GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 18, 2024

Matthew Sufnar
Encore McHenry
Suite 710
230 West Monroe
Chicago, IL 60606

RE: License #: AL500416945
Investigation #: 2024A0990025
The Courtyard at Sterling Heights 4

Dear Mr. Sufnar:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500416945
Investigation #:	2024A0990025
Complaint Receipt Date:	07/22/2024
Investigation Initiation Date:	07/23/2024
Report Due Date:	09/20/2024
LicenseeName:	Encore McHenry
LicenseeAddress:	Suite 710 - 230 West Monroe Chicago, IL 60606
LicenseeTelephone #:	(248) 340-9296
Administrator:	Matthew Sufnar
Licensee Designee:	Matthew Sufnar
Name of Facility:	The Courtyard At Sterling Heights 4
Facility Address:	13400 19 Mile Road Sterling Heights, MI 48313
Facility Telephone #:	(586) 254-5719
Original Issuance Date:	03/12/2024
License Status:	TEMPORARY
Effective Date:	03/12/2024
Expiration Date:	09/11/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was hospitalized. At discharge, the facility staff informed the hospital staff that Resident A could not return to the facility.	Yes
Resident A went home with Relative A. Relative A has not been given her refund for the 15 days Resident A did not live in the facility.	Yes
Resident A has bruises and cuts on her body and the facility staff does not know how the bruises were inflicted.	No
The facility did not return Resident A's medication after discharge.	No

III. METHODOLOGY

07/22/2024	Special Investigation Intake 2024A0990025
07/23/2024	Special Investigation Initiated - Letter I emailed Matt Sufnar, licensee designee. I requested the resident record.
07/30/2024	Contact - Telephone call made I conducted a phone interview with interview with Relative A.
07/31/2024	APS Referral Adult Protective Services (APS) referral made. APS denied the investigation on 08/01/2024.
07/31/2024	Contact - Document Sent I requested additional documentation from Mr. Sufnar.
07/31/2024	Contact - Document Received I received photos of photos from Relative A of Resident A's bruises.
08/26/2024	Contact - Telephone call made I conducted a phone interview with Relative A.

08/26/2024	Contact - Document Received I reviewed Resident A's resident record.
08/26/2024	Contact - Telephone call made I conducted a follow-up inteview with Relative A.
08/26/2024	Contact - Document Sent I emailed Hollie Macias, nurse at the facility. Ms. Macias replied in detail.
08/26/2024	Contact - Document Sent I emailed Mr. Sufnar. Mr. Sufnar replied in detail.
08/30/2024	Contact - Telephone call made I left a detailed messag e at Beamont Hospital Social work department for "Anna". No return call received to date.
09/03/2024	Exit Conference I conducted an exit conference with Mr. Sufnar.
09/11/2024	Inspection completed onsite I conducted an onsite. I conducted a follow-up interview with Ms. Macias and Mr. Sufnar. A refund check has been submitted to Relative A.

ALLEGATION:

- **Resident A was hospitalized. At discharge, the facility staff informed the hospital staff that Resident A could not return to the facility.**
- **Resident A went home with Relative A. Relative A has not been given her refund for the 15 days Resident A did not live in the facility.**

INVESTIGATION:

On 07/22/2024, I received the complaint via email. In addition to the above allegations, it was reported that Resident A was hospitalized from June 9, 2024, through June 14, 2024, at Beaumont Hospital Troy. The facility's nurse informed the family that the facility was not taking Resident A back because they could not care for her anymore.

On 07/30/2024, I conducted a phone interview with Relative A. Resident A has early onset dementia because of a vehicle accident brain injury that occurred 12 years ago. Resident A is 60 and had to return to Michigan from Arizona because her children could not care for her. Relative A said that before Resident A moved to the facility, she lived with her until she became aggressive with her, which resulted in a physical attack. Due to the physical attack, APS became involved and advised her to place Resident A in a

memory care setting. Relative A said that Resident A moved into the facility on April 24, 2024, directly from the hospital. Relative A confirmed that Resident A was hospitalized from 6/9/2024, to 6/14/2024, but returned to the hospital two days later. Relative A received a call from the facility nurse, Hollie Macias, who informed her that Resident A was sick and needed to return to the Emergency Room (ER). Resident A was walking at the facility bent over and sideways. Resident A also claimed that she could not see.

Relative A said that Ms. Macias came to assess discharge but left Resident A's room and spoke to the nurses on duty at the nurse's station. Relative A said that Ms. Macias left and never returned to the room. Shortly after, a nurse came to Resident A's room and informed her that Ms. Macias told them that Resident A could not return to the facility because she requires one-on-one care and a sitter, which they do not have. Relative A discharged Resident A from the hospital to her private residence. Relative A did not receive a 30-discharge notice or an emergency discharge notice from the facility. Resident A cannot be interviewed due to her decline in cognitive abilities.

On 08/26/2024, I reviewed Resident A's resident record. I reviewed the Troy Beaumont Hospital discharge notice dated 6/92024-6/14/2024. Resident A's diagnosis is altered mental status, gait instability, and dementia with behavioral disturbance. I reviewed the Resident *Care Agreement*, and the cost of care is $5,300 monthly. I reviewed the *Resident Funds II,* and the following payments were made $5300 April-July 2024.

