GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 13, 2025

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

RE: License #: AL630007352
Investigation #: 2025A0991021
Courtyard Manor Farmington Hills II

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) 972-9136.

Sincerely,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007352
Investigation #:	2025A0991021
Complaint Receipt Date:	07/28/2025
Investigation Initiation Date:	07/30/2025
Report Due Date:	09/26/2025
Licensee Name:	Courtyard Manor Farmington Hills Inc
Licensee Address:	3275 Martin - Suite 127 Walled Lake, MI 48390
Licensee Telephone #:	(248) 926-2920
Administrator:	James 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 DEVELOPMENTALLY DISABLED MENTALLY ILL AGED; ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff would not allow Resident A to use the phone when she was trying to call law enforcement to make a report that her bridge card was stolen from the mail. Staff snatched the phone out of her hand and said, “don’t let her use that phone.”	No
Additional Findings	Yes

III. METHODOLOGY

07/28/2025	Special Investigation Intake 2025A0991021
07/28/2025	APS Referral Received from Adult Protective Services (APS) - denied for investigation
07/30/2025	Special Investigation Initiated - On Site Unannounced onsite inspection
07/30/2025	Inspection Completed On-site Unannounced onsite inspection- interviewed Resident A and staff
07/30/2025	Contact - Document Received Assessment plan, health care appraisal, letter from behavior specialist
07/31/2025	Contact - Telephone call made To Resident A's guardian
08/01/2025	Contact - Telephone call made To Resident A's behavior specialist at PACE
08/05/2025	Contact - Telephone call made Interviewed staff, Anitra Hawkins
08/05/2025	Contact - Telephone call made Interviewed staff, Shkela Woods
08/05/2025	Contact - Telephone call made Interviewed staff, Chris Close

08/05/2025	Contact - Telephone call made Interviewed staff, Pamela Edwards
08/06/2025	Contact - Telephone call received From Resident A's behavior specialist
08/07/2025	Contact - Document Received Informational orders for caregivers
08/12/2025	Exit Conference Left message for licensee designee, Ronald Paradowicz

ALLEGATION:

Staff would not allow Resident A to use the phone when she was trying to call law enforcement to make a report that her bridge card was stolen from the mail. Staff snatched the phone out of her hand and said, “don’t let her use that phone.”

INVESTIGATION:

On 07/28/25, I received a complaint from Adult Protective Services (APS) alleging that staff would not allow Resident A to use the phone when she was trying to call law enforcement to make a report that her bridge card was stolen from the mail. Staff snatched the phone out of her hand and said, “don’t let her use that phone.” APS denied the complaint for investigation.

I initiated my investigation on 07/30/25 by conducting an unannounced onsite inspection at Courtyard Manor Farmington Hills II. I attempted to interview Resident A. Resident A is diagnosed with schizoaffective disorder, bipolar type. Resident A had difficulty answering interview questions, as she demonstrated a tangential organization of thought, often veering off topic and discussing things that happened years ago. Resident A stated that her daughter, who is her guardian, was abusing her bridge card by spending over $1000 in five days, so Resident A called and cancelled her old bridge card. She ordered a replacement card on 07/11/25, but it never arrived. Resident A stated that she wanted to call the police to report that her card might have been stolen from the mail. The nurse, Marlene, stopped her from using the phone. Marlene snatched the phone off the wall and stated, “don’t let her use that phone.”

On 07/30/25, I interviewed the director of nursing, Marlene Jones, and the director of operations, Kallee Lizzamore. They stated that Resident A has a history of inappropriately using the phone to call the governor, the police, and Brink security. She will try to call the police all day long. They stated that Resident A called the police over one hundred times. The police called Resident A’s guardian and stated that they would

start fining her $500 for calling the police. Ms. Jones stated that they updated Resident A's care plan in April 2025 to state that she is only allowed to call her guardian and daughters. Resident A's guardian and behavioral specialist from PACE were in agreement with this plan. They stated that staff stand by Resident A if she is using the phone and will tell her that she has to hang up the call if she is calling anyone other than her daughters. Ms. Jones stated that they can see on the phone screen who Resident A is contacting. If she is calling anyone other than her daughters, they will end the call. Ms. Jones denied ever snatching the phone out of Resident A's hand. Ms. Jones and Ms. Lizzamore were not aware of any other staff grabbing the phone out of Resident A's hand. They stated that Resident A will hit you with the phone and will often beat the phone with the receiver.

On 07/31/25, I interviewed Resident A's guardian via telephone. She stated that they do have to restrict Resident A's telephone usage. Resident A has severe mental health issues, but she is very intelligent, so she knows how to get in contact with the authorities and knows "how to handle business". Resident A's guardian stated that they have had to restrict Resident A's phone access everywhere she has lived. She used to live in her own apartment, but she called the Macomb County Sheriff's Office over one hundred times. Resident A eventually had to move to an assisted living facility because of the issues this was causing. Resident A is only allowed to call her daughters. Resident A's guardian stated that she has Resident A's bridge card in her possession, and it has been cut off for a while. She stated that Resident A does not need food assistance, as the facility provides meals. She was not aware of Resident A requesting a new bridge card. Resident A's guardian did not have any concerns about the facility or staff at Courtyard Manor.

On 08/01/25, I interviewed Resident A's behavioral specialist from PACE, Evie Dickman. Ms. Dickman stated that Resident A moved to Courtyard Manor at the end of January 2025. It is baseline for Resident A to frequently call the police and other authorities. She will call them "for anything and everything". The police have stated that they will start charging Resident A if she continues to make inappropriate phone calls. Ms. Dickman stated that Resident A has restrictions in place, so she is only allowed to call her daughters. Staff must be present when she is using the phone, and they will end the phone call if she is contacting someone other than her daughters. Ms. Dickman stated that she is in one hundred percent agreement with this restriction. Ms. Dickman stated that Resident A has a history of making accusations against staff. Ms. Dickman visits the facility every two to three weeks and has witnessed Resident A making accusations. She stated that some staff are hesitant to approach Resident A because of this behavior. Ms. Dickman stated that she does not have any concerns about Resident A's placement and she feels Courtyard Manor is the safest place for Resident A to live.

On 08/05/25, I interviewed shift supervisor, Anitra Hawkins, who stated that she works in all of the buildings at Courtyard Manor Farmington Hills. Ms. Hawkins stated that she was not aware of any staff not allowing Resident A to make a phone call or taking the phone away from her. Ms. Hawkins stated that Resident A can use the phone if she wants to. No one has ever told Resident A that she cannot use the phone. Ms. Hawkins stated that there are no restrictions on Resident A's phone calls.

On 08/05/25, I interviewed direct care worker, Shkela Woods. Ms. Woods stated that she was not aware of anyone not allowing Resident A to use the phone or snatching the phone away from her. She stated that Resident A is allowed to use the phone. She can call anybody she wants to call. Ms. Woods stated that everyone has access to the phone, and they cannot stop them from using it. She has never taken the phone away from anybody.

On 08/05/25, I interviewed direct care worker, Chris Close. Mr. Close stated that he was not aware of anyone stopping Resident A from using the phone or taking the phone from her. He stated that she has access to the phone. He was not aware of any phone use restrictions for Resident A.

On 08/05/25, I interviewed direct care worker, Pamela Edwards. Ms. Edwards stated that Resident A is able to use the phone, but her phone use must be monitored. She stated that Resident A frequently calls the police and fire department or will call for an ambulance. Ms. Edwards stated that staff must sit close to Resident A when she is making calls. She stated that she was not sure what staff are supposed to do if Resident A calls the police, as this has not happened while she was working. She stated that Resident A is typically reaching out to family members. She was not aware of any restrictions regarding who Resident A can call. She stated that she never witnessed anyone taking the phone out of Resident A's hand or ending her phone call. Ms. Edwards stated that Resident A is not currently at the facility, as she was sent out last Friday for assaulting the nurse, Marlene.

I received and reviewed a copy of Resident A's assessment plan dated 01/28/25. The plan includes a note dated 04/25/25, which states that all resident calls need to be monitored per Officer Fitzpatrick with Farmington PD (police department) and guardian. Resident A will call 911 multiple times and report fictitious stories. Resident A can talk to her guardian and daughters only, per guardian and police.

I reviewed a copy of a placement request sent to Courtyard Manor from a behavioral health specialist at PACE regarding Resident A's behaviors at her prior placements. It notes that Resident A has a longstanding mental health history and is diagnosed with schizoaffective disorder, bipolar type. She demonstrates paranoid persecutory delusions and this results in consistent medication non-compliance. Due to her paranoid delusions secondary to her mental health diagnosis, she has a history of making false

claims of elder abuse against staff and stating that staff members were stealing her medications and selling them. Staff reported that she will go around and harass staff members and make false accusations about care to other residents and guests. Prior to her recent hospitalization, she was actively going around using staff phones for hours at a time to contact government officials and lawyers to report these false accusations. She then became verbally aggressive when staff would limit her phone use.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that Resident A does not have reasonable access to a telephone. None of the staff who were interviewed had knowledge of staff taking the phone from Resident A or telling her she could not use the phone. The director of nursing, Marlene Jones, stated that Resident A's phone calls are monitored and restricted, after the police stated that they would begin fining Resident A $500 for making numerous inappropriate phone calls to law enforcement. Resident A's assessment plan notes that her phone calls are restricted to calling her daughters, due to Resident A making frequent calls to 911. Resident A's guardian and behavioral specialist from PACE stated that they were aware of this restriction and were in agreement with it.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection, I observed a Hoyer lift in Resident A's bedroom. Resident A stated that staff do not use the Hoyer lift, as it has been broken and does not work. I observed that when plugged in, the screen of the Hoyer lift shows a warning message that states "Attention Recharge or Exchange" with a picture of a battery with an exclamation point. Resident A's assessment plan dated 01/28/25 notes that she has a Hoyer lift and hospital bed that are used for safety and fall prevention, which were ordered and delivered by PACE. Resident A's informational orders in QuickMAR not that she has a Hoyer lift and sling to be used with a two person assist for safe transferring, safety and fall prevention.

During the onsite inspection, the director of nursing, Marlene Jones, stated that Resident A does not use the Hoyer lift. She stated that Resident A is able to transfer herself. Resident A refuses to allow staff to assist her with her ADLs (activities of daily living). She stated that Resident A acts like she cannot walk, but then she will stand on chairs in her room to remove lightbulbs from the light fixtures.

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(1) As assistive device shall only be used to promote the enhanced mobility, physical comfort, and well-being of a resident.
ANALYSIS:	Resident A's assessment plan indicates that she requires a Hoyer lift for safety and fall prevention. During the onsite inspection, I observed that the Hoyer lift was not working properly, as the screen showed the battery needed to be recharged or exchanged. Resident A and the director of nursing stated that the Hoyer lift is not being used due to it being broken and Resident A's refusal. Resident A's assessment plan was not updated to show that she does not require a Hoyer lift, and it was unclear if it is needed or not.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my investigation, I received and reviewed a copy of Resident A's assessment plan dated 01/28/25. The plan includes a note dated 04/25/25, which states that all resident calls need to be monitored per Officer Fitzpatrick with Farmington PD (police department) and guardian. Resident A will call 911 multiple times and report fictitious

stories. Resident A can talk to her guardian and daughters only, per guardian and police.

