GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 30, 2023

Lisa Cavaliere
Windemere Park Assisted Living I
31900 Van Dyke Avenue
Warren, MI 48093

RE: License #: AH500315395
Investigation #: 2023A0585023
Windemere Park Assisted Living I

Dear Ms. 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. 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) 284-9730.

Sincerely,

Brender L. 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 #:	AH500315395
Investigation #:	2023A0585023
Complaint Receipt Date:	01/12/2023
Investigation Initiation Date:	01/13/2023
Report Due Date:	03/11/2023
Licensee Name:	Van Dyke Partners LLC
Licensee Address:	Suite 300 30078 Schoenherr Rd. Warren, MI 48088
Licensee Telephone #:	(586) 563-1500
Administrator:	Shelly DeKay
Authorized Representative:	Lisa Mancini-Cavaliere
Name of Facility:	Windemere Park Assisted Living I
Facility Address:	31900 Van Dyke Avenue Warren, MI 48093
Facility Telephone #:	(586) 722-2605
Original Issuance Date:	11/15/2012
License Status:	REGULAR
Effective Date:	03/02/2023
Expiration Date:	03/01/2024
Capacity:	90
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents are getting abuse on the second floor.	No
Resident inappropriately touched another resident.	No
Residents are left in urine overnight.	No
Residents' rooms are not being cleaned.	Yes
Juice dispensers are not cleaned, and ice machine does not work.	No
Additional Findings	Yes

III. METHODOLOGY

01/12/2023	Special Investigation Intake 2023A0585023
01/13/2023	APS Referral Emailed referral to Adult Protective Services (APS).
01/13/2023	Special Investigation Initiated - Telephone Attempted contact with listed complainant. A message was left to return call.
01/18/2023	Contact - Telephone call received. Complainant returned call to discuss allegations.
01/18/2023	Inspection Completed On-site Completed with observation, interview and record review.

ALLEGATION:

Residents are getting abused on the second floor.

INVESTIGATION:

On 1/12/2023, the department received a complainant from via the Attorney General (AG) Office via BCHS Online Complaint website. The complaint alleges that another staff was told by a staff member that the memory care residents are getting abused and are turning red and green.

On 1/18/2023, I contacted the listed complainant for additional information. The complainant stated that she did not observe any abuse, but someone told her about it. She did not give me the name of the person who told her. The complainant stated that Resident A is a spitter and very combative. She stated that a staff put a sheet over Resident A's face.

On 1/18/2023, an onsite was completed at the facility. I interviewed administrator Shelly Dekay at the facility. Ms. Dekay stated that she does not have any abuse in the building, and nothing has been reported to her. She stated that all residents are safe. She stated that all staff are trained on residents' rights, abuse and ways to redirect residents.

On 1/18/2023, I interviewed Employee #1 at the facility. Employee #1 stated that she has not heard anything about residents being abused. She stated that Resident A was very aggressive and was biting and spitting. Employee #1 stated that another staff member who was from the agency spit back on the resident and was terminated.

On 1/18/2023, I interviewed Employee #2 at the facility. Employee #2 stated that all staff are trained on abuse, residents' rights, and ways to redirect residents. She stated that there is no abuse going on at the facility. She stated that there was an incident with an agency staff. Employee #2 stated that Resident A was spitting, and the agency staff spit back on the resident. She stated that staff was told not to force resident to do anything but to redirect them. Employee #2 states that the agency staff no longer works at the facility.

On 1/18/2023, I interviewed Employee #3 at the facility. Employee #3 stated that Resident A was spitting, and the agency staff did not like it. She stated that the agency staff spit back on the resident. She stated that the agency staff do not work there anymore. Employee #3 stated they have training on abuse and residents' rights.

On 1/18/2023, I interviewed Employee #4 at the facility. Employee #4 stated that she has not witness or heard about residents being abused at the facility. Employee #4's statement was consistent with Ms. Dekay and Employee #3 regarding training.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; 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 or a physician's assistant to whom the physician has delegated the performance of medical care services 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 or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	The complaint alleges that residents are being abused on the second floor of the facility. There is no evidence to support this claim. A staff member spit on a resident and was terminated. The facility reasonably complied with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

A resident inappropriately touched another resident.

INVESTIGATION:

The complainant alleged that Resident B was inappropriately touched by Resident C when she sat in the living room of the facility.

Ms. Dekay stated that nothing inappropriately happened between Resident B and Resident C. She stated that Resident C is a PACE participant that has behaviors, and they are attempting to discharge him. Ms. DeKay stated that nothing happened, but Resident B and Resident C were sitting on the couch.

Employee #1 stated that Resident C has behaviors and she heard about him grabbing her but nothing about him being inappropriately like that.

