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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 14, 2021

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

RE: License #: AH500315395
Investigation #: 2022A1027012
Windemere Park Assisted Living I

Dear Ms. Cavaliere-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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative 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 (517) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500315395
Investigation #:	2022A1027012
Complaint Receipt Date:	11/10/2021
Investigation Initiation Date:	11/11/2021
Report Due Date:	01/10/2022
Licensee Name:	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 Cavaliere-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?
Residents were left unattended on the third floor.	No
The facility did not have a shift supervisor on duty.	Yes
Additional Findings	No

III. METHODOLOGY

11/10/2021	Special Investigation Intake 2022A1027012
11/11/2021	Special Investigation Initiated - Letter Email sent to administrator Lisa Mancini and AR Aaron Rodino to request resident roster, employee list and October/November 2021 staffing schedule
11/12/2021	Contact - Document Sent Email sent to administrator Lisa Mancini requesting Resident A's facesheet and service plan
12/01/2021	Inspection Completed On-site
12/03/2021	Contact - Telephone call made Voicemail left with resident care provider Natisha Edge
12/03/2021	Contact - Telephone call made Telephone interview conducted with resident care provider Ejanee Cole
12/03/2021	Contact - Telephone call made Telephone interview conducted with medication technician Jessica Mitchell
12/03/2021	Contact - Telephone call made Telephone interview conducted with resident care provider Moet Nevins
12/06/2021	Contact - Telephone call made Telephone interview conducted with resident caregiver Natisha Edge
12/14/2021	Contact - Telephone call made

	Telephone interview conducted with staff coordinator Kristal Stemplewski and additional documentation requested
12/14/2021	Contact - Document Received Documentation received from Ms. Stemplewski
12/14/2021	Contact - Document Sent Email sent to authorized representative Aaron Rodino requesting level of care documentation
12/14/2021	Contact – Document Received Level of care documentation received from Ms. Stemplewski
12/14/2021	Inspection Completed – BCAL Sub. Compliance
12/17/2021	Exit Conference Conducted with authorized representative Ms. Cavaliere-Mancini and administrator Mr. Rodino

ALLEGATION:

Residents were left unattended on the third floor.

INVESTIGATION:

On 11/10/21, the department received a complaint which read residents were left unattended on the third floor of the facility. The complaint read Resident A called the police and stated to them she had been on the ground for one hour without staff to help. The complaint read

> "(Resident A) (85) resides in a senior living facility on the dementia floor. On 11/1/21 at 9:30 pm, (Resident A) was on the floor for an hour and nobody was around to help her get back up. She had to pull a fire alarm to get help to come. Fire and police arrived on scene. The floor had dementia patients wandering around and no staffing to watch them. It is unknown how long they leave the floor unsupervised. The management could not explain why there was no staffing for the residents."

On 12/1/21, I conducted an on-site inspection at the facility. I interviewed administrator Aaron Rodino. Mr. Rodino stated Resident A has history of dementia with sundowners. Mr. Rodino stated Resident A complains of headaches and hears music playing frequently in which she will call the police for help. Mr. Rodino stated Resident A will state "I need someone to tell me why I'm here." I interviewed staff coordinator Kristal Stemplewski. Ms. Stemplewski's statements regarding Resident A were consistent with Mr. Rodino. Ms. Stemplewski stated Resident A complains of

headaches daily around 4:00 PM and hears music playing in which will often call the police to ask for it to be turned off. Ms. Stemplewski stated Resident A has auditory hallucinations and her physician has been notified. Ms. Stemplewski stated Resident A has an appointment with her physician to evaluate the hallucinations. Ms. Stemplewski stated she worked the floor as a medication technician on 11/1 when Resident A called the police but had left the facility around 9:00 PM and then spoke with the Fire Marshall around 10:45 PM. Ms. Stemplewski stated Jessica Mitchell was the medication technician who worked after her then Sharron Montgomery. Ms. Stemplewsi and I reviewed the staffing schedule for October and November. Ms. Stemplewski stated the facility's goal is to have eight care staff on days/afternoons and four on midnights. Mr. Stemplewski stated on day and afternoon shifts there are two resident care providers (RCP) on first and second floors, one resident care provider on third floor and one medication technician assigned to each floor as well. Ms. Stemplewski stated the midnight shift has one resident care provider per floor and one medication technician. Ms. Semplewski stated the midnight medication technician will float to each floor to cover staff when they need a break, so the floors are not left unattended. Ms. Stemplewski stated the shift supervisor for each shift is always the first-floor medication technician. Ms. Stemplewski stated the first and third floors are less acuity while the second floor requires higher acuity staffing due to residents with dementia. Ms. Stemplewsi stated there was some confusion when the police and Fire Marshall visited the facility on 11/1 in which staff were not able to locate Resident A's facesheet. Ms. Stemplewski stated she re-educated staff after the incident. Ms. Stemplewski stated police conducted a wellness check two weeks to check on the facility's staffing. While on-site, I attempted to interview Resident A however she was sleeping. While on-site, Mr. Rodino requested his staff run a record of Resident A's call pendant use on 11/1, in which records revealed she did not utilize her call pendant at all that day.

