GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 19, 2021

Lisa Mancini
Windemere Park Assisted Living I
31900 Van Dyke Avenue
Warren, MI 48093

RE: License #: AH500315395
Investigation #: 2021A0784057
Windemere Park Assisted Living I

Dear Ms. Mancini:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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. 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 (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500315395
Investigation #:	2021A0784057
Complaint Receipt Date:	09/28/2021
Investigation Initiation Date:	09/28/2021
Report Due Date:	11/27/2021
LicenseeName:	Van Dyke Partners LLC
Licensee Address:	Suite 300 30078 Schoenherr Rd. Warren, MI 48088
Licensee Telephone #:	(586) 563-1500
Administrator:	Aaron Rodino
Authorized Representative:	Lisa Mancini
Name of Facility:	Windemere Park Assisted Living I
Facility Address:	31900 Van Dyke Avenue Warren, MI 48093
Facility Telephone #:	(586) 722-2605
Original Issuance Date:	11/15/2012
License Status:	REGULAR
Effective Date:	03/02/2021
Expiration Date:	03/01/2022
Capacity:	90
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Inadequate supervision and protection	No
Residents A is not provided adequate care	No
Additional Findings	Yes

III. METHODOLOGY

09/28/2021	Special Investigation Intake 2021A0784057
09/28/2021	Special Investigation Initiated - Telephone Interview with Witness 1
10/06/2021	Inspection Completed On-site
10/06/2021	Inspection Completed-BCAL Sub. Compliance
10/19/21	Exit Conference – Telephone conducted with authorized representative Lisa Mancini

ALLEGATION:

Inadequate supervision and protection

INVESTIGATION:

On 9/28/21, the department received this complaint from adult protective services (APS) centralized intake. Information in the complaint indicated it was denied for investigation. Additional information provided in the compliant named Witness 1 as a possible contact.

According to the complaint, several residents do not have the briefs they require. Several resident rooms have leaking ceilings when it rains and the facility uses buckets to catch the rain drops. Some employees are smoking marijuana on the job.

On 9/28/21, I interviewed Witness 1 by telephone. Witness 1 stated she was unable to recall specific residents who did not have necessary briefs. Witness 1 stated several resident rooms on the third floor of the facility leak when it rains and that residents are living in those rooms while administration is not addressing the

issue. Witness 1 stated administration has been made aware of staff using marijuana duirng breaks and coming back to work and have not addressed it. Witness 1 stated the facilities policy is that staff cannot used substances, including marijuana.

On 10/6/21, I interviewed administrator Aaron Rodino at the facility. Mr. Rodino stated he is unaware of any residents who do not have an adequate supply of briefs. Mr. Rodino stated some residents obtain briefs from family and others from the PACE program. During the onsite I inspected several rooms including rooms 336, 353, 357, 238, 247, 261 and 146 and each room was observed to have an adequate supply of briefs. Mr. Rodino stated there are a few rooms on the third floor of the building which do leak when it rains. Mr. Rodino stated the rooms with leaks are currently unoccupied as residents were moved from the rooms as soon as the leaks were discovered. Mr. Rodino stated contractors have been hired to work on the room in order to mitigate the leaking. Mr. Rodino stated that damage has been done to the ceilings of the rooms and that residents won't be moved back into those rooms until repairs can be made. Mr. Rodino identified rooms 343, 344, 345 and 359 as rooms which have had leaking. Mr. Rodino escorted me to each of the identified rooms which were all locked at the time of the inspection with no residents currently living inside. Mr. Rodino stated the facility has a zero tolerance policy regarding marijuana use. Mr. Rodino stated he recently received reporting that Staff 1 and Staff 2 had smelled like marijuana when coming into the facility after a break. Mr. Rodino stated he approached both staff and requested them to get drug tested. Mr. Rodino stated Staff 1 took the test and tested negative. Mr. Rodino stated Staff 2 refused to take the test stating she knew she would not pass the test. Mr. Rodino stated Staff 2 walked off the job at that time and never returned to work. Mr. Rodino stated that if Staff 2 had taken the drug test and tested positive, she would have been terminated.

I reviewed receipts from WINDEMERE REAL ESTATE LLC which were consistent with statements provided by Mr. Rodino regarding the work being completed on the room of the facility to address the leaking.

I reviewed the facilities *DRUG/ALCOHOL TESTING* policy, provided by Mr. Rodino, which was consistent with statements provided by Mr. Rodino. I reviewed a URINE PRELIMINARY DRUG SCREEN RESULT FORM for Staff 1, provided by Mr. Rodino, dated 9/22/21, which was consistent with statements provided by Mr. Rodino. I reviewed a document titled *NOTICE OF RESIGNATION,* provided by Mr. Rodino, dated 9/22/21, which indicated Staff 2 was resigned due to "Refusal Drug Screen" and further indicated Staff 2 "Refused to sign".

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	The complaint alleged several residents did not have adequate briefs, were left in unsafe rooms due to leaking water from the ceilings and that staff using unauthorized substances were not being held accountable. Review of evidence and observations made at the facility do not support the allegations. Based on the findings the allegations are not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents A is not provided adequate care

INVESTIGATION:

According to the complaint, Resident A requires wound care on her lower back which is not being dressed properly.

When interviewed, Witness 1 stated Resident A has a wound on her lower back by her tailbone which is not getting better do to not being adequately cleaned and dressed. Witness 1 stated staff are expected to conduct the dressing of the wound even though staff are not trained for wound care. Witness 1 stated administration is aware of this issue and will not obtain the appropriately trained staff or professionals to provide proper wound care.

When interviewed, Mr. Rodino stated he was aware that Resident A had been being treated for a lower wound. Mr. Rodino stated he was of the understanding that the wound has healed. Mr. Rodino stated staff at the facility are not expected to perform wound care on residents and that outside services are scheduled for such care.

On 10/6/21, I interviewed assisted living coordinator Kristal Stemplewski at the facility. Ms. Stemplewski provided statements consistent with those of Mr. Rodino stating Resident A's lower back wound has "resolved".

Ms. Stemplewski stated hospice had been providing wound care services for Resident A.

On 10/6/21, I interviewed Resident A at the facility. Resident A was unable to provide responses logical or specific to the questions. Resident A did report she felt safe and cared for at the facility.

I reviewed *Wound Records* for Resident A, provided by Mr. Rodino, which were consistent with statements provided by Mr. Rodino and Ms. Stemplewski.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	The complaint alleged Resident A had a wound which was not being treated appropriately. Interviews and review of Resident A's documentation do not support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

During the inspection, I observed medication technician (Med Tech) Crystal Jenkins standing by a med cart located on the first floor. I observed four small plastic med cups which contained pre-set medications inside each one. I interviewed Ms. Jenkins at that time. Ms. Jenkins stated she knew she was not supposed to pre-set the medications in such a manner. Ms. Jenkins stated she had been trained to administer one residents medications at a time. Ms. Jenkins provided no reason why she decided to set out several medications prior to administration. Ms. Jenkins stated the medications were for Residents H, I, J and K which was consistent with the names labeled on the corresponding plastic med cups and the meds as listed on the electronic medication administration record (MAR) shown on computer attached to the medication cart.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
For Reference: R 325.1901	**Definitions**
	(14) "Medication management" means assistance with the administration of a resident's medication as prescribed by a licensed health care professional.
ANALYSIS:	Based on the findings the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/19/21, I conducted an exit conference with authorized representative Lisa Mancini.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L Clum 10/18/21

Aaron Clum Date
Licensing Staff

Approved By:

Russell Misiak 10/18/21

Russell B. Misiak Date
Area Manager