STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

July 14, 2021

Ronald Paradowicz
Courtyard Manor Farmington Hills Inc
Suite 127
3275 Martin
Walled Lake, MI 48390

RE: License #: AL630007351
Investigation #: 2021A0602018
Courtyard Manor Farmington Hills I

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) 975-5053.

Sincerely,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007351
Investigation #:	2021A0602018
Complaint Receipt Date:	04/15/2021
Investigation Initiation Date:	04/16/2021
Report Due Date:	06/14/2021
Licensee Name:	Courtyard Manor Farmington Hills Inc.
Licensee Address:	3275 Martin, Suite 127 Walled Lake, MI 48390
Licensee Telephone #:	(248) 926-2920
Administrator:	Ronald Paradowicz
Licensee Designee:	Ronald Paradowicz
Name of Facility:	Courtyard Manor Farmington Hills I
Facility Address:	29750 Farmington Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-0104
Original Issuance Date:	01/19/1993
License Status:	REGULAR
Effective Date:	11/28/2020
Expiration Date:	11/27/2022
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell on 2/21/21 and on 2/23/21. Resident A was taken to the hospital and admitted after the second fall and was diagnosed with a broken nose, broken ribs, a brain bleed and died in the hospital.	Yes
Resident B is being confined to his bed (picture provided).	Yes

III. METHODOLOGY

04/15/2021	Special Investigation Intake 2021A0602018
03/26/2021	Inspection Completed On-site Interviewed the Director of Operations, Belinda Whitfield, observed Resident B, and observed Resident B's room.
03/26/2021	Contact – Telephone call received Spoke with the Director of Nursing, Tammy Lemieux.
03/26/2021	Contact – Document Received Received requested documents regarding Resident A and Resident B.
04/16/2021	Contact – Telephone call received Spoke with Staff Member #1.
06/28/2021	Contact – Telephone call received Spoke with Staff Member #2.
06/29/2021	Exit Conference Email sent to the licensee designee, Ronald Paradowicz
06/30/2021	Contact – Telephone call received Spoke with Mr. Paradowicz.
07/01/2021	Contact – Telephone call received Had a conference call with Mr. Paradowicz, Jim Cubr and Tammy Lemieux.

ALLEGATION:

- **Resident A fell on 2/21/21 and on 2/23/21. Resident A was taken to the hospital and admitted after the second fall and was diagnosed with a broken nose, broken ribs, a brain bleed and died in the hospital.**
- **Resident B is being confined to his bed (picture provided).**

INVESTIGATION:

NOTE: While conducting another investigation at this facility, it was determined that this complaint should be opened and investigated separately. Although the investigation began on 3/26/2021, the complaint was opened on 4/15/2021. On 3/26/2021 information was received from an anonymous source alleging that Resident A fell on 2/21/21 and 2/23/21 and was taken to the hospital after the second fall. Resident A was diagnosed with a broken nose, broken ribs, brain bleed and died in the hospital. The complainant also alleges that Resident B is being confined to his bed. A picture of Resident B lying in bed with a mattress and wheelchair pushed against his bed was provided.

On 3/26/2021 I conducted an unannounced on-site investigation at which time I interviewed staff member Marlene Jones who stated she is the Director of Nursing in training and primarily works in Building #3 and 4. Ms. Jones did not have any firsthand information regarding Resident A or Resident B. I also spoke with the Director of Operations, Belinda Whitfield and requested documents from Resident A and Resident B's file.

On 3/26/2021, I spoke with the Director of Nursing, Tammy Lemieux by telephone. Ms. Lemieux stated in January 2021 Resident A began displaying periods of combative behavior which was not a normal baseline for him. He was tested for COVID-19 on 1/13/2021 and received a negative test result. Resident A was tested again on 1/15/2021 and received a positive test result. According to Ms. Lemieux, Resident A never neurologically recovered after contracting COVID-19 and began to decline becoming move confused. On 2/22/2021 around 2:00 am, Resident A was found on the floor face down near his closet. His right eye was observed with a reddish color bruise. On this same date around 6:00 pm, Resident A became unsteady and fell backwards hitting his head. He was transported to the hospital where he was diagnosed with a rib fracture, nose fracture and a hematoma on the brain.

On 3/26/2021, I received and reviewed Resident A's nurse's notes dated 1/13/21 through 2/26/2021, health care appraisal dated 1/31/2021, and Optimal Home Care notes dated 1/25/2021. According to the nurse's notes, on 1/13/2021 Resident A tested negative for COVID-19, positive on 1/15/2021 and negative again on 1/21/2021. On 1/20/2021, Resident A was observed on the floor in his room beside his bed with no injuries observed. Physical and occupational therapy ordered at that time. On 1/25/2021 Resident A seen by visiting physician and an order was written for home care. On

2/9/2021 Resident A was observed with a purple bruise on his right hip (size not documented) denied falling but could not explain how he obtained the bruise. On 2/22/2021 at 1:54 am Resident A was observed on the floor face down in his closet with a reddish colored bruise near his right eye. The visiting physician was notified of Resident A's unsteady gait. A wheelchair and hospital bed were ordered and Resident A's Xanax 0.25 mg tab twice daily was discontinued. On this same date at 6:11 pm, Resident A was being assisted from his wheelchair and into bed when he lost his balance, fell backwards hitting his head on the wall. 911 was called and Resident A was transported to Henry Ford Hospital-West Bloomfield where he was admitted. Resident A's family member informed the facility that Resident A was diagnosed with a hematoma on the brain, a rib fracture, and a nose fracture. Resident A died on 2/26/2021 while hospitalized. Resident A's health care appraisal dated 1/31/2021 documents that he suffers from dementia, confusion, and insomnia. The Optimal Home Care notes dated 1/25/2021 lists Resident A's primary diagnosis as weakness, unsteady gait with history of falls and post COVID.

On 4/16/2021, I interviewed Staff Member #1 (by telephone) who requested to remain anonymous. Staff Member #1 stated she recalls Resident A being found in his closet face down with blood on the floor near him. He was not taken to the hospital until he fell again later in that same day. Resident A never returned to the facility.

On 7/1/2021, I spoke with the licensee designee, Mr. Paradowicz, the Executive Director, Jim Cubr and the Director of Nursing, Tammy Lemieux by conference call. Additional information was provided indicating that Resident A's psychiatrist and primary physician were notified regarding his first fall on 2/22/21 and it was not recommended to send him out to the hospital at that time. Ms. Lemieux stated when she arrived at the facility on the morning of 2/22/21, she personally observed Resident A and spoke with him. He did have a bruise on his face near his eye but did not complain of being in any pain and did not show any signs of being in pain. A hospital bed and wheelchair were ordered, staff were instructed to check on him hourly and his medication was adjusted. When Resident A fell again on that same day, the physician instructed that Resident A be transported to the hospital at which time he was.

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 my review of the nurse's notes, interview with Ms. Lemieux and Staff Member #1, I determined that Resident A's physician was notified of both of his falls on 2/22/2021. After the first fall the physician did not advise sending him out to the hospital but ordered a wheelchair and hospital bed and advised staff to conduct hourly checks. Resident A's psychiatrist was

	also notified and discontinued his Xanax 0.25 mg tab twice daily. After the second fall on this same date, Resident A was transported to the hospital. While hospitalized, Resident A was diagnosed with a fractured rib, a fractured nose, and a hematoma on the brain. Resident A died at the hospital on 2/26/2021.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B is being confined to his bed (picture provided).

INVESTIGATION:

On 3/26/2021 I conducted an unannounced on-site investigation at which time I interviewed the Director of Operations, Belinda Whitfield, the Director of Nursing (in training at the time) Marlene Jones and observed Resident B and his room. Ms. Whitfield stated she had no information or knowledge regarding Resident B being confined to his bed. I showed her the picture of Resident B lying in bed with a mattress pushed up against his bed and a wheelchair pushed against the mattresses. Ms. Whitfield stated she had no information regarding the picture and had never seen it before. Ms. Jones stated she had no knowledge of Resident B being confined to his bed and had never seen the picture before.

