GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 12, 2022

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

RE: License #: AL630007351
Investigation #: 2023A0605004
Courtyard Manor Farmington Hills I

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,

Frodet Dawisha

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL630007351 |
| | |
| **Investigation #:** | 2023A0605004 |
| | |
| **Complaint Receipt Date:** | 11/01/2022 |
| | |
| **Investigation Initiation Date:** | 11/02/2022 |
| | |
| **Report Due Date:** | 12/31/2022 |
| | |
| **Licensee Name:** | Courtyard Manor Farmington Hills Inc |
| | |
| **Licensee Address:** | Suite 127<br>3275 Martin<br>Walled Lake, MI 48390 |
| | |
| **Licensee Telephone #:** | (248) 926-2920 |
| | |
| **Administrator:** | James Cubr |
| | |
| **Licensee Designee:** | Ronald Paradowicz |
| | |
| **Name of Facility:** | Courtyard Manor Farmington Hills I |
| | |
| **Facility Address:** | 29750 Farmington Road<br>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<br>AGED/ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A is wheelchair bound and on 10/30/2022 he suffered a broken nose. Staff stated that Resident A fell without any detail and was sent to hospital. Resident A has six red dime sized bruises and cuts above his nose, on the nose, under the eye and eyebrow and forehead. There are concerns that Resident A is having a negative reaction to his prescribed medications. | No |
| Resident A wears briefs for extended periods of time and is not changed regularly. | No |

## III. METHODOLOGY

| | |
|---|---|
| 11/01/2022 | Special Investigation Intake<br>2023A0605004 |
| 11/02/2022 | APS Referral<br>Adult Protective Services (APS) made referral. |
| 11/02/2022 | Special Investigation Initiated - Telephone<br>Left message for APS worker Heather Goodin. |
| 11/02/2022 | Contact - Telephone call made<br>Discussed allegations with Resident A's relative 1. |
| 11/03/2022 | Inspection Completed On-site<br>I conducted an unannounced on-site investigation. I interviewed the administrator, Jim Cubr, registered nurse Marlene Jones, direct care staff (DCS) Kanard Daniel, Shameta McGee, supervisor Tasha Williams, Resident A, and Resident B. |
| 11/03/2022 | Contact - Telephone call made<br>I interviewed Resident A's Relative 1. |
| 12/01/2022 | Contact - Telephone call received<br>Discussed allegations with APS Heather Goodin. |
| 12/12/2022 | Contact - Telephone call made<br>Discussed allegations with Resident A's guardian and with medication technician Sharon Wiggins. |

| | |
|---|---|
| 12/12/2022 | Exit Conference<br>Conducted the exit conference with licensee designee Ron Paradowicz. |

**ALLEGATION:**

**Resident A is wheelchair bound and on 10/30/2022 he suffered a broken nose. Staff stated that Resident A fell without any detail and was sent to hospital. Resident A has six red dime sized bruises and cuts above his nose, on the nose, under the eye and eyebrow and forehead. There are concerns that Resident A is having a negative reaction to his prescribed medications.**

**INVESTIGATION:**

On 11/02/2022, intake #191428 was referred by Adult Protective Services regarding Resident A suffered a broken nose with dime sized bruises and cuts above his nose, on his nose, under his eye and eyebrow and on his forehead. Resident A is having negative reaction to prescribed medications.

On 11/02/2022, I discussed the allegations with Resident A's Relative 1 via telephone. Relative 1 stated they have concerns about Resident A residing at Courtyard Manor of Farmington Hills 1 because Resident A was hospitalized for a broken nose. Relative 1 stated they have not been to this facility for about three months but were informed by another relative that the broken nose Resident A sustained along with the bruising was not consistent with the fall as reported to the hospital by this facility. Relative 1 stated that Resident A's bed sits high and that there are no bed rails or a mat around Resident A's bed to prevent Resident A from being injured if there was a fall. Relative 1 would like an update via telephone after an on-site investigation is conducted.

On 11/03/2022, I conducted an unannounced on-site investigation at Courtyard Manor of Farmington Hills 1. Resident A was present, and I attempted to interview him but was unable to understand him because "he mumbles." Resident A was having lunch and sitting in his wheelchair in the dining room with the other residents. Resident A appeared to have good hygiene and there was no odor of urine. I observed healing abrasions on Resident A's nose and above his left eyebrows. The abrasions looked like rug burns.

