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	10/01/2024

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 This citation pertains to Intake: MI00147215. Based on observation, interview, and record review the facility failed to prevent incidents of misappropriation of narcotic pain medication for three residents (R604, R605, R606) of five residents reviewed for misappropriation of property. Findings include: A review of the Facility Reported Incident revealed the following, Incident Summary: Missing Medication: Lorazepam (Anti-anxiety) 0.5 MG (milligrams) 30 Tabs (tablets). On [DATE] at approximately 8:45am [Licensed Practical Nurse (LPN) F], removed 5 controlled substances from her medication cart and handed off to [Director of Nursing (DON)] for destruction. At approximately 9:15(am), the pack of Lorazepam 0.5 MG 30 Tabs was missing from the DON's possession. During the investigation, the information did not line up. The Director of Nursing has been suspended pending investigation . On [DATE] at 10:04 AM, an interview was completed with LPN F via phone, and was asked about the day they provided medications to the DON for destruction. LPN F explained the facility recently began working with a new pharmacy, and she had a number of as needed medications from the previous pharmacy in her fifth floor medication cart, that needed to be discarded for two residents, one of them being R604. LPN F explained they handed off a total of five cards (blister packets, unit dose packaging for pharmaceutical drugs), two cards which contained Ativan, and three cards of Tramadol, all which were full containing about 30 pills to the DON. LPN F indicated she signed the narcotic count sheet when doing so however, the DON did not sign the Controlled Substance Proof of Use sheet for removal from the medication cart. LPN F explained Registered Nurse (RN) G was present at the time she handed the medications to the DON and this was the last time she saw the DON with the medications. LPN F explained the DON later called back to the unit indicating she misplaced the medication, and didn't know what she had done with them. (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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:42 AM, an interview was completed with RN G regarding the missing medications. RN G explained LPN F called the DON to the 5th floor and informed them that they had medications that needed to be destroyed. RN G confirmed witnessing LPN G provide the medications to the DON, and together they rode the elevator to the 4th floor where the medications were to be destroyed in the DON's office. RN G explained as soon as they arrived to the 4th floor, the DON said there were residents on the floor that needed assistance to be fed, and proceeded to entered into room [ROOM NUMBER] where a Certified Nursing Assistant (CNA H) was feeding a resident. RN G explained they observed the DON lay the cards of narcotic medication down on the resident's nightstand, inform CNA H they could leave, and she (the DON) would assist the resident with eating. RN G said that they made attempts to get the DON to leave and destroy the medications, as their morning meeting was scheduled to begin in approximately 5 minutes, however, the DON stayed in the room and continued to feed the resident. RN G explained they left the room to obtain water for the 4th floor residents, returning back to room [ROOM NUMBER] approximately , d+[DATE] minutes later. RN G explained upon entering the room, they observed the resident's food tray looked as though it had not been touched since the duration the DON was in the room. RN G said that upon returning to room [ROOM NUMBER], they and the DON went to destroy the medications however, upon counting the cards, the DON only had four cards, and not five. RN G explained the DON attributed it to LPN F not giving her five cards, and then started to indicate that maybe she had dropped the 5th card. RN G explained the missing card was for R604, and was later identified as Ativan. RN G said they told the DON they needed to retrace their steps and go back to room [ROOM NUMBER] however, the DON stated it wasn't necessary, and began to frantically look for the medication. RN G explained that they went to the Nursing Home Administrator (NHA), and provided them with the controlled substance record for the missing medication. RN G was asked if she had witnessed any other incidents of missing medications, and she explained on [DATE], the DON stood at the nurses' station with the white container used to destroy medications along with a bag of narcotics. RN G said the DON began punching medications out of blister packets onto the desk at the nurses' station making it difficult to identify what packet the medications were coming from. RN G went on to say, after they were able to organize and count the medications, and 17 Hydrocodone pills were missing for [R605 and R606]. RN G said the DON had a new LPN (LPN I) sign documents presented to her by the DON regarding the destruction of the medications, and said they would notify the medical director about the missing medications. On [DATE] at 11:18 AM, CNA H was interviewed regarding the day they assisted the resident in room [ROOM NUMBER] with breakfast. CNA H confirmed the DON entered into the room and explained that they would assist the resident, so they subsequently left the room to collect trays. CNA H explained to the DON that they only had one other resident that needed assistance with meals, but that resident was asleep. CNA H confirmed upon returning to room [ROOM NUMBER], the residents plate of food looked the same as it had when they had left the DON in the room to assist. On [DATE] at 11:37 AM, an attempt to contact the DON via phone was unsuccessful. On [DATE] at 1:09 PM, an interview was completed with LPN I regarding the day they and the DON disposed of medication. LPN I confirmed they did sign off on a few narcotic sheets, but refused to sign the sheets that were missing medications. LPN I explained they didn't think they were able to assist the DON in the destruction of medications, but the DON insisted that it was fine. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R604 A review of R604's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Alzheimer's Disease, Chronic Kidney Disease, Diabetes and Anxiety. Further review revealed the resident was severely cognitively impaired, and had three separate PRN (as needed) orders dated for [DATE], [DATE] and [DATE], and are as follows,Lorazepam Oral Tablet 0.5 MG (Lorazepam). Give 1 tablet by mouth every 6 hours as needed for Anxiety . R605 A review of R605's medical record revealed they were admitted into the facility on [DATE], and expired on [DATE]. The resident was admitted with diagnoses that included Alzheimer's Disease, Diabetes, and Hypertension. Further review of the medical record revealed the resident was prescribed the following order on [DATE], Hydrocodone-Acetaminophen Oral Tablet ,d+[DATE] MG (milligrams). Give 5.325 mg by mouth every 6 hours as needed for Moderate Pain. R606 A review of R606's medical record revealed they were admitted into the facility on [DATE] under hospice care, and expired on [DATE]. A review of the resident's diagnoses include Chronic Pain and Malignant Neoplasm of the Esophagus. Further review of the medical record revealed the resident had the following physician order on [DATE], Hydrocodone-Acetaminophen Oral Tablet ,d+[DATE]MG. Give 1 tablet via Percutaneous Gastrostomy Tube (PEG-tube for foods, liquids and medication)-every 6 hours for Pain. On [DATE] at 11:45 AM, the Nursing Home Administrator (NHA) was asked about they're investigation regarding the DON, and she explained when the DON was interviewed about the missing medications, the DON could not provide an explanation for the missing medications, and said they did not have any destruction logs for medications that had been destroyed during the course of her employment. On [DATE] at 2:37 PM, an interview was completed with LPN J regarding the process for medications needing to be destroyed. LPN J explained there isn't a schedule for when medications are to be destroyed, it's as needed however, the nurse further explained there have been so many different nurses in the role of Director of Nursing (DON), and they all had a different procedure for how they wanted things done, so they really was not sure what the procedure is. A review of a partial destruction log binder was reviewed revealing multiple unorganized and incomplete documents titled Controlled Drug Record and Control Substance Record that were missing signatures and witnesses however, RN E's name and signature was noted on a number of the incomplete documents. On [DATE] at 3:36 PM, an interview was completed with Minimum Data Set Assessment (MDS) nurse, RN E and was asked about the number of times they were involved in the destruction of medications with the DON. RN E explained they were not very involved and disposed of narcotic medications one time with the DON. RN E was shown the partial log binder with their name listed on multiple incomplete documents, however, the nurse could not explain why their name or initials were on the sheets. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:00pm, Pharmacist K was interviewed via phone regarding the process of narcotic delivery and storage to the facility, and explained the nurse signs for the medications when they are delivered and the nurse signs them into their inventory. Regarding facility advisement of controlled substance destruction, Pharmacist K explained the facility should have their own controlled systems and guidelines with a nurse and a witness. A review of the Discarding and Destroying Medications policy which was undated revealed the following, 1. All unused controlled substances shall be retained in a securely locked area with restricted access until disposed of .7. For unused, non-hazardous controlled substances that are disposed of by an authorized collector, the Environmental Protection Agency (EPA) recommends destruction an disposal of the substance with other solid waste following the steps below: .d. Document the disposal on the medication disposition record. e. Include the signatures(s) of at least two witnesses .12. Completed medication disposition records shall be kept on file in the facility for at least (2) two years, or as mandated by state law governing the retention and storage of such records .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 This citation pertains to Intake: MI00147215 Based on interview and record review, the facility failed to report and investigate an allegation of misappropriation of narcotic medicaitons to the State Agency for two residents, (R605 and R606) of five residents reviewed for misappropriation of property. Findings include: On [DATE] at 10:42 AM, an interview was completed with Regeistered Nurse (RN) G regarding the Director of Nursing (DON) handling of medications that needed to be destroyed. RN G explained on [DATE], the DON stood at the nurses' station with a white container that is used to destroy medications along with a bag of narcotics. The nurse said the DON began punching medications out of blister packets onto the desk at the nurses' station making it difficult to identify what packet the medications were coming from. RN G explained they were able to organize and count the medications, they identified that 17 Hydrocodone pills were missing for R605 and R606. RN G said the DON had a new Licensed Practical Nurse (LPN) I sign documents presented to them by the DON regarding the destruction of the medications, and the DON said they would notify the Medical Director about the missing medications. RN G confirmed they reported the missing medications to the Nursing Home Administrator (NHA). R605 A review of R605's medical record revealed they were admitted into the facility on [DATE], and expired on [DATE]. The resident was admitted with diagnoses that included Alzheimer's Disease, Diabetes, and Hypertension. Further review of the medical record revealed the resident was prescribed the following order on [DATE], Hydrocodone-Acetaminophen Oral Tablet ,d+[DATE] MG (milligrams). Give 5.325 mg by mouth every 6 hours as needed for Moderate Pain. R606 A review of R606's medical record revealed that they were admitted into the facility on [DATE] under hospice care, and expired on [DATE]. A review of the resident's diagnoses includes Chronic Pain and Malignant Neoplasm of the Esophagus. Further review of the medical record revealed that the resident had the following physician order on [DATE], Hydrocodone-Acetaminophen Oral Tablet ,d+[DATE]MG. Give 1 tablet via Percutaneous Gastrostomy Tube (PEG-tube for foods, liquids and medication)-every 6 hours for Pain. On [DATE] at 1:09 PM, an interview was completed with LPN I regarding the day they and the DON disposed of medication. LPN I confirmed they did sign off on a few narcotic sheets, but refused to sign the sheets that were missing medications. LPN I explained they didn't think they were able to assist the DON in the destruction of medications, but the DON insisted it was fine. On [DATE] at 11:45 AM, the Nursing Home Administrator (NHA) was asked if they reported the allegations of missing narcotics brought to they're attention by RN G on [DATE]. The NHA confirmed awareness of the concern and spoke to the DON about it, however, were not able to provide an explanation as to why the incident was not investigated or report to the State Agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Unusual Occurrent Reporting policy which was undated revealed the following, Our facility will report the following events to appropriate agencies .g. Allegations of abuse, neglect and misappropriation of resident property; h. other occurrences that interfere with facility operations and affect the welfare, safety, and health of residents, employees or visitors. 2. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations .