



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 1, 2026

Ronald Paradowicz
Courtyard Manor of Wixom Inc
Suite 127
3275 Martin
Walled Lake, MI 48390

RE: License #: AL630007340
Investigation #: 2026A0612031
Courtyard Manor of Wixom III

Dear Mr. Paradowicz:

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,

A handwritten signature in cursive script that reads "Johnna Cade".

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3044 West Grand Boulevard
2nd Floor Annex, Suite 2-730
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007340
Investigation #:	2026A0612031
Complaint Receipt Date:	07/27/2026
Investigation Initiation Date:	07/27/2026
Report Due Date:	09/25/2026
Licensee Name:	Courtyard Manor of Wixom Inc
Licensee Address:	Suite 127 - 3275 Martin Walled Lake, MI 48390
Licensee Telephone #:	(248) 926-2920
Administrator:	Serenity Brain
Licensee Designee:	Ronald Paradowicz
Name of Facility:	Courtyard Manor of Wixom III
Facility Address:	48578 Pontiac Trail Wixom, MI 48393
Facility Telephone #:	(248) 669-5263
Original Issuance Date:	12/27/1991
License Status:	REGULAR
Effective Date:	08/20/2024
Expiration Date:	08/19/2026
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 07/19/26, Resident A eloped from the building while Courtyard Staff, Arun Chetri, was leaving. The incident report written following the incident was falsified.	Yes
On 05/19/26, Resident B fell in the bathroom while being transferred by Courtyard Staff, Daniel Wu. Following the incident Resident B did not receive immediate health care, causing the injury to her leg to worsen.	No

III. METHODOLOGY

07/27/2026	Special Investigation Intake 2026A0612031
07/27/2026	Special Investigation Initiated - Letter Email sent to Reporting Source requesting additional information.
07/27/2026	Contact - Document Received Evidence received from Reporting Source 1 via email (screenshots of text messages).
08/03/2026	Contact - Document Received I received a second referral from Reporting Source 2.
08/03/2026	Referral - Recipient Rights Referral made via email to Oakland Community Health Network (OCHN) - Office of Recipient Rights (ORR) regarding the allegations involving Resident A.
08/03/2026	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed licensee designee Serenity Brain, Courtyard Staff 1, Courtyard Staff 4, Courtyard Staff 5, Courtyard Staff 6, Courtyard Staff 7, and Courtyard Staff 8.
08/03/2026	Contact - Document Received Relevant facility documentation received while onsite.

08/04/2026	APS Referral Referral made to Adult Protective Services (APS) via the Michigan Online Reporting System.
08/04/2026	Referral - Recipient Rights Referral made via email to Macomb County Community Mental Health (MCCMH) - Office of Recipient Rights (ORR) regarding the allegation involving Resident B.
08/21/2026	Contact - Telephone call made Telephone interview completed with Courtyard Staff 3.
08/24/2026	Contact - Telephone call made Telephone interview completed with Courtyard Staff 2.
08/26/2026	Exit Conference I placed a telephone call to administrator Serentiy Brain to conduct an exit conference. I also placed a telephone call to licensee designee Ronald Paradowicz to conduct an exit conference. There was no answer. I left a detailed voicemail regarding my findings.
08/28/2026	Contact - Document Received Email received from APS worker Tina Edans.

ALLEGATION:

On 07/19/26, Resident A eloped from the building while Courtyard Staff Arun Chetri was leaving. The incident report written following the incident was falsified.

INVESTIGATION:

On 07/27/26, I received a referral from an anonymous reporting source. In summary, the referral indicates, I am writing to report serious safety violations, resident negligence, and systemic falsification of official records occurring at the alternative care facility located at 48578 Pontiac Trail Wixom, MI 48393. I am submitting this report anonymously out of deep concern for the residents, as administrative leadership routinely forces staff to alter documentation to protect the facility from liability.

