GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 21, 2021

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

RE: License #: AL630007352
Investigation #: 2022A0991005
Courtyard Manor Farmington Hills II

Dear Mr. Paradowicz:

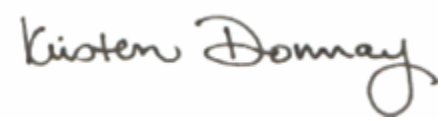
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007352
Investigation #:	2022A0991005
Complaint Receipt Date:	11/05/2021
Investigation Initiation Date:	11/08/2021
Report Due Date:	01/04/2022
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 II
Facility Address:	29760 Farmington Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-0104
Original Issuance Date:	08/25/1993
License Status:	REGULAR
Effective Date:	06/15/2020
Expiration Date:	06/14/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 11/04/21, Resident A was assaulted by staff, Michelle. Resident A and Michelle were involved in a verbal altercation. Michelle pushed Resident A to the ground and started kicking him in the abdomen and legs. Resident A has a quarter size injury on his knee that was bleeding.	No
Additional Findings	Yes

III. METHODOLOGY

11/05/2021	Special Investigation Intake 2022A0991005
11/05/2021	APS Referral Received from Adult Protective Services (APS) - denied for investigation
11/08/2021	Special Investigation Initiated – Telephone Call to Belinda Whitfield, director of operations
11/08/2021	Contact - Telephone call made Left message for responding officer
11/10/2021	Inspection Completed On-site Interviewed staff and residents
11/10/2021	Contact - Document Received Received assessment plan and staff list
12/20/2021	Contact - Telephone call made Interviewed staff, Michelle Jackson
12/20/2021	Contact - Telephone call made Call to staff, Lashantia Johnson- voicemail full
12/20/2021	Contact - Telephone call made Interviewed staff, Shante Davis

12/20/2021	Contact - Telephone call made Interviewed staff, Carrie Travis
12/20/2021	Contact - Telephone call made Interviewed behavioral health specialist, Tynese Vinson, LMSW
12/21/2021	Exit Conference Left message for licensee designee, Ronald Paradowicz

ALLEGATION:

On 11/04/21, Resident A was assaulted by staff, Michelle. Resident A and Michelle were involved in a verbal altercation. Michelle pushed Resident A to the ground and started kicking him in the abdomen and legs. Resident A has a quarter size injury on his knee that was bleeding.

INVESTIGATION:

On 11/08/21, I received a complaint from Adult Protective Services (APS) alleging that on 11/04/21, Resident A was physically assaulted by staff, Michelle. The complaint indicated that Resident A and Michelle were engaged in a verbal altercation, which escalated and resulted in Michelle pushing Resident A to the ground and kicking him in the abdomen and legs. Resident A had a quarter-sized injury on his knee that was bleeding. Resident A has a history of multiple surgeries on his legs and cannot walk without the assistance of a walker. The complaint was denied for investigation by APS.

I initiated my investigation on 11/08/21 by contacting the Director of Operations for Courtyard Manor, Belinda Whitfield. Ms. Whitfield indicated that that accused staff, Michelle Jackson, was removed from the schedule pending the investigation. She stated staff reported that Resident A was trying to attack Ms. Jackson with his walker and he fell in the process. She was not aware of Ms. Jackson hitting, kicking, or pushing Resident A to the ground.

On 11/10/21, I conducted an unannounced onsite inspection. I spoke with Belinda Whitfield. She indicated that Courtyard Manor conducted an internal investigation into the incident and did not have any findings of wrongdoing. Ms. Whitfield indicated that Resident A has a history of aggressive behavior and receives behavioral health services through PACE. She stated that Resident A's behavioral health specialist through PACE, Tynese Vinson, could provide additional information. Ms. Whitfield provided a copy of Resident A's assessment plan dated 10/11/2021. The plan notes that Resident A controls his aggressive behavior at times, but has behaviors of hitting staff with his walker and fighting staff.

