STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Lakeland Center was surveyed for a Recertification and Abbreviated survey on 3/31/23. Intake #s: MI100131469, MI100131551, MI100131552, MI100131553, MI100131621, MI100131801, MI100131999, MI100132711, MI100132913, MI100134950, MI100134718, MI100134820, MI100135117, MI100135146 Census = 71	F0000		
F0550 SS= E	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights	F0550	F 550 Element 1 It is the practice of the facility to ensure residents are treated with dignity and respect. Resident #30 has been interviewed for any concerns regarding dignity and respect. The concerns expressed have been corrected to ensure resident #30 is being treated with dignity and respect. Resident council cited residents were confidential. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Those residents have been interviewed and any concerns were addressed at the time to ensure they are being treated with dignity and respect. Element 3 The Interdisciplinary Team reviewed the policy and procedure for dignity and respect and deemed it appropriate. All staff have been educated on treating the residents with dignity and respect with emphasis on knocking on the door before entering the room, cell phone	4/26/2023

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

Electronically Signed | 04/21/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #s: MI00131551, MI00131552, MI00131553 and MI00132711. Based on observation, interview and record review, the facility failed to ensure residents were treated with dignity and respect for one (R30) of three residents reviewed for dignity, and multiple residents that attended the confidential resident council, resulting in expressions of feelings of diminished self-worth, anger, and frustration. Findings include: On 3/29/23 at 11:00 AM, a confidential resident council interview was conducted with eight residents who reported they either sometimes or frequently attended the resident council meeting in the facility. When asked about whether they felt the staff treated them with dignity and respect, multiple residents reported concerns which included: "Some do and some don't."		usage in resident care areas, giving showers, changing sheets and assisting the residents when they need assistance. Element 4 The DON/designee will audit 5 residents weekly for 2 months, then every other week for 2 months to ensure all residents are being treated with dignity and respect with emphases on knocking on the door before entering the room, cell phone usage in resident care areas, giving showers, changing sheets and assisting the residents when they need assistance. Any deficient practice will be corrected immediately, and the Administrator will be notified immediately and the associated staff with be re-educated/disciplined. The results will also be taken to the Quality Assurance and performance review meeting. The DON is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

"They say they're not my aide and can't help."

"I hadn't had a shower in three weeks and didn't get sheets cleaned. One aide said your sheets look clean so I'm gonna change just the draw sheet."

"They treat us like we're nothing."

"They treat us like dogs. Like no respect, made to feel like a dog, who does that?"

"Nurse will say is everything ok? And just walk away without listening."

"Need to hire people that care."

When asked if they had ever discussed some of these concerns with the current Administration, multiple residents reported they had, but nothing happens. When asked what was told to them about follow-up, residents reported the DON (Director of Nursing) told them to just be patient.

During this group interview, Staff 'Z' was observed to enter the room, without knocking or waiting for acknowledgment and proceed to walk throughout the room to attempt to access a smaller office. When informed there was a confidential meeting with the residents in progress, Staff 'Z' exited the room. When asked about how whether any of the residents had concerns about staff walking into their rooms unannounced,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	several residents reported: "Some just walk right in." "They just be coming in." "I can see if they knock and wait , but they knock and just come on in." On 3/30/23 at approximately 4:00 PM, the Administrator was informed of the concerns identified in resident council regarding dignity and reported they had only began working at the facility since December 2022. The Administrator was unable to offer any further explanation but reported there were many changes that were needed. On 3/28/23 at 10:37 AM, the fire alarm in the building was activated. After responding to the fire alarms, Nurse Aide 'PP' was observed leaning on the wall in the unit 2 corridor scrolling through their cell phone. On 3/29/23 at 11:35 AM, an observation of the dining room between unit 1 and unit 2 was conducted. Several residents were present watching television, two staff were observed charting and supervising residents, and Nurse Aide 'MM' was observed seated near the doorway of the dining room scrolling through their cell phone. Eye contact was made with Nurse Aide 'MM' and they continued to scroll through their cell phone.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/29/23 at 11:45 AM, Nurse Aide 'WW' was observed and overheard having a personal conversation on speaker phone in the large dining room on the second floor. At that time, they were asked to identify themselves. After identifying themselves, they continued to conduct their personal speaker phone conversation in the dining room. On 3/29/23 at 11:50 AM, an interview was conducted with Unit Manager 'XX' regarding personal cell phone usage. Unit Manager 'XX' said staff were not to be using personal cell phones in any common areas.			
F0558 SS= E	Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure drinking water and call lights were within a resident's reach for one resident, (R30) of one resident reviewed for accommodation of needs. Findings include: A review of a facility provided policy titled, "Call Light Response Monitor" issued 6/1/18 was conducted and read, "...2. A resident's call light should be within reach when they	F0558	F 558 Element 1 It is the practice of the facility to ensure drinking water and call lights are within a resident's reach. Resident #30 has been assessed and fresh water and call light is within Resident #30 reach. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Those residents have been assessed to ensure drinking water and call lights are within their reach. Element 3 The Interdisciplinary Team reviewed the policy and procedure for call lights and deemed it appropriate. All staff have been educated on ensuring residents have their drinking water and call light within reach. Element 4	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	are in their room..." On 3/28/23 at 10:41 AM, R30 was observed in their bed asleep. R30's bed was in a high position and their call light was on the floor under their bed. It was further observed R30's drinking water was at the foot of the bed on a bedside table. On 3/28/23 at 12:23 PM, and 2:40 PM, R30 was observed in their bed. The bed was in a high position, the call light remained on the floor under the bed and the drinking water was observed at the foot of the bed on the bedside table. On 3/30/23 at 8:10 AM and 3/31/23 at 8:40 AM, R30 was observed in their bed asleep. The bed was in a high position and the call light remained on the floor under the bed. . A review of R30's clinical record revealed they most recently re-admitted to the facility on 3/31/21 with diagnoses that included: dementia, diabetes, morbid obesity, and pressure ulcers. R30's most recent Minimum Data Set assessment revealed R30 had severe cognitive impairment, was non-ambulatory, and required extensive to total assistance from one to two staff members for all activities of daily living. On 3/31/23 at 12:30 PM, an interview was conducted with the facility's Director of Nursing and they indicated call lights and water should be kept within resident's reach.		The DON/designee will complete random audits on 5 residents weekly for 2 months, then every other week for 2 months to ensure all residents have their drinking water and call light within reach. Any deficient practice will be corrected immediately, and the Administrator will be notified immediately and the associated staff with be re-educated/disciplined. The results will also be taken to the Quality Assurance and performance review meeting. The DON is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0565 SS= E	Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate and timely	F0565	F 565 Element 1 It is the practice of the facility to provide adequate and timely resolutions to grievances expressed by the resident council. A special resident group committee was established with the administrator to discuss past unresolved grievances and gather concerns for resolutions. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Residents have been interviewed for any grievances or unresolved grievances to ensure there is timely resolution in place. Element 3 The Interdisciplinary Team reviewed the policy and procedure for grievances and deemed it appropriate. IDT have been educated on providing adequate and timely resolutions to grievances. The grievance/concern form have been revised to documentation of facility follow up and resolutions to concerns. Element 4 The Administrator/designee will audit 5 residents weekly for 2 months, then every other week for 2 months with resident interviews to ensure all residents grievances are resolved in a timely manner. Any deficient practice will be corrected immediately, and the Administrator will be notified immediately and the associated staff with be re-educated/disciplined. The results will also be taken to the Quality Assurance and performance review meeting.	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resolutions to grievances expressed by the resident council for eight of eight residents who attended the confidential resident council interview, resulting in unresolved complaints from residents. Findings include: On 3/28/23 at approximately 9:00 AM, the Administrator was requested to provide the previous six months of resident council minutes. The Administrator reported the facility was currently without an Activity Director and were attempting to get access via their IT (Information Technology) department to access the former staff's computer files to provide the requested documentation. Limited documentation was not provided until 3/29/23 at 4:07 PM and only included documentation from July - December 2022. There was no additional documentation of resident council minutes provided by the end of the survey. On 3/29/23 at 11:00 AM, a confidential group interview was conducted with eight residents who reported they either sometimes or frequently attended the resident council meeting in the facility. During the interview, the residents reported multiple complaints regarding lack of adequate staffing, improper medication administration, food, housekeeping, activities of daily living, and response to call lights that have not yet been resolved. When asked about the facility's response to their concerns, it was reported		The Administrator is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that nothing happens and the concerns remain unresolved. When asked if anyone from Administration had offered any follow-up, several residents reported Nursing Administration told them to "just be patient". Review of the available resident council minutes from July 2022 - December 2022 revealed there was no acknowledgment of resolution to the identified concerns by the resident council which included: Resident Council meeting on 12/29/22: "...Nursing: answering call lights timely, check and change timely, medicine pass timely; Dietary: sometimes condiments aren't on trays, juice is warm, and menu preferences aren't always followed per residents; Housekeeping/Laundry: socks are missing...". Resident Council meeting on 11/17/22: "...Nursing: answering call lights timely, timely check and change, midnight shift rounding more frequently. Shower chairs being cleaned in front of residents; Physician: some residents see their doctor others don't; needs to know when they come in and what days ongoing; Dietary: resident states their likes and dislikes regarding the menu, not receiving alternate of choice on menu; Housekeeping/Laundry: curtains in rooms needs to be cleaned...". Resident Council meeting on 10/27/22:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"...Nursing: answering call lights timely; Physician: would like to know who their doctors are and when to the <sic> come to the facility; Dietary: fresh fruit to continue; Housekeeping/Laundry: deep cleans in rooms and equipment...". Resident Council meeting on 9/20/22: "...Mattress smells of urine - smells better but still wants it cleaned ...long call lights ...hasn't seen doctor, no showers, not making the bed, not changing the sheets, wants to get up around 8:30, nurses have bad attitudes the last few nights, not being washed up properly...". On 3/30/23 at approximately 4:00 PM, the Administrator was informed of the concerns identified in resident council regarding lack of resolution to grievances discussed and reported they had only began working at the facility since December 2022. The Administrator was unable to offer any further explanation but reported there were many changes that were needed.			
F0578 SS= D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services	F0578	F 578 Element 1 It is the practice of the facility to ensure the requirements to legally initiate and activate the "Durable Power of Attorney" (DPOA) prior to initiation of hospice services and have the correct person sign the code status process. Resident #29 DPOA paperwork has been	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to comply with the requirements to legally initiate and activate the "Durable Power of Attorney" (DPOA) prior to initiation of hospice services and had an advance directive form for "Do Not Resuscitate" (DNR) signed by a family member for one (R29) of one resident reviewed for Advance Directives,		reviewed, legally initiated, and the appropriate DPOA has signed residents #29 Code status. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Those residents' charts have been reviewed to ensure the appropriate DPOA paper is on file and have been legally initiated with the correct person signing the code status. Element 3 The Interdisciplinary Team reviewed the policy and procedure for Advance Directives and deemed it appropriate. The IDT including Social Services have been educated on the Advance Directives process including legally initiating the DPOA and signing of the code status. Element 4 The Administrator/designee will audit 5 residents weekly for 2 months, then every other week for 2 months to ensure the Advance Directives policy is being followed including legally initiating the DPOA and signing of the code status. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resulting in a DNR order and initiation of hospice care services without appropriate DPOA documentation on R29's Electronic Medical Record (EMR). Findings include: R29 was initially admitted to the facility on 2/10/22 with diagnoses that included metastatic prostate cancer, dementia, psychotic disturbance, mood disturbance, history of falls, and obstructive uropathy. R29 was recently hospitalized on 2/22/23 and readmitted back to the facility on 2/27/23. An initial observation of R29 was completed on 3/28/23, at approximately 2:40 PM, in their room. R29 was observed in their bed with eyes closed. R29's bed was positioned against the wall on their right side. A bed bolster or a long cushion, measured approximately 3 feet in length, was secured to the left side of R29's bed along the perimeter of the mattress. R29 had a mattress with built up perimeter (concaved mattress) on their bed. There was no staff in the room during this observation. A wheelchair was observed in the room. A subsequent observation was completed later that day, at approximately 4:30 PM. R29 was observed in their bed during this 2nd observation, with the bed positioned against the wall, and a bed bolster attached to the left side of their bed. No staff member was observed in the room. On 3/29/23 at approximately, 9:20AM, a 3rd observation was completed. R29 was in their bed with their eyes closed. Based on the Minimum Data Set Assessment (MDS) dated 2/16/23, R29 had a Brief Interview for Mental Status (BIMS) score of 00, indicative of a severe cognitive impairment. R29 needed limited assistance from staff for their mobility in bed and to get in and out of bed. R29 was also able walk in the room with limited assistance from the staff.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A review of R29's EMR revealed a physician order that read, "Advance Directive: Full Cardiopulmonary Resuscitation (CPR)" order dated 2/20/23. The order for full CPR was discontinued on 2/27/23 and R29's code status was changed with reason that read "changed to DNR (Do not Resuscitate)". Another order dated 2/27/23, read "Advance Directive: DNR, Apply purple wrist band. Verify placement of band every shift. Patient Rights verify order and replace band if missing. DPOA paperwork is active and verified. Enter location RA (right arm), LA (left arm), OTH (other)". A nursing progress note dated 3/25/23 read in part, "Hospice care maintained. Meds given as tolerated. Resident sitting quietly with one-on-one sitter ...".