The first matter involves a dangerous resident elopement and vehicle breach that occurred July 19, 2026, at 2:51 pm. Resident A who has a documented history of elopement and commandeering vehicles managed to escape the secured building because a supervisor from another building, Arun Chetri, was leaving his shift early and was distracted on the phone while entering the keypad code. Resident A bolted out the door right past him and immediately targeted his running vehicle parked outside the front door, attempting to get into the driver's seat. When Arun blocked her, she

managed to get into the backseat. Staff opened the backseat door attempting to convince Resident A to come back out; however, Arun felt that was agitating her, dismissed safety protocols, and told staff to close the door. He then drove Resident A around the property in his personal vehicle to "cool her down" before multiple staff members intervened to get her back inside. Arun abandoned the shift without writing the required incident report. The staff who witnessed Resident A go out the door was made to write the incident report. Nurse Aireanna Flemming instructed that staff not to put the driver's seat attempt in the report- doing so even before she contacted Executive Director Serenity Brain, reflecting on their routine on falsifying documents. Once Serenity was notified over the phone, she confirmed those instructions.

The second matter involves a prior history of document falsification and severe resident neglect that took place approximately one to two months ago. Resident B fell in the large handicap bathroom while a staff member was assisting her because the staff member failed to move the wheelchair foot pedals, causing her to trip and sustain an injury when the staff member fell on top of her. Due to improper wound care and significant delays, Resident B's leg wound became severely swollen, bruised, and leaked for about 1-2 weeks after the incident. One day, a caregiver was doing her last brief checks and noticed Resident B's leg wrap falling off, reporting the visual state and foul smell of the leg to the alternate medication tech. The medication tech took a picture of Resident B's leg and sent it to the nurse on duty around 6:25 pm that day.

Nurse Aireanna Flemming came over and looked at the leg in person, but instead of sending Resident B out, she said we would wait to see how the leg looked the next morning. Resident B was sent out the next morning. Ms. Flemming told me she was texting other on-call nurses who also said not to send Resident B out. Resident B really should have been sent out immediately the night before due to how severely infected her leg appeared and smelled. Resident B returned from the hospital the same day, but she did not stay at the facility long due to the severity of her leg, and she was ultimately transferred out to a different facility because our facility claimed they did not do wound care. It was only after Resident B was transferred that I learned management lied in the official incident report, claiming that Resident B fell in her own room's bathroom and pulled the call light, to cover up the staff error in the hallway bathroom and the intentional delay in medical treatment.

On 08/03/26, I received a second referral from an anonymous Reporting Source 2. In summary, the referral indicates this facility has falsified documents stating certain people were witnesses when they were not even scheduled to work that day. They delayed calling police when Resident A eloped. The director, Serenity Brain, has directed nurses to lie, falsify, and delete reports. I have personally seen and filed the report they falsified regarding Resident B and her injury.

On 07/27/26, I contacted Reporting Source 1 via email to confirm what building the residents resided in as this information was not indicated in the complaint and Courtyard Manor of Wixom has several buildings on their campus. Additionally, I requested additional information/evidence to support the allegation. Reporting Source 1 verified

which building the residents reside in and provided screenshots of text messages to support the allegation.

On 08/04/26, I made a referral to Adult Protective Services (APS) via the Michigan Online Reporting System. The allegation regarding Resident A was assigned to APS worker T. Anderson. On 08/07/26, I spoke with Ms. Anderson via telephone. Ms. Anderson stated she completed an onsite investigation, Resident A was unable to be interviewed regarding the allegation. Resident A got upset, stormed off and said, “stop lying I did not get in a staff car. My dad and brother are supposed to come and pick me up.” As such, Ms. Anderson stated she interviewed Resident A’s guardian via telephone. Resident A’s guardian indicated that Resident A has a long history of elopement and staff do a good job at redirecting her. Resident A’s guardian was aware of the elopement, but she had not been informed that Resident A got into the staff’s car and then went for a ride around the building.

On 08/03/26, I made a referral via email to Oakland Community Health Network (OCHN) – Office of Recipient Rights (ORR) regarding the allegations involving Resident A. Recipient Rights Specialist Rachel Moore notified me that OCHN – ORR would not be initiating an investigation.

Note: Staff names are coded throughout this investigation as they requested to remain anonymous.

On 08/03/26, I completed an unscheduled onsite investigation. I interviewed licensee designee Serenity Brain, Courtyard Staff 1, Courtyard Staff 4, Courtyard Staff 5, Courtyard Staff 6, Courtyard Staff 7, and Courtyard Staff 8. While onsite I observed that Courtyard Manor of Wixom is a locked facility with delayed exit doors. There is a keypad off to the side of the front entrance where staff enter a code to unlock/open the doors.

