GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 16, 2026

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

RE: License #: AL630007354
Investigation #: 2026A0626008
Courtyard Manor Farmington Hills IV

Dear Mr. 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,

Sara Shaughnessy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202 (248) 320-3721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007354
Investigation #:	2026A0626008
Complaint Receipt Date:	12/05/2025
Investigation Initiation Date:	12/08/2025
Report Due Date:	02/03/2026
Licensee Name:	Courtyard Manor Farmington Hills Inc
Licensee Address:	Suite 127 3275 Martin Walled Lake, MI 48390
LicenseeTelephone #:	(248) 926-2920
Administrator:	Ronald Paradowicz
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:	06/15/2024
Expiration Date:	06/14/2026
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A developed a severe pressure ulcer that became infected, causing septic shock.	Yes
Resident A did not receive immediate medical care for an infected pressure ulcer.	Yes
Relative A1 was given another resident's prescription medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/05/2025	Special Investigation Intake 2026A0626008
12/08/2025	Special Investigation Initiated - Telephone I initiated the special investigation by completing a phone interview with Relative A1.
12/09/2025	Contact - Face to Face I completed an unannounced, onsite investigation at Courtyard Manor Farmington Hills. I completed interviews with director, James Cubr, and nurses, Marlene Jones and Ashlee Eddie.
12/10/2025	APS Referral I submitted a referral to Adult Protective Services via MI Bridges Mandated Reporter portal.
12/11/2025	Contact - Document Received I received an email indicating the referral to Adult Protective Services was denied, due to being referred to other investigative authority.
12/12/2025	Contact - Document Received I received a text message from Relative A1 indicating Resident A had passed away.
12/15/2025	Contact - Telephone call made

	I attempted phone contact with direct care staff Gabrielle Anderson and Shavonte Hutterson, the two who signed off on the shower assessments for Resident A.
12/17/2025	Contact - Document Received I received a text message from Relative A1 containing a photograph of the prescription medications she stated were given to her in error.
12/19/2025	Contact - Document Received I received, via email, the nursing notes for Resident A from Compassus Home Care.
12/26/2025	Contact - Telephone call made I attempted phone contact with direct care staff members, Gabrielle Anderson and Shavonte Hutterson.
12/29/2025	Contact - Document Sent I sent an email to program director, Jim Cubr, requesting assistance arranging telephone interviews with direct care staff members, Gabrielle Anderson and Shavonte Hutterson.
01/02/2026	Contact - Document Sent I sent an email to Vanessa Nunnelly from Compassus, requesting a phone number for the nurse who was seeing Resident A. She indicated she is not able to provide me the phone number, but agreed to give her my phone number.
01/02/2026	Contact - Document Sent I sent an email to program director, Jim Cubr, requesting information for Resident B.
01/06/2026	Contact – Document Sent I sent an email to Jim Cubr, following up on my previous request.
01/08/2026	Contact – Document Sent I sent an email to anita@courtyardmanor.com, the email address licensed for the licensee, to request assistance with the interviews and information regarding Resident B.
01/08/2026	Contact – Telephone call made I completed a telephone interview with Compassus registered nurse, Nancy Luna.
01/08/2026	Contact – Telephone call made

	I attempted telephone contact with licensee designee, Ronald Paradowicz. A message was left requesting a return call.
01/09/2026	Contact – Telephone call made I completed telephone interviews with direct care staff members, Jaslin Allen and Shavonte Hutterson.
02/25/2026	Exit Conference I completed an exit conference with administrator, Jim Cubr. Mr. Cubr was informed of the findings and indicated he did not agree with all of them and would review the report.

ALLEGATION:

Resident A developed a severe pressure ulcer that became infected, causing septic shock.

INVESTIGATION:

On 12/08/2025, I received a complaint, via email, indicating Resident A had developed a severe pressure ulcer on his buttocks that became infected, resulting in a diagnosis of septic shock. There was also an allegation that the prescription medication for another resident was given to Relative A1 when she went to pick up the belongings of Resident A from Courtyard Manor Farmington Hills.

