GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 21, 2024

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

RE: License #: AL630007351
Investigation #: 2024A0611015
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,

Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007351
Investigation #:	2024A0611015
Complaint Receipt Date:	02/07/2024
Investigation Initiation Date:	02/13/2024
Report Due Date:	04/07/2024
Licensee Name:	Courtyard Manor Farmington Hills Inc
Licensee Address:	Suite 127 - 3275 Martin 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:	11/28/2022
Expiration Date:	11/27/2024
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents are not being fed.	No
Residents are not receiving medications. A medication was left on a nightstand and a medication has been found on the floor where other residents had access to it.	Yes
Other residents have been denied proper medical care.	No

III. METHODOLOGY

02/07/2024	Special Investigation Intake 2024A0611015
02/13/2024	APS Referral An Adult Protective Services (APS) referral was made.
02/13/2024	Special Investigation Initiated - On Site I completed an unannounced onsite. I interviewed the director of operations, Belinda Hunter, the building manager, Kallee Lizzamore, staff member Jessica Sims, staff member Henritta Varner, staff member Anitra Hawkins, Nurse Marlena Jones, staff member Latoshia Stoddard, Resident G, Resident P, and Resident B. I received a copy of the staff schedule and a menu.
02/14/2024	Contact - Document Received I received an email stating the Adult Protective Services referral was denied.
02/15/2024	Contact - Document Received I received a copy of all the residents MAR's for the month of February.
02/20/2024	Contact - Telephone call made I made a telephone call to the building manager Kallee Lizzamore. Ms. Lizzamore directed me Nurse Marlene regarding my questions about Resident M's MAR.
02/20/2024	Exit Conference I completed an exit conference with the licensee designee Ronald Paradowicz via telephone.

ALLEGATION:

Residents are not being fed.

INVESTIGATION:

On 02/07/24, a complaint was received and assigned for investigation alleging that someone's husband is not being fed and he is not receiving his medications. The manager and supervisor of the caregivers have been made aware of the situation and completely ignored it. Other residents have been denied proper medical care and medications have been left on the nightstand where other residents have access to it if they walk into the room. A pill was found on the floor in the group home. Someone threatened to call the police on a visitor if they did not leave the group home.

On 02/07/24, I contacted Dana Trierweiler from LARA/BCH Adult Licensing Section to request additional information regarding the allegations and contact information for the reporting source. Ms. Trierweiler informed me that she did not have any additional information to help clarify the allegations and the reporting source was anonymous.

On 02/13/24, I completed an unannounced onsite. I interviewed the director of operations, Belinda Hunter, the building manager, Kallee Lizzamore, staff member Jessica Sims, staff member Henritta Varner, staff member Anitra Hawkins, Nurse Marlena Jones, staff member Latoshia Stoddard, Resident G, Resident P, and Resident B. I received a copy of the staff schedule and a menu.

On 02/13/24, I interviewed the director of operations Belinda Hunter. Regarding the allegations, Ms. Hunter stated there have not been any issues with meals being prepared for the residents. The residents are served three meals a day and snacks. There is a delivery truck that brings food to the home every Wednesday. Ms. Hunter is not aware of any resident refusing to eat.

Ms. Hunter stated during the summer in 2023 there was an altercation between family members outside in front of another AFC group home. The police were called, and the family members were escorted off the property. Ms. Hunter denied any police being called to this AFC group home.

On 02/13/24, I interviewed the building manager Kallee Lizzamore. Ms. Lizzamore stated all the residents eat very well. Ms. Lizzamore stated no resident is denied any meals nor does any resident refuse to eat.

On 02/13/24, I interviewed staff member Jessica Sims. Ms. Sims started working for the AFC group home in November 2023. Ms. Sims works from 7:00am to 3:00pm. Ms. Sims is present when breakfast and lunch is served to the residents. Ms. Sims stated the residents are served three meals a day and they get a snack between meals. Ms. Sims denied any resident not getting three meals a day. Ms. Sims stated in the event a

resident refuse to eat, the staff will wrap up their meal and provided to them at a later time if they choose to eat it.

