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

February 6, 2024

RE: License #: AH500315395
Investigation #: 2024A1022005
Windemere Park Assisted Living I

Dear Lisa 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.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500315395
Investigation #:	2024A1022005
Complaint Receipt Date:	10/12/2023
Investigation Initiation Date:	10/13/2023
Report Due Date:	12/11/2023
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 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:	03/02/2023
Expiration Date:	03/01/2024
Capacity:	90
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) did not receive appropriate assistance.	Yes
The ROC did not receive appropriate assistance because the facility was short staffed.	No
The ROC was not provided her special diet.	Yes
The ROC was not able to enter or exit the building when she needed to.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/12/2023	Special Investigation Intake 2024A1022005
10/13/2023	Special Investigation Initiated - Telephone Call placed to complainant. No answer. Left message to return call.
11/03/2023	Inspection Completed On-site
01/04/2024	Contact - Telephone call made Videoconference held with the facility for further clarification of investigation details.
01/08/2024	Contact - Telephone call received Information exchanged with the facility via email.
02/06/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) did not receive appropriate assistance.

INVESTIGATION:

On 10/12/2023, the Bureau of Community and Health Systems (BCHS) received a referral from Adult Protective Services (APS) that in part read, "[Name of the Resident of Concern/ROC] is on dialysis, has a pacemaker and defibrillator… The individuals (residents) sometimes wait hours for their medications because there is only one person who can pass out medications. Sometimes the only staff on the floor is not trained to pass medications and the residents have to wait for a staff who is trained to start their shift… On 9/23/23, [name of the ROC] fell and was not able to get back up. She pushed the button and waited around four hours before anyone helped her." The referral was marked, "Denied," signifying that APS had determined they would not be investigating the allegations.

On 10/12/2023, a phone call was placed to the complainant, who returned the call on 10/18/2023. On 10/19/2023, I interviewed the complainant by phone, who clarified her written allegations.

The complainant explained that her mother, the ROC, was alert, oriented and able to reliably answer questions, however, was physically dependent due to both kidney and heart failure. The ROC was enrolled in the Program of All-Inclusive Care for the Elderly (PACE). Recently, she had become too weak to bear weight and needed physical assistance to transfer out of bed and into a wheelchair, to get dressed and to use the toilet. The complainant went on to say that the ROC had problems getting the attention of the care staff. The ROC would have to wait for a caregiver to answer her emergency call pendant, sometimes for as long as an hour. The complainant alleged that the facility's emergency call system did not directly summon the assigned caregivers. It was the complainant's understanding that when a resident pressed the call on their pendant, it actually rang in another part of the facility. A staff member in the other part of the facility then would contact the caregiver on the unit, leading to very long emergency call response times.

According to the complainant, on 09/23/2023, a Saturday, the ROC attempted to get out of bed unassisted at 6 am and fell. After pressing her emergency call pendent and receiving no response, the ROC placed a phone call to her daughter, the complainant, around 6:30 am. The complainant went on to describe how she placed multiple calls to the facility to get someone's attention, but the calls were not answered. The complainant acknowledged that she then called the local 911, whose operator told the complainant that they would attempt to contact the facility. Meanwhile, the ROC was able to pull herself off the floor and into the bed. According

to the complainant, no facility staff members came into the ROC's room until 10 am. The caregiver told the complainant that she (the caregiver) was there by herself. On that day the ROC did not receive her morning medications or a breakfast meal.

The complainant went on to say that the ROC did not get adequate assistance each day after that. The ROC was scheduled for her regular dialysis treatment on Monday, 09/25/2023, but when her transportation to the dialysis center arrived at the facility, the ROC was not ready, and the transport van left without her. The complainant stated that she had to arrange for a van to come back for the ROC, and the ROC did not receive her full dialysis treatment on that day. The complainant alleged that this reoccurred on the ROC's next dialysis day, Wednesday, 09/27/2023. The complainant stated that one of the caregivers untruthfully told the van driver that the ROC had decided not to go to dialysis that day. The complainant stated that this lack of assistance had put her mother's health and life at risk, as she required the dialysis treatments to remain alive.

According to the complainant, on Thursday, 09/28/2023, the ROC left the building for a physician appointment. When she returned, a caregiver wheeled her chair into her room, but did not stay to assist her with removing her coat, or to ensure that she had her pendent within reach. The ROC then attempted to take off her coat by herself, and she fell out of the wheelchair, toppling the wheelchair on top of her and obstructing the door. The facility staff were not able to get the ROC off the floor, so they called 911, who transported the ROC to a local emergency room. The ROC did not return to the facility.

On 11/03/2023, at the time of the onsite visit, I interviewed the authorized representative (AR) and the administrator. According to the administrator, the ROC required a great deal of care, and the facility tried their best to provide it to her.

