GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2025

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

RE: License #: AL630417060
Investigation #: 2025A0605005
The Courtyard At Auburn Hills 4

Dear Matthew 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.
- 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,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd.
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 #:	AL630417060
Investigation #:	2025A0605005
Complaint Receipt Date:	01/24/2025
Investigation Initiation Date:	01/27/2025
Report Due Date:	03/25/2025
Licensee Name:	Encore McHenry
Licensee Address:	Suite 710 230 West Monroe Chicago, IL 60606
Licensee Telephone #:	(248) 340-9296
Administrator/Licensee Designee:	Matthew Sufnar
Name of Facility:	The Courtyard At Auburn Hills 4
Facility Address:	3033 N. Squirrel Rd. Auburn Hills, MI 48326
Facility Telephone #:	(248) 340-9296
Original Issuance Date:	08/01/2024
License Status:	TEMPORARY
Effective Date:	08/01/2024
Expiration Date:	01/31/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED; ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident was found on the floor and staff did not know what to do.	Yes

III. METHODOLOGY

01/24/2025	Special Investigation Intake 2025A0605005
01/27/2025	Special Investigation Initiated - On Site I conducted an unannounced on-site investigation
01/27/2025	Contact - Telephone call made Interviewed All American Home Care Hospice registered nurse (RN) and direct care staff (DCS)
01/27/2025	Contact - Document Sent Email to licensee designee Tonya Carter
01/27/2025	APS Referral Adult Protective Services (APS) made referral but will not be investigating these allegations
01/29/2025	Contact - Document Received Email from licensee designee
03/03/2025	Contact - Telephone call made Interviewed DCS and Resident A's daughter. Left messages for DCS.
03/03/2025	Contact - Telephone call made Interviewed Resident B's hospice staff with Careline
03/03/2025	Contact - Telephone call received Interviewed home health care aide with Careline Hospice regarding Resident B
03/03/2025	Contact - Telephone call made Registered Nurse (RN) Jodi Caloni stated she will call me back to discuss allegations
03/03/2025	Contact - Telephone call received Jodi Caloni left message

03/03/2025	Contact - Telephone call made Left message for Jodi Caloni to return call
03/04/2025	Contact - Telephone call made Left another message for Jodi Caloni
03/04/2025	Contact - Telephone call received Interviewed Jodi Caloni regarding the allegations
03/11/2025	Exit Conference Conducted exit conference with licensee designee Matthew Sufnar

ALLEGATION:

Resident was found on the floor and staff did not know what to do.

INVESTIGATION:

On 01/24/2025, intake #204065 was referred by Adult Protective Services regarding a resident (name unknown) fell on the floor and staff did not know what to do in Cottage I.

On 01/27/2025, I conducted an unannounced on-site investigation at The Courtyard at Auburn Hills. I met with licensee designee Tonya Carter in Cottage 3. Ms. Carter denied there was a fall in Cottage I but stated there was a resident fall in Cottage 4. Resident A fell on 01/20/2025 and then fell again on 01/24/2025. Resident A is bedbound, requires full care and is receiving hospice services with All American Hospice. There are no new staff in Cottage 4 that would not know how to provide care to any resident. There is one direct care staff (DCS) for six residents at Cottage 4. According to Ms. Carter, there is no resident including Resident A that is a two-person assist. On 01/20/2025, Resident A was found during rounds sitting on her buttocks on the bed as she was trying to get out of bed. According to the incident report (IR) written by the medication technician Barbara Blackmon, it stated, “Resident was sitting on buttocks leaning on bed on floor during routine rounds.” It is unclear if Resident A was found on the bed or on the floor and what staff did after finding Resident A. The IR was incomplete.

I reviewed an IR dated 01/24/2025, regarding Resident A’s second fall. According to the IR written by Licensed Practical Nurse (LPN) Jodi Caloni, “Resident found bedside with laceration on her forehead. Fall was unwitnessed. Unable to state what she was trying to do. Nurse on duty came and applied first aide to laceration to her head. Cleaned laceration and applied pressure with gauze. Notified hospice.” The protective measures that were put in place after both falls was a floor mat and two-hour checks by staff. Also, after the fall on 01/24/2025, hospice increased visits to three times a week. Ms. Carter stated that the corporate office does not allow bed rails or bed alarms as that is “the policy.”