A physician progress dated 3/21/23, read in part, "Metastatic cancer of prostate, hematuria, guarded prognosis, under hospice care ...". R29's EMR had a DNR consent dated 2/8/23, initiated by the hospice provider, signed by R29's family member under "Patient Advocate". R29's EMR did not have documents to verify if they had a legally appointed DPOA. There was no mental capacity assessment for R29 completed by the physician. A social work initial assessement note dated 2/13/23 read, "Social work has reviewed Advance Directive. Per spouse and Program for All inclusive Care for Elderly ('PACE') pt (patient)/family wants pt to be DNR".

An interview with staff member "F" was completed on 3/30/23, at approximately 10:40 AM, regarding the facility's advance directive process. Staff member "F" reported that they will meet with the resident upon admission to the facility to review their advance directive. If resident was alert, oriented, and had the capacity to sign they would have the resident sign the form. If a resident did not have the capacity to sign the form, they would follow up on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	DPOA or guardianship documentation verfication. Staff member "F"confirmed that R29 was receiving hospice care services. When queried on R29's DPOA documentation, they reported that it was found after verifying R29's record. Staff member "F" also reported that they had reached out for documents, and they had not received them. When queried further on code status change, verification of the DPOA, current DNR order, and the services that R29 were receiving since admission to the facility, Staff member "F" did not provide any further explanation and reported that they would follow up on the documentation. A facility policy titled "Advance Directive" dated 6/29/22 read: "The facility will recognize wishes in writing from properly executed documents of other States and Living will documents as evidence of resident's expressed wishes for care as long as the documents were completed in a manner that complies with the state law in the state where the facility is located. If the resident's capacity is in question: a. Where the patient has appointed a patient advocate ('DPOA-HC'): the resident's inability to participate should be determined and documented in the clinical record by attending physician and one other physician or a licensed psychologist. Facility staff should then follow the instructions of the resident's duly appointed patient advocate regarding care, custody, and medical treatment of the resident as written in the health care document".			
F0584 SS= E	Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F0584	F 584 Element 1	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #: MI00132913. Based on observation, interview and record review, the facility failed to maintain a clean, comfortable, homelike environment for two residents (R4 and R9) and multiple residents that attended the confidential resident		It is the practice of the facility to ensure a clean, comfortable, homelike environment. R#4 mattress overlay with the padded border has been cleaned and changed. The floor has been cleaned including the edges around the nightstand, the trash and crumbs. The foot board of the bed, the low air loss mattress machine, and the overbed table have been cleaned. R#9 has been interviewed with expressed satisfaction with the resolution. The Patient Lounge-214 dining room has been cleaned and the equipment, including three wheelchairs, one Geri chair have been removed. The missing dining chairs have been replaced. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. An audit was completed on like resident rooms to ensure compliance. Element 3 The Interdisciplinary Team reviewed the policy and procedure Routine Cleaning and Disinfection and deemed it appropriate. The IDT including Housekeeping Supervisor, housekeepers, nurses and CENA's have been educated on the routine cleaning process including odors in residents' room, cleaning of floors, cleaning of footboards, cleaning of overbed tables, cleaning of low air loss machines and proper storage of equipment. Element 4 The administrator/designee will audit 5 rooms/dining room weekly for 2 months, then every other week for 2 months to ensure the residents rooms are free of odor with no debris on floors, foot boards, overbed tables, low air loss machines are clean, and equipment is stored in the correct area. Any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	council interview, resulting in lingering urine and fecal odors throughout the second floor and resident dissatisfaction with their current living situation. Findings include: On 3/29/23 at 11:00 AM, a confidential group interview was conducted with eight residents who reported they either sometimes or frequently attended the resident council meeting in the facility. During the interview, the residents reported multiple complaints which included housekeeping concerns. Responses included: "Some days we miss housekeeping, especially on the weekend". "If we say anything about lack of housekeeping, they say we're short today". Review of the available resident council minutes from July 2022 - December 2022 identified concerns by the resident council which included lack of cleanliness in resident rooms and a mattress that smelled of urine. R4 and R9 On 3/28/23 at approximately 9:00 AM, R4 was observed in a wheelchair in their room and staff removed the resident from the room. Upon approaching the door to R4's room, a strong urine odor was observed. Upon entrance to R4's room, their bed was		deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observed with a mattress overlay that had a padded border and appeared to be the source of the odor. There were several faded, worn, and discolored spots on the mattress overlay and the odor became stronger closer to the mattress. The floor was observed to have thick caked on debris around the edges of the night stand, and the floor was littered with trash and food crumbs. Three medication patches were observed on the floor, one dated 3/27/22 and the other two were not able to be read. The foot board of the bed was observed to have a dried brown substance, as well as the low air loss mattress machine. An overbed table was observed to be covered with a white wet substance that was half dry. On 3/28/23 at approximately 10:43 AM, R4's room remained in the same condition as above. R4 was not in the room at that time. At that time, R9, R4's roommate was interviewed about the cleanliness of the room. R9 was on their side of the room with the privacy curtain slightly closed. They asked, "Is there still stuff all over the floor over there?" When queried about the odor in the room, R9 reported they can smell it and it has been like that for a while. R9 reported the housekeeping staff come in to clean the room, but they do not do a thorough job. On 3/31/23 at 4:15 PM, an interview was conducted with Housekeeping Supervisor (HS) 'Y'. When queried about how it was ensured that residents did not have soiled			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mattresses that smelled like urine, HS 'Y' reported if residents had "accidents" the mattresses were wiped down and the beds were deep cleaned one time per month and as needed. HS 'Y' reported they conducted audits to ensure rooms were cleaned thoroughly on a weekly basis, but it did not cover every room. When queried about the strong urine odor on Unit 1 and Unit 2, HS 'Y' reported it was not acceptable for the residents rooms to not be cleaned thoroughly. Resident Dining Room: An observation of the dining room was made on the 2nd floor "Patient Lounge-214" on 3/29/23 at approximately 1:30PM. During this observation there were three wheelchairs, one geri-chair, and one wheel chair scale were stored in the resident dining room. There were several dining tables with missing dining chairs. A second observation was completed later that day at approximately 3 PM. All the equipments that were observed during the first observation were still in the resident dining area with missing dining chairs. On 3/30/23, a third observation was completed at approximately 8:45 AM. Observed one resident eating their breakfast in the dining room. Three wheelchairs, one geri chair, and wheelchair scale were still present in the resident's dining area with missing dining chairs on several tables.			
F0600 SS= K	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not	F0600	F 600 Element 1 Resident #28,57,14,36,45,24,68,60 and 7 have been assessed/interviewed. Any concerns have been addressed immediately.	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00131469, MI00131551, MI00131999, and MI00131552. Based on observation, interview, and record review, the facility failed to protect residents' rights to be free from deprivation of goods and services by staff for nine (R28, R57, R14, R36, R45, R24, R68, R60, and R7) of 13 residents reviewed for neglect. This resulted in an Immediate Jeopardy (IJ) to the health and safety of the resident when these residents were not assigned a licensed or registered nurse for 12 hours (7:00 PM on 9/22/22 until 7:00 AM on 9/23/22) and did not receive multiple physician ordered medications needed to treat medical conditions, such as, pain, cardiac disease, blood clots, psychiatric disorders, diabetes, and post kidney transplant therapy; did not provide wound treatments and catheter care; complete nursing assessments for pain and blood sugar monitoring; provide supervision; and respond to potential crisis/medical complications. This resulted in R28 and R60		Nursing assignments and schedule were audited immediately by Regional Nurse Consultant from 9/22/22 to ensure all residents are assigned to Licensed or Registered Nurse every shift daily to prevent neglect. The Director of Nursing is to monitor daily. Element 2 All Residents were reassessed to make sure residents are in stable condition. All licensed Nurses files are audited by the Administrator to ensure no nurse with a history of refusal to take an assignment or with the other significant infarction which put residents at risk for neglect are not employed at the facility. Element 3 Administrator, Director of Nursing, Nurse Managers, and Nurse supervisors and staffing Coordinator are educated on facility's policy to ensure all residents have licensed and registered nurse assigned to ensure residents' safety and prevent neglect. The facility staff was reeducated on the abuse/neglect policy to ensure that they take immediate action to identify instances of abuse/neglect with a thorough investigation to prevent neglect. Any staff nurses refusing assignment will be terminated and reported to LARA. 58 staff members were educated on Abuse and Grievances. Any additional staff members not educated by 3/30/23 will be in-serviced before their next working shift. Element 4 DON/Designee will audit daily nursing assignments/schedules daily times 8 weeks, then monthly times 4 weeks to ensure residents have a licensed nurse scheduled every shift with finding submitted to QAPI for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	calling 911 due to unrelieved pain and experiencing anxiety due to nobody being available to check their vital signs when they experienced blurry vision. Because there was no nurse willing to provide nursing care to these residents, it increased the likelihood of serious harm, serious injury and/or death. Findings include: The IJ began 9/22/22. The Immediate Jeopardy was identified on 3/30/23. The Administrator was notified of the Immediate Jeopardy on 3/30/23 at 1:30 PM, and a plan to remove the immediacy was requested. The immediacy was removed on 9/23/22 based on the facility's implementation of an acceptable plan of removal as verified on-site by the survey team. Although the immediacy was removed, the deficient practice was not corrected and remained patterned with potential for more than minimal harm that is not immediate jeopardy due to sustained compliance that has not been verified by the State Agency. Review of a complaint submitted to the State Agency on 9/23/22 revealed the following allegations: "Last night, 9/22, there was no nurse and the midnight supervisor refused to pass medications on Unit 2. Resident called		review and recommendations. ADM/Designee will audit three times a week for 8 weeks, then monthly for 4 weeks to ensure that any concerns/grievances have been followed up on with a thorough investigation completed with findings submitted to QAPI for review and recommendations. Compliance date 4/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the police because medication was not being passed. Medication was still not passed even after the police was called..." Review of a second complaint submitted to the State Agency on 9/23/22 revealed the following allegations: "...Patient (R28 - who is quadriplegic) called police at 3am (3:00 AM) because he needed his pain medication and there is no nurse able to give it to him...The person in charge at that time is (Nurse 'FF'). She says she is responsible for Unit 1. (R28) is in Unit 2 and they have no nurse to hand out any medication until the day nurse comes in at 6AM (6:00 AM). (Nurse 'FF') said she was not going to be responsible for another unit's med (medication) cart. Unit 2 consisted of many beds, possible 30+ (more than 30) patients. (R28) said this situation occurs regularly...". Review of a third complaint submitted to the State Agency on 9/23/22 revealed the following allegations: "...(R28) is bedridden... (facility name) is short on staff. There are two aides at the facility who cannot administer medication. None of the patients are getting their medication. The supervisor, (Nurse 'FF'), is capable of administering medication to the patients but is refusing to do so. (R28) is supposed to get pain medication every six hours but have not received pain medication for 11 hours since day shift. This has occurred multiple times a week...". Review of a "Case Report" from the local			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	police department revealed the following: "...Subject...Cruelty/Neglect...Report Date/Time 09/23/2022 02:41 (2:41 AM)...Occurrence Date/Time 09/23/2022 02:41...Dispatched Offense...Welfare Check...Verified Offense...Cruelty/Neglect... ...Suspect...(Nurse 'FF')...Victim...(R28)... ...Officers were dispatched to (facility name) to check on (R28). We made contact with (R28) in (room number). (R28) said he has not received his medication since 5pm the previous day, which was almost 11 hours prior. (R28) said he is supposed to get his pain medication every 6 hours...(R28) said the medication neglect has been an on going issue with (R28), the only supervisor in the building when officers were on scene. (R28) said not getting his meds through the night has been happening several times a week. Officer spoke with staff on scene. There were two nurses on the floor near (R28's room). Offers inquired about medications. They said they did not have the ability of giving medication. I could hear numerous rooms complains that they did not get their medication. The nurses were just telling the patients to go to sleep. I asked the floor nurses why everyone was asking for meds. They said the <sic> do not have enough staff and the only person that could give medication is (Nurse 'FF'), the supervisor on scene. The nurses took us to (Nurse 'FF')'s office. When we opened the door (Nurse 'FF')			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was just sitting in the room listening to music on her phone. (Nurse 'FF') said she is the staffing manager. She said they have 4 wings and only 3 nurses that can give medication so the wing with (R28) on it will not get medication until day shift comes back to work. I noted that 15 plus patients will not be receiving any medication from approx. (approximately) 7pm to 7am on this date. (Nurse 'FF') is an LPN (Licensed Practical Nurse). When we were interviewing her she said she can give medications but she is not willing to take responsibility of signing out the medication cart and giving meds. (Nurse 'FF') said her boss is (former Director of Nursing, DON 'II')and gave us her phone number. I tried to call several times and (Officer name) tried to call her several times as well, with no response...(Officer)...filed a complaint about (facility) and the negligent medical care they are providing...". On 3/28/23 at 10:12 AM, R28 was observed lying in bed. R28 appeared to have limited use of their arms and reported they were unable to move the lower half of their body. When queried about any time when they called the police, R28 reported they did call 911 before because there was no nurse to pass medications and they did not receive their pain medication for approximately 12 hours. R28 reported there was not enough staff to take care of the residents, but the facility continued to admit new residents. On 3/30/23 at 1:49 PM, R60 was interviewed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	When queried about whether there was any time when a nurse was not available to provide nursing care or pass medications, R60 reported there was a night when they did not have a nurse. R60 explained it was several months ago. R60 reported they did not receive their pain medications and they were having trouble with "blurry vision" which they said they were instructed to have their blood pressure monitored if that happened. R60 further explained they tried to get a nurse, but there was nobody to come help them. R60 called the front desk from their cellular phone and nobody answered. They called their family to call the front desk and they did did not get anyone on the phone. R60 reported they called 911 and EMS (emergency medical services) came and took their blood pressure. R60 stated, "After they left, I thought my nurse was going to get my medicine and we never got any meds that night." Review of a "Grievance Documentation, Investigation & Follow-Up" Form dated 9/23/22 revealed R28 filed a grievance on that date. The nature of the concern was documented as follows: "Res (resident) stated it has been 2 nites <sic> of not receiving 9p (9:00 PM) and 6a (6:00 AM) meds due to no nurse on Unit 2. Res. stated that he used light multiple times and sent cena (CNA) to nurse who never came so he called 911. Police came out. Res. stated the police spoke with (Nurse 'FF') and said 'she is not doing it'. Police filled out a victim's report. Res. also			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

stated that police came due to multiple calls." The signature of the person who received the grievance was illegible and the facility was unable to identify who signed it. The following was documented in the "investigation" section: "Nurse suspended. Investigation indicates that she failed to supervise or pass medications on Unit 2. Termination paperwork pending." The investigation section was signed by the former Administrator, (Administrator 'JJJ"). The following was documented in the "Action Taken" section: Nurse responsible, (Nurse 'FF'), suspended. Nurse was terminated...(the rest of the handwriting was illegible). That section was signed by former DON 'LL'.

Review of a resident census for the date of 9/22/22 revealed all residents listed on the census did not receive nursing services, including medication administration, treatments, assessments/monitoring, and supervision on the 7:00 PM to 7:00 AM shift.

