GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 26, 2022

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

RE: License #: AL630007339
Investigation #: 2022A0602017
Courtyard Manor of Wixom IV

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 #:	AL630007339
Investigation #:	2022A0602017
Complaint Receipt Date:	02/14/2022
Investigation Initiation Date:	02/15/2022
Report Due Date:	04/15/2022
Licensee Name:	Courtyard Manor of Wixom 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 of Wixom IV
Facility Address:	48578 Pontiac Trail Wixom, MI 48393
Facility Telephone #:	(248) 669-5263
Original Issuance Date:	08/14/1991
License Status:	REGULAR
Effective Date:	10/31/2020
Expiration Date:	10/30/2022
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Per incident report, on 2/11/22, Resident A had bruising on her right arm and left eye alleged to be from staff.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/14/2022	Special Investigation Intake 2022A0602017
02/15/2022	Special Investigation Initiated - Telephone Call made to the facility
03/03/2022	Inspection Completed On-site Interviewed the executive director, Serenity Bain, staff members Kelly Berry, Jerica Parker, Resident A and Resident B.
03/03/2022	APS Referral Adult Protective Services (APS) referral denied.
03/28/2022	Contact – Telephone call made Call made to staff member, John Ray – no answer.
04/05/2022	Contact – Telephone call made Spoke with the assigned Recipient Rights worker, Susan Feld.
04/05/2022	Contact – Telephone call made Call made to staff member, John Ray – no answer.
04/15/2022	Contact – Telephone call made Interviewed Staff Member 1.
04/19/2022	Contact – Telephone call made Interviewed staff member, John Ray.
04/19/2022	Exit Conference Message left for the licensee designee, Ronald Paradowicz.
04/22/2022	Contact – Face to Face Met with Ms. Brain.

ALLEGATION:

Per incident report, on 2/11/22, Resident A had bruising on her right arm and left eye alleged to be from staff.

INVESTIGATION:

On 2/14/2022, a complaint was received and assigned for investigation alleging that on 2/11/2022 Resident A had bruising on her right arm and left eye that was caused by staff.

On 3/03/2022, I conducted an unannounced on-site investigation at which time I interviewed the executive director, Serenity Bain, staff member, Kelly Berry, Jerica Parker, Resident A and Resident B. Ms. Bain stated on 2/11/2022 Resident A had a very faint bruise on her right arm and left eye. Bruising is not unusual for Resident A as she has an unsteady gait and history of falling. On 2/12/2022 the bruising became more pronounced. Staff members Kellie Berry and Jerica Parker were working on 2/12/2022 and asked Resident A what happened. Resident A stated staff member Johnathan Ray did it. Ms. Bain stated Mr. Ray was suspended pending the outcome of the investigation and advised that I speak with Ms. Berry and Ms. Parker to obtain firsthand information regarding the incident.

On 3/03/2022, I interviewed staff member, Kellie Berry while at the facility. Ms. Berry stated she has worked for the company for three years. On 2/12/2022 she worked the day shift between the hours of 7 am and 7 pm. When she arrived for her shift, Resident A was sitting on the couch wearing a pair of sunglasses. When Ms. Berry asked her why she was wearing sunglasses, she pulled the glasses down from her eyes and said, “He did this to me. He tried to kill me. He’s the devil.” Ms. Berry observed a bruise around Resident A’s left eye and asked her who caused the injury. Resident A said, “John, the one with the wife with the curly hair.” Resident A proceeded to pull her sleeve up and show Ms. Berry a large dark purple bruise on her upper right arm. Resident A then repeated, “He did this to me.” Ms. Berry notified the nurse, Rebecca Pivato. On 2/13/2022, Ms. Berry worked the day shift and was giving Resident A a shower. Resident A was rubbing her right upper arm and said, “He did this to me. He bent my arm. He’s the devil.” She then asked, “Am I going to see him again?” Ms. Berry asked Resident A to show her how he bent her arm. Resident A said, “I can’t hurt you like that.” Ms. Berry stated Mr. Ray has always been nice to her, but he has a temper and a history of blowing up on staff. Resident A likes to wear layers of clothing and staff will redirect her and assist with removing some of the layers. Mr. Ray has had an attitude with Resident A in the past for wearing layers of clothing. Ms. Berry went on to state that Resident A has been consistent with story of how she obtained the bruises, and she believes her. Resident A has a history of falling due to an unsteady gait and it is not unusual for her to have bruises. However, with the bruise to her left eye and right upper arm, her statements have been very consistent what happened to her, and she has never responded this way with any other incidents.