Ms. Sims has never seen the police called to the AFC group home or anyone threatening to call the police. Ms. Sims did not have any concerns to report regarding the AFC group home.

On 02/13/24, I interviewed staff member Henritta Varner. Ms. Varner started working at the AFC group home in January 2024. Ms. Varner works from 8:00am to 8:00pm. Regarding the allegations, Ms. Varner stated the residents are fed three meals a day and snacks. Ms. Varner stated there has never been a time when a resident was not given three meals a day.

Ms. Varner stated no one has threatened to call the police nor has the police been to the AFC group home.

On 02/13/24, I interviewed staff member Anitra Hawkins. Ms. Hawkins has worked at the AFC group home for three years. Ms. Hawkins works from 7:00am to 3:00pm. Ms. Hawkins stated the residents are fed three meals a day. Ms. Hawkins has never observed a resident missing a meal. Ms. Hawkins stated if a resident is sleep during mealtime, there food is wrapped up for them to eat later.

Ms. Hawkins denied the police being called to the AFC group home or anyone threatening to call the police.

On 02/13/24, I interviewed Nurse Marlene Jones. Regarding the allegations, Ms. Jones stated the residents are fed three meals a day and given two snacks every day. The residents are also given additional snacks while participating in activities. Ms. Jones stated a resident only misses a meal if they refuse to eat or they are unable to eat due to sickness. If a resident is too sick to eat than they are transported to the hospital. Ms. Jones stated if a resident refuses to eat then their meal is wrapped up and/or they are offered a substitute meal.

On 02/13/24, I interviewed staff member Latoshia Stoddard. Ms. Stoddard is a med technician. Ms. Stoddard has worked at the AFC group home since October 2022. Ms. Stoddard works from 7:00am to 7:00pm. Ms. Stoddard stated the residents are fed three meals a day and two snacks every day. Ms. Stoddard stated there has never been a time where a resident was not fed three meals a day.

Ms. Stoddard stated Resident J has dementia and he calls the police about once a month about his wife not coming home. The police do not come to the home as they are familiar with Resident J. This is the only instance Ms. Stoddard provided regarding the police being called.

On 02/13/24, I interviewed Resident G. Resident G has lived at the AFC group home for six months. Resident G likes living at the AFC group home as well as the staff.

Regarding the allegations, Resident G stated he is fed three meals a day and snacks in between meals. Resident G is fed plenty of food.

On 02/13/24, I interviewed Resident P. Resident P has lived at the AFC group home for three years. Resident P stated he likes living at the AFC group home and he is treated well by the staff. Resident P stated he eats three meals a day. Resident P stated he is given plenty of food to eat.

On 02/13/24, I interviewed Resident B. Resident B has lived at the AFC group home for 1½ years. Resident B stated he does not like living at the AFC group home because he prefers to live at home. Resident B stated he gets plenty of food to eat. Resident B likes that the AFC group home has activities and he enjoys painting at the home.

Resident B stated there has been instances where male residents have gotten into fights because that is what men do. Resident B stated the police have been called as a result of a fight between residents. Resident B stated the staff break up the fights. Resident B could not provide a timeframe of when these instances have occurred, or which residents were involved. Resident B seemed to be speaking in general as opposed to any specific events that have transpired at the AFC group home.

On 02/13/24, I observed the refrigerator, freezer, and pantry area. There is plenty of food in the AFC group home. I observed the menu and found that only today's menu was posted. The kitchen staff provided another menu that was dated from 02/11/24 through 02/17/24. However, there was only one meal listed for 02/11/24 and there was only lunch and dinner listed for 02/13/24.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	There is no evidence to support this allegation as every resident and staff interviewed confirmed that there are three meals served every day as well as snacks. On 02/13/24, I observed plenty of food in the AFC group home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	On 02/13/24, I observed the menu at the AFC group home and saw that a complete menu was not posted for at least one week in advanced.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are not receiving medications. A medication was left on a nightstand and a medication has been found on the floor where other residents had access to it.

