GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 31, 2022

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

RE: License #: AL630007353
Investigation #: 2022A0605016
Courtyard Manor Farmington Hills 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) 975-5053.

Sincerely,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007353
Investigation #:	2022A0605016
Complaint Receipt Date:	12/06/2021
Investigation Initiation Date:	12/06/2021
Report Due Date:	02/04/2022
Licensee Name:	Courtyard Manor Farmington Hills Inc
Licensee Address:	Suite 127 3275 Martin Walled Lake, MI 48390
Licensee Telephone #:	(248) 926-2920
Administrator/Licensee Designee:	Ronald Paradowicz
Name of Facility:	Courtyard Manor Farmington Hills III
Facility Address:	29770 Farmington Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-0104
Original Issuance Date:	08/11/1994
License Status:	REGULAR
Effective Date:	06/15/2020
Expiration Date:	06/14/2022
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A has been given Haldol and Ativan in the past for making phone calls, but this is no longer happening. Staff is yelling at patients and not allowing Resident A to have contact with her friend, Resident B. Staff verbally humiliated a woman and then she died 10 days later.	No
Male staff are walking in on female residents while they are getting dressed. Resident A is worried that Courtyard Manor of Farmington Hills gives all her mail to her guardian who does not have to share her mail with her.	No No

III. METHODOLOGY

12/06/2021	Special Investigation Intake 2022A0605016
12/06/2021	Special Investigation Initiated - Telephone I interviewed Resident A via telephone regarding the allegations.
12/06/2021	APS Referral Adult Protective Services (APS) denied referral.
12/13/2021	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed Resident A, Resident B, Resident C, Resident D, direct care staff (DCS) Anitra Hawkins, Shanuntia Pitts, and Marlene Jones, licensed practical nurse (LPN) regarding the allegations. I reviewed Resident A's assessment plan, discharge papers from Munson Medical Center and psychiatric evaluation management completed by Dr. Theodore Ruza and medication logs.
01/06/2022	Contact - Document Received I received additional allegations regarding male staff walking in on female residents while changing.
01/10/2022	Contact - Face to Face I conducted another unannounced on-site investigation and interviewed Belinda Whitfield, LPN Marlene Jones and Resident A regarding the allegations. I reviewed the staff schedule.

01/26/2022	Exit Conference I left a voice mail message for licensee designee Ronald Paradowicz with my findings.

ALLEGATION:

Resident A has been given Haldol and Ativan in the past for making phone calls, but this is no longer happening. Staff is yelling at patients and not allowing Resident A to have contact with her friend, Resident B. Staff verbally humiliated a woman and then she died 10 days later.

INVESTIGATION:

On 12/06/2021, intake #183741 was assigned for investigation regarding staff yelling at residents and not allowing Resident A to have contact with her friend, Resident B and staff are threating to give Resident A "shots," but sometimes staff don't give Resident A the shots. Additional information from Adult Protective Services (APS) who denied their referral was received regarding male staff walking into female residents' rooms while changing and that Resident A was concerned her mail was being sent to her guardian who does not have to share mail with Resident A.

On 12/06/2021, I contacted Resident A via telephone regarding the allegations. Resident A stated there are two direct care staff (DCS) Shanuntia (Pitts) and Anitra (Hawkins) who threaten her with either a Haldol or Ativan injection. Resident A stated three days ago, she sat next to Resident B at the dinner table when Shanuntia told Resident B, "get up off from that table, you're not going to sit next to Resident A anymore." Resident A stated she does not know why Shanuntia told Resident B to get up from the table. Resident A stated other DCS, names unknown yell at residents for no reason. Resident A did not have any details as to when Resident A observed DCS yelling at residents and which residents DCS were yelling at.

On 12/13/2021, I conducted an unannounced on-site investigation at Courtyard Manor of Farmington Hills. I was advised by the Director of Operations Belinda Whitfield that Resident A resides in building #3, but that Resident A was at a doctor's appointment; however, should be returning soon. In the meantime, I interviewed Resident B regarding the allegations. Resident B has dementia, and her responses were, "I don't know my name or my date of birth or today's date." She stated, "I'm embarrassed, I don't know these things." Due to Resident B's dementia, I was unable to interview her regarding these allegations.

On 12/13/2021, I interviewed Resident C regarding the allegations. Resident C stated she likes it here but that some DCS are "better than others." Resident C does not know the names of the DCS, but stated, "it's ok, they're good." Resident C stated she does not know who Resident A is and has never seen or heard any DCS yell at a resident or become verbally aggressive towards her or any other resident.