I interviewed the administrator Jim Cubr regarding the allegations. Mr. Cubr stated when Resident A sleeps, he normally does not move in bed. He believes that Resident A had a fall or a seizure that resulted in the fall and the abrasions on Resident A's face. On 10/30/2022 around 7:15PM, Mr. Cubr stated staff did rounds and saw that Resident A was sleeping in his bed. Around 7:45PM, staff made rounds again and found Resident A lying on his face on the floor. Staff called the on-call supervisor Tasha Williams who was in one of the other buildings. Ms. Williams arrived at Resident A's bedroom, assessed Resident A and then 911 was contacted. Mr. Cubr stated a couple of weeks prior to this incident, Resident A had multiple seizures that led to hospitalization and a

stint procedure. Mr. Cubr stated Resident A has a hospital bed and the hospital bed has always been low to the floor. There is carpet on the floor, therefore, he believes Resident A had the seizure, fell out of bed, and continue having seizures that resulted in the rug burns on his nose and face.

I interviewed registered nurse (RN) Marlene Jones regarding the allegations. The RN stated this was the first time Resident A fell out of his bed. She stated that Resident A began declining in 08/2022. On 08/28/2022, Resident A went to the hospital for low blood sugar and returned on 08/29/2022 with new medication orders. On 09/21/2022, he went to the hospital for pneumonia and returned on 09/25/2022 with a couple of new medications. On 09/29/2022, he was hospitalized for altered mental status due to a urinary tract infection (UFI) and blood clots to his lungs and had his medications changed again. On 10/07/2022, Resident A had his first seizure, was unresponsive, sent to the hospital and returned the same day with diagnosis of dementia, altered mental status, and did not receive any medication changes. On 10/08/2022, Resident A had three seizures back-to-back, was unresponsive sent to the hospital and did not return until 10/21/2022. His diagnosis was UTI, stage three kidney failure, sepsis, seizures, dementia, retention of urine and heart failure. He received new medications and was but on a pureed diet. Resident A is to follow-up with his neurologist on 11/09/2022, but family has canceled transportation for that appointment. On 10/24/2022, Resident A was hospitalized due to altered mental status change and became total 1:1 care. He was weak and the hospital put a foley catheter on him and he returned on 10/25/2022. His diagnosis was failure to thrive and the doctor recommended hospice.

The RN stated she called Resident A's family/guardian to discuss hospice, but they refused. On 10/30/2022, the day of the incident, staff observed Resident A on the floor and blood from his nose. The staff called 911 and he was transported to the hospital and did not return until 11/02/2022. His diagnosis was a fall with intercranial hemorrhage with an order for physical and occupational therapy and a CT scan of the head scheduled for 11/28/2022. The RN believes Resident A had a seizure while he was sleeping, rolled out of bed onto his face and continued to have seizures causing the abrasions on his face and nose. The RN stated with so many medications changes that Resident A has gone through due to being hospitalized, it is unsure what is causing his seizures. The RN stated that all his medications are being administered as prescribed. The RN stated that the following are interventions they are putting in place for Resident A, seizure helmet, bedside floor mat, bed pad alarm and bed bolters. She stated that they are waiting on orders from his physician for these assistive devices and that the guardian has agreed.

On 11/03/2022, I interviewed direct care staff (DCS) Kanard Daniel. Mr. Daniel has been employed with this corporation about a year. He works first shift 7AM-3PM. He stated there are three DCS per shift. On 10/30/2022, Mr. Daniel stated he was doing rounds around 7:45 AM when he passed by Resident A's room and found Resident A on the floor. Mr. Daniel checked on Resident A, left the room and got DCS Shameta McGee to assist. They both returned to the room and noticed that Resident A was

bleeding from his head. Ms. McGee notified the supervisor Tasha Williams of what happened. Ms. Williams was in another building and arrived minutes later at Resident A's room. Ms. Williams checked Resident A and then called 911. The ambulance arrived and transported Resident A to the hospital. Mr. Williams stated he did not witness Resident A fall and this was the first time he is aware of Resident A falling. Mr. Williams stated about two weeks ago, Resident A had a seizure. Mr. Williams did not witness the seizure but Resident A was “unresponsive.” He believes that Resident A had a seizure, rolled out of bed, and continued to seize causing the marks on his face. Mr. Williams stated whenever residents are in their bedrooms, he conducts 30-minute bed checks to ensure their safety.

Mr. Williams stated he does not know anything about Resident A’s medications because he does not administer medications as he is not medication trained.

