will continue to manage Barns Senior Living, Shelby House, Adams, and Beacon. Each of these managers will carry the responsibility of overseeing all resident and staff affairs within their respective communities. They will be the primary contacts for families, admissions, physician group rounds, and will be tasked with ensuring the highest quality of service delivery. Please make sure to communicate with them during business hours and allow them ample time to address and resolve any issues.

> Additionally, Jen will retain her existing duties related to scheduling, hiring, payroll, and broader management responsibilities, with assistance from Amanda. Cyle Pickett will guide the higher management division, supporting business operations and development. Amanda will continue to manage office administration and ensure that the entire team performs at their best. We have also implemented the ConnectTeam platform to improve our internal communication. Please refrain from calling Jen or Amanda directly for concerns. Instead, use the chat feature within ConnectTeam to message the relevant team member directly unless it is an emergency. This will help streamline communication and ensure timely responses. For your convenience, here are the direct contacts for the new community managers and management team [Omitted: all staff listed above were referenced, along with their phone numbers and email addresses]. Thank you all for your cooperation and dedication during this transition. Together, we will continue to uphold the highest standards of care and service. We are also excited about our new software implementation starting next week to ensure care delivery and documentation is at high standards. We will be scheduling trainings at different locations starting next week. Please feel free to reach out if you have any questions or concerns about these changes. Thank you Best regards, Lijo Antony"

On 6/18/2026, I spoke to Ms. Henry, who stated that she has been working at the facility for one week. Ms. Henry stated, "Lijo hired me and Paulette. He interviewed us together. If there is an emergency, we call Lijo."

On 6/22/2026, I received a call from AFC licensing consultant, Johnna Cade, via telephone. Ms. Cade stated, "I received a call from Mr. Pickett. He stated in the last week or two, Lijo reached out to him to offer two staff, Margaret and Paulette, from another state, who he was seeking employment for. Mr. Pickett acknowledged that he did hire these two staff from Lijo."

On 6/22/2026 at 2:19pm, I received a call from Mr. Pickett via telephone. Mr. Pickett stated, "Lijo does not own this facility. He owns some of my other properties. He has always been a landlord for some of my homes. The problem is obviously with me. I have not corrected my issue. I ran into a situation where I literally had no one. And I pulled on an old resource. Not through HireMe. But I needed staff. I did reach out to Lijo, but not HireMe."

On 6/22/2026 at 2:23pm, I received an email from Mr. Pickett, which contained Resident E's AFC documents. I reviewed Resident E's *Assessment Plan for AFC Residents* and *Resident Care Agreement,* dated 3/20/2026, which both included Mr. Antony's signature along with the word "Administrator," directly below his name.

On 7/24/2026 at 9:30am, I attended a Microsoft Teams conference call with Mr. Pickett, AFC licensing consultant, Kristine Ciluffo, and area manager, Kristen Donnay. Mr. Pickett was provided with an email copy of the ConnectTeam message dated 6/9/2026 at the time of this call, as well as the information provided to me from

Ms. Pacheco and Ms. Henry regarding their interactions with Mr. Antony. Mr. Pickett stated, “ConnectTeam is a team chat that I use to directly manage my facilities. I am denying Lijo’s involvement with my homes. He is not involved. I did not know about his disciplinary action until several months ago when I was told by you. I ended the business relationship with Lijo. He operates as the landlord for several of my properties still, but that is all. I ended the business relationship with Lijo. He has no involvement. It’s so fresh in staff’s minds, it’s confusing. This message was a message that was sent out to restructure the company and to notify everyone that Lijo was no longer going to be involved. That was the intent of the message. I drafted and copied and pasted this message myself.”

On 7/24/2026 at 12:34pm, I received a telephone call from Mr. Pickett. Mr. Pickett stated, “I am calling to ask for another chance. I can see how the [ConnectTeam] messages appear, but that is not what it is. I am going to be honest and trust you right now. I have not disclosed that I was in the process of merging with Lijo, we were almost about to merge our companies and then you did the investigation and I found out about his restriction. There was a planned merger before everything happened. I cut ties with Lijo several months ago. But I did reach out to him a few weeks ago because I needed staff and I was desperate. He has been more involved, but he is not anymore. I thought when I was told Lijo could not be involved, it was referring to the day to day, such as administering medication and overseeing the operations in the home. How does sending a message show that Lijo is still involved?”

