GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 14, 2025

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

RE: License #: AL630417059
Investigation #: 2025A0612015
The Courtyard at Auburn Hills 3

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.
- 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,

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630417059
Investigation #:	2025A0612015
Complaint Receipt Date:	03/25/2025
Investigation Initiation Date:	03/26/2025
Report Due Date:	05/24/2025
Licensee Name:	Encore McHenry
Licensee Address:	Suite 710 - 230 West Monroe Chicago, IL 60606
Licensee Telephone #:	(248) 340-9296
Administrator:	Matthew Sufnar
Licensee Designee:	Matthew Sufnar
Name of Facility:	The Courtyard At Auburn Hills 3
Facility Address:	3033 N. Squirrel Rd. Auburn Hills, MI 48326
Facility Telephone #:	(312) 623-0884
Original Issuance Date:	11/13/2023
License Status:	REGULAR
Effective Date:	05/13/2024
Expiration Date:	05/12/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 02/22/25, Resident A's sugar was low, the facility gave her a dose of insulin. When they came back later to take her blood sugar it was even lower than before, they administered another dose of insulin. Resident A was unresponsive.	Yes
Resident A's BiPAP was not put on her at night.	Yes
Courtyard at Auburn Hills 3 has no residents. The facility is being updated.	Yes

III. METHODOLOGY

03/25/2025	Special Investigation Intake 2025A0612015
03/26/2025	APS Referral An Adult Protective Services (APS) referral was not made as the resident is deceased.
03/26/2025	Special Investigation Initiated - Telephone Telephone call to reporting source.
03/27/2025	Contact - Telephone call made Telephone call to reporting source.
03/27/2025	Contact - Document Received Documentation received from reporting source via email.
03/27/2025	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed executive administrator Tonya Carter. Ms. Carter provided copies of facility documentation.
04/01/2025	Contact - Telephone call received Telephone call received from direct care staff Devlyn Norris.
04/01/2025	Contact - Document Sent

	Email sent to St. Croix hospice vice president of clinical operations Jennifer Lemere requesting medical records.
04/01/2025	Contact - Telephone call made Telephone call to direct care staff Devlyn Norris. No answer. I left a voicemail requesting a return call. I sent a follow up text message requesting a return call.
04/02/2025	Contact - Document Received Resident A's medical record received via email from St. Croix hospice.
04/02/2025	Contact - Telephone call made Telephone interview completed with Courtyard assistant wellness director Amber Carmichael.
04/07/2025	Contact - Telephone call made Telephone call to direct care staff Devlyn Norris. No answer. I left a voicemail requesting a return call. I sent a follow up text message requesting a return call.
04/07/2025	Contact - Telephone call made Telephone interviews completed with St. Croix hospice vice president of clinical operations Jennifer Lemere, executive administrator Tonya Carter, and licensing consultant Cindy Berry.
04/07/2025	Contact – Documentation sent Text messages exchanged with Courtyard assistant wellness director Amber Carmichael to set up a time to interview direct care staff Devlyn Norris. Interview scheduled for 04/08/25, at 3:00 pm during Ms. Norris's scheduled shift.
04/08/2025	Contact - Telephone call received Telephone call received from direct care staff Devlyn Norris.
04/09/2025	Contact - Telephone call made Telephone call to direct care staff Devlyn Norris. No answer. I left a voicemail requesting a return call. I sent a follow up text message requesting a return call.
04/09/2025	Contact – Telephone call made Telephone interviews completed with direct care staff LayLa Murphy and Barbara Blackmon. Telephone call to direct care staff Tanisha Cichoracki. No answer. I left a voicemail requesting a return call. I sent a follow up text message requesting a return call.

04/10/2025	Contact – Telephone call made Telephone interview completed with direct care staff Tanisha Cichoracki.
04/15/2025	Exit Conference I placed a telephone call to licensee designee Matthew Sufnar and executive administrator Tonya Carter to conduct an exit conference.
04/15/2025	Exit Conference I placed a telephone call to the reporting source to review my findings.

ALLEGATION:

On 02/22/25, Resident A's sugar was low, the facility gave her a dose of insulin. When they came back later to take her blood sugar it was even lower than before, they administered another dose of insulin. Resident A was unresponsive.