Employee #2 stated that the camera was viewed of the alleged incident between Resident B and Resident C. She stated that after they heard about the alleged incident, they immediately looked at the camera and saw that Resident C never touched Resident B. Employee #2 stated that she saw that Resident B lifted up her own gown and was redirected to put it down. She stated the camera showed that he was sitting on the right and she was sitting on the left. Employee #2 stated that never inappropriately happened between Resident B and Resident C.

The camera did not show anything inappropriately happen between Resident B and Resident C.

During the onsite, I observed Resident B at the facility. Resident B stated that everything is good. Communication with Resident B was limited due to her cognition. Resident B appeared to be safe with no issues noted.

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:	This claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are left in urine overnight.

INVESTIGATION:

Ms. Dekay stated that all residents are changed, and they are not sitting in urine overnight. She stated there is enough staff to care for the needs of the residents.

Employee #2 stated that resident's care is consistent to their service plan. She stated that residents are checked frequently, and no residents are left sitting in their urine.

During the onsite, I observed residents on all three floors. Residents appeared to be clean, no issues noted.

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:	Residents were observed to be clean and well groomed. This claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility feed residents like prisoners.

INVESTIGATION:

Ms. Dekay stated that residents are served three meals a day. She stated that residents are served according to the menu. Ms. Dekay stated that residents also receive snacks, and they have options if they don't like something that is being served.

During the onsite, a posted menu was observed. Food was served according to the posted menu. Residents were observed eating lunch. No issues noted.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(5) A home shall prepare and serve meals in an appetizing manner.

ANALYSIS:	Food was served according to the posted menu. No issues were noted with food observed being served. This claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents' rooms are not being cleaned.

INVESTIGATION:

The complaint alleges that the residents' rooms are not being cleaned, especially the second floor.

Employee #2 stated that a deep cleaning is completed every week in the residents' rooms.

Employee #4 stated that residents' rooms are cleaned twice a week and more if needed. She stated that there are regular housekeepers that do most of the cleaning.

Employee #5 stated that residents' rooms are deep cleaned once a week. She stated that there are two housekeepers.

During the onsite, the facility floors were inspected. The second-floor kitchen area was sticky. Several rooms on the second floor smelled like urine.

APPLICABLE RULE	
R 325.1962	**Exteriors.**
	(2) The premises shall be maintained in a safe and sanitary condition and in a manner consistent with the public health and welfare.
ANALYSIS:	Residents' rooms on the second floor were not clean as evidence of the smell and the floor being sticky. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Juice machine are not being cleaned and the ice machine does not work.

INVESTIGATION:

Employee #3 stated that the ice machine is in working order. She stated that if something is wrong with an ice machine, they have one in the main kitchen to use until that one is repaired.

During the onsite, I observed the juice machine and the ice machine to be clean and in working order.

APPLICABLE RULE	
R 325.1976	**Kitchen and dietary.**
	(12) Food service equipment and work surfaces shall be installed in such a manner as to facilitate cleaning and be maintained in a clean and sanitary condition, and in good repair.
ANALYSIS:	This claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

Employee #3 stated that whatever staff see an incident they are the ones that suppose to write it up. Employee #3 stated that staff are inserviced on how to properly complete an incident report.

Upon request, I received three incident reports. The reports read as follows:

> Resident A: “Resident spit in staff face. Staff pushed her (Resident A) to keep her from doing it again. We all moved away from her and that when staff spit on the lady (Resident A). No injury. She was pushed and fell back on to the floor. She didn’t hit her head on the floor. I picked her up and she was fine. Responsible party called.”
>
> Resident B: “While doing rounds, resident (A) was in her apartment with a large bruise on her head with minor cut. Resident stated she had a fall. Resident had

a large cut o her forehead, vitals taken. Resident stated that he had a headache. Physician called. Send her out for observation. Responsible party called."

Resident D: "Resident pushed pendant. Resident on bathroom floor on buttock. Resident refused to let staff assist. Notice small injury on resident's forehead. EMS was notified. Resident started being combative toward EMS, etc. Resident refused for vital to be taken. Responsible party called."

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) **The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information:** (a) **The name of the person or persons involved in the incident/accident.** (b) **The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** (c) **The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** (d) **Written documentation of the individuals notified of the incident/accident, along with the time and date.** (e) **The corrective measures taken to prevent future incidents/accidents from occurring.**
ANALYSIS:	All three incident reports were missing information. There were no correction measures completed on the forms.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION

State files were checked for incident reports from the facility. There was no incident. reports sent to the State from the facility.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	The facility did not send incident reports to the State.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

03/30/2023

Brender Howard Date
Licensing Staff

Approved By:

03/30/2023

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