| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235714 | A. Building<br>B. Wing | 06/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Windemere Park Health and Rehabilitation Center | 31800 Van Dyke Avenue<br>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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake number 3003145. Based on observation, interview, and record review, the facility failed to maintain resident's right to privacy for five residents (R6, R5, and anonymous resident (AR B) of five reviewed for privacy. Findings include:<br><br>R6<br><br>A review of an Intake called into the State Agency revealed, Complainant states for the past several months resident [R6] has been wandering in and out of [R13's] and other residents' rooms and taking their personal belongings . [R6] took [R13's] roommate [R4's] dentures twice, [R6] took an unknown (resident's) . bible, [R6] steals food from residents' trays and other items. The complainant states [R6] will also get into other residents' beds when they aren't in their rooms .residents have complained to nursing staff and they said nothing can be done because the resident [R6] has dementia. Complainant states staff make excuses for [R6] and said [R6] has the right to wander. The complainant states [R6] is allowed to violate [other residents] . right to privacy.<br><br>On 6/09/2026 at 9:47 AM, 10:51 AM, R6 was observed walking up and down the hallway entering rooms not assigned to R6. Multiple rooms were observed with stop signs across the entry to resident's rooms. Staff were not observed to redirect R6 out of the unassigned rooms.<br><br>On 6/09/2026 at 11:12 AM, R6 was observed with a cup of juice in their hand, walking in and out of rooms that were not assigned to them. R6 walked into an unassigned room, placed the cup of juice down, on an overbed table while an unknown staff member walked past the resident without addressing or redirecting them.<br><br>On 6/10/2026 at 3:39 PM, R6 was observed walking in and out of unassigned resident's rooms without staff awareness. At 12:39 PM, R4 was interviewed and reported R6 has taken their dentures out of the water cup two times and has woken up with R6 standing over them.<br><br>A review of R6's medical record noted, R6 was admitted to the facility on [DATE] with diagnoses Adjustment disorder, Dementia, Mood disorder, Cognitive deficits, and non-verbal. A review of R6's Minimum Data Set (MDS) assessment dated [DATE] revealed R6 with a severely impaired-never/rarely made decisions and required assistance from staff for activities of daily living.<br><br>A review of R6's care plan noted, I am at risk for elopement R/T (related to): Dementia wanders in and out of other resident's rooms. Date Initiated: 1/30/26. Goal: I will not leave unit/facility unattended thru next review date. Interventions: Provide frequent visual checks/supervision. Provide redirection/reorientation as needed. Supervise me when wandering about unit/facility. I am at risk for decreased leisure activity participation due to; Adjustment, Mood D/O (disorder), cognitive defects,<br>(continued on next page) |



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

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Dementia, Mood D/O, is non-verbal. Date Initiated: 2/16/26. Goal: I will accept 1:1 visits through next review date. Interventions: Provide 1:1 room visits as I choose. Provide audio/tactile stimuli as I am able to tolerate .<br><br>On 6/11/2026 at 12:27 PM, the Activities Director (AD) was asked about the services they provide to R6 AND reported R6 does not participate with the group or other individual activities.<br><br>Further review of R6's medical record progress notes revealed, 6/8/26 17:36 (5:36 PM) Health Status Note: Resident was sleeping at start of shift, resident at 100% of [their] meal, has been walking in and out of residents rooms and at times is lying in their beds and eating their food resident is on a puree diet, resident is nonverbal and cannot communicate with staff well, is not easily redirected, will continue plan of care.<br><br>6/11/26 13:27 (1:27 PM) Behavior note; resident is alert to self and pleasant. Resident wanders up and down hall and room to room taking applesauce and medication cups from nursing cart. Care is ongoing.<br><br>A review of R6 admission documentation dated 1/27/26 revealed, The IDT (interdisciplinary) team met to review an incident involving the resident [R6], who was observed being kicked on the buttocks by another resident . A root cause analysis determined that environmental factors contributed to the incident, as the resident independently ambulates and may unintentionally enter other resident's personal spaces; shared living areas and open room access increased the likelihood of unplanned resident to resident contact. Supervision challenges were also identified, as the event occurred during routine resident movement under standard supervision, indicating the need for enhanced environmental strategies, visual cue interventions, and staff redirection .<br><br>On 6/11/2026 at 2:52 PM, the Social Service Director (SW D) was asked about R6 and reported the resident had been at a previous facility where other residents retaliated when R6 entered their space. SW D confirmed R6 was being followed by psych services quarterly and as needed.<br><br>On 6/11/2026 at 2:33 PM, the Nursing Home Administrator (NHA) asked about R6's wondering behaviors and confirmed they use the stop signs and staff are to redirect the resident. The NHA explained they will look revisiting the interventions that are in place to ensure other resident's privacy.<br><br>A review of the facility's policy titled, Resident Rights dated December 2016, revealed, Policy Statement. Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: 1. a dignified existence; 2. be treated with respect, kindness, and dignity; 3. be free from abuse, neglect, misappropriation of property, and exploitation . 20. privacy and confidentiality; 21. voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal .<br><br>AR B<br><br>On 06/09/2026 at 9:31 AM, AR B reported they heard a commotion in the hall about a resident (R6) who wanders into everyone's room.<br><br>They reported the resident moves fast and is a thief taking drinking cups and looking into closets<br>(continued on next page) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | taken things out. AR B reported they have yelled or cuss at the resident (R6) to get them to leave but the resident (R6) simply stares at them and just ignores you. AR B confirmed staff dismiss their concerns as the wandering resident has dementia and may not know what they are doing. AR B reports this has gone on for weeks and weeks.<br><br>From 06/09-06/11/26 observations of R6 were made. R6 walked the hallways of the fifth floor and repetitively entering and exiting the rooms of other residents for up to 10 minutes at a time and leave with an item and sit in an armchair.<br><br>On 06/10/2026 at 3:47 PM, R5 reported R6 had been walking in and out of their room since they arrived at the facility on 1/2/23 and described R6 as a nuisance.<br><br>R5 recounted a day when R6 sat in an armchair at the foot of their roommate's bed for a long while until two staff members came in and attempted to remove R6 from the room. R5 was admitted into the facility with diagnoses that included Adjustment Disorder, Stroke and Dementia. The Minimum Data Set (MDS) dated [DATE] documented impaired cognition and the need for substantial/maximal assistance for bed mobility and dependent on staff for transfers. R5 was conversational and could make their needs known. |