On 12/13/2021, I interviewed Resident D regarding the allegations. Resident D also has dementia and was unable to provide any details as to the allegations. Resident D stated, “I’m a Vatican nun, you’re crazy.” The interview was ended.
On 12/13/2021, I interviewed DCS Anitra Hawkins regarding the allegations. Ms. Hawkins has been working for this corporation since May 2021 as a DCS. She stated that Resident A has a diagnosis of schizophrenia and bipolar disorder. Resident A is prescribed with Haldol and Ativan on an as needed basis. Ms. Hawkins stated that Resident A has significant behavioral issues; verbal aggression towards other residents and DCS. Ms. Hawkins stated that she does not threaten Resident A with the Haldol or Ativan injection; however, she does inform Resident A that if “Resident A’s behavior continues, then she (Ms. Hawkins) will contact the LPN, Marlene Jones to give Resident A the injection.” Ms. Hawkins stated for example, “one time I (Ms. Hawkins) observed Resident A trying to kiss another resident. I (Ms. Hawkins) immediately intervened and told Resident A to stop kissing the resident because of Covid. Resident A became very upset and was still trying to kiss the resident. I (Ms. Hawkins) asked Resident A again to stop, but Resident A did not stop. I (Ms. Hawkins) then told Resident A, if you continue this behavior, you will get an injection.” Ms. Hawkins stated Resident A immediately changed her behavior and stopped trying to kiss the resident. Ms. Hawkins stated Resident A requires a lot of redirecting but redirecting does not always work because if Resident A does not get what she wants, then Resident A will threaten DCS that she will report DCS to APS. Ms. Hawkins stated another time Resident A was observed “trying to feed Resident B at the table.” Ms. Hawkins immediately intervened by removing Resident B from the table and informing Resident A that Resident A is not DCS; therefore, Resident A cannot feed Resident B. Resident A was upset and continued to try to feed Resident B even after Resident B was removed from the table. Resident A then told Ms. Hawkins, “I’m going to report you.” Ms. Hawkins stated this is an ongoing issue with Resident A. Ms. Hawkins stated she has never yelled at Resident A or any other Resident. Ms. Hawkins stated Resident A’s assessment plan states the behaviors Resident A exhibits but does not state what DCS should do to address these behaviors. Ms. Hawkins stated, “I do my best to redirect especially when Resident A is trying to feed another resident who may be allergic to what Resident A is feeding them or that resident may choke.”

On 12/13/2021, I interviewed DCS Shanuntia Pitts who stated she was promoted to “host,” of Courtyard Manor of Farmington Hills two weeks ago. Ms. Pitts stated she has been with this corporation for two years and now that she is a host, she no longer provides direct care services to residents. However, Ms. Pitts was able to give information to these allegations. Ms. Pitts stated Resident A has significant behaviors that continuously require redirection. Ms. Pitts stated, “one day Resident A was on my neck. Resident A was telling me how to do my job and whenever I asked Resident A to stop, Resident A stated no and continued to harass me.” Ms. Pitts stated, “I then told Resident A if her behavior continues, then I (Ms. Pitts) will call the LPN Marlene Jones to assess you (Resident A) to receive an injection.” Ms. Pitts stated, “Resident A said OK and stopped those behaviors.” Ms. Pitts stated she nor any other DCS are threatening Resident A with the injection, but she and other DCS remind Resident A that her behaviors are not tolerated; therefore, if those behaviors continue, then

Resident A will receive the injection. Ms. Pitts stated other incidents have occurred with Resident A where Resident A was observed several times “trying to feed Resident B.” Resident A was told to stop but she continued to try to feed Resident B. Ms. Pitts advised Resident A to move to another table so Resident B could finish eating, but Resident A refused. Ms. Pitts then removed Resident B from the table and Resident A became very upset and told Ms. Pitts, “I’m going to report you to APS.” Resident A was told if she continued to try to feed Resident B, and if Resident A’s behaviors did not stop, then she (Resident A) will possibly receive a Haldol injection or the Ativan gel. Ms. Pitts stated Resident A has not received numerous injections because her behaviors stop when Resident A is told she will receive an injection. Ms. Pitts stated she does not yell at Resident A or threaten Resident A; Ms. Pitts merely informs Resident A her behaviors are unacceptable and if redirection does not work, then Ms. Pitts informs Resident A she will be receiving an injection or gel. Ms. Pitts stated Resident A talks on her cell phone a lot. Resident A calls her guardian, family, attorneys, and Resident A’s doctor’s office. Ms. Pitts has received calls from family members asking Courtyard Manor to stop allowing Resident A telephone access because they (family) are getting harassed by Resident A. Ms. Pitts explained to family that Courtyard Manor cannot stop Resident A’s phone access; therefore, Ms. Pitts advises family to “block,” Resident A’s phone number. Ms. Pitts does not recall what Resident A’s assessment plan stated regarding Resident A’s behaviors, but believes to redirect Resident A.