I reviewed Resident A's assessment plan and according to the plan, Resident A is a one-two person assist with personal care and transfers. Ms. Carter stated that was "incorrect," because if Resident A was a two-person assist she would be in Cottage 2, where there are two DCS per shift. Ms. Carter is working with Ms. Caloni to get the assessment plan corrected to reflect one-person assist.

On 01/27/2025, I interviewed Amber Carmichael, the care team coordinator regarding the allegations. Ms. Amber was present at the facility on 01/24/2025 when Resident A fell the second time. She was in a business meeting when she received a text message saying that "Resident A fell, and her forehead was bleeding." She went to Resident A's bedroom, got a towel and placed it on Resident A's forehead. All American Hospice nurse Derrick was contacted and arrived at the facility and evaluated Resident A. It was determined after Derrick contacted the family that Resident A would not go to the hospital. Derrick treated the laceration. She does not know what happened afterwards. The DCS on shift was Jameela Powell and she was the only staff member working as there is one DCS per shift at Cottage 4.

On 01/27/2025, Ms. Carter escorted me to Resident A's bedroom. Resident A was lying in bed with her Geri Chair right up against her hospital bed with the floor mat underneath the bed. It appeared staff were placing the Geri Chair next to the bed preventing Resident A from getting out. Ms. Carter moved the chair and stated she will talk to staff informing them not to place the chair against Resident A's bed. I attempted to interview Resident A but was unsuccessful. She did not respond to any question and was nodding off. I observed a cut above her left eye and a right black eye.

On 01/27/2025, I interviewed Resident B in her bedroom. Resident B uses a walker to ambulate. She likes it here, but it took time to get used to living here. She heard Resident A is not doing well but does not know how she got the cut on her forehead. Resident B reported there are times when she pulls the string for help, and it takes staff awhile to help her.

On 01/27/2025, I attempted to interview Resident C, but she had a headache and was not feeling well.

On 01/27/2025, I interviewed husband and wife Resident D and Resident E. They share a bedroom. Resident D and Resident E said that living here was "OK." There have been times when they can't locate staff. Resident D stated, "One time I walked the entire building and couldn't find staff. I had a question but then when I didn't find them, I returned to my bedroom and said, "I guess it's not important."

On 01/27/2025, I attempted to interview Resident F who was lying in bed. Resident F is non-ambulatory and has a wheelchair in her bedroom. I was unable to gather any information from Resident F.

Note: After speaking with the residents, I was unable to locate staff and began calling out Tonya Carter and received no response. I then began yelling “Hello,” anyone here.” I walked around the building and found DCS Portia Pierce in Resident C’s bedroom.

On 01/27/2025, I interviewed DCS Portia Pierce who was working at the time of my onsite at Cottage 4. She has been working for this corporation for three months. She works first shift from 7AM-3:30PM alone as there is one DCS per shift. On 01/20/2025, she arrived at her shift at 6:40AM and Resident A was sleeping. Ms. Pierce said that Resident A was found during her second set of rounds, leaning against the bed with her feet flat on the mat. It took three staff to get her up and put her back into bed. Ms. Pierce wanted to complete the IR but was told by LPN Jodi Caloni not to and to have Barbara Blackmon complete instead. Ms. Pierce is not sure if Ms. Blackmon completed the IR or not. Ms. Pierce stated she “repeatedly advised Jody the LPN at Courtyard Manor of Auburn Hills that Resident A is a two-person assist. Jody told me that Resident A is not a two person assist and that she (Resident A) was high on morphine which caused her to be a two person assist.” Ms. Pierce then told Jody “I provide the care to Resident A, and I know that Resident A requires two people to provide care.” Ms. Pierce stated there are times when she is helping a resident when another resident needs her help, but they must wait until she is done before she can help them. Ms. Pierce believes there needs to be at least two DCS per shift for the care of these residents since she believes Resident A is a two-person assist. As a protective measure for Resident A, DCS Chris told her that the Geri Chair placed against Resident A’s bed was to “prevent her from getting out of bed and falling.” Ms. Pierce was told that the Geri Chair was placed against the bed since Resident A’s initial fall on 01/20/2025. There are no bed alarms or bed rails other than a U-shaped bed rail at one side of Resident A’s bedroom to have Resident A hold onto the rail when she used to assist with pivots and transfers.

