



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

December 29, 2025

Lorenzo Cavaliere  
Belmar Oakland  
5990 Adams Road  
Troy, MI 48098

RE: License #: AH630369651  
Investigation #: 2026A1035002  
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,

A handwritten signature in blue ink, appearing to read "Jennifer Heim".

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**

<b>License #:</b>	AH630369651
<b>Investigation #:</b>	2026A1035002
<b>Complaint Receipt Date:</b>	10/13/2025
<b>Investigation Initiation Date:</b>	10/16/2025
<b>Report Due Date:</b>	12/12/2025
<b>Licensee Name:</b>	Windemere Park of Troy Operations LLC
<b>Licensee Address:</b>	Suite 300 30078 Schoenherr Rd. Warren, MI 48088
<b>Licensee Telephone #:</b>	(586) 563-1500
<b>Administrator:</b>	Lorenzo Cavaliere
<b>Authorized Representative:</b>	Patricia Laugavitz
<b>Name of Facility:</b>	Belmar Oakland
<b>Facility Address:</b>	5990 Adams Road Troy, MI 48098
<b>Facility Telephone #:</b>	(248) 602-2400
<b>Original Issuance Date:</b>	05/02/2016
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	08/01/2025
<b>Expiration Date:</b>	07/31/2026
<b>Capacity:</b>	69
<b>Program Type:</b>	AGED ALZHEIMERS

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Facility management team openly talks about Residents violating their rights.	No
Resident A care needs were not being met. Resident A was not fed, causing a decline.	Yes
The facility is short-staffed.	No
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

## III. METHODOLOGY

10/13/2025	Special Investigation Intake 2026A1035002
10/16/2025	Special Investigation Initiated - Letter
10/28/2025	Contact - Face to Face
12/23/2025	Inspection Complete. BCAL Full Compliance.
12/23/2025	Exit Conference.

### **ALLEGATION:**

Facility management team openly talks about Residents violating their rights.

### **INVESTIGATION:**

On October 13, 2025, the Department received an anonymous complaint through the online complaint system which read:

“I frequently come to the building while the care is not in question, it is the upper management who openly talks about residents and staff. I walked past 2 of upper management berated residence and staff and openly talking about getting rid of staff members and putting better functioning residents in the building, openly

talking about how incompetent the residents are, and how the crowd needs to change.”

On October 10, 2025, an onsite investigation was conducted. While onsite, I interviewed staff person (SP)1 who stated she’s new to the position and facility and has not heard anyone talk ill about staff or residents. SP1 states resident privacy is very important, there is no tolerance to disrespect and violating resident rights.

While onsite, I interviewed SP2 who states she has never heard management talk about staff nor residents in a disrespectful manor.

While onsite, I interviewed SP3 who states everyone is good to each other and she has no concerns.

Through direct observation, approximately five residents observed and three staff members engaging in conversation in the common area. Four residents observed in the common area on the second floor engage in conversation.

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

<b>APPLICABLE RULE</b>	
<b>MCL 333.20201</b>	<b>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.</b>
	<b>(5) In the case of a nursing home patient, the rights enumerated in subsection (2)(c), (g), and (k) and subsection (3)(d), (g), and (h) may be exercised by the patient's representative.</b>
<b>ANALYSIS:</b>	Due to the anonymous nature of the complaint, I was unable to obtain additional information from the complainant.  Through interview staff state they have never engaged nor heard management talk disrespectfully about staff or residents.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

## **ALLEGATION:**

Resident A care needs were not being met. Resident A was not fed, causing a decline.

## **INVESTIGATION:**

On October 13, 2025, the Department received an anonymous complaint through the online complaint system which read:

“Resident A went a week without eating or drinking before going out to the hospital with low blood sugar. Her mouth was full of old, decaying food! Medicine wasn't passed out, residents complained about having nothing to drink, and unanswered questions or being talked to very disrespectful from the ones over the building. Residents are left in their own urine and feces or left in the same clothes for days.”

While onsite, I interviewed SP1 who states she is unaware of an incident that involved Resident A.

On November 24, 2025, SP1 provided the following statement:

*“After lots of research, I found out that Optimal Home Health care’s nurse was at the community, called EMS and completed the discharge transfer form on 9-25-25. I have also included the clinical progress note from Optimal HH. The med tech did not initiate incident report.*

*Attached:*

- *Optimal HH discharge/transfer note 9-25-25*
- *Optimal HH clinical note 9-35-25*
- *September MAR*
- *Belmar did not complete incident report for Resident A transferring to the hospital. Education completed about incident reports to be completed as per policy including hospitalizations to caregivers and med techs. Completed 11-25-25.*
- *Optimal HH reported that on 9-30-25, she was admitted to Serenity Hospice at Corewell.”*

*Through record review of facility incident and accident policy which states for “non-life threatening but resident needs to go to the hospital staff are trained upon hire and at least annually on calling hospice if resident is on hospice, call transport to hospital, complete transfer form and incident report and fax it to the physician, provide emergency packet and a copy of current MAR , notify the clinical provider and on-call staff.”*

Through record review Resident A missed multiple doses of medication in the months of September and October with reason noted “withheld per Dr./ LPN orders.” Dr./ LPN was not identified, SP1 states staff do not write progress notes. Resident B medications had been administered as ordered for the months of September and October. Resident C medications had been administered as ordered.

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

<b>APPLICABLE RULE</b>	
<b>R 325.1921</b>	<b>Governing bodies, administrators, and supervisors.</b> <b>(1) The owner, operator, and governing body of a home shall do all of the following:</b> <b>(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.</b> <b>(2) An administrator shall meet all of the following requirements:</b> <b>(c) Be capable of assuring program planning, development, and implementation of services to residents consistent with the home's program statement and in accordance with the residents' service plan and agreements.</b>
<b>ANALYSIS:</b>	Resident A was sent to the hospital via home health care staff. Home health care staff transfer form states Resident A was hypoxic, shortness of breath, and drug-resistant UTI.  Facility did not follow policy and procedure related to incident. Resident A had a change in condition and was sent to the hospital 9/25/2025. Facility staff did not document events, fill out transfer form, or incident report.  Through record review Resident A did not receive medications as ordered. Resident B & C received medications as ordered for months in review.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

The facility is short-staffed

**INVESTIGATION:**

On October 13, 2025, the Department received an anonymous complaint through the

online complaint system which read:

“This place is severely under staff with absolutely no help from what I see every time I'm in the building. I have been in the building when there was no staff in site at all. Medicine wasn't passed out, residents complained about having nothing to drink, and unanswered questions or being talked to very disrespectful from the ones over the building. Residents are left in their own urine and feces or left in the same clothes for days.”

On October 10, 2025, an onsite investigation was conducted. While onsite I interviewed SP1 who states the facility has made several changes in staff from management to direct care members. SP1 states there were several staff let go related to poor quality of care and not meeting the standards of care. SP1 states the facility staffing goals are six staff members on days and afternoons and four staff members on midnights for a census of 34 residents.

While onsite I interviewed SP2 who states staffing is “good.” SP2 states all current staff work well together.

While onsite I interviewed SP3 who states staffing has improved over the past few months. Staff work well together.

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

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Through record review and staff interviews, facility staffs according to staffing goals. Staff interviewed stated that staffing is good and the team works well together.  Multiple residents observed in common area well-groomed and dressed appropriately.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### **IV. RECOMMENDATION**

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



12/08/2025

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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