INVESTIGATION:

On 03/25/25, I received an intake that indicated Resident A died on March 13, 2025. Resident A was a diabetic, she received insulin for years. Resident A's sugar was low, and the facility gave her a dose of insulin. When they came back to take her blood sugar it was even lower than before, they administered another dose of insulin. When they came in to do their regular check, Resident A was unresponsive, and they could not wake her up. Resident A's sugar was low starting in the afternoon, and they did not contact the hospice nurse until 9:30 pm when they found Resident A unresponsive. On 03/26/25, I initiated my investigation by placing a telephone call to reporting source. There was no answer. I left a voicemail requesting a return call.

On 03/27/25, I placed a telephone call to the reporting source (RS). I acknowledged the receipt of the complaint and informed RS that an investigation has been initiated. RS chose to provide written correspondence detailing her complaint. RS provided a detailed summary of daily visits with Resident A dated 02/08/25 – 03/13/25. The notes include, but are not limited to, observations and discussions with Courtyard at Auburn Hills staff, discussions with St. Croix hospice staff, discussions with hospital doctors, Resident A's medical status, and medication changes. Below is a summary of the written correspondence provided for dates that pertinent to this allegation.

- **02/22/25 –** at 12:30 pm RS, Family Member 1 (FM1), Family Member (FM3), and Family Member 4 (FM4) visited Resident A at Courtyard. Direct care staff Barb was feeding Resident A ice cream. Barb said Resident A's sugar was low.

Resident A was still awake. The family completed their visit around 4:00 pm. At 11:15 pm Family Member 2 (FM2) received a call from St, Croix hospice nurse Ashely who said they called 911 to take Resident A to the hospital for blood sugar of 36. Resident A was unresponsive. Resident A was transported to Henry Ford Health for treatment.

- **02/23/25 -** While Resident A was in the hospital RS spoke to St. Croix hospice nurse Ashley who said Courtyard called the hospice nurse between 9:00 pm and 9:30 pm on 02/22/25, when they found Resident A unresponsive. Ashley stated that even though they knew her sugar was low, she was given two separate doses of insulin. Ashley asked why they gave her insulin, and they said because it was on the medication list. Courtyard staff told Ashley they tried calling Courtyard head of nursing Julie and there was no response. Courtyard staff told Ashley they finally got ahold of Courtyard assistant wellness director Amber and was told to give her insulin.
- **02/24/25 -** Henry Ford Health RN said they are discharging Resident A. RS said no because she was not comfortable sending her back to Courtyard after she almost died from an insulin overdose. RS asked to speak to the doctor who was discharging. Dr. Samrah with Henry Ford called RS at 1:43 pm and RS expressed concern about the insulin. RS asked for hospital to keep Resident A for one more day because she and FM1 setup a meeting with Courtyard and St. Croix hospice for 02/25/25, to discuss this error. The doctor acknowledged the concern and said he will talk to the diabetic doctor and call back. Dr. Samrah called back and said he will remove all insulin doses and just use a sliding scale (Resident A was also on mandated timed doses along with sliding scale) so they know exactly how much insulin to give based on her sugar number. No more mandated timed doses. RS agreed and Resident A was discharged and transported back to Courtyard.
- **02/25/25 –** At 2:30 pm, there was a meeting regarding Resident A and the insulin incident. In attendance was RS, FM1, Courtyard staff - Tonya, Julie, Amber, St. Croix hospice case worker Karrie, St. Croix hospice nurse Latasha, and St. Croix hospice nurse Ashley who was involved but did not attend. Courtyard cannot defend their actions because they clearly know it is negligence that almost killed Resident A. They stated that they are having a meeting to retrain the employees on insulin injections.

On 03/28/25, I completed an unscheduled onsite investigation. I interviewed executive administrator Tonya Carter. Ms. Carter provided copies of relevant facility documentation.

