



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 13, 2024

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

RE: License #: AL630007354
Investigation #: 2024A0612021
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,

A handwritten signature in cursive script that reads "Johnna Cade".

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007354
Investigation #:	2024A0612021
Complaint Receipt Date:	04/16/2024
Investigation Initiation Date:	04/17/2024
Report Due Date:	06/15/2024
Licensee Name:	Courtyard Manor Farmington Hills Inc
Licensee Address:	Suite 127 3275 Martin Walled Lake, MI 48390
Licensee Telephone #:	(248) 926-2920
Administrator:	James Cubr
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
License Status:	REGULAR
Effective Date:	06/15/2022
Expiration Date:	06/14/2024
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Courtyard Manor Staff administer medication to Resident A, but they are unable to provide an explanation regarding what the medication is for.	No
<ul style="list-style-type: none"> • The food at the Courtyard Manor of Farmington is bad and there is no nutritional food for Resident A to eat. • When Resident A request food after 6:00 pm she is advised that kitchen is closed. 	No
The shower water at Courtyard Manor of Farmington is not hot.	No
There is no placement in the shower to prevent Resident A from slipping.	No
Courtyard Manor Staff take Resident A's clothes to be washed and she does not receive her clothes back until hours later.	No

III. METHODOLOGY

04/16/2024	Special Investigation Intake 2024A0612021
04/17/2024	Special Investigation Initiated - Telephone Telephone call to administrator, James Cubr.
04/17/2024	APS Referral Intake received from Adult Protective Services (APS). APS denied the referral for investigation.
05/13/2024	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed director of operations Belinda Hunter, director of nursing Marlene Jones, direct care staff Tasha Williams, direct care staff Latora Sibby, Resident A, and Resident B.
05/13/2024	Contact - Telephone call made Telephone call to Resident A's Guardian. No answer, I left a voicemail requesting a return call.
05/14/2024	Contact - Telephone call made Telephone call to Resident A's Guardian. No answer, I left a voicemail requesting a return call.
05/14/2024	Exit Conference

	I placed a telephone call to licensee designee, Ronald Paradowicz to conduct an exit conference.
06/11/2024	Contact – Telephone call made Telephone call to director of nursing Marlene Jones to request a copy of Resident A's May 2024, Medication Administration Record.
06/11/2024	Contact – Document Received Resident A's May 2024, Medication Administration Record received via email.

ALLEGATION:

Courtyard Manor Staff administer medication to Resident A, but they are unable to provide an explanation regarding what the medication is for.

INVESTIGATION:

On 04/17/24, I received a complaint from Adult Protective Services (APS). APS denied the referral for investigation. The complaint alleged that Resident A resides at Courtyard Manor of Farmington. Courtyard Manor Staff take Resident A's clothes to be washed and she does not receive her clothes back until hours later. The shower water is not hot, so Resident A has to let the water run for a few minutes. However, the water still does not maintain a good temperature. There is also no placement in the shower to prevent Resident A from slipping. It is unknown if Resident A has ever slipped in the shower due to their being no place mat. The food at Courtyard Manor of Farmington is bad and there is no nutritional food for Resident A to eat. When Resident A request food after 6:00 pm she is advised that kitchen is closed. However, it unknown when the kitchen closes. Courtyard Manor Staff administer medication to Resident A, but they are unable to provide an explanation regarding what the medication is for. When asked, Courtyard Manor Staff typically say, "I don't know" and "here just take them." On 04/17/24, I placed a telephone call to administrator, James Cubr to request facility documents. There was no answer. I left a voicemail and requested a return call.

On 05/13/24, I completed an unscheduled onsite investigation. I interviewed director of operations Belinda Hunter, director of nursing Marlene Jones, direct care staff Tasha Williams, direct care staff Latora Sibby, Resident A, and Resident B. While onsite I observed Resident C, Resident D, Resident E, Resident F, Resident G, Resident H, and Resident I, sitting in the common area at the facility. They appeared appropriately dressed and well groomed. Due to their respective cognitive abilities Resident C – I could not be interviewed. While onsite, I observed a 2024 Nursing Drug Reference book in the medication cart.

