STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

May 29, 2026

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

RE: License #: AL500416945
Investigation #: 2026A0990014
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.
- 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) 972-9136.

Sincerely,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
3044 W Grand Boulevard
2nd Floor Annex, Suite 2-730
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 #:	2026A0990014
Complaint Receipt Date:	04/06/2026
Investigation Initiation Date:	04/07/2026
Report Due Date:	06/05/2026
Licensee Name:	Encore McHenry
Licensee Address:	Suite 710 230 West Monroe Chicago, IL 60606
Licensee Telephone #:	(586) 254-5719
Administrator:	Tonya Carter
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 ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A fell in February 2026, resulting in a fractured hip, with conflicting accounts of the fall.	No
There is concern that Resident A was prescribed medication associated with higher risks for individuals with dementia.	No
Additional Findings	Yes

III. METHODOLOGY

04/06/2026	Contact – Telephone call received I received a phone call from Relative A inquiring about a complaint that was made. Relative A was informed that the complaint was dismissed due to lack of information.
04/06/2026	Special Investigation Intake 2026A0990014
04/06/2026	APS Referral Denied at intake.
04/07/2026	Special Investigation Initiated - Telephone I conducted a phone interview with Relative A.
04/07/2026	Contact - Document Sent I emailed Matthew Sufnar, licensee designee, requesting resident files. I received the documents from Marie Wieland Regional Vice President of Operations as Mr. Sufnar resigned.
04/07/2026	Contact – Document sent I emailed Relative A.
04/11/2026	Contact - Document Sent I received an email from Relative A.

04/20/2026	Inspection Completed On-site I interviewed Marie Wieland Regional Vice President of Operations.
04/29/2026	Contact - Document Received I received an email from Relative A requesting a copy of the report. I replied on 04/30/2026 informing Relative A that the investigation was not 30 days old and she would receive copy of the report when completed.
05/06/2026	Contact - Document Sent I emailed Relative A requesting contact information for Resident A. This information was not provided.
05/19/2026	Contact - Document Received I reviewed the resident record and staff schedules.
05/19/2026	Contact - Telephone call made I interviewed Antoinette Williamsonon, med coordinator.
05/19/2026	Contact - Telephone call made I left a detailed voice message for direct care staff members Daja Sanchez and Barbara Szynal. No return call to date.
05/20/2026	Contact- Document Sent I emailed Ms. Wieland with questions. Ms. Wieland responded on 05/21/2026.
05/22/2026	Contact – Document Sent I emailed Relative A with additional questions. Relative A replied.
05/26/2026	Contact- Telephone call made I conducted a phone conference with Ms. Wieland.
05/26/2026	Contact- Document Sent I emailed Relative A. Realtive A responded.

05/28/2026	Exit Conference I attempted to schedule an exit conference but did not receive a call back on 05/26/2026. I called Ms. Wieland and no answer was received. An email will be sent with the tentative violations.
05/29/2026	Exit Conference I conducted an exit conference with Ms. Wieland.

ALLEGATION:

- **Resident A fell in February 2026, resulting in a fractured hip, with conflicting accounts of the fall.**
- **There is concern that Resident A was prescribed medication associated with higher risks for individuals with dementia.**

INVESTIGATION:

On 04/06/2026, I received a phone call from Relative A inquiring about a complaint that was made. Relative A was informed that the complaint was dismissed due to lack of information.

On 04/07/2026, the complaint was generated after additional information was received. Prior to the above phone call, on 04/03/2026, I received partial complaint details via email, but it did not specify which of the four licenses was linked to the address for Resident A. The complaint stated Resident A had several caregivers and a director. The complainant said Resident A lost her footing and could not stand, but no more details were provided. Since there were no specific rules identified and limited information, the complaint was dismissed.

On 04/07/2026, I emailed Relative A requesting a copy of the POA and the address of Resident A's location.

On 04/11/2026, I informed Relative A that Seroquel is commonly prescribed for dementia, and Relative A replied, providing POA documents. Relative A said Resident A will not return to the facility and is now at a skilled nursing facility in St. Clair Shores. No address or phone number was given.