On 12/08/2025, I initiated the special investigation by completing a phone interview with Relative A1. Relative A1 stated she is also the guardian to Resident A. Resident A is no longer at Courtyard Manor Farmington Hills, he was recently moved to another facility after he was discharged from the hospital. Resident A was at Courtyard Manor Farmington Hills from 10/09/2025-11/24/2025. Relative A1 did not want Resident A to go back due to him developing a pressure ulcer which was 10cmx5cm, which she described as the size of a saucer. The pressure ulcer was on his bottom, was black, and necrotizing. She was not aware of it until 11/23/2025, when she went to visit Resident A at the facility, but could not fully see it due to it being covered in pink cream. On 11/24/2025, Resident A went to the hospital and was in septic shock, he was discharged on 12/01/2025, on hospice care. He was not expected to survive through the upcoming weekend. Relative A1 stated that Courtyard Manor of Farmington Hills tried to tell her that they notified her about the sore on 11/22/2025, and that she had told them she did not want Resident A to be sent to the hospital, but this is not true. The doctor had told her in October that Resident A was at risk for bed sores. Resident A appeared greasy when she went to visit him and requested, he be bathed more often. She was told they bathe residents two times per week. She wanted them to shower him more often to keep an eye on his skin. Resident A has been diagnosed with Parkinson's disease and could have lived longer, but now he is on hospice and not expected to make it through the weekend.

On 12/09/2025, I received a photograph, via text message, of the pressure ulcer located on Resident A's bottom. It appeared to be large and was spread over most of his buttocks. The ulcer appeared black and had red skin around it. There is a copious amount of milky brown substance leaking from the ulcer, which appears to be blood mixed with pus.

On 12/09/2025, I completed an unannounced onsite investigation at Courtyard Manor Farmington Hills. I interviewed James Cubr, director. Mr. Cubr only knows that Resident A went to the hospital due to a wound. He summoned the nurses employed there to meet with us. Mr. Cubr informed me that Relative A1 had filed a grievance and he provided me with a copy of it.

Marlene Jones, licensed practical nurse, was the first to arrive. Ms. Jones stated that she saw the wound on Resident A, on 11/24/2025 and it was an open area on his bottom. She contacted registered nurse, Ashlee Eddie, to come look at it and she contacted the family immediately and informed them he had to go to the hospital. It was first reported on 11/22/2025.

Ms. Eddie arrived and I completed an interview. Ms. Eddie stated that she received a text message on 11/22/2025 from their medication technician indicating Resident A had a sore on his bottom. She instructed her to contact Relative A1 and inform her of the wound and to ask if she would consent to him being taken to the hospital, which she declined. She instructed staff to keep an eye on Resident A. On 11/24/2025, she observed the wound and immediately contacted Relative A1, who asked her to wait to have Resident A taken to the hospital until she could get there, but she insisted he had to go immediately. She contacted 911 and Resident A was transported to Henry Ford Bloomfield. Relative A1 came to the facility that evening and thanked her for insisting on Resident A going to the hospital. She told Ms. Eddie that they were going to change Resident A's plan to hospice care and Ms. Eddie informed her that Resident A can come back and receive hospice care at Courtyard Manor. Ms. Eddie contacted Relative A1 on 11/26/2025, and Relative A1 was upset due to Resident A's wound being infected, stating he was neglected and would not be returning. He was there for approximately one month. Resident A was not dropped off with durable medical equipment and could not stand on his own, they contacted Relative A1 and they asked the hospital for a wheelchair. When Resident A was admitted on 10/09/2025, they completed a skin assessment, he did not have any wounds, just some scabbing on his knees.

Ms. Eddie explained their protocol regarding pressure ulcers. The protocol regarding residents who are immobile is to reposition the resident every two hours, and to watch for changes. Resident A was able to shift his weight, so they did not institute the protocol for Resident A. On 11/22/2025, Relative A1 asked for Resident A to be repositioned every two hours, there is no documentation showing this took place. Relative A1 visited Resident A on 11/23/2025, and she checked out the wound, which was covered with cream.