On 08/03/26, I interviewed licensee designee Serenity Brain. Ms. Brain stated Resident A moved into Courtyard Manor on 03/09/23, with behaviors of elopement. She was transferred to building III on 11/13/25. Since living in building III her elopements have decreased. Resident A has a history of mental illness. When she elopes from the facility it is due to various reasons such as believing she has a job to get to. Ms. Brain stated she was not present when the incident occurred, however, she was informed that on 07/19/26, Courtyard Staff 3’s shift ended at 3:00 pm, he went to talk to Courtyard Staff 5 before leaving, she was not present. He called Courtyard Staff 5 on the phone. While on the phone with Courtyard Staff 5, Courtyard Staff 3 put his code into the keypad to exit the building. Resident A got to the door before him and exited the building. Resident A went to Courtyard Staff 3’s car opened the back door and got into the back seat. Courtyard Staff 3 drove Resident A around the property and brought her back to building III. While this incident was occurring Courtyard Staff 3 called Courtyard Staff 9 and Courtyard Staff 4 to report what was happening. When Resident A returned to the building, she exited the car without further issue or concern.

On 08/03/26, I interviewed Courtyard Staff 1. Courtyard Staff 1 stated on 07/19/26, she was sitting in the lobby at a table with Resident A. Courtyard Staff 3 came to tell Courtyard Staff 5 that he was leaving. Courtyard Staff 5 was in the bathroom. Courtyard Staff 3 put his code into the keypad and Resident A slipped out of the door. Courtyard

Staff 1 stated she and other staff immediately went outside. Resident A approached Courtyard Staff 3's running car and opened the driver's door. Courtyard Staff 3 prevented Resident A from getting into the driver's seat, so she opened the back door and went inside. Courtyard Staff 1 stated she opened the back door and verbally tried to redirect Resident A out of the car. Courtyard Staff 3 advised that she close the door and he took Resident A on a ride around the property. While this incident was occurring Courtyard Staff 3 called and reported to Courtyard Staff 9 what was happening. When they returned Resident A was redirected back into the building. Courtyard Staff 1 stated following the incident, Courtyard Staff 3 left and she was advised to complete an incident report. She was directed by Courtyard Staff 4 not to indicate that Resident A attempted to get into the driver's seat of the car.

On 08/03/26, I interviewed Courtyard Staff 4. Courtyard Staff 4 stated on 07/19/26, when the incident occurred, she was not present as she was in building 4. She was informed by Courtyard Staff 1 that Resident A went out of the front door after Courtyard Staff 3 entered his code into the keypad. Resident A got into Courtyard Staff 3's car and he took her for a ride around the property. Courtyard Staff 4 stated she was unsure if Resident A was in the front seat or the backseat of the car. Courtyard Staff 4 stated if Resident A elopes the protocol is for staff to stay with her and redirect her back into the building. Courtyard Staff 4 explained the Resident A elopes frequently, often exiting through open doors. Courtyard Staff 4 stated she wrote the incident report despite not witnessing the incident occur because she a nurse and nurses regularly are response for reporting incidents. Courtyard Staff 4 denies telling any staff to leave out information when completing an incident report.

On 08/03/26, I interviewed Courtyard Staff 5. Courtyard Staff 5 stated on 07/19/26, when Resident A eloped, she was in the bathroom. She received a call from Courtyard Staff 3 informing her that he was preparing to leave the building. Courtyard Staff 5 stated by the time she came out of the bathroom Resident A and Courtyard Staff 3 had already gone on a drive around the property. There were multiple staff outside assisting with the situation. Courtyard Staff 5 stated when they returned Resident A was redirected back inside of the building. She came inside without further issue. Courtyard Staff 5 stated if Resident A elopes the protocol is to follow her and redirect her back inside.

On 08/03/26, I interviewed Courtyard Staff 6, Courtyard Staff 7, and Courtyard Staff 8. All three staff consistently stated that they had no information regarding this allegation as they were not present when the incident occurred.