INVESTIGATION:

Ms. Hunter stated there is a med technician scheduled to work each shift for 12 hours. Ms. Hunter is not aware of any instances where a resident was not administered there medication or not given their medication on time.

Ms. Lizzamore is not aware of any resident not being administered their medication or any pills being left on a nightstand.

Ms. Sims does not administer medications. Ms. Sims has observed a med technician administer medications to the residents. Ms. Sims stated the med technicians administer medications as prescribed and on time to each resident. Ms. Sims denied ever seeing a pill on the floor or on a residents nightstand. The medications are locked up in a medication cart.

Ms. Varner does not administer medications. Ms. Varner has observed a med technician administer medications to residents. Ms. Varner stated as far as she knows the med technicians administer medications as prescribed and on time to every resident. Ms. Varner has never seen a pill on the floor or on a residents nightstand.

Ms. Hawkins stated sometimes she fills in as a med technician and passes medications to the residents. Ms. Hawkins stated the residents medications are administered as prescribed and on time to every resident. Ms. Hawkins denied seeing any pills on the floor or on a residents nightstand. The medications are kept in a locked medication cart.

Ms. Jones has observed med technicians administer medications. Ms. Jones stated the residents are administered their medications as prescribed and on time to every resident. Ms. Jones has never seen any pills on the floor or on a nightstand. The medications are kept in a locked medication cart.

Ms. Stoddard stated there has never been a time where a resident was not administered their medications as prescribed. Ms. Stoddard confirmed that she knows the 5 medication rights. The medications are kept in a locked medication cart. Ms. Stoddard is not aware of any pills on the floor or on a nightstand. Ms. Stoddard stated if a resident refuses to take their medication, the med technician will make three attempts to administer the medication before documenting that the resident refused their medication. Ms. Stoddard stated she will also provide a comment as to why the resident refused their medication. Ms. Stoddard stated she is not aware of any complaints from a resident or anyone else about a medication that should not be prescribed to a resident. Ms. Stoddard stated a residents allergies are listed on their MAR and; the med technicians are in the habit of checking the residents allergies to ensure they don't contradict with their medications.

Resident G stated he takes medications every day. Resident G's medications are administered to him by staff. Resident G stated the staff never forget to give him his medications. Resident G has never seen a pill on the floor or laying around.

Resident P stated the staff administer his medications and; they never forget to give him his medications. Resident P has never seen a pill on the floor or laying around.

Resident B is administered medications from a med technician. The med technician administers his medications as prescribed. Resident B denied any instance where he was not given his medications. Resident B stated the other residents appear to get their medications as prescribed as well. Resident B denied seeing any pills on the floor or laying around.

On 02/13/24, I observed several residents bedrooms, and every bedroom was clean and appropriate. I did not observe any medications or loose pills in the bedrooms.

On 02/13/24, I received a copy of the staff schedule for the month of February. There are four med technicians scheduled to work twelve-hour shifts during the month of February. The med technicians are Latoshia Stoddard, Andre Cade, Sharon Wiggins, and Michelle Jackson.

On 02/15/24, I received copies of all the residents MAR for the month of February. According to the MAR's for every resident, it appears that staff are properly

administering the medications and documenting the required comments and/or explanations with the exception of one resident. Regarding the MAR for Resident M, he is prescribed Quetiapine 50mg once a day at bedtime. According to the comments for Resident M's Quetiapine 50mg the AFC group home was awaiting for this medication to arrive to the home from February 1st through February 12th with the exception of February 5th and February 9th. The MAR indicates that Resident M received this medication on February 5th and February 9th despite the comments that indicate this medication had not been delivered to the home from February 1st through February 4th, February 6th through February 8th, and February 10th through February 12th. The staff initials on the MAR that indicated this medication was administered on February 5th and February 9th was "MJ".