On 03/28/25, I interviewed executive administrator Tonya Carter while onsite. On 04/07/25, I completed a second interview with Ms. Carter via telephone. Ms. Carter

stated Resident A lived in this facility for approximately two years. Initially, she received hospice services from Accent Care. In early February 2025, Resident A began to decline. The family was notified. The family chose to send Resident A to the hospital to receive acute care. Resident A was hospitalized from 02/15/25 – 02/20/25. The hospital said that she was not doing well, but she was discharged back to the facility with hospice care, she was a full code. Upon discharge from the hospital Resident A changed hospice providers to St. Croix hospice. Ms. Carter stated Resident A was bedbound, she did not eat much, and she was not very responsive.

Ms. Carter stated on 02/22/25, at 9:31 pm she received a text message from assistant wellness director Amber Carmichael who said that direct care staff Devlyn Norris tried to call her because Resident A's blood sugar "bottomed out" and she was being sent to the hospital per hospice directive. Ms. Carter stated she was unaware of the extent of what happened until 02/25/25, when Resident A's son and daughter called and requested a meeting. They informed her that a staff administered insulin to Resident A when her blood sugar was low. Ms. Carter stated she investigated the issue and noted that Resident A was on scheduled insulin with no directive for when to hold the medication. On 02/22/25, direct care staff Devlyn Norris checked Resident A's blood sugar at 6:16 pm it was 61. Ms. Norris administered 16 units of insulin. Ms. Norris checked Resident A's blood sugar again at 9:30 pm it was 46. Ms. Norris administered another 16 units of insulin. Ms. Carter stated a healthy blood sugar is between 70 – 100, both of Resident A's reads were very low. Ms. Carter stated typically when administering insulin, the prescription order will indicate when to administer the medication and when to hold it depending on the person's blood sugar level. Resident A's prescription did not include this information. Ms. Carter stated Resident A was nonresponsive, cold, and clammy however, she notes it was not uncommon for Resident A to present this way. Ms. Norris called St. Croix hospice and assistant wellness director Amber Carmichael. St. Croix hospice staff arrived between 9:30 pm – 9:40 pm and advised that Resident A be sent to the hospital. Ms. Carter stated Resident A was hospitalized from 02/22/25 – 02/24/25. Upon discharge from the hospital, she returned to the facility.

Ms. Carter stated all staff completed an in-service on administering insulin. All resident medications were audited to insure they include all necessary instructions. Ms. Norris received a corrective action and one on one coaching. Ms. Carter stated she added a note on the medication administration record which indicates when to hold the insulin depending on the resident's blood sugar. Ms. Carter stated the original insulin prescription was received from Accent Care hospice, then St. Croix hospice picked it up when they became Resident A's hospice provider. Pharma Script of Michigan filled the medication order. Ms. Carter stated the director of wellness Jodi Caloni, was responsible for verifying all resident medications are accurate and the orders included all the necessary instructions. Ms. Caloni is no longer employed with Courtyard at

Auburn Hills, her last day was 03/05/25. Her departure was not related to this investigation.

On 04/01/25 and 04/07/25, I interviewed St. Croix hospice vice president of clinical operations Jennifer Lemere via telephone. Ms. Lemere informed me that St. Croix nurse Ashley Cooper is no longer employed with St. Croix hospice. Ms. Lemere further stated that St. Croix social worker Karrie Burnett is currently out on medical leave. Ms. Lemere stated that it is the facilities responsibility to ensure that the instructions for when to hold insulin are on the facilities records. This information was not included on the prescription. Ms. Lemere stated a normal blood sugar is around 100. I requested any written documentation on file related to this investigation. Per Ms. Lemere's request I followed up with a written email detailing my request.

On 04/02/25, I interviewed Courtyard assistant wellness director Amber Carmichael via telephone. Ms. Carmichael stated on 02/22/25, around 9:16 pm she received a telephone call from direct care staff Devlyn Norris who said Resident A's blood sugar was low. Ms. Norris had previously tried to call the director of wellness Jodi Caloni and executive administrator Tonya Carter, but neither of them answered. Ms. Norris had already contacted St. Croix hospice. Ms. Carmichael stated she advised Ms. Norris to give Resident A orange juice with sugar in it and peanut butter while she waited for hospice to arrive. Ms. Carmichael denies that she instructed Ms. Norris to administer any medications.