Relative A said that after Resident A was hospitalized, she researched the medications prescribed to her mother and found that one of the medications was known to carry a "high fatality" risk, especially for dementia patients. Relative A was unsure why this medication was prescribed and sought clarification.

On 04/20/2026, I interviewed Marie Wieland, Regional Vice President of Operations. Ms. Wieland stated they are hiring a new administrator to replace Mr. Sufnar, and she was not present at the time of the fall. She reported Resident A is independent but confused, with a history of hallucinations, delusions, and agitation, and was ambulatory. Ms. Wieland completed Resident A's *Assessment Plan* in October or November 2025. She recounted being told by med coordinator Antoinette Williamson that Resident A was walking in the dining room area when the fall was heard but not observed. Ms. Wieland was informed that Resident A got up from the floor and sat in a chair, and no one observed the fall. She reported that several calls were made to Relative A, but there was no response until later that day; Ms. Williamson called twice from the facility phone and once from her personal cell, and Relative A returned the call to her personal phone. Ms. Wieland also indicated that Relative A left a large balance for Resident A's care, which they are no longer pursuing.

On 05/06/2026, Relative A emailed requesting a copy of the report. I responded that the investigation status is reported within 30 days from assignment, and once approved by the area manager, a copy will be sent via email.

On 05/19/2026, I reviewed Resident incident report from 02/06/2026 fall. The report, written by Antoinette Williamson, states Resident A fell in the dining room while walking, landed on her left side, and complained of hip pain. Vital signs were taken, and Relative A and 911 were called. Resident A was taken to Henry Ford Hospital, and a hip fracture was reported. Ms. Williamson stated she was passing meds during the fall, and Resident A sat in a chair afterward. Ms. Williamson called and left a voicemail for Relative A, who called back about 30 minutes later for information about the fall.

On 05/19/2026 I reviewed Resident A's resident record. Resident A was admitted to the home on 08/22/2023. Resident A is prescribed Quetiapine (generic for Seroquel), 50 mg tablet to take one at bedtime. Relative A had expressed concern that Quetiapine is associated with an increased risk of mortality in older adults with dementia and was uncertain about the reason for its prescription. The MAR documents that the medications were filled at Pharrmscript, and Quetiapine is used for agitation and prescribed by Darcy Paisey.

Resident A's *Resident Care Agreement* was completed and signed by Mr. Sufnar on 09/15/2024. Relative A signed the *Resident Care Agreement* but did not date it. The *Resident Care Agreement* basic fee includes room, meals, and housekeeping. There are additional fees for the hair salon, pharmacy, and supplies. I reviewed the staff schedule for the afternoon shift on 02/26/2026, and five staff members were listed on the schedule. Resident A's *Assessment Plan* documents that Resident A moves independently, is not prescribed assistive devices, can communicate needs, understands verbal communication, and is alert to surroundings.

On 05/19/2026, I interviewed Antoniette Williamson, medication coordinator, who has been employed with the company for nine years. On the day of the incident, while passing medication near the dining room, Ms. Williamson heard a loud "boom." Direct

care staff Daja Sanchez told her Resident A had fallen. Ms. Williamson found Resident A in a dining room chair, and Ms. Sanchez said Resident A was walking, looking out the window, and fell. Staff member Barbara Szynal was present; both Ms. Sanchez and Ms. Szynal said Resident A got herself up and into the chair. Resident A complained of left hip pain. Mr. Sufnar (previous licensee designee/administrator) arrived, assessed Resident A, and decided she should be sent for medical evaluation. EMS arrived about 30 minutes later and transported Resident A to the hospital. Ms. Williamson said she called Relative A from both the facility and her personal phone, receiving no answer; Relative A returned the call about 15 minutes later, explaining she was at a job interview. The next day, Relative A informed Ms. Williamson that Resident A had emergency hip surgery. Ms. Williamson added that later, Ms. Sanchez clarified that she and Ms. Szynal had helped Resident A off the floor, contrary to their initial account. Ms. Williamson discussed this discrepancy with Ms. Sanchez, having already written the incident report and informed Relative A that Resident A got up independently. No other residents were in the dining room at the time of the fall.

