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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 25, 2021

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

RE: License #: AL630007351
Investigation #: 2021A0602023
Courtyard Manor Farmington Hills I

Dear Mr. Paradowicz:

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 (248) 975-5053.

Sincerely,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007351
Investigation #:	2021A0602023
Complaint Receipt Date:	05/14/2021
Investigation Initiation Date:	05/14/2021
Report Due Date:	07/13/2021
Licensee Name:	Courtyard Manor Farmington Hills Inc
Licensee Address:	3275 Martin, Suite 127 Walled Lake, MI 48390
Licensee Telephone #:	(248) 926-2920
Administrator:	Ronald Paradowicz
Licensee Designee:	Ronald Paradowicz
Name of Facility:	Courtyard Manor Farmington Hills I
Facility Address:	29750 Farmington Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-0104
Original Issuance Date:	01/19/1993
License Status:	REGULAR
Effective Date:	11/28/2020
Expiration Date:	11/27/2022
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The assisted living facility often has staffing issues. There are times they have one staff member to 13 adults. The director of operations, Belinda Whitfield, is not scheduling staff correctly.	Yes
On 4/21/2021, Resident C tested positive for COVID-19 and was transported to Beaumont Hospital-Farmington Hills. Resident C was not allowed to return to the facility because he was COVID-19 positive.	No

III. METHODOLOGY

05/14/2021	Special Investigation Intake 2021A0602023
05/14/2021	APS Referral Adult Protective Services (APS) referral denied.
05/14/2021	Special Investigation Initiated - Telephone Call made to Adult Protective Services
05/28/2021	Inspection Completed On-site Received requested documents
06/28/2021	Contact – Telephone call made Interviewed Staff Member #2
06/28/2021	Contact – Telephone call made Interviewed Staff Member #3
07/21/2021	Inspection Competed On-site Interviewed the Executive Director, Jim Cubr, the charge nurse, Marlene Jones and received staff schedules for the months of April, May, June, and July 2021.
07/22/2021	Contact – Telephone call made Interviewed Staff Member #5
07/23/2021	Contact – Face to face Met with Jim Cubr to pick up documents regarding Resident C.

07/28/2021	Contact – Telephone call made Interviewed Staff Member #4
08/04/2021	Contact – Documents received Resident registry.
08/13/2021	Contact – Document sent Email sent to Jim Cubr requesting discharge notice for Resident C.
08/13/2021	Contact – Document sent Email sent to Resident C's family member.
08/25/2021	Exit conference Message left for the licensee designee, Ronald Paradowicz.

ALLEGATION:

The assisted living facility often has staffing issues. There are times they have one staff member to 13 adults. The Director of Operations, Belinda Whitfield, is not scheduling staff correctly.

INVESTIGATION:

On 5/14/2021, a complaint was received and assigned for investigation alleging that the facility often has staffing issues. There are times they have one staff member to 13 adults. The Director of Operations, Belinda Whitfield, is not scheduling staff correctly. On 4/21/2021, Resident C tested positive for COVID-19 and was transported to Beaumont Hospital-Farmington Hills. Resident C was not allowed to return to the facility because he was COVID-19 positive.

On 5/28/2021, I conducted an unannounced on-site investigation at which time I spoke with the Director of Operations, Belinda Whitfield and received copies of the resident registry for all four buildings. Ms. Whitfield stated she is responsible for creating the staff schedules for all and four buildings. If a staff member does not show up for their scheduled shift, it is her responsibility to find a replacement staff.

On 6/28/2021, I interviewed Staff Member #2 (who requested to remain anonymous) by telephone. Staff Member #2 stated the facility is often short staffed. There was an incident (exact date unknown) when there were three staff members scheduled to work in four buildings leaving one building without any staff. There was a supervisor on shift, but the supervisor was not assigned to a specific building. The supervisor was rotating in all four buildings. Staff Member #2 could not recall what building this took place in.

On 6/28/2021, I interviewed Staff Member #3 (who requested to remain anonymous) by telephone. Staff Member #3 stated the there was an incident when there was one staff member working in a building with 14 residents. Staff Member #3 said there should be at least two staff members working with 14 residents for staff to monitor each of them sufficiently. Staff Member #3 could not recall the date this occurred or the building it occurred in.

On 7/21/2021, I conducted another unannounced on-site investigation at which time I interviewed the Executive Director, Jim Cubr, the charge nurse Marlene Jones, and reviewed staff schedules for the months of April, May, June, and July 2021. Mr. Cubr stated the Director of Operations, Belinda Whitfield was responsible for scheduling staff for all four buildings. If a staff member did not show up for their shift, Ms. Whitfield was responsible for finding another staff member to work the shift or she had to work the shift themself. Ms. Whitfield is no longer responsible for scheduling staff members. Mr. Cubr stated the company has implemented a new system where Buildings #1 and #2 will be assigned a supervisor and Buildings #3 and #4 will be assigned a different supervisor. Each supervisor will be responsible for creating a staff schedule for the two buildings they are assigned, and staff members will be assigned to work in a specific building. Ms. Whitfield will be responsible for overseeing the two supervisors rather than all employees and each supervisor will be responsible for overseeing the employees assigned to their buildings.

On 7/21/2021, Ms. Jones stated she is a charge nurse (registered nurse, RN) for the company. She was considering taking on the position of Director of Nursing but decided not to accept it. The company recently hired more registered nurses and she is looking forward to the additional help.

On 7/22/2021, I reviewed the staff schedules for April, May, June, and July 2021. According to the schedules, there were quite a few staff members who called in sick, or were a no call, no show for the month of April 2021. Some of the schedules did not contain the building number in which staff worked making it difficult to determine exactly how many staff were assigned to each building. The schedules documented that there was a supervisor scheduled on each shift (day, afternoon, and midnight) but not assigned to a specific building. There were also two to three medication technicians that were scheduled daily, but again not assigned to a specific building.