On 04/09/25, I interviewed direct care staff LayLa Murphy via telephone. Ms. Murphy stated she works the morning shift 7:00 am – 3:00 pm and second shift 3:00 pm – 11:00 pm. Ms. Murphy is a med tech, and she has administered medications to Resident A including her insulin. Ms. Murphy stated when she was trained to administer medications, she learned about blood sugar and when insulin should and should not be administered depending on the resident's blood sugar level. Ms. Murphy stated if a resident's blood sugar is too high or too low the staff should follow the chain of command and contact their supervisor and/or hospice if applicable.

On 04/09/25, I interviewed direct care staff Barbara Blackmon via telephone. Ms. Blackmon stated she is a lead med aid. She works the morning shift 7:00 am – 3:00 pm. Ms. Blackmon stated she administered Resident A medications including her insulin. When administering medication, if Resident A's blood sugar was 100 or lower, she would contact Resident A's hospice provider. Typically, they would advise her to not administer insulin. Ms. Blackmon stated when this occurred, she would document on the medication log. Ms. Blackmon further stated if Resident A's sugar was low in the morning, she would give her orange juice to bring it up. Additionally, if Resident A's blood sugar was below 60, she was prescribed Glucagon to use as needed.

On 04/10/25, I interviewed direct care staff Tanisha Cichoracki via telephone. Ms. Cichoracki stated she is a med tec. She works second shift 3:00 pm – 11:00 pm. Ms. Cichoracki stated she administered Resident A medications including her insulin. When administering medication, if Resident A's blood sugar was 100 or lower, she would contact Resident A's hospice provider and management. Insulin would not be administered.

On 04/02/25, I reviewed Resident A's St. Croix hospice medical records that were provided via email from St. Croix hospice. The following is relevant information:

Triage note: 02/22/2025 8:12:31 pm written by Maria Edwards RN, triage nurse. Facility staff Devlyn called to report hypoglycemic episode. Blood sugar measured at 46, patient is not able to swallow medications due to being mostly unresponsive. Caller requesting nurse visit. RN on-call notified to complete visit.

On Call note: 02/22/2025 PRN visit due to hypoglycemia written by Ashley Cooper, RN. Upon arrival patient in bed, unresponsive to verbal and tactile stimuli. Blood sugar noted to be 38, RN inquired about what interventions were already completed. Facility staff reports when patients' blood sugar was 46, she contacted St. Croix hospice. However, when getting off the phone she contacted her supervisor who advised her to administer 16 units of Humalog and 22 units of Lantus. RN immediately contacted MD, ordered to send out 911. RN contacted 911 and family to report. RN checked facility Medication Administration Record and noted insulin was not given in the morning with blood sugars of 100, however at 1800 blood sugar was 64 and facility administered 16 units of Humalog at that time as well. RN educated staff on blood sugar parameters, when to hold insulin and when to contact St. Croix hospice. RN also educated facility staff that when calling 24/7 number, they speak to nurses who are fully capable of advising of next steps. Admin on call notified and made aware of situation. RN unable to reach director of nursing, Jodi.

I reviewed Courtyard at Auburn Hill's Incident Report, the AFC Licensing Division Incident Report, Resident A's Medication Administration Record, Resident A's Med Pass history and Resident A's care history dated 02/22/25. The following was noted:
As of 02/22/25, Resident A was prescribed Humalog 100 units/ ml Kwikpen. The directions indicate inject 16 units subcutaneously three time daily before meals. The prescription did not include instructions on when to hold/ not administer the medication based on Resident A's blood sugar. Incident Reports consistently indicate direct care staff Devlyn Norris, following order as written, administered scheduled Humalog to Resident A at 6:16 pm,16 units with blood sugar reading of 61 and again at 9:30 pm with blood sugar reading of 46. Ms. Norris contacted St. Croix hospice to request direction when resident was nonresponsive. Resident A was transferred to Ascension hospital for

treatment. Per Courtyard at Auburn Hills documentation on 02/22/25, at 8:37 am Resident A's blood sugar was 112, no insulin was administered per resident's vitals. At 1:05 pm Resident A's blood sugar was 100, no insulin was administered per resident's vitals. At 6:16 pm Resident A's blood sugar was 61, Humalog 16 units/ ml Kwikpen was administered. At 9:30 pm Resident A's blood sugar was 46, Humalog 16 units/ ml Kwikpen was administered and PRN medication Glucagon Kit 1 mg (instructions: inject 1 dose subcutaneously as needed for blood glucose below 70 and unable to drink juice.)

