STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235714	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windemere Park Health and Rehab Center	31800 Van Dyke Avenue Warren, MI 48093

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34851 This citation pertains to Intake MI00145241. Based on interview and record review, the facility failed to schedule a follow up appointment for one resident (R701) of three reveiwed for quality of care. Findings include: A review of the intake allegation noted, [They] has been in the facility for approx (approximately). 2.5 wks (weeks). Staff were supposed to schedule [their] a follow-up appt. (appointment) with [their] cancer doctor, which hasn't been done. [They] . supposed to have a CAT scan (CT-Computed tomography is a noninvasive medical examination or procedure that uses specialized X-ray equipment to produce cross-sectional images of the body)w (with)/contrast done of [their] left lobe . A review of R701's medical record noted, R701 was admitted to the facility on [DATE] and readmitted [DATE] and then discharged on [DATE]. A review of R701's admission Minimum Data Set (MDS) dated [DATE], revealed R701 with an intact cognition, used a walker, and required some assistance with activities of daily living. Further review of R701's medical record revealed, progress notes, 6/12/2024 10:40 (AM) Physician Progress Note . History and Physical . this patient was recently treated for COPD (Chronic obstructive pulmonary disease). [R701] reports [R701] does have lung cancer diagnosed in the past and recommended for follow-up CT with contrast .I called oncology radiation and clinic staff reports they will fax a prescription for patient to do CAT scan of the lungs . ASSESSMENT/PLANS: Left lung primary malignant neoplasm. Placed a call to clinic of [local] oncology . spoke with clinic staff, will fax prescription for CT with contrast needed for patient before follow-up visit. Patient agreeable to do CAT scan in [local hospital] . 6/14/2024 08:20 (AM) Physician Progress Note: [local] Consultants . Placed a call to clinic of [local]/radiation oncology . spoke with clinic staff, will fax prescription for CT with contrast needed for patient before follow-up visit. Patient agreeable to do CATscan in [local hospital] . 6/25/2024 10:00 (AM) Physician Progress Note: Placed a call to clinic of [local]/radiation oncology . spoke with clinic staff, will fax prescription for CT with contrast needed for patient before follow-up visit. Patient agreeable to do CATscan in [local hospital] . 6/18: Placed a call to oncology clinic again, clinic staff and gave a prescription for CT scan of the lungs with contrast 6/20. Awaiting scripts for CT scan from radiation oncology clinic . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER: Windemere Park Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 31800 Van Dyke Avenue Warren, MI 48093	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/27/2024 08:00 (AM) Physician Progress Note: [local hospital] . Left lung primary malignant neoplasm. Placed a call to clinic of [local]/radiation oncology . spoke with clinic staff, will fax prescription for CT with contrast needed for patient before follow-up visit. Patient agreeable to do CAT scan in [local hospital] .6/18: Placed a call to oncology clinic again, clinic staff and gave A prescription for CT scan of the lungs with contrast .6/20: Awaiting scripts for CT scan from radiation oncology clinic . On 7/16/24 at 1:45 PM, the appointment clerk was asked about R701's appointments. The clerk stated [R701] didn't have any (outside) appointments .I never knew that [R701] had any appointments. I don't see any orders from the doctor. The clerk was asked about the process for outside appointments. The clerk explained, she reviews the hospital discharge summary, then talks to the resident/responsible party to find out how they want to handle any follow up appointments. If it is a new order, the clerk explained, that she would get the order from the nurse and make the appointment. On 7/16/24 at 2:15 PM, The Nursing Home Administrator (NHA) was asked about the appointments that were not made for R701. The NHA explained, she was not sure why the appointments were not made for R701, but she would look into the issue. A review of the facility's policy titled Outside Appointments/Consults undated, revealed, Residents may require outside specialty appointments, outside consults, ancillary services or any other services that require the resident to receive additional care outside of the facility. External appointments require a physician's order before the appointment can be scheduled. Once the order is obtained, the order will be forwarded to the Medical Records Department for scheduling. Medical Records will contact the Resident/Responsible Party to communicate the appointment. Once the appointments are scheduled, the appointment will be placed on the dashboard. The day prior to the appointment, the appointment will be placed on the communication board. A packet of information will accompany the resident to the appointment. All documents and recommendations will be provided to the nurse upon return from the appointment. The nurse will contact the attending physician and review recommendations. Any changes in the residents' plan of care will be reviewed by the physician. The physician will provide orders as indicated. Medical Records will review the documents for further information to determine if there is a need for a follow-up appointment.