During my investigation, I interviewed staff, Anitra Hawkins, Shkela Woods, Chris Close, and Pamela Edwards. All of the staff who were interviewed stated that Resident A can use the phone. They were not aware of any restrictions for Resident A's phone use. Pamela Edwards stated that Resident A's calls need to be monitored because she frequently calls for an ambulance; however, she did not know what staff were supposed to do if they observed Resident A calling the police or another authority. She stated that the residents have a book with their care plan and behaviors. Staff are supposed to review the book, but once they are familiar with the residents, there is no need to review it unless something changes. Direct care worker, Chris Close, stated that he had not seen anything in Resident A's plan regarding phone restrictions. He stated that he does go back and check the residents' plans if they are having a behavior.

The director of nursing, Marlene Jones, stated that at Courtyard Manor the nurses complete the resident assessments and enter the data into an electronic system (QuickMAR). From there, a copy of the information orders is printed and placed in the care plan book, which is accessible to all staff. As part of the training protocol, staff are required to review the care plan book at the start of each shift to stay updated on any changes to resident care. This process ensures that all staff are informed and following the most current care guidelines for each individual.

I reviewed Resident A's informational orders, which included the same information as her assessment plan that all resident calls need to be monitored per Officer Fitzpatrick with Farmington PD (police department) and guardian. Resident A will call 911 multiple times and report fictitious stories. Resident A can talk to her guardian and daughters only, per guardian and police.

On 08/06/25, I conducted a follow-up interview with Resident A's behavioral specialist from PACE, Evie Dickman. Ms. Dickman stated that PACE typically completes a care plan every six months; however, Resident A is not receptive to services through PACE and refuses all care. As such, Resident A does not have any specific mental health goals and does not have a formal care plan or behavior plan in place. Ms. Dickman stated that she believed all staff at Courtyard Manor were aware of the phone restrictions for Resident A. She stated that she would follow up with them to put a more formal behavior plan in place.

APPLICABLE RULE	
R 400.15307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a

	specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that interventions to address Resident A's unacceptable behaviors were not addressed in her assessment plan. Resident A has an extensive history of calling the police and other authorities numerous times for inappropriate reasons. While her assessment plan notes that her phone calls are restricted to calling her daughters, the plan does not provide any additional information regarding behavioral interventions including how staff are supposed to monitor Resident A or implement these restrictions. Resident A's behavioral specialist from PACE stated that Resident A does not have a formal care plan or behavior plan in place with mental health goals due to her refusing to participate in care.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15307	**Resident behavior interventions generally.**
	(3) A licensee and direct care staff who are responsible for implementing the resident's written assessment plan shall be trained in the applicable behavior intervention techniques.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff were not trained regarding Resident A's assessment plan. Resident A's assessment plan notes that her phone calls are restricted to contacting her daughters. During my investigation, I interviewed staff, Anitra Hawkins, Shkela Woods, Chris Close, and Pamela Edwards. All of the staff who were interviewed stated that Resident A can use the phone freely. They were not aware of any restrictions for Resident A's phone use.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection on 07/30/25, I observed the cord to Resident A's hospital bed was broken. One of the prongs on the plug for the bed was snapped off and

missing. During the onsite inspection, I observed the drain pipes under the sink in Resident A's bathroom were stained and dirty.

On 08/12/25, I contacted the licensee designee, Ronald Paradowicz, to conduct an exit conference. Mr. Paradowicz was not available, so I left a message regarding my findings and requested a return phone call.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the home was not maintained for the health and safety of the occupants. I observed that one of the prongs on the electrical plug for Resident A's hospital bed was snapped off and broken. The drain pipes under the sink in Resident A's bathroom were stained and dirty.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/12/2025

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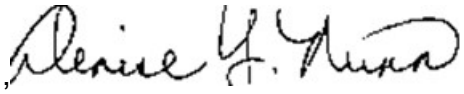
Kristen Donnay Date
Licensing Consultant

Approved By:



08/13/2025

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Denise Y. Nunn Date
Area Manager