On 3/03/2022, I interviewed staff member Jerica Parker while at the facility. Ms. Parker stated she worked on 2/07/2022 and 2/09/2022, gave Resident A a shower and did not observe any bruises on her. She was off on 2/08/2022 and 2/10/2022. When she returned to work on 2/11/2022 she noticed a bruise on Resident A's right upper right arm and under her left eye. Resident A said, "The devil did it." Staff member Lauren Ray entered the room and Resident A put her head down and stopped talking. Ms. Parker reported this information to the nurse, Ms. Pivato. On 2/12/2022 Ms. Parker worked the day shift between the hours of 7 am and 7 pm. When she arrived for her shift, Resident A was sitting on the couch wearing a pair of sunglasses. When she removed the sunglasses, the bruise around her eye had gotten worse and was a much darker purple color than the previous day. Resident A said, "John did it. The one whose wife works here. He tried to kill me. He's the devil." Ms. Parker said Resident A likes to wear layers of clothing. When she does this, staff will remove the layers and Resident A usually cooperates. Resident A said John did it because she was putting on extra layers of clothes. Ms. Parker stated Mr. Ray becomes angry with Resident A because she puts on layers of clothing. Ms. Parker went on to state that she likes Mr. Ray but she is not happy with what happened to Resident A.

On 3/03/2022, I interviewed Resident A privately at the facility. I observed a bruise under her left eye. I asked Resident A what happened to her eye, and she responded, "John tried to beat me. He's satin. He's not a very nice person and I hope I never see him again." I asked Resident A when this occurred, and she was unable to provide a date. I asked Resident A if I could look at her right arm, and she refused. This is all the information Resident A had regarding the incident.

On 4/05/2022, I spoke with the assigned Recipient Rights worker, Susan Feld by phone. Ms. Feld stated her investigation is complete and she substantiated against Mr. Ray for abuse as it is more likely than not that he caused the bruises to Resident A's left eye and upper right arm.

On 4/15/2022, I interviewed Staff Member 1 by phone. Staff Member 1 requested to remain anonymous. On 2/10/2022 or 2/11/2022 (exact date unknown), Staff member 1 was working the day shift with John Ray. After lunch Resident A came out of her room yelling, "He beat me! He beat me!" Staff Member 1 noticed that Mr. Ray was in the hallway near Resident A's bedroom but did not see him in the room. Staff Member 1 asked Resident A who beat her and she said, "John." Mr. Ray said, "I don't know why she's saying that." Staff Member 1 noticed Resident A's left eye was watery like it was irritated. Resident A started crying. Staff Member 1 attempted to calm her down. Staff Member 1 did not observe any bruises at that time, only her watery left eye. Staff Member 1 did not report the incident. A few days later Staff Member 1 observed that Resident A had a black left eye and a bruise on her right arm. At that time, Staff Member 1 reported the incident to Ms. Brain.

On 4/19/2022, I interviewed staff member John Ray by telephone. Mr. Ray stated he worked for the company for 10 years. He denied that he caused any harm or injuries to Resident B and feels as if someone is out to get him. Mr. Ray said Resident A was

obsessed with him and at times would target him. He asked management to have another staff present when he had to assist Resident A, but he was told there was not enough staffing for that to happen. Mr. Ray stated there was never an incident when Resident A came out of her room yelling that he beat her.