When the administrator and the AR were asked to describe what had happened to the ROC between 09/23/2023 and 09/28/2023, the AR explained that she was in another section of the building on 09/23/2023 and was called to the Home for the Aged section after being informed that "someone called the police," and that a family member was coming to the facility. The AR went on to say that the ROC's family came into the building sometime after lunch, and that she (the AR), the ROC, the ROC's family member and the wellness director met to discuss what had occurred that morning. According to the AR, when she asked the caregivers assigned about not responding to the ROC's call light, the caregivers denied not responding to all of their calls. The AR acknowledged that she had no further information about what had happened to the ROC on 09/23/2023 and no knowledge of events after that date.

On 01/08/2024, via an email exchange with the facility, the administrator provided a statement written by caregiver #1 on 01/05/2024, explaining her version of what happened to the ROC on 09/23/2023. Caregiver #1 was on duty on the third floor on that day and had direct knowledge of the ROC. Caregiver #1 stated that a caregiver

assigned to another floor informed her that the ROC's family member was on the phone and was angry. The two caregivers went to the ROC's room where the ROC told them that she had fallen and had paged "hours ago," but no one came to answer the page. When the two caregivers checked the monitor, it indicated that the pager had been on "only minutes, not hours…" Caregiver #1 went on to describe how the ROC missed her dialysis appointment two days later because "the nurse had forgot to make a note of it…"

When asked to describe how the facility's call system worked, the administrator stated that the facility used a combination of pagers and a monitoring screen. The monitoring screen was located on the desk in the first-floor nursing station. For both the second and third floors, either the med tech or the most senior resident care person (RCP) held the pager. Whenever a resident activated their pendant, regardless of which floor they lived, the signal would be transmitted to both pagers and to the first floor monitoring screen, alerting the RCPs and medication techs in the building that the resident in the designated room needed help. It was the responsibility of whomever held the pager on the second or third floors or the staff member closest to the nursing station to ensure that either an RCP or a medication tech would answer the call. Care staff members on all three floors were expected to cover for one another in the event a resident on another floor needed help and the pager or monitor continued to go off.

At the time of the onsite visit, the staffing coordinator took me to both the first floor and the third floor to observe the facility's call system in action. When the staffing coordinator activated a pendant for resident who lived on the first floor, the alert appeared on the first-floor monitoring screen and on the third-floor pager as well. The alert did not disappear from the screen until the pendant was cleared.

The administrator and the AR provided a record of pendant response times that indicated that on 09/23/2023, the ROC waited for a caregiver 20 minutes starting at 9:42 am and another 20 minutes starting at 11:17 am.

At the time of the videoconference on 01/04/2024, when I asked the AR and the administrator about events that occurred on 09/25/2023, 09/27/2023, and 09/28/2023, both individuals denied having any knowledge of these events. The only documentation they were able to provide concerned the events of 09/28/2023. On 01/08/2024, via an email exchange, they provided the progress note for 09/28/2023 and the incident report. According to the progress note, "Resident returned home (and) writer assisted her to room…she (the ROC) said she was good from there. Resident is independent… I (writer) hear yelling…she (the ROC) is on floor by her entry door… She (the ROC) stood up out of the wheelchair then went to sit down and missed chair, or chair moved, and she fell. She didn't have pendant on… Writer witnessed wheelchair not locked…" According to the incident report, "Resident (the ROC) was found on floor by entry door. She stated she was going through clothes located in a cubby by entrance and bathroom to apartment and went to sit back down and missed the wheelchair. Resident didn't use W/C (wheelchair) locks. She

fell on left side. C/O (complaints of) pain on entire right side… Resident was assessed by EMT (emergency medical technician) and sent out by ambulance…"

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:	Interview and review of available documentation indicate that for the most part, the ROC did receive appropriate assistance. However, the ROC missed at least one dialysis treatment, which the facility was to coordinate transportation for.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The ROC did not receive appropriate assistance because the facility was short staffed.

INVESTIGATION:

When interviewed, the complainant alleged that the inadequate assistance provided to the ROC was due primarily to too few caregivers. According to the complainant, she had had a number of conversations with one of the facility managers, who purportedly told her that they could not help it if their caregivers did not show up to do their jobs.

At the time of the onsite visit, the administrator and the AR explained that to determine staffing, the facility used an acuity score to determine the staffing for each floor, using the total assessment care points for all residents living on the floor. In general, for the third floor, where the ROC resided, the acuity score mandated 3 care staff members including the medication tech, for both the morning and the afternoon shifts. According to the administrator, 2 care staff members, including the medication tech was the minimum acceptable staffing. The administrator and the AR acknowledged that there had been occasions when a care staff member had indicated to them that they would be coming in, but then did not show up. The AR went on to say that the facility used a staffing agency to fill positions as necessary. The agency used a phone application (app) that alerted all of their employees that a

position was opened at the facility and any eligible employees could “pick it up.” The AR went on to say that on occasion, the position might not be picked up immediately, but that this staffing agency had been fairly reliable, and they did not plan any changes. The administrator and the AR acknowledged that if the facility’s own employees did not report for duty and the staffing agency was not able to fill the position, facility managers would then “work the floor.”