Review of R28's Physician's orders, Medication Administration Record (MAR), and Treatment Administration Record (TAR) for September 2022 revealed they did not receive the following physician ordered treatments, medications, and assessments on 9/22/22 and 9/23/22:

1. Percocet (a narcotic pain medication), was given at 7:10 AM on 9/22/22 and was not given again until 12:10 PM on 9/23/22. According to R28, this medication was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	needed the night on 9/22/22 which is why they called 911. 2. Acetaminophen Tablet (medication used to treat pain) 9:00 PM dose. 3. Pain Assessment during second shift (7:00 PM-7:00 AM). 4. COVID-19 Screen for symptoms during second shift. 5. COVID-19 Screen to monitor vital signs during second shift. 6. Monitor catheter anchor during second shift. 7. Midodrine HCl (a medication to treat low blood pressure) 10:00 PM dose on 9/22/22 and 6:00 AM dose on 9/23/22. 8. Docusate Sodium (stool softener) 9:00 PM dose. 9. Assessment of heels and sacral areas which were ordered to be done during the evening shift. 10. Suprapubic catheter care ordered to be done every night shift. 11. Bowel movement monitoring during second shift. 12. Colostomy care during second shift.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

13. Irrigation of suprapubic catheter during second shift.

14. Wound care to the sacro-coccyx area on second shift.

Further review of R28's clinical record revealed R28 was admitted into the facility on 7/25/22 and readmitted on 3/6/23 with diagnoses that included: quadriplegia, stage 4 pressure ulcers, cervical spinal cord injury post gun shot wound, hypertension, morbid obesity, compression of the brain, and contractures of the right and left upper arms. Review of a Minimum Data Set (MDS) assessment dated 7/31/22 revealed R28 had intact cognition, was totally dependent on staff for all activities of daily living (ADLs), had an indwelling catheter and a colostomy, had multiple pressure ulcers, and frequent pain.

Review of R60's Physician's Orders, MAR, and TAR for September 2022 revealed they did not receive the following physician ordered treatments, medications, and assessments on 9/22/22 and 9/23/22:

1. Lidocaine to rectum 9:00PM dose.

2. Pain Assessment during second shift.

3. Calmoseptine Ointment to sacrococcyx, ordered to be done at 9:00 PM.

4. COVID-19 Screen for symptoms during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	second shift. 5. COVID-19 Screen to monitor vital signs during second shift. 6. Monitor catheter anchor during second shift. 7. Hydrocodone-Acetaminophen (a narcotic pain medication) 10:00 PM dose on 9/22/22 and 6:00 AM dose on 9/23/22. The medication was ordered to be administered every 8 hours. 8. Tizanidine HCl (a medication to treat muscle spasms) 10:00 PM dose on 9/22/22 and 6:00 AM dose on 9/23/22. 9. Assessment of heels and sacral areas which were ordered to be done during the evening shift. 10. Biscodyl Suppository (to treat constipation) due at 9:00 PM which was ordered every day at bedtime. 11. Bowel movement monitoring during second shift on 9/22/22 and first shift on 9/23/22. 12. Monitoring of urine output from indwelling catheter during second shift on 9/22/22 and first shift on 9/23/22. 13. Wound care to bilateral legs/feet/toes, 9:00 PM.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

14. Catheter care during evening and night shift.

Further review of R60's clinical record revealed R60 was admitted into the facility on 7/21/22 with diagnoses that included: quadriplegia, neuralgia (severe pain due to damaged nerves), type 2 diabetes mellitus, constipation, and neuromuscular dysfunction of bladder. Review of a MDS assessment dated 7/27/22 revealed R60 had intact cognition, required extensive physical assistance from staff for bed mobility, transfers, and all ADLs, had an indwelling urinary catheter, and experienced frequent pain.

Review of a Staffing Assignment sheet for 9/22/22 revealed the facility census was 73 on that date. Further review of the staffing assignment sheet, time punches for facility employees, an invoice from a staffing agency used by the facility that indicated who worked in the facility, and MARs for residents who resided on the second floor on 9/22/22 revealed the following:

The following nurses were scheduled and/or worked in the facility on 9/22/22 during the 7:00 PM to 7:00 AM shift:

Nurse 'GG' worked from 7:00 PM until 7:15 AM and was assigned to Unit 3.

Nurse 'HH' worked from 7:00 PM until 8:31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	AM and was assigned to Unit 2. Nurse 'YY' was assigned to Unit 4 according to the assignment sheet, but there was no time punch for that day. Review of MARs for residents who resided on Unit 4 revealed Nurse 'GG' administered medications to those residents on the 7:00 PM-7:00 AM shift on 9/22/22. Nurse 'FF' was assigned to Unit 1 according to the assignment sheet, but there was no time punch for that day. Review of the MARs for residents who resided on Unit 1 on 9/22/22 revealed Nurse 'FF' administered medications on that day which indicated they did work. Five Certified Nursing Assistants (CNAs 'AA', 'BB', 'CC', 'ZZ' and 'AAA') worked the 7:00 PM to 7:00 AM shift according to the assignment sheet and corresponding time punches provided by the facility. Review of MARs for residents who resided on Unit 3 revealed Nurse 'HH' administered medications to residents on Unit 3 on the 7:00 PM-7:00 AM shift on 9/22/22. Review of MARs for residents who resided on Unit 1 revealed Nurse 'GG' administered medications to residents on Unit 1 on the 7:00 PM-7:00 AM shift on 9/22/22. Based on the time punches and documentation in the clinical record, there			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was no indication that Nurse 'YY' worked on 9/22/22. On 3/29/23 at 12:56 PM, a telephone interview was conducted with CNA 'AA'. CNA 'AA' reported she did not remember police coming to the building or the building being without a nurse. On 3/29/23 at 12:58 PM, CNA 'BB' who was assigned to work on Unit 1 on 9/22/22 was interviewed. CNA 'BB' was not available for interview prior to the end of the survey. On 3/29/23 at 12:34 PM, a telephone interview was conducted with CNA 'CC' who was assigned to Unit 2, the unit documented on the police report as not having an assigned nurse and residents who complained of not getting their medications. When queried about the night of 9/22/22, CNA 'CC' reported they did not remember that night. When queried about the police being called because residents were not getting their medications, CNA 'CC' reported they would not know if a resident did not get medications because they were not a nurse and further explained that they remembered "police coming a couple of times." On 3/29/23 at 1:27 PM, a telephone interview was conducted with Nurse 'DD' who was the outgoing nurse on 9/22/22 at 7:00 PM and the incoming nurse on 9/23/22 at 7:00 AM. When queried about any knowledge of a set of residents not getting medications or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nursing services and police response during the night shift, Nurse 'DD' reported they did not have any specific information, but "that used to happen a lot because they cut one of the night shift nurses out". Nurse 'DD' reported when that occurred they would be coming in at 6:00 AM instead of 7:00 AM to pass medications. Nurse 'DD' further explained the nurse assigned to Unit 1 and the nurse assigned from Unit 3 would split Unit 2. When queried about who they counted the Unit 2 narcotics with when they left their shift on 9/22/22, Nurse 'DD' could not remember. When queried about what happened if a nurse did not show up to relieve them from their medication cart, Nurse 'DD' reported the narcotics were counted with the afternoon/night supervisor and keys to the cart were handed over to the supervisor. When queried about any time they arrived for their day shift and residents had not received medications from the previous 12 hour shift, Nurse 'DD' could not remember. When queried about what they would do if they discovered that happened, Nurse 'DD' reported they would report it to the unit manager or DON and stated, "But, it is my word against the nurses. They will ask me who told me that and if I say it was the resident, then it's the resident's word against the nurse. They have to investigate." Review of Nurse 'FF's personnel file revealed the following: An "Employee Personal Change Form" that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documented Nurse 'FF' was hired as a "LPN - supv (supervisor)" on 8/18/22. A "Personal Change Form" that documented Nurse 'FF' was "discharged" effective 9/27/20 (confirmed with Human Resources Director - HR 'C' that the date was 9/27/23). It was documented Nurse 'FF' was not recommended for re-employment in the same department or in other departments. In the "remarks" section the following was documented: "Terminated first 90 days not taking cart". The form was not signed. An "Employee Counseling & Corrective Action Record" for Nurse 'FF' documented they were suspended (not terminated) on 9/29/22 and the form was signed by former Administrator 'JJJ' and former DON 'LL'. On 3/29/23 at 3:08 PM, an interview was conducted with the current DON of the facility. When