On 7/22/2021, I interviewed Staff Member #5 by telephone (requested to remain anonymous). Staff Member #5 stated there seems to be a staffing issue during the afternoon and midnight shifts. There have been instances where only one staff member would be on shift in each building with one of the buildings containing 14 residents. There would be one supervisor to monitor all four buildings. This would make it seem as if there were two staff members working per building, but this was not the case. Staff Member #5 stated the facility is absolutely understaffed and it is believed if there were more staff on shift, resident falls would be reduced significantly because staff would be able to monitor the residents more closely.

On 7/28/2021, I interviewed Staff Member #4 by telephone (requested to remain anonymous). Staff Member #4 stated there have been times when there is only one staff member working in each building during the midnight shift, but this is not a daily occurrence. When the census was low (because of COVID-19), it was not an issue for one staff member per building to be on a shift.

On 7/29/2021, I interviewed Staff Member #6 by telephone (requested to remain anonymous). Staff Member #6 stated another staff member said she was going to call the state and make a complaint but really did not have a basis to make a complaint. Staff Member #6 said it is believed that this staff member was trying to get the supervisor in trouble for unknown reasons. Staff Member #6 could not give specific examples of the other staff members issues but said she was constantly in other staff members business. Staff Member #6 felt the need to report that possible false complaints were being made to the department.

On 8/04/2021, I received and reviewed a copy of the resident registry for all four buildings. According to the registries, as of 8/04/2021 there are 11 residents residing in Building #1, no residents in Building #2, 12 residents in Building #3, and 14 residents in Building #4.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	Based on the information obtained during the investigation, I was unable to determine the exact number of staff members working in each building as the staff schedules did not document this information sufficiently. Although there appears to be at least one staff member working during the day, afternoon, and midnight shifts, it is difficult to determine exactly what buildings some of the staff worked. Staff members #2, #3, and #5 were unable to provide exact dates and times as to when there was only one staff member working and the exact building where this took place. Therefore, it is unknown if insufficient staffing occurred when the census was low and one staff member was sufficient to meet the needs of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the information obtained from Staff Members #2, #3, #4 and #5, the facility has been short staffed with one staff member working per building on some shifts. When the census is low this is not an issue. However, Staff Member #5 stated it is difficult for one staff member to meet the needs of 14 residents with a floating supervisor and a floating medication technician.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 4/21/2021, Resident C tested positive for COVID-19 and was transported to Beaumont Hospital-Farmington Hills. Resident C was not allowed to return to the facility because he was COVID-19 positive.

INVESTIGATION:

On 7/22/2021, I interviewed Jim Cubr and Marlene Jones at the facility regarding Resident C. Mr. Cubr stated Resident C's resident record was no longer at the facility and he would have to go to the corporate office to retrieve it. Ms. Jones stated she would have to look at Resident C's file to provide specific information regarding the care he received while at the facility.

On 7/23/2021, I received and reviewed Resident C's nurse's notes dated 3/18/2021 thru 4/21/2021, discharge policy signed and dated 3/18/2021, Open Arms Hospice admission paperwork dated 3/31/2021 and durable power of attorney for health care. According to the nurse's notes, Resident C was admitted to the facility on 3/18/2021, and was petitioned in the hospital for mental health treatment on this same date due to combative behaviors, breaking a window and attempting to elope from the facility. Resident C returned to the facility on 3/22/2021. On 3/23/2021, Resident C retrieved a rock from the courtyard and threw it through a window causing the window to break.

Resident C became combative with staff and was transported back to the hospital. On 3/31/2021, Resident A returned to the facility. On 4/05/2021, Resident A was experiencing diarrhea. A COVID-19 test was administered and returned a negative result. On 4/21/2021, Resident C was experiencing shortness of breath and difficulty breathing. A COVID-19 rapid test was administered and returned a positive result. Resident C was transported to Beaumont Hospital where he was admitted. This was the last nurse's note entry for Resident C. The facility was not informed of a forwarding address for Resident C. On 8/13/2021 I sent an email to Resident C's family requesting a response. As of this date, I have not received a response.

On 8/13/2021, I sent an email to Jim Cubr requesting a copy of the discharge notice Resident C was given. Mr. Cubr stated Resident C was not issued a discharge notice but did not return to the facility after his hospitalization on 4/21/2021. He said Resident C's family was never informed by anyone from Courtyard Manor of Farmington Hills that he could not return to the facility because he was COVID positive. Courtyard Manor of Farmington Hills utilized Building #2 as the COVID building. Any resident who tested positive were moved to Building #2 until they had a negative test result. Mr. Cubr stated that no resident was turned away due to COVID-19.

On 8/25/2021, I left a voicemail message for the licensee designee, Ronald Paradowicz informing him of the investigative findings and recommendation documented in this report.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provision of the act.
ANALYSIS:	Based on the documentation reviewed and the information received from Mr. Cubr, Resident C was not issued a discharged notice and was not told he could not return to the facility because he was COVID-19 positive. Resident C did not return to the facility and there was no forwarding address provided.
CONCLUSION:	VIOLATION NOT ESTABLISHED

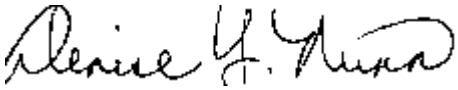
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

08/25/2021

Cindy Berry — Date
Licensing Consultant

Approved By:



08/25/2021

Denise Y. Nunn — Date
Area Manager