On 12/3/21, I conducted a telephone interview with midnight shift resident care provider Moet Nevins who stated the police were at the facility when she arrived for her shift. Ms. Nevins stated the police asked for her name to make a report.

On 12/3/21, I conducted a telephone interview with resident care provider Ejanaee Cole who stated the facility is short staffed. Ms. Cole stated Ms. Stemplewski assisted on the floor until around 8:00 PM, then the medication technician Ms. Mitchell left at 9:00, then she and Ms. Edge worked the floor. Ms. Cole stated the police/Fire Marshall were at the facility around 10:00 PM.

On 12/6/21, I conducted a telephone interview with resident care provider Natisha Edge who stated she worked the first floor on the night of 11/1 and there was a resident care provider assigned to all three floors that night.

I reviewed the police investigation report which read the occurrence was 11/1/21 at 22:37 [10:37 PM]. The report read Officers Addis and Rauen responded to a radio run around 2100 [9:00 PM] at the facility for Resident A, who was on the ground and had no one to help her off the ground for an hour. The report read Officers Addis and

Rauen were disregarded by dispatch due to a callback from the facility staff saying someone helped Resident A up. The report read upon arrival, Officers Addis and Rauen spoke with Squad 4's Lieutenant who stated elderly residents were left unattended and wandering the halls of the third floor in distress. The report read Squad 4 had been called to the location by Resident A who had attempted to leave and set off the fire alarm. The report read Officers Addis and Rauen had interviewed staff Ms. Edge who stated the staff member who worked the third floor had left early and residents were left without a care provider for approximately one hour. The report read Ms. Edge had come in early (7:45 PM) to help due to being short staffed when her shift started at 11:00 PM. The report read Officers Addis and Rauen interviewed medication technician Sharron Montgomery who was assigned to work the third floor and would be distributing medications to other floors, in which the residents on third floor would be left alone. The report read Officers Addis and Rauen interviewed resident care provider Ms. Nevins who stated she was working the third floor with Ms. Montgomery. The report read Officers Addis and Rauen requested to speak with a supervisor and Ms. Edge stated there was not a supervisor on site.

I reviewed the resident roster. There were approximately 19 residents on first floor, 22 on second floor and 14 on third floor.

I reviewed the levels of care assigned to each resident on third floor. There was one resident designated as a level one, 12 residents designated as a level two, and one resident designated as a level three. I reviewed the facility's assessment of each level of care. Level one assessment read residents who do not require special precautions or monitoring, eat independently or with setup, generally continent, independent with eating, dressing and ambulation, skin intact, requires oral medications only, can self-manage decision making skills and is socially appropriate. Level two assessment read residents who have intermittent episodes of illness, need encouragement to eat, use incontinence products independently, require supervision/ stand by assist, require cueing/encouragement with mobility, require creams/lotion/powder applied by staff or history of skin breakdown, require alternate route medication such as an inhaler or eye drops, require cueing/encouragement for meals and activities as well as require frequent staff intervention for mild confusion or forgetfulness. Level three assessment read level residents who have advanced stage of chronic disease or cognitive impairment, but are stable, need special food preparation, request regular assistance with toileting or incontinence, require some physical assist with hygiene/dressing, require stand by assist or minimum assist with transferring: ambulate independently, skin/wound requires clean technique dressing changes by staff, require 11 or more medications per day or require routine blood sugar testing, does not use the call light-requiring extra supervision every two hours for toileting or walking, and some behaviors which require an intervention plan.

I reviewed the monthly staffing schedule from October through November 2021. The schedule from 10/7 through 11/3 read on most days were at least three medication technicians scheduled on day and afternoon shifts. The schedule read on most days there were three or more RCPs scheduled on all three shifts. The schedule from 11/4

through 12/1 read on most days were at least three medication technicians scheduled on day and afternoon shifts, and two on midnight shift. The schedule read there were one or two full time RCPs scheduled for day and afternoon shifts along with agency staff. The schedule read there were two or three RCPs scheduled for midnight shift.

I reviewed the weekly staffing schedule from 10/14/21 through 11/3/21. The schedule read six to nine staff worked dayshift, five to eight staff who worked afternoon shifts, and three to five who worked midnight shift. The weekly staffing schedule for 11/1 read medication technicians were Ms. Mitchell and Ms. Stemplewski, the RCPs were Ms. Cole, Ms. Brown, Ms. Edge, Ms. White (agency) and another agency staff.

