GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 10, 2024

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

RE: License #: AH500315395
Investigation #: 2024A0585066
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 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 (517) 284-9730.

Sincerely,

Brender L. Howard

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
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH500315395
Investigation #:	2024A0585066
Complaint Receipt Date:	07/15/2024
Investigation Initiation Date:	07/16/2024
Report Due Date:	09/14/2024
Licensee Name:	Van Dyke Partners LLC
Licensee Address:	Suite 300 30078 Schoenherr Rd. Warren, MI 48088
Licensee Telephone #:	(586) 563-1500
Administrator/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:	03/02/2024
Expiration Date:	07/31/2024
Capacity:	90
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents are being neglected in the facility.	Yes
Insufficient staff on duty.	Yes
Staff does not have training to care for the residents.	Yes
Residents are not getting their medication.	Yes
Residents are not being brought down to the dining rooms for meals.	Yes
Maintenance is not being performed at the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/15/2024	Special Investigation Intake 2024A0585066
07/16/2024	Special Investigation Initiated - Letter Emailed referral to Adult Protective Services (APS).
07/18/2024	Inspection Completed On-site Completed with observation, interview and record review.
07/18/2024	Inspection Completed – BCAL Sub. Compliance
07/23/2024	Contact Document Sent Emailed administrator Lisa Cavalier-Mancini.
07/31/2024	Contact – Face to Face 2nd visit to the facility with supervisor Andrea Moore.
12/10/2024	Exit Conference. Conducted via email to authorized representative Lisa Mancini.

ALLEGATION:

Residents are being neglected at the facility.

INVESTIGATION:

On 7/14/2024, the department received a complaint through the BCAL online complaint system. The complaint read in part, “Resident A did not get his showers, was not getting his water, did not always get his clothes changed nor was he getting the level of care that he was paying for. Resident A had numerous falls at the facility.”

On 7/16/2024, the department received a second complaint through BCAL online complaint system. This complaint was anonymous. The complaint read in part, “Resident B would be found soaking wet. There were other residents asking for assistance to the bathroom but was often ignored by staff.”

On 7/16/2024, a referral was made to Adult Protective Services (APS).

On 7/18/2024, I spoke to complainant from the first complaint. The complainant stated that Resident A was a resident at the facility since 2019 and he had declined a lot. She said that there have been days where they would call her to come help get him back into bed. She said that Resident A had developed bed sores, and the facility didn’t give him showers. She said he had falls when at the facility.

On 7/18/2024, I spoke to Relative A1 who statements were consistent to the complainant. She said that she visited Resident A at the facility every Sunday. She said that the facility did not shower Resident A. She said that she had to do his nails. She said that Resident A could get himself in the wheelchair, but he fell.

On 7/18/2024, an onsite visit was completed at the facility. I interviewed administrator Lisa Cavaliere-Mancini at the facility. Ms. Cavaliere-Mancini stated that they are providing care to their residents. She said that they have PACE participants, and they are having problems with the service that they are providing. She said that PACE also have another agency that provides care. She said that their staff have to change the residents because PACE employees don’t always do it. She said that Resident A was not always in compliance with care. She said that he wanted his daughter to come in and do his showers.

I interviewed Employee #1 who statements about Resident A and Resident B were consistent with Ms. Cavaliere-Mancini. Employee #1 stated that Resident A would have falls because he would often refuse to push the pendant. She stated that Resident A was hospice. She stated that they monitor the residents because PACE employees will not do it. Employee #1 stated that they would have try different approaches to get Resident A to comply. She said that they found out that he likes

ice cream, and they would often give him some. She said that the family of Resident A was ask could they put skid socks on him to prevent falls.

On 7/30/2024, I interviewed Witness #1 by telephone. Witness #2 stated that residents who are PACE participants are not being taken care of and their needs are not being met. Witness #1 stated that PACE hired a company to provide care because they said the facility staff was not taking care of the residents but the company, they hired, was not doing nothing for the residents and had to often be reminded to do things.

I interviewed PACE worker #1 who stated that they are responsible for doing all care for the residents which includes taking them to the bathroom, showering, monitoring and any care that they may need.

During the onsite, I interviewed Resident B at the facility. She said that staff takes a long time when she calls them. She said that she would ask them to take her downstairs and they won't take her. She said that she has to stay up there all day. She said that she doesn't always want to go to PACE activities, but they tell her she has to go.

During the onsite, I interviewed Resident C at the facility. She said that she was okay but sometime staff will be taking care of others, and it takes a long time to receive care.

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.

R 325.1901	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Residents don't always get the care consistent to their service plan. Although they may be PACE participants, they are still residents of the facility. Therefore, the facility is expected to meet the residents' needs. The facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED.**

ALLEGATION:

Insufficient staff at the facility.

