GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 18, 2025

Tonya Carter
Encore McHenry
230 West Monroe, Suite 710
Chicago, IL 60606

RE: License #: AL630417059
Investigation #: 2026A0602002
The Courtyard at Auburn Hills 3

Dear Ms. Carter:

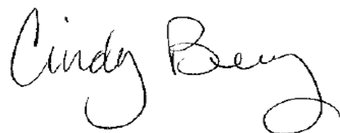
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630417059
Investigation #:	2026A0602002
Complaint Receipt Date:	10/10/2025
Investigation Initiation Date:	10/10/2025
Report Due Date:	12/09/2025
LicenseeName:	Encore McHenry
Licensee Address:	230 West Monroe, Suite 710 Chicago, IL 60606
Licensee Telephone #:	(248) 340-9296
Administrator:	Tonya Carter
Licensee Designee:	Tonya Carter
Name of Facility:	The Courtyard at Auburn Hills 3
Facility Address:	3033 N. Squirrel Rd. Auburn Hills, MI 48326
Facility Telephone #:	(312) 623-0884
Original Issuance Date:	11/13/2023
License Status:	REGULAR
Effective Date:	05/13/2024
Expiration Date:	05/12/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On October 9, 2024, neglect at Courtyard of Auburn Hills led to a serious knee infection from an untreated UTI, requiring emergency care to prevent possible amputation.	No
Additional Findings	Yes

III. METHODOLOGY

10/10/2025	Special Investigation Intake 2026A0602002
10/10/2025	Special Investigation Initiated – Telephone Call made to complainant.
11/06/2025	Contact – Document received Received email from the complainant.
10/30/2025	Inspection Completed On-site I Interviewed the wellness director, Amber Carmichael and the licensee designee, Tonya Carter.
12/08/2025	Contact – Telephone call made Spoke with staff member Barbara Blackmon.
12/09/2025	Contact – Document sent Email sent to Ms. Carter regarding the remaining requested documents.
12/17/2025	Exit Conference Held with the licensee designee, Tonya Carter by telephone.

ALLEGATION:

On October 9, 2024, neglect at Courtyard of Auburn Hills led to a serious knee infection from an untreated urinary tract infection (UTI), requiring emergency care to prevent possible amputation.

INVESTIGATION:

On 10/10/2025, a complaint was received and assigned for investigation alleging neglect on 10/09/2024 by Courtyard at Auburn Hills that led to a serious knee infection from an untreated urinary tract infection (UTI) that required emergency care to prevent possible amputation.

On 10/30/2025, I conducted an unannounced on-site investigation at which time I interviewed the director of wellness, Amber Carmichael and the licensee designee, Tonya Carter. Ms. Carmichael stated that Resident A no longer resides in the facility. She was admitted to the facility on 6/17/2024 and was discharged on 11/30/2024. She was seen by Optimal Home Care.

According to Ms. Carter, Resident A was obese, incontinent with urine and was resistant to receiving care. She suffered from recurrent urinary tract infections and would stuff shirts or paper towels in her briefs. Ms. Carter went on to state she would receive calls from Resident A's son informing her that Resident A would call him numerous times complaining that she was not being fed or staff would not come in to assist her. When staff would go in to assist Resident A, she would at times refuse assistance and refuse to eat dinner but would call her son and tell him they were not feeding her. Ms. Carter stated that Resident A only had one hospitalization while residing at the facility and that was on 10/09/2024. Resident A was complaining of chest pain and pain in her left arm. She was transported to the hospital, admitted and later went to a rehabilitation facility. While at the rehab facility, Resident A was assessed by the Director of Wellness (who no longer works for the company) and it was determined that she could not return to the facility as her mobility declined. She was no longer able to transfer herself and required at least three people to assist.

On 10/30/2025, I requested copies of Resident A's nursing notes from the home care agency servicing her, a copy of the visit note and assessment that determined she was unable to return to the facility upon her discharge from the rehab facility and any notes documented by the Director of Wellness. Ms. Carter stated the facility uses a new computer system and she needs time to figure out how to access the old files. She agreed to email the documents to me on 11/07/2025.

On 10/30/2025, I received and reviewed copies of Resident A's health care appraisal dated 5/7/2024, an incident report dated 10/09/2024, and an Optimal Home Care intake assessment dated 5/07/2024. The health care appraisal documents that Resident A suffered from hypertension, depression, dementia, anxiety, obesity, generalized weakness, moisture associated skin lesions, wheelchair bound with significant leg lymphedema, bilateral lower extremities lymphedema, and osteoarthritis. The incident report documented that on 10/09/2024 at 5:40 pm, staff attempted to administer Resident A her evening medication when she complained of chest/arm pain and was breathing heavily. Her vitals were taken and her temperature was 96.7 Fahrenheit, pulse, 65, blood pressure 102/64, and her oxygen level was 96. Resident A was transported to the hospital at 6:45 pm. The Optimal Home Care intake assessment documented the following diagnosis, hypertension, osteoarthritis, Alzheimer's, dementia, depression, anxiety and lymphedema.