The facility was asked to provide the acuity estimates per floor, the staffing schedule as worked including any agency employees, and clock-in records for the week of 09/17/2023 through 09/23/2023 were reviewed. This review revealed that for both the morning afternoon shifts, staffing needs varied between 5 and 7 caregivers; and for the overnight shift, 3 or 4 caregivers were needed. Staffing schedules and the clock-in records confirmed that the facility was not short-staffed in terms of caregivers.

When asked about the complainant’s allegation that on 09/23/2023, during the morning shift, there was only one caregiver on the ROC’s unit, the administrator explained that there were actually two care staff members on the third floor, a caregiver and a medication technician. Both the staffing schedule and the clock-in records reflected these two individuals were present.

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:	There was no evidence that the facility was short of staff.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The ROC was not provided her special diet.

INVESTIGATION:

According to the written allegation, “There are not healthy food options. They will make foods without regard to dietary restrictions…”

According to the administrator and the AR, the menus for the facility were approved by a Registered Dietitian to be healthy for the entire resident population. The administrator stated that she did not know what the ROC’s diet order was, but that

the ROC was known to have a very good appetite and would eat all kinds of food items, including snack items brought into the facility by the ROC's family.

According to both a level of care assessment, dated 10/26/2022 and the ROC's "Care Guide," the ROC was to receive a "regular renal" diet. Neither document went into any description of what was to be served to a resident on a regular renal diet.

The administrator acknowledged that residents with a diet order for a renal diet were served the same foods as residents with a regular diet order.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(4) Medical nutrition therapy, as prescribed by a licensed health care professional and which may include therapeutic diets or special diets, supplemental nourishments or fluids to meet the resident's nutritional and hydration needs, shall be provided in accordance with the resident's service plan unless waived in writing by a resident or a resident's authorized representative.
ANALYSIS:	The facility did not provide a special renal diet to the ROC.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The ROC was not able to enter or exit the building when she needed to.

INVESTIGATION:

According to the written allegation, "[Name of the ROC] is cognitively very alert… The patients are locked in their floor. They cannot get out of the building during fire alarms… If a resident returns to the facility after the doors are locked, she will wait outside for sometimes two hours before someone hears the knocking and comes to the door." When interviewed, the complainant described her difficulty entering the building and further alleged that the providers of private health care services that had been arranged for the ROC also had difficulty with access to the resident.

At the time of the onsite visit, the administrator acknowledged that none of the residents had the ability to either leave or enter the building on their own. With the exception of the main entrance, which was monitored by a receptionist during business hours, all of the entrances required a key fob, that were not distributed to

residents. Further, on the third floor where the ROC resided, the elevators could not be used without an elevator key. Like the key fob, no resident was provided an elevator key. According to the administrator, information regarding the access control had been explained to the ROC's daughter at the time the ROC moved into the facility, but there was no evidence to support this.

When the administrator and the AR were asked about outside venders and visitors ability to enter the facility, the administrator stated that before 5 pm, visitors and vendors entered through the lobby area and signed-in at the reception desk with the receptionist. After 5 pm, the doors were locked and any visitor or vender could ring the doorbell, and a care staff member would let them in.

At the time of the onsite visit, the staffing coordinator took me to the lobby to see how the doorbell worked. The doorbell was located inside a vestibule adjacent to the Home for Aged lobby. The staffing coordinator explained that when the doorbell was activated, it would sound as well as activate strobe lights that were visible on both wings of the first floor. When the staffing coordinator demonstrated how the doorbell worked, observation revealed that each time the doorbell was punched, the doorbell would issue a chime sound. A strobe light was observed on the east end of the west hallway but was only visible when facing east. From the east hallway, the chime of the doorbell was inaudible, and the strobe light could not be seen.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(2) 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.**
For Reference: R325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.

ANALYSIS:	Residents do not have a reliable way of getting into the facility should they arrive after the business hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

When the administrator and the AR were asked to provide their version of what happened to the ROC from 09/23/2023 until the day she left the facility for good on 09/28/2023, the AR was only able to recall that she had met with the ROC and the ROC's daughter after lunch on 09/23/2023. Neither individual was able to speak to the complainant's allegations of what occurred on the following days. The only documentation they were able to provide concerned the events of 09/28/2023. There were no notes regarding the call to local police, the meeting between facility representatives and with ROC and ROC's family member, and no charting pertaining to missed dialysis treatments.

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.**
	(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization.
ANALYSIS:	The facility did not document important observations regarding the ROC.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 02/06/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

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

02/04/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

01/11/2024

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