On 3/26/2021 I received and reviewed physician orders for Resident B. According to the orders, Resident B uses a wheelchair or Broda chair for mobility when out of bed with a one person assist with transfers and a one person assist to push. A chair pad alarm must be turned on and activated when Resident B is in the chair. Resident B has a low hospital bed with a bed pad alarm that is to be turned on and activated when he is in bed. Resident B has toilet support bars that are used for assistance, safety and fall prevention along with a low air loss mattress to be placed on top of the bed for pressure relief while Resident B is in bed. Resident B also has a soft lap belt to be worn after meals for two hours only while utilizing the wheelchair.

On 3/26/2021, I observed Resident B sitting in a Broda chair in the common area of the facility. Resident A was unable to provide any information regarding the allegation as he suffers from aphasia and has difficulty speaking.

On 3/26/2021, I observed Resident B’s room and found there to be a bed, a mattress propped against the wall along with a wheelchair.

On 4/16/2021 I interviewed Staff Member #1 by telephone. Staff Member #1 stated Resident B has been confined to his bed with a mattress pushed up against it and a wheelchair pushed up against the mattress. This is done to prevent Resident B from falling out of bed. Resident B also has an order for a soft lap belt with Velcro to be used

while he is in his wheelchair. When the lap belt is used properly, it is placed across his lap and the Velcro strap is attached to the back of the chair. Resident B can still get up from the chair and the alarm will go off, but this gives staff enough time to redirect him to sit back down. However, instead of using the lap belt properly, staff will strap it across Resident B's lap and tie the strap to the bar on the back of his Broda chair making it difficult for him to get up. When State employees come to the facility (exact dates unknown), staff are instructed by the director of operations to remove the restraints. Staff Member #1 stated management is aware of the situation.

On 6/28/2021, I interviewed Staff Member #2 (who requested to remain anonymous) by telephone. Staff Member #2 stated she has never witnessed Resident B being confined to his bed but has witnessed other residents placed in bed with a mattress pushed against the bed and a wheelchair pushed up against the mattress. This is done to prevent the residents from falling out of bed.

On 6/29/2021, I sent an email to the licensee designee, Ronald Paradowicz requesting a call to discuss the allegations, findings and recommendation documented in this report.

On 6/30/2021, I conducted an exit conference with the licensee designee, Ronald Paradowicz by telephone and discussed the allegations, findings and recommendation documented in this report. Mr. Paradowicz stated he would discuss the allegations with the executive director of the facility and the director of nursing and get back with me on 7/1/2021 to discuss the allegations further.

On 7/1/2021, I spoke with Mr. Paradowicz, the Executive Director, Jim Cubr and the Director of Nursing, Tammy Lemieux by a conference call. Mr. Paradowicz, Mr. Cubr and Ms. Lemieux stated they had no knowledge of the confinements being used by staff. Ms. Lemieux said she immediately conducted an in-service with staff when she was informed of the allegation after the unannounced on-site investigation on 3/26/2021. Mr. Paradowicz agreed to submit a corrective action plan upon receipt of this report.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based the information received from Staff Member #1, Staff Member #2 and my review of a picture provided by the complainant, I determined that Resident B was not treated with dignity as he was lying in bed with a mattress pushed against the bed and a wheelchair pushed against the mattress confining him to the bed.

CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the homes shall not do any of the following: (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.
ANALYSIS:	Based on the information received from Staff Member #1, Staff Member #2 and my review of a picture provided by the complainant of Resident B lying in bed with a mattress pushed against the bed and a wheelchair pushed against the mattress, I determined that on an unknown date Resident B was confined to a bed. I was unable to determine if Resident B is being confined to his wheelchair. However, staff should be in-serviced on the proper use of his soft lap belt as Staff Member #1 indicated it is not being used properly.
CONCLUSION:	**VIOLATION ESTABLISHED**

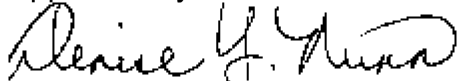
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

7/12/2021

Cindy Berry Date
Licensing Consultant

Approved By:



07/14/2021

Denise Y. Nunn Date
Area Manager