GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 16, 2022

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

RE: License #: **AL630007351**
Investigation #: **2021A0602012**
Courtyard Manor Farmington Hills I
ADDENDUM REPORT
Original Report dated April 16, 2021

Dear Mr. Paradowicz:

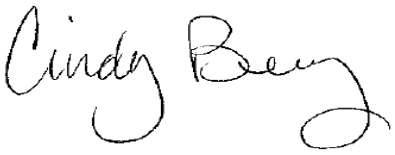
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2021A0602012
Complaint Receipt Date:	02/19/2021
Investigation Initiation Date:	02/19/2021
Report Due Date:	04/20/2021
Licensee Name:	Courtyard Manor Farmington Hills Inc.
Licensee Address:	Suite 127, 3275 Martin 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 lost approximately 30 lbs in 4 months.	Yes
There was lack of documentation of food intake.	No
Resident A was admitted to the hospital with stage two wounds and it is questionable if adequate care was provided at the facility.	No

III. METHODOLOGY

02/19/2021	Special Investigation Intake 2021A0602012
02/19/2021	Special Investigation Initiated - Telephone Call made to the complainant – no answer.
03/01/2021	Inspection Completed On-site Interviewed the executive director Jim Cubr, director of nursing Tammy Lemieux and staff members.
04/01/2021	Contact – Telephone call made Message left for the complainant.
04/16/2021	Exit Conference Message left for the licensee designee, Ronald Paradowicz.

ALLEGATION:

- **Resident A lost approximately 30 lbs in 4 months.**
- **There was lack of documentation of food intake.**
- **Resident A was admitted to the hospital with stage two wounds and it is questionable if adequate care was provided at the facility.**

INVESTIGATION:

On 2/19/2021, a complaint was received and assigned for investigation alleging that Resident A lost approximately 30 pounds in 4 months, there was lack of documentation of food intake and Resident A was admitted to the hospital with stage two wounds. The complainant also stated it is questionable if adequate care was provided at the facility.

On 3/1/2021, I conducted an unannounced on-site investigation at which time I interviewed the executive director, Jim Cubr, the director of nursing, Tammy Lemieux, staff members Malesa Appling, LaKindra Mitchell and Carrie Travis. Mr. Cubr stated he recalled Residing A residing in the facility and advised that I speak with Ms. Lemieux for detailed information.

On 3/1/2021, Ms. Lemieux stated Resident A moved into the facility on 8/19/2020 weighing 150.2 pounds and had edema in his lower legs. He was prescribed medication to assist with removing some of the fluid from his legs. Resident A began losing weight in September 2020 and continued throughout his stay at the facility. In November 2020 Resident A's weight was down to 139.5 pounds. Ms. Lemieux stated Resident A's physician was aware of his weight loss and was actively involved with his care. On 11/12/2020 Resident A's diet was downgraded to soft and bite sized. On 11/13/2020 he was prescribed ensure three times daily as his appetite was decreasing. On 11/18/2020 his prescribed morning Haldol was discontinued, and he was prescribed Megace to stimulate his appetite. On 11/19/2020, Resident A's Haldol was discontinued all together and his diet was downgraded again but to minced and moist. It appeared as if his dementia was progressing and on 11/20/2020 Resident A was transported to the hospital. Ms. Lemieux stated a peg tube was recommended but the family was not happy about the recommendation. Resident A did not return to the facility and on 1/5/2021 the family called and reported that he died. It was originally documented that the family called to report his death on 12/6/2020 but this could have been documented incorrectly. Ms. Lemieux went on to state that Resident A had a shower two days prior to being transported to the hospital on 11/20/2020 and there were no wounds observed at that time.

On 3/1/2021, Ms. Appling stated she has worked for the company for about a year as a direct care worker. She said Resident A suffered from dementia and became aggressive at times. When he initially moved into the facility, he was eating regular meals but began to rapidly decline. His diet was changed from regular to chopped and later to minced and moist. He started losing a lot of weight and his legs were swollen. Ms. Appling stated Resident A's daughter would visit with him and bring him fast food when he initially moved into the facility. Visitation was restricted due to COVID-19 and when she was able to visit him again about two weeks later (exact date unknown), Resident A had declined a great deal. He did not recognize her and was not eating. Ms. Appling said she showered Resident A and never observed any ulcers on him.

On 3/1/2021, Ms. Mitchell stated she has worked for the company for 14 years and works on Tuesdays, Thursdays, and every other weekend. Resident A resided in the facility for about two months when he started to decline. He would sleep during the day and stay up most of the night. During dinner he would only eat a few bites of his food. Ms. Mitchell said staff would document how much Resident A ate at each meal. Resident A was prescribed Megace to enhance his appetite, but it only worked for a couple of days. Ms. Mitchell stated she never observed any ulcers on Resident A.