On 05/20/2026, I emailed Ms. Wieland with some questions to clarify. Resident A was the originally prescribed Quetiapine medication by Karen Genter. Resident A was prescribed this on 11/03/2024. Ms. Wieland said that the Relative A/POA was aware of the Resident A's medications prescribed because "all families are made aware of resident medications and medication changes via multiple routes." Ms. Wieland said that medication lists are available at any time requested, reviewed during care conference meetings, which would include a review of their *Assessment Plans*, and families would be contacted at the time of medication change. I inquired about Resident A's diagnoses on the MAR and *Health Care Appraisal* regarding her muscle weakness and difficulty walking, and whether there was safety measures implemented. Ms. Wieland responded, stating that it was her understanding that Resident A's care plan listed her as a "Fall Risk" and that increased safety checks were in place for this, along with behavioral concerns. Though she was independent in mobility, she did not use an assistive device for ambulation.

I inquired if Relative A/POA, given a list of Resident A's medications and whether Relative A ever visited the facility. Ms. Wieland said that Resident A's medications are included in the *Assessment Plan* (although the one initially sent did not have them).

On 05/22/2026, I emailed Relative A with additional questions. Relative A said that she initially visited Resident A every day until she became ill. Relative A said that she would visit twice a week when able or once a week. Relative A said she receives assessments from MORC every three months. Relative A said that she did receive monthly billing statements from the facility.

On 05/26/2026, I emailed Relative A. Relative A said that she had never reviewed any medication list and that she attended case conferences for the first 6 to 8 months. Relative A said that she thought that an in-house male doctor prescribed medicine who prescribed Resident A's medication. Relative A said that Resident A has Alzheimer's and dementia; she will not be able to be interviewed. I informed Relative A that due to

Resident A’s limited cognitive abilities and the length of time since the fall, I would not interview her.

On 05/29/2026, I conducted an exit conference with Ms. Wieland. Ms. Wieland clarified that the Quetiapine medication was initially prescribed by Tanya Genter who was Resident A’s primary care physician in 2024. The facility began using a behavioral health practitioner, Darcey Paisey she is the new prescriber of Quetiapine medication. The other prescribers listed on the MAR were previous medical providers that prescribed medications.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Based on the investigation, there is insufficient evidence to support the claim that Resident A was not provided with adequate protection and supervision because of a fall that occurred on 02/06/2026. Resident A fell in the dining room. Initially, it was written that Resident A fell and got herself up to sit in a chair. According to Med Coordinator Antoinette Williamson, she was initially told by direct care staff Barbara Szynal and Daja Sanchez that Resident A got herself up from the fall. The following day, Ms. Sanchez told her that she and Ms. Szynal had picked Resident A up from the floor. Ms. Williamson said that she wrote the incident report as it was reported to her when she did not witness the fall or Resident A being removed from the floor. Resident A sustained a fractured left hip and is currently in rehabilitation. Resident A is at risk of falls and wandering and has muscle weakness but is not prescribed any assistive devices. Per Resident A's *Health Care Appraisa*l, she is fully ambulatory. Resident A's *Assessment Plan* documents that she can move independently, that she understands verbal communication, and that she is alert to her surroundings. Therefore, Resident A did not require supervision or assistance with ambulation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	Based on the investigation, there is no evidence to support that Resident A was prescribed a medication that was deemed inappropriate. Resident A was originally prescribed in 2024 Quetiapine (generic for Seroquel), 50 mg tablet to take one at bedtime by Tanya Genter. Resident A's *Resident Care Agreement* documents that the facility would charge additional fees for pharmacy, which Relative A signed. Although Relative A claims not to authorize medications, the medications were prescribed for agitation which is consistent with her diagnosis of dementia with behavioral disturbances. Resident A had been taking this medication since 11/03/2024. Relative A said that she visits the facility one or two times per week.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 05/19/2026, I reviewed the resident record. I observed that Resident A's *Assessment Plan* was not signed by Relative A in 2025. There was a note that said: Mailed to POA on 10/25/2025. I observed that Resident A's *Resident Care Agreement* was last signed by the POA and the license designee on 09/15/2024 and there was no *Resident Care Agreement* provided for 2025.

