



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

September 30, 2025

Hemant Shah  
Cranberry Park West Bloomfield LLC  
Suite 230  
25500 Meadowbrook Rd  
Novi, MI 48375

RE: License #: AH630402042  
Investigation #: 2025A0628007  
Cranberry Park of West Bloomfield

Dear Licensee:

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) 335-5985.

Sincerely,

Rebekah Looney, Licensing Staff  
Bureau of Community and Health Systems  
611 W. Ottawa Street, P.O. Box 30664  
Lansing, MI 48909

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

**I. IDENTIFYING INFORMATION**

|                                       |   |
|---------------------------------------|---|
| <b>License #:</b>                     | AH630402042   |
| <b>Investigation #:</b>               | 2025A0628007  |
| <b>Complaint Receipt Date:</b>        | 07/14/2025  |
| <b>Investigation Initiation Date:</b> | 07/17/2025  |
| <b>Report Due Date:</b>               | 09/13/2025  |
| <b>Licensee Name:</b>                 | Cranberry Park West Bloomfield LLC                  |
| <b>Licensee Address:</b>              | Suite 230<br>25500 Meadowbrook Rd<br>Novi, MI 48375 |
| <b>Licensee Telephone #:</b>          | (248) 692-4355                                      |
| <b>Administrator:</b>                 | Pamela Skatzka                                      |
| <b>Authorized Representative</b>      | Hemant Shah   |
| <b>Name of Facility:</b>              | Cranberry Park of West Bloomfield                   |
| <b>Facility Address:</b>              | 2450 Haggerty Rd<br>West Bloomfield, MI 48323       |
| <b>Facility Telephone #:</b>          | (248) 671-4204                                      |
| <b>Original Issuance Date:</b>        | 03/10/2022  |
| <b>License Status:</b>                | REGULAR   |
| <b>Effective Date:</b>                | 08/01/2025  |
| <b>Expiration Date:</b>               | 07/31/2026  |
| <b>Capacity:</b>                      | 53  |
| <b>Program Type:</b>                  | AGED<br>ALZHEIMERS                                  |

## II. ALLEGATION(S)

|  | <b>Violation<br/>Established?</b> |
|--|-----------------------------------|
| The facility won't allow a resident to self-administer medications.  | Yes                               |
| The facility does not treat the residents with respect and kindness. | No                                |
| Additional Findings  | No                                |

## III. METHODOLOGY

|            |  |
|------------|--|
| 07/14/2025 | Special Investigation Intake<br>2025A0628007   |
| 07/17/2025 | Special Investigation Initiated - On Site  |
| 08/06/2025 | Contact - Document Sent<br>email sent to administrator requesting additional documentation   |
| 08/06/2025 | Contact - Document Received<br>email received with requested documentation   |
| 08/18/2025 | Contact - Document Sent<br>email sent to administrator requesting additional documentation   |
| 08/26/2025 | Contact - Document Sent<br>email sent to the administrator requesting additional<br>documentation. 2nd request for this documentation. |
| 08/27/2025 | Contact - Document Received<br>email received with requested documentation   |
| 09/30/2025 | Exit Conference<br>Conducted via email with Hemant Shah and Pamela Skatzka   |

### **ALLEGATION:**

**The facility won't allow Resident A to self-administer medications.**

## INVESTIGATION:

On 07/14/2025, the department received a complaint that alleged the facility entered the room of Resident A on 07/10/2025 and removed their medications.

On 07/17/2025, while onsite, I interviewed the administrator. The administrator reported that it was accurate that Employee #1 removed the medication from Resident A on 07/10/2025 and that the facility has been administering medications to Resident A since that time.

While onsite, I interviewed Employee #1. Employee #1 reported that they entered Resident A's apartment on 07/10/2025 and observed a bowl of mixed pills sitting in the sink. Employee #1 reported that Resident A could not identify which pills were in the bowl and didn't state why they were in the bowl. Employee #1 reported that they removed the medications from Resident A's room and updated the service plan to reflect that the facility would administer medications to Resident A. Employee #1 reported that they had not, as of 07/17/2025, completed a self-administration medication assessment with Resident A. Employee #1 also reported that they were unable to find a prior self-administration medication assessment completed and filed in Resident A's chart.