On 11/10/21, I interviewed the charge nurse, Rosalind Terry. Ms. Terry is a licensed practical nurse (LPN) and has worked at Courtyard Manor for two weeks. She stated that on 11/04/21, she was in her office with the door open. She heard a commotion and

yelling, so she looked up. She saw an altercation between Resident A and staff, Michelle Jackson. She stated that she saw Ms. Jackson holding Resident A's wrists. They both turned and Resident A fell to the ground. Ms. Jackson was holding Resident A's wrists when he fell. Ms. Jackson took what was in Resident A's hands after he was on the ground. Ms. Terry believed it was the remote for the television. Ms. Terry stated that she went into the common area and asked Ms. Jackson to leave. Ms. Jackson stated that she was trying to stop Resident A from attacking her. Ms. Terry stated that she did not see Resident A charge at Ms. Jackson, and she did not see him threatening anyone with his walker. She indicated that she did not see the beginning of the incident, because she looked up after she heard the commotion. She could not tell who was yelling. She did not see Ms. Jackson kick Resident A or hit him when he was on the ground. Ms. Terry indicated that Resident A had a skin tear on his knee. He refused medical treatment. Resident A called 911 from his iPad. When the police arrived, Resident A stated that he was attacked and beat up. Ms. Terry stated that it is a known behavior for Resident A to be aggressive and try to swing at staff. Staff should remove themselves from the situation. Residents should not be physically restrained.

On 11/10/21, I interviewed Resident A. Resident A stated that he remembered one night when staff "got a little rough" with him. He stated that staff knocked him down on the carpet. He could not recall when this happened, and he did not know the names of the staff who were involved. He stated that it was "a couple of big guys" and one woman. Resident A stated that his legs got torn up and he had scrapes on both knees. Resident A stated that staff grabbed him from behind and put their arms around his neck. He stated that one time he was laying on the floor and staff kicked him everywhere. He just laid there and let them do whatever they wanted. Resident A stated that he tries to mind his own business, but he can have a temper sometimes.

On 11/10/21, I interviewed Resident B. Resident B stated that she recalled Resident A having a "scuffle" with staff a few days ago. She stated that Resident A can be very combative. It took several staff to calm him down. She did not know if staff put their hands on Resident A. She stated that "arms were going everywhere." Resident B stated that Resident A was on the floor. He was using bad language. She did not know what started the incident. She did not see anyone kick Resident A or put him in a chokehold. Resident B did not know which staff were involved. She stated that all of the staff are nice to her and she does not have issues with any of the staff in the home.

On 11/10/21, I interviewed Resident C. Resident C stated that Resident A can be violent. He cusses and throws things. Resident C stated that she saw staff drag Resident A to his room. She did not know when this happened or which staff were involved.

On 12/20/21, I interviewed direct care worker, Michelle Jackson, via telephone. Ms. Jackson stated that on 11/04/21, she was in the dining area cleaning up after dinner. She heard a commotion in the front room, so she went to see what was happening. She saw Resident D storm off towards his room. She did not say anything to Resident D and things calmed down. She was standing by the television and another resident told her

that Resident D got mad about the TV. She told the residents that they must share the TV in the common area. She was turning something on for them to watch when Resident A ran up on Ms. Jackson and began swinging his walker at her. As Resident A was swinging his walker, he fell. Ms. Jackson stated that she tried to help Resident A up, but he was in a rage and kept coming after her. He lost his balance a few times and fell back down. Ms. Jackson screamed for help and the nurse, Rosalind, and staff, Shante, came to help.