On 11/03/2022, I interviewed DCS Shameta McGee regarding the allegations. Ms. McGee has been working for this corporation since 07/19/2022. She works first shift 7AM-3PM. On 10/30/2022, Ms. McGee stated she arrived late around 7:30AM. There were already three DCS on shift, so Ms. McGee called her manager asking if she should stay or leave and was told to work the floor. Ms. McGee stated that Resident A was assigned to her as were three other residents. Ms. McGee was helping a resident when DCS Kanard Daniel came to her and asked her if she needed help. Ms. McGee stated no, so Mr. Daniel offered to go check on her other residents. Ms. McGee stated that Mr. Daniel returned stating that Resident A was on the floor. She went with Mr. Daniel to go and check on Resident A. She and Mr. Daniel noticed blood on Resident A’s face. She called the supervisor Tasha Williams while Mr. Daniel stayed with Resident A. Ms. Williams soon arrived at Resident A’s room, checked Resident A, and then called 911. The ambulance arrived and transported Resident A to the hospital.

Ms. McGee stated she does not know how Resident A fell out of bed but stated she asked Resident A what happened and Resident A said, “I fell out of bed.” Ms. McGee stated this was an isolated incident with Resident A falling. She reported that Resident A had seizures about two weeks ago that she has not witnessed but was told about the seizures. She stated she’s not familiar with what happens to Resident A during or after the seizures but believes he may have had one that resulted in him falling out of bed. Ms. McGee stated she too does not know anything about Resident A’s medications because she does not pass medications as she is not medication trained.

On 11/03/2022, I interviewed the supervisor Tasha Williams regarding the allegations. Ms. Williams has been employed with this corporation for over a year. She usually works at Courtyard Manor Farmington Hills II. On 10/30/2022, she received a telephone call from DCS Shameta McGee informing her that Resident A was found on the floor. Ms. Williams arrived at Resident A’s bedroom and observed blood on his face. Ms. Williams called the RN, Marlene Jones and advised her what she observed. The RN advised Ms. Williams to call 911, which she did. The ambulance arrived and transported Resident A to the hospital. Ms. Williams stated this was the first time she is aware of Resident A falling. She stated that she has never witnessed him having a seizure and

reported that she has never observed Resident A have a bad reaction to any of his medications. Ms. Williams stated she has administered medication to Resident A as prescribed and stated there have been no issues.

On 11/03/2022, I interviewed Resident B regarding the allegations. Resident B stated he has never observed any resident including Resident A fall. He stated that the staff here are “great,” and that he has no concerns about anything. Resident B stated that staff are “good,” with residents and that “staff take really good care of us.” Resident B stated he is usually in the common area, but sometimes when he is in his bedroom, staff check on him to make sure he is ok.

On 11/03/2022, the RN Marlene Jones contacted DCS Lakindra Mitchell via telephone. Ms. Mitchell stated she has been working for this corporation for 15 years. She stated she has never witnessed Resident A fall nor has she witnessed him having a seizure. She stated she does not have any other information to offer.

During the onsite, I observed Resident A’s bedroom, and his hospital bed was low to the floor. I reviewed the Beaumont Hospital’s discharge papers dated 10/30/2022-11/02/2022 and Resident A was seen for a fall and his diagnosis was dementia, fall from ground level, and intracranial hemorrhage. There is no indication of abuse and/or neglect. I also reviewed incident reports (IRs) regarding Resident A that correspond with the dates that the RN provided as to Resident A’s hospitalizations. I reviewed Resident A’s 10/2022 and 11/2022 medication logs and medication orders and there were no medication errors found.

On 12/01/2022, I received a telephone call from Adult Protective Services (APS) Heather Goodin. Ms. Goodin stated that she attempted to interview Resident A, but he mumbled, and she was unable to gather any information. Ms. Goodin stated that Resident A’s physician is ordering a bed guard for Resident A and that there have not been any new incidents. Ms. Goodin stated she will not be substantiating her case.

On 12/12/2022, I contacted Resident A’s guardian and discussed the allegations via telephone. The guardian stated their concern was that Resident A was in and out of the hospital numerous times after being admitted to Courtyard Manor. The guardian acknowledges that Resident A’s health declined but was concerned that Courtyard Manor was stating that Resident A was more ill than he really was. The guardian stated that Resident A never had seizures prior to being admitted into Courtyard Manor and that he may began having seizures, but the guardian does not believe that Resident A had a seizure and fell out of bed. The guardian stated they cannot say if the marks are consistent with the seizure and cannot rule out foul play, but now that Resident A is back in the hospital, the guardian will be looking for a skilled nursing facility and Resident A will not be returning to Courtyard Manor.

