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	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windemere Park Health and Rehabilitation 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. This citation pertains to intake 2800927:Based on observation, interview, and record review, the facility failed to implement fall care plan interventions for one resident (R902) of three residents reviewed for falls. Findings include:Review of a concern called into the State Agency documented concerns pertaining to R902's bed height, mechanical functioning of the bed, and the facility's management of the resident's risk for falls.Review of the facility record for R902 revealed a most recent admission date of 01/15/26 with pertinent diagnoses including Dementia and Muscle Weakness. The Brief Interview for Mental Status (BIMS) dated 02/02/26 indicated moderate cognitive impairment. The baseline care plan dated 01/16/26 revealed a fall risk reduction focus area that included the interventions Bed in lowest position when occupied (initiated 01/16/26) and Bilateral fall mats on floor when in bed (initiated 01/28/26 in response to a fall from the bed).On 04/07/26 at 11:15 AM, R902 was observed in bed. The bed was positioned with the mattress surface at a height of approximately three feet from the floor and not appearing to be in a lowered or lowest position available. There were no fall mats in place on either side of the bed.On 04/07/26 at 11:50 AM, Licensed Practical Nurse (LPN) A accompanied the surveyor to R902's room and demonstrated the bed was functioning properly including raising and lowering of the bed height. Prior to operating the bed, the bed height remained at approximately three feet from the floor as observed previously. No fall mats were in place on the floor and upon further observation of the room, fall mats were observed folded up and resting in the corner of the room. On 04/07/26 at 1:40 PM, R902 was observed in bed. The bed remained at a height of approximately three feet from the floor, and no fall mats were present on the floor. The fall mats remained in the corner of the room as previously observed. R902 was interviewed and asked if they mind if staff lower their bed closer to the floor and they reported they did not mind and could not recollect if fall mats are kept on the floor. On 04/07/26 at 3:00 PM, the facility's Director of Nursing (DON) was queried about the observations of R902 not having fall mats in place and not having the bed lowered as care planned and reported they should be in place when the resident is in bed as indicated in care plan.Review of the facility policy Fall Management dated 04/28/25 revealed the Procedure item 2. Residents identified at risk for falls will have a care plan developed and fall prevention interventions will be implemented as needed based on their assessment.

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