Ms. Eddie stated that Resident A was receiving services through a home health care agency, Compassus. The nurse was supposed to do skin assessments whenever she was there to see Resident A. She was there on 11/21/2025, the day before staff discovered the wound. Ms. Eddie and Ms. Jones have been trying to get the nursing notes and were told they would not be provided to them. They contacted Relative A1 and tried to get them, but she was told the same thing. When the home care nurse was there on 11/21/2025, she had a conversation with Relative A1 regarding a transition to hospice care and when they attempted to contact her on 11/22/2025, she informed Ms. Eddie that Resident A had been discharged from their care. Ms. Eddie explained that if a resident is receiving nursing care from another agency, the nurse from the agency handles all nursing care and are supposed to do a skin assessment at every visit. Ms. Eddie stated Resident A was receiving physical therapy through the home health agency and it was the only time he would walk with a walker.

On 11/21/2025, Ms. Eddie stated the nurse from Compassus informed her that Resident A's blood pressure was low and after contacting the doctor, his lisinopril was discontinued.

Ms. Eddie, Ms. Jones, and Mr. Cubr stated they had a great relationship with the family until this. Relative A1 had told them she felt Resident A was receiving incredible care.

During the onsite, Mr. Cubr provided me with a copy of Resident A's file. I reviewed the documents provided to me from Resident A's file. The following items were pertinent.

The file included "Nurse's Notes". According to the notes, Resident A was admitted on 10/09/2025. The notes indicate Resident A is non-ambulatory and came with a walker. He was unable to stand or pivot. His speech was low. He had a scratch on his right lower leg area. He wears briefs and occasionally has accidents. He was very confused and can be combative. A wheelchair was ordered at this time. He later fell when attempting to stand at the dining room table, further illustrating his non-ambulatory status. On 11/21/2025, the Compassus nurse was there to see Resident A. There were concerns regarding Resident A's blood pressure, no notations regarding a pressure ulcer. On 11/24/2025, there is an entry regarding the pressure ulcer, the entry reads:

> "Staff reported resident had pressure injury to his sacrum on 11/22/2025, wife/guardian did not want him sent out at that time. Upon assessment by writer on 11/24/2025, skin appeared infected. Writer contacted wife/guardian and discussed sending resident out for treatment at the hospital."

After he was assessed on 11/24/2025, 911 was called and he was sent to the hospital.

In Resident A’s file is a document entitled "Physician's Orders". On 10/15/2025, an order was made for a high back wheelchair, signed by Dr. Jeffrey Kraft. The narrative says the following:

"Resident has mobility limitations that significantly impair his ability to participate in activities of daily living in a reasonable time. The wheelchair will significantly improve the resident's ability to participate in MRADLS, the resident is willing to use the high back wheelchair, a cane/walker has been eliminated as treatment option, a caregiver can adequately propel the high back wheelchair. The wheelchair will fit in the resident's home. The resident is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift."

Also included in the file were shower review documents. According to the documents, Resident A was showered on 10/11/2025, 11/12/2025,11/15/2025, 11/19/2025, 11/22/2025, and 11/24/2025. Any wounds or injuries were not noted until 11/22/2025, which notes that his buttocks were bleeding, there was a color change to black, and the wound was "pussing" and bleeding. Resident A refused a shower on 11/05/2025.

On 12/12/2025, I received a text message from Relative A1 informing me that Resident A had passed away that morning, she stated the cause of death on his death certificate is severe sepsis/septic shock.

On 12/15/2025, I attempted phone interviews with direct care staff members, Gabrielle Anderson and Shavonte Hutterson. Ms. Anderson completed the shower review for Resident A on 11/19/2025 and Ms. Hutterson completed the shower review on 11/22/2025. I left messages for both and requested return phone calls.