queried about why Nurse 'FF' was terminated and/or suspended on 9/27/22 or 9/29/22, the DON reported she was not aware of the reason. On 3/29/23 at approximately 3:45 PM, the current Administrator was interviewed. The Administrator, who was also the Abuse Coordinator for the facility, reported they began working in the facility on 12/5/22. When queried about any investigation into the grievance provided for R28 from 9/23/22 regarding Nurse 'FF' and medications and care not being administered, the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator explained that was before they started working in the facility and they did not find an investigation. When queried about what was the protocol if a nurse refused to pass medications or there was nobody available or willing to pass medications or care for a set of residents, the Administrator reported it was fully investigated and the physician was called about missed medications. The Administrator reported they did not know anything about this incident. On 3/29/23 at 4:32 PM, a telephone interview was conducted with Nurse 'HH'. Nurse 'HH' reported they worked at the facility two times and was contracted through a staffing agency. When queried about whether they recalled if police came to the facility when they were working, Nurse 'HH' reported they recalled one night EMS came because there was "a patient that wanted pain medicine and the young lady that was supervising would not pass medications. Nurse 'HH' explained that Nurse 'FF' sent a nurse home at the start of the night shift on 9/22/22 and that left the building short of nurses (three instead of four). Nurse 'HH' reported that they worked on Unit 3 on second shift. Nurse 'HH' further explained when they went upstairs, a resident was very upset because he had not yet received pain medication. Nurse 'HH' looked for Nurse 'FF', the nurse supervisor, to assist the resident. Nurse 'HH' stated, "I found her (Nurse 'FF') in the cubby hole and told her that the resident needed pain medication.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	She was sitting there, with no socks or shoes on, eating candy, and on her phone." When Nurse 'HH' informed Nurse 'FF' that the resident needed medication, Nurse 'FF' told Nurse 'HH', "Well do you want to give it to him?" Nurse 'HH' explained that she did not acquire the keys to that cart and did not count the narcotics on the cart and was not comfortable. Nurse 'HH' further explained that they were assigned to 20-30 patients on the other side of the floor. Nurse 'FF' accused Nurse 'HH' of refusing an assignment and Nurse 'FF' remained in the cubby for the shift eating candy and sitting on her phone. Nurse 'HH' explained they did not pass medications to any residents on Unit 2 and either did Nurse 'FF' who was the supervising nurse. When queried about if they contacted anybody to report that there was nobody to take care of the residents on Unit 2, Nurse 'HH' reported that she told her manager at the agency, but did not contact anyone at the facility. On 3/30/23 at 8:32 AM, Nurse 'FF' was interviewed. When queried about why the police came to the facility on 9/22/22, Nurse 'FF' reported there was a "situation where they did not have a nurse scheduled for a particular unit". When queried about what was done about that, Nurse 'FF' reported they contacted the DON, but the DON did not return the phone call and they were given no directives. When asked if they were a nurse supervisor, Nurse 'FF' stated, "The position I had was not specific of my title. I			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was more of a working supervisor or charge nurse. I just made CNA assignments". When queried about who acquired the keys from the Unit 2 medication cart at the beginning of second shift on 9/22/22, Nurse 'FF' reported the keys were in the cart and they reported to the DON that another nurse was needed. When queried about their interaction with the police, Nurse 'FF' reported the police asked what was going on and they told them they were working on a whole other unit and the DON was notified. When queried about any interaction with other nurses who were working to ensure all residents were cared for, Nurse 'FF' reported there was interaction but one of the nurses concerns was that it was unsafe to assign them to Unit 2 when they were already working on Unit 3 because of how the floor was designed. When asked if they took the medication cart on Unit 2 in the absence of another nurse due to being the supervisor, Nurse 'FF' reported they did not because "I had a whole other cart". Nurse 'FF' explained they did not pass medications or provide any nursing care to the residents on Unit 2 for the entirety of second shift and they told the police they would have to wait until the day shift (first shift) came in at 6:00 AM. When queried about whether there was any disciplinary action taken due to them not providing medications, treatments, and assessments on Unit 2, Nurse 'FF' reported they were taken off the schedule while the facility investigated and then they brought them back to work. Nurse 'FF' reported the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	DON 'II' stopped coming to work and never returned after that night. On 3/30/23 at 9:04 AM, a telephone interview was attempted with former DON 'II'. There was no response from DON 'II' prior to the end of the survey. On 3/30/23 at 9:34 AM, an interview was conducted with the Assistant Director of Nursing (ADON). When queried about whether they were aware of the reason for termination/suspension of Nurse 'FF' in September 2022, the ADON reported they were informed by the previous Administrator that Nurse 'FF' refused to pass medications when staffing was short. When queried about what the proper protocol would be, the ADON reported Nurse 'FF' was the second shift supervisor and had access to the medication cart. In the absence of another nurse, Nurse 'FF' would have been responsible to pass medications, provide treatments, and do assessments on the residents without an assigned nurse. In addition, the nurse supervisor was responsible to contact the contracted staffing agencies to find a nurse to come in and then contact the DON and/or on call managers if there was one assigned. and DON should be contacted. When queried about what should be done if a staff member became aware that a set of residents did not have an assigned nurse, the ADON reported the DON and Administrator would be contacted.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/30/23 at 9:42 AM, a telephone interview was attempted with the Medical Director, Physician 'JJ'. There was no response from Physician 'JJ' prior to the end of the survey. On 3/20/23 at 10:26 AM, a telephone interview was conducted with former Administrator 'KK'. Administrator 'KK' reported they were the former interim Administrator in the facility and their last day at the facility was 11/18/22. When queried about any knowledge of what occurred on 9/22/22 when the police came to the facility, Administrator 'KK' reported they remembered the police coming to the facility because there was a resident who said they did not get their medications and the nurse would not administer them. Administrator 'KK' did not have any further details and reported she thought there was an investigation, but it might have been done by Administrator 'JJJ'. Administrator 'KK' reported there were several different DONs and Administrators within a six month period. On 3/30/23 at 10:32 AM, a phone interview was conducted with former DON 'LL'. DON 'LL' reported they worked at the facility as a consultant for two months and left the first week of October 2022. DON 'LL' could not remember details of what occurred on 9/22/22 with R28 and Nurse 'FF' and stated, "There were several times when nurses had to split a unit and staffing was such a problem." When queried about whether they recalled being contacted and they could not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	remember. Review of the residents who resided on Unit 2 on 9/22/22 revealed a total of 21 residents total did not receive medications, treatments, assessments, and/or supervision by a licensed nurse between the hours of 7:00 PM and 7:00 AM (on 9/23/22). Review of R45's clinical record revealed R45 was admitted into the facility on 12/3/21 and readmitted on 1/10/23 with diagnoses that included: Type 2 diabetes mellitus, chronic obstructive pulmonary disease (COPD), osteoarthritis, anxiety disorder, hyperlipidemia, lymphedema, chronic kidney disease, and depression. Review of a MDS assessment dated 9/6/22 revealed R45 had intact cognition, was totally dependent on staff for transfers, bed mobility, and most ADLs, and experienced frequent pain. Review of R45's physicians orders, MAR and TAR from September 2022, and progress notes revealed the following: On 9/22/22, R45 was not administered their 9:00 PM dose of melatonin (a medication used to treat insomnia, trazadone (a medication used to treat depression), sertraline (a medication used to treat anxiety and depression), erythromycin ointment (a medication used to treat eye inflammation), meloxicam (a medication used to treat pain), hydralazine HCl (a medication used to treat high blood pressure), and tramadol (a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