On 7/24/2026 at 3:40pm, I received an email from Mr. Pickett, which stated the following:

> I sent you all a text earlier and am simply pleading for my beautiful AFC homes that I have worked diligently over the years to establish. I understand this announcement [ConnectTeam message] may suggest that Mr. Antony had a leadership role. The purpose of this communication was to announce an internal restructuring and identify the individuals who would be responsible for daily operations. As reflected in the announcement, operational responsibility was assigned to the Community Managers, while I was responsible for higher-level business operations and development. Mr. Antony was not designated as the manager of any licensed AFC home in this communication. After I became aware of the State’s concerns regarding Mr. Antony’s eligibility, I have worked diligently to take steps to remove him entirely from any involvement with my licensed facilities. As mentioned on call, He no longer has any ownership interest, management authority, operational responsibilities, supervisory role, access to records, or ability to direct employees or make decisions concerning the AFC homes. I’m praying that you guys can take this into consideration and grant us an opportunity to fix this so that we can focus on our residents

On 7/31/2026, I spoke to former direct care staff, Salena Baldwin, via telephone. Ms. Baldwin stated, “I used to work at the facility but now I work at one of the other

facilities that Cyle [Pickett] owns. I have met Cyle and Lijo [Antony]. I met Lijo two weeks ago. He was at the staff meeting that I attended at the Mt. Clemens facility. He and Cyle were both there. Lijo was part of the meeting to discuss staff duties. I am not sure if he is an owner or not. If there is an emergency or I need to contact a manager, I call Cyle, Lijo or Jen [Hiller]."

On 7/31/2026, I conducted a follow-up phone call with Ms. Pacheco. Ms. Pacheco stated, "Lijo is the head of the facility. He handles emergencies."

On 7/31/2026, I spoke to Guardian B1 via telephone. Guardian B1 stated, "Resident B lived at the facility for six months. Resident B moved out of the facility on 7/7/2026 due to the home needing roofing repair. I was told by staff, Navia Salinas, that Cyle and Lijo had merged in January 2026 and are now operating the businesses together. I don't know more than that."

On 4/24/2026, I completed a prior special investigation at The Troy-Modern Assisted Living, SIR #: 2026A0465015, in which a violation was established for MCL 400.722(2). During the investigation, it was determined that the licensee designee, Cyle Pickett, had been utilizing the staffing agency, HireME, LLC, operated by Lijo Antony, to staff the facility. Mr. Antony had a denial of issuance for an adult foster care facility on 02/11/2025 and is not permitted to have a "relationship" with a licensed adult foster care facility for a period of five years. During the investigation, staff at The Troy- Modern Assisted Living indicated that there had been a company merger between Mr. Pickett and Mr. Antony, and they stated that they had regular contact with Mr. Antony, using him as a point of contact for direct care staff needs. On 4/24/2026, due to the significant number and seriousness of the rule violations, a six-month provisional license was recommended. On 5/19/2026, Mr. Pickett submitted a corrective action plan stating that he terminated his contract with HireMe, LLC effective May 2026. On 5/22/2026, a six-month provisional license was issued.

On 04/20/2026, Department of Licensing & Regulatory Affairs Division Director, Jay Calewarts, sent a letter to Lijo Antony via email indicating that it had been brought to the attention of the department that Mr. Antony created a staffing agency by the name of "HireMe" and was providing staff through the staffing agency to another AFC licensee, Cyle Pickett. Mr. Calewarts noted that this is in direct conflict with the Adult Foster Care Facility Licensing Act, specifically MCL 400.713 (11) and MCL 400.722 (2). The email indicated that Mr. Antony had established a "relationship" with Cyle Pickett by providing staff to his licensed facilities, which also resulted in a financial interest. The email noted that this relationship puts Cyle Pickett's AFC licenses in jeopardy of licensing action and is in violation of the law. Mr. Antony was advised to cease relationships with current AFC licensees in accordance with MCL 400.713 (11) and 400.722 (2).

