GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 28, 2025

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

RE: License #: AL630007352
Investigation #: 2025A0605003
Courtyard Manor Farmington Hills II
AMENDED REPORT
Original Report dated January 15, 2025

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 #:	AL630007352
Investigation #:	2025A0605003
Complaint Receipt Date:	12/10/2024
Investigation Initiation Date:	12/10/2024
Report Due Date:	02/08/2025
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 II
Facility Address:	29760 Farmington Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-0104
Original Issuance Date:	08/25/1993
License Status:	REGULAR
Effective Date:	06/15/2024
Expiration Date:	06/14/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was observed with two black eyes. It is alleged staff punched Resident A, and staff have long nails that caused the scratches on Resident A's arms.	Yes

III. METHODOLOGY

12/10/2024	Special Investigation Intake 2025A0605003
12/10/2024	APS Referral Adult Protective Services (APS) made referral
12/10/2024	Special Investigation Initiated - Letter Email sent to APS worker Gene Evans
12/11/2024	Contact - Document Received Email from APS worker Gene Evans
12/11/2024	Contact - Telephone call made Discussed allegations with staff
12/19/2024	Inspection Completed On-site On-site investigation conducted
12/19/2024	Contact - Telephone call made Discussed allegations with administrator Jim Cubr
01/08/2025	Contact - Telephone call made I spoke with Careline Hospice, and I left messages for direct care staff (DCS) Shirley Welch and Resident A's legal guardian
01/08/2025	Contact - Telephone call received I interviewed DCS and Resident A's legal guardian and the registered nurse (RN) with Careline Hospice
01/09/2025	Exit Conference Conducted with licensee designee Ronald Paradowicz

ALLEGATION:

Resident A was observed with two black eyes. It is alleged staff punched Resident A, and staff have long nails that caused the scratches on Resident A's arms.

INVESTIGATION:

On 12/10/2024, intake #203599 was referred by Adult Protective Services (APS) regarding Resident A being physically abused by a staff member at Courtyard Manor Farmington Hills II.

On 12/10/224, I initiated the special investigation by emailing APS to find out who was assigned this investigation.

On 12/11/2024, I received an email from APS worker Gene Evans stating that he is investigating these allegations and will update me once he has contacted the facility.

On 12/11/2024, I interviewed medication technician Nakisha Smith via telephone regarding the allegations. She works midnight shift and is the medication technician for building III and IV. Resident A resides in building II. Ms. Smith saw Resident A about a week ago and stated she did not observe any black eyes or bruising or scratches on his forehead or arms. She had no further information.

On 12/11/2024, I contacted via telephone medication technician Sharon Wiggins regarding Resident A. Ms. Wiggins is the medication technician for building I and building II. She saw Resident A yesterday he did not have a black eye on his right or left eye, and she did not observe any bruising and/or scratches on his forehead or arms. Ms. Wiggins stated that she has not observed any staff member grab Resident A by the arm, nor has she seen any staff with long nails scratch Resident A. She does not have any other information regarding these allegations.

On 12/11/2024, I contacted licensed practical nurse (LPN) Marlene Jones via telephone regarding the allegations. Resident A moved into building II on 11/11/2024. Resident A is ambulatory and had an unwitnessed fall in his bedroom, hitting his face on the vent. He was taken to the hospital and because of the fall, he had bruising under his right eye. Resident A will be going on hospice today. Ms. Jones will send me the incident report (IR).

On 12/11/2024, I received the IR from Marlene Jones regarding Resident A's fall. According to the IR, Resident A fell on 11/16/2024 at 8:57PM. Jarira Collazo, a direct care staff (DCS) reported staff was walking past Resident A's bedroom and observed Resident A get out of bed and fall on his left side hitting the left side of his head on the air vent. A small cut to the left cheek and above the left eyebrow. Staff called 911 and sent Resident A to Henry Ford West (HFH) Bloomfield Hospital. Ms. Jones also sent a

picture she took of Resident A's face dated 11/17/2024, the day he returned from the hospital. I observed light bruising under his left eye that appeared to be healing.

On 12/11/2024, I contacted DCS Jarira Collazo via telephone. Ms. Collazo works midnight shift. She did not see Resident A get out of bed. The DCS was China Crawford that saw him get out of bed. China called Ms. Collazo and saw Resident A face down on the floor. She turned him over to make sure he was ok. He had a slight mark above his left eye and bruising under his eye. He went to the hospital. Ms. Collazo denied that she nor any staff punched him in the eye or grab his arm.

On 12/11/2024, I contacted Janay Greer DCS via telephone regarding the allegations. She has been with this corporation for one year and works day shift from 7AM-3PM. Ms. Greer works in building II. Resident A has not had a recent fall. She has never punched, grabbed, or scratched Resident A nor has she observed any other staff member harm Resident A. She stated, "we don't do that to anyone here." Ms. Greer has not observed any bruising or scratches to Resident A's face or arms.