On 4/22/2022, I conducted another unannounced on-site investigation at which time I spoke with the executive director, Serenity Brain. I was unable to interview any residents as there was a COVID outbreak in building 4 and Ms. Brain advised that I do not enter the building.

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: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Based on the information obtained from Ms. Berry, Ms. Parker, Resident A and Ms. Feld, I determined that Mr. Ray more likely than not, caused bruises to Resident A's left eye and upper right arm Resident A informed Ms. Berry and Ms. Parker that Mr. Ray caused her bruises. Resident A informed Ms. Feld and I that John the devil did it. The one with the wife with the curly hair that works here.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 3/03/2022, at the time of the unannounced on-site investigation, Ms. Berry stated on 2/13/2022 she observed a bruise on Resident B's wrist that was the size of a hand imprint. She asked Resident B what happened, and she initially stated, "I don't know." Ms. Berry asked Resident B again what happened to her wrist, and she said, "John did it. He grabbed me out of bed and kicked me." Resident B then pointed to her shin. Ms. Berry checked Resident B for other bruises and did not observe any.

On 3/03/2022, I attempted to interview Resident B in her bedroom. I asked Resident B if she had a bruise on her wrist, but she did not answer. I asked her if anyone hurt her and

she replied, “I don’t remember his name. He pushed me on my stomach in my room.” I observed Resident B’s wrist and did not see any bruises.

On 4/05/2022, I interviewed the assigned Recipient Rights worker, Susan Feld by phone. Ms. Feld stated her investigation is complete and she substantiated against Mr. Ray for abuse as it is more likely than not that he caused the bruises to Resident A’s left eye and upper right arm.

On 4/15/2022, I interviewed Staff Member 1 by telephone. On 2/10/2022 or 2/11/2022 (exact date unknown) Staff member 1 was working the day shift with John Ray. Staff Member 1 was attempting to get Resident B out of bed, but she did not want to get up and would not let go of her blanket. Mr. Ray entered the room and offered to assist with getting Resident B out of bed. Staff Member 1 stepped aside, and Mr. Ray grabbed Resident B’s arm, pushed her hand down and her elbow up, pulling her out of bed. He then kicked Resident B in the stomach as he pulled the blanket off her. Staff Member 1 felt very uncomfortable with Mr. Rays actions and immediately left the room. Staff Member 1 was upset but did not know what to do as Mr. Ray’s mother is a supervisor at the facility and she was fearful of retaliation if she reported the incident. Staff Member 1 reported the incident to Ms. Brain a few days later.

On 4/19/2022, I interviewed staff member, John Ray by telephone. Mr. Ray denied that he grabbed Resident B in any way that would cause injury to her. He said she did not like to eat breakfast and would want to stay in bed. Mr. Ray stated he would prompt her to get out of bed several times and if she still refused, he would ask another staff member to attempt to get her up. If that did not work, he would let her remain in bed until she was ready to get up.

On 4/19/2022, I left a message for the licensee designee, Ronald Paradowicz informing him of the investigative findings and recommendation documented in this report. I also informed Mr. Paradowicz that a copy of the report will be emailed to him upon manager approval and requested that a corrective action plan be submitted upon receipt.

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: (b) Use any form of physical force other than physical restraint as defined in these rules.

ANALYSIS:	Based on the information obtained from Ms. Berry, Ms. Feld and Staff Member 1, there is sufficient information to determine that injury was caused to Resident B more likely than not by Mr. Ray. Resident B reported to Ms. Berry that Mr. Ray grabbed her out of bed and kicked her. Staff Member 1 observed Mr. Ray grab Resident B by her arm, push her hand down and her elbow up, pulled her out of bed and kicked her in the stomach.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

4/26/2022

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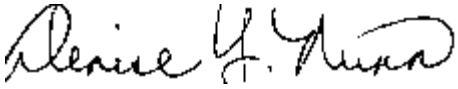
Cindy Berry Date
Licensing Consultant

Approved By:



04/26/2022

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Denise Y. Nunn Date
Area Manager