RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

February 13, 2018

Ronald Paradowicz
Courtyard Manor Farmington Hills Inc.
3275 Martin
Suite 127
Walled Lake, MI 48390

RE: License #: AL630007354
Investigation #: 2018A0991010
Courtyard Manor Farmington Hills IV

Dear Mr. Paradowicz:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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) 975-5053.

Sincerely,

Kristen Donnay

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007354
Investigation #:	2018A0991010
Complaint Receipt Date:	01/09/2018
Investigation Initiation Date:	01/09/2018
Report Due Date:	03/10/2018
Licensee Name:	Courtyard Manor Farmington Hills Inc.
Licensee Address:	3275 Martin Suite 127 Walled Lake, MI 48390
Licensee Telephone #:	(248) 926-2920
Licensee Designee:	Ronald Paradowicz
Name of Facility:	Courtyard Manor Farmington Hills IV
Facility Address:	29780 Farmington Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-0104
Original Issuance Date:	04/06/1995
LicenseLicense **Status:**	REGULAR
Effective Date:	06/15/2016
Expiration Date:	06/14/2018
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There are mice in the building and the Director of Operations does not address the issue.	No
The building is unsanitary and cleaning supplies are not available to disinfect things as needed, causing residents and staff to be sick with cold symptoms.	No
The facility had no heat on 01/06/18 and 01/07/18. The residents were moved to another building during the day on 01/06/18, but returned to the building to sleep.	No

III. METHODOLOGY

01/09/2018	Special Investigation Intake 2018A0991010
01/09/2018	Special Investigation Initiated - Telephone Call to Adult Protective Services (APS) worker, Adam Plater
01/09/2018	APS Referral Referral received from Adult Protective Services (APS)
01/10/2018	Inspection Completed On-site Unannounced onsite inspection
01/10/2018	Contact - Document Received Maintenance documentation
01/12/2018	Contact - Document Received Boiler maintenance documentation
01/16/2018	Contact - Telephone call received From Resident A's guardian
01/17/2018	Exit Conference With administrator James Cubr

ALLEGATION:

There are mice in the building and the Director of Operations does not address the issue.

INVESTIGATION:

On 01/09/18, I received a complaint alleging that there are mice in the building and the Director of Operations has not addressed the issue other than placing traps around the furnace area. It was alleged that one of the residents caught lice from the mice. I initiated my investigation on 01/09/18 by contacting the assigned Adult Protective Services (APS) worker, Adam Plater. On 01/10/18, Mr. Plater and I conducted an unannounced onsite inspection at Courtyard Manor Farmington Hills IV.

On 01/10/18, I interviewed the Director of Operations, Belinda Whitfield. Ms. Whitfield indicated that they have had issues with mice in the past; however, they have a contract with Eradico, a pest control company, to address the issue. Eradico comes to the facility at least once a month or more often if necessary to address any pest issues. Eradico placed large mouse bait stations around the perimeter of the courtyard outside to prevent the mice from coming inside. Ms. Whitfield was not aware of any resident catching lice from mice in the home.

On 01/10/18, I interviewed the Director of Nursing, Carol Ward. Ms. Ward indicated that one of the residents was treated for lice in October; however, there was no indication that this was transmitted from mice in the home.

On 01/10/18, I interviewed direct care workers Karen Walton and Partina Palmer. Ms. Walton and Ms. Palmer both indicated that the pest control company comes out at least once a month to put out bait and traps. Ms. Walton stated that there was an issue with mice during the summer months, but it was addressed promptly. Ms. Palmer indicated that she never observed any mice or droppings in the home.

On 01/10/18, I walked through the facility and did not observe and mice or mouse droppings. I observed the bait boxes that were placed in the courtyard to prevent mice from entering the home.

On 01/16/18, I interviewed Resident A's guardian. He indicated that he visits the home on an almost daily basis. He stated that there was an issue with mice in the home during the summer months and a mole once got into the home, but the facility had a company come out to take care of these issues. He had no concerns with regards to how the facility handles pest control.