On 12/11/2024, I interviewed via telephone DCS China Crawford. Her employment began with this corporation on 11/12/2024 and she works afternoon shift from 3PM-11PM. Resident A was admitted into this facility ambulatory but had somewhat of an unsteady gate. Staff are always standing by to ensure his safety and if not being watched, then he can fall and get hurt because of his unsteady gait. Due to his rapid decline, he is currently in a wheelchair. Ms. Crawford has never witnessed any staff punching or grabbing him. She stated, "I'm there to help residents and would never hurt them." On 11/16/2024, when she was going on break, she heard water running from Resident A's bathroom, she went into the bathroom and saw him in the shower with the water running. He was naked and showering himself. Ms. Crawford then stuck her head out of the bathroom, calling to staff saying, "did y'all know he was in the shower?" Jarira Collazo came into the bathroom. Ms. Collazo helped Resident A, out of the shower and followed behind Resident A towards his bedroom while Ms. Crawford followed behind Ms. Collazo. Ms. Crawford saw Resident A lose his footing by his bed and dresser area and fell on his left side near the window. Ms. Collazo got him up off the floor onto the bed. Ms. Crawford assessed him and there were no bruises or marks on his face or arms. The med technician (male) came to the building assessed him, and then called 911. Ms. Crawford is unclear why Ms. Collazo did not hear the water running when Ms. Collazo was sitting at the table with her back to the wall of Resident A's bedroom, which is bedroom #1and the bedroom door was wide open. Ms. Crawford stated that the information reported by Ms. Collazo was not accurate nor was what was written on the IR.
On 12/16/2024, I emailed Director of Operations Belinda Hunter requesting November's staff schedule.

On 12/16/2024, I followed up with DCS Jarira Collazo regarding her interview. Ms. Collazo worked with Shirley (last name unknown) and China Crawford. Ms. Collazo and Shirley got Resident A dressed for bed and put him in bed. Then she and Shirley went to the common area right around Resident A's bedroom and began writing up residents'

daily logs. Ms. Crawford then walked by Resident A's bedroom, looked over around the corner and said, "y'all didn't see this?" Ms. Collazo immediately got up, went into Resident A's bedroom and saw Resident A lying face down on the floor between the chest and the nightstand. Ms. Collazo turned him over, picked him up and checked to see if he was ok. She then ran across to building III and told Nya Ford (unknown position) about what happened to Resident A. Ms. Ford came to building II, checked Resident A out, wrote the IR and had Ms. Collazo sign it. The medication technician Chris McQueen called 911. Ms. Collazo was asked about Resident A being in the shower. She stated, "I told China you cannot say what you did not witness, so I'm not sure why China would say Resident A was in the shower or say that I took Resident A out of the shower when she did not see that." Ms. Collazo stated when she put Resident A to bed, he was fully dressed; however, when she saw him lying on the floor, he was only in his brief. She stated, "Resident A undresses fast and can do it himself so that's why he was only in his brief." Resident A was completely dry, so she is not sure again why China said he was in the shower. Ms. Collazo stated what was written on the IR is accurate and again she is not sure why Ms. Crawford is stating otherwise. She stated the fall was unwitnessed by her.

On 12/18/2024, I received an email from APS worker Gene Evens with the following: There was no evidence of physical abuse.

On 12/19/2024, I conducted an on-site investigation regarding the allegations. I interviewed Belinda Hunter, the Director of Operations. Ms. Hunter was unsure when Resident A fell but stated that APS contacted her and advised her that there was no abuse found during their investigation. She was informed that staff found Resident A on the floor, and he went out to the hospital. She was not present and does not know if the fall was witnessed or unwitnessed. Ms. Hunter provided the list of staff who worked on 11/16/2024.

I interviewed Marlene Jones, the licensed practical nurse (LPN) regarding the allegations. On 11/11/2024, Resident A was admitted to this facility with a wheelchair, a walker for his unsteady gait and he was confused. Resident A was ambulatory, but when he would walk, he would lose his footings, so staff began using his wheelchair. While sitting in the wheelchair, he would try to get up and run but staff were there to redirect him. Ms. Jones arrived in the AM on 11/17/2024 and was informed that staff walked by Resident A's bedroom and saw Resident A get out of bed and then fell. Staff picked him up, checked his vitals and found a cut on his face so an ambulance was called, and Resident A was transported to the hospital. Resident A never had a black eye and was never abused by staff. He fell which resulted in his injuries. Resident A is currently on hospice because of his decline. He is receiving services through Careline Hospice. Currently, he is total care after this fall.

