GRETCHEN WHITMER
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 #: AL630007340
Investigation #: 2023A0465021
Courtyard Manor of Wixom 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,

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
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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 #:	AL630007340
Investigation #:	2023A0465021
Complaint Receipt Date:	04/10/2023
Investigation Initiation Date:	04/13/2023
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 III
Facility Address:	48578 Pontiac Trail Wixom, MI 48393
Facility Telephone #:	(248) 669-5263
Original Issuance Date:	12/27/1991
License Status:	REGULAR
Effective Date:	08/20/2022
Expiration Date:	08/19/2024
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 3/7/2023, direct care staff served Resident A food items that did not adhere to her prescribed special diet.	Yes

III. METHODOLOGY

04/10/2023	Special Investigation Intake 2023A0465021
04/13/2023	Special Investigation Initiated - Letter I spoke to administrator, Serenity Brain, via email exchange
04/18/2023	Inspection Completed On-site I conducted an onsite investigation. I reviewed resident files, conducted a walkthrough of the facility, observed residents, and interviewed administrator, Serenity Brain
05/02/2023	Contact - Document Received Facility documents received via email
05/11/2023	Contact - Telephone call made I spoke to Guardian A1 via telephone
05/24/2023	Contact - Document Received Facility documents received via email
05/30/2023	Contact - Telephone call made I spoke to direct care staff, Eldrada Meeks, via telephone
05/30/2023	Contact - Telephone call made I spoke to direct care staff, Rebecca Pivato, via telephone
06/05/2023	Exit Conference I conducted an Exit Conference with licensee designee, Mr. Paradowicz, via telephone

ALLEGATION:

On 3/7/2023, direct care staff served Resident A food items that did not adhere to her prescribed special diet.

INVESTIGATION:

On 4/10/2023, I reviewed and located an *Incident/Accident Report*, dated 3/8/2023, which was sent from administrator, Serenity Brain. The incident report indicated the following:

> *On 3/7/2023 at 4:45pm; Completed by Kayla Edgar and Rebecca Pivato: We received a call from Guardian A1, telling us she was having food delivered to Resident A. Items being delivered (pita wrap and chips specifically) didn't adhere to Resident A's prescribed diet. We explained risks of Resident A eating the food. Per Guardian A1, Resident A is to "get all of it," despite knowing the risks. When the food arrived, the kitchen cut up the pita wrap per diet order. While staff was feeding her the pita wrap, Resident A was observed trying to talk but couldn't and she grabbed her throat. We asked if she was okay, but she was unable to answer. We performed Heimlich Maneuver. A piece of pita from the sandwich came out of her throat. Consumer began talking again wanting to finish her dinner. We took out the pieces of pita in the sandwich and fed her only the meat and cheese. Will follow Dr. Rudnick's instructions on further care or follow-up.*

On 4/13/2023, I spoke to administrator, Serenity Brain, via email exchange. Ms. Brain confirmed the information contained in the incident report is accurate.

On 4/18/2023, I conducted an onsite investigation. The facility specializes in caring for the aged/dementia population. Due the limited memory and cognitive functioning of residents, I was unable to interview residents for this investigation. I reviewed resident files, conducted a walkthrough of the facility, observed residents, and interviewed Ms. Brain and Resident A.

The *Face Sheet* stated that Resident A moved to the facility on 8/6/2019 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Schizoaffective Disorder, Bi-Polar Disorder, and Intellectual Disability.

The Assessment Plan for AFC Residents indicated that Resident A requires supervision in the community, is delusional at times, needs assistance with personal care tasks, uses a wheelchair for mobility assistance, has a history of Dysphagia, aspiration and is currently prescribed a cut-up, fluid restriction, low sodium, diet. The *Physician's Order* dated 3/7/2023, indicated that Resident A is prescribed an unlimited calories, cut-up with aspiration precautions, low sodium, honey thickened liquids, fluid restriction diet. Due to Resident A's medical diagnosis, I was unable to interview her as part of this investigation.

I interviewed administrator Serenity Brain, who stated that she is familiar with Resident A and the incident that occurred related to this investigation. Ms. Brain stated, “Resident A is on a fluid restriction, low sodium, cut-up diet. Resident A’s guardian sends her food, and we are required to give the food to Resident A, even if it goes against her diet restrictions because it is considered her personal property. We have told Guardian A1 that Resident A cannot eat certain foods, but she still sends food items. On 3/7/2023, the staff did cut up the food items to make sure it adhered to her special diet but there were items that were sent that we would not have served to Resident A according to her special diet.” Ms. Brain acknowledged that staff served Resident A food items that did not adhere to her special diet and subsequently led to Resident A choking.

On 5/11/2023, I spoke to Guardian A1 via telephone. Guardian A1 stated, “I have been sending food to Resident A. I didn’t know that she was on a restricted diet. I have sent her subs/wraps, chips, food from McDonalds, etc. I didn’t know she was not allowed to have these things. I won’t send food to her anymore. It’s my fault because I have been sending her food that she isn’t supposed to be eating.”

On 5/30/2023, I spoke to direct care staff, Eldrada Meeks, via telephone. Mr. Eldrada stated that he has worked at the facility for 21 years. Mr. Eldrada stated, “I am familiar with Resident A, and I was working on 3/7/2023, when Resident A choked on the food Guardian A1 sent to her. That day, Guardian A1 sent Resident A a tortilla sandwich wrap, and the tortilla bread was very hard and thick. The kitchen staff cut the wrap into very small pieces. I left the area to go do something and when I came back, I was by Ms. Pivato and Ms. Edgar that Resident A choked, and they had to perform the Heimlich Maneuver to get the tortilla bread out of her airway. I immediately told Ms. Pivato and Ms. Edgar to take the meat, cheese, and lettuce out of the tortilla and only serve the soft items to her. I told the staff not to feed her the tortilla. We have always been told that we have to do what Guardian A1 tells us to, even if it goes against Resident A’s special diet. We did not know that we had to option to not serve Resident A the food that Guardian A1 was sending to her.”

On 5/30/2023, I spoke to direct care staff, Rebecca Pivato, via telephone. Ms. Pivato stated, “I was working the day of the incident. Guardian A1 called us and told us that she had ordered some food to be delivered to the facility. She sent Resident A food from a restaurant. It was a tortilla sub wrap, chips and a shake drink. But Resident A is on a special diet for cut-up, fluid restrictions, aspiration precaution, low sodium, diabetic diet and thickened liquids. She isn’t supposed to have chips, shakes or other food items that are high in sodium. But we have been told that the legal guardian gets the final say and we have to do what they tell us. We cut up the wrap into very small pieces but regardless, it was not safe to give to her and did not adhere to her special diet. Resident A did end up choking on the wrap and the Heimlich Maneuver had to be performed.” Ms. Pivato acknowledged that this allegation is true.

On 6/5/2023, I conducted an exit conference with licensee designee, Ron Paradowicz, via telephone. Mr. Paradowicz is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	According to the Physician's Order, dated 3/7/2023, Resident A is prescribed an unlimited calorie, cut-up with aspiration precautions, low sodium, honey thickened liquids, fluid restriction diet. According to the *Incident/Accident Report*, dated 3/8/2023, and Ms. Pivato, Ms. Brain, and Mr. Meeks, on 3/7/2023, Ms. Edgar and Ms. Pivato served Resident A food items that that did not adhere to her prescribed special diet, which subsequently led to Resident A choking and requiring the Heimlich Maneuver. Based on the information above, there is sufficient information to confirm that direct care staff did not provide the prescribed special diet to Resident A on 3/7/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Stephanie Gonzalez 6/8/2023

Stephanie Gonzalez Date
Licensing Consultant

Approved By:

Denise Y. Nunn 06/13/2023

Denise Y. Nunn Date
Area Manager