GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 19, 2026

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

RE: License #: AL630007353
Investigation #: 2026A0605013
Courtyard Manor Farmington Hills III

Dear Ronald Paradowicz:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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,

Frodet Dawisha

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd., Ste 9-100
Cadillac Place
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 #:	AL630007353
Investigation #:	2026A0605013
Complaint Receipt Date:	03/02/2026
Investigation Initiation Date:	03/02/2026
Report Due Date:	05/01/2026
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 III
Facility Address:	29770 Farmington Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-0104
Original Issuance Date:	08/11/1994
License Status:	REGULAR
Effective Date:	06/15/2024
Expiration Date:	06/14/2026
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A, with dementia, was hospitalized with aspiration pneumonia after staff forced food down his throat, causing him to choke and become hypoxic.	No

III. METHODOLOGY

03/02/2026	Special Investigation Intake 2026A0605013
03/02/2026	APS Referral Adult Protective Services (APS) made referral
03/02/2026	Special Investigation Initiated - Letter Email to assigned APS worker Jonathan Johnson
03/02/2026	Contact - Document Received Email from APS Jonathan Johnson
03/02/2026	Contact - Document Sent Email to Farmington Hills Fire Department (FHFD) records
03/03/2026	Contact - Document Received Email from APS Jonathan Johnson
03/04/2026	Contact - Telephone call made Discussed allegations with direct care staff (DCS)
03/04/2026	Contact - Document Received Email from FHFD records
03/05/2026	Inspection Completed On-site Conducted unannounced on-site investigation
03/12/2026	Contact - Telephone call received From APS Jonathan Johnson
03/17/2026	Contact - Telephone call made Discussed allegations with DCS
03/18/2026	Contact - Telephone call made Followed up with DCS

03/18/2026	Exit Conference Left message of findings with licensee designee Ronald Paradowicz and advised administrator Jim Cubr of my findings too.

ALLEGATION:

Resident A, with dementia, was hospitalized with aspiration pneumonia after staff forced food down his throat, causing him to choke and become hypoxic.

INVESTIGATION:

On 03/02/2026, intake #209624 was referred by Adult Protective Services (APS). APS worker Jonathan Johnson is investigating these allegations.

On 03/02/2026, I emailed APS worker Jonathan Johnson. Mr. Johnson made contact with Resident A at Henry Ford West Bloomfield Hospital. He also visited this facility and discussed the allegations with staff. Mr. Johnson stated that Resident A cannot hold a conversation and the registered nurse (RN) was not familiar with case. Resident A is bed bound and receiving tube feeding through the nose at the hospital. The facility stated Resident A went to the hospital on 02/13/2026 when he had pneumonia and diet was changed. Resident A came back to the facility on one-on-one purée feed. Then Resident A went back to the hospital on 02/21/2026 due to being lethargic and leaning over in chair. Mr. Johnson interviewed the medication technician, Aja Clark, that called emergency services. No one at the facility knows anything about him choking, only him being lethargic. Everyone I spoke with denied Resident A being forced fed.

On 03/02/2026, I emailed Farmington Hills Fire Department (FHFD) records requesting the report dated 02/21/2026 regarding contact with Resident A at this facility.

On 03/03/2026, I received an email from APS worker Jonathan Johnson with staff contact information. He is still investigating these allegations. Mr. Johnson also sent the incident report (IR) dated 02/21/2026 and the 02/21/2026 staff schedule.

Note: I reviewed IR dated 02/21/2026 at 8:30AM, which stated, “staff reported this resident was observed leaning over in wheelchair while also drooling and very lethargic. Staff completed vitals blood pressure 166/79, oxygen was 82%. Resident A was taken to the hospital.”

On 03/04/2026, I interviewed direct care staff (DCS) Destiny Williams regarding the allegations via telephone. Ms. Williams normally works in buildings I and II. She stated she was not working on 02/21/2026 even though her name was on the staff schedule.