medication used to treat pain). In addition, R45 was not administered their 6:00 AM dose of tramadol on 9/23/22. R45 was not assessed on second shift according to physicians orders for COVID-19 symptoms and vital signs and their blood sugar was not checked at 9:00 PM according to physicians orders.

There were no progress notes written to indicate a physician was contacted regarding the missed medications for R45.

R57's clinical record was reviewed and revealed R57 was admitted into the facility on 1/12/22 and readmitted on 6/8/22 with diagnoses that included: type 2 diabetes mellitus, end stage renal disease (on dialysis), kidney transplant status (on immunosuppression therapy), anemia, hypothyroidism, hyperlipidemia, heart failure, peripheral vascular disease, major depressive disorder, hypertension, pleural effusion, constipation, and insomnia. Review of a MDS assessment dated 9/14/22 revealed R57 had intact cognition and required set up and supervision with most ADLs.

Review of R57's physicians orders, MAR and TAR from September 2022, and progress notes revealed the following:

On 9/22/22, R57 was not administered their 9:00 PM dose of tacrolimus (an immunosuppresive medication used to prevent organ rejection after a transplant),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mycophenolate mofetil (a medication used to prevent organ rejection after a transplant), insulin glargine-yfgn (a medication used to treat diabetes), clonidine (a medication used to treat high blood pressure), hydralazine HCl, isosorbide dinatrate (a medication used to treat chest pain), amlodipine (a medication to treat high blood pressure), atorvastatin (a medication used to treat high cholesterol), levothyroxine (medication used to treat underactive thyroid), remeron (a medication used to treat depression), carvedilol (a medication used to treat heart failure and high blood pressure), and colace (a medication used to treat constipation). In addition, R57 was not assessed for COVID-19 symptoms and vital sign monitoring according to physicians orders, pain was not assessed, and orthotic splints and ace wraps were not applied. There were no progress notes written to indicate a physician was contacted regarding the missed medications for R57. Review of R68's clinical record revealed R68 was admitted into the facility on 6/15/22 with diagnoses that included: COPD, bipolar disorder, major depressive disorder, thrombophilia (a blood clotting disorder), chronic pain disorder, spinal stenosis, and constipation. Review of a MDS assessment dated 9/21/22 revealed R68 had intact cognition, required set up and supervision for ADLs, and had frequent pain.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of R68's physicians orders, MAR and TAR from September 2022, and progress notes revealed the following: On 9/22/22, R68 was not administered their 9:00 PM dose of allergy medication, antifungal medication for itching, atorvastatin, trazodone, diclofenac sodium gel (a topical medication used to treat pain), eliquis (a medication used to prevent blood clots), acetaminophen (a mediation used to treat pain), their 10:00 PM dose of baclofen (a medication used to treat muscle spasms) on 9/22/22 and their 6:00 AM dose on 9/23/22, their 10:00 PM dose (9/22/22) and 6:00 AM dose (9/23/22) of gabapentin (a medication used to treat nerve pain), and their 12:00 AM and 6:00 AM dose of tramadol on 9/23/22. In addition, R68 was not assessed for pain, COVID-19 symptoms, or vital sign monitoring according to physician's orders. There were no progress notes written to indicate a physician was contacted regarding the missed medications for R68. On 3/30/23 at 1:45 PM, R7 was observed seated in a wheelchair in their room. When queried about any time when he did not receive medications, R7 reported they remembered a few months ago not getting medications at night, but could not recall if the police came. R7 reported he had seen police in the building before though. Review of R7's clinical record revealed R7 was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	admitted into the facility on 9/14/22 with diagnoses that included: wedge compression fracture of lumbar vertebra, cardiomyopathy, atrioventricular block, hypertension, type 2 diabetes mellitus, dementia, anemia, and depression. Review of a MDS assessment dated 9/20/22 revealed R7 had severely impaired cognition, required extensive assistance with ADLs, transfers and bed mobility, and experienced frequent pain. Review of R7's physicians orders, MAR and TAR from September 2022, and progress notes revealed the following: On 9/22/22, R7 was not administered their 9:00 PM dose of atorvastatin, melatonin, seroquel (a medication used to treat psychosis), enulose (a medication used to treat constipation), lidocaine patch (a patch used to treat pain), and acetaminophen. R7 did not receive insulin lispro at 12:00 AM and 6:00 AM on 9/23/22. In addition, R7 was not assessed for pain, COVID-19 symptoms, or vital sign monitoring according to physician's orders. There were no progress notes written to indicate a physician was contacted regarding the missed medications for R7. Review of R14's clinical record revealed R14 was admitted into the facility on 6/28/22 with diagnoses that included: cerebrovascular disease, vascular dementia, hypertensive heart disease, artherosclerosis, dysphagia			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(difficulty swallowing), osteoarthritis, major depressive disorder, and major depressive disorder. Review of a MDS assessment dated 7/4/22 revealed R14 had moderately impaired cognition and required set up and supervision with ADLs. Review of R14's physicians orders, MAR and TAR from September 2022, and progress notes revealed the following: On 9/22/22, R14 was not administered their 9:00 PM dose of paxil (a medication used to treat depression and anxiety), senna, memantine (a medication used to treat symptoms of dementia), metoprolol tartrate (a medication used to treat high blood pressure). In addition, R14 was not assessed for pain, COVID-19 symptoms, or vital sign monitoring according to physician's orders. There were no progress notes written to indicate a physician was contacted regarding the missed medications for R14. Review of R36's clinical record revealed R36 was admitted into the facility on 4/24/20 and readmitted on 11/21/22 with diagnoses that included: acute kidney failure, chronic kidney disease, type 2 diabetes mellitus, sickle cell disease, and anemia. Review of a MDS assessment dated 8/2/22 revealed R36 had intact cognition, required extensive physical assistance for ADLs, and experienced frequent pain. Review of R36's progress notes revealed R36 was sent to the hospital on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9/21/22 for a blood transfusion and returned to the facility on 9/22/22 at 10:00 AM. Review of R36's physicians orders, MAR and TAR from September 2022, and progress notes revealed the following: On 9/22/22, R36 was not administered their 9:00 PM dose of atorvastatin and metoprolol tartrate. R36 was not administered their 10:00 PM dose (9/22/22) and 6:00 AM dose (9/23/22) of hydralazine and methocarbamol (a muscle relaxer). In addition, R36 was not assessed for pain, COVID-19 symptoms, or vital sign monitoring according to physician's orders and did not receive wound care to their right heel according to physicians orders on the second shift. There were no progress notes written to indicate a physician was contacted regarding the missed medications for R36. Review of R24's clinical record revealed R24 was admitted into the facility on 7/7/22 and readmitted on 1/10/23 with diagnoses that included: dementia, hemiplegia, end stage renal disease (on dialysis), hyperkalemia (high levels of potassium), hyperlipidemia, and chronic viral hepatitis C. Review of a MDS assessment revealed R24 had intact cognition. Review of R24's physicians orders, MAR and TAR from September 2022, and progress notes revealed the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

