GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 9, 2024

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

RE: License #: AH500315395
Investigation #: 2024A0585050
Windemere Park Assisted Living I

Dear Ms. Cavaliere-Mancini:

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 #:	2024A0585050
Complaint Receipt Date:	05/02/2024
Investigation Initiation Date:	05/03/2024
Report Due Date:	07/01/2024
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 Cavaliere-Mancini
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:	03/02/2024
Expiration Date:	07/31/2024
Capacity:	90
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A blood sugar was low, had abrasion on elbow, sheets/clothes were covered with red juice and his socks were dirty with brown substance.	No
Additional Findings	Yes

III. METHODOLOGY

05/02/2024	Special Investigation Intake 2024A0585050
05/03/2024	Special Investigation Initiated - Telephone Contacted the complainant by telephone to discuss allegations.
05/03/2024	APS Referral Referral sent to Adult Protective Services (APS).
05/03/2024	Inspection Completed On-site Completed with observation, interview and record review.
06/12/2024	Contact – Document Sent to Shelly DeKay for additional information.
06/13/2024	Contact – Document Received. Requested additional information received.
07/09/2024	Exit Conference Conducted via email to authorized representative Lisa Cavaliere-Mancini.

ALLEGATION:

Resident A blood sugar was low, had abrasion on elbow, sheets/clothes were covered with red juice and his socks were dirty with brown substance.

INVESTIGATION:

On 4/30/2024, the department received this complaint through the BCAL online complaint system. The complaint alleged that Resident A had abrasion on his left elbow, his sheet and clothes were covered with red juice and his socks had brown substance on them. The complaint alleged that Resident A's blood sugar was low and went to the hospital.

On 5/3/2024, I interviewed the complainant by telephone. The complainant stated that Resident A was on respite stay at the facility. Complainant stated that Resident A was in a semi-comatose state, and she told the nurse to do his blood sugar. She said the nurse said that they did not have a meter to check Resident A's blood sugar. The complainant stated that the facility did not call her to bring a meter. She said the staff brought Resident A some orange juice to drink and they called 911. The complainant stated that Resident A had a fall, and no one called her regarding the fall.

On 5/3/2024, an onsite was completed at the facility. I interviewed administrator Shelly DeKay at the facility. Ms. DeKay stated that Resident A was there on respite stay. She stated that Resident A is a PACE participant. She said, Resident A had a fall on 2/26/2024. She said that Relative A1 never brought the insulin. She said the nurse gave Resident A juice to bring his sugar back up. Ms. DeKay said that the nurse told Relative A1 to have Resident A sip on the juice until she returns back in the room. She said that Resident A was sent out to the hospital. She said Resident A did not have a sliding scale or monitor due to Relative A1 not bringing it in.

During the onsite, I interviewed Employee #1 who stated that Resident A was there at the facility for a respite stay for a week. She said that Relative A1 came to pick him up and he was lethargic. She said that orange juice was given to Resident A due to his sugar being low. She stated that the meter that he had was not working properly and another one was not brought in.

I interviewed Employee #2 who stated that when she was taking Resident A's blood sugar it was a reading error. She said that nurse gave Resident A some juice and Relative A1 gave him the whole thing. She said that Relative A1 did not bring his glucose machine.

Level of Care assessment sheet reads, "requires oral medication only and obtains medication through house pharmacy." The assessment show that Resident A is a level 2 resident who was admitted for a respite stay from 4/22/2024 – 4/27/2024.

I observed several residents at the facility. Residents observed during the onsite appeared to be clean, and no issues noted at that time.

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:	Resident A was a respite resident and was there at the facility for four days before being admitted to the hospital. Based on the interview and review of documentation, there is no evidence to support this claim.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

Ms. Dekay stated that Resident A was a respite resident before but don't know if they have a service plan.

I reviewed service plans for Resident B, and Resident C. The service plan shows blood pressure monitoring and blood sugar monitoring. There was no available service plan for Resident A.

APPLICABLE RULE	
R 325.1931	**Governing bodies, administrators, and supervisors.**
	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:	Resident A did not have a completed service plan. The service plan for Resident B and Resident C indicates blood sugar monitoring but does not show how often it is to be monitored. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/09/2024

Brender Howard Date
Licensing Staff

Approved By:

07/09/2024

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