GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 30, 2025

Lorenzo Cavaliere
Belmar Oakland
5990 Adams Road
Troy, MI 48098

RE: License #: AH630369651
Investigation #: 2026A1027017
Belmar Oakland

Dear Licensee:

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 877-458-2757.

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) 285-7433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630369651
Investigation #:	2026A1027017
Complaint Receipt Date:	12/19/2025
Investigation Initiation Date:	12/23/2025
Report Due Date:	02/18/2026
LicenseeName:	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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents were being physically abused and neglected.	No
The facility was understaffed.	Yes
Residents were not administered their medications consistent with home's policies and procedures.	Yes
Additional Findings	No

III. METHODOLOGY

12/19/2025	Special Investigation Intake 2026A1027017
12/23/2025	Special Investigation Initiated - On Site
12/23/2025	Inspection Completed-BCAL Sub. Compliance
12/30/2025	Exit Conference Conducted by email with Lorenzo Cavaliere and Patricia Laugavitz

ALLEGATION:

Residents were being physically abused and neglected.

INVESTIGATION:

On December 22, 2025, the Department received allegations from Adult Protective Services (APS) which read that residents had been physically abused and neglected for over a month. The allegations indicated that residents had bruises from being handled roughly by staff. APS did not open an investigation.

On December 23, 2025, I conducted an on-site inspection of the facility and interviewed staff members.

The Administrator, Patricia Laugavitz, and Employee #1 reported that three staff members had recently been terminated. One of those employees, Employee #2, was investigated for possible physical abuse; however, physical abuse could not be substantiated. Verbal abuse toward Resident A was confirmed following further investigation, and Employee #2 was terminated as a result on December 17, 2025.

Employee #1 further stated that she was aware of one resident with bruising currently, which was Resident B. She reported that Resident B's bruising was related to her medications and history of falls and that the resident was currently receiving hospice services. Employee #1 stated that Accent Care Hospice was aware of the bruising observed on Resident B's feet. She also explained that residents were checked for bruising during showers and/or while being changed, and that any identified bruising was reported to her and documented in an incident report.

During the on-site visit, I observed eight assisted living residents and 12 memory care residents. All residents appeared to be interacting positively with staff, and no noticeable or obvious bruising was observed.

I reviewed Employee #2's personnel file, which documented that she had received training including, but not limited to, resident rights, abuse and neglect, incident reporting, and care specific to memory care residents. A review of the Workforce Background Check System showed that Employee #2 was eligible for employment as of July 12, 2025.

I also reviewed the Administrator's investigation records related to Employee #2. An investigation summary dated December 16, 2025, indicated that Employee #2 was allegedly speaking with Employee #4 when she reportedly slapped Resident A after being hit by the resident. Employee #2 denied the allegation, stating she would never strike a resident. Statements from other staff were obtained; however, the allegation of physical abuse could not be substantiated. The summary noted that abuse re-education was provided for all staff.

A second investigation summary, related to a complaint dated December 14, 2025, documented that the Administrator interviewed Resident A on December 15, 2025. Although Resident A had dementia, she was able to report that Employee #2 yelled at her and was mean to her. Employee #3 provided a written statement dated December 16, 2025, indicating she had previously spoken with Employee #2 multiple times regarding her loud tone when interacting with residents. The summary read that the allegation of verbal abuse was substantiated, and Employee #2 was subsequently terminated.

Regarding the allegations of bruising to Resident B, I reviewed her resident file, which indicated she moved into the home on December 9, 2024, and resided in the second-floor memory care unit. Relative A1 was listed as her primary emergency contact. Shower logs showed that bathing was provided by Accent Care Hospice, and no bruising was documented. An incident report dated December 22, 2025, indicated that Resident B was found lying face down on her

bedroom floor. She denied pain, and no injuries were observed. Relative A1 and the hospice team were notified.

I reviewed the facility's abuse and neglect policies and procedures, which were found to be consistent with the actions taken by the Administrator.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician, by a physician's assistant with whom the physician has a practice agreement, or by an advanced practice registered nurse, for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician, physician's assistant, or advanced practice registered nurse who authorized the restraint. In case of a chemical restraint, the physician, or the advanced practice registered nurse who authorized the restraint, shall be consulted within 24 hours after the commencement of the chemical restraint.**

ANALYSIS:	In summary, an investigation into the allegations of physical and verbal abuse toward Resident A substantiated verbal abuse by Employee #2, and appropriate corrective action was taken through termination on December 17, 2025. Physical abuse could not be substantiated. Regarding the allegations of bruising to Resident B, a memory care resident with a history of falls who was receiving hospice services, there was insufficient evidence to determine that the bruising was caused by staff. Additionally, in general, observations of assisted living and memory care residents during the inspection did not reveal obvious bruising. Based on the information reviewed, the allegations were not substantiated, as the Administrator took actions consistent with the facility's abuse and neglect policies and procedures, and there was insufficient evidence to link staff to the residents' bruising.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility was understaffed.

