



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

Lorenzo Cavaliere
Belmar Oakland
5990 Adams Road
Troy, MI 48098

RE: License #: AH630369651
Investigation #: 2025A0585083
Belmar Oakland

Dear Mr. Cavaliere:

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.

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) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "Brender d. 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 #:	AH630369651
Investigation #:	2025A0585083
Complaint Receipt Date:	09/05/2025
Investigation Initiation Date:	09/09/2025
Report Due Date:	11/05/2025
Licensee Name:	Windemere Park of Troy Operations LLC
Licensee Address:	Suite 300 30078 Schoenherr Rd. Warren, MI 48088
Licensee Telephone #:	(586) 563-1500
Administrator:	Kathleen Walker
Authorized Representative:	Lorenzo Cavaliere
Name of Facility:	Belmar Oakland
Facility Address:	5990 Adams Road Troy, MI 48098
Facility Telephone #:	(248) 602-2400
Original Issuance Date:	05/02/2016
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	69
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was injured during a one-person transfer, resulting in a leg cut.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/05/2025	Special Investigation Intake 2025A0585083
09/09/2025	Special Investigation Initiated - Letter Emailed administrator for a roster.
09/11/2025	Inspection Completed On-site Completed with observation, interview and record review.
09/11/2025	Inspection Completed-BCAL Sub. Compliance
09/11/2025	APS Referral A referral made to Adult Protective Services (APS)
09/30/2025	Exit Conference Conducted via email to the authorized representative Lorenzo Cavaliere.

ALLEGATION:

Resident A was injured during a one-person transfer, resulting in a leg cut.

INVESTIGATION:

On 09/5/2025, the licensing department received a complaint via BCHS online complaint. The complaint alleged that Resident A was hurt during a transfer. The complaint alleged that one person was getting Resident A out of bed and got her foot caught in the wheelchair and sustained an injury to her leg.

On 09/11/2025, a referral was made to Adult Protective Services.

On 09/12/2025, onsite was completed at the facility. I interviewed Employee 1 who stated, Resident A got her foot caught in her wheelchair and had to get stitches. She said that Resident A is a two person assist.

On 09/12/2025, I interviewed Employee #2 who stated that she took Resident A out of her chair and her foot got caught in the wheelchair. She stated that although Resident A is a two-person assist, she was transferring her that day by herself and she did not call for assistance because the other caregiver was with another resident. Employee #2 stated, she called the supervisor and was told to call 911. She said that she did an in-service about transferring. She said that an incident report was completed. She said staff were trained in the proper way to transfer residents.

On 09/12/2025, I interviewed Employee #3 who stated that she was off during the incident, but Employee #2 called her and she told her to call 911. Employee #3 stated, Resident A is a two person assist.

Service plan dated 3/26/2025 for Resident A read, "Small stroke, 1 leg don't move; transferring – two person.

A review of training documentation show that staff had in-service on 9/3/2025 regarding service plan and the proper way to transfer residents.

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.
	(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.
	(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:	<p>The complaint alleged Resident A was injured during a one-person transfer, resulting in a leg cut.</p> <p>Resident A service plan shows that she is a two person assist for transferring.</p> <p>The investigation concluded that Resident A was transferred by one person and not two resulting in an injury to her leg.</p> <p>Therefore, this claim was substantiated.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS

INVESTIGATION:

During the onsite, administrator Kathleen Walker was not there. I was told by Employee #4 that the administrator was no longer there and had not been employed there for over two weeks.

On 9/11/2025, I spoke to state licensing state Jennifer Heim who stated that she has not received any information regarding a change of administrator.

APPLICABLE RULE	
R 325.1913	Licenses and permits; general provisions.
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.
ANALYSIS:	The facility did not inform the department regarding change in administrator. Therefore, the facility did not comply with this rule.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Brender L. Howard

09/30/2025

Brender Howard
Licensing Staff

Date

Approved By:

Andrea L. Moore

09/30/2025

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

Date