GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 18, 2022

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

RE: License #: AH500315395
Windemere Park Assisted Living I
31900 Van Dyke Avenue
Warren, MI 48093

Dear Ms. Cavaliere-Mancini:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. 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 dates 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 licensee or licensee designee or home for the aged authorized representative and a date.

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 feel free to contact the local office at (517) 284-9730.

Sincerely,

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 268-1788

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AH500315395
Licensee Name:	Van Dyke Partners LLC
Licensee Address:	Suite 300 30078 Schoenherr Rd. Warren, MI 48088
Licensee Telephone #:	(586) 563-1500
Authorized Representative:	Lisa Cavaliere
Administrator:	Aaron Rodino
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
Capacity:	90
Program Type:	ALZHEIMERS AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 03/18/2022

Date of Bureau of Fire Services Inspection if applicable: 1/31/2022

Inspection Type: ☐Interview and Observation ☒Worksheet ☐Combination

Date of Exit Conference: 03/18/2022

No. of staff interviewed and/or observed 11
No. of residents interviewed and/or observed 32
No. of others interviewed 2 Role Resident's family members

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☐ No ☒ If no, explain. No residents' funds held.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  Interviewed staff on policies and procedures.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☒ IR date/s:2/24/22 N/A ☐
- Corrective action plan compliance verified? Yes ☒ CAP date/s and rule/s: 2022A1027012 11/11/2021 1931(3)
- Number of excluded employees followed up? N/A ☒

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	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.**

I observed that Resident A and Resident B had bed rails attached to their bed frame. It was a device commonly referred to as a "bed assist" that slid underneath the mattress and was held in place solely by the weight of the occupant and mattress. Inspection revealed that the distance between the slats (horizontal or vertical supports between the perimeter of the bed rails) was large enough for a hand, foot or limb to fit through and cause possible entanglement or entrapment. This device easily slid away from the device when manipulated and posed an entrapment hazard to the occupant of the bed.

The facility had no manufacturer's guidelines available for review to determine proper installation, ongoing maintenance and correct resident assessment and use of the bed devices.

Employment records reviewed for three care staff did not include any evidence of training related to the use of mobility devices.

In addition, there was no evidence that staff were instructed on how to assess the device was secured appropriately to the bed, maintained it integrity over time, did not pose an entrapment or entanglement risk, or allowed for an open distance between the device the resident could become entrapped or entangled within. There were no manufacturer instructions for appropriate use available for review.

The use of beside assistive devices without an organized plan of protection that considers physician authorization, resident assessment for competency of safe use, proper service plan development and training to ensure staff are aware of their responsibilities to ensure safe use does not reasonably comply with this rule.

R 325.1964	**Interiors.**
	(9) Ventilation shall be provided throughout the facility in the following manner:

	(b) Bathing rooms, beauty shops, toilet rooms, soiled linen rooms, janitor closets, and trash holding rooms shall be provided with a minimum of 10 air changes per hour of continuously operated exhaust ventilation that provide discernable air flow into each of these rooms.
The residents' bathing/toilet facilities located in rooms 151, 139, 141, 144, 340, 350 and 352, and janitor closet on the first floor lacked adequate and discernable air flow.	
R 325.1970	**Water supply systems.**
	(7) The temperature of hot water at plumbing fixtures used by residents shall be regulated to provide tempered water at a range of 105 to 120 degrees Fahrenheit.
The water temperature in room 144 was 103.5 and the temperature in room 236 was 103.8.	

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, renewal of the license is recommended.

Brenda L. Howard 3/18/2022

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Date

Licensing Consultant