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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 13, 2023

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

RE: License #: AL630007339
Investigation #: 2023A0465023
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,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012
Fax: 517-763-0204
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007339
Investigation #:	2023A0465023
Complaint Receipt Date:	04/10/2023
Investigation Initiation Date:	04/10/2023
Report Due Date:	06/09/2023
Licensee Name:	Courtyard Manor of Wixom Inc
Licensee Address:	Suite 127 - 3275 Martin Walled Lake, MI 48390
Licensee Telephone #:	(248) 926-2920
Administrator:	Serenity Brain
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:	10/31/2022
Expiration Date:	10/30/2024
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 4/1/2023, Resident A was able to elope from the secured facility without staff knowing.	Yes

III. METHODOLOGY

04/10/2023	Special Investigation Intake 2023A0465023
04/10/2023	Special Investigation Initiated – Letter I spoke to administrator, Serenity Brain, via email exchange
04/28/2023	Inspection Completed On-site I conducted an onsite investigation. I conducted a walkthrough of the facility, observed residents, reviewed resident files, and interviewed administrator, Serenity Brain
05/02/2023	Contact - Document Received Facility documents received via email
05/12/2023	Contact - Telephone call made I spoke to Guardian A1 via telephone
05/24/2023	Contact - Document Received Documents received via email
05/24/2023	Contact - Telephone call made I attempted to contact direct care staff, Jennifer Hinojsz. I requested a return call
05/30/2023	Contact - Telephone call made I spoke to direct care staff, Dajuana Dawson, via telephone
06/05/2023	Contact - Telephone call received I spoke to direct care staff, Cheryl Fuqua, via telephone
06/05/2023	Contact - Telephone call received I spoke to direct care staff, Jennifer Hejnosz, via telephone
06/05/2023	Exit Conference I conducted an Exit Conference with licensee designee, Ron Paradowicz, via telephone

ALLEGATION:

On 4/1/2023, Resident A was able to elope from the secured facility without staff knowing.

INVESTIGATION:

On 4/10/2023, I received an *Incident/Accident Report* from administrator, Serenity Brain, via email. The incident report indicated the following information:

> On *4/1/2023 at 7:15pm: Direct care staff, Jennifer Hejnosz, responded to code green and observed Resident A walking outside of the building. Staff was able to redirect resident back into her building. Resident A remains on 15-minute safety checks and will talk to social worker and will follow up with Dr. Paris.*

On 4/10/2023, I spoke to administrator, Serenity Brain, via email exchange. Ms. Brain provided the following additional information:

> *Resident A is new to the facility. She moved in on 3/9/2023 and has a long history of elopement. The building and perimeter alarm was armed. Resident A did not communicate how she got out. Resident A has been observed trying to elope from the building and staff are all very aware and continue to monitor her.*

On 4/28/2023, I conducted an onsite investigation. The facility specializes in caring for the aged/Alzheimer's population. Therefore, I was unable to interview residents for this investigation. I conducted a walkthrough of the facility, observed residents, reviewed resident files, and interviewed administrator, Serenity Brain.

The *Face Sheet* indicated that Resident A moved into the facility on 3/9/2023 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Schizophrenia and Intellectual/Cognitive Delay. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, has a history of delusional and psychotic mindset, history of elopement, history of physical aggression, requires prompting for self-care tasks and does not use assistive devices.

Due to Resident A's medical diagnosis, I was unable to interview her. I did attempt to interview Resident A but she could not recall any information regarding this incident.

I interviewed Ms. Brain, who stated, "Resident A has a history of elopement. Staff are aware of her elopement history, and we ensure we keep her within eyesight at all times. I am not sure how she eloped from the facility. Staff do provide supervision for safety and protection, but we do not know exactly how Resident A eloped. But staff immediately observed her outside of the facility and were able to redirect her back inside. She has not eloped since that time, and we have not had any further issues." Ms. Brain acknowledged that this complaint is accurate, as reflected in the incident report.

On 5/12/2023, I spoke to Guardian A1 via telephone. Guardian A1 stated, “I do not have any concerns related to the staff’s care and supervision of Resident A. Resident A has a long history of elopement because she likes to be outside. I think staff are doing a good job.”

On 5/30/2023, I spoke to direct care staff, Dajuana Dawson, via telephone. Ms. Dawson stated that she has worked at the facility for six months. Ms. Dawson stated, “I am familiar with Resident A. She has a history of trying to elope. She often will pace back and forth in front of the front doorway. We know that she is trying to find a way to get outside. She likes to take walks and will often tell us that she wants to go outside and go walking. I was working the day of the incident. I was just getting off work and I observed direct care staff, Cheryl Fuqua, go towards the laundry room, which leads to an exit door to the outside of the building. Ms. Fuqua left shortly after 7pm and Resident A was observed outside right around the same time. I believe that Resident A followed Ms. Fuqua outside, snuck past her and got outside. But within minutes of Resident A being outside, she was observed by staff and immediately brought back inside of the building. Resident A has not eloped since this time that I am aware of. This was an isolated incident and hasn’t happened since. We now provide additional monitoring and complete 10-minute checks on Resident A as well.”

On 6/5/2203, I spoke to Cheryl Fuqua, via telephone. Ms. Fuqua stated that she has worked at the facility for 18 years. Ms. Fuqua stated, “I was working the day of the incident. I was just getting off work at the end of my shift. I went into the laundry room, and I did see Resident A standing near me when I went to punch out. She must have moved quickly and slid out behind me. I didn’t know that she was going to elope from the facility. But staff, Jennifer Hejnosz, saw Resident A outside and was able to redirect her into the building. As far as I know, Resident A has not eloped since this time. We also perform 10-minute checks and keep her in line of sight as much as possible.”

On 6/5/2023, I spoke to direct care staff, Jennifer Hejnosz, via telephone. Ms. Hejnosz stated that she has worked at the facility for 20 years. Ms. Hejnosz stated, “I was at work when Resident A eloped. I was getting ready to leave work. It was a little after 7pm. I was about to leave the building and out of the corner of my eye, I saw Resident A outside in the yard area. I immediately went outside and spoke to Resident A. I asked Resident A what she was doing, and she told me she was taking a walk. I walked with Resident A for a few moments and then I redirected her back inside the building. Resident A is sometimes confused but is easily redirected. We now do 10-minute checks on Resident A, and she has not eloped since the one incident occurred. We do make more effort to keep Resident A in line-of-sight as much as possible.”

On 6/5/2023, I conducted an exit conference with licensee designee, Ron Pardowicz, via telephone. Mr. Pardowicz agrees with the findings contained in 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:	According to the *Incident/Accident Report, dated 4/1/2023,* and Ms. Brain, Ms. Dawson, Ms. Fuqua, and Ms. Hejnosz, on 4/1/2023, Resident A was able to elope from the facility without staff knowledge and remained outside for a few minutes before being observed and redirected into the building.Ms. Brain, Ms. Dawson, Ms. Fuqua, and Ms. Hejnosz all acknowledged being aware that Resident A had a history of elopement prior to moving into the facility. Based on the information above, on 4/1/2023, direct care staff did not provide adequate supervision to ensure that Resident A's personal needs, including supervision and protection were attended to at all times during the time that she was able to elope from the facility without staff knowledge.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the special investigation be close with no change to the status of the license.

Stephanie Gonzalez

6/8/2023

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Stephanie Gonzalez Date
Licensing Consultant

Approved By:

Denise Y. Nunn

06/13/2023

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Denise Y. Nunn Date
Area Manager