On 12/16/2025, I completed a phone interview with Cindy Voelker, manager at Compassus. She was not the nurse for Resident A. Ms. Voelker agreed to contact her compliance department to inquire about providing me with the nursing notes for Resident A and an interview with the assigned nurse. She indicated there had been an internal investigation completed regarding the care of Resident A but could not provide information until she has approval from the compliance department.

On 12/17/2025, I received an email from Cindy Voelker indicating she has reached out to her compliance department regarding my request for nursing notes and an interview with Resident A's nurse. She agreed to follow-up when she receives directions and that she believes a formal request may be necessary.

On 12/19/2025, I received, via email, nursing notes from Vanessa Nunley at Compassus Home Care. The nurse from Compassus that was seeing Resident A is Nancy Luna. The notes indicate that Resident A was receiving home care from 10/11/2025 until 11/21/2025. When Resident A was first assessed, on 10/11/2025, it was indicated that Resident A had ambulation difficulties and needed a wheelchair. The notes also indicated that nursing services were also employed for wound care. At this first visit, an assessment of his integumentary system was made, and it indicates he had scrapes on his knees. It is also noted that Resident A did not have any pressure ulcers at that time. A Braden Risk Assessment Scale, a standardized tool used to evaluate a patient's risk of developing pressure injuries, was completed. The scale is used to help in determining prevention strategies for the development of pressure

ulcers. On this visit, it was indicated that Resident A's score was 10 and that anything lower than 12 is high risk. It should be noted that the scale indicates that Resident A was slightly limited in sensory perception and was not always able to communicate discomfort or the need to be turned or has some sensory impairment which limits the ability to feel pain or discomfort in 1-2 extremities. The assessment indicated that Resident A's linens should be changed three times in 24 hours and that he was completely immobile and did not make even slight changes in body or extremity position without assistance. The notes also indicate that Resident A required frequent repositioning with maximum assistance.

On the notes for 11/21/2025, it indicates that the nurse had a meeting with the family to discuss moving Resident A to hospice care. They also indicated that Resident A was not engaged during the appointment and was sleeping. The notes indicate that Ms. Luna completed an integumentary system assessment and it is noted that bruising and scabbing from previous falls were observed. There are no notes regarding pressure ulcers.

On 12/26/2025, I attempted telephone interviews with direct care staff members, Gabrielle Anderson and Shavonte Hutterson. I left a message with a request for a return call.

On 01/06/2026, I sent an email to jim@courtyardmanor.com, requesting assistance with arranging telephone interviews with Gabrielle Anderson and Shavonte Hutterson.

On 01/08/2026, I completed a telephone interview with registered nurse, Nancy Luna. Ms. Luna is the nurse who was assigned to Resident A from Compassus Home Care. She did not perform the admission examination for Resident A. She did two assessments on his bottom early on in his care and he did not have one. She advised Relative A1 to purchase a coccyx pillow for Resident A, to keep pressure off his bottom and she did. She educated the aid at the home on pressure ulcers and showed her how to do massages to help prevent them. She did see him on 11/21/2025 and was not able to perform a full skin assessment on Resident A, as he was sitting in his wheelchair during the visit and was sleeping. Ms. Luna and Relative A1 both tried to wake him up but were not successful. At that visit, she recommended hospice for Resident A and Relative A1 agreed. Ms. Luna stated the pressure ulcer happened from Resident A sitting all day and possibly being left in wet briefs. He was not eating and was dehydrated, which would have made the ulcer progress more rapidly, but it was something that most likely developed over the course of a week or two. She stated something like this should not be happening in a facility and they should have been re-positioning him regularly from the beginning. She stated he would not have been able to tell anyone if he was in pain. She stated this happened due to the facility not doing what they were supposed to be doing. Ms. Luna stated if they had been showering and changing Resident A as they should have been, they would have noticed the pressure ulcer prior to it becoming as large as it was. When pressure ulcers reach the severity of the one Resident A had, they are harder to heal and are painful.

