



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

February 12, 2026

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

RE: License #: AH500315395  
Investigation #: 2026A0784011  
Windemere Park Assisted Living I

Dear Licensee:

Attached is the Special Investigation Report for the above-mentioned 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. If 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 that reads "Aaron L. Clum".

Aaron Clum, Licensing Staff  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(517) 230-2778

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AH500315395
<b>Investigation #:</b>	2026A0784011
<b>Complaint Receipt Date:</b>	12/10/2025
<b>Investigation Initiation Date:</b>	12/11/2025
<b>Report Due Date:</b>	02/08/2026
<b>Licensee Name:</b>	Van Dyke Partners LLC
<b>Licensee Address:</b>	30078 Schoenherr Rd. Suite 300 Warren, MI 48088
<b>Licensee Telephone #:</b>	(586) 563-1500
<b>Administrator/Authorized Representative:</b>	Lisa Mancini
<b>Name of Facility:</b>	Windemere Park Assisted Living I
<b>Facility Address:</b>	31900 Van Dyke Avenue Warren, MI 48093
<b>Facility Telephone #:</b>	(586) 722-2605
<b>Original Issuance Date:</b>	11/15/2012
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	08/01/2025
<b>Expiration Date:</b>	07/31/2026
<b>Capacity:</b>	90
<b>Program Type:</b>	AGED ALZHEIMERS

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Inadequate care for Resident A	Yes
Resident A was not administered her breathing treatments	Yes
Additional Findings	No

**III. METHODOLOGY**

12/10/2025	Special Investigation Intake 2026A0784011
12/11/2025	Special Investigation Initiated - Telephone Interview with administrator Lisa Mancini
12/11/2025	Contact - Document Sent Email to administrator with request for investigation documentation
12/12/2025	Contact - Document Received Email received from administrator with investigative documents
02/12/2026	Exit - Email Report sent

**ALLEGATION:**

**Inadequate care for Resident A**

**INVESTIGATION:**

On 12/10/2025, the department received this complaint from adult protective services (APS) centralized intake.

According to the complaint, Resident A was admitted to the facility on 12/03/2025 and went to the hospital on 12/07/2025. During the time at the facility, when Resident A used her call light to summon staff, staff allegedly took an extended amounts of time to respond to her call light.

On 12/11/2025, I interviewed administrator Lisa Mancini by telephone. Administrator stated she was not aware of any complaints regarding Resident A. Administrator stated Resident A has only been with the facility for a short period of time. Administrator stated she would provide any documentation

needed regarding Resident A. Administrator stated Resident A is a person who is unable to transfer out of bed on her own and requires staff assistance.

I reviewed pendent call light response records, provided by administrator, dated between 12/03/2025 and 12/07/2025. The record indicated the following response times:

- 12/03/2025: .04 sec
- 12/03/2025: .04 sec
- 12/03/2025: 6 h 10min 31sec
- 12/04/2025: 14 min 52sec
- 12/04/2025: 1h 19min 10sec
- 12/04/2025: 18min 27sec
- 12/04/2025: 30min 10sec
- 12/04/2025: 1h 8min 51sec
- 12/04/2025: 2 min 10dec
- 12/04/2025: 17min 13sec
- 12/05/2025: 2h 9min 33sec
- 12/05/2025: 1h 3min 18sec
- 12/05/2025: 10h 6min 23sec
- 12/07/2025: 174h 52min 52sec

I reviewed Resident A's service plan, provided by administrator. The plan read consistently with statements provided by administrator.

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	The complaint alleged that in the short period of time Resident A was at the facility, staff did not respond to her call light in a timely manner. Evidence reviewed supports a finding.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Resident A was not administered her breathing treatments**

**INVESTIGATION:**

According to the complaint, Resident A was asking for breathing treatments as she is prescribed them twice a day and staff did not administer them to her.

I reviewed Resident A's medication administration record (MAR) from 12/03/2025 to 12/07/2025, provided by administrator. According to the record, Resident A was prescribed *ALBUTEROL SULFATE 1.25 MG/3ML*, on 12/03/2025, to be administered "Twice a day for shortness of breath" at 8am and 8pm. Administration of a medication on the MAR is indicated by staff initials in a box to the right of the scheduled time and under the scheduled date. Review of the MAR revealed no staff initials on 12/03/2025, no staff initials on 12/04/2025, no staff initials for the morning dose on 12/05/2025 and no staff initials for the evening dose of 12/07/2025.

<b>APPLICABLE RULE</b>	
<b>R 325.1932</b>	<b>Resident medications.</b>
	<b>(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.</b>
<b>ANALYSIS:</b>	The complaint alleged Resident A was not administered her breathing treatments according to her orders. Based on the findings, there is sufficient evidence to support the allegation.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

*Aaron L Clum* 2/11/2026

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 Aaron Clum Date  
 Licensing Staff

Approved By:

*Andrea L Moore* 02/12/2026

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