During the onsite inspection, Ms. Whitfield provided copies of the summary of service statements from Eradico Pest Services. Eradico came to the home on 10/27/17, 11/09/17, and 12/07/17 for preventative services. The reports from 10/27/17 and

11/09/17 addressed problems with insects. The report from 12/07/17 stated that one mouse was caught on a glue board in the kitchen and droppings were seen as well. The technician indicated that he believed the mice were coming from the inner courtyards. He replaced the glue boards and added two stations in the courtyard.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	Based on the information gathered through my interviews and onsite investigation, there is insufficient information to conclude that the facility is not maintaining a pest control program to protect the health of the residents. The facility has a contract with Eradico to address any pest control issues. Eradico comes to the home on a monthly basis and has placed traps both inside and outside of the home to target mice and prevent them from entering the facility. While one of the residents did have lice, there is no information to support that this was caused by mice in the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The building is unsanitary and cleaning supplies are not available for staff to disinfect things as needed, causing residents and staff to be sick with cold symptoms.

INVESTIGATION:

On 01/10/18, I interviewed the Director of Operations, Belinda Whitfield. Ms. Whitfield indicated that they have housekeepers on staff who clean the home every day and direct care staff are also responsible for cleaning the resident's bedrooms and bathrooms. The day shift cleans the even numbered rooms and the afternoon shift cleans the odd numbered rooms. Cleaning supplies are kept in the laundry room in the building. She never received any complaints from staff indicating that they did not have the cleaning supplies necessary to disinfect the home. Ms. Whitfield never observed any issues with unsanitary conditions in the home. Ms. Whitfield indicated that a stomach bug had been going around; however, it is cold and flu season so she did not attribute this to unsanitary conditions in the facility. Ms. Whitfield provided copies of the

housekeeping duties and day/afternoon shift job duties which outline the assigned cleaning tasks for staff.

On 01/10/18, I interviewed direct care workers Karen Walton and Partina Palmer. Ms. Walton and Ms. Palmer both indicated that the home is always clean and they did not have any concerns regarding unsanitary conditions. The housekeeper splits her time between the buildings, but does a good job cleaning the common areas. Direct care staff are responsible for cleaning the resident's bedrooms. The even numbered rooms are cleaned by morning staff and the odd numbered rooms are cleaned by afternoon staff. Ms. Walton and Ms. Palmer stated that all staff do a good job of cleaning the home and they always have the needed supplies. Ms. Walton stated that they have to ask housekeeping staff if they need to use bleach, as only the housekeeper has access to the bleach, but they do get it once they ask.

On 01/10/18, I observed the facility's common areas, dining room, resident bedrooms, and bathrooms. The facility appeared to be clean and smelled like disinfectant. I observed the laundry room and saw adequate cleaning supplies. There were dispensers on the wall that contained cleaning solutions.

On 01/16/18, I interviewed Resident A's guardian. He did not have any concerns regarding the cleanliness of the facility and never observed unsanitary conditions in the home.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based on the information gathered through my interviews and onsite inspection, there is insufficient information to conclude that the facility is not maintaining appropriate housekeeping standards. During my unannounced onsite inspection, the home was comfortable, clean, and orderly in appearance. The Director of Operations and staff who were interviewed indicated that the housekeepers and direct care staff adhere to a cleaning schedule to ensure the home is clean and safe for the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility had no heat on 01/06/18 and 01/07/18. The residents were moved to another building during the day on 01/06/18, but returned to the building to sleep.

INVESTIGATION:

On 01/10/18, I interviewed the Director of Operations, Belinda Whitfield. Ms. Whitfield indicated that the building did have heat; however, they were in the process of getting the boilers repaired. The repairs were expected to be completed by the end of the day on 01/10/18. The residents did go to another building during the day, but Ms. Whitfield did not know why. She was not aware of any of the residents complaining that it was cold in the building.