On 01/27/2025, I interviewed All American Hospice nurse Derrick via telephone. Resident A fell twice; once on 01/20/2025 and again on 01/24/2025. After her fall on 01/24/2025, Resident A became a two-person assist with transfers and one person for turns when DCS are providing care in bed. Resident A was alert and oriented times four when she moved into this facility, but due to her decline, she is now alert and oriented times zero. The family is adamant not to administer morphine and due to no morphine, her needs increased. She began wanting to get out of bed which resulted in the falls. He was informed that floating staff were assisting DCS during the day, but he did not get a sense of any floating staff during the midnight shift.

On 01/27/2025, I called DCS Aviance James regarding the allegations. Ms. James has only been working at this facility for two weeks. She was present with DCS Portia Pierce on 01/20/2025 when Resident A fell. She and Ms. Pierce were making rounds when both found Resident A on the edge of the bed almost on the floor. Ms. James stated, “It took three of us to get her up and back into bed because she’s heavy.” The third person was the medication technician Barbara Blackmon. Ms. James had no other information to provide.

On 01/27/2025, I called DCS Rayneisha White regarding the allegations. Ms. White has been with this corporation for one month. She works midnight shift. Ms. White was not working on 01/20/2025; but stated she arrived at Cottage 4 last night and saw the cut on Resident A's forehead. She was told by the medication technician Barbara Blackmon that "Resident A fell three times on 01/24/2025 during the morning shift." Ms. White was informed by another staff member (name unknown) that the Geri chair is placed against Resident A's bed to "prevent her from falling." When Resident A moved into Cottage 4, she was ambulatory and a one-person assist, but since Ms. White has worked at Cottage 4, Resident A has always been a two-person assist with all care including changing in bed and transfers. Ms. White stated, "I asked Jodi the LPN how I'm supposed to care for Resident A with only one person when she's a two-person assist. Jodi said, "she's not a two-person assist and that one-person can provide care." Jodi told Ms. White that the high morphine Resident A was given prior to admission was causing Resident A not to assist with her transfers or rolling over in bed when being changed. Ms. White stated that she cannot provide care to Resident A without another DCS, and this has been expressed to Jodi numerous times but there is no increase in staff at Cottage 4 to help meet the needs of Resident A who is a two-person assist especially since her falls on 01/24/2025.

On 03/03/2025, I contacted medication technician Barbara Blackmon regarding the allegations. Ms. Blackmon has been with this corporation for two years. She is a floater between Cottage 3 and Cottage 4. She was present on 01/20/2025, working between both cottages when she was called by another staff regarding Resident A. She does not recall how she fell as it was "a while ago," but stated that "Resident A has always been a two-person assist." Ms. Blackmon stated there is only one DCS per shift at Cottage 4. In addition, Resident F is also a two-person assist but Resident F has since passed away. Ms. Blackmon had no additional information to provide.

On 03/03/2025, I contacted DCS Jameela Powell via telephone regarding the allegations. Ms. Powell was with this corporation for eight months before her employment was terminated one month ago. She worked morning shifts from 7AM-3PM. She was not present on 01/20/2025 but was present morning of 01/24/2025 when Resident A "fell, multiple times." Ms. Powell found Resident A on the floor, head bleeding and because she was the only DCS working, she left Cottage 4, ran to Cottage 3 to get help. Three staff members, Ms. Powell, Amber the care coordinator, and another manager Amanda had to pick up Resident A off the floor. After this fall, Ms. Powell expressed concerns to Jodi, the LPN that Resident A is a two-person assist because every time Resident A fell, the staff on shift must request help from another staff member at Cottage 3. Ms. Powell denied that any protective measures were put in place other than the mat. She stated, "Jodi told us to put the Geri chair against her bed to prevent her from falling." Ms. Powell asked for bed rails, but she was denied stating that this corporation does not allow bed rails. Ms. Powell believes Resident F was a two-person assist too because the aide with Careline Hospice complained to her about needing two people to transfer her and shower her. Ms. Powell stated that staff was never increased after her complaints.