On 07/21/2025, I spoke with Resident A via telephone. Resident A reported that on 07/10/2025, someone came into their apartment and removed all their medications. Resident A reported that the staff member said Resident A couldn't give their own medications and that the facility would administer them. Resident A reported that they had never completed a competency to self-administer their medications.

On 07/22/2025, I spoke with the administrator via telephone. The administrator reported that Employee #1 attempted to do the self-administration medication assessment with Resident A, but Resident A was unable to complete the assessment.

On 08/27/2025, I received a copy of the facility's Medication Self-Administration policy and procedure. The facility's policy states:

- Each resident is offered the opportunity to self-administer medications. If the resident requests to do so, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medication is safe and clinically appropriate for the resident.
- The decision that a resident can safely self-administer medications is re-assessed periodically based on a significant change in the resident's status, decision-making status, and/or when a medication error occurs.

| <b>APPLICABLE RULE</b> |  |
|------------------------|--|
| <b>R 325.1921</b>      | <b>Governing bodies, administrators, and supervisors.</b>  |
|                        | <p><b>(1) The owner, operator, and governing body of a home shall do all of the following:</b></p> <p><b>(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.</b></p>   |
| <b>ANALYSIS:</b>       | <p>Through a review of the service plan, there was no documentation of a medication self-administration assessment being completed. Additionally, Resident A denied completing one and Employee #1 reported not completing one with Resident A at the time the medications were discovered and removed from Resident A's apartment.</p> <p>Employee #1 also reported Resident A's chart revealed no indication that a medication self-administration assessment had been completed previously. Although the facility did attempt to complete a medication self-administration assessment with Resident A on 07/22/2025, it was after this complaint was brought to their attention.</p> <p>Upon review of the facility's policy and procedure for Medication Self-Administration, it could not be determined that the facility followed their policy for assessing Resident A's ability to self-administer medications due to lack of documentation. Additionally, it was found that the facility did not have an organized process in place to periodically assess Resident A's ability to self-administer medications. Therefore, this allegation was substantiated.</p> |
| <b>CONCLUSION:</b>     | <b>VIOLATION ESTABLISHED</b>   |

**ALLEGATION:**

**The facility did not treat Resident A with respect and kindness.**

**INVESTIGATION:**

On 07/14/2025, the department received a complaint that the facility tried to force Resident A to take a shower when they didn't want to. It was also alleged that the staff threw some of Resident A's papers on the floor. Additionally, it was alleged that Resident A should be receiving physical therapy, but the facility is not providing it.

On 07/17/2025, I spoke with Employee #2 at the facility. Employee #2 reported that Resident A had therapy in the past, but they were discharged 04/01/2025 because they plateaued. Employee #2 reported that they are unable to screen Resident A and put them back on therapy because Resident A does not have a physician to give those orders and Resident A refused to appoint a physician over their care.

While onsite, I spoke with the administrator who was unaware of any staff forcing Resident A to take a shower. The administrator reported that Resident A will often refuse to do things when staff approaches and wants to do things on her own time, which changes from day to day. The administrator also reported that Resident A often will decline to let staff clean her apartment. The administrator reported no knowledge of staff throwing Resident A's papers on the floor. Additionally, the administrator reported that Resident A routinely has papers out on all surfaces in the apartment and perhaps some fell on the floor.

While onsite, I observed Resident A's apartment and noted no papers on the floor.

On 07/21/2025, when I spoke with Resident A via telephone, they reported that one month prior three staff members pushed Resident A's wheelchair into the bathroom and were going to force them to get a shower until another staff member intervened. Resident A reported that they only want to shower 1-2 times/week and only with "nice" people. Resident A could not provide any names of "nice" staff that would be acceptable to help with showers.

When I asked Resident A about appointing a doctor over their care in order to write orders for therapy, Resident A reported they didn't need a doctor and that they could write those orders themselves.

In discussing the papers that were allegedly thrown on the floor by staff, Resident A stated that a staff member threw some of Resident A's papers on the floor. Resident A could not recall when this occurred or which staff member threw the papers on the floor.

| <b>APPLICABLE RULE</b> |   |
|------------------------|---|
| <b>R 325.1931</b>      | <b>Employees; general provisions.</b>   |
|                        | <b>(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.</b> |