On 3/1/2021, Ms. Travis stated she has worked for the company for almost 9 years as a direct care worker. Resident A quickly started declining after moving into the facility. He started sleeping a lot, his legs became swollen, he stopped eating as much and began to lose weight. Ms. Travis said she never observed any ulcers on Resident A.

On 3/1/2021, I received and reviewed the following documents contained in Resident A's resident record:

- Health care appraisal
- Breakfast, lunch, and dinner food intake logs
- Weight records
- Nurses notes
- Physician telephone orders

According to Resident A's health care appraisal dated 8/18/2020, he was fully ambulatory, weighed 152, had a diagnosis of dementia complicated by acute psychosis, prostate cancer, hypertension, and a grade IV heart murmur. He was prescribed Amlodipine, Vitamin D, Haldol, Lisinopril, and Paroxetine. Resident A's food intake logs document the percentage of his food intake at each meal. The first entry was documented on 9/28/2020. It appears that Resident A's appetite began to decline around 11/7/2020 during breakfast and lunch with dinner being the meal he ate 100 percent the most often.

Resident A's weight records document the following: 8/19/2020 - 150.2, 8/28/2020 - 155.5, 9/20/2020 - 152.5, 10/18/2020 - 144, 11/6/2020 - 139.5.

According to the nurse's notes and the physician's telephone orders on 9/10/20 Resident A was not sleeping at night and Haldol (PRN) was administered but was not effective. The doctor was notified, and Trazadone 50 mg daily was ordered for bedtime. Resident A was administered Haldol (PRN) again on 9/18/2020, 9/19/2020, 9/20/20 and on 9/23/2020. The doctor was notified and at that time no new medication changes were made. On 9/28/2020, the doctor visited Resident A and discontinued Haldol 2 mg three times daily and ordered Haldol 5 mg twice daily. On 9/30/2020, Resident A's Haldol 5 mg twice daily was discontinued, and Haldol 2 mg three times daily was prescribed to begin on 10/1/2020. Resident A was seen by the doctor on 10/7/2020 with no changes noted. On 11/12/2020, Resident A's diet was downgraded to soft, bite sized pieces with thin liquids after being seen by the speech therapist. On 11/13/2020, Resident A was prescribed Ensure three times daily as his weight dropped from 144 lbs on 10/18/2020 to 139lbs on 11/6/2020. On 11/18/2020 there was a care conference held at which time the doctor prescribed Megace 20 ml daily and requested that Resident A's weight be monitored weekly. On 11/19/2020, the doctor discontinued all of Resident A's Haldol and his diet was downgraded again to minced moist as it was noted that he was pocketing food (holding food in the mouth without swallowing it). On 11/20/2020, around 7:49 am Resident A was sleeping in a recliner in the common area of the facility. It was documented that he had only eaten 25 percent of his breakfast, lunch, and dinner the day before. The doctor was notified and advised to have him

transported to the hospital. Resident A was transported to Beaumont Hospital - Farmington Hills and did not return to the facility.

On 4/16/2021, I left a message for the licensee designee, Ronald Paradowicz informing him of the investigative findings and recommendation of the investigation.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	According to Ms. Lemieux, Resident A began losing weight in September 2020 and continued throughout his stay at the facility. After reviewing Resident A's weight records, I determined that he did not lose 30 pounds in four months. However, he did lose 8 pounds between 9/20/2020 and 10/18/2020 and another 4 pounds between 10/18/2020 and 11/6/2020 but was not prescribed ensure three times daily until 11/13/2020 and Megace 40 ml on 11/18/2020. Based on this information, Resident A's 12-pound weight loss between 9/20/20 and 11/6/2020 was not addressed until 11/13/2020.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (b) Special diets. (d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.