On 05/13/24, I interviewed director of operations, Belinda Hunter and director of nursing, Marlene Jones. Ms. Hunter and Ms. Jones consistently stated Resident A is nonverbal therefore, she is unable to verbally inquire about the use of her medications. However, when a resident does have questions regarding their medications the medication cart contains a 2024 Nursing Drug Reference book that staff can use to look up medications. In addition, the electronic medication administration record (MAR) that is used to administer medications contains information on each prescribed medication that staff can use to educate the resident. Ms. Hunter and Ms. Jones consistently stated there have been no instance of Resident A inquiring about her medications and not receiving an appropriate response from staff.

On 05/13/24, I interviewed direct care staff Tasha Williams. Ms. Williams is a team lead and has been employed at this facility for three years. Ms. Williams works day shift from 7:00 am – 3:00 pm or 7:00 am – 7:00 pm. Ms. Williams stated Resident A's medications are crushed and she takes them in yogurt. Resident A takes her medication as they are prescribed. Resident A has never refused her medications. Ms. Williams explained that Resident A is nonverbal and therefore, she has not asked for an explanation regarding what her medication is for. However, if a resident was to ask for information regarding their medication Ms. Williams stated the medication cart has a drug reference book and the MAR contains information regarding each medication, and she would use this information to educate the resident.

On 05/13/24, I interviewed direct care staff Latora Sibby. Ms. Sibby has been employed at this facility for 20 years. She works on the day shift twice a week from 7:00 am – 11:00 pm. Ms. Sibby stated she does not pass medications and therefore she has no information to provide regarding this allegation.

On 05/13/24, I interviewed Resident A. Resident A is nonverbal and was unable to answer interview questions. Resident A was appropriately dressed and well groomed. I observed Resident A in the common area. She appeared comfortable interacting with staff and other residents.

On 05/13/24, I interviewed Resident B. Resident B has lived at this facility for seven years. Resident B stated she receives her medications as they are prescribed. Resident B said if she has questions about her medication she asks the director of nursing, Marlene Jones. Ms. Jones has always answered any questions that she has about her medications.

I reviewed Resident A's May 2024, Medication Administration Record. Resident A is prescribed Escitalopram 10 mg, Losartan pot 50 mg, Quetiapine 25 mg, and Nystop powder.

APPLICABLE RULE	
R 400.15312	Resident medications.
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude that Courtyard Manor Staff are unable to provide an explanation regarding what Resident A's medication are and what they are for. Resident A's medication administration record provides a comprehensive list of her prescribed medications. Director of operations Belinda Hunter and direct care staff Tasha Williams consistently stated that they would use the drug reference book and/or the medication administration record to answer any questions a resident has regarding their medications. On 05/13/24, I observed a 2024 Nursing Drug Reference book in the medication cart. The facility also has a nurse on staff, Marlene Jones, to assist with medication related concerns. Resident B stated Ms. Jones has always answered any questions that she has about her medications.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **The food at the Courtyard Manor of Farmington is bad and there is no nutritional food for Resident A to eat.**
- **When Resident A request food after 6:00 pm she is advised that kitchen is closed.**

INVESTIGATION:

On 05/13/24, I interviewed director of operations, Belinda Hunter and director of nursing, Marlene Jones. Ms. Hunter and Ms. Jones consistently stated Resident B has a regular diet. She is served breakfast, lunch, dinner and two snacks during the day. Ms. Hunter and Ms. Jones consistently stated the menu is created by the facility's dietary manager, Latrisha Alexander. The meals are balanced and nutritional. After dinner, the kitchen closes around 7:00 pm. When the kitchen is closed residents can help themselves to snacks that are available in the common area. The snacks vary but typically include sandwiches, cookies, chips, juice, doughnuts, cake, bagels, and/or fruit.

On 05/13/24, I interviewed direct care staff Tasha Williams. Ms. Williams stated there is a menu posted in the dining room. The meals are planned by the dietary manager. The food is nutritious. Resident A eats all her meals without issue. Ms. Williams stated the kitchen is closed after dinner. There are snacks available to residents when the kitchen

is closed. The residents do not have to ask for the snacks they are out and available to them at any time. The snacks typically include sandwiches, cookies, chips, juice, doughnuts, cake, bagels, and/or fruit.