Ms. Williams denied observing any staff force feed Resident A when she worked in building III. Her responses were “I have no idea what you’re talking about.”
On 03/04/2026, I interviewed DCS Shakeelah Simpson regarding the allegations via telephone. Ms. Simpson works in building III and has been with this corporation for three years. She works day shift. On 02/21/2026, she was present when she observed Resident A in his bedroom “not looking like himself.” He was not responding to her and appeared lethargic. He was slouched over his chair. Ms. Simpson left his bedroom and went to get assistance from the medication technician Ajah Clark. Ms. Clark checked his vitals and his oxygen was low. Ms. Simpson left the room and stated she did not know what happened next but that the ambulance was called and Resident A was taken to the hospital. Ms. Simpson stated that Resident A normally feeds himself, but that morning he did not eat as breakfast is usually served between 8AM-9AM. She does not know if Resident A had aspiration pneumonia. She denied any staff force feeding him that morning.

On 03/04/2026, I received from FHFD records the report dated 02/21/2026 regarding Resident A. According to the report, EMS was dispatched to this facility regarding Resident A being lethargic, unable to ambulate, and low oxygen. Staff was actively feeding patient oatmeal. Resident A was alert to verbal and no obvious signs of respiratory distress. While transporting Resident A, he began to cough up oatmeal. Resident A required coaching to clear his mouth of oatmeal. **Note:** There is no mention in this record that Resident A was being forced fed nor any mentioning of Resident A choking while being fed.

On 03/05/2026, I conducted an unannounced on-site investigation. Present were the administrator Jim Cubr, RN Ashley Eddie, DCS Shakeelah Simpson, Director of Operations Kallee Lizzamore, cook Trish Alexander, and Nya Ford. Mr. Cubr was interviewed regarding the allegations. On 02/21/2026, Resident A was lethargic, had a change in status and an ambulance was called and Resident A was transported to Henry Ford West Bloomfield Hospital. Mr. Cubr was unaware of Resident A being fed oatmeal or choking until APS contacted the facility. Mr. Cubr stated the IR never mentioned Resident A was choking or that oatmeal had to be suctioned out.

I interviewed RN Ashley Eddie regarding the allegations. RN stated she received a telephone call from medication technician Ajah Clark regarding Resident A appeared lethargic, leaning over on his chair. RN advised Ms. Clark to take his vitals, which she did and reported them to the RN. The RN informed Ms. Clark to call an ambulance, which Ms. Clark did. The RN was never informed that Resident A was force fed oatmeal during this call. Resident A is on a pureed diet, therefore, he would not eat oatmeal but instead cream of wheat.

I interviewed DCS Shakeelah Simpson again regarding the allegations. Ms. Simpson stated she misinformed me regarding Resident A not being fed on 02/21/2026. She stated that DCS Pamela Edwards was feeding Resident A cream of wheat at the dining room table after an ambulance was called. However, Resident A was not choking nor was he being forced fed. He was still lethargic when he was being fed.

I interviewed Trish Alexander, the cook at this facility. She stated that as of 02/19/2026, Resident A was on a pureed diet; therefore, would not make oatmeal, but instead cream of wheat. She made cream of wheat for breakfast on 02/21/2026 and staff into the kitchen and got it, but she is unsure which staff and if Resident A was fed. She stated she had no concerns about staff and did not hear anything about Resident A choking.
I interviewed team lead office manager Nya Ford regarding the allegations. Ms. Ford did not work on 02/21/2026 but was the manager on call. She was informed by Ajah Clark that Resident A went to the hospital. She did not hear nor was she informed that Resident A was choking or aspirating during this day.

On 03/05/2026, I interviewed via telephone Ajah Clark while at this facility. Ms. Clark was the medication technician who worked on 02/21/2026. She was contacted by a midnight staff, name unknown advising her that “Resident A was lethargic and oxygen dropped.” She came to building III, contacted RN Ashley who advised her to take his vitals. Ms. Clark took his vitals, shared them with the RN who advised her to call 911. Resident A was put in his wheelchair and wheeled to the dining room. Ms. Clark does not believe he was fed breakfast because 911 was called and then he was transported to the hospital. Ms. Clark stated that breakfast starts at 8AM and again she does not believe he ate breakfast.

On 03/05/2026, I observed Resident A in his hospital room at Henry Ford West Bloomfield Hospital. Resident A was sleeping and would not wake when I called his name. I spoke with RN Katie. Katie stated that Resident A is confused, has aspiration pneumonia diagnosed on 02/19/2026 when he was hospitalized. Katie was not present on 02/21/2026 when Resident A was brought in but heard from other hospital staff that the ambulance reported that “staff were feeding Resident A while he was coughing and choking.” Resident A had to be suctioned at the time of arrival. Katie did not have any other information.