On 11/06/2025, I received an email from the complainant inquiring about the status of the complaint. I informed the complainant that the complaint was being investigated.

On 12/08/2025, I interviewed staff member Barbara Blackmon by telephone. Ms. Blackmon stated she could not recall specific information regarding Resident A as it has been over a year since she resided in the facility. Ms. Blackmon said she recalled that Resident A was transported to the hospital (exact date unknown) but she did not know the reason for the transport. Resident A did not return to the facility. Ms. Blackmon went on to state that she did not recall Resident A having a urinary tract infection and that if there were any concerns, the family would contact Ms. Carter. This is all the information Ms. Blackmon had regarding Resident A.

On 12/10/2025, I received an email from Ms. Carter with copies of nursing notes from Optimal Home Care. Resident A was seen by the nurse, Rachel Simms on 6/18/24, 6/21/24,6/25/24, 7/2/24, 7/9/24, 7/16/24, 7/23/24, 7/29/24, 8/6/24, and 8/15/24. Resident A was seen by the occupational therapist on 7/8/24, 7/12/24, 7/17/24, 7/19/24, 7/22/24, 7/26/24, 7/29/24, and 8/2/24. Resident A was seen by the physical therapist on 6/24/24, 6/26/24, 7/8/24, and 7/15/24. According to the notes reviewed, Resident A was also seen on 7/18/24 by a psychiatric nurse, Angela Rodriguez as she was staying in her room most days, had a body odor and refused to shower. I did not observe anything documented in any of the notes reviewed that Resident A suffered from recurrent urinary tract infections.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on the information obtained during the investigation, there is insufficient information to determine that Resident A was neglected while residing at the facility. According to the documents reviewed, Resident A was under the care of Optimal Home Care and was seen on a regular basis during the months of June, July and August 2024 and there was nothing documented about a urinary tract infection.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS

INVESTIGATION:

On 10/30/2025 during the unannounced on-site investigation, I requested copies of Resident A's resident file. Ms. Carter informed me that at the time Resident A resided at the facility, they used a different computer system to store resident records. She stated she needed some time to figure out how to access the old system so that she could provide me with notes documented by the Director of Wellness at that time. On

12/09/2025, I emailed Ms. Carter reminding her that I had not received the requested documents. On 12/10/2025, I received an email from Ms. Carter indicating that due to the change in the computer system, she was unable to obtain a copy of the visit note or assessment that was completed by the Director of Wellness and could not locate a paper copy. She stated she would continue to dig for it.

As of this date, I still have not received a copy of the visit note and assessment that determined Resident A was unable to return to the facility upon her discharge from the rehab facility due to her decreased mobility. Nor have I received any notes documented by the Director of Wellness.

On 12/17/2025, I conducted an exit conference with the licensee designee, Tonya Carter by telephone. I informed Ms. Carter of the investigative findings and recommendation documented in this report.

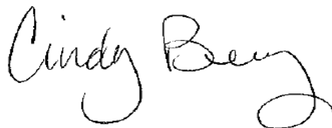
APPLICABLE RULE	
R 400.691	**Resident records.**
	(3) Resident records must be kept on file in the facility for 2 years after the date of resident discharge unless a shorter retention is specified elsewhere in these rules.
ANALYSIS:	Based on the information obtained during the investigation, there is sufficient information to determine that Resident A's entire resident record was not kept on file in the facility for 2 years after she had been discharged. On 10/30/2025, I requested copies of Resident A's resident file. Ms. Carter informed me that at the time Resident A resided at the facility, they used a different computer system to store resident records. She needed some time to figure out how to access the old system so that she could provide me with notes documented by the Director of Wellness at that time. As of this date, I have not received the requested documents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.605	**Rule compliance; cooperation by applicant or licensee.**
	(1) An applicant or licensee shall make available to the department any document necessary to determine compliance with the act and these rules.

ANALYSIS:	Based on the information obtained during this investigation, there is sufficient information to determine that the licensee designee, Tonya Carter did not provide the requested documentation for Resident A. On 10/30/2025, I requested copies of notes documented by the Director of Wellness from Resident A's file and was informed by Ms. Carter that at the time Resident A resided at the facility, they used a different computer system to store resident records. She needed some time to figure out how to access the old system. She agreed to provide these documents to me by 11/07/2025. On 12/09/2025, I emailed Ms. Carter informing her that I had not received the requested documents. On 12/10/2025, I received an email from Ms. Carter indicating that she was unable to obtain a copy of the visit note or assessment that was completed by the Director of Wellness and could not locate a paper copy. She stated she would continue to dig for it.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

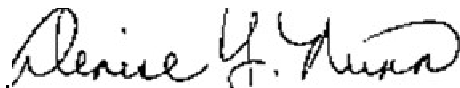
Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



12/17/2025

Cindy Berry Date
Licensing Consultant

Approved By:



12/18/2025

Denise Y. Nunn Date
Area Manager