I observed Resident A sitting in the common area in his wheelchair. He was brought into his bedroom so I could interview him; however, I was unable to understand him because his speech was unclear. During my interview, Resident A was trying to take his

shirt off and Ms. Hunter had to redirect him from taking his clothes off. I was unable to gather any information regarding his fall.

I interviewed Nya Ford, the assistant administrative coordinator who worked on 11/16/2024 during Resident A's fall. Ms. Ford has worked for this corporation for three years. She works both day and afternoon shifts. On 11/16/2024, she was paged to this building by DCS Jarira Collazo stating that Resident A fell. Ms. Ford arrived at the building and observed Resident A sitting in his wheelchair. Ms. Collazo told Ms. Ford that Ms. Collazo was sitting in the common area and "heard a noise." Then Ms. Collazo, "got up went to Resident A's bedroom and to check on him and found him on the floor." Then Ms. Ford heard from Ms. Collazo that "Resident A got out of bed and fell and hit his head on the vent." Ms. Ford evaluated Resident A and because of the bruise above his eyebrow, they called the police and had Resident A transported to the hospital. Ms. Ford stated that Resident A was in his pajamas when she arrived at the building, he was not wet, and she did not see any wet towels in his bedroom. Ms. Ford stated that Ms. Collazo is a "good worker," who "helps everyone." She had no concerns about Ms. Collazo. She was unable to provide any information why the staff who worked that night gave different narratives of how Resident A fell.

On 12/19/2024, I contacted the administrator Jim Cubr via telephone. Mr. Cubr agreed to conduct an internal investigation as to Resident A's fall on 11/16/2024. He will submit his findings to me via email.

On 12/20/2024, I received an email from Marlene Jones and the administrator Jim Cubr regarding the findings of their investigation. Staff members China Crawford, Jarira Collazo, Shirley Welch and medication technician Chris McQueen were interviewed regarding the incident on 11/16/2024. The findings were that "Resident A had an unwitnessed fall."

On 01/08/2025, I attempted to speak with Resident A's legal public guardian, but she was unavailable. I was advised by the receptionist she will have someone call me back.

On 01/08/2025, I contacted Careline Hospice regarding Resident A. I spoke with Madison, the Clinical Supervisor. He signed up for hospice services on 12/11/2024. The nurses see him twice weekly and personal aides see him twice weekly too. There are no concerns documented in their system; however, Madison will call both the nurse and the aide to confirm no concerns and will call me back.

On 01/08/2025, I received a call from Careline Hospice, registered nurse (RN) Stacey Smith who stated she has no concerns about the care Resident A is receiving from this facility.

On 01/08/2025, I received a return call from DCS Shirley Welch regarding the allegations. She worked on 11/16/2024 during the afternoon shift. She was sitting in the common area folding clothes with Jarira Collazo. DCS China came in from break and walking through the hall where Resident A's room was. China said, "Oh my God." Ms.

Welch and Ms. Collazo said, “Oh my God what!” She said, “You don’t see him?” They both got up and Ms. Welch saw Resident A on the floor near his window. Jarira and China were both up first and in the bedroom. Ms. Welch went into the bathroom because she saw the shower head leaning on the floor running. There was a shower chair in the shower, and he wasn’t naked, so I was assuming he went into the bathroom, reached in and turned the shower on, and he either lost balance or fell because the shower curtain was on the floor. She turned the shower off and picked up the shower head put it back and then picked up the curtain. Ms. Collazo and Ms. Crawford attended to Resident A. Resident A had a brief on when she observed him on the floor, he had no socks, but she cannot remember if he had a shirt on. Ms. Collazo was responsible for Resident A that day. Ms. Welch and Ms. Collazo put Resident A to bed and when he went to bed, he had on pajamas prior to his fall. His feet were wet because she saw a footprint on the floor, but he was not wet. She nor Ms. Collazo did not hear anything. It was only when Ms. Crawford brought it to their attention regarding Resident A on the floor that they went into the bedroom. Ms. Welch stated, “Jarira and China were going back and forth arguing and then Ms. Collazo said to Ms. Crawford, “why didn’t you catch him?” Ms. Collazo contacted, Nya Ford the lead on shift to come to building II. Ms. Ford contacted the medication technician to check Resident A’s vitals and then Ms. Ford wrote the IR. Ms. Welch did not see any of the injuries, but stated “when Resident A gets nervous, he picks at the scabs on his arms if there is a scar. Ms. Welch reported Resident A picking at his scabs it to his hospice nurse. There is no staff punching Resident A or scratching Resident A with their nails.