On 01/10/18, I interviewed maintenance worker, Joe Cubr. Mr. Cubr staated that there are four boilers in each building, but only three boilers are needed to heat the building. The fourth boiler functions as a backup. The maintenance department completes daily checks on the boilers and noticed on 01/04/18 that one of the boilers was not working. HVAC Pro, a heating and cooling company, was contacted and came out the same day to work on the boiler. Mr. Cubr stated that the temperature dropped a few degrees in the home, but this was also due to the extreme cold weather.

On 01/10/18, Ms. Whitfield provided a copy of the service order invoice from HVAC Pro dated 01/04/18. The invoice states, “Bad ignitor module, replaced control boiler. Cycles ok- boiler 3. Boiler 4 needs flue dampener replaced. Unit cycles ok.”

On 01/10/18, I interviewed direct care worker, Karen Walton. Ms. Walton stated that she was aware that there was an issue with the boiler during the previous week. The heat in the home was working, but the thermostat was turned up to 90°F and the home was heated to 70°F. She indicated that she heard the home was colder on Saturday and Sunday 01/06/18 and 01/07/18; however, she was not working.

On 01/10/18, I interviewed direct care worker, Partina Palmer. Ms. Palmer stated that she worked during the weekend on 01/06/18 and 01/07/18. The facility was cold on Saturday and the residents were moved to building #3 during the day and ate dinner at the other facility. She stated that the temperature in the home on 01/06/18 was in the upper 60s and never went below that. On Sunday, 01/07/18, they put plastic over the windows and the home maintained a temperature of 70°F, but the dining room was slightly colder.

During the onsite inspection, I observed the thermostats in the home, which showed a temperature of 74°F. I attempted to interview Resident A on 01/10/18; however, she was unable to answer questions due to advanced dementia.

On 01/12/18, I received a copy of a service order invoice from HVAC Pro indicating that the repairs on the boiler were complete.

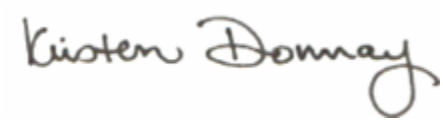
On 01/16/18, I interviewed Resident A's guardian. He indicated that he did visit the facility over the weekend on 01/06/18 and 01/07/18. The facility was colder than normal and the residents were moved to another building during the day on Saturday. He did not know how cold it was in the facility, but stated that some staff were wearing their jackets. Resident A's guardian stated that they were in the process of fixing the boiler and they began making repairs right away. He did not have concerns with regards to how the facility addressed this issue.

On 01/17/18, I completed an exit conference with the administrator, James Cubr. Mr. Cubr did not have any additional information regarding the investigation.

APPLICABLE RULE	
R 400.15406	**Room temperature.**
	All resident-occupied rooms of a home shall be heated at a temperature range between 68 and 72 degrees Fahrenheit during non-sleeping hours. Precautions shall be taken to prevent prolonged resident exposure to stale, non-circulating air that is at a temperature of 90 degrees Fahrenheit or above. Variations from the requirements of this rule shall be based upon a resident's health care appraisal and shall be addressed in the resident's written assessment plan. The resident care agreement shall address the resident's preferences for variations from the temperatures and requirements specified in this rule.
ANALYSIS:	Based on the information gathered through my interviews and onsite inspection, there is insufficient information to conclude that resident-occupied rooms were not heated to a range of 68°F and 72°F during non-sleeping hours on 01/06/18 and 01/07/18. One of the boilers in the home was not functioning properly; however, staff indicated that the home was still heating to nearly 70°F. A heating and cooling company was immediately contacted to address the issues with the boiler and the residents were moved to another building when the temperature dropped.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

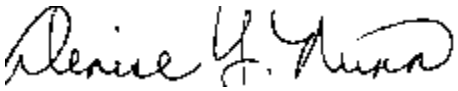
I recommend no change to the status of the license.



01/16/18

Kristen Donnay Date
Licensing Consultant

Approved By:



02/13/2018

Denise Y. Nunn Date
Area Manager