Several attempts were made to interview direct care staff Devlyn Norris. I placed telephone calls and sent text messages to Ms. Norris on 04/01/25 and 04/07/25. On 04/07/25, I coordinated with Courtyard assistant wellness director Amber Carmichael to arrange a time to interview Ms. Norris while she was on shift. The interview was scheduled for 04/08/25, at 3:00 pm. I did not receive a call from Ms. Norris. At 3:22 pm, I contacted Ms. Carmichael, and she informed me that Ms. Norris had not yet arrived at work. At 7:13 pm I received a telephone call from Ms. Norris. She left a voicemail requesting a return call. The following day, 04/09/25, I returned Ms. Norris's call. There was no answer. I left a voicemail requesting a return all. I sent a follow up text message.

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: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude that the facility failed to record written instructions in Resident A's record for her prescribed Humalog. Resident A was prescribed Humalog 100 units/ ml Kwikpen. The directions indicate inject 16 units subcutaneously three time daily before meals. The prescription and the facilities medication records did not include instructions on when to hold/ not administer the medication based on Resident A's blood sugar. Due to the lack of written instructions on 02/22/25, at 6:16 pm direct care staff Devlyn Norris administered 16 units of Humalog

	to Resident A, her blood sugar was 61. Then again at 9:30 pm Ms. Norris administered another 16 units of Humalog to Resident A, her blood sugar was 46. As a result of receiving two dosages of insulin while her blood sugar was low Resident A became unresponsive and hypoglycemic which resulted in hospitalization. St. Croix hospice vice president of clinical operations Jennifer Lemere stated that it is the facilities responsibility to ensure that the instructions for when to hold/not administer the insulin are included on the facilities records. This information is not written on the prescription. Executive administrator Tonya Carter stated director of wellness Jodi Caloni was responsible for verifying all resident medications were accurate and the records obtained all the necessary information. As of 03/05/25, Ms. Caloni is no longer employed with Courtyard at Auburn Hills. Ms. Carter confirmed that she had the ability to add instructions for use on Resident A's medication record. The instructions were added following the incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 the information gathered during this investigation there is sufficient information to conclude that on 02/22/25, Resident A's blood sugar dropped significantly causing her to have a change in behavior she became hypoglycemic and unresponsive, and care was not obtained immediately. RS reported that around 12:30 pm direct care staff Barbara Blackmon was feeding Resident A ice cream as Ms. Blackmon said that Resident A's sugar was low. Per Courtyard at Auburn Hills documentation dated 02/22/25, at 8:37 am Resident A's blood sugar was 112. At 1:05 pm Resident A's blood sugar was 100. At 6:16 pm Resident A's blood sugar was 61, and at 9:30 pm Resident A's blood sugar was 46, at which time Resident A was unresponsive. Per St. Croix hospice triage note dated

	02/22/25, direct care staff Devlyn Norris did not call to report the hypoglycemic episode until 8:12 pm. Based on the documentation reviewed it can be concluded that Resident A's blood sugar was consistently dropping throughout the day and dropped below 100 after 6:16 pm ultimately resulting in Resident A becoming unresponsive. Although the drop in blood sugar was documented care was not obtained until several hours after Resident A's blood sugar dropped.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's BiPAP was not put on her at night.

INVESTIGATION:

On 03/27/25, I placed a telephone call to the reporting source (RS). RS chose to provide written correspondence detailing her complaint. RS provided a detailed summary of daily visits with Resident A dated 02/08/25 – 03/13/25. The notes include, but are not limited to, observations and discussions with Courtyard at Auburn Hills staff, discussions with St. Croix hospice staff, discussions with hospital doctors, Resident A's medical status and medication changes. Below is a summary of the written correspondence provided for dates that are pertinent to this allegation.