On 08/21/26, I interviewed Courtyard Staff 3 via telephone. Courtyard Staff 3 stated on 07/19/26, he was taking half a day, so he was leaving his shift at 3:00 pm. He called the other supervisor on shift, Courtyard Staff 5, to notify her that he was leaving. Courtyard Staff 5 was unavailable, so he came over to building III to tell the staff on shift that he was leaving for the day. Courtyard Staff 3 stated upon exiting the building he did not see Resident A near him or near the door. He entered his code into the keypad and

Resident A jumped to the door and pushed him and the door opened going outside. Courtyard Staff 1 stated he went out after Resident A, and she stopped on the porch. Then, Resident A approached his car. Courtyard Staff 3 stated his car was off, Resident A opened the door to the backseat and got inside. Resident A said, "lets go for a ride." Courtyard Staff 3 stated in an effort to redirect Resident A, make an easy transition back into the building, and to keep her happy, he drove her around the building. While doing so Courtyard Staff 3 notified the other supervisors of the incident so they could be present to assist with redirecting Resident A back inside. Courtyard Staff 3 stated when they returned Resident A said that she had fun on the ride and she got out of the car and was taken back inside the building. Courtyard Staff 3 stated if Resident A elopes it is protocol for staff to call a code green, stay with her and redirect her back inside. Courtyard Staff 3 stated at no time did Resident A attempt to get into the driver's seat of the car. Courtyard Staff 3 stated he did not complete an incident report regarding this incident as he had already clocked out of his shift. However, he informed the nurse on duty about what occurred and she was to complete the incident report.

I reviewed an Incident Report (IR) written on 07/19/26, by Courtyard Staff 4. In summary, the IR indicates Courtyard Staff 3 entered code into the keypad to exit the building. Resident A eloped before Courtyard Staff 4 could get out of the door Resident A ran out on the front porch. Staff remained with Resident A and quickly redirected her back inside. Resident A walked with them into the building. The IR is also signed by licensee designee Serenity Brain.

Note – there was no incident report written by Courtyard Staff 1 onsite and available for review.

I reviewed a Next Step note completed by Courtyard Staff 1. The note is dated 07/19/26, and in summary indicates, at 2:51 pm, Courtyard Staff 3 was exiting the front door. After entering the code on the pin pad Resident A got out before the staff member. Courtyard Staff 3 followed Resident A out. Caregivers, supervisors, and nurses came out as well to get Resident A back inside. Staff were successfully able to redirect Resident A back inside.

I reviewed Resident A's annual assessment plan for AFC consumers dated 11/13/2025. In summary, the assessment indicates Resident A requires monitoring every 15 minutes due to confusion, wandering (related to cognitive impairments / dementia). Resident A has a history of eloping. She is a very high elopement risk. She will climb out of her windows or follow staff out of doors.

I reviewed Resident A's Courtyard Manor of Wixom Individual Plan of Service (IPOS), Psychiatric Evaluation dated 11/14/25, and her Psychosocial case management assessment dated 12/05/26. Resident A's lack of safety skills and high risk of elopement is thoroughly documented including her many attempts to exit out of the front door at the beginning, middle, and end of shifts. Resident A's IPOS indicates she has a history of stealing a staff vehicle from her AFC provider and driving around the community without permission or a license.

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 upon the information gathered during this investigation there is sufficient information to conclude that Resident A received supervision, protection, and personal care as specified in her assessment plan. Resident A's assessment plan thoroughly documents her lack of safety skills and high risk of elopement. On 07/19/26, when Courtyard Staff 3 was exiting the front door after entering the code on the pin pad Resident A went out the door and Courtyard Staff 3 followed. Resident A got into Courtyard Staff 3's car and wanted to go for a ride. Courtyard Staff 3 drove Resident A around the building to reduce the risk of a crisis. While doing so Courtyard Staff 3 notified his team members of what was occurring and obtained additional assistance to get Resident A back inside of the building. There are no proactive and/or reactive measures identified in Resident A's assessment plan to guide staffs' behavior in the event of an elopement. In the absence of such guidance, Courtyard Staff 3 chose the least restrictive measure to keep Resident A, the staff, and others safe.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.693	Incident notification, incident records.
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: (e) Elopement from the facility if the resident's location is unknown.

