GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 23, 2025

Lorenzo Cavaliere
Belmar Oakland
5990 Adams Road
Troy, MI 48098

RE: License #: AH630369651
Investigation #: 2025A1035095
Belmar Oakland

Dear Lorenzo 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.

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) 335-5985.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630369651
Investigation #:	2025A1035095
Complaint Receipt Date:	09/26/2025
Investigation Initiation Date:	09/29/2025
Report Due Date:	11/26/2025
Licensee Name:	Windemere Park of Troy Operations LLC
Licensee Address:	Suite 300 30078 Schoenherr Rd. Warren, MI 48088
Licensee Telephone #:	(586) 563-1500
Administrator:	Patricia Laugavitz
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 care was not being monitored. Facility did not follow their incident and accident policy and procedure.	Yes
Facility became understaffed on 9/26/2025 on afternoon shift. Management did not respond promptly to afternoon staff challenge.	No
Additional Findings	No

III. METHODOLOGY

09/26/2025	Special Investigation Intake 2025A1035095
09/29/2025	Special Investigation Initiated - Letter
10/28/2025	Contact - Face to Face
12/23/2025	Inspection Complete. BCAL Sub-Compliance.
12/23/2025	Exit Conference.

ALLEGATION:

Resident A was not being monitored throughout the night.

INVESTIGATION:

On September 29, 2025, the Department received an anonymous complaint through the online complaint system which read:

> "Dining staff found resident this am while delivering her breakfast blue in color. She had been left in bed with her legs above her head. Clearly no staff had checked on her if she was found by the dining staff. She had to be sent to the hospital!"

On October 28, 2025, an onsite investigation was conducted. While onsite I interviewed Staff Person (SP)1 states she is new to the facility and is unaware of an incident related to a resident being observed "blue in color" by a dietary aide.

On November 21, 2025, SP1 provided additional information stating Resident A was

last observed during a 9 a.m. medication pass. Resident A was lethargic, therefore, sent to the hospital for further evaluation. SP1 states there are no care notes or progress notes.

Through record review facility policy states for life threatening and non-life threatening events where a resident needs to be sent to the hospital the staff should:

- Notify family/ authorized representative to inform.
- Complete a transfer form and incident report
- Call 911
- Notify clinical director.

Due to the anonymous nature of the complaint, I was unable to obtain additional information from the complainant.

APPLICABLE RULE	
MCL 333.20175(1)	**Maintaining Records**
	(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided.
ANALYSIS:	Through record review facility did not follow incident and accident policy and procedure. Facility was unable to provide documentation related to Resident A's change in condition and transfer to the hospital completed by a facility staff member.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility became understaffed on 9/26/2025 on afternoon shift. Management did not respond promptly to afternoon staffing challenge.

INVESTIGATION:

On September 26, 2025, the Department received a complaint through the online complaint system which read:

> "Sunday 2nd shift - 2 staff walked off the job leaving one staff for the residents. Management was called and took forever to find solution and to come into the building and help."

While onsite, I interviewed SP1 who states, “I remember that day because it was my husband’s birthday and I was called on 9/21 that 2 staff members had walked off the job. I came in at approximately 5:30/6p to 10pm when 3rd shift relieved me. This was my 7th day on the job at Belmar.”

Through record review of statements SP2 states she was notified around 2:20 p.m. that two staff members were upset and quitting. SP1 notified. SP1 arrived at facility to assist with medication administration and resident care.

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:	Through record review and interview facility average daily census was 35 Residents. On 9/21/2025, five care staff members had been scheduled two staff members “walked off” leaving three care staff onsite. The facility contacted SP2 notifying her of the situation. SP1 reported to the facility to provide additional help.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

11/25/2025

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Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

12/23/2025

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