On 08/26/2024, I conducted a phone interview with Relative A. Relative A said she still needed a refund from the facility. Relative A also stated that neither Ms. Macias nor Mr. Sufnar informed her that Resident A required a sitter before returning to the facility. Relative A described that Resident A liked living there. Relative A said she had decorated her apartment nicely, and everything was going fine until the hospitalization. Relative A said that Resident A should not be residing with her due to the previous assault in March 2024. APS advised her to place her in a residential setting. Relative A said that Ms. Macias informed the hospital that she could not return, which forced her to return home without any services in place. Relative A said that she recently got linked with a home health aide to assist Resident A, dependent on assistance with ADLs. Relative A became emotional and stated that the facility discharged her without allowing her time to prepare for a new placement.

On 08/26/2024, I emailed Hollie Macias, the nurse at the facility. Ms. Macias replied that Resident A's family transported her to the emergency room (ER) on 6/92024. The nurse did not assess Resident A before returning to the facility on 6/14/2024. On 6/17/2024, the facility sent Resident A back to the Troy Beaumont Hospital due to a change in posture and balance. Ms. Macias said that after assessing at the hospital on 6/20/2024, she spoke to a nurse named Gina. Gina informed her that Resident A's admitting diagnosis was a "progression of dementia." Ms. Macias informed Gina that Resident A would need 1:1 care/sitter if returning to their facility due to safety concerns. Ms. Macias said that, according to Gina, Resident A had been in restraints. Ms. Macias informed Gina that Resident A must be restraint-free for 24 hours before returning to the community. Before leaving the hospital, Ms. Macias called the hospital social worker

named Anna and left a message regarding a safe discharge plan for Resident A. Ms. Macias said she never received a call back. Ms. Macias said that Relative A had received a discharge notice. She denies that she told Relative A that Resident A could not return. Multiple attempts were made to connect with social workers at the hospital to ensure a safe discharge for Resident A. Ms. Macias said that no one returned her calls. Relative A took Resident A home with her on 6/20/2024.

On 08/26/2024, I emailed Mr. Sufnar. Mr. Sufnar replied that Resident A's last day at the facility was 6/17/2024, as this was the day that she went back to the hospital. Resident A never returned to the facility. Mr. Sufnar received the discharge paperwork when she returned from the hospital on the 14th but did not receive the last discharge notice because she did not return. Mr. Sufnar said that Resident A was a level one for care. Resident A's cost of care for July 2024 was not prorated because they held the family to a "30-day notice" per the contract. Mr. Sufnar said that Relative A was not refunded because she was eligible to return to the facility but did not return. Mr. Sufnar said that Ms. Macias reassessed Resident A and determined that if the hospital was going to send her back, she would need a sitter until she regained strength. Ms. Macias spoke to Resident A's doctor about trying short-term rehab to assist with regaining mobility, but the doctor told her that Resident A would not qualify because she would not participate. Mr. Sufnar said that he explained this to Relative A when she came to the facility before the discharge date to retrieve some clothing and shoes for Resident A. Mr. Sufnar said that he wanted to make sure Relative A knew that if Resident A were to come back, there needed to be interventions to ensure she was safe. Mr. Sufnar said he also had this conversation with Relative A after she took Resident A back home from the hospital. Mr. Sufnar told Relative A about always having someone with Resident A for safety reasons because she was very unsteady.

Mr. Sufnar said that they did not process a refund because they made every attempt to have Resident A come back to the facility, but in the end, the family chose to take her home. Mr. Sufnar did not give Relative A a written discharge notice.

On 09/11/2024, I conducted an onsite investigation. I conducted a follow-up interview with Ms. Macias and Mr. Sufnar. Based on previous conversations, Ms. Macias said that Relative A wanted Resident A back home with her. Ms. Macias said the communication breakdown with the hospital social worker was confusing. Mr. Sufnar said that he issued a refund check h to Relative A.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall

	state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	Based on the investigation, evidence supports that the facility needed to provide Relative A with a written 30-day discharge notice. On 6/20/2024, Hollie Macias visited Resident A while she was hospitalized at Troy Beaumont. Ms. Macias spoke with a nurse about discharge planning. Before Resident A could return to the facility, she needed to be out of restraints for 24-hours and a 1:1 sitter. Ms. Macias did not inform Relative A of this and left the hospital. The hospital staff told Relative A that the facility would not be taking her back and that she had to take her home. As a result, Resident A never returned to the facility and was not provided with a written 30-day notice. Mr. Sufnar admitted that a written 30-day discharge notice was not provided to Relative A.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(14) A licensee shall have a written refund agreement with the resident or his or her designated representative. The agreement shall state under what conditions a refund of the unused portion of the monthly charge that is paid to the home shall be returned to the resident or his or her designated representative. The refund agreement shall provide for, at a minimum, refunds under any of the following conditions: **(b) When a resident has been determined to be at risk pursuant to the provisions of sections 11 and 11a to 11f of Act No. 280 of the Public Acts of 1939, as amended, being SS400.11 and 400.11a to 400.11f of the Michigan Compiled Laws.**

ANALYSIS:	Based on the investigation, there is sufficient evidence that Resident A did not return to the facility after 6/17/2024. On 6/20/2024, Ms. Macias visited the hospital. She informed the hospital nurse that Resident A's needs exceeded the facility's ability to care for her. As a result, Relative A had to move her back home. Relative A had not received a refund of the July 2024 cost of care.
CONCLUSION:	**VIOLATION ESTABLISHED (BUT CORRECTED)**

ALLEGATION:

Resident A has bruises and cuts on her body and the facility staff does not know how the bruises were inflicted.