ANALYSIS:	Based upon the information gathered during this investigation there is sufficient information to conclude following Resident A's elopement on 07/19/26, an Incident Report (IR) was completed. However, the IR was not completed by the involved staff, Courtyard Staff 3, as he had ended his shift at the time of the incident. Courtyard Staff 3 communicated to Courtyard Staff 4 the nature of the incident and Courtyard Staff 4 was to complete the necessary documentation. Courtyard Staff 4, who is a nurse, said that it is a common practice for nurses to write IR's when incidents occur. Although an IR was completed the IR does not provide thorough and accurate details of the incident that occurred. A review of the IR written on 07/19/26, by Courtyard Staff 4, in summary, indicates Courtyard Staff 3 entered his code into the keypad to exit the building. Resident A eloped before Courtyard Staff 4 could get out of the door Resident A ran out on the front porch. Staff remained with Resident A and quickly redirected her back inside. Resident A walked with them into the building. The IR fails to include details regarding Resident A getting into the staff's vehicle and being taken on a ride around the building before returning inside. It is important to document that Resident A got into a staff vehicle as it indicates in her IPOS that she has a history of stealing staff vehicles. As such, this behavior should be properly documented in her record. Furthermore, the incident was not accurately communicated to Resident A's guardian as Resident A's guardian informed APS worker Ms. Anderson that she was aware of the elopement, but she had not been informed that Resident A got into the staff's car and then went for a ride around the building. Moreover, the IR was written by Courtyard Staff 4, who indicated when interviewed that she did not witness the incident occur. However, Courtyard Staff 1, who was a witness to the incident stated that she completed an IR following the elopement. However, during the unscheduled onsite investigation completed on 08/03/26, the IR written by Courtyard Staff 1 was not onsite and available for review.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

On 05/19/26, Resident B fell in the bathroom while being transferred by Courtyard Staff, Daniel Wu. Following the incident Resident B did not receive immediate health care, causing the injury to her leg to worsen.

INVESTIGATION:

On 07/27/26, I received a referral from an anonymous reporting source. In summary, the referral indicates Resident B fell in the large handicap bathroom while a staff member was assisting her because the staff member failed to move the wheelchair foot pedals, causing her to trip and sustain an injury when the staff member fell on top of her. Due to improper wound care and significant delays, Resident B's leg wound became severely swollen, bruised, and leaked for about 1-2 weeks after the incident. One day, a caregiver was doing her last brief checks and noticed Resident B's leg wrap falling off, reporting the visual state and foul smell of the leg to the alternate medication tech. The medication tech took a picture of Resident B's leg and sent it to the nurse on duty around 6:25 pm that day. Nurse Aireanna Flemming came over and looked at the leg in person, but instead of sending Resident B out, she said we would wait to see how the leg looked the next morning. Resident B was sent out the next morning. Ms. Flemming told me she was texting other on-call nurses who also said not to send Resident B out. Resident B really should have been sent out immediately the night before due to how severely infected her leg appeared and smelled. Resident B returned from the hospital the same day, but she did not stay at the facility long due to the severity of her leg, and she was ultimately transferred out to a different facility because our facility claimed they did not do wound care. It was only after Resident B was transferred that I learned management lied in the official incident report, claiming that Resident B fell in her own room's bathroom and pulled the call light, to cover up the staff error in the hallway bathroom and the intentional delay in medical treatment.

On 08/03/26, I received a second referral from an anonymous Reporting Source 2. In summary, the referral indicates this facility has falsified documents stating certain people were witnesses when they were not even scheduled to work that day. The director, Serenity Brain, has directed nurses to lie, falsify, and delete reports. I have personally seen and filed the report they falsified regarding Resident B and her injury.

On 07/27/26, I contacted Reporting Source 1 via email to confirm what building the residents resided in as this information was not indicated in the complaint and Courtyard Manor of Wixom has several buildings on their campus. Additionally, I requested additional information/evidence to support the allegation. Reporting Source 1 verified which building the residents reside in and provided screenshots of text messages to support the allegation.

On 08/04/26, I made a referral to Adult Protective Services (APS) via the Michigan Online Reporting System. The allegation regarding Resident B was assigned to APS worker Tina Edans. On 08/28/26, I received an email from Ms. Edans which indicated

that she will not be substantiating. Ms. Edans interviewed Resident B's guardian on 08/28/26, who indicated she has no concerns about the care that Courtyard Manor of Wixom provided. She remarked that Resident B is safe and happy at Courtyard Manor of Wixom. Resident B is currently in rehab at Medilodge in Milford, MI and upon completion of rehab she will return to Courtyard Manor of Wixom.