Ms. Jackson stated that during the altercation, she was holding her hands up to protect herself. She never pushed Resident A or physically restrained him. She stated that she did try to grab his hands as he was falling, so that he would not hit the floor too hard. She never kicked, hit, or put Resident A in a chokehold. Ms. Jackson stated that she did not yell or swear at Resident A. She indicated that she is a very calm person and remained calm during the interaction with Resident A, except when she was calling for help. Staff came to assist Ms. Jackson, but they were not there when the incident began. Ms. Jackson indicated that this incident happened out of the blue. Resident A was fairly new to the home, and she never witnessed aggressive behavior from him prior to this incident. Following the incident, Resident A contacted the police and stated that he hurt his legs. Ms. Jackson did not observe the injuries on Resident A's legs. She stated that the area where Resident A fell is carpeted and it is possible he scraped his legs when he fell. Ms. Jackson indicated that she never saw any other staff person being physically aggressive towards Resident A. She never saw anyone physically restrain Resident A, put him in a chokehold, or drag him to his room. She did not have any concerns about any of the other staff in the home. Ms. Jackson stated that Resident A is very strong, and it would be difficult for female staff to restrain him.

On 12/20/21, I interviewed staff, Shante Davis, via telephone. Ms. Davis indicated that she has worked in the home for approximately four months. On 11/04/21, the residents were coming back from dinner and were in the TV area. Resident D got upset about the television, turned it off, and stormed off to his room. Staff, Michelle Jackson, came up to the front room to see what the commotion was about. Another resident asked Ms. Jackson to turn the TV back on. As Ms. Jackson was turning on the TV, Resident A got upset. He began yelling, swearing, and threatening to tear the TV off the wall. Resident A was ramming his walker into Ms. Jackson. She held onto his walker to get him to stop. Resident A also tried to hit Ms. Jackson over the head with a travel coffee mug. Hot coffee was spilling on Ms. Jackson, so she shook his hand to get him to drop the mug. Ms. Davis then saw Resident A charging at Ms. Jackson with his walker. Ms. Jackson stepped to the side, and Resident A fell. Ms. Davis indicated that Ms. Jackson never put her hands on Resident A or tried to restrain him. She was not angry with Resident A. She was trying to deescalate the situation and protect herself. Ms. Davis indicated that the nurse, Rosalind, was in her office the whole time and did not try to intervene. The nurse eventually came out of her office and told Ms. Jackson that she could not be hitting the residents. Ms. Davis stated that Ms. Jackson never hit Resident A. Resident A called the police after the incident from his iPad. One of the officers stated that Resident A's leg was bleeding. Ms. Davis stated that this likely happened when Resident A fell during the incident. She stated that he kept falling because his

balance is off. He had his walker over his head and was trying to charge at Ms. Jackson. He fell at least three times. Ms. Davis stated that Resident A has issues with his legs. His legs are frequently swollen and his skin tears easily. Ms. Davis stated that she has worked shifts with Ms. Jackson previously and she does not have any concerns about her interactions with the residents. Ms. Jackson is very calm and respectful towards the residents. Ms. Davis stated that Resident A was cussing and being disrespectful and physically aggressive during the incident. This is a known behavior for Resident A. Staff are supposed to verbally deescalate the situation by talking to Resident A in a calm, reassuring manner. Ms. Davis never saw any staff being physically aggressive towards Resident A. She never saw anyone kick, hit, drag, restrain, or put Resident A in a chokehold.

On 12/20/21, I interviewed the med tech, Carrie Travis. Ms. Travis has worked for Courtyard Manor for nine years. Ms. Travis indicated that she was working on 11/04/21, but she was not in building #2 when the incident occurred. She stated that Ms. Jackson came over and spoke with her after the incident. Ms. Jackson told Ms. Travis that Resident A was attacking her with his walker, and she was trying to get away and get him to put his walker down. Ms. Travis stated that Ms. Jackson has worked at Courtyard Manor for five years and it is not in her character to be physically aggressive towards any of the residents. She stated that she has never witnessed Ms. Jackson putting her hands on any of the residents or getting upset. Ms. Travis stated that when residents are being physically aggressive, staff are supposed to walk away and verbally deescalate the situation. They are not allowed to use physical restraint. Ms. Travis stated that following the incident, she went to building #2. She observed abrasions on Resident A's legs. She believed these injuries occurred when Resident A fell during the altercation. Ms. Travis stated that she has never witnessed any staff person being physically aggressive towards Resident A or any other residents. She did not have any concerns about any of the staff in the facility.