On 05/13/24, I interviewed direct care staff Latora Sibby. Ms. Sibby stated breakfast, lunch, dinner, and snacks are prepared for the residents daily. The menu is posted in the dining room. The meals are well balanced and nutritious. Ms. Sibby stated after dinner the kitchen closes between 7:00 pm – 7:30 pm. After the kitchen closes there are snacks out and available for residents. The residents do not have to ask for snack, they can help themselves. Ms. Sibby explained as many of the residents are nonverbal staff also pass out snacks and offer them to the residents in an attempt to anticipate their needs if they cannot ask directly. Ms. Sibby stated she has never witnessed Resident A go without food after the kitchen is closed.

On 05/13/24, I interviewed Resident A. Resident A is nonverbal and was unable to answer interview questions. Resident A was appropriately dressed and well groomed. I observed Resident A in the common area. She appeared comfortable interacting with staff and other residents.

On 05/13/24, I interviewed Resident B. Resident B stated she is served breakfast, lunch, dinner, and snacks. Resident B remarked, the food is good. Resident B stated the kitchen closes after dinner. Staff bring around snacks after the kitchen is closed. Resident B stated snacks are usually cookies, juice, and sandwiches.

On 05/13/24, I completed an unscheduled onsite investigation. I completed a walkthrough of the facility. I observed in the dining room a posted monthly and daily menu. The menu includes a regular meal plan and a meal plan for residents who have special diets. The menu has a variety of options for breakfast, lunch, and dinner. The meals include a protein, vegetable, and a starch. There are a variety of options for dessert.

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:	Based on the information gathered through my investigation there is insufficient information to conclude that the food at Courtyard Manor of Farmington is not nutritional and/or that Resident A does not have access to food when the kitchen is closed. On 05/13/24, I observed a posted monthly and daily menu. The menu includes a regular meal plan and a meal plan for residents who have special diets. The menu has a variety of options for

	<p>breakfast, lunch, and dinner. The meals include a protein, vegetable, and a starch. There are a variety of options for dessert.</p> <p>It was consistently reported by director of operations Belinda Hunter, director of nursing Marlene Jones, direct care staff Tasha Williams, direct care staff Latora Sibby, and Resident B that breakfast, lunch, dinner, and snacks are served to the residents daily. After dinner the kitchen closes between 7:00 pm – 7:30 pm. After the kitchen closes there are snacks out and available for residents. Snacks typically include sandwiches, cookies, chips, juice, doughnuts, cake, bagels, and/or fruit.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The shower water at Courtyard Manor of Farmington is not hot.

INVESTIGATION:

On 05/13/24, I interviewed director of operations, Belinda Hunter and director of nursing, Marlene Jones. Ms. Hunter and Ms. Jones consistently stated there have been no issues with the water temperature. The water is maintained within the safe range. Resident A is showered twice a week by Courtyard Manor staff and twice a week by her hospice provider. Ms. Hunter and Ms. Jones consistently stated they have not received any complaints regarding the water temperature.

On 05/13/24, I interviewed direct care staff Tasha Williams. Ms. Williams stated Resident A receives a shower from Courtyard Manor staff on Wednesday and Saturday. Her showers are given in the morning. Resident A’s hospice provider showers her on Tuesday and Thursday. Resident A has a shower in her bedroom and there is a community shower. Resident A is usually showered in the community shower. Ms. Williams stated there has been no issues with the water not being hot enough in either bathroom.

On 05/13/24, I interviewed direct care staff Latora Sibby. Ms. Sibby stated she does not shower Resident A however; she has not observed any issues with the temperature of the water.

On 05/13/24, I interviewed Resident A. Resident A is nonverbal and was unable to answer interview questions. Resident A was appropriately dressed and well groomed. I observed Resident A in the common area. She appeared comfortable interacting with staff and other residents.

On 05/13/24, I interviewed Resident B. Resident B stated she has not experienced any issues with the water not being hot enough.

On 05/13/24, I completed an unscheduled onsite investigation. I completed a walkthrough of the facility. I tested the water in Resident A's bathroom and the community bathroom in the hallway. The water in Resident A's bathroom was 110 degrees Fahrenheit. The water in the community bathroom was 112.1 degrees Fahrenheit.

