



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 22, 2026

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

RE: License #: AL630007352
Investigation #: 2026A0612022
Courtyard Manor Farmington Hills II

Dear Mr. 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,

A handwritten signature in cursive script that reads "Johnna Cade".

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(248) 302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007352
Investigation #:	2026A0612022
Complaint Receipt Date:	04/09/2026
Investigation Initiation Date:	04/10/2026
Report Due Date:	06/08/2026
Licensee Name:	Courtyard Manor Farmington Hills Inc
Licensee Address:	Suite 127 3275 Martin 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
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II. ALLEGATION(S)

	Violation Established?
Resident A has experienced prolonged neglect, including lack of toileting assistance and improper nutrition, leading to daily accidents and illness.	No

III. METHODOLOGY

04/09/2026	Special Investigation Intake 2026A0612022
04/09/2026	APS Referral Referral received from Adult Protective Services (APS) assigned APS worker Erica Brown.
04/10/2026	Special Investigation Initiated - Letter Email sent to APS worker Erica Brown.
04/10/2026	Contact - Telephone call received Telephone interview completed with APS worker Erica Brown.
04/13/2026	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed director of nursing Marleen Jones, PACE behavioral health specialist Evie Dickman, and Resident A.
04/13/2026	Contact - Document Received Facility documentation received via email from director of nursing Marleen Jones.
04/22/2026	Exit Conference I placed a telephone call to licensee designee Ronald Paradowicz to conduct an exit conference and review my findings.

ALLEGATION:

Resident A has experienced prolonged neglect, including lack of toileting assistance and improper nutrition, leading to daily accidents and illness.

INVESTIGATION:

On 04/09/26, I received a referral from Adult Protective Services (APS), that in summary, indicates Resident A has been neglected for five years by the staff. Resident A urinates on herself every day. Resident A tells staff that she needs to urinate, but she does not get any assistance to go to the bathroom. The food Resident A is served upsets her stomach. Resident A throws up daily. The facility does not have the food that Resident A needs.

On 04/10/26, I initiated my investigation with an email to the assigned APS worker Erica Brown. I received a telephone call from Ms. Brown. Ms. Brown stated she completed an onsite investigation on 04/09/26, she interviewed Resident A, director of nursing Marleen Jones, and director of operations Kallee Lizzamore. Ms. Brown also contacted Resident A's PACE coordinator Danielle (last name unknown). Ms. Brown was advised that Resident A is off her psychiatric medications as she is refusing to take them. There is an appointment scheduled next week to discuss increasing the dose of her injection. While onsite, Ms. Brown observed Resident A walk to the bathroom independently. Once finished Resident A called for staff assistance by pushing the call button in the bathroom and staff arrived promptly to assist her with completing her toileting. Ms. Brown stated Resident A refuses to wear briefs. Ms. Brown indicated that at the time of her onsite investigation Resident A's bedroom did not smell of urine. Ms. Brown stated she is not substantiating her investigation.

On 04/13/26, I completed an unscheduled onsite investigation. I interviewed director of nursing Marleen Jones, PACE behavioral health specialist Evie Dickman, and Resident A. While onsite I observed a posted menu in the dining room that contained a minimum of 3 meals a day. The facility was tidy and odor free.

On 04/13/26, I interviewed Resident A. Resident A was observed sitting in the dining room in her wheelchair. Resident A stated she can walk but she prefers to use her wheelchair. Resident A self-propels her wheelchair, and she said that she can take herself in and out of the bathroom. Resident A stated she requires assistance with all activities of daily living. Resident A stated when she urinates in the bathroom if she pushes the button for staff assistance, they run to assist her. However, it is not the staff who is supposed to be assisting her. Resident A was unable/unwilling to provide additional information on which staff should be assisting her. Resident A stated she is supposed to have three protein shakes a day. A Premiere protein shake in the morning, an Equate protein shake in the afternoon, and a Sequel protein shake in the evening. She is not receiving them. Resident A stated that when she eats food from the facility, she gets nauseous. Resident A stated she ate breakfast this morning and it was good.

She had bacon and hashbrowns. Resident A denies feeling nauseous. At the time of this interview Resident A did not appear to be soiled and she did not smell of urine.

On 04/13/26, I interviewed director of nursing Marleen Jones. Ms. Jones stated Resident A has been non-compliant with her medications for three months. Resident A will take her long-acting injection, Prolixin and her insulin, but no oral medications. When Resident A is having a behavior, she will not allow staff to come near her to provide care, this is a behavioral pattern for Resident A. This happened to Resident A at the same time last year. Ms. Jones stated Resident A refuses to wear briefs or underwear. When she refuses staff assistance with toileting she will urinate in her wheelchair. There was a recent incident where Resident A urinated on a sofa in the common area. Ms. Jones stated Resident A can walk and toilet herself with staff assistance to ensure she is thoroughly cleaned. However, sometimes after she has finished toileting Resident A will refuse staff assistance and scream and yell at staff. Ms. Jones stated regarding the allegations related to the facility not having the food that Resident A needs. Resident A is on a regular diet with cut-up meat. Resident A is not prescribed protein drinks. Ms. Jones stated that when Resident A is sick or not feeling well, she will tell staff, call PACE, or call 911. Recently, Resident A contacted PACE and said that she was not feeling well. Resident A was sent to the hospital via EMS. She was prescribed Zofran for nausea. The medication was prescribed as needed; Resident A has not taken the medication since being discharged from the hospital.