On 03/03/2025, I contacted Candy, the administrator with Careline Hospice regarding Resident F. She reviewed Resident F's care plan and according to the plan or care, Resident F is a one-two person assist with transfers. Candy acknowledged that the care plan was unclear when noted one-two persons and stated she will have Albert, Resident F's aide call me.

On 03/03/2025, I received a call from Albert, Resident F's personal aide with Careline Hospice. Albert stated he was visiting with Resident F twice weekly and then increased to three times weekly. He stated, "it depended on the day, but Resident F was a one-two person transfer." When Resident F was able to assist with pivoting and standing, she was a one-person assist but that towards the end, she became a two-person assist because she could no longer assist with transfers. Therefore, he switched from showers to bed baths since he could not get a DCS to assist with showers. There was only one DCS per shift. However, there were times that only two DCS would assist him with showers while all others would not. Resident F's services stopped on 02/22/2025 after she passed away.

On 03/03/2025, I contacted Resident A's daughter to discuss the allegations. Resident A's son-in-law is Resident A's durable power of attorney (DPOA); therefore, Resident A's daughter would feel more comfortable if the call took place with the DPOA. The daughter agreed to a conference call on 03/04/2025 at 10:30AM.

On 03/03/2025, I contacted Jodi Caloni, the LPN with this corporation and discussed the allegations. Resident A moved in on 01/06/2025. She was assessed a week prior to her admission as a one-person standby assist as she was ambulatory and can do everything on her own; however, after she moved in, she had morphine toxicity which attributed to her decline. Even with her decline, she was assisting staff with transfers and was still a one-person assist. The family believed that once the morphine wore off, she would get better, but then she fell on 01/20/2025. After this fall, Jodi stated she reassessed Resident A and talked to family who continued to believe that one-person could transfer Resident A even after Jodi expressed that staff were not comfortable with one-person and that she possibly requires two-persons for care. On this day, Jodi picked Resident A up off the floor with a gait belt. The protective measures put in place by Tonya Carter was the floor mat from All American Hospice that was providing services and every two hours checks. There was no injury after this fall. However, on 01/24/2025, Resident A fell again, hit her head on the nightstand resulting in a laceration above her eye.

Jodi conducted another assessment and informed Ms. Carter that Resident A is now a two-person assist and needed to transfer to Cottage 2. A verbal consultation was conducted with the family, but an assessment was not completed until 01/30/2025 which then it was agreed that Resident A would move. Resident A was moved to Cottage 2. From 01/24/2025-01/30/2025, Ms. Carter never increased staffing from one-DCS to two-DCS after being informed that Resident A was now a two-person assist. The nightstand was pushed away from the bed, staff were advised to continue to have

the floor mat near bed, and then to move to Cottage 2 even though the move was not done until 01/30/2025. Jodi stated she never advised any staff member to place Geri chair against Resident A's bed and that she re-educated staff on not blocking Resident A with the chair. Jodi has put in her notice for resignation due to the many concerns she has observed with Ms. Carter. Jodi has expressed to Ms. Carter that Resident A is a two-person assist but Ms. Carter disagrees and completes the assessments herself to reflect one-person assist. Jodi gets dismissed by Ms. Carter who does not act with the many concerns that Jodi brings to her attention. Specifically concerns regarding residents' assessment plans. Jodi stated that when I was at the facility on 01/27/2025 and requested Resident A's correct assessment plan, Jodi was told by Ms. Carter to edit the plan to reflect one-person assist. Jodi is the third nurse that has been working at this facility since Ms. Carter has been in charge. Jodi believes that Ms. Carter is falsifying documents because when Ms. Carter does not agree with Jodi's assessment plans, Ms. Carter is reassessing the residents ensuring that the assessment plan reflects one-person assist even though they require two-persons. Jodi has emailed all her concerns to corporate, but nothing is done. Ms. Carter continues to disregard Jodi's concerns and alters documents to fit Ms. Carter's needs.