On 01/09/2026, I completed a telephone interview with direct care staff member, Gabrielle Anderson. Ms. Anderson is the direct care staff member who signed the shower review for Resident A for 11/19/2025. Ms. Anderson remembers giving that shower, as Relative A1 showed up while she was showering Resident A. She looked at Resident A's bottom and did not see any sores. Resident A was not changed much because he was not a heavy wetter. His linens were changed only when he was showered, and his briefs were checked every two hours. She denied having any concerns regarding the care Resident A received.

On 01/12/2026, I received an email containing documents sent via mail, from Relative A1. One of the included documents are the medical records for Resident A from his hospital admission on 11/24/2025. The records indicate that Resident A arrived in the emergency department on 11/24/2025 ill appearing and toxic appearing. He was unresponsive and cachectic. The chief complaint was altered mental status, and he was found to be severely hypotensive. He had a large unstageable pressure wound with significant surrounding erythema, concerning for cellulitis. His mental status improved with fluids. He was evaluated for hospice. The records indicate he has had a progressive decline over the last few months. His cat scan showed necrotizing fasciitis, chronic pelvic fractures, and a large stool burden in the colon. It also showed that there was a subcutaneous gas measuring approximately 6 cm transverse by 1.6 cm in dimension, extending over a 14 cm craniocaudal distance extending from approximately the S3 level inferiority to the perianal subcutaneous tissue and then into the ischiorectal fossa fat bilaterally, which is concerning for necrotizing fasciitis. The records indicate that Resident A was in septic shock and his diagnoses upon admission were necrotizing fasciitis, hypotension, hypoxia, abnormal heart rhythm, altered mental status, and pressure injury of sacral region, unstageable.

In the documents was a copy of Resident A's death certificate. It indicated that Resident A died on 12/12/2025 and the cause of death is listed as severe sepsis with septic shock.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Based on the information gathered during this special investigation, it has been determined that the licensee did not follow instructions or recommendations of Resident A's designated health care professional. Resident A had a signed physician's order in his file, dated 10/15/2025, indicating he was at high risk for developing pressure ulcers. On 10/11/2025, Resident A's home care nurse indicated he was at high risk for developing a pressure ulcer and would need to be repositioned

	due to him not being able to do it himself and that he would have difficulty feeling pain and expressing that he is feeling it. On 12/09/2025, when I completed my interview with the Courtyard Manor Farmington Hills IV nurse, Ashlee Eddie, she explained that Resident A was not receiving the protocol they put in place for residents who are at risk of developing pressure ulcers and that he was not at risk of them due to her stating he was able to reposition himself. The physician's order and nursing notes indicate he was at high risk for developing pressure ulcers and the physician's order was in the file for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Courtyard Manor Farmington Hills gave relative A1 prescription medications for another resident.

On 12/08/2025, I completed a phone interview with Relative A1. Relative A1 is also the guardian to Resident A. On 11/28/2025, Relative A1 went to gather Resident A's belongings and was given a trash bag full of prescription medication, which had the name of another resident on it, when she contacted the nurse, she was advised to dispose of the medication.

On 12/17/2025, I received a photograph, via text message, from Relative A1, of prescription medication. There were three bottles, and the labels all stated they were amlodipine 10mg tablets. The name on the bottles was not the name of Resident A.

On 01/02/2026, I sent an email to jim@courtyardmanor.com, requesting the information for the resident whose name was on the prescription bottles.

On 01/09/2026, I completed a telephone interview with direct care staff member, Jaslin Allen. Ms. Allen has been employed at Courtyard Manor Farmington Hills for approximately three years and is now a team lead. She is the staff member who gave Relative A1 the wrong medication to take home. She was in the office when Relative A1 came to retrieve Resident A's belongings. When Relative A1 arrived, she was mad and a little rude, so she wanted to hurry up and get her the belongings that had already been gathered and were in the office. There were two bags of medications in there, she did not get them all together, so she was not aware that they were each for different residents. It was an honest mistake. Resident B did not miss any medications; he is currently hospitalized.

