



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 25, 2025

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

RE: License #: AH500315395
Investigation #: 2025A0585066
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) 335-5985.

Sincerely,

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 #:	2025A0585066
Complaint Receipt Date:	07/03/2025
Investigation Initiation Date:	07/03/2025
Report Due Date:	09/02/2025
Licensee Name:	Van Dyke Partners LLC
Licensee Address:	Suite 300 30078 Schoenherr Rd. Warren, MI 48088
Licensee Telephone #:	(586) 563-1500
Authorized Representative/Administrator:	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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	90
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was left soaked in urine for hours with severe catheter injuries, unmet care needs, and a pressure ulcer, highlighting serious neglect and lack of proper hygiene and repositioning. Call light was not answered for over 90 minutes.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/03/2025	Special Investigation Intake 2025A0585066
07/03/2025	Special Investigation Initiated - Telephone I made a referral to Adult Protective Services (APS).
07/10/2025	Inspection Completed On-site Completed with observation, interview and record review.
07/10/2025	Inspection Completed-BCAL Sub. Compliance
07/15/2025	Contact - Document Received Requested documents received.
09/25/2025	Exit Conference Conducted via email to authorized representative Lisa Cavaliere-Mancini.

ALLEGATION:

Resident A was left soaked in urine for hours with severe catheter injuries, unmet care needs, and a pressure ulcer, highlighting serious neglect and lack of proper hygiene and repositioning. Call light did not get answered for over 90 minutes.

INVESTIGATION:

On 08/12/2025, the licensing department received a complaint via BCHS online complaint. The complaint alleged that Resident A was sitting in urine saturated sheets/mattress and staff said that his catheter was leaking. The complaint alleged

staff did not answer the call light for over 190 minutes. The complaint alleged that staff did not clean Resident A and he has a pressure ulcer on his right hip from not being repositioned enough. Due to the nature of the complaint, no additional information could be obtained.

On 07/10/2025, an onsite was completed at the facility. I interviewed the administrator Lisa Cavaliere-Mancini who stated that Resident A was no longer a resident. She said that Resident A had a wound and it was monitored by a wound care nurse. She explained that Resident A was a PACE participant who provided his care. She said the expected respond time to call lights was at least ten minutes.

Employee #1's statements were consistent with the administrator. She said that she has only been here for a couple of weeks and really not familiar with Resident A.

On 8/19/2025, I interviewed representatives #1 and #2 from PACE Southeast Michigan. Representative #1 reported Resident A is a PACE recipient. Representative #1 reported, as a PACE recipient, they provide all his care and Windemere does his housekeeping and provides all meals. Representative #1 said the wound care is provided to residents at their clinic and not at the facility. Representative #1 reported, Resident A has a catheter, and his bag leaked on the bed. Representative #1 said the care staff cleaned him up and changed his bedding after the catheter bag leaked. The representative stated they gave Resident A a new catheter bag. The representative stated that Resident A was given a special chair, and he was on antibiotics for his wound. Representative #1 stated that Resident A was moved from assisted living due to him needing more care.

Upon request, the administrator shared copies of Resident A's ADL sheet, and shower sheets.

I reviewed the ADL sheets from June 1, 2025, to July 1, 2025. The ADL sheet included showers, toileting, laundry, and safety checks. There were no issues with the ADL that was provided.

A review of the call light pendant audit report for Resident A revealed the following:

Date	Time	Duration
6/21	9:00:34 am	21:20
6/21	5:07:01 pm	01:00
6/21	8:06:08 pm	47:52
6/22	12:53:25 pm	36:46
6/22	11:44:36 am	01:41:31
6/22	01:34:59 pm	54:54
6/22	03:19:31 pm	37:40
6/22	05:01:15 pm	37:19
6/24	07:13:31 pm	24:54

6/24	09:21:13 pm	01:24:02
6/25	01:30:35 am	28:50
6/26	01:48:50 pm	22:02
6/27	07:59:29 pm	31:03

APPLICABLE RULE	
R 325.1921	Employees; general provisions.
	(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:	The complaint alleged Resident A was left soaked in urine for hours with severe catheter injuries, unmet care needs, and a pressure ulcer, highlighting serious neglect and lack of proper hygiene and repositioning. Based on interviews and a review of Resident A's ADL report, care was provided to Resident A, including wound care provided by a wound care nurse. However, the call light pendant audit shows that there were times when the respond time was lengthy. Therefore, the facility did not comply with this rule.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS

INVESTIGATION:

The administrator reported Resident A is a PACE recipient and they provide all of his care. She stated, PACE has the file, and she has to get it from them. She did not have a copy of his records. She explained that they have meetings with PACE to get updates and to discuss the residents.

PACE Representative #3 stated that there are six PACE recipients on the first floor, twelve residents on the second floor and eight residents on the third floor. She said

there are no facility employees on the second floor. Representative #3 stated, they complete incident reports for all of their participants and give the facility a copy.

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: (a) Assume full legal responsibility for the overall conduct and operation of the home.
ANALYSIS:	Resident is a PACE recipient who resided on the second floor of the facility. The administrator did not maintain a file on their own resident.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

Upon request, the administrator emailed me a copy of Resident A's service plan. Upon review of the service plan, it was last updated on 02/22/2022.

APPLICABLE RULE	
R 325.1922	Admission and retention of residents.
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Facility did not update service plan for Resident A annually. 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.



09/25/2025

Brender Howard
Licensing Staff

Date

Approved By:



09/25/2025

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

Date