GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 29, 2026

Lorenzo Cavaliere
Belmar Oakland
5990 Adams Road
Troy, MI 48098

RE: License #: AH630369651
Investigation #: 2026A0628010
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 (517) 335-5985.

Sincerely,

Rebekah Looney

Rebekah Looney, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH630369651 |
| | |
| **Investigation #:** | 2026A0628010 |
| | |
| **Complaint Receipt Date:** | 11/07/2025 |
| | |
| **Investigation Initiation Date:** | 11/11/2025 |
| | |
| **Report Due Date:** | 01/06/2025 |
| | |
| **Licensee Name:** | Windemere Park of Troy Operations LLC |
| | |
| **Licensee Address:** | Suite 300<br>30078 Schoenherr Rd.<br>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<br>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<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| The home was negligent in their care for Resident A. | Yes |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 11/07/2025 | Special Investigation Intake 2026A0628010 |
| 11/11/2025 | Special Investigation Initiated - email sent to administrator requesting documentation |
| 11/13/2025 | Document sent - second email sent to administrator requesting documentation |
| 11/13/2025 | Document received – email received from administrator with requested documents |
| 11/17/2025 | Special Investigation – onsite |
| 02/02/2026 | Exit Conference -conducted with Lorenzo Cavaliere |

**ALLEGATION: The home was negligent in the care of Resident A.**

**INVESTIGATION:**

On 11/10/2025, the department received a complaint that alleged Resident A had numerous falls. The complaint alleged that Resident A had a fall on 10/29/2025, had a brain bleed from the fall and died. The complaint alleged that the home did not provide proper care and treatment for Resident A after they had fallen numerous times.

On 11/17/2025, while onsite, I interviewed the administrator and Employee #1. The administrator reported that Resident A had some recent falls and was overall declining. The administrator reported that Hospice had been discussed with the son of Resident A, multiple times, but he declined.

Review of incident reports over the past 30 days revealed that Resident A had fallen twice. On 10/16/2025, Resident A fell and hit their head. They were transported to the hospital and received 5 staples. Per the progress note from the NP on 10/17/2025, Resident A is a high fall risk. Fall interventions include physical therapy

for gait training, strength, and balance. Resident A is also to have fall and safety precautions. On 10/28/2025, Resident A was sent to the hospital due to their head bleeding. The incident report states that Resident A was walking out of their room with their head bleeding.
The progress notes from the NP on 10/17/2025 and 10/24/2025 state that Resident A has stable vital signs. Additionally, both notes state that Resident A is a high fall risk with fall interventions including physical therapy for gait training, strength building and balance exercises. Both NP notes also state to continue with fall and safety precautions. The NP notes also stated that palliative care had been discussed with Resident A's son, who is the DPOA.

When I interviewed the administrator onsite, she stated that Resident A was not getting any physical therapy services. Review of the service plan for Resident A revealed that it was last updated 09/21/2025 and therapy was checked "no" as to indicate that Resident A was not receiving therapy services. Resident A's service plan states that they are independent in transferring and require 1-person assistance with mobility, but handwritten text states Resident A walks independently. The administrator reported that Resident A ambulates independently. There is nothing in the service plan that addresses Resident A being a high fall risk or that there are any fall interventions in place.

| **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.** |
| **ANALYSIS:** | Through an interview with the administrator and review of Resident A's service plan, along with the chart notes from the NP, it was determined that Resident A's service plan was not consistent in reflecting the observations and plan of care needs documented by the NP. There is no documentation to support that the home was providing fall and safety precautions to Resident A. Additionally, care needs such as physical therapy, were not provided to Resident A. Therefore, this allegation is substantiated. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

12/02/2025

Rebekah Looney Date
Licensing Staff

Approved By:

01/29/2026

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