On 12/12/2022, I interviewed via telephone the medication technician Sharon Wiggins. Ms. Wiggins has been working for Courtyard Manor for 20 years. She works from 7AM-7PM. Ms. Wiggins stated she observed Resident A having seizures during her shift. She

stated that Resident A had about three seizures back-to-back. Resident A would shake and become unresponsive. Ms. Wiggins stated the seizures did not have anything to do with his medications because when she passed medications to Resident A, he never had a negative reaction to them. Ms. Wiggins stated she has never witnessed Resident A fall so she cannot provide any information as to the fall on 10/30/2022 as she was not present.

| **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 provisions of the act.** |
| **ANALYSIS:** | Based on my investigation and information gathered, Resident A's protection and safety were attended to at all times by staff. On 10/30/2022, Resident A fell out of bed and possibly had a seizure that resulted in abrasions on his face. Resident A was hospitalized and according to Beaumont Hospital's discharge papers, Resident A's diagnosis was a fall from the ground level and there is no mention of any findings of abuse and/or neglect. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.** |
| **ANALYSIS:** | Based on my investigation and review of Resident A's 10/2022 and 11/2022 medications and medication orders, Resident A was given his medications as prescribed. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ALLEGATION: Resident A wears briefs for extended periods of time and is not changed regularly.**

**INVESTIGATION:**

On 11/02/2022, Relative 1 stated they also observed Resident A sitting in soiled briefs when they were at the facility about three months ago. They did not report the soiled briefs to any staff.

On 11/03/2022, Mr. Cubr stated all residents including Resident A are checked every two hours or more frequently to ensure residents are not sitting soiled in their briefs. Mr. Cubr stated they do not keep a tracking sheet of brief checks, but this is something he will be implementing.

On 11/03/2022, the RN stated Resident A does not sit soiled in his briefs. She stated Resident A is always in the common area when he is awake and checked frequently by staff. The RN has not received any complaints about Resident A being soiled by staff or by family. The RN stated they do not have a tracking sheet for brief changes, but that is something they can implement. The RN stated that staff check on residents every two hours, but more frequently if staff are aware that a resident is incontinent and needs to be checked more often.

On 11/03/2022, Mr. Williams stated he has never witnessed Resident A soiled in his briefs. He stated that Resident A and all the residents are checked every one to two hours and changed as needed. However, Resident A usually sits in the common area; therefore, Resident A gets checked frequently and his brief is changed when needed. Mr. Williams stated that family members have never reported to him that Resident A was observed sitting soiled in his briefs.

On 11/03/2022, Ms. McGee stated she has never left Resident A soiled in his briefs and that she checks on him frequently and changes him as needed. She reported that no one has complained to her about Resident A being soiled. Ms. McGee reported that prior to Resident A having seizures, she would assist Resident A onto the commode at least three times per her shift and that Resident A was very vocal about needing to be changed so he would tell her when he was soiled.

On 11/03/2022, Ms. Williams stated she has never observed Resident A soiled in his briefs nor has she received any complaints from family members or staff about Resident A being observed soiled. She stated that staff are trained to check on residents every two hours or more frequently if needed and to change the briefs when necessary.

On 11/03/2022, Ms. Mitchell stated during her shift, she checks on residents every two hours to ensure they do not need to be changed. She stated she has never left Resident A, or any other resident soiled in their briefs.

On 12/12/2022, the guardian stated they have never observed Resident A soiled when they visited Resident A at least three times per day. The guardian stated that this facility was “doing a good job in changing Resident A.”

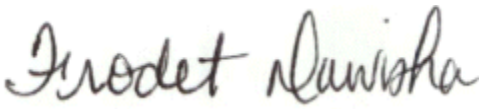
On 12/12/2022, Ms. Wiggins stated she has never observed Resident A sit soiled in his briefs nor has she received any complaints from anyone stating that Resident A was soiled.

On 12/12/2022, I contacted licensee designee Ronald Paradowicz via telephone and discussed my findings. Mr. Paradowicz stated he was aware of the concerns regarding Resident A and had no questions as to my investigation.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15314** | **Resident hygiene.** |
| | **(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.** |
| **ANALYSIS:** | Based on my investigation and information gathered, Resident A's personal hygiene has been met by staff. I interviewed multiple staff members who reported that they check Resident A every two hours and more frequently if needed to see if his briefs require to be changed. According to all staff including Resident A's guardian, Resident A was never observed sitting soiled in his briefs nor have any family members reported to staff that they have observed Resident A sitting soiled in his briefs. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

## IV. RECOMMENDATION

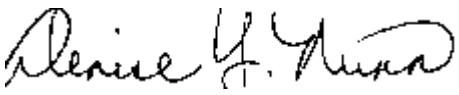
I recommend that this special investigation be closed and no change to the status of the license.



12/12/2022

Frodet Dawisha Date
Licensing Consultant

Approved By:



12/12/2022

Denise Y. Nunn Date
Area Manager