ANALYSIS:	Based on the information obtained during the investigation, there is insufficient information to determine that staff did not follow the physician's instructions related to Resident A's special diet. On 11/12/2020 Resident A's diet was downgraded to soft and bite sized with thin liquids and again on 11/19/2020 to minced and moist with regular thin liquids.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on the information obtained during the investigation, there is insufficient information to determine that Resident A was not provided with a minimum of 3 regular meals daily. According to Resident A's food intake logs dated 9/28/2020 through 11/19/2020, Resident A received breakfast, lunch, and dinner daily but did not always eat 100 percent of his meals.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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 obtained during the investigation, there is insufficient information to determine that Resident A's personal needs were not met. Ms. Lemieux, Ms. Appling, Ms. Mitchell and Ms. Travis stated they never observed any ulcers on Resident A. I did not observe anything documented in Resident A's resident record indicating that he had any ulcers on his body.
CONCLUSION:	VIOLATION NOT ESTABLISHED

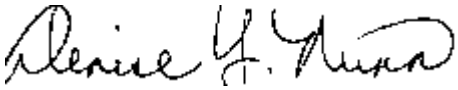
IV. RECOMMENDATION

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

04/16/2021

Cindy Berry Date
Licensing Consultant

Approved By:



04/16/2021

Denise Y. Nunn Date
Area Manager

ADDENDUM REPORT
SPECIAL INVESTIGATION #2021A0602012

PURPOSE

The purpose of this addendum is to correct information contained in the special investigation report.

ALLEGATION(S)

	Violation Established?
Resident A lost approximately 30 lbs in 4 months.	No

METHODOLOGY

06/30/2021	Contact – Telephone call made Spoke with the licensee designee, Ron Paradowicz.

07/01/2021	Contact – Telephone call received Conference call held with Ron Paradowicz, Jim Cubr and Tammy Lemieux.
07/01/2021	Contact – Document received Received documents from Mr. Paradowicz.

DESCRIPTION OF FINDINGS AND CONCLUSION

Special investigation report #2021A0602012 documents that Resident A's 12-pound weight loss between 9/20/20 and 11/6/2020 was not addressed until 11/13/2020.

Upon further review, the following allegation regarding Rule 400.15310 (3) has been changed to violation not established.

ALLEGATION:

Resident A lost approximately 30 lbs in 4 months.

INVESTIGATION:

On 6/30/2021 I spoke with the licensee designee Ron Paradowicz by telephone to conduct an exit conference regarding another investigation that was conducted at the facility. Mr. Paradowicz stated he never received the report regarding this investigation. I informed him of the allegations and recommendation documented in this report. He stated he had documentation to support that Resident A was being monitored by a physician and the physician was aware of this weight loss and staff followed all orders given. Mr. Paradowicz requested that a conference call be conducted with the registered nurse, Tammy Lemieux and the executive director, Jim Cubr to further discuss the allegations.

On 7/01/2021 I spoke with Mr. Paradowicz, Mr. Cubr and Ms. Lemieux by way of a conference call. Mr. Paradowicz stated it was documented on a nurse note dated 9/30/2020 that Resident A was prescribed a medication that would cause weight loss (water weight) as he was suffering from heart problems, including high blood pressure. Ms. Lemieux agreed and stated that Resident A suffered from edema in his lower legs. He was admitted to the facility on 8/19/2020 weighing 150 pounds and on 8/28/2020 his weight increased to 155 pounds. On 9/30/2020 Aldactone was prescribed to assist with removing some of the fluid Resident A was retaining. Resident A's weight continued to drop but the physician was aware and was monitoring his care.

A review of the physician and nurse's notes indicate that Resident A was seen by a physician on 8/21/2020, 9/02/2020, 9/25/2020, 9/30/2020, 10/07/2020, 11/11/2020 and 11/18/2020. On 9/30/2020, Dr. Kraft prescribed Aldactone 25 mg twice daily due to

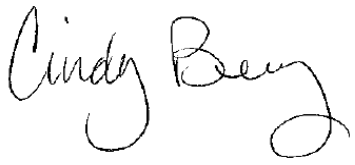
Resident A's elevated blood pressure. According to a google search of this medication, it is a diuretic that removes fluid from the body and can cause weight loss.

On 7/01/2020 I informed Mr. Paradowicz that an addendum report will be completed, and the rule violation will be changed to violation not established.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Based on a review of the physician's and nurse's notes, on 9/30/2020, Dr. Kraft prescribed Resident A Aldactone 25 mg twice daily due to elevated blood pressure. Aldactone is a diuretic and can cause weight loss. Dr. Kraft was monitoring Resident A while on this medication and was aware of his weight loss.
CONCLUSION:	VIOLATION NOT ESTABLISHED

RECOMMENDATION

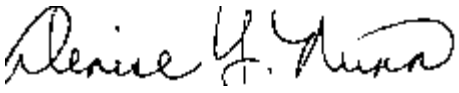
I recommend that the special investigation be closed with no change to the status of the license.



02/07/2022

Cindy Berry — Date
Licensing Consultant

Approved By:



02/16/2021

Denise Y. Nunn — Date
Area Manager