I reviewed the daily staffing schedule for 11/1/21. The top of the schedule read staff (and agency) must sign in and out with time of breaks (if there are two RCPs working on a floor only one at a time may go even if there is a medication technician on the floor). The schedule read there were three RCPs and two medication technicians on staff for the afternoon shift from 3:00 PM to 11:30 PM. The schedule read there was one medication technician and three RCPs on midnight shift from 11:00 PM to 7:30 PM.

I reviewed the RCP timecards for 11/1/21 on the afternoon 3:30 PM to 11:00 PM shift. The timecards read Ms. Edge worked 7:52 PM to 7:45 AM, Ms. Cole worked 3:04 PM to 11:22 PM, Ms. Brown worked 6:55 AM to 7:00 PM, agency staff Ms. White worked 3:09 PM to 11:07 PM and agency staff Ms. Christian worked 3:45 PM to 11:30 PM. I reviewed the medication technician timecards for 11/1 on the afternoon shift which read Ms. Stemplewski worked from 11:58 AM to 9:21 PM and Ms. Mitchell worked from 4:00 PM to 10:06 PM.

I reviewed Resident A's service plan which read she had a watch call button. The plan read she utilizes a rolling walker with assist and requires one person assist to transfer. The plan read no recent falls. The plan read Resident A has dementia (irritation) and family were to discuss medications with Program of All-Inclusive Care for the Elderly (PACE). The plan read to re-direct resident when she is irritated and that she enjoys coffee, movies, and snacks. The plan read, if possible, to walk and conversate with Resident A when she was upset. The plan was updated on 7/3/21.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.

ANALYSIS:	Staff interviews along with review of police records and facility documentation revealed although staff were not able to provide consistent statements to the police officers, there were staff on duty and assigned to third floor on 11/1 as well as the other two floors of the facility. Review of staff schedules for October and November revealed the facility utilized a staffing agency when there were not sufficient staff on duty to provide care consistent with the resident's level of care and their service plans.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not have a shift supervisor on duty.

INVESTIGATION:

On 11/10/21, the department received a complaint which read facility staff member Ms. Edge told the complainant there was not a shift supervisor on duty.

On 12/1/21, I conducted an on-site inspection at the facility. Ms. Stemplewski stated on 11/1 she worked as a medication technician/shift supervisor then Ms. Mitchell was the primary medication technician/shift supervisor for the facility. Ms. Stemplewski stated Sharron Montgomery was the midnight shift medication technician. Ms. Stemplewski stated the first-floor medication technician is always designated as the shift supervisor for each shift.

On 12/3/21, I conducted a telephone interview with third shift resident care provider Moet Nevins who stated the medication technician is the shift supervisor on duty. Ms. Nevins stated if there is more than one medication technician, then the head medication technician is the shift supervisor.

On 12/3/21, I conducted a telephone interview with resident care provider Ejanaee Cole who stated there was no shift supervisor on duty on 11/1.

On 12/6/21, I conducted a telephone interview with resident care provider Natisha Edge who stated the shift supervisor is the medication technician and on her shift that night it was Sharron Montgomery.

On 12/14/21, I conducted a telephone interview with Ms. Stemplewski. Ms. Stemplewski stated the facility maintains a weekly floor schedule of staff who actual worked in which at the top of it reads the first-floor medication technician is the shift supervisor. Ms. Stemplewski stated her timecard read she clocked in at 11:58 AM and clocked out at 9:21 PM on 11/1. Ms. Stemplewski stated afternoon shift medication technician Ms. Mitchell's timecard read she clocked in at 4:00 PM and

clocked out at 10:06 PM on 11/1. Ms. Stemplewski stated midnight shift medication technician Ms. Montgomery's timecard read she clocked in at 10:41 PM and clocked out at 7:36 AM on 11/1.

I reviewed photos sent by Ms. Stemplewski of each staff member's timecard which read consistent with her statements.

I reviewed the weekly staffing floor schedule sent by Ms. Stemplewski which read consistent her statements.

I reviewed the daily staffing schedule for 11/1/21 which read consistent with statements from Ms. Stemplewski.

I reviewed the police investigation report which read Officers Addis and Rauen requested to speak with a supervisor and Ms. Edge stated there was not a supervisor on scene.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(3) The home shall designate 1 person on each shift to be supervisor of resident care during that shift. The supervisor of resident care shall be fully dressed, awake, and on the premises when on duty.
ANALYSIS:	Staff interviews along with review of facility documentation revealed although the facility does specify the shift supervisor on duty is the first-floor medication technician, on 11/1/21 from 10:06 PM to 10:40 PM, there was not a medication technician on duty, thus there was not supervisor of resident care during that time frame.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/17/2021, I shared the findings of this report with authorized representative Ms. Cavaliere-Mancini and administrator Mr. Rodino who both verbalized understanding of the findings.

IV. RECOMMENDATION

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

12/14/21

Jessica Rogers Date
Licensing Staff

Approved By:

12/16/2021

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section