On 9/22/22, R24 was not administered their 9:00 PM dose of mirtazipine, zyprexa (a medication used to treat psychosis), and did not receive their 10:00 PM dose (9/22/22) and 6:00 AM dose (9/23/22) of hydralazine. In addition, R24 was not assessed for pain, COVID-19 symptoms, or vital sign monitoring according to physician's orders

There were no progress notes written to indicate a physician was contacted regarding the missed medications for R24.

Review of a facility policy titled, "Abuse Program: Elder Justice Act (Abuse, Neglect, Mistreatment, Misappropriation, Suspicion of Crime, Investigation and Reporting)", dated 4/13/22, revealed, in part, the following: "It is the policy of this facility to provide protections for health, welfare and rights of each reisdnet by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property...Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress..."

The facility submitted a removal plan on 03/30/2023, revealing the following:

- Identified Nurse is no longer employed at the facility, termed on 12/20/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- Nursing assignments and schedule were audited immediately by Regional Nurse Consultant from 9/22/22 to ensure all residents are assigned to Licensed or Registered Nurse every shift daily to prevent neglect. The Director of Nursing is to monitor it daily. -Resident #28, 57, 14, 36, 45, 24, 68, 60 and 7 have been assessed/interviewed. Any concerns have been addressed immediately. - All Residents are reassessed to make sure residents are in stable condition. - All Licensed Nurse files are audited by the Administrator to ensure no nurse with history of refusal to take assignment or with the other significant infarction which put residents at risk for neglect are not employed at the facility. - Administrator, Director of Nursing, Nurse Managers and Nurse Supervisors and Staffing Coordinator are educated on facility's policy to ensure all residents have licensed and registered nurse assigned to ensure residents' safety and prevent neglect. The facility staff was reeducated on the abuse/neglect policy to ensure that they take immediate action to identify instances of abuse/neglect with a thorough investigation to prevent neglect. Any staff nurses refusing assignment will be terminated and reported to the LARA (licensing and regulatory affairs).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	58 staff members were educated on Abuse and Grievances. Any additional staff members not educated by 3/30/23 will be in serviced before their next working shift. DON/Designee will audit daily nursing assignments/schedules daily times 8 weeks, then monthly times 4 weeks to ensure residents have Licensed Nurse scheduled every shift with findings submitted to QAPI (quality assessment process improvement) for review and recommendations. ADM/Designee will audit three times a week for 8 weeks, then monthly for 4 weeks to ensure that any concerns/grievances have been followed up on with a thorough investigation completed with findings submitted to QAPI for review and recommendations. The Compliance Date is 3/30/2023.			
F0604 SS= D	Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical	F0604	F 604 Element 1 It is the practice of the facility to ensure an environment free from physical restraints. The bolster has been removed from R# 29 at this time. Element 2 Residents that currently reside in the facility that are using a bolster have the potential to be affected by this cited practice. An audit was conducted to ensure those residents that require the use of a bolster that orders are in place, care plans are updated, and an assessment is completed to ensure the	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	symptoms. §483.12(a) The facility must-§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure an environment free from physical restraints for one resident (R29) of one reviewed for restraints, resulting in the likelihood for physical discomfort and psychosocial distress utilizing the reasonable person concept. Findings include: R29 was initially admitted to facility on 2/10/22 with diagnoses that included metastatic prostate cancer, dementia, psychotic disturbance, mood disturbance, history of falls, and obstructive uropathy. R29 was recently hospitalized on 2/22/23 due to aggressive behaviors based on physician note dated 2/28/23. R29 was readmitted back to the facility on 2/27/23. An initial observation of R29 was completed on 3/28/23 at 2:40 PM in their room. R29 was observed in their bed with eyes closed. R29's bed was positioned against the wall on their right side. A bed bolster (a long cushion, measured approximately 3 feet in length), was secured to the left side of R29's bed along the perimeter of the mattress. R29 had a mattress with a built up perimeter (concaved mattress) on their bed. There		residents are able to remove the bolster without difficulty to ensure the highest practicable wellbeing. Element 3 The Interdisciplinary Team reviewed the policy and procedure Restraint Free Environment and deemed it appropriate. The IDT and nursing staff have been educated on providing a Restraint free environment with emphasis on bolsters. Element 4 The DON/designee will audit 5 residents weekly for 2 months, then every other week for 2 months to ensure the use of bolsters are not in place as a form of restraints. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Compliance Date : 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

was no staff in the room during this observation. A wheelchair was observed in the room. A subsequent observation was completed later that day at 4:30 PM. R29 was observed in their bed with the bed positioned against the wall, and a bed bolster attached to the left side of their bed. No staff member was observed in the room.

On 3/29/23, at approximately 9:20 AM, a 3rd observation was completed. R29 was in their bed with their eyes closed. Staff member "III" was observed sitting in the room. R29's bed was positioned against the wall on their right side. Bed bolster-cushion was observed laying on the sofa behind the bed, by the window. Staff member "III" reported that they were the sitter for R29. Staff member "III" was queried on the use of bolster. Staff member reported that the bolster was to prevent R29 falling out of bed as they had anxiety. Staff member also reported that R29 was able to walk in the room with staff assistance.

Based on the Minimum Data Set Assessment (MDS) dated 2/16/23, R29 had a Brief Interview of Mental Status (BIMS) score of 00, indicative of severe cognitive impairment. R29 needed limited assistance from staff for their mobility in bed and to get in and out of bed. R29 was able walk in the room with limited assistance from the staff.