On 4/20/2026, Mr. Antony sent an email to Mr. Calewarts in response to his email. Mr. Antony noted that he was not aware that providing staff to an AFC facility

through his staffing agency was not permitted under the current arrangements. He stated that once staff are hired by any company, they cease to be employees of HireMe, so he believed this exempted them from any issues. Mr. Antony stated that he could now recognize where potential conflicts of interest may arise, and he promptly decided to terminate all existing relationships with both HireMe and Cyle's AFC. He stated, "I assure you unequivocally that we have ceased all relations with HireMe, Cyle's AFC, and any other AFCs."

On 8/4/2026, Mr. Pickett sent an email to area manager, Kristen Donnay, which included a document titled, *Termination Agreement*, with an effective date of 4/21/2026. The document, in part, stated that Mr. Pickett and HireMe, LLC agreed to terminate their prior business relationship in its entirety effective 4/21/2026. The document stated that there would be no new placements or staffing assignments. The document stated that any ongoing placements or staffing assignments in progress shall be concluded within a 60-day transition period (end date of 6/20/2026). This document was never submitted to LARA prior to 8/2/2026 and was not approved as part of Mr. Pickett's written corrective action plan he submitted on 5/19/2026.

APPLICABLE RULE	
MCL 400.722	**Denying, suspending, revoking, refusing to renew, or modifying license; grounds; written notice; hearing; decision; protest; receiving or maintaining adults requiring foster care as felony; penalty; relocation services.**
	(2) The department may deny, suspend, revoke, or modify an application for licensure or a license of a licensee if the department determines that the applicant or licensee has a relationship with a former applicant whose application under this act has been denied or a former licensee whose license under this act has been suspended, revoked, or refused renewal under this section or section 13(9) or a convicted person to whom a license has been denied under section 13(9). This subsection applies for 10 years after the suspension, revocation, or refused renewal of the former licensee's license, the denial of the former applicant's application for licensure, or the denial of the convicted person's application for licensure. As used in this subsection, an applicant has a relationship with a former licensee or convicted person if the former applicant, licensee, or convicted person is involved with the facility in 1 or more of the following ways: **(a) Participates in the administration or operation of the facility.** **(b) Has a financial interest in the operation of the facility.** **(c) Provides care to residents of the facility.**

	(d) Has contact with residents or staff on the premises of the facility. **(e) Is employed by the facility.** **(f) Resides in the facility.**
ANALYSIS:	According to Resident E's *Assessment Plan for AFC Residents* and *Resident Care Agreement*, both dated 3/20/2026, Mr. Antony completed these documents, and signed his name, acting in the capacity of an administrator. According to Cyle Pickett and Lijo Antony, the relationship between Mr. Pickett's licensed adult foster care facility and Mr. Antony's staffing agency ceased effective 4/20/2026. According to staff, Ms. Pacheco and Ms. Henry, they were both interviewed by Lijo Antony on 6/8/2026 and subsequently hired by Mr. Antony to work at the facility. Ms. Pacheco and Ms. Henry stated that, if an emergency arises, Mr. Antony is one of the managers they will call. According to Ms. Pacheco, Mr. Antony has visited the facility at least once to check in on her and Ms. Henry, since her hire date. According to the ConnectTeam messages dated 6/8/2026, Mr. Antony sent a message to staff, which included Ms. Pacheco and Ms. Henry. In the messages, Mr. Antony referenced staff promotions, staff directives, management restructuring and upcoming training to be offered at a future time. I did not read any information in the message that stated Mr. Antony was severing ties with Mr. Pickett's limited liability company or facility. According to Mr. Pickett, he acknowledged that he contacted Mr. Antony in June 2026 to request assistance with staffing for the facility, which subsequently led to the hiring of Ms. Pacheco and Ms. Henry. According to Ms. Baldwin, she attended a staff meeting during the month of July 2026. Ms. Baldwin stated that Mr. Antony and Mr. Pickett were both present for this meeting and discussed staffing duties. Based on the information above, there is sufficient information to confirm that Mr. Pickett continues to have a relationship with Mr. Antony. Mr. Antony conducted interviews and hired staff for the facility, visited the facility, sent electronic communications to direct care staff via ConnectTeam, and attended a staff meeting