On 03/04/2025, I conducted the conference call with Resident A's family: daughters and DPOA. Resident A's health was descent, she was ambulatory with a walker, and she had All American Hospice seeing her twice weekly. A week prior to moving in, she began having problems with her hands and her mobility. She was unable to use her hands to help her get up because they swelled and would cause pain. She was on high morphine which resulted in her decline so family believed that once the morphine was out of her system, she would be better. However, within two-three weeks at Cottage 4, she had a couple of falls and was informed that she required additional help. On 01/24/2025, The daughter went to Cottage 4 after being called regarding Resident A fell, hit her head resulting in a laceration on her forehead. The daughter stated that Resident A was talking to her and then Derrick, the nurse with All American Hospice arrived to evaluate her along with the LPN Jodi. It was determined and agreed by all that Resident A did not need to go to the hospital. However, after this fall, she was assessed as a two-person assist which the family believes was being provided with a floater staff. The DPOA stated that he and the family are satisfied with the care being provided as everyone has been very transparent and overall supportive with Resident A's needs. On 01/30/2025, Resident A was moved into Cottage 2 with two DCS to assist for her care. They all feel comfortable that Resident A is at this facility.

On 03/11/2025, I conducted the exit conference with licensee designee Matthew Sufnar. Mr. Sufnar stated that he believed that Tonya Carter has been updated to reflect she is the licensee designee. Mr. Sufnar was advised that the department has been waiting for Ms. Carter's fingerprinting that have yet to be completed. Mr. Sufnar was not informed of this investigation; therefore, I advised him of the allegations and of my findings. I also expressed the concerns that were brought to my attention regarding Ms. Carter and her decision to edit assessment plans to reflect one-person assist instead of assessing residents properly to staff adequately per their needs. Mr. Sufnar stated he will take these concerns to their Regional Director Marie Lynn.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on my investigation and information gathered, there was insufficient staff on duty to provide for Resident A's supervision, personal care, and protection. Resident A resided at Cottage 4 where there is only one DCS per shift. On 01/06/2024, Resident A moved into Cottage 4 as a one-person assist. However, after her second fall on 01/24/2025, her care increased. It was determined by both All American Hospice nurse and LPN Jodi Caloni that Resident A required additional help with transfers and was now a two-person assist. This information was shared with acting licensee designee Tonya Carter. Ms. Carter did not increase staff to meet the needs of Resident A. Instead, staff were blocking Resident A's bed with her Geri chair to prevent her from falling.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**

ANALYSIS:	Based on my investigation and information gathered, Cottage 4 along with staff did not have the amount of personal care, supervision, and protection that is required by Resident A available. Resident A became a two-person assist on 01/24/2025; however, acting licensee designee Tonya Carter did not have sufficient staff per shift nor did she advise staff on how to provide for the care of Resident A. Instead, staff were placing a Geri chair against Resident A's bed to block Resident A from getting up and falling out of bed. Resident A was not moved into the appropriate cottage until 01/30/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 supervision, personal care, and protection are not attended to at all times. Resident A moved into Cottage 4 as a one-person assist; however, after falling on 01/20/2025 and again on 01/24/2025 her care increased. It was determined by both All American Hospice nurse and LPN Jodi Caloni that Resident A required additional help and was a two-person assist. This information was shared with acting licensee designee Tonya Carter, but staff was not increased from one DCS to two DCS. Resident A was moved from Cottage 4 into Cottage 2 where there is two-DCS per shift on 01/30/2025. In addition, Ms. Carter was not completing assessments properly to staff adequately in Cottage 4. Jodi was completing assessments based on the residents' needs and when it was expressed to Ms. Carter that the resident is a two-person assist, Ms. Carter was reassessing the resident and editing the assessment plans to reflect one-person assist.
CONCLUSION:	**VIOLATION ESTABLISHED**

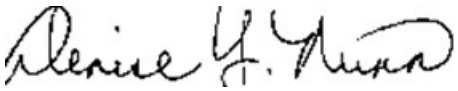
IV. RECOMMENDATION

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

03/11/2025

Frodet Dawisha — Date
Licensing Consultant

Approved By:



03/11/2025

Denise Y. Nunn — Date
Area Manager