GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 5, 2021

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

RE: License #: AL630007351
Investigation #: 2021A0988031
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,

Kenyatta Lewis, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 296-2078

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007351
Investigation #:	2021A0988031
Complaint Receipt Date:	08/16/2021
Investigation Initiation Date:	08/17/2021
Report Due Date:	10/15/2021
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 has been found sitting in urine on many occasions, as recently as 08/15/2021. Resident A is supposed to be changed every two hours, but the personnel has not been doing that.	No
Additional Findings	Yes

III. METHODOLOGY

08/16/2021	Special Investigation Intake 2021A0988031
08/16/2021	APS Referral Intake #181423 complaint denied by adult protective services (APS) per email from Jessica Vance, Centralized Intake Supervisor. The complaint was forwarded to the department for investigation.
08/17/2021	Special Investigation Initiated - Telephone I left a message for the complainant.
08/18/2021	Contact - Telephone call received I conducted an interview with the complainant.
08/18/2021	Contact - Document Received I received an email from the complainant containing photos of Resident A and the facility.
08/19/2021	Inspection Completed On-site I conducted interviews with facility staff, complainant, and Resident A.
08/23/2021	Contact - Telephone call made I conducted an interview with the administrator, Jim Cubr and shared the photos I received from the complainant via email.
09/29/2021	Contact - Document Received I received photos of a glove and sandwich on the floor at the facility via email from the complainant.

09/29/2021	Contact - Telephone call made I spoke to Jim Cubr.
09/30/2021	Contact - Document Received I received photos of a glove and syringe on the floor of the facility, via email from the complainant.
10/13/2021	Contact - Document Sent I sent the photos to Jim Cubr, via email.
11/03/2021	Exit Conference I conducted the exit conference with Ron Paradowicz and Jim Cubr via email.

ALLEGATION:

Resident A has been found sitting in urine on many occasions, as recently as 08/15/2021. Resident A is supposed to be changed every two hours, but the personnel has not been doing that.

INVESTIGATION:

On 08/16/2021, Intake #81423 denied by adult protective services (APS) per email from Jessica Vance, Centralized Intake Supervisor. The complaint was forwarded to the department for investigation.

On 08/18/2021, I conducted an interview with the complainant, who reiterated the allegations. The complainant also stated that Resident A moved to Courtyard Manor because she is not able to care for herself and she needs 24-hour supervision, due to her progressed stage of Dementia. On 08/15/2021, Resident A was found in a soaked undergarment during lunch at noon. The complainant stated that concerns are shared with Courtyard Manor first line and executive level staff, but not much is done to make sure that Resident A is always dry. Resident A likes to walk and wander through the hallways at Courtyard. Resident A has been found wandering barefoot on dirty floors and has even escaped into the inner yard area unsupervised. Courtyard staff set up a book to make sure that staff check on Resident A every two hours, as well as a tracking sheet to make sure that Resident A's undergarments are changed regularly. The complainant stated that wet diapers have been found on the floor of Resident A's bedroom.

On 08/18/2021, I received an email from the complainant containing pictures of Resident A and the facility: I observed a photos of Resident A's feet dated 9/7/2020,11/24/2020, 5/14/2021,7/12/2021. I observed that Resident A's feet were dirty from dust and dirt. Her soles were caked with dirt. I observed a photo dated 3/16/2021 of Resident A wearing socks with worn holes at the heels. I observed a photo dated

7/12/2021 of a dirty diaper lying on the floor of Resident A's bedroom. I observed a photo dated 7/28/2021, of Resident A's undergarment (diaper) loosely secured around her waist. I observed photos dated 8/15/21. I observed dirt in the shower area and a sticky/shiny stain on the floor.

On 08/19/2021, I conducted an unannounced onsite investigation. I conducted interviews with the director of operations, Belinda Whitfield, licensed practical nurse (LPN), Marlene Jones, the complainant, and Resident A. I shared the allegations with Ms. Whitfield and Ms. Jones.