INVESTIGATION:

The complaint alleged that Resident A did not always get his depends on changed due to the facility having very poor staffing.

The complainant stated that residents are left unattended to and in jeopardy of severe neglect. The complainant said that Resident A did not always gets his depends on changed due to the facility having poor staffing. The complainant stated that there were only two staff to care for the residents.

Relative A1 stated that Resident A would attempt to get himself out of the chair and would fall. Relative A1 stated that the facility has agency staff in the building.

Ms. Cavaliere-Mancini stated that there are 16 private pay residents and 31 PACE residents. She said there is usually five aides that are from the 1-3 floor. She said that PACE has a station on the third floor. She said that a PACE worker should be on each floor.

When I entered the facility, I was allowed entry by Employee #2. Once Employee #2 allowed me entry into the facility she got on the elevator. I stood at the entry waiting on Ms. Cavaliere-Mancini and there were no other staff on the floor at that time.

When Employee #2 returned I asked her if there were any staff on the floor and she responded and said that there is one that supposed to be on the floor. I asked did she know where the aide was, and she said no.

A review of the staff schedule for the month of June 2024 notes that med tech are the shift supervisor. The staff schedule shows discretions, for example:

On 6/3/2024 - Afternoon Shift (3:00 p.m. – 11:30 p.m.):
Floor 1: one med tech until 7 p.m. – no aide listed.
Floor 2: No med tech listed, one care aide.
Floor 3: Midnight Shift: (11 p.m. – 7:30 a.m. – one med tech, one aid on second floor, one on the third floor – no aide on the first floor.

On 6/4/2024 – Morning Shift (7:00 am – 3:30 p.m.):
Floor 2: No med tech, one aide until 7 p.m., one aide until 8 p.m.
Floor 3: One med tech, and one aide
Afternoon shift (3:00 pm. – 11:30 p.m.)-One aide until 7 pm, one aide until 8 pm

On 6/14/2024 – Afternoon Shift (3:00 p.m. – 11:30 p.m.):
Floor 1: Agency Staff,
Floor 2: Agency Staff, 4p.m. – 8 p.m. one staff until 7 p.m.,
Floor 3: one med tech and the only aide was no call no show.
Midnight Shift (11 p.m. – 7:30 p.m.) one med tech to do first and second floor, two aides called in, one aide on third floor.

On 6/17/2024 – Afternoon Shift (3:00 p.m. – 11:30 p.m.):
One med tech, one aide, floor 2 (4-8pm) one aide.

On 6/21/2024 – Afternoon shift (3:00 p.m. – 11:30 p.m.)
Floor 1: One med tech, agency staff.
Floor 2: No staff listed; Floor 3: one med tech until 7:00 p.m. and one aide until 7:00 p.m.
Midnight shift (11 p.m. – 7:30 p.m.) one med tech and one aide, no aide listed on the second floor or the third floor.

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:	There were not enough staff to care for the needs of the residents. There were discrepancies from the expected staff schedule to actual staff working. Therefore, this claim was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff does not have training to care for the residents.

INVESTIGATION:

The complainant stated that the staff is untrained.

Ms. Cavaliere-Mancini stated that all staff are trained to care for the needs of the residents. She stated that the agency staff was not trained by the facility. She said the staff was not trained to be familiar with the residents. She said the facility trained their staff and PACE trained their own staff.

Employee #1 stated that she was trained in caring for the residents. She said staff is trained with another staff and they have to complete a check off sheet and show that they are competent in providing care for residents.

A review of training documents show that training was consistent to Ms. Cavaliere-Mancini and Employee #1 statements that facility staff were trained, but agency staff provided by PACE were not trained.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**

ANALYSIS:	Facility is not training agency staff provided by PACE, even though the agency staff are consistently providing care to facility residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are not getting their medication.

INVESTIGATION:

The complaint alleged that Resident A was not given his medication correctly. The complaint alleged that Resident A was given morphine instead of his prescribed anxiety medication. The complaint alleged that medication is always given late to the residents. The second complaint alleged that medication is always late. The second complaint was anonymous, and further information could not be obtained.

Ms. Cavaliere-Mancini stated that they have been having problems with PACE with the medication coming in late.

Employee #1 stated that all medication that is given to their residents are given as prescribed. She said all refusals are documented. She said that PACE provide their residents with medication.

Resident B said that some of the “girls” had the wrong medication cart trying to give me my medication. Resident B could not remember who the aide was that she interacted with regarding the med cart. Resident B said they gave her two pills and she told them it wasn’t right. She said that she knows her medication and know what she is supposed to take. Resident B said they are always late with her medication.