On 03/12/2026, I received a call from APS worker Jonathan Johnson stating that he will not be substantiating his case.

On 03/17/2026, I interviewed DCS Laqujha Johnson regarding the allegations via telephone. Ms. Johnson has only been working for this corporation for about one month. She works the midnight shift from 11PM-7AM. She worked 02/21/2026 but was in training and did not provide care to Resident A. She stated that she would have left her shift before breakfast was served at 8AM; therefore, she has no information to provide regarding the allegations. Also, she usually works building IV and not often at building III.

On 03/17/2026, I interviewed DCS Regine Fulton regarding the allegations via telephone. Ms. Fulton works the midnight shift from 11PM-7AM. She worked 02/21/2026 but stated that all the residents are sleeping during her shift as was Resident A. She checked on the residents throughout her shift, and she does not recall

any concerns occurring during the shift. She too had no additional information regarding the allegations.

On 03/17/2026, I attempted to interview DCS Pamela Edwards, but she stated she was working and to call back later.

On 03/17/2026, I contacted Resident A's wife regarding the allegations. Resident A's wife stated that Resident A passed away on 03/12/2026. She did not have concerns about this facility and was contacted on 02/21/2026 by this facility advising her that Resident A was going to the hospital. She went to the hospital and was informed by the hospital RN that "Resident A was force fed oatmeal." She was not present, so she does not know if this is true or not. She used to visit Resident A every other day and when she was at the facility, she had no concerns about staff. Resident A began declining a week prior to being hospitalized on 02/21/2026. He used to feed himself but then he needed staff to feed him. She stated, "I can't imagine anyone force feeding him if he was choking. I would hope that did not happen." She had no concerns to report.

On 03/18/2026, I interviewed DCS Pamela Edwards via telephone regarding the allegations. Ms. Edwards immediately began by saying she was tired of being called regarding these allegations. She stated she has no information even though she was working on 02/21/2026. Ms. Edwards was defensive during the interview. She denied feeding Resident A and stated, "He was not on my schedule that day. I don't know why you're calling me about this." Ms. Edwards was advised that several staff members observed her feeding Resident A on 02/21/2026. Ms. Edwards was adamant that she did not feed Resident A.

On 03/18/2026, I followed up with DCS Shakeelah Simpson. Ms. Simpson stated that she and DCS Destiny Williams got Resident A into his wheelchair and out to the dining room. Ms. Simpson observed Pamela Edwards sitting at the dining table where Resident A was at. Ms. Simpson told Ms. Edwards that Resident A was getting ready to go to the hospital because an ambulance was called, so Ms. Edwards put the spoon down. Ms. Simpson stated that Resident A was not choking nor was he in distress when Ms. Edwards was feeding him cream of wheat.

On 03/18/2026, I followed up with Nya Ford who advised that DCS Destiny Williams no longer works at this facility and her last day was on 02/27/2026. Ms. Ford's name is on the IR dated 02/21/2026 only because she was the team lead on call that day. Again, she advised she had no other information to provide.

On 03/18/2026, I followed up with DCS Destiny Williams. Ms. Williams stated that she misinformed me regarding her not being present on 02/21/2026 when she was working at building III that day. She recalls DCS Pamela sitting at the dining room table with Resident A, feeding him cream of wheat. Resident A was not choking nor was he in distress when Ms. Edwards was feeding him.

On 03/18/2026, I contacted RN Marlene Jones via telephone regarding the allegations. Jim Cubr was also present via speaker phone. Marlene was not the RN responsible for building III. She is responsible for buildings I and II. She heard that APS was at this facility and informed the facility that EMS made allegations regarding staff forced food down Resident A's throat while he was choking. Marlene stated that the protocol is that if a resident is lethargic and there is a change of status, then staff should not be feeding the residents. Mr. Cubr stated that the allegations stated that Resident A was forced fed by staff while he was choking and finds it hard to believe that if EMS observed this happening, they did not intervene. Mr. Cubr stated that staff would not have fed Resident A if he was "leaning over in his chair," or "in distress," at the time he was fed. I advised Mr. Cubr that it was concerning that staff fed Resident A given that staff reported on the IR that Resident A was lethargic and leaning over in his wheelchair. He stated that Resident A may have been leaning over in his wheelchair initially, but then he was no longer in distress. I advised him that staff reported that Resident A was not "responding," to them which if that is the case, then how does staff know he was not in distress. He stated that even if residents do not respond to staff or have their eyes closed, it does not mean they are in distress and cannot eat.

