GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 9, 2024

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

RE: License #: AL630007354
Investigation #: 2024A0605019
Courtyard Manor Farmington Hills IV

Dear Ronald 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
3026 W. Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007354
Investigation #:	2024A0605019
Complaint Receipt Date:	02/26/2024
Investigation Initiation Date:	02/26/2024
Report Due Date:	04/26/2024
Licensee Name:	Courtyard Manor Farmington Hills Inc
Licensee Address:	Suite 127 3275 Martin Walled Lake, MI 48390
Licensee Telephone #:	(248) 926-2920
Administrator:	Jim Cubr
Licensee Designee:	Ronald Paradowicz
Name of Facility:	Courtyard Manor Farmington Hills IV
Facility Address:	29780 Farmington Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-0104
Original Issuance Date:	04/06/1995
License Status:	REGULAR
Effective Date:	06/15/2022
Expiration Date:	06/14/2024
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 02/21/2024, Farmington Hills Fire Department (FHFD) arrived at Courtyard Manor Building IV for a fire outside in the courtyard. The staff did not evacuate the residents out of the building.	Yes

III. METHODOLOGY

02/26/2024	Special Investigation Intake 2024A0605019
02/26/2024	Special Investigation Initiated - Telephone Discussed allegations with reporting person (RP)
02/26/2024	Contact - Telephone call made Discussed allegations with administrator Jim Cubr
03/04/2024	Inspection Completed On-site Conducted unannounced on-site investigation
03/18/2024	Contact - Telephone call made Interviewed direct care staff (DCS) Viola Pilica and Rayona Kurtz regarding the allegations Left message for on-call manager Taketa Hampton
03/18/2024	Contact - Document Sent Email to administrator Jim Cubr
03/18/2024	Contact - Document Received Email from RN Marlene Jones
03/20/2024	Contact - Telephone call made Interviewed DCS Miguel Jones regarding the allegations
03/20/2024	Contact - Telephone call made Discussed allegations with DCS Miguel Jones
03/21/2024	Contact - Document Received Email from Bureau Fire Safety (BFS) Fire Marshal Don Christensen

03/25/2024	Exit Conference Left detailed voice mail message for licensee designee Ron Paradowicz with my findings

ALLEGATION:

On 02/21/2024, Farmington Hills Fire Department (FHFD) arrived at Courtyard Manor Building IV for a fire outside in the courtyard. The staff did not evacuate the residents out of the building.

INVESTIGATION:

On 02/26/2024, intake #199831 was assigned for investigation regarding a fire in the courtyard at this facility that damaged the siding. A cigarette disposal can was at the door of the courtyard that caught fire along with the siding leading to the facility. Residents were not evacuated. Staff used buckets of water to put out the fire because staff did not know how to use the fire extinguisher. Bureau of Fire Safety (BFS) were not notified of the fire.

On 02/26/2024, I discussed allegations with the reporting person (RP). The RP received a telephone call regarding a fire at this facility. The RP was not notified of the fire by this facility which was protocol. The RP will be investigating.

On 02/26/2024, I interviewed the administrator Jim Cubr regarding the allegations. On 02/21/2024, around 7:30PM a fire occurred at this facility. Resident A was smoking a cigarette in the courtyard when the metal cigarette receptacle caught on fire. The receptacle somehow was moved near the door and after staff put the fire out with buckets of water, the siding melted because the can was “smoldering.” The staff, Rayona Kurtz did not know how to get the zip tie off the fire extinguisher, so another staff got buckets of water and threw it onto the metal receptacle, which put out the fire. Ms. Kurtz did not evacuate the residents because the “fire was out,” but did call “911.” FHFD came out but the fire was already out. Mr. Cubr is in-servicing staff on how to properly use the fire extinguisher.

On 03/04/2024, I along with BFS Fire Marshal Don Christensen and FHFD Fire Marshal Jason Baloga conducted an unannounced on-site investigation. I followed up with Jim Cubr. Mr. Cubr stated that Resident A thought she put out the cigarette butt, but then realized she did not when she saw the fire in the metal receptacle. The fire was contained in the receptacle and Mr. Cubr denied that the buildings siding caught on fire. He stated that the siding melted because of the smoldering smoke from the metal receptacle after DCS Viola put the fire out with a bucket of water. There was no evacuation because the fire was put out and there were no injuries.

On 03/04/2024, I interviewed Executive Director of Operations Belinda Hunter regarding the allegations. Ms. Hunter received a text message from the on-call supervisor Taketa

Hampton stating that the “ashtray caught on fire in the courtyard.” Ms. Hunter arrived at the facility and the fire was out after DCS Viola Pilica put out the fire with buckets of water. There was no smoke in the courtyard and the siding melted because of the smoldering smoke from the ashtray. Resident A is the only person who was smoking in the courtyard, but now they are not allowing anyone to smoke in the courtyard and moved the approved cigarette receptacle to the front porch. Resident A will be supervised when she is outside on the front porch.

On 03/04/2024, I interviewed Resident A in her bedroom regarding the allegations. Resident A was smoking a cigarette outside by herself in the courtyard and then “put it out in the ashtray can,” located next to the door. She came back inside the building and then walked to the dining room and saw flames in the can. She yelled and the staff (name unknown) came and then Resident A returned to her bedroom. She did not see how the fire was put out. Resident A did not evacuate out of the building and the fire alarm was not sounded.