- **03/11/25** - at 10:13 pm The night med tech Tanisha came in to put the CPAP machine on Resident A. RS told her that they had not been putting it on Resident A. RS and her brother have spent the night there, so they know it is not being used. RS called her brother to ask him about it and he confirmed that they have not been using it. He said have Tanisha go ask LayLa. Tanisha did so and when she came back, she said that LayLa stated they have not been putting it on her because Resident A has been taking it off. This machine is strapped around Resident A's head. There is no way my she would be able to remove it.
- **03/12/25 -** at 7:30 am RS told Barb (Courtyard nurse) about the night before and asked why a med tech would make that decision, not to put the CPAP machine on. Barb said that LayLa does not have the authority to make that decision. RS told Barb that she wants the machine on her from now on and if she is restless, give her something to calm her.

On 03/28/25, I interviewed executive administrator Tonya Carter while onsite. On 04/07/25, I completed a second interview with Ms. Carter via telephone. Ms. Carter stated Resident A was prescribed a BiPAP that she wore at night. According to staff Resident A would remove the BiPAP and it had to be placed back on her during the

night. Ms. Cater explained that Resident A did not take the BiPAP off her head, but she moved it off her mouth where it was not effective. Ms. Carter stated the facility did not require staff to document when they put the BiPAP on or off Resident A.

On 04/09/25, I interviewed direct care staff LayLa Murphy via telephone. Ms. Murphy stated she works morning shifts 7:00 am – 3:00 pm and second shift 3:00 pm – 11:00 pm. Ms. Murphy stated Resident A wore a BiPAP at night. Staff were responsible for putting it on her. Ms. Murphy stated when she worked second shift, she always put Resident A's BiPAP on her. Ms. Murphy stated when she would come in for morning shifts, she would see the midnight staff taking off Resident A's BiPAP so she knows that she wore it during the evening. Ms. Murphy stated Resident A could not remove the BiPAP herself. Ms. Murphy had no concerns that Resident A did not have her BiPAP on nightly. Ms. Murphy stated staff were not required to document when they put the BiPAP on or took it off Resident A.

On 04/09/25, I interviewed direct care staff Barbara Blackmon via telephone. Ms. Blackmon stated she is a lead med aid. She works the morning shift 7:00 am – 3:00 pm. Ms. Blackmon stated Resident A was prescribed a BiPAP machine to be worn every night. Ms. Blackmon stated when she arrived in the morning, she would remove Resident A's BiPAP machine to administer her medications. Ms. Blackmon stated majority of the time the BiPAP was on Resident A when she arrived for the morning shift. However, there was one or two occasions that she was told from other staff that Resident A had been fighting with it, and it was removed. Ms. Blackmon believes this occurred on the nights the family stayed overnight at the facility. Ms. Blackmon cannot confirm if staff took it off or if Resident A removed it as she did not witness this occur. Ms. Blackmon stated staff were not required to document when they put the BiPAP on or took it off Resident A.

On 04/10/25, I interviewed direct care staff Tanisha Cichoracki via telephone. Ms. Cichoracki stated Resident A was prescribed a BiPAP machine to be worn every night. During second shift she would put Resident A's BiPap on at night. Ms. Cichoracki stated on an unknown date Resident A's family asked her why Resident A's BiPAP was not being put on her so she inquired with another staff whose name she cannot recall. She was told that Resident A has been taking her BiPAP off, so the staff took it off. Ms. Cichoracki stated she did not observe any documentation that indicated when the BiPAP was put on or taken off Resident A.

On 04/02/25, I reviewed Resident A's St. Croix hospice medical records that were provided via email from St. Croix hospice. The following is relevant information:

Intake Coordination Note: 02/19/2025 Resident A was prescribed a BiPAP machine to wear at night - settings 10/5 - needs full face mask.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude that Resident A was prescribed a BiPAP machine to wear every night. There is no documentation in Resident A's record to reflect when the BiPAP was put on, taken off, her refusal to wear it for the duration of the night and/or any recommendations. The reporting source indicated on more than one occasion Resident A's family stayed overnight at the facility and the BiPAP was not put on Resident A. Direct care staff Barbara Blackmon stated Resident A wore the BiPAP machine most of the time. However, there was one or two occasions that she was told from other staff that Resident A had been fighting with the BiPAP, and it was removed. Ms. Blackmon stated this may have occurred on the nights the family stayed overnight at the facility. Executive administrator Tonya Carter stated staff reported that Resident A would move/remove the BiPAP, and it had to be placed back on her during the night. Ms. Carter stated staff were not required to document any information regarding the BiPAP use. Courtyard at Auburn Hills did not provide any documentation that indicated that Resident A was unwilling and/or refused to wear the BiPAP.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Courtyard at Auburn Hills 3 has no residents. The facility is being updated.