On 04/13/26, I interviewed PACE behavioral health specialist Evie Dickman. Ms. Dickman stated Resident A has been non-compliant with her medication for three months. Resident A will take her Prolixin injection and insulin. Resident A will not allow staff to come near her to provide care, this is a behavioral pattern for Resident A. This happened to Resident A at the same time last year. Ms. Dickman stated Resident A's guardian has been contacted and they discussed Resident A's current behaviors. Ms. Dickman stated when Resident A is on her medications, she is compliant and accepts staff assistance. Ms. Dickman stated Resident A refuses to wear briefs or underwear and will urinate in her wheelchair. Ms. Dickman stated Resident A is scheduled to attend PACE daily but at this time she is coming approximately twice a week. Resident A eats all meals at PACE without issue. Ms. Dickman stated Resident A called PACE last week and said that she was nauseous and vomiting. Resident A was sent to the hospital via EMS. She was prescribed Zofran for nausea. Resident A has not taken the medication since being discharged from the hospital.

On 04/13/26, I received and reviewed facility documentation sent via email from director of nursing Marleen Jones. The information included Resident A's Information and Identification Record, Resident A's AFC Assessment Plan, Nursing Notes, Resident A's Medication List, and a Medication Refusal Statement.

The following is relevant information:

- Resident A's AFC Assessment Plan completed on 03/11/26 indicates Resident A is ambulatory, however she uses a wheelchair and walker for stability. Resident A can self-propel her wheelchair. Resident A is able to complete activities of daily living including toileting and hygiene herself with assistance from staff. Resident A is on a regular diet with cut up meats. The assessment plan further indicates Resident A will sit in her wheelchair and urinate on herself then refuse help from staff.
- I reviewed Nursing Notes dated 03/23/26 – 04/11/26. Pertinent details are as follows:
 - 04/04/26, Resident A called PACE reporting she was sick. PACE called EMS and Resident A was transferred to Henry Ford West Bloomfield Hospital. Resident A was diagnosed with nausea, vomiting, and diarrhea. She returned to the facility the same day. New med orders were sent to PACE.
 - 04/09/26, Resident A urinated on a couch in the common area. Staff had to beg Resident A to get up and take a shower. After refusing several times she agreed. The couch had to be deep cleaned by maintenance.
 - 04/11/26, meeting with Evie from PACE to discuss med noncompliance.
- I reviewed a medication refusal form signed by Resident A's psychiatrist, Dr. Ruza, indicating that he is aware that Resident A is refusing medication and has provided appropriate medical guidance.
- I reviewed Resident A's prescribed medication list. Resident A is not prescribed protein drinks.

On 04/22/26, I placed a telephone call to licensee designee Ronald Paradowicz to conduct an exit conference and review my findings. There was no answer, I left a voicemail notifying Mr. Paradowicz that no substantial violations were found.

APPLICABLE RULE	
R 400.663	Nutrition; adoption by reference.
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	Based upon the information gathered during this investigation there is insufficient information to conclude that Resident A is not receiving proper nutrition. When interviewed Resident A stated that she is supposed to receive three protein shakes a day. Resident A stated that when she eats food from the facility, she gets nauseous. At the time of

	my onsite inspection completed on 04/13/26, Resident A had recently eaten breakfast, she said that it was good. Resident A denied feeling nauseous. Director of nursing Marleene Jones denied that Resident A is prescribed protein drinks. Per Resident A's assessment plan, she is prescribed a regular diet. I reviewed Resident A's prescribed medication list she is not prescribed protein drinks. During the onsite inspection I observed a posted menu in the dining room that listed a minimum of 3 nutritious meals a day.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	<p>Based upon the information gathered during this investigation there is insufficient information to conclude that Resident A is not receiving personal care as specified in her assessment plan.</p> <p>Resident A's assessment plan indicates that she is able to complete activities of daily living including toileting and hygiene herself with assistance from staff. The assessment plan further indicates Resident A will sit in her wheelchair and urinate on herself then refuse help from staff.</p> <p>When interviewed, Resident A stated when she urinates in the bathroom if she pushes the button for staff assistance, they run to assist her.</p> <p>Director of nursing Marleene Jones and PACE behavioral health specialist Evie Dickman consistently reported that Resident A has been non-compliant with her medications for three months. As such, Resident A has been engaging in the behavior of urinating in her wheelchair or on the couch and refusing personal care from staff. Resident A refuses to wear a brief. Resident A's guardian and her psychiatrist, Dr. Ruza, are aware of Resident A's medication refusals and associated behaviors. Ms. Jones and Ms. Dickman stated that this is a behavioral pattern for Resident A. At the time of the onsite inspection</p>

	completed on 04/13/26, the facility was odor free and Resident A did not appear to be soiled.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend that this special investigation be closed with no change to the status of the license.

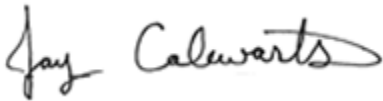


04/22/2026

Johnna Cade
Licensing Consultant

Date

Approved By:



For

04/23/2026

Denise Y. Nunn
Area Manager

Date