Ms. Whitfield stated Resident A is a "heavy wetter", so she must be changed often. There is a toileting log and staff check on Resident A at least two hours each day. Ms. Jones stated that Resident A is a wanderer, and she constantly removes her shoes and socks. Ms. Jones stated that she makes sure that staff clean and wipe Resident A's feet because she walks the halls day and night. Ms. Jones stated that Resident A does not like to keep shoes on. Resident A has worn holes in all her socks. Resident A's partner, and Resident A's mother purchase socks regularly. Ms. Jones also stated that Resident A is a "heavy wetter", and staff change her undergarment every two hours as needed. Resident A is small in stature, and she continues to lose weight due to increased walking and pacing. The hospice staff recently changed the size of Resident A's undergarments to youth small. Hospice also provided a pad for Resident A to add to her undergarment for extra absorption due the large amount of urine output Resident A produces. Ms. Jones and Ms. Whitfield stated that sometimes Resident A picks at the front of her undergarment which causes it to become loose. Ms. Whitfield stated that the allegations are an exaggeration of minor incidents that staff address appropriately.

Ms. Whitfield and Ms. Jones stated that the floors at Courtyard are mopped and vacuumed each day. Ms. Whitfield stated that there are 15 resident's total. There are always two direct care workers on each shift including the midnight shift. During waking hours, there is always at least one nurse on the morning and afternoon shift in addition to the direct care workers. Resident A is supervised. Ms. Whitfield stated that approximately one month ago, Resident A was found in the inner yard area one time. An incident report (IR) was completed, and alarms have been placed on the inner doors in addition to the alarms that were always on the outer doors.

Ms. Jones stated that Resident A's partner visits each day at various times of the day. Resident A's partner does not seem to be happy with Resident A residing at Courtyard and she makes multiple complaints almost each time she visits Resident A. Ms. Jones stated that Resident A's partner visited Resident A around noon (date unknown) and found Resident A's toothbrush bristles dry. Resident A's partner accused staff of failing to brush Resident A's teeth, even though her teeth are brushed each morning and at night before bed. There have been ongoing complaints about Resident A having dirt on her feet. Ms. Jones stated that the staff do the best they can. Resident A's feet may get dirty from time to time because of the way she walks and wanders most of the day. Staff make every effort to wash Resident A's feet if she is found without her socks and shoes. Ms. Jones and Ms. Whitfield stated that sometimes Resident A picks at the front

of her undergarment which causes it to become loose. Ms. Whitfield stated that the allegations are an exaggeration of minor incidents that staff address appropriately.

During the onsite, I observed toileting logs dated 08/12/2021, 08/15/2021, and 08/17/2021. I observed staff notes every two hours between 7:00 AM – 11:00 PM on each log. Staff documented if Resident A was wet and changed, or dry. I also observed staff schedules dated 08/01/2021 – 08/15/2021. I observed that there were two direct care workers scheduled each shift, AM, PM, and midnight.

During the onsite visit, I attempted to interview Resident A. Resident A was not able to communicate with me due to her dementia. Resident A did not answer my questions and did not appear to be engaged or oriented. I observed Resident A walking and wandering around the facility. I observed staff at the front of the facility. Staff did not follow Resident A around the facility. The facility is shaped like a square with an inner courtyard in the middle of the hallways. While Resident A is not always in eyesight of staff, there are not a lot of places she can go without being supervised for a lengthy amount of time.

The complainant was at Courtyard during the onsite. I spoke to the complainant who stated that it would make sense if staff were spaced out in the facility. Perhaps one staff person in the front of the building and one in the hallway, to keep an eye on residents who are not in the common area at the front of the facility.