INVESTIGATION:

On 07/22/2024, in addition to the above allegation, it was reported that Resident A was at Troy Beaumont Hospital's emergency room (ER) with several bruises and cuts. The facility staff did not know how the bruises occurred. The hospital was waiting for the facility to come to the hospital.

On 07/30/2024, I conducted a phone interview with Relative A. Relative A said Resident A was transported to the hospital via ambulance. Upon arriving at the ER, several bruises and cuts were observed on her arms and legs. Relative A sent photos via text message of the bruises. Relative A said that when Resident A was ready for discharge, Ms. Macias came to the hospital to visit Resident A. Relative A said that Ms. Macias observed Resident A's bruises but did not say how they were inflicted.

On 07/31/2024, Relative A sent me photos of Resident A's bruises. I reviewed seven photos. There were round, circular red bruises on the lower calves, below the knees, on each shoulder, and each upper inner arm.

On 08/26/2024, I interviewed Ms. Macias. Ms. Macias said that when Resident A returned from the hospital on 6/14/2024, the ambulance (EMS) stated that she was combative and had to be restrained to get her on the stretcher. Ms. Macias did a skin assessment while Relative A was present when she returned. Resident A had multiple areas on bilateral arms and legs with bruising, and that was documented. Ms. Macias said Resident A had to be restrained at the hospital for both visits. Ms. Macias said that the bruises were due to the restraints.

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:	There is insufficient evidence that the staff did not protect Resident A. Resident A had to be restrained by EMS and at Troy Beaumont. As a result, the bruises appear in areas where an EMS or the hospital would restrain Relative A. The bruises were in circular patterns on her calves, knees, upper arms, and shoulders. The bruises are a result of Resident A's altered state and aggression at the time of hospitalization.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The facility did not return Resident A's medication after discharge.

INVESTIGATION:

On 07/22/2024, I received the complaint via email. In addition to the above allegation, it was reported Resident A's medication was picked up from the facility after the facility refused to allow her back. Resident A's meds are missing. The facility is now saying they will pay for missing meds. The facility had signed for Resident A's medicine without her living there. They did not contact Relative A about the medicine.

On 07/30/2024, I interviewed Relative A. Relative A said that the pharmacy facility sent her a bill for $29.12 for June 15 and June 21, 2024. Relative A said that Resident A never returned to the facility after June 17, 2024, and is unsure why they filled a new script. Relative A said that she went to the facility after they discharged her and retrieved her medications. Relative A spoke to a pharmacist named Eddie, who informed her he would take care of the bill. Relative A said that she now has the medications from the facility.

On 08/26/2024, I interviewed Ms. Macias. Ms. Macias said that Relative A picked up and signed out all Resident A's medications on June 22, 2024. The facility did not order any prescriptions after June 14, 2024. Cornwell Health (Troy Beaumont) sent orders directly to the pharmacy on two separate occasions. On June 15, 2024, the hospital sent an order directly to Pharmascript for Vitamin D, and on June 20, 20, 2024, the hospital sent orders directly to Pharmascript for Depakote and Seroquel.

On 08/26/2024, I reviewed Resident A's resident record. I reviewed a Medication Release form dated June 22, 2024, signed by Ms. Macias and Relative A. I also reviewed the Medication Administration Record (MAR); all medications were listed on the release form.

On 09/03/2024, I conducted an exit conference with Mr. Sufnar. Mr. Sufnar was informed that a 30-day discharge notice should always be provided, as well as for emergency discharges. We discussed the findings, and it was determined that the hospital communicated to Relative A that the facility was not taking Resident A back. I advised Mr. Sufnar that Ms. Macias should have directly explained the discharge plan to Relative A. Mr. Sufnar agreed that Relative A's July rent should be prorated due to the discrepancies with the discharge from the facility. Ms. Sufnar agreed. Mr. Sufnar will submit a corrective action plan once the report is finalized.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	There is insufficient evidence to support that Relative A did not receive Resident A's medications after she moved out of the facility. On 6/22/2024, Relative A signed a medication release form with 10 medicines provided. According to Ms. Macias, the facility did not order a new prescription for Resident A. According to Ms. Macias, Troy Beaumont Hospital ordered two prescriptions on 6/20/2024.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

L. Reed

09/11/2024

LaShonda Reed Date
Licensing Consultant

Approved By:

Denise Y. Nunn

09/18/2024

Denise Y. Nunn Date
Area Manager