INVESTIGATION:

On December 22, 2025, the Department received allegations from APS which read that the facility was understaffed. APS did not open an investigation.

On December 23, 2025, I conducted an on-site inspection at the facility and interviewed staff.

Administrator Patricia Laugavitz and Employee #1 reported that there were 33 residents residing in the home. They stated that the first floor housed assisted living residents, including two residents who required two-person assistance. The second-floor housed memory care residents, including one resident who required two-person assistance.

The Administrator and Employee #1 reported that employees worked three shifts: 6:00 a.m. to 2:00 p.m., 2:00 p.m. to 10:00 p.m., and 10:00 p.m. to 6:00 a.m. They stated that six staff members were scheduled to work the first and second shifts, while three staff members were scheduled to work the third shift. Employee #1

stated that she routinely scheduled additional staff due to call-offs and that both she and the Administrator picked up shifts as needed.

I reviewed the staffing schedules from December 11, 2025, through December 24, 2025. The schedules were generally consistent with staff statements; however, on some first shifts, only five staff members were scheduled, and on some second shifts, only four or five staff members were scheduled. On the third shift, three staff members were scheduled, except on December 19, 2025, and December 20, 2025, when only two staff members were on duty.

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 attestations indicated that staffing levels were generally sufficient to meet residents' needs; however, on December 19, 2025, and December 20, 2025, only two staff members were on duty. Given that residents on both floors required two-person assistance, staff would have needed to leave residents unattended to provide assistance when needed. As a result, residents' needs could not be always met. Therefore, this allegation was substantiated, and a violation cited.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents were not administered their medications consistent with home's policies and procedures.

INVESTIGATION:

On December 22, 2025, the Department received allegations from APS which read residents were administered expired medications and medications not prescribed to them. The allegations further claimed that residents were given medications to keep them asleep or sedated, medications were left on the floors of the home, and residents' blood pressures were not monitored. APS did not open an investigation.

On December 23, 2025, I conducted an on-site inspection of the facility and interviewed staff members.

The Administrator, Patricia Laugavitz, and Employee #1 reported that medications were administered in accordance with physicians' orders. They stated that the pharmacy conducted monthly audits to remove expired medications from medication carts. They further reported there were no incidents in which medications were left on the floor. Employee #1 explained that residents' blood pressures were monitored when ordered, and that Resident B's blood pressure was currently being monitored and reported to the Accent Care Hospice team.

During the on-site inspection, I interviewed Employee #5, whose statements were consistent with those of other staff. Employee #5 reported that she verifies each medication card against the resident's name in the electronic system prior to administration to ensure medications are given to the correct resident. She stated that each medication card is labeled with the resident's identifying information and medication details to verify the five medication administration rights. Medications were organized in the medication cart by resident name, and further labeled for morning, afternoon, and evening administration times.

Employee #5 and I reviewed the narcotic drawer on the first-floor medication cart. During this review, we identified medication cards labeled "Discard After 6 Months." One medication card was dated December 2024, and two were dated March 2025, indicating they expired. Employee #5 immediately removed the expired medications from the cart and stated they would be disposed of in accordance with the facility's policies and procedures.

I reviewed the findings related to the expired medications with the Administrator and Employee #1. Upon further review, it was noted that each medication card contained two different dates. Although the medications were confirmed to be expired, staff indicated they would contact the pharmacy to ensure that a clear expiration date is written on each medication card going forward.

While on-site, I observed both the first and second floors of the facility and did not observe any medications on the floor. Additionally, I observed residents alert and participating in activities on both floors.

I reviewed the facility's medication policies and procedures, which were consistent with staff interviews. The policy read, in part, that medications must be discarded or destroyed when they are expired or outdated.

I reviewed Resident B's December 2025 Medication Administration Records (MARs), which indicated she was prescribed blood pressure medication twice daily. Staff administered the medication in accordance with the prescribed parameters, and

blood pressure readings were documented twice daily. Additionally, two other residents' files were reviewed in which also recorded their blood pressures.

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.**
ANALYSIS:	Staff statements and on-site observations were generally consistent with the facility's medication policies and procedures; however, three expired narcotic medications were identified in the first-floor medication cart. Based on this finding, the facility did not follow its policy and procedures regarding expired medications, and a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Jessica Rogers 12/29/2025

Jessica Rogers Date
Licensing Staff

Approved By:

Andrea L. Moore 12/30/2025

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