On 03/18/2024, I interviewed DCS Viola Pilica via telephone regarding the allegations. On 02/21/2024 after dinner around 7:30PM she was still working the shift waiting for another staff to arrive at Building III. Ms. Kurtz came to Building III and told Ms. Pilica, “the ashtray is on fire.” Ms. Pilica and Ms. Kurtz ran to Building IV. Ms. Pilica went into the laundry room and saw the fire extinguisher on the wall by the door. Ms. Pilica immediately got a bucket, filled it with water and ran to the courtyard and dumped the water on the fire. She returned into the laundry room, got another bucket of water, and dumped it on the siding after she kicked the ashtray away from the building. The siding was on fire but after dumping water on it, the fire was out. Then the FHFD arrived as Ms. Kurtz must have contacted them when Ms. Pilica was putting out the fire. The FHFD came, checked the courtyard out and then left because the fire was out. The residents were sitting in the common area and did not evacuate because, “the fire was put out.” Ms. Pilica does not know if Ms. Kurtz attempted to use the fire extinguisher or not. Ms. Pilica does not recall who was working with Ms. Kurtz but there was another staff member there.

On 03/18/2024, I interviewed DCS Rayona Kurtz regarding the allegations. Ms. Kurtz has been with the corporation for about two and a half years. On 02/21/2024, she was working the shift with DCS Miguel Jones. She arrived at work around 3PM. After dinner, she was making her rounds and checking to see if the residents needed anything. Around 7:30PM she went to check on Resident A, but Resident A was not in her bedroom. She noticed Resident A was in the courtyard smoking a cigarette. Ms. Kurtz then went to room 14 and that is when Ms. Kurtz heard Resident A yell in a panicked voice. Ms. Kurtz immediately ran to Resident A and noticed the ashtray was on fire near the door in the courtyard. Ms. Kurtz went to the laundry room to get the fire extinguisher, but she could not get the zip tie off. She stated, “It’s supposed to pop off, but it didn’t.”

She then called Ms. Pilica who was in Building III telling her there is a fire in the courtyard. Ms. Kurtz then called 911. Ms. Pilica came to building IV, went into the laundry room took a bucket of water and put out the fire. Ms. Pilica went back into the laundry room, got another bucket of water, came out and kicked the ashtray away from the door. The fire was now on the siding of the building. Ms. Pilica poured the bucket of water on the siding and put out the fire. The FHPD arrived and because the fire was out, they just told Ms. Kurtz do not allow anyone to smoke in the courtyard and that the ashtray must be 25 feet away from the building. Ms. Kurtz stated that the residents were in the common area and Mr. Jones was assisting another resident in their bedroom and Mr. Jones had no idea about the fire. Ms. Kurtz did not evacuate anyone because she said, “it’s impossible to evacuate everyone by myself.” Ms. Kurtz did not sound the fire alarm because the “fire was out.” Ms. Kurtz asked Resident A what happened and Resident A stated, “I don’t know, I didn’t do it.” After this incident, a fire drill was conducted, and all staff were made familiar with the evacuation process and how to properly use the fire extinguisher.

On 03/20/2024, I interviewed DCS Miguel Jones regarding the allegations via telephone. Mr. Jones has been with this corporation since October 2023. He was working with a staff he does not recall her name on 02/21/2024. During the fire, he was not aware of anything as he was in a residents’ bedroom assisting the resident. He cannot recall which resident. After the fire was out, he was informed of what happened. He never heard the fire alarm and there was no evacuation during the fire. He stated he has no additional information regarding the incident.

On 03/21/2024, I received an email from BFS Don Christensen that included the inspection report that included pictures of the damage due to the fire on 02/21/2024. Mr. Christensen reported that the staff should have sounded the fire alarm and evacuated all residents out of the building per the adult foster care (AFC) fire and safety rules for large group homes.

On 03/25/2024, I left detailed voice mail message for licensee designee Ron Paradowicz with my findings.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(f) Safety and fire prevention.**

ANALYSIS:	Based on my investigation and information gathered, DCS Rayona Kurtz was not competent in safety and fire prevention. On 02/21/2024, Ms. Kurtz was working with DCS Miguel Jones when a fire started in the ashtray located in the courtyard. Resident A was observed smoking a cigarette in the courtyard and put the cigarette out. Moments later, a fire started, and Resident A yelled for help. Ms. Kurtz saw the fire and tried to use the fire extinguisher but did not know how to remove the zip tie. Ms. Kurtz called another staff, Viola Pilica for assistance. Ms. Pilica used buckets of water to put out the fire that was in the ashtray and on the siding of the building. Ms. Kurtz never sounded the fire alarm and never evacuated any of the residents. According to BFS Don Christensen, the alarm must be sounded, and residents must evacuate when there is a fire per the AFC licensing rules for fire and safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

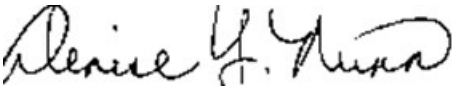
IV. RECOMMENDATION

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

03/26/2024

Frodet Dawisha — Date
Licensing Consultant

Approved By:



04/09/2024

Denise Y. Nunn — Date
Area Manager