A review of R29's EMR did not reveal any assessment for use of the bolster cushion in bed. There was no documented clinical rationale in the EMR for using a bolster-cushion in bed and positioning bed against the wall. There was no physician order for use of a bolster cushion in bed or a concaved mattress. There was no informed consent from R29 or their DPOA (Dual Power of Attorney). R29's EMR did not have documents to verify if they had a legally appointed DPOA. There was no mental capacity assessment for R29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	completed by their physician. R29's MDS assessment dated 2/16/23 did not reveal the use of bolster cushion in bed. A review of R29's care plan revealed that a one-on-one sitter was initiated on 2/22/23 and did not indicate the use of a bolster cushion in bed. A review of R29's nurses progress notes revealed documentation on one-to-one sitter only for the following dates (since the start date of 2/22/23): 2/27/23, 3/4/23, 3/5/23, 3/6/23, 3/11/23, 3/13/23, 3/18/23, 3/19/23, 3/20/23, 3/21/23, 3/24/23, 3/25/23, and 3/27/23. An interview was completed with staff member "CCC" on 3/30/23 at 10:30 AM. Staff member "CCC" was queried regarding the use of the bolster cushion in bed and the facility protocol. Staff member "CCC" reported the therapy team completed an assessment to determine the need for any device. If the assessment indicated the need for any device, a consent was obtained from the resident or resident representative with an order from the physician. Then the resident's care plan was updated to reflect the use of the device. When queried on the bolster cushion that was observed on R29's bed, Staff member "CCC" reported that they were not aware that R29 had any devices in bed. An interview was completed with Staff member "FFF" on 3/20/23 at 11:50 AM. Staff member "FFF" was queried on the therapy assessment and documentation for R29. Staff member "FFF" reported that the therapy team did not assess R29 for any devices in bed. Staff member "FFF" reported that resident was admitted under Program of All inclusive Care for the Elderly ("PACE"). Staff member "FFF" also reported that facility therapy team provided assessments and treatments if they received a referral from PACE. R29's EMR did not have additional			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation for the use of a bolster cushion in bed on one side and why the bed was positioned against the wall on the other side. A facility policy titled "Restraint Free Environment" dated 7/1/17 read in part: "Each resident shall attain and maintain his/her highest practicable wellbeing in an environment that prohibits the use of restraints for discipline or convenience and limits restraints use to circumstances in which resident has medical symptoms that warrant the use of restraints. Physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to resident's body, that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Physical restraints may include but not limited to: .... c. Tucking in or using Velcro to hold a sheet, fabric, or clothing tightly so that a resident's movement is restricted. ... f. Placing chair or bed so close to a wall so that the wall prevents the resident from rising out of chair or voluntarily getting out of bed. g. Placing a resident on a concave mattress so that the resident cannot independently get out of bed .... Before a resident is restrained, the interdisciplinary team will determine the presence of a specific medical symptom (e.g., Indication of physical or psychological condition that would require the use of restraints) and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	How the restraint would treat the residents' medical symptom ... Medical symptoms warranting the use of restraints should be documented in resident's medical record, ongoing assessments, and care plans. A physician order must be obtained before a physical restraint may be applied, except in an emergency situation. In emergency a physician order must be obtained within 24 hours of initiating a restraint ....".			
F0607 SS= F	Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by:	F0607	F 607 DPS 1 Element 1 It is the practice of the facility to ensure the facility implements its policies and procedures related to screening procedures for work eligibility in a nursing home prior to employment. Social Worker F, Housekeeper G, CNA H, Receptionist J, Non-Certified Nurse aide K all have been removed from the schedule until fingerprints have been completed with the results. CNA E, Staff I and Nurse FF no longer are employed at the facility. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. An audit was conducted on current staff employed at the facility to ensure background checks including fingerprints have been completed. Staff that have not yet completed the fingerprints have been removed from the schedule until the fingerprints have been completed with the results. Element 3	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This citation has two deficient practice statements (DPS). DPS #1 This citation pertains to intake #MI00135117, MI00131469, MI00131551, and MI00131552. Based on interview and record review, the facility failed to implement its policies and procedures related to screening procedures for work eligibility in a nursing home prior to employment for eight (Nurse 'FF', Certified Nursing Assistant/CNA 'E', Staff 'F', Staff 'G', CNA 'H', Staff 'I', Staff 'J', and Staff 'K') of 124 employee personnel records reviewed. Findings include: According to the facility's policy titled, "Criminal Background Checks" dated 4/18/2019: "...An individual who applies for employment either as an employee, an independent contractor or for clinical privileges with the Facility and has received a good faith offer of employment or clinical privileges from the Facility shall give written consent at the time of application for a complete criminal background check including fingerprinting...If the Facility determines it is necessary to employ or grant clinical privileges to an applicant before receiving the results of the applicant's fingerprint results, the Facility may conditionally employ or grant conditional		The Interdisciplinary Team reviewed the policy and procedure Criminal Background Checks and deemed it appropriate. The HR director and Administrator have been educated on the Criminal Background Checks with emphasis on completing the background checks and Fingerprints prior to working at the facility. Element 4 The Administrator/designee will complete random audits on 5 employees weekly for 2 months, then every other week for 2 months to ensure background checks and fingerprints are completed. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Compliance Date: 04/26/2023 F 607 DPS 2 Element 1 It is the practice of the facility to ensure to develop and implement written policies and procedures for Abuse policy in accordance with current regulatory standards. The abuse policy has been updated to include the current regulatory standards. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. An audit was conducted on current residents to ensure any concerns or allegations have been reported. No concerns noted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	clinical privileges to the individual is all of the following apply...If the employee will not have direct access to patients or residents they may work without supervision or restriction...The employee's file should contain...the results of the criminal history record check and fingerprinting...The Facility is responsible to pay the cost of any criminal history check and fingerprints and shall not seek reimbursement from the applicant...". Review of two complaints submitted to the State Agency on 9/23/22 revealed allegations that Nurse 'FF' refused to pass medications on Unit 2 on 9/22/22. Review of a police report dated 9/23/22 revealed when officers were dispatched to the facility, residents were complaining that they had not received their medications. When officers made contact with Nurse 'FF', the nurse supervisor working at that time, they were found sitting in an office listening to music on their phone and reported to police that the residents on Unit 2 would not be getting their medications until the next shift came in on day shift. Review of a "Grievance Documentation, Investigation & Follow-Up" Form dated 9/23/22 revealed R28 filed a grievance on that date. The nature of the concern was documented as follows: "Res (resident) stated it has been 2 nites <sic> of not receiving 9p (9:00 PM) and 6a (6:00 AM) meds due to no nurse on Unit 2. Res. stated that he used light		Element 3 The Interdisciplinary Team reviewed the New Abuse policy and procedure with the updates for the current regulatory standards and deemed it appropriate. Current staff have been educated on the Abuse Policy with emphasis on the current regulatory standards. Element 4 The Administrator/designee will audit 5 residents weekly for 2 months, then every other week for 2 months to ensure staff is aware of the current Abuse policy with the current regulatory standards. Results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	multiple times and sent cena (CNA) to nurse who never came so he called 911. Police came out. Res. stated the police spoke with (Nurse 'FF') and said 'she is not doing it'. Police filled out a victim's report. Res. also stated that police came due to multiple calls." Review of Nurse 'FF's personnel file revealed the following: Review of an "Employee Personal Change Form" documented Nurse 'FF' was hired as a "LPN (licensed practical nurse) - supv (supervisor)" on 8/18/22. Review of a "Personnel Change Form" documented Nurse 'FF' was "discharged" effective 9/27/20 (confirmed with Human Resources Director - HR 'C' that the date was 9/27/23). It was documented Nurse 'FF' was not recommended for re-employment in the same department or in other departments. In the "remarks" section the following was documented: "Terminated first 90 days not taking cart". The form was not signed. Review of an "Employee Counseling & Corrective Action Record" for Nurse 'FF' documented they were suspended (not terminated) on 9/29/22 and the form was signed by former Administrator 'JJJ' and former Director of Nursing (DON) 'LL'. Review of an "Employee Personnel Change Form" revealed Nurse 'FF' was "Re-hired" on 11/1/22 as an LPN (not a supervisor). An			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

"Intent to Hire" form was signed off by former Interim Administrator 'KK' to approve the re-hire on 10/19/22.

Review of an "Employee Personnel Change Form" documented Nurse 'FF' was "discharged" from payroll on 12/19/22 and to "see disciplinary file". The form indicated that Nurse 'FF' was not be re-hired and was signed off by the current DON and Administrator.

Review of an "Employee Counseling & Corrective Action Record" for Nurse 'FF' revealed they were terminated on 12/17/22 for "refusal of directive" with a note to "see attached".

Review of an attached typed document signed by former Unit Manager, Nurse 'EE' and the DON, revealed documentation that Nurse 'FF' was found by Nurse 'EE' "sitting in the dark using her cell phone on (video call)...call lights going off..." It was documented that Nurse 'FF' did get up to answer call lights but then was found again on her personal cell phone. On the second shift on 12/17/22, it was documented Nurse 'FF' immediately went back to the "Dr. office" and sat down while call lights were going off and had to be asked to go help staff. Approximately three hours later, Nurse 'EE' found Nurse 'FF' in the "Dr. office" again with the lights off talking on her cell phone. It was further documented that Nurse 'FF' did not sign off any of her narcotics that she said she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	gave earlier in the shift. There was no evidence that Nurse 'FF' obtained fingerprints in their personnel file. On 3/29/23 at 5:10 PM, an interview with Human Resources Director (Staff 'C') was conducted. When queried about whether Nurse 'FF' had fingerprints done prior to their 8/18/22 or 11/1/22 hire dates, Staff 'C' reported Nurse 'FF' did not have fingerprints done initially or at rehire and did not have an explanation as to why. When queried about who was responsible for rehiring Nurse 'FF' after she was found to have neglected a set of residents on 9/22/22, Staff 'C' explained the Director of Nursing (DON) and Assistant Director of Nursing (DON) would have interviewed Nurse 'FF' and if they wanted to rehire her the Administrator had to approve it. Review of Nurse 'FF's time punches after being rehired on 11/1/22 revealed she worked on the following dates: 11/1/22, 11/7/22, 11/8/22, 11/9/22, 11/11/22, 11/14/22, 11/15/22, 11/16/22, 11/18/22, 11/19/22, 11/20/22, 11/21/22, 11/23/22, 11/25/22, 11/28/22, 11/29/22, 11/30/22, 12/2/22, 12/3/22, 12/4/22, 12/5/22, 12/9/22, 12/16/22, and 12/17/22 before her termination on 12/20/22. On 3/29/23 at 3:08 PM, an interview was conducted with the current DON of the facility, who would have been the DON at the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	time Nurse 'FF' was rehired on 11/1/22. When queried about why Nurse 'FF' was rehired when she already was terminated for neglecting residents on 9/22/22, the DON reported she was not aware of the incident or that she did not have fingerprints done. On 3/30/23 at 2:16 PM, Staff 'C' was requested to provide documentation of evidence the facility had obtained a full criminal background check including fingerprinting to determine eligibility to work directly with residents in a nursing home prior to employment. Review of the documentation provided by Staff 'C' revealed as of 3/30/23, the following employees had worked directly with/around residents without having the required fingerprinting completed: 1) Certified Nursing Assistant/CNA 'E', hire date 1/10/23. 2) Director of Social Work/Staff 'F', hire date 9/19/22. 3) Housekeeper/Staff 'G', hire date 2/7/23. 4) CNA 'H', hire date 9/6/22. 5) Former Recreational Therapy (Activities) Manager/Staff 'I', hire date 10/18/22, last day worked 3/10/23. 6) Receptionist/Staff 'J', hire date 10/4/22.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	7) Non-Certified Nurse Aide/Staff 'K', hire date 3/7/23. On 3/31/23 at 9:10 AM, an interview and record review was conducted with Staff 'A' who reported they began working in their role as the Director of Human Resources at the facility on 10/24/22. When asked about what the facility's process was for ensuring potential and/or current staff obtained the required fingerprinting to determine their eligibility to work in a nursing home, Staff 'A' reported normally when employees started, they will run a background check and that would tell you if they need to do fingerprints, or not. When asked to clarify if everyone was asked to get fingerprints prior to employment/upon hire, Staff 'A' reported everyone should have before they started orientation, and before they were out on the floor. Staff 'A' was asked to further review the above employees as there was no evidence that any had been sent for fingerprinting since their employment at the facility. Staff 'A' confirmed they were not and further reported: Regarding CNA 'E', Staff 'A' reported there were no fingerprints obtained and CNA 'E' was also no longer employed as of 2/3/23. Staff 'A' confirmed they appeared on the current employee roster provided during the survey but was not sure why they were still			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	showing as a current employee. Staff 'A' further reported they were sent for fingerprints on 1/6/23, but the electronic fingerprint verification system showed currently as "withdrawn". When asked to explain what that meant, Staff 'A' reported they were not sure, maybe it was as situation in which the "coupon code" staff were given to pay for the fingerprinting might not have been working and they might not have been able to cover it out of their own pocket. Staff 'A' further explained that frequently, the coupon codes provided to new hires would not work and usually the employee would pay and get reimbursed. When asked what had been done to correct this, or follow-up to ensure the fingerprinting had been completed, Staff 'A' offered no further response. Regarding Staff 'F', Staff 'A' reported Staff 'F' had gone today to get fingerprints and also explained the electronic fingerprint verification system showed as "withdrawn". Staff 'A' reported the fingerprinting had initially been requested on 10/2/22 and was not sure if they just didn't go, or what had happened. Staff 'A' reported Staff 'F' also had a different last name in which they also ran in the system and there were no results for either name. Regarding Staff 'G', Staff 'A' reported they had a similar situation in which the coupon code was not working and they did not obtain fingerprints.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