	to discuss staff duties. Additionally, Mr. Antony completed AFC paperwork acting in the role of an administrator, raising additional concerns that he is involved in Mr. Pickett's facility beyond that of a landlord or staffing agency.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #: 2026A0465015 dated 4/24/2026 and Corrective Action Plan dated 5/19/2026**

INVESTIGATION:

On 6/18/2026, I conducted an onsite investigation at the facility and interviewed direct care staff, Ms. Pacheco and Ms. Henry.

I spoke to Ms. Pacheco, who stated, "I have been working and living here for two weeks. I live in the room by the kitchen. I was hired on 6/8/2026 and moved in on the same day."

I spoke to Ms. Henry, who stated, "I have been working and living here for one week. I live in the basement. I interviewed on the same day with Paulette and moved in last week."

On 6/22/2026, I received a call from Mr. Pickett via telephone. Mr. Pickett stated, "This morning, I was gathering all the documents that I am sending to you for the employee files and I don't have the fingerprinting for the two people that just started. Since I last talked to you, I have had a situation of staffing issues since ending my contract with HireMe. I brought these staff over from a roster of staff connected to Mr. Antony and I have not gotten their fingerprinting done as of yet. I kind of thought I have 10 days to get it done."

On 6/22/2026 and 7/31/2026, I reviewed the *Workforce Background Check System* (WFBC)*, Bureau of Information Tracking System* (BITS), and Resident E's *Medication Administration Record* for the month of May 2026 to determine which staff were employed at the facility during this time. I then completed a search of the WFBC System and BITS, to determine if the staff living in the home and the staff listed on the MAR had completed the required criminal background checks. I determined the following discrepancies:

Paulette Pacheco: Ms. Pacheco was entered into the WFBC System on 6/22/2026 and deemed eligible on 6/30/2026. Ms. Pacheco is not listed in BITS as a household member and has not submitted the required AFC-100 to be approved as a live-in direct care staff.

Marjorie Henry: Ms. Henry was entered into the WFBC System on 6/18/2026 and deemed eligible on 6/23/2026. Ms. Henry is not listed in BITS as a household member and has not submitted the required AFC-100 to be approved as a live-in direct care staff.

Latoi Grant: Ms. Grant is listed on the MAR as having administered medication to Resident E on 5/5/2026, 5/12/2026, 5/17/2026 and 5/18/2026. I was unable to locate Ms. Grant as an eligible employee under the facility's license. On 5/26/2026, Ms. Grant was entered into the WFBC System and deemed eligible under a separate licensed facility, Shelby AL (AS500419642), also operated by Mr. Pickett.

Lauryn Stevenson: Ms. Stevenson is listed on the MAR as having administered medication to Resident E on 5/4/2026, 5/14/2026, 5/15/2026, 5/16/2026, 5/18/2026 and 5/19/2026.I was unable to locate Ms. Stevenson as an eligible employee under the facility license. On 4/16/2026, Ms. Stevenson was entered into the WFBC System and deemed eligible under a separate licensed facility, Amor Novi (AS630418307), which is also operated by Mr. Pickett.

Nilam Umwell: Mr. Umwell is listed on the MAR as having administered medication to Resident E on 5/1/2026, 5/2/2026, 5/3/2026, 5/5/2026, 5/6/2026, 5/7/2026, 5/11/2026 and 5/12/2026. According to the WFBC System, Mr. Umwell has never been entered into the system as a new hire, nor has he completed the required fingerprinting/criminal background check.