On 12/13/2021, Resident A returned to Courtyard Manor of Farmington Hills from her eye doctor appointment. Resident A had gauze on her right eye due to having eye surgery. The allegations were discussed. Resident A stated she already discussed these allegations “the last time with licensing,” and advised me to speak with “Kristen Donnay,” the last licensing consultant that interviewed her not to long ago. I advised Resident A that these were different allegations I am investigating and would like to speak with her regarding them. Resident A stated, “they (DCS) gave me shots for really little things, but they’re not giving me shots really, because they know I’m making complaints.” Resident A then stated, “I’ve called an attorney and I’m waiting for them to get back to me. Ok I’m done now.” Resident A ended the interview and walked out.

On 12/13/2021, I interviewed LPN Marlene Jones regarding the allegations. Ms. Jones has worked for this corporation since 2019. She does not administer medications but reviews all residents’ medication orders and approves medications, such as Resident A’s Haldol injection and Ativan gel. Ms. Jones stated Resident A has behaviors both verbal and physical aggression. Resident A’s psychiatrist ordered the Haldol and Ativan injections as an as needed medication. Resident A has been observed by Ms. Jones and other DCS to yell, walks up to the medication technician and “demands medications that are not prescribed to Resident A and then becomes verbally aggressive towards DCS.” Resident A has been going into other residents’ bedrooms uninvited and is very argumentative with DCS. Ms. Jones stated the injection and/or gel are prescribed as an anxiety medication when Resident A is agitated, aggressive or has erratic behaviors. Therefore, Ms. Jones has advised all DCS that when Resident A is having these behaviors to first try to redirect Resident A and then when that does not work, and Resident A is yelling at DCS, DCS will then walk away. Ms. Jones stated Resident A is

“persistent,” and “will follow DCS yelling right behind them,” and if Resident A’s behavior continues, then DCS will give a warning; go to your room or on the porch and if that does not work, then DCS will call Ms. Jones and then Resident A may receive the injection or the gel or both if the gel does not work. Ms. Jones stated DCS do not threaten Resident A with the injection or gel, the DCS merely give Resident A several warnings before DCS advise Resident A that if her behaviors continue, then she may receive an injection. Ms. Jones stated Resident A has probably received the Haldol injection and/or Ativan gel about five times total. Ms. Jones stated she has not heard DCS yell at Resident A or any other resident. Ms. Jones stated, “it’s usually Resident A yelling at staff and other residents.”

On 12/13/2021, Ms. Jones provided me with a copy of Resident A’s assessment plan dated 08/06/2021. The assessment plan was incomplete and under the heading, “Social/Behavioral Assessment- (I.) Controls Aggressive Behavior and (K.) Gets Along with Others; “Yes,” is checked indicating that Resident A does not have any aggressive behaviors and does get along with others. I advised Ms. Jones that Resident A’s assessment plan does not reflect the concerns regarding Resident A’s behaviors that Ms. Jones and all the other DCS have reported. In addition, the assessment plan was not signed by Resident A’s designated representative which is Resident A’s guardian.

On 12/13/2021, Ms. Jones provided me with a copy of Resident A’s psychiatric evaluation and management completed by Dr. Ruza on 10/25/2021. Dr. Ruza prescribed Resident A with a Haldol injection as an as needed medication due to Resident A being “very anxious and agitated.”

On 12/13/2021, Ms. Jones provided me with Munson Medical Center’s discharge papers regarding Resident A’s hospitalization from 09/28/2020-10/15/2020 for bipolar disorder, current episode manic severe.

On 12/13/2021, I reviewed Resident A’s medication logs from October 2021-December 2021. According to the medication logs, Resident A was given a Haldol injection on 10/04/2021, 10/15/2021 and 10/21/2021. Resident A was given the Ativan gel on 10/15/2021 and on 10/21/2021. Resident A was not given Haldol or Ativan in November or December 2021.

On 01/27/2022, I contacted Resident A’s guardian who is an attorney that was court appointed to Resident. The guardian stated that Resident A is currently at McLaren Oakland Hospital for about 10 days due to having an erratic manic episode. The guardian stated Resident A will not be returning to Courtyard Manor of Farmington Hills because she has been discharged. The guardian was able to locate placement for Resident A in Traverse City. The guardian stated Resident A had been “booted out of four group homes in Traverse City and Courtyard Manor was the only facility to accept her.” The guardian stated she told Courtyard Manor they will be receiving many complaints from Resident A that will be unfounded. The guardian stated Resident A is prescribed with Haldol and Ativan and due to Resident A’s significant behaviors, DCS have been advised to administer the medications on an as needed basis. The guardian