On 12/20/21, I interviewed Resident A's behavioral health specialist from PACE, Tynese Vinson, LMSW. Ms. Vinson stated that she was aware of the incident that occurred on 11/04/21. She stated that this is not the first time that Resident A has attempted to use his walker as a weapon. He has done this several times at PACE and at the nursing home where he was residing prior to moving into Courtyard Manor. Resident A would use his walker to strike staff. Resident A is often triggered by little things, like being told "no" by staff. Ms. Vinson indicated that following the incident, she went to Courtyard Manor to observe Resident A, his behaviors, and the way staff interacted with Resident A. She stated that she stayed at the facility for a couple of hours and did not have any concerns with regards to the way staff interacted with Resident A. Resident A had an outburst during her visit and staff were appropriate in redirecting Resident A to his room. Staff are supposed to verbally deescalate the situation and redirect Resident A when he is being aggressive. They are not allowed to use physical restraint. Ms. Vinson stated that she did not have any concerns about the staff at the facility or their interactions with Resident A. She was very satisfied and felt that they were appropriate. Ms. Vinson indicated that Resident A is diagnosed with paranoid schizophrenia and has a history of making false reports. He previously had a tablet device similar to an iPad, which he was

supposed to use for therapy appointments or to contact PACE. Resident A was using the tablet to call the police. He contacted the police 17 times, stating that he had been kidnapped and was being held against his will at Courtyard Manor. Ms. Vinson indicated that she took the device from Resident A, as he lacked insight into what it was supposed to be used for and was contacting the police when it was not warranted.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that staff, Michelle Jackson, was physically aggressive towards Resident A. The information provided by Resident A and the other residents who were interviewed was inconsistent. Resident A was being physically aggressive towards Ms. Jackson and attempted to hit her with his walker. Ms. Jackson indicated that she was protecting herself and did not push, kick, or physically restrain Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the investigation, I reviewed a copy of Resident A's assessment plan dated 10/11/2021. The plan indicates that Resident A controls his aggressive behavior at times, but he has behaviors of hitting staff with his walker and fighting staff. There is a note added to the assessment plan on 11/05/21, which indicates that a care conference was held with the behavioral health specialist from PACE, Tynese Vinson. It states that due to aggressive behavior, Resident A is to see the psychiatrist, Dr. Ruza, and receive medication treatment if/when needed. The assessment plan does not contain any further information with regards to what interventions staff are supposed to use when Resident A is having aggressive behaviors.

During the investigation, all of the staff who were interviewed indicated that it was a known behavior for Resident A to be aggressive at times and use his walker as a weapon. They stated that they are not supposed to use physical restraint and are supposed to verbally redirect Resident A and deescalate the situation. These interventions were not specified in Resident A's written assessment plan.

On 12/21/21, I contacted the licensee designee, Ronald Paradowicz, via telephone to conduct an exit conference. Mr. Paradowicz was not available, so I left a voicemail message.

APPLICABLE RULE	
R 400.15307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A's written assessment plan does not include information about interventions to address unacceptable behaviors. A note was added following the incident on 11/04/21, which indicates that Resident A will receive medication treatment and psychiatric services; however, there are no steps outlined for staff to follow if Resident A is being aggressive or hitting staff with his walker. This was a known behavior that Resident A had prior to his placement at Courtyard Manor.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

12/21/2021

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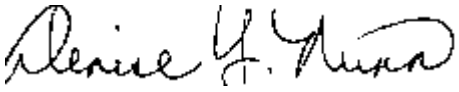
Kristen Donnay Date
Licensing Consultant

Approved By:



12/21/2021

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Denise Y. Nunn Date
Area Manager