Sherlian Austin: Ms. Austin is listed on the MAR as having administered medication to Resident E on 5/10/2026. I was unable to locate Ms. Austin as an eligible employee under the facility license. On 7/9/2026, Ms. Austin was entered into the WFBC System and deemed eligible under two separate licensed facilities, The Shelby AL (AS500419642) and The Franklin House (AS630418745), both operated by Mr. Pickett. In 2023, Ms. Austin was also deemed eligible under two additional licensed facilities as a new hire for Meadows Assisted Living II (AL500388683) and Barns Senior Living 2 (AS630415337), both operated by Mr. Antony.

On 4/24/2026, I completed a prior special investigation at The Troy-Modern Assisted Living, SIR #: 2026A0465015, in which a violation was established for MCL 400.734b(2). I noted the following findings during that investigation:

On 2/26/2026, I conducted an unannounced onsite investigation at the facility related to special investigation #2026A0465015. During this investigation, Mr. Pickett informed me that he has been utilizing live-in staff since December 2025. On 4/13/2026, Mr. Pickett provided me with a staff list and timeframes for staff that have lived in the home. According to BITS, Ms. Salinas, Mr. Murray and Ms. Heck did not complete the required AFC-100 criminal history background check prior to moving into the facility as live-in staff. According to the WFBC System, Ms. Hilario

was entered into the system as a new hire on 4/12/2026, approximately two months after she began working at the facility, with her eligibility currently pending. Mr. Murray was entered into the system and deemed eligible on 4/13/2026, approximately two months after he began working at the facility. Ms. Heck was entered into the system on 4/13/2026, approximately five weeks after she began working at the facility. Ms. Rogers was entered into the system and deemed eligible on 4/13/2026, approximately two months after she began working at the facility. Ms. Blanding was entered into the system on 4/13/2026, approximately two months after she began working at the facility, with her eligibility still pending. Ms. Stevenson worked at the facility from 1/2/2026 to 2/8/2026 and was never entered into the system as a new hire. Ms. Lewis was entered into the system on 4/13/2026, approximately two months after she began working at the facility, with eligibility currently pending. Ms. Salinas was deemed eligible on 1/12/2026, approximately two weeks after she began working at the facility. Ms. Sills worked at the facility from 1/31/2026 – 2/27/2026 and was never entered into the system as a new hire. Based on the information above, Mr. Pickett did not complete the required criminal history background checks for direct care staff prior to allowing them direct access to residents. On 4/24/2026, due to the significant number and seriousness of the rule violations, a six-month provisional license was recommended. On 5/4/2026, 5/7/2026 and 5/19/2026, Mr. Pickett submitted revised corrective action plans. On 5/22/2026, a six-month provisional license was issued.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of

	fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	According to BITS, Ms. Pacheco and Ms. Henry did not complete the required AFC-100 criminal history background check prior to moving into the facility as live-in staff. According to the WFBC System, Ms. Pacheco was fingerprinted deemed eligible to work in the facility on 6/30/2026, approximately 22 days after she began living at the facility as a direct care staff. Ms. Henry was fingerprinted and deemed eligible to work in the facility on 6/23/2026, approximately 12 days after she began living at the facility as a direct care staff. Ms. Grant was never entered into the system as a new hire but was deemed eligible under a separate facility on 5/26/2026, approximately 21 days after she began working as a direct care staff. Ms. Stevenson was never entered into the system as a new hire but was deemed eligible under a separate facility on 4/16/2026. Mr. Umwell was never entered into the system as a new hire and never completed the required criminal background check. Ms. Austin was never entered into the system as a new hire but was deemed eligible on 7/9/2026 under two separate facilities, approximately two months after she began working as a direct care staff at the facility. Based on the information above, Mr. Pickett did not complete the required criminal history background checks for direct care staff prior to allowing them to live in the home and have direct access to residents.

CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #: 2026A0465015 dated 4/24/2026 and Corrective Action Plan dated 5/19/2026**

INVESTIGATION:

On 6/18/2026 at 10:42am and 6/22/2026 at 11:45am, I sent emails to Mr. Pickett, requesting, in part, the following AFC documents:

1. Resident Registrar
2. All resident face sheets (4) plus Resident E's face sheet
3. All AFC Assessment Plans (4)
4. All health care appraisals (4)
5. All resident care agreements (4)
6. Staff schedule for last 90 days
7. Employee Phone list for all staff that have worked at the home in the last 90 days (include anyone no longer employed)
8. All *Incident/Accident Reports* for the last 90 days
9. MARS for all residents
10. OCHN care plans if applicable
11. Employee files for all staff currently employed at the facility
12. All legal guardians/NOK (next of kin) names and numbers

On 6/18/2026 at 5:47pm, Mr. Pickett sent me an email, stating he would submit the requested documents to me on 6/22/2026 by 4:00pm.

On 6/22/2026 at 2:23pm, Mr. Pickett sent three attachments of facility documents to me via email; however, it did not include the following items: Face sheets, staff schedule for last 90 days, employee phone list/numbers, incident reports for last 90 days, MARS, employee files and legal guardians' names/numbers.

As of the date of this report, I have not received copies of the above documents from Mr. Pickett.

On 4/24/2026, I completed a prior special investigation at The Troy- Modern Assisted Living, SIR #: 2026A0465015, in which violations were established for R 400.621 (Capability); R 400.629(5) (Direct care staff qualifications and training); R 400.631(2) & (5) (Health screenings); and R 400.639(1) (Staff records). During the investigation, it was determined that staff at The Troy- Modern Assisted Living were sleeping on shift due in part to improper scheduling, were not trained in all required areas, did not have health and communicable disease screenings completed, and did not have reference checks on file. On 4/24/2026, due to the significant number and seriousness of the rule violations in the prior special investigation #: 2026A0465015, a six-month provisional license was recommended. The licensee

designee, Cyle Pickett, submitted a corrective action plan (CAP) dated 5/19/2026. The CAP noted that there are currently no “live in staff” and staff schedules were reviewed and deemed appropriate to include full-time and part-time workers. It stated that LARA would be notified and an AFC-100 would be completed prior to any staff living in the home. The CAP also noted that all staff were trained in the required areas, had health and communicable disease screenings completed, and had reference checks on file. The CAP stated that the administrator and/or his designee, Jen Hiller, would ensure all new employee files were in direct alignment with required AFC guidelines prior to staff performing any assigned task. It noted that employee files would be audited monthly to ensure continued compliance.

APPLICABLE RULE	
R 400.605	**Rule compliance; cooperation by applicant or licensee.**
	(2) An applicant or licensee shall cooperate with the department to determine compliance with the act and these rules during the review of an application and during an inspection or investigation.
ANALYSIS:	On 6/18/2026 and 6/22/2026, I informed Mr. Pickett of the request for facility documents as part of my investigation. On 6/18/2026, Mr. Pickett stated that he would send me the requested documents. As of the date of this report, Mr. Pickett has not cooperated and submitted the documents requested to assist in my investigation. Based on the information above, there is sufficient information to confirm that Mr. Pickett has not cooperated and complied with submission of adult foster care documents for the purposes of this special investigation.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.621	**Capability.**
	Licensees, staff, volunteers, and members of the household shall be capable of ensuring the welfare of residents.
ANALYSIS:	Mr. Pickett has demonstrated a lack of capability to operate the facility in compliance with the Adult Foster Care Licensing Act and administrative rules. The investigation determined the licensee repeatedly allowed staff to provide direct resident care and administer medications before completing required criminal history background checks or being deemed eligible to work in

	the home through the Workforce Background Check System. The licensee designee also permitted unapproved live-in staff to reside in the facility and failed to maintain required personnel records, including medical clearances, communicable disease documentation, and documentation of required training. Without these required qualifications, the licensee could not verify that staff were medically fit to perform their duties, free from communicable disease, or adequately trained to safely meet resident care needs, demonstrating a lack of staff capability to provide appropriate care. These violations occurred despite prior investigations, corrective action plans, and the issuance of a six-month provisional license for similar violations. The continued pattern of noncompliance demonstrates that the licensee has failed to maintain a qualified workforce or implement effective oversight necessary to ensure the health, safety, and welfare of residents. Based on the information above, there is sufficient information to confirm that Mr. Pickett and the direct care staff have not adhered to and completed the necessary requirements to deem them capable of ensuring the welfare of residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #: 2026A0465015 dated 4/24/2026 and Corrective Action Plan dated 5/19/2026**