On 08/23/2021, I conducted an interview with the administrator, Jim Cubr and shared the photos I received from the complainant via email. Mr. Cubr stated the following regarding each picture:

- Dirty undergarment: Resident A has not had that color of brief for almost two months (white with blue bands). She has a full white brief because she is so small. At times, Resident A's partner will change her and groom her private area so maybe she put the brief on the floor. Mr. Cubr also stated that sometimes Resident A will start to walk away while being changed so that may be a reason for a brief on the floor. If Resident A's partner happens to walk in right after Resident A has been changed and staff have not had a chance to pick up a dirty brief, Resident A's partner will take a photo and threaten to make a complaint to the department and adult protective services.
- Worn socks: About two months ago, Resident A's partner told staff that it was ok to throw away socks with holes and let her know when Resident A needed new ones.
- Dirty feet: These photos appear to be when Resident A went out into the courtyard. After this incident staff walk with Resident A in the courtyard. Alarms have been added to the doors for the courtyard in case someone opens the doors with no staff present. The courtyard area in enclosed. A resident cannot elope from the facility from the courtyard area.

Mr. Cubr stated that most of the residents like to congregate in the front of the facility where the television is. Therefore, the staff spend a lot of time in the area where most of

the resident are. On 03/15/2021, Resident A was found in the inner courtyard at the facility after. Alarms were installed on the courtyard doors on 03/16/2021. Resident A walks around the facility and it is rare that staff cannot see her. Ms. Cubr stated that Resident A is properly supervised and well taken care of at Courtyard.

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 on the information that I gathered from interviews with the complainant, Jim Cubr, Belinda Whitfield, and Marlene Jones, I cannot conclude that Resident A is not properly supervised by staff at Courtyard. Resident A is a wanderer who does not like to wear shoes and socks. I observed Resident A walking around the facility. I concluded that due to Resident A's compulsive need to wander, her feet may get dirty at times, and she may continue to cause holes in her socks. I cannot conclude that staff failed to meet Resident A's needs, or that she was left in wet undergarments for extended periods of time. I observed a toileting chart that documented two-hour checks and changes of Resident A's undergarment if she was found wet. I could not conclude that the photo of the soiled diaper was left on the floor for a long period of time as Mr. Cubr provided a reasonable explanation staff could have just changed Resident A's brief when the photo was taken.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 09/29/2021, I received photos of a glove and sandwich on the floor at the facility via email from the complainant. The photos appeared to be of the dining area.

On 09/29/2021, I spoke to Jim Cubr and shared photos that I received. Mr. Cubr stated that staff clean the facility on a regular basis. Mr. Cubr stated that several of the residents suffer from dementia and there is no telling who put the sandwich on the floor, or if staff was in the process of cleaning when the pictures were taken. Staff use gloves when they clean and sometimes remove the gloves to sweep with the trash when they clean the facility.

On 09/30/2021, I received photos of a glove and syringe on the floor of the facility, via email from the complainant.

On 10/13/2021, I sent the photos to Jim Cubr, via email. I communicated that I was very concerned about a syringe and a second glove being found on the floor at the facility.

On 11/03/2021, I conducted the exit conference with Ron Paradowicz and Jim Cubr via email. I shared my findings and requested a corrective action plan. Mr. Cubr responded and stated that he shares my concerns, and he will address my findings with his staff, and submit a corrective action plan.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based on the photographs I observed from the complainant, I concluded that staff have failed to keep the facility clean and orderly on 09/29/2021 and 09/30/2021. On both dates, dirty gloves were found on the facility floor, along with a discarded sandwich and a syringe.
CONCLUSION:	**VIOLATION ESTABLISHED**

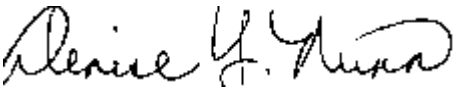
IV. RECOMMENDATION

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

11/05/2021

Kenyatta Lewis Date
Licensing Consultant

Approved By:



11/05/2021

Denise Y. Nunn Date
Area Manager