stated she does not believe DCS threatened Resident A with the medication, but instead warn Resident A if her behavior does not stop, then Resident A would receive the injection. The guardian stated Resident A's behaviors are "atrocious," and Resident A is "mean," and because of these behaviors, Resident A does not have a relationship with her own daughter. The guardian has no concerns with any of the DCS at Courtyard Manor and believes all the allegations were due to Resident A's mental illness.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on my investigation and review of Resident A's assessment plan dated 08/06/2021, the assessment plan was incomplete and was not signed by Resident A's guardian. Resident A has significant behavior issues; however, the assessment plan does not reflect those behaviors and does not indicate how DCS will be addressing those behaviors.
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 home shall not do any of the following: (f) Subject a resident to any of the following: (ii) Verbal abuse. iv) Threats.
ANALYSIS:	Based on my investigation and information gathered, DCS were not verbally abusive towards Resident A or any other resident. I interviewed Resident C who stated she has never witnessed any DCS yell at any resident. I also interviewed DCS Anitra Hawkins and Shanuntia Pitts who denied yelling at Resident A or any other resident. In addition, DCS denied threatening Resident A with Haldol injections or Ativan gel, but merely

	warning Resident A if her behaviors did not stop, such as feeding or kissing other residents, she may receive a Haldol injection or Ativan gel. Resident A's psychiatrist prescribed these medications for agitation and anxiety, which Resident A continues to exhibit according to staff when attempting to redirect Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Male staff are walking in on female residents while they are getting dressed.

INVESTIGATION:

On 01/10/2022, I conducted another unannounced on-site investigation regarding male staff walking in on female residents while they are getting dressed. I interviewed Belinda Whitfield who stated the building that Resident A resides at; building #3 does not have any male staff due to Resident A not wanting male staff there. Ms. Whitfield stated there are all female staff at building #3 and denied any male walking into female residents' bedrooms while the female residents were changing. She stated no resident including Resident A have made complaints regarding male staff walking into residents' bedrooms. Ms. Whitfield provided me with building #3 staff schedule dated 01/02/2022-01/09/2022 and all the DCS on the schedules are female staff.

On 01/10/2022, I interviewed LPN Marlene Jones regarding the allegations. Ms. Jones stated there are no male staff working at building #3 because Resident A did not want any male staff in that building. Ms. Jones stated no resident has complained to her about a male staff walking into their bedroom while they were changing including Resident A.

On 01/10/2022, Ms. Whitfield walked me over to building #3 to speak with Resident A. Ms. Whitfield knocked on Resident A's bedroom door identifying herself. Resident A opened the door and I identified myself. Resident A stated, "I don't have time for you," then closed her bedroom door.

On 01/10/2022, I reviewed Resident A's personal order that specifically states, "Resident is very alert. Only female caregivers."

On 01/27/2022, Resident A's guardian stated about two years ago, Resident A made allegations at another at a psychiatric hospital in Traverse City about male staff walking into her hospital room. The guardian stated there were cameras inside Resident A's bedroom and the allegation was unfounded. The guardian stated building #3 does not have male staff because Resident A does not want any male staff to provide direct care services to her; therefore, Courtyard Manor only has female staff in building #3.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.
ANALYSIS:	Based on my investigation and information gathered, Resident A is treated with consideration and respect and has privacy at Courtyard Manor. Resident A's personal order specifically indicated that Resident A only wants female caregivers; therefore, building #3 where Resident A lives only has female staff. I reviewed the staff schedule from 01/02/2022-01/09/2022 and only female staff are on the schedule. Therefore, there is no male staff walking into residents' bedrooms while they are dressing including Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A is worried that Courtyard Manor gives all her mail to her guardian who does not have to share her mail with her.

INVESTIGATION:

On 01/10/2022, I attempted to interview Resident A regarding the allegations, but Resident A did not want to be interviewed.

On 01/27/2022, Resident A's guardian stated that all financial and legal mail must come directly to the guardian per court order; however, Resident A has been calling her banks and providing the banks with Courtyard Manor's address and receiving the mail. When Courtyard Manor receives the mail and it's from a financial or legal institution, then the mail gets sent to the guardian per the court order. The guardian stated Resident A only receives personal mail at Courtyard Manor, but because Resident A has no contact with her daughter nor does Resident A have friends, she rarely receives personal mail. The guardian stated there are no concerns about Courtyard Manor not giving personal mail to Resident A.

On 01/26/2022, I left a voice mail message for licensee designee Ronald Paradowicz with my findings.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (d) The right to write, send, and receive uncensured and unopened mail at his or her own expense.
ANALYSIS:	Based on my investigation and information gathered, Resident A has access to her personal mail, but according to Resident A's guardian, Resident A does not have access to any of Resident A's financial or legal mail per a court order.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend no change to the license.

Frodet Dawisha 01/27/2022

Frodet Dawisha Date
Licensing Consultant

Approved By:

Denise Y. Nunn 01/31/2022

Denise Y. Nunn Date
Area Manager