INVESTIGATION:

On 03/27/25, I placed a telephone call to the reporting source (RS). RS chose to provide written correspondence detailing her complaint. RS provided a detailed summary of daily visits with Resident A dated 02/08/25 – 03/13/25. The notes include, but are not limited to, observations and discussions with Courtyard at Auburn Hills staff, discussions with St. Croix hospice staff, discussions with hospital doctors, Resident A's medical status and medication changes. Below is a summary of the written correspondence provided for dates that are pertinent to this allegation.

- **03/13/25 -** Courtyard is in the process of moving all other residents to different buildings because they are renovating. For the past couple of days, Resident A is the only one in her building. RS and her brother stay around the clock to make sure she is not alone and gets the care she needs. One person is sitting in the lobby. Today was the first dose of morphine for Resident A. RS was at her side when the morphine wore off and she is in extreme pain. RS screamed for help. Finally, Tonya comes from her office, and she had to go find the nurse (Barb) so Resident A can get more morphine. If RS was not there, how long would Resident A have been laying there in extreme pain. In an empty building with only the admin in her office. Resident A passed later in the evening on this day.

On 03/28/25, I completed an unscheduled onsite investigation. I observed that the facility does not have any residents, and they are in the process of doing cosmetic updates (painting, replacing carpets, etc.)

On 04/07/25, I interviewed executive administrator Tonya Carter via telephone. Ms. Carter stated the facility currently has no residents and it is being updated. The carpet in the hallways is being replaced, several bedrooms will be painted, and shiplap will be installed in the dining room. Most of the resident bedrooms are currently empty, the furniture has been removed and put into storage. There is one bedroom that was left staged. Ms. Carter stated the residents were moved from the facility and put into other Courtyard buildings on the Auburn Hills campus due to low census. However, while the facility is being updated it is not inhabitable. Ms. Carter confirmed that there are no structural changes being made. The changes are cosmetic only. Ms. Carter stated they currently have one resident on a waiting list, when they get a total of three residents, they plan to move them in and staff the facility. Ms. Carter stated she did not inform the assigned licensing consultant, Cindy Berry of these changes.

On 04/07/25, I interviewed licensing consultant Cindy Berry via telephone. Ms. Berry stated that she was not made aware that this facility was being updated or that the residents were moved to other buildings due to the census being low.

On 04/15/25, I placed a telephone call to licensee designee Matthew Sufnar and executive administrator Tonya Carter to conduct an exit conference. Ms. Carter did not answer. I left a voicemail informing her that the investigation was completed and there were rule violations established. I spoke to Mr. Sufnar and reviewed my findings in detail. I informed Mr. Sufnar that a corrective action plan is required. He acknowledged and agreed. I informed Mr. Sufnar that Ms. Norris did not respond to attempts made to interview her for this investigation. Mr. Sufnar acknowledged and indicated that he will follow up and address this concern.

On 04/15/25, I placed a telephone call to the reporting source to review my findings. The reporting source was advised of my recommendation that the facility submit a corrective action plan.

APPLICABLE RULE	
R 400.15103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(5) An applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license, including any changes in the household and in personnel-related information, within 5 business days after the change occurs.
ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude that the department was not made aware that this facility was being updated and/ or that the residents were moved to other buildings on the Courtyard at Auburn Hills campus due to the census being low. Executive administrator Tonya Carter confirmed that she did not notify licensing consultant Cindy Berry of these changes.
CONCLUSION:	**VIOLATION ESTABLISHED**

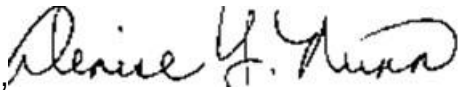
IV. RECOMMENDATION

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

04/15/2025

Johnna Cade — Date
Licensing Consultant

Approved By:



05/14/2025

Denise Y. Nunn — Date
Area Manager