GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 24, 2025

Tonya Carter
Encore McHenry
Suite 710
230 West Monroe
Chicago, IL 60606

RE: License #: AL500416945
Investigation #: 2025A0617021
The Courtyard At Sterling Heights 4

Dear Ms. Carter:

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) 972-9136.

Sincerely,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500416945
Investigation #:	2025A0617021
Complaint Receipt Date:	09/04/2025
Investigation Initiation Date:	09/05/2025
Report Due Date:	11/03/2025
Licensee Name:	Encore McHenry
LicenseeAddress:	Suite 710 - 230 West Monroe Chicago, IL 60606
Licensee Telephone #:	(248) 340-9296
Administrator:	Matthew Sufnar
Licensee Designee:	Tonya Carter
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:	REGULAR
Effective Date:	09/11/2024
Expiration Date:	09/10/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell and fractured her hip.	Yes
Residents are not being properly cared for.	No

III. METHODOLOGY

09/04/2025	Special Investigation Intake 2025A0617021
09/05/2025	Special Investigation Initiated - Telephone TC to complainant
09/09/2025	Inspection Completed On-site I conducted an unannounced onsite investigation at the facility. I interviewed staff Antionette Williamson, Matthew Surner, Rayanna Young, Daijhanai Watt, hospice nurse Kelly Crothers and Residents B, C, D, E, F, G.
09/09/2025	Contact - Telephone call made TC to Resident A's daughter.
10/20/2025	Contact - Telephone call made TC to Resident A's daughter.
10/21/2025	Contact - Telephone call made TC to Resident A's daughter.
10/21/2025	Exit Conference I held an exit conference with licensee designee Matthew Sufnar informing him of the findings of the investigation. He did not answer and a voicemail was left for him.

ALLEGATION:

- **Resident A fell and fractured her hip.**
- **Residents are not being properly cared for.**

INVESTIGATION:

On 09/04/25, I received a complaint on The Courtyard at Sterling Heights 4. The complaint stated Resident A (86) is deceased as of 08/14/2025. Resident A previously resided at The Courtyard at Sterling Heights 4. Resident A's children were Resident A's Power of Attorney. Resident A was diagnosed with dementia, and Alzheimer's. Resident A required assistance with her daily needs. The staff were supposed to check on Resident A every two hours and they did not check on her as often as they should have. When Resident A was put in her bed, the staff put her walker across the room from Resident A. Resident A got up several times at night without the use of her walker. Resident A fractured her hip, and the staff did nothing about it for two weeks. On 08/04/2025, Resident A fell on the floor at approximately 3:30am. From that day onward Resident A was unable to walk and was in consistent pain screaming. The care staff told Resident A she was heavy and pulled Resident A up by her arms while she was in pain. Resident A was put in a wheelchair. An unknown nurse moved Resident A out of the wheelchair instead of using the Hoyer lift to put Resident A in bed. Resident A was screaming and the unknown nurse ended up cutting Resident A's leg on the bed. The staff yelled and rolled Resident A on her side while she was screaming in pain. An Xray was ordered on 08/12/2025 and the results were received on 08/15/2025. Resident A had a fractured hip from falling on 08/04/2025. The staff were pushing, pulling Resident A, and making Resident A stand up during that time she had a fractured hip. On 08/11/2025 Resident A's mouth was dry and cracked. There were no cups or water available for Resident A to drink. Half of the unknown residents do not know how to get water for themselves due to their disabilities. Resident A had five UTI's while she was residing at the facility due to not having enough water intake. There were sixteen unknown residents at a time in the dining room. At least six unknown residents were not able to feed themselves. There were only 1-2 care staff available to help feed the unknown residents. Some unknown residents did not get fed. On 08/12/2025 there was only one care staff available to feed one unknown resident. An unknown resident picked up a Styrofoam bowl that contained salad. The unknown resident began to eat Styrofoam. The care staff member did not help the unknown resident. Other unknown residents ate with their fingers; some residents did not eat all. The nursing staff sit around in a group on their phones instead of helping the unknown residents.

On 09/09/25, I conducted an unannounced onsite investigation at the facility. I interviewed staff Antionette Williamson, Matthew Surner, Rayanna Young, Daijhanai Watt, hospice nurse Kelly Crothers, and Residents B, C, D, E, F, G.

During the onsite investigation, I inspected the facility. The facility was clean and there were no concerns. Residents appeared to be clean and did not have a noticeable odor. During the onsite investigation, I reviewed several resident files, and the facility appears to be properly caring for the residents. I also reviewed staff files and staff included all required documentation. I observed cups for water in the facility that are available for the residents use.

