



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 #: 2025A0585069
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,

A handwritten signature in cursive script, appearing to read 'Brender 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

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

I. IDENTIFYING INFORMATION

License #:	AH500315395
Investigation #:	2025A0585069
Complaint Receipt Date:	07/09/2025
Investigation Initiation Date:	07/10/2025
Report Due Date:	09/08/2025
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 found deceased.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/09/2025	Special Investigation Intake 2025A0585069
07/10/2025	Special Investigation Initiated - Telephone Contacted the complainant to discuss allegations.
07/10/2025	Inspection Completed On-site Completed with interview and record review.
07/10/2025	Inspection Completed-BCAL Sub. Compliance
07/21/2025	Contact - Document Sent Email request the administrator for additional information.
07/22/2025	Contact - Document Received Requested information received.
09/25/2025	Exit Conference Conducted via email to authorized representative Lisa Cavaliere-Mancini.

ALLEGATION:

Resident A was found deceased.

INVESTIGATION:

On 07/10/2025, the licensing department received a complaint via BCHS online complaint. The complaint read in part, "Resident A died in the care of the facility on Thursday July 3 at 6 am. Resident A was found lying in a pool of blood next to her bed deceased. The police report says she was pronounced dead at 6am I receive a phone call 2 hours later stating that my mom was wrapped up in a sheet and must have fell out of bed and hit her head and died. I have been given very limited information about this very serious incident which caused Death. I have been denied

camera access to room check that night and log documents about the last time someone seen her alive.”

On 07/10/2025, I interviewed the complainant by telephone. The complainant’s statements were consistent with what was reported in the written complaint. The complainant stated Resident A was found lying in a pool of blood next to her bed deceased. The complainant stated that she had been given very limited information and all she knows is that Resident A was wrapped in a sheet and they said she must have hit her head during the fall.

On 7/10/2025 and on 7/22/2025, onsite was completed at the facility. I interviewed the administrator, Lisa Mancini. She stated that Resident A was found deceased in her room. The administrator stated that Resident A is a PACE recipient who resides on the second floor. She said that PACE has its own workers, and the facility nurse makes rounds to the second floor. She said that they have been requesting incident reports from PACE but have not received them yet and the PACE manager will not be back until the following Monday (7/14).

On 7/22/2025, manager Andrea Moore and I conducted an interview with PACE representative #1 who stated, Resident A was found on the midnight shift. She said Resident A was found on the floor next to her bed. She said there are no facility staff on the second floor. She said PACE has residents on all three floors.

On 08/19/2025, I interviewed PACE Representative #2 and Representative #3 by telephone who stated they have PACE recipients throughout the building. Representative #2 stated that it was a very unfortunate incident that happened to Resident A. She said they received the death certificate, and it had the caused listed as cardiovascular disease. Representative #2 stated that PACE staff did not do rounding like they were supposed to, and she was terminated. Representative #2 stated that the last time someone saw Resident A was around 12:30 and the next time she was seen was at 5:00 when she was found on the floor.

A review of Resident A’s service plan in the section *Sleep Pattern* which reads: Sleep through the night. Gets up through the night. Note: Resident may get up to use the bathroom. In the section *Fall interventions* it reads: Staff will do checks every two hours. Outside Providers: PACE. Section marked *Bowel/Bladder Condition*: Toileting schedule every two hours.

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.

R 325.1901	Definitions.
	(p) "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.
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Resident A was found deceased on the floor in her room from an apparent fall. The service plan showed that checks should be completed every two hours. Based on interviews with PACE representatives, rounding was not completed as instructed in her service plan. Therefore, the facility did not comply with the rules of protection and care was not provided consistently with Resident A's service plan.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS

INVESTIGATION:

The administrator said that PACE would not give her a copy of the incident report based on their investigation not being completed. She said that Resident A is on the second floor with PACE and PACE did the rounding. The administrator stated she didn't know when the last time staff saw Resident A because PACE did not give her the information.

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:	The administrator did not have any details regarding the incident. She did not have any documentation regarding Resident A. 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