On 08/04/26, I made a referral via email to Macomb County Community Mental Health (MCCMH) - Office of Recipient Rights (ORR) regarding the allegation involving Resident B. The investigation was assigned to Recipient Rights Specialist Stacey Bluteau.

On 08/03/26, I completed an unscheduled onsite investigation. I interviewed licensee designee Serenity Brain, Courtyard Staff 1, Courtyard Staff 4, Courtyard Staff 5, Courtyard Staff 6, Courtyard Staff 7, and Courtyard Staff 8.

On 08/03/26, I interviewed licensee designee Serenity Brain. Ms. Brain stated Resident B has lipoidemia in her legs. She retains water. Resident B fell at the facility. She was sent out to the hospital three times. Every time she was sent out, she was returned to the facility. Finally, they requested she be taken to a different hospital. She was admitted and upon discharge she was sent to Medi lodge. Ms. Brain stated she has keep in communication with Resident B's guardian who informed her that Resident B has an surface level infection and she was transferred to Huron Valley Hospital, and she is not in the intensive care unit (ICU). Ms. Brain stated Resident B has been out of care for over a month.

On 08/03/26, I interviewed Courtyard Staff 1. Courtyard Staff 1 stated she was not present when Resident B fell. However, Courtyard Staff 10 was present, and she told her that Courtyard Staff 2 was assisting Resident B in the hallway bathroom and he did not move her wheelchair out of the way resulting in Resident B tripping over the peddles. Resident B fell onto the floor and Courtyard Staff 2 fell on top of her. Initially, Resident B's leg was bruised. It was being bandaged with an ace bandage. Courtyard Staff 1 stated on 05/30/26, she informed Courtyard Staff 4 that Resident B's leg smelled like fish, it was blistering, and leaking fluid. Courtyard Staff 4 advised monitoring the leg overnight and see how it looked in the morning. The next morning at 9:00 am, Resident B was sent to the hospital.

On 08/03/26, I interviewed Courtyard Staff 4. Courtyard Staff 4 stated on an unknown date she received a report that indicated Resident B hit her left on the foot peddles of her wheelchair while in the bathroom. Resident B was sent to the hospital. The hospital did not admit her and sent her back to the facility. On a different date Resident B was sent to the hospital again. She was admitted and now she is in rehab.

On 08/03/26, I interviewed Courtyard Staff 5. Courtyard Staff 5 stated she was not present when the incident occurred however, she heard after the fact that Resident B sustained an injury to her leg as a result of falling in the bathroom while being transferred. Resident B had a big red bruise on her leg. Courtyard Staff 5 stated she informed a nurse of the bruising and Resident B was sent to the hospital at the time of the injury.

On 08/03/26, I interviewed Courtyard Staff 6. Courtyard Staff 6 stated Resident B fell while being transferred in the bathroom with Courtyard Staff 2. Her leg hit the peddles of the wheelchair. Courtyard Staff 2 called out for assistance and another staff arrived to assist in getting Resident B off the floor. Courtyard Staff 6 stated following the incident she assessed Resident B. Resident B has lymphoedema in her legs, but there was no bruising. A few hours later staff assisted Resident B to the bathroom and noticed her leg was very swollen. Courtyard Staff 6 called Courtyard Staff 8 who also came to assess Resident B's leg. Resident B was sent to the hospital. She remained in the hospital for two days then she returned to the facility. Her leg was wrapped and the facility continued to wrap it as prescribed. Following this Resident B was sent back to the hospital multiple times for concerns, but the hospital returned her to the facility. Courtyard Staff 6 stated finally staff requested that Resident B be sent to a different hospital. Resident B was taken to Huron Valley Hospital and she was admitted.