I asked Marlene if I could speak with RN Ashley as I did not have her contact information. Marlene handed the phone to RN Ashley. Ashley does not recall what time it was when she was contacted by Ajah Clark on 02/21/2026 but does recall it being in the AM. She was told by Ms. Clark that "Resident A was leaning over in his chair." Ashley recalls Ms. Clark taking vitals and Ashley advised Ms. Clark to call 911. Ashley stated she would not have instructed any staff to feed Resident A and if she had known that staff were going to feed Resident A, she would have instructed them to stop. Ashley stated that protocol is if an ambulance is called, then staff should not feed the residents. The RNs at this facility are only responsible for training and overseeing medication technicians and Kallie Lizzamore is responsible for ensuring DCS are trained and in-serviced on this protocol.

On 03/18/2026, I contacted Kallie Lizzamore via telephone. Responsible for staff in-servicing them regarding plan of care. Alert med tech or nurse and follow directives. Ms. Lizzamore was not present; however, she had Ajah Clark come to her office and was available on speaker phone. Ms. Clark stated that on 02/21/2026, during rounds at 7AM, she was informed that Resident A appeared lethargic and leaning over his chair. After rounds, Ms. Clark went to the dining room where Resident A was, and his oxygen levels were at 92%. She contacted RN Ashley who advised her to retake the vitals and now they decreased to 72%. Ashley instructed her to call 911, which she did. Ms. Clark also contacted Resident A's wife and documented what occurred. When she returned to the dining room, the ambulance arrived. Staff were unaware that 911 was called because Ms. Clark never had the opportunity to advise them so that is why Resident A was fed cream of wheat. EMS tech was informed by Ms. Clark of Resident A's oxygen levels, but the EMS did not want to take Resident A to the hospital until Ms. Clark advised EMS tech that Resident A cannot make decisions and his wife agreed to let him go to the hospital. Ms. Clark stated that Resident A was not choking nor did EMS suction anything out while at the facility. She does not know what happened on the way

to the hospital, but the time EMS was at the facility there were no concerns. I advised Ms. Lizzamore that there needs to be a protocol in place for when medication technicians assess residents and determine when 911 is called to inform staff immediately to ensure residents' safety. Ms. Lizzamore acknowledged and stated she will put in place procedures to inform staff immediately once it has been determined that residents are in distress and 911 has been contacted.

On 03/18/2026, I left a detailed message for licensee designee Ronald Paradowicz with my findings and advised administrator Jim Cubr of the finings too. He did not have any questions but was advised of the conversation I had with Kallee Lizzamore regarding implementation of protocol regarding staff being informed immediately when 911 is called for a resident. He acknowledged.

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 my investigation and information gathered, Resident A was protected and safe on 02/21/2026 when he was lethargic and staff called 911. During rounds at this facility around 7AM, the medication technician Ajah Clark was informed that Resident A was observed lethargic and leaning over in his wheelchair. Ms. Clark observed Resident A in the dining room, took his vitals, left the dining room and contacted RN Ashley Eddie. Ashley instructed Ms. Clark to call 911, which Ms. Clark did. DCS were unaware that 911 was contacted, so DCS Pamela Edwards was observed by other staff feeding Resident A cream of wheat. Resident A was on a pureed diet at the time. Resident A was not being forced fed nor was he choking. The ambulance arrived and transported Resident A to Henry Ford West Bloomfield Hospital. I reviewed the FHFD report and according to the report dated 02/21/2026, Resident A was observed to be fed by staff, but Resident A began coughing during transport, not while he was being fed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend no change to the status of the license.

03/19/2026

Frodet Dawisha — Date
Licensing Consultant

Approved By:

For 03/19/2026

Denise Y. Nunn — Date
Area Manager