APPLICABLE RULE	
R 400.15401	Environmental health.
	(2) Hot and cold running water that is under pressure shall be provided. A licensee shall maintain the hot water temperature for a resident's use at a range of 105 degrees Fahrenheit to 120 degrees Fahrenheit at the faucet.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude that the shower water at Courtyard Manor of Farmington is not hot. On 05/13/24, the water in Resident A's bathroom was 110 degrees Fahrenheit. The water in the community bathroom was 112.1 degrees Fahrenheit. The water in both bathrooms was within the safe range of 105 degrees Fahrenheit to 120 degrees Fahrenheit. There were no reports of the water not being hot enough.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

There is no placement in the shower to prevent Resident A from slipping.

INVESTIGATION:

On 05/13/24, I interviewed director of operations Belinda Hunter, director of nursing, Marlene Jones, direct care staff Tasha Williams, and direct care staff Latora Sibby. Ms. Hunter, Ms. Jones, Ms. Williams, and Ms. Sibby consistently stated Resident A has a shower in her bedroom and there is a community shower in the hallway. Both showers are equipped with non-slip strips on the bottom. The showers have handrails and a shower chair. Resident A has not experienced any falls at the facility.

On 05/13/24, I interviewed Resident A. Resident A is nonverbal and was unable to answer interview questions. Resident A was appropriately dressed and well groomed. I observed Resident A in the common area. She appeared comfortable interacting with staff and other residents.

On 05/13/24, I interviewed Resident B. Resident B stated she is claustrophobic and prefers to take a sponge bath as opposed to getting in the shower. Therefore, she does not have any information regarding this allegation.

On 05/13/24, I completed an unscheduled onsite investigation. I completed a walkthrough of the facility. I observed that the shower in Resident A's bedroom and the community bathroom in the hallway. Both showers have handrails and nonskid surfacing. The showers also contain a shower chair.

APPLICABLE RULE	
R 400.15403	Maintenance of premises.
	(11) Handrails and nonskid surfacing shall be installed in showers and bath areas.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude that there is no placement in the shower to prevent Resident A from slipping. Ms. Hunter, Ms. Jones, Ms. Williams, and Ms. Sibby consistently stated that there were no reports of Resident A experiencing a fall at the facility. On 05/13/24, I observed the shower in Resident A's bedroom and the community bathroom in the hallway. Both showers have handrails and nonskid surfacing. The showers also have a shower chair.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Courtyard Manor Staff take Resident A's clothes to be washed and she does not receive her clothes back until hours later.

INVESTIGATION:

On 05/13/24, I interviewed director of operations, Belinda Hunter and director of nursing, Marlene Jones. Ms. Hunter and Ms. Jones consistently stated laundry is done daily. Resident A's clothes are washed in the morning and returned to her by the end of the day. There has been no report of issues, missing items, etc.

On 05/13/24, I interviewed direct care staff Tasha Williams. Ms. Williams stated laundry is done daily. Resident A's laundry is done in the morning, and it is returned to her by

the end of the day. Ms. Williams stated there have been no issues with Resident A's laundry being completed and returned to her.

On 05/13/24, I interviewed direct care staff Latora Sibby. Ms. Sibby stated laundry is done daily. The laundry is returned to the resident the same day. There have not been no issues with laundry not being returned to Resident A.

On 05/13/24, I interviewed Resident A. Resident A is nonverbal and was unable to answer interview questions. Resident A was appropriately dressed and well groomed. I observed Resident A in the common area. She appeared comfortable interacting with staff and other residents.

On 05/13/24, I interviewed Resident B. Resident B stated she does her own laundry with minimal support from staff. Resident B stated she has no issues or concerns with her ability to access the laundry at the facility.

On 05/14/24, I placed a telephone call to licensee designee, Ronald Paradowicz to conduct an exit conference and review my findings. There was no answer. I left a detailed message and indicated that there were no rule violations found.

APPLICABLE RULE	
R 400.15404	Laundry.
	A home shall make adequate provision for the laundering of a resident's personal laundry.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude that Courtyard Manor Staff take Resident A's clothes to be washed and she does not receive her clothes back until hours later. It was consistently reported that laundry is done daily. Resident A's clothes are washed in the morning and returned to her by the end of the day. There have been no reports of issues related to Resident A not receiving her laundry back in a timely manner.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

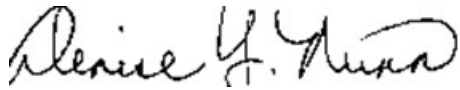


06/12/2024

Johnna Cade
Licensing Consultant

Date

Approved By:



06/13/2024

Denise Y. Nunn
Area Manager

Date