On 08/03/26, I interviewed Courtyard Staff 7. Courtyard Staff 7 stated she was on shift when the incident occurred. Courtyard Staff 2 assisted Resident B to the hallway bathroom while she was on break. Courtyard Staff 7 remarked that Resident B is a two person assist to toilet. Courtyard Staff 7 heard Courtyard Staff 2 call out for help, and she and Courtyard Staff 10 responded. Courtyard Staff 7 stated when she arrived to the bathroom Resident B's wheelchair was near the shower. She asked what happened and Courtyard Staff 2 said Resident B fell. Courtyard Staff 7 stated an hour after the incident occurred she and Courtyard Staff 10 went in to change Resident B and they noticed a bruise on her leg. Courtyard Staff 6 was contacted and she came to assess. Resident B was sent to the hospital. The hospital did not admit her, and she was sent back to the facility. Courtyard Staff 7 stated on unknown dates Resident B was sent to the hospital several times following the incident and she was repeatedly sent back to the facility.

On 08/03/26, I interviewed Courtyard Staff 8. Courtyard Staff 8 stated she was contacted by Courtyard Staff 6 following the incident to assess the bruising to Resident B's leg. Resident B was sent to the hospital. Courtyard Staff 8 stated at baseline Resident B's legs are filled with fluid. There was no bleeding, just bruising. Resident B returned from the hospital; her left was wrapped. Following this Resident B was sent to the hospital again for an assessment and she was sent back to the facility. Finally, it was requested that Resident B be taken to a different hospital. She was taken to Huron Valley Hospital and admitted.

On 08/03/26, I interviewed Courtyard Staff 2 via telephone. Courtyard Staff 2 stated he began his employment in March 2026. On 05/19/26, the date the incident occurred, was his first time working in building III with Resident B. Courtyard Staff 2 stated he was trained to transfer residents for toileting. On 05/19/26, he took Resident B to the bathroom in the hallway and while he was assisting her off the toilet her right foot slipped and she fell. Courtyard Staff 2 stated he held onto Resident B's arms and protected her head to prevent injury while falling. Courtyard Staff 2 remarked he fell to the floor with Resident B, but he did not fall on her. Courtyard Staff 2 stated he called for help and two staff whose name he cannot not recall came to assist him. The two staff assisted Resident B off the floor. Courtyard Staff 2 stated those staff later told him that Resident B needed to be transferred by two staff. Courtyard Staff 2 said that he did not

read in Resident B's assessment plan or individual plan of service that she required two staff to transfer. Courtyard Staff 2 stated following the incident he observed bruising on Resident B's leg. Resident B was taken to the hospital via EMS. Courtyard Staff 2 stated he is not aware of what medical treatment Resident B received after being taken to the hospital following the accident.

I reviewed Resident B's annual assessment plan dated 08/05/2025 and 07/20/26. The assessment plan indicates, "personal hygiene x1 person assistance and prompting for all ADL's."

I reviewed the following Incident Reports (IR) the following is a summary of relevant information:

IR dated 05/19/26, in summary indicates on 05/19/26, Resident B had a fall in her bathroom while being transferred she slipped and fell. Several hours later an extremely large hematoma was present on her leg. Resident B was transported via EMS to Henry Ford Providence Novi.

IR dated 05/31/26, in summary indicates significant swelling, extensive dark/purple/black bruising and pen areas with active bleeding to the lower calf/ leg. Resident B sent to Henry Ford Providence Novi via EMS.

IR dated 06/03/26, in summary indicates Resident B was seen at Henry Ford Providence Novi twice for her leg since 05/19/26. Extremely large edematous bruised area noted after fall on 05/19/26 and she was seen at the ER. She returned on 05/21/26. No new orders and over 1/3 of her RLE including the shin just below her knee to almost her ankle, wrapping around to the calf a very dark purple bruising. On 05/31/26, the ecchymosis had darkened to almost black with weeping/oozing areas. Resident B was sent back to Henry Ford Providence Novi via EMS on 05/31/26 for evaluation. She was returned the same day with no new orders and to follow up with PCP. She was seen in the PCP office on 06/02/26. Resident B was given no new orders other than to follow up with infectious disease and wound care. Today, dressing was changed and blackened area appeared large with malodorous odor. Sent to different ER, Huron Valley Hospital, via Courtyard Manor Staff and vehicle for further evaluation. Resident B was admitted.