On 02/15/24, I made a telephone call to the building manager Kallee Lizzamore. Ms. Lizzamore directed me Nurse Marlene regarding my questions about Resident M MAR. Nurse Marlene explained that Resident M was admitted on 01/15/24 and his prescription for Quetiapine 50mg was ordered on 01/22/24. Nurse Marlene reviewed the receipt from the pharmacy and confirmed Resident M's Quetiapine 50mg was delivered to the home on 02/13/24. Nurse Marlene also confirmed an error was made on the MAR as Resident M did not receive his Quetiapine 50mg until 02/13/24. The staff that made the documentation error was Michelle Jackson. Nurse Marlene stated Ms. Jackson documented incorrectly that Resident M received his Quetiapine 50mg on 01/31/24, 02/5/24, and 02/09/24. Nurse Marlene stated she will conduct an in-service as this medication error should not have happened.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The residents and staff interviewed confirmed that medications are administered as prescribed. On 02/15/24, I received a copy of the MAR's for every resident. According to the MAR's, it appeared that every resident is receiving their medications as prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	According to Resident M's MAR, he is prescribed Quetiapine 50mg once a day at bedtime. According to the comments for Resident M's Quetiapine 50mg the AFC group home was awaiting for this medication to arrive to the home from February 1st through February 12th with the exception of February 5th and February 9th. The MAR indicates that Resident M received this medication on February 5th and February 9th despite the comments that indicate this medication had not been delivered to the home from February 1st through February 4th, February 6th through February 8th, and February 10th through February 12th. The staff initials on the MAR that indicated this medication was administered on February 5th and February 9th was "MJ". Nurse Marlene confirmed an error was made on the MAR as Resident M did not receive his Quetiapine 50mg until 02/13/24. The staff that made the documentation error was Michelle Jackson. Nurse Marlene stated Ms. Jackson documented incorrectly that Resident M received his Quetiapine 50mg on 01/31/24, 02/5/24, and 02/09/24.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Other residents have been denied proper medical care.

INVESTIGATION:

Ms. Hunter denied any resident complaining about not receiving medical care. Ms. Hunter is not aware of any medications left out on a residents nightstand or the floor.

Ms. Lizzamore denied any resident not receiving medical care. Ms. Lizzamore stated every resident gets the medical care they need.

Ms. Sims is not aware of any resident requesting medical care and did not receive it.

Ms. Varner stated if a resident requires medical care the staff will call EMS. Ms. Varner stated no resident has been denied medical care.

Ms. Hawkins is not aware of a resident requesting or needing medical care and not receiving it. Ms. Hawkins stated if a resident does need medical care, an incident report is completed, the med technician, nurse, and supervisor are notified. If the medical care is severe than staff will contact 911, the manager, and hospice if applicable.

Ms. Jones stated the staff always give medical care to the residents. Ms. Jones denied medical care being refused for any resident.

Ms. Stoddard is not aware of any resident requesting or needing medical care and did not receive it.

Resident G stated the staff ensures his needs are met. Resident G stated the other residents appear to be taken care of as well. Resident G did not have any complaints about the AFC group home.

Resident P stated his needs are met by the staff.

Resident B stated he has never been refused medical care. Resident B has never seen a resident needing medical care and not receive it.

On 02/15/24, I completed an exit conference with the licensee designee Ronald Paradowicz. Mr. Paradowicz was informed of which rule violations will be substantiated and require a corrective action plan.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

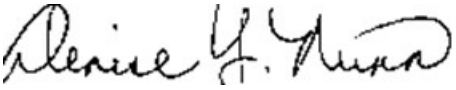
ANALYSIS:	Based on my findings and information gathered, there is no evidence to support this allegation. The residents and staff interviewed confirmed that medical care is provided whenever it is requested and/or needed for a resident.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

02/20/24
Sheena Worthy Date
Licensing Consultant

Approved By:



02/21/2024
Denise Y. Nunn Date
Area Manager