On 01/20/2026, I completed a telephone interview with Relative B1. Relative B1 did not know about Resident B's medication being given to anyone else. She informed me that the prescription in question was for his blood pressure. When Resident B came to

Courtyard Manor Farmington Hills, he had a bag full of prescriptions, and they ordered them from their pharmacy, so she believed it may have been that. Resident B is now deceased, and his blood pressure was not a concern when he went into the hospital in December. When Resident B entered the facility, there were some hiccups in getting all the durable medical equipment he needed, but the facility did a good job and making do with what they had. She had no concerns with the care Resident B was receiving at Courtyard Manor Farmington Hills and is thankful that is where Resident B was able to go, she appreciates what they did for Resident B and felt that they really cared.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(r) Have confidentiality of records.**
ANALYSIS:	Based on the information collected during my special investigation, there is sufficient evidence to support that the confidential records of Resident B were not safeguarded. On 11/28/2025, Relative A1 went to the facility to obtain Resident A's belongings and she was handed a garbage bag with medications in it. There were three prescription medication bottles, containing medication, for Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 12/08/2025, I completed a telephone interview with Relative A1. She stated Resident A's pressure ulcer was discovered on 11/22/2025. She saw it covered in a cream on 11/23/2025 and did not realize the severity of the situation, since it was mostly covered. She was called on 11/24/2025, by registered nurse, Ashlee Eddie, informing her that Resident A had to go to the hospital. She stated they said they called her about it on 11/22/2025, which, she stated is not true.

On 12/09/2025, during my onsite investigation, I interviewed registered nurse, Ashlee Eddie. Ms. Eddie was contacted by direct care staff members on 11/22/2025, regarding the discovery of the pressure ulcer on Resident A's bottom. Ms. Eddie instructed the staff member to contact Relative A1 to ask if she wanted him to go to the hospital and Relative A1 stated she did not. Ms. Eddie saw the pressure ulcer on Resident A on 11/24/2025 and she sent him to the hospital.

On 01/09/2026, I completed a telephone interview with direct care staff member, Shavonte Hutterson. Ms. Hutterson was the first to observe and document the pressure

ulcer on Resident A. Ms. Hutterson noticed the pressure ulcer while she was showering Resident A on 11/22/2025. She reported it to the medical technician and photographs were taken. The photographs were sent to Ms. Eddie. The pressure ulcer was across Resident A's buttocks and was black. She observed pus and stated it looked like a big bruise. She was absolutely concerned. She had only been working there for approximately two weeks before that and it was her first time showering Resident A. He seemed ok that day, then took a turn for the worse after the shower. He seemed to have trouble breathing, so they got him into his bed. He seemed very tired and not like himself. They started repositioning him after that.

On 01/12/2026, I received documents via email, that were sent via mail, by Relative A1. In the documents is a statement from Relative A1 regarding the claim that she was contacted on 11/22/2025 regarding the pressure injury. She wrote that she was contacted on 11/22/2025 and was informed that Resident A had fallen in the shower and did not hit his head. The aids asked told her they didn't like how he was breathing and how his eyes looked. She was asked if she wanted them to send him to the hospital. She did not want him sent out and informed them that her and her sister, who is a nurse, would be there in 30 minutes. Her sister did not have concerns with his breathing, so they did not have him sent out. She denied that she was told of the pressure injury.

On 02/25/2026, I completed an exit conference with administrator, Jim Cubr. Mr. Cubr was informed of the findings and indicated he did not agree with all of them and would review the report.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Based on the information collected during my special investigation, there is sufficient evidence to support the claim that Resident A did not obtain needed health care immediately. The pressure ulcer on Resident A was discovered by direct care staff on 11/22/2025. In the shower review, it indicates the pressure ulcer was found and was black and "pussing". The direct care staff member's notes indicate they contacted the on-call nurse and then Relative A1, who had stated she did not want him to go to the hospital. Relative A1 denied this phone call took place. He did not receive needed health care immediately, as he had no medical attention until 11/24/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

03/16/2026

_____

Sara Shaughnessy — Date
Licensing Consultant

Approved By:

03/16/2026

_____

Denise Y. Nunn — Date
Area Manager