I reviewed the following Next Step Notes the following is a summary of relevant information:

Next Step Note dated 05/19/26 – In the handicap bathroom next to the breakroom staff observed Resident B on the floor sitting upright with her back against the sink. The caregiver assisting her holding her left arm. Resident B's wheelchair legs were facing towards the toilet and the back of the chair toward the shower, unlocked. The caregiver stated he was trying to assist Resident B off the toilet and back to her wheelchair. Staff assisted Resident B off the floor and into her wheelchair. Supervisor and nurse were notified.

Next Step Note dated 05/19/26 – per caregiver Resident B had a fall earlier this morning in the bathroom. Several hours later, an extremely large hematoma was present on her LLE. Resident B was transported to the ER via EMS.

Next Step Note dated 05/21/26 – Resident B returned to Courtyard from hospital via EMS.

Next Step Note dated 05/31/26 – Resident B returned from Henry Ford Providence Hospital Novi. No new medications prescribed. Follow – up with PCP recommended within 1 – 7 days. Dressing/ wound care instructions noted per hospital discharge paperwork.

Next Step Note dated 06/01/26 – Large dark purple hematoma preset. Some areas peeling/open with bloody drainage. Area clean, TAO applied, covered with several ADB pads and wrapped with kerlix.

Next Step Note dated 06/02/26 – Resident B had an appointment with Dr. Rudnick at Harper Family Practice for a hospital following. Doctor advised resident to follow up with an infectious disease doctor. There is an appointment scheduled in October for annual visit.

Next Step Note dated 06/03/26 –Dark/blackened area larger than it was previously. Numerous open/weeping areas with malodorous odor. Resident B has been to Henry Ford Novi twice since 05/19/26 for her leg. Resident B was sent back to Henry Ford Providence Novi via EMS on 05/31/26 for evaluation. She was returned the same day with no new orders and to follow up with PCP. She was seen in the PCP office on 06/02/26. Resident B was given no new orders other than to follow up with infectious disease and wound care. On 06/03/26, dressing was changed. Resident B was sent to a different ER, Huron Valley Hospital, via Courtyard Manor Staff. Resident B was admitted.

I reviewed a text message dated 05/30/26 at 6:17pm, sent from Courtyard Staff 1 to Courtyard Staff 4. In summary, Courtyard Staff 1 sent a photo of Resident B's leg to Courtyard Staff 4 saying it looks like it is getting worse and it has a smell. Courtyard Staff 4 responds saying it looks bad for sure. Courtyard Staff 1 says you don't think she needs to go to the hospital. There is no further correspondence until the next day, 05/31/26 at 8:44 am when Courtyard Staff 4 says EMS is on the way please get Resident B ready. EMS left at 9:10 am.

On 08/26/26, I placed a telephone call to administrator Serentiy Brain to conduct an exit conference and review my findings. Ms. Brain was advised that a corrective action plan is required. She acknowledged and agreed to submit a corrective action plan. I also placed a telephone call to licensee designee Ronald Paradowicz to conduct an exit conference. There was no answer. I left a detailed voicemail regarding my findings.

APPLICABLE RULE	
R 400.689	Resident health care.
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.

ANALYSIS:	Based upon the information gathered during this investigation there is insufficient information to conclude that Resident B failed to receive health care immediately following an accident. On 05/19/26, Resident B fell in the bathroom while being transferred by Courtyard Staff 2. Following the accident there was an extremely large, bruised area noted on her leg. Resident B was transferred to Henry Ford Providence Novi Hospital via EMS. She returned to the facility on 05/21/26. On 05/31/26, Resident B was sent back to Henry Ford Providence Novi Hospital via EMS for evaluation. She was returned the same day with no new orders and to follow up with her primary care provider (PCP). Resident B was seen in the PCP office on 06/02/26. Resident B was given no new orders other than to follow up with infectious disease and wound care. On 06/03/26, when the dressing was changed the area appeared blackened with malodorous odor. Resident B was sent to a different hospital, Huron Valley Hospital, for evaluation. Resident B was admitted. Based upon the documentation reviewed there is no indication that Resident B failed to obtain needed health care immediately.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

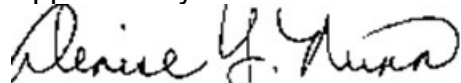


08/28/2026

Johnna Cade
Licensing Consultant

Date

Approved By:



09/01/2026

Denise Y. Nunn
Area Manager

Date