Resident C said that she gets her medication on most days, but she can’t remember if they give it on time.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.

ANALYSIS:	Morphine and anxiety medication were both PRNs and both were given on certain days. There is no evidence to suggest that they were given as needed. Based on interview with Ms. Cavaliere-Mancini, medication has been coming in late from PACE, therefore the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are not being brought down to the dining room for meals.

INVESTIGATION:

The complainant alleged that residents are not being given their meals and sometimes they are not bringing them down to the dining room to eat.

Ms. Cavalier-Mancini stated that PACE is responsible for bringing their residents to meals. She said that residents didn't eat until they stepped in and start doing it.

Resident B stated that sometimes the aides forget to come get them and they must try to go by themselves. She said that some of the other residents who can't go by themselves don't always eat.

Resident C was making a sandwich in her room and said they have not brought her lunch yet. She said that she didn't know if they were going to bring it. She said they forget her sometimes.

During the visit, I observed residents eating lunch in the dining room. I didn't see any staff in the hallways delivering lunch at that time. I was in Resident C's room for a while talking, and no one came to bring her lunch at that time.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular mealtimes. A home shall make snacks and beverages available to residents.

ANALYSIS:	Residents are not always getting their meals. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Maintenance is not being performed at the facility.

INVESTIGATION:

The complaint alleged that the facility is falling apart due to lack of maintenance.

Ms. Cavaliere-Mancini stated that they do have a maintenance person that complete repairs for the building. She stated that they have a new roof and there are no leaks in the building. She said that they are in the process of getting a new ice machine

During the onsite, I observed broken and stained tile in a resident's room. The ceiling tile was wet that appeared from a leak. There was a broken air conditioning unit on the second floor which was unplugged. I also observed a broken ice machine in the kitchenette on the first floor.

I interviewed Employee #3 at the facility. Employee #3 stated that he does all the maintenance in the building. He stated that he did not know that the air conditioning unit was broken. He said that there are no leaks, and he has not made it to repair the tile in the room.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Maintenance is not always completed at the facility as evidenced by several items needing repair. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Cavalier-Mancini said that they have two smokers. She said that staff supposed to keep the lighter and give it to the resident only when they go out to smoke.

During the onsite, I observed Resident D sitting at the dining room table. At the table there were two cigarettes and a lighter.

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.**
R 325.1901	**Definitions.**
	(**p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision**
ANALYSIS:	Resident E had access to a cigarette lighter in the dining room of the facility. This can be dangerous to other residents who were also present in the dining room if they pick it up. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite investigation, I inspected the medication cart, and one was found to be unlocked with no medication tech nearby.

A review of the controlled substance shift inventory showed that the narcotic sheet was consistently completed at shift change.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(i) The name of the prescribed medication.** **(ii) The prescribed required dosage and the dosage that was administered. Page 12 *Courtesy of Michigan Administrative Rules*** **(iii) Label instructions for use of the prescribed medication or any intervening order.** **(iv) The time when the prescribed medication is to be administered and when the medication was administered.** **(v) The initials of the individual who administered the prescribed medication.** **(vi) A record if the resident refuses to accept prescribed medication and notification as required in subdivision (c) of this subrule.** **(vii) A record of the reason for administration of a prescribed medication that is on an as-needed basis.**
ANALYSIS:	The staff did not have the medication cart locked which could easily be assessed by residents and other unauthorized staff. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Cavaliere-Mancini stated that residents' rooms are cleaned every day.

During the onsite, residents' rooms were inspected. Several rooms had the smell of urine.

APPLICABLE RULE	
R 325.1962	**Exteriors.**
	(2) The premises shall be maintained in a safe and sanitary condition and in a manner consistent with the public health and welfare.
ANALYSIS:	Residents' rooms were not always clean and free from smells. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/31/2024, another onsite visit was completed at the facility, including Andrea Moore, Long-Term-Care State Licensing Section Manager. During this onsite visit, a meeting with the Administrator was held to discuss the expectation that the facility ensure care, medication administration, and meals are provided to the residents, regardless of participation status with PACE.

The Administrator explained the PACE contract, and that PACE is actively providing care for their residents through agency staff. The Administrator explained when the call pendant is pressed from a PACE resident, the request for care is received by the facility, but that agency staff are providing care to the PACE residents. The Administrator said that there is nothing on the door that identifies PACE residents.

The Administrator acknowledged the importance of ensuring care is provided to all residents in accordance with the service plan. Methods to ensure care is provided, medications are administered, and meals are provided were identified and implemented during the onsite visit.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Brandon L. Howard

12/10/2024

_____

Brender Howard Date
Licensing Staff

Approved By:

12/10/2024

_____

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