On 01/08/2025, I received a return call from Resident A’s public legal guardian. Resident A was admitted into this facility mid-November 2024. He had been hospitalized for two months with mobility issues, cognitive impairment, and behavioral concerns including hallucinations. He was initially placed in a group home in Wayne County, but due to his behavioral concerns, that group home sent him back to the hospital. At the hospital, Resident A was diagnosed with Louie Body Dementia. He was given medication which showed positive changes and then was discharged to this facility. Resident A was ambulatory with a walker; however, Resident A would not consistently use his walker and was a former runner, so when he walked, he walked quickly. On 11/16/2024, public guardian received a phone call from this facility stating that Resident A fell, hit his head, had a laceration above his eye and was being transported to the hospital. At the hospital, the public guardian was informed that Resident A needed to follow-up at HFH in Detroit, with a plastic surgeon because he had an orbital facial fracture and required surgery. The public guardian declined surgery given how fragile Resident A was. HFH then recommended hospice due to Resident A’s decline. The public guardian does not believe that any staff caused the injuries to Resident A and stated that staff are very attentive to Resident A and his needs. The public guardian has observed Resident A pick his scabs causing them to bleed. She is pleased with the care he is receiving. She reported no concerns.

On 01/09/2025, I conducted the exit conference with licensee designee Ronald Paradowicz regarding my findings. Mr. Paradowicz is aware of these allegations and acknowledged my findings. He also agreed to submit a corrective action plan.

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:	On 11/16/2024, Resident A fell, hit his face on the floor and went to Henry Ford Hospital (HFH) in West Bloomfield. An incident report (IR) was written by DCS Jarira Collazo who reported that staff was walking past Resident A's bedroom, saw Resident A get out of bed and then fall, hitting his head on the vent. However, after interviewing DCS Jarira Collazo, China Crawford, and Shirley Welch who were working the afternoon shift, I was told three different versions of how Resident A sustained the injuries to his face. Ms. Collazo stated she was not the staff who observed Resident A get out of bed and fall. Ms. Collazo stated it was China Crawford. After interviewing Ms. Crawford, her narrative was different from the IR and from Ms. Collazo. Ms. Collazo denied Resident A had the shower running and denied he was in the shower or that he had fallen as she was walking behind him. She stated it was an unwitnessed fall. Ms. Crawford stated she heard water running from Resident A's bedroom as she was walking by, went into Resident A's bathroom and observed Resident A taking a shower. Then Ms. Collazo and Ms. Welch were called into the bedroom. Ms. Collazo took Resident A out of the shower and as Ms. Collazo was walking behind Resident A to his bed, Resident A fell, hitting his face on the vent resulting in the injuries. Ms. Welch reported that the water was running as she observed the shower head on the floor as well as the shower curtain. Ms. Welch stated that Resident A was on the floor when she and Ms. Collazo went into his bedroom. She too stated that the fall was unwitnessed by her and Ms. Collazo, but Ms. Welch believes that Ms. Crawford did witness the fall. Resident A fell, hitting his face on the vent and according to his public guardian, that fall resulted in a facial fracture. It is unclear if Resident A's fall was witnessed or unwitnessed, therefore, due to the inconsistent information given by DCS Jarira Collazo,

	China Crawford, and Shirley Welch, and what was written on the IR, Resident A's safety and protection was not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

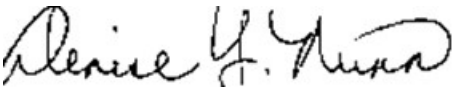
IV. RECOMMENDATION

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

01/09/2025

Frodet Dawisha Date
Licensing Consultant

Approved By:



01/15/2025

Denise Y. Nunn Date
Area Manager

AMENDED REPORT
Special Investigation Report #2025A0605003

PURPOSE:

The purpose of this amended report is to clarify information contained in the special investigation report completed on 01/15/2025.

DESCRIPTION OF FINDINGS & CONCLUSIONS:

In the SIR report, under heading II Allegations: "Yes, was marked under "Violation Established," for the following allegations: "**Resident A was observed with two black eyes. It is alleged staff punched Resident A, and staff have long nails that caused the scratches on Resident A's arms**." Although, the violation was established, the

violation was not established for staff punching Resident A in the eye, nor was it established for staff scratching Resident A due to their long nails.

The violation was established due to the inconsistent information given by DCS Jarira Collazo, China Crawford, and Shirley Welch, and what was written on the IR, regarding Resident A's fall. Therefore, Resident A's safety and protection was not attended to at all times.

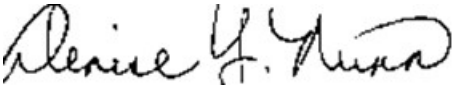
RECOMMENDATION:

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

01/28/2025

Frodet Dawisha Date
Licensing Consultant

Approved By:



01/28/2025

Denise Y. Nunn Date
Area Manager