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(5) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be trained and competent in all of the following areas before performing assigned tasks independently: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases including recognizing signs of illness.**

	(h) Food safety, which includes food storage, preparation, distribution, and serving in a safe manner. **(i) Nutrition and special diets.**
ANALYSIS:	On 6/18/2026 and 6/22/2026, I informed Mr. Pickett of the request for facility documents as part of my investigation. On 6/18/2026, Mr. Pickett stated that he would send me the requested documents. As of the date of this report, Mr. Pickett has not submitted copies of direct care staff training records for Ms. Pacheco, Ms. Henry, Ms. Atkinson, Ms. Grant, Mr. Umwell, and Ms. Austin. Based on the information above, I am unable to confirm that direct care staff are competent, trained and qualified to provide direct care to residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #: 2026A0465015 dated 4/24/2026 and Corrective Action Plan dated 5/19/2026**

APPLICABLE RULE	
R 400.631	**Health screenings.**
	(2) A licensee shall have on file a statement signed by a licensed physician or physician's designee attesting to the physical health of the licensee, staff, and members of the household. Statements for the licensee and administrator must be signed no more than 6 months before the issuance of a temporary license and at any other time requested by the department. Statements for staff and members of the household must be obtained within 30 days of employment start date, assumption of duties, or occupancy in the facility.
ANALYSIS:	On 6/18/2026 and 6/22/2026, I informed Mr. Pickett of the request for facility documents as part of my investigation. On 6/18/2026, Mr. Pickett stated that he would send me the requested documents. As of the date of this report, Mr. Pickett has not submitted the medical clearances/health screenings for Ms. Pacheco, Ms. Henry, Ms. Atkinson, Ms. Grant, Mr. Umwell, and Ms. Austin.

	Based on the information above, I am unable to confirm that direct care staff are in good physical health to provide direct care to residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #: 2026A0465015 dated 4/24/2026 and Corrective Action Plan dated 5/19/2026**

APPLICABLE RULE	
R 400.631	**Health screenings.**
	(5) A licensee shall maintain documentation of a baseline screening for communicable diseases and records of illness on hiring. Staff who have direct physical contact with residents or resident food may perform those duties only when they are noninfectious or when proper precautions are taken to prevent the spread of a communicable disease. A licensee shall follow a staff's health care professional or local health department guidance on controlling the spread of a communicable disease when identified.
ANALYSIS:	On 6/18/2026 and 6/22/2026, I informed Mr. Pickett of the request for facility documents as part of my investigation. On 6/18/2026, Mr. Pickett stated that he would send me the requested documents. As of the date of this report, Mr. Pickett has not submitted the communicable disease screenings for Ms. Pacheco, Ms. Henry, Ms. Atkinson, Ms. Grant, Mr. Umwell, and Ms. Austin. Based on the information above, I am unable to confirm that direct care staff are in good physical health and free from communicable disease prior to providing direct care to residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #: 2026A0465015 dated 4/24/2026 and Corrective Action Plan dated 5/19/2026**

APPLICABLE RULE

R 400.639	**Staff records.**
	(1) A licensee shall maintain a record for each staff that contains all of the following: **(a) Name, address, telephone number, and Social Security number.** **(b) Copy or number of a professional or vocational license, certification, or registration if staff provides professional or vocational services.** **(c) Copy of a driver's license if staff provide transportation services.** **(d) Verification of age.** **(e) Verification of experience, highest level of education completed, and training.** **(f) Verification of not less than 2 reference checks. If reference checks cannot be obtained, documentation verifying reference checks were attempted must be maintained.** **(g) Beginning and ending dates of employment on separation.** **(h) Health information as required by these rules.** **(i) Verification of the receipt by the staff of personnel policies and job descriptions.**
ANALYSIS:	On 6/18/2026 and 6/22/2026, I informed Mr. Pickett of the request for facility documents as part of my investigation. On 6/18/2026, Mr. Pickett stated that he would send me the requested documents. As of the date of this report, Mr. Pickett has not submitted the staff records for Ms. Pacheco, Ms. Henry, Ms. Atkinson, Ms. Grant, Mr. Umwell, and Ms. Austin. Based on the information above, I am unable to confirm that Mr. Pickett obtained and retained all of the required documents for direct care staff as required per adult foster care licensing rules.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #: 2026A0465015 dated 4/24/2026 and Corrective Action Plan dated 5/19/2026**