On 05/20/2026, I emailed Ms. Wieland with some questions to clarify. I asked why Resident A's *Assessment Plan* was not signed by the POA. Ms. Wieland responded that obtaining signatures is a challenge. But they could not specify or recall if they provided a printed copy. Ms. Wieland said that they reach out to families, attempting to schedule a meeting to review. Some families agree, and others decline the meeting. If that is the case, we ask them to come in to sign the *Assessment Plan*. If they are not able, we then email and mail copies out, requesting a signature. Ms. Wieland said that she completed Resident A's *Assessment Plan* in October of 2025, and it was mailed to Relative A/POA at Mr. Sufnar's discretion. Ms. Wieland said that *Assessment Plans* are usually mailed twice. Ms. Wieland is currently working with staff to outline a better system, as this is a challenge in many cases. Ms. Wieland said that she does not know if Relative A visited the community and has never personally met her. Ms. Wieland said that staff voiced difficulty getting in touch with her when this incident occurred.

On 05/29/2026, I received copies of Resident A's 2023 (at admission) and 2024 *Assessment Plans*. Neither *Assessment Plan* were signed by Relative A. I observed that Resident A's *Assessment Plan* completed at admission in 2023, she was not

prescribed any medications. I observed Resident A’s 2024 *Assessment Plan*, that she was prescribed seven medications.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	I observed that Resident A’s *Assessment Plan* 2023, 2024 and 2025 was not signed by Relative A/POA. Relative A reported that she has never signed an *Assessment Plan* or any authorizations for medications prescribed for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident, resident's designated representative, or responsible agency at least annually or more often if necessary. Any changes to the resident care agreement must be re-signed by all applicable parties. If the annual review results in no changes to the resident care agreement the resident care agreement does not need to be re-signed but the licensee shall document that all applicable parties were contacted and agreed that no changes were necessary.
ANALYSIS:	Resident A’s *Resident Care Agreement* was completed in 2024. She remained at the facility until 02/06/2026. There was no *Resident Care Agreement that* was completed or reviewed in 2025 when this is required to be done annually.

CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/29/2026, I conducted an exit conference with Ms. Wieland. Ms. Wieland clarified that the Quetiapine medication was initially prescribed by Tanya Genter who was Resident A's primary care physician in 2024. The facility began using a behavioral health practitioner, Darcey Paisey she is the new prescriber of Quetiapine medication. The other prescribers listed on the MAR were previous medical providers that prescribed medications.

Ms. Wieland was informed of the rule violations that were additional findings. Ms. Wieland clarified that care conferences are conducted with the POA's within 30 days of placement at the facility and annually thereafter. Care conferences can be held as needed. Ms. Wieland said that during the annual care conferences, the annual forms should be signed. Ms. Wieland could not attest to why Resident A's *Assessment Plans* were unsigned. We discussed alternative ways signatures can be obtained such as conducting phone conferences and sending the *Assessment Plans* to be signed electronically. I also suggest that they can be sent certified mail. I emphasized that the families should understand at admission that annual forms must be signed by them. I discussed with Ms. Wieland that there was no *Resident Care Agreement* provided for 2025 and this form is to be done annually. Ms. Wieland was also informed that the *Resident Care Agreement* completed in 2024 was signed by Relative A/POA, however she did not date it. Ms. Wieland said that she would submit a corrective action plan. I also provided technical assistance regarding completing *Assessment Plans* thoroughly and documenting witnesses on Incident Reports.

IV. RECOMMENDATION

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

L. Reed 05/29/2026

LaShonda Reed Date
Licensing Consultant

Approved By:

Jay Calewarts For 05/29/2026

Denise Y. Nunn Date

Area Manager