According to Ms. Daijhanani Watt, she has worked at the facility for approximately two months as a caregiver. Ms. Watt stated that there are at least two staff members working at all times (a caregiver and a medication technician) but they try and have three members working as much as possible. Ms. Watt stated that she was unaware of Resident A falling and injuring herself. Ms. Watt stated that Resident A would often attempt to get up without assistance and if she fell, that could be why. Ms. Watt stated that there are 19 residents in the facility and there are four who need assistance with feeding. The four residents who need assistance feeding are Residents B, C, D, and E. Ms. Watt stated that additional care staff will come during feeding times to assist with the feeding of the residents. Ms. Watt reported that there are no issues with the residents being fed. According to Ms. Watt, there are five residents in the building with Covid, therefore they are currently keeping the residents in their rooms for safety.

I attempted to interview Resident B but she had Covid and did not want to participate in the interview.

I attempted to interview Resident C but she lacked the cognitive ability to answer questions.

I attempted to interview Resident D but she lacked the cognitive ability to answer questions.

I attempted to interview Resident E but she lacked the cognitive ability to answer questions.

According to Resident F, he has no issues living in the home and he is well cared for.

According to Resident G, she has no issues living in the home and she is well cared for.

According to staff Rayanna Young, she has worked at the facility since 2020 as both a caregiver and med tech. According to Ms. Young, Resident A fell but she was not working when it happened. Ms. Young stated that she doesn't know when Resident A fell but her coworkers told her about it after. Ms. Young stated that Resident A did not show signs of pain until the week of her death. Ms. Young stated that the facility notified Resident A's hospice nurse Ms. Crothers. Ms. Young stated that there are 19 residents in the facility and there are four who need assistance with feeding. The four residents who need assistance feeding are Residents B, C, D, E, F, and G. Ms. Young stated that additional care staff will come during feeding times to assist with the feeding of the residents. Ms. Young reported that there are no issues with the residents being fed.

According to Hospice nurse Ms. Kelly Crothers, she was Resident A's hospice nurse since July 2025. Ms. Crothers stated that when Resident A fell, the facility made her aware and she assessed Resident A for injuries and pain. Ms. Crothers stated that Resident A did not show any signs of pain or discomfort after the fall until the week of her death. Ms. Crothers stated that an x-ray was not scheduled immediately after the

fall because it is not protocol to send hospice residents out for them unless requested by the family. Ms. Crothers stated that they assess the residents for pain and adjust their medication for comfort. According to Ms. Crothers, during the final week of Resident A's life, she started to show signs of pain, therefore Ms. Crothers adjusted her medication by increasing it to provide Resident A with more comfort and pain relief. Ms. Crothers stated that Resident A passed away due to natural causes. Ms. Crothers stated that she has no concerns or issues about the care that Resident A received at the facility. Ms. Crothers stated that she has several patients at the facility, and she has no concerns about the care they are receiving there.

During the onsite investigation, I interviewed licensee designee and administrator, Matthew Sufnar. According to Mr. Sufnar, an incident report was not completed when Resident A fell due to her not being sent out for medical treatment. According to Mr. Sufnar, Resident A fell and fractured her hip, but she showed no signs of pain or discomfort. Resident A received hospice services twice a week and the hospice nurse was made aware of the fall. Mr. Sufnar stated that hospice residents are not sent out for x-rays unless requested by the family. According to Mr. Sufnar, cups for water are located throughout the facility and are available for residents by request in addition to water/drinks being provided at meal and snack times. Mr. Sufnar stated that snack times are 10:30am, 2pm, and after 6pm. Mr. Sufnar stated that there are no issues with feeding the residents as he has sufficient staff to do so.

On 10/21/25, I held an exit conference with licensee designee Matthew Sufnar informing him of the findings of the investigation. He did not answer, and a voicemail was left for him.

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:	The facility did not treat and care for Resident A's personal needs, including protection and safety. The staff did not know how Resident A fell and the extent of Resident A's injuries led her having a fractured hip.
CONCLUSION:	**VIOLATION ESTABLISHED**

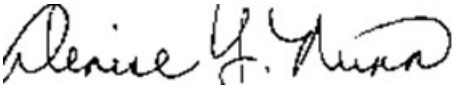
IV. RECOMMENDATION

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

10/21/25

Eric Johnson — Date
Licensing Consultant

Approved By:



10/24/2025

Denise Y. Nunn — Date
Area Manager