APPLICABLE RULE	
R 400.639	**Staff records.**

	(3) A licensee shall maintain for 90 days a daily work schedule and assignments that includes all of the following: **(a) Names of staff on duty.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Scheduling changes when made.**
ANALYSIS:	On 6/18/2026 and 6/22/2026, I informed Mr. Pickett of the request for facility documents as part of my investigation. On 6/18/2026, Mr. Pickett stated that he would send me the requested documents. As of the date of this report, Mr. Pickett has not submitted a copy of the staff schedule for the last 90 days. Based on the information above, I am unable to confirm that Mr. Pickett has completed and maintained a staff schedule as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 6/18/2026, I conducted an onsite investigation at the facility. I conducted a walk-through of the facility. I observed Ms. Pacheco's bedroom in the room off the kitchen. I observed Ms. Henry's bedroom in the basement of the home.

I spoke to Ms. Pacheco, who stated, "I have been working and living here for two weeks. I live in the room by the kitchen. I was hired on 6/8/2026 and moved in on the same day."

I spoke to Ms. Henry, who stated, "I have been working and living here for one week. I live in the basement. I interviewed on the same day with Paulette and moved in last week."

On 4/24/2026, I completed a prior special investigation at The Troy-Modern Assisted Living, SIR #: 2026A0465015, in which a violation was established for R 400.657(2). During the investigation, it was determined that the licensee designee, Cyle Pickett, was utilizing live-in staff. A direct care staff was living in the room that was labeled as a common area on the facility's floor plan at the time of the original license issuance. On 4/24/2026, due to the significant number and seriousness of the rule violations, a six-month provisional license was recommended. Mr. Pickett submitted a corrective action plan (CAP) dated 5/19/2026. The CAP noted that the room listed

in the citation is no longer being used for sleeping purposes by anyone. The room is currently being used as a common area for residents and family use. On 5/22/2026, a six-month provisional license was issued.

APPLICABLE RULE	
R 400.657	**Bedrooms.**
	(2) Living rooms, dining rooms, hallways, or other rooms that are not ordinarily used for sleeping, or a room that contains a required means of egress, must not be used for sleeping purposes by anyone.
ANALYSIS:	According to the *Floor Plan*, submitted by Mr. Pickett as part of his application process, the bedroom that Ms. Pacheco is residing in is only approved as a common sitting area and not for sleeping purposes. The basement area that Ms. Henry is currently living in is not approved for sleeping purposes. In May 2026, Mr. Pickett submitted a corrective action plan related to special investigation #: 2026A0465015, stating he would no longer be utilizing live-in staff. Mr. Pickett stated that if he did choose to use live-in staff, he would notify LARA first to ensure compliance with all requirements. According to Ms. Pacheco and Ms. Henry, they have been living in the facility for one to two weeks. According to Mr. Pickett, he acknowledged that, as of June 2026, Ms. Pacheco and Ms. Henry have been living in the home, in rooms that have not been approved for sleeping purposes. Based on the information above, there is sufficient information to confirm that the facility is using the common room area for sleeping purposes.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #: 2026A0465015 dated 4/24/2026 and Corrective Action Plan dated 5/19/2026**

IV. RECOMMENDATION

Due to the facility currently being on a provisional license and the intervening quality of care violations, I recommend revocation of the license.

8/6/2026

Stephanie Gonzalez — Date
Licensing Consultant

Approved By:

WOC Area Manager for — 08/07/2026

Denise Y. Nunn — Date
Area Manager