Regarding CNA 'H', Staff 'A' reported that was another employee that showed as "withdrawn" in the electronic fingerprint system and had not had fingerprints done.

Regarding Staff 'I', Staff 'A' reported they had been hired 10/18/22, last day worked was 3/10/23, and confirmed they had not had fingerprints done.

Regarding Staff 'J', Staff 'A' reported they had not had fingerprints done.

Regarding Staff 'K', Staff 'A' reported they were not sure why the document in their employee file said fingerprints were requested on 3/30/23, since they had not gone yet.

Staff 'A' was unable to offer any further explanation as to the lack of oversight and monitoring of employees screening process.

DPS #2

Based on interview and record review, the facility failed to develop and implement written policies and procedures for their Abuse policy in accordance with current regulatory standards. This deficient practice has the potential to affect all 71 residents that reside within the facility.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	**3/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	**26900 FRANKLIN ROAD SOUTHFIELD, MI 48034**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the facility most current abuse prohibition policy titled, "Abuse Program: Elder Justice Act (Abuse, Neglect, Mistreatment, Misappropriation, Suspicion of Crime, Investigation and Reporting) dated 4/13/22 failed to include/address the required CMS (Centers for Medicare & Medicaid Services) written policies and procedures that were effective 10/21/22, implemented on 10/24/22 as identified below: VIII. Coordination with QAPI (Quality Assurance Process Improvement): The facility must develop written policies and procedures that define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program under §483.75. Cases of physical or sexual abuse, for example by facility staff or other residents, always require corrective action and tracking by the QAA Committee, at §483.75(g)(2). This coordinated effort would allow the QA (Quality Assurance) Committee to determine: *If a thorough investigation is conducted; *Whether the resident is protected; *Whether an analysis was conducted as to why the situation occurred;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	**3/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	**26900 FRANKLIN ROAD SOUTHFIELD, MI 48034**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	*Risk factors that contributed to the abuse (e.g., history of aggressive behaviors, environmental factors); and *Whether there is further need for systemic action such as: *Insight on needed revisions to the policies and procedures that prohibit and prevent abuse/neglect/misappropriation/exploitation, *Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about, *Efforts to educate residents and their families about how to report any alleged violations without fear of repercussions, *Measures to verify the implementation of corrective actions and timeframes, and The facility must develop and implement written policies and procedures that: Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. *Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual ' s obligation to comply with the following reporting requirements. * Each covered individual shall report to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. * Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. A facility ' s policies and procedures for reporting under 42 CFR 483.12(b)(5) should specify the following components, which include, but are not limited to: · Identification of who in the facility is considered a covered individual; · Identification of crimes that must be reported; · Identification of what constitutes "serious bodily injury;" · The timeframe for which the reports must be made; and · Which entities must be contacted, for example, the State Survey Agency and local law enforcement.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility's policy mentions that "all alleged violations" are to be reported to "law enforcement when applicable", but did not specify when law enforcement would be contacted and what crimes were required to be reported. On 3/30/23, an interview was conducted with the Administrator, who was also the facility's Abuse Coordinator. When queried about whether she was aware of the updates made to regulatory requirements for Abuse Prohibition on 10/21/22, the Administrator reported she would look into it. The Administrator was not aware that there were any updates needed to the current facility Abuse policy.			
F0609 SS= D	Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law	F0609	F 609 Element 1 It is the practice of the facility to report an any allegations of misappropriation in a timely manner. The allegation of misappropriation for Resident 52 has been reported to the state agency. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Those residents have been interviewed for any misappropriation. No other misappropriation has been noted. Element 3 The Interdisciplinary Team reviewed the policy and procedure Abuse Program: Elder Justice Act (Abuse, Neglect, Mistreatment,	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #: MI00135117. Based on observation, interview and record review, the facility failed to report an allegation of misappropriation (R52) one of four residents reviewed for abuse, resulting in the State Agency (SA) not being informed of the allegations in a timely manner, and the potential for further allegations to go unreported and not thoroughly investigated. Findings include: According to the facility's policy titled, "Abuse Program: Elder Justice Act (Abuse, Neglect, Mistreatment, Misappropriation, Suspicion of Crime, Investigation and Reporting) dated 4/13/2022: "..Possible indicators of abuse include, but are not limited to...Resident, staff or family report of abuse...Resident reports of theft of property, or missing property...Failure to provide care needs such as feeding, bathing,		Misappropriation, Suspicion of Crime, Investigation and reporting) and deemed it appropriate. IDT, including the Administrator, have been educated on the abuse program and thoroughly investigating allegations of misappropriation and timely reporting to the state agency. Element 4 The Administrator/designee will complete audits on 5 residents weekly for 2 months, then every other week for 2 months to ensure any allegations of misappropriation have been reported in a timely manner to the state agency. Any deficient practice will be corrected immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Compliance Date April 26 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dressing, turning & positioning...Sudden or unexplained changes in behavior and/or activities such as fear of a person or place, or feelings of guilt or shame...Reporting of all alleged violations to the Administrator, state agency...within specified timeframes...Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse...Taking all necessary actions..." R52 On 3/28/23 at 12:13 PM, R52 was observed seated in a wheelchair in their room. R52 was informed that an investigation was being conducted regarding their allegation of misappropriation of money while they were temporarily transferred to another nursing facility due to testing positive for COVID-19. R52 further reported this was not the first time this occurred and had several other items missing. They were unable to offer any explanation as to what had been done to address that concern and reported it happened in the past fall (2022). Review of the clinical record revealed R52 was admitted into the facility on 6/4/22, readmitted on 2/28/23 with diagnoses that included: encounter for orthopedic aftercare following surgical amputation, type 2 diabetes mellitus with diabetic peripheral angiopathy and hyperglycemia, acquired absence of right leg above knee, acquired absence of left leg below knee, acute kidney			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

failure, hyperkalemia, major depressive disorder recurrent, other pericardial effusion and rhabdomyolysis.

According to the Minimum Data Set (MDS) assessment dated 12/9/22, R52 had no communication concerns, and had intact cognition.

Review of R52's grievance/concern documentation provided by the facility included a document dated 11/17/22 which alleged "...Resident stated she's missing dove body wash, body spray, powder, and a wedding ring..." This form had been completed by former Activity Director (Staff 'I').

The remaining sections for "ACTION TAKEN", "FOLLOW UP", AND "QUALITY ASSURANCE COMMITTED - PEER REVIEW ONLY" including signature from administrator were left incomplete (blank).

Review of one of three witness statements included an entry from the Director of Nursing (DON) dated 11/22/22 which read, "...Once I was made aware of (R52) claim of missing items I went to interview her...She stated she was missing some toiletry items that she had won playing BINGO. The items consisted of body wash, body lotion and powder of an unknown scents/fragrance. She also described her ring as a wedding ring, large "platinum/gold" setting with a center stone setting and other stones "diamond" all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	around the band. She said she took her ring off on Friday evening approx. 5:30 pm and laid it on the bedside table along with other jewelry including a gold watch and another ring with a large light green stone. She said it was there when she went to bed but gone in the morning. She stated she looked around but didn't see the ring so she put on the ring with the light green stone. She said she notified housekeeping at that time and then on Monday notified Laundry. She denied having an appraisal or a receipt. She said she wasn't trying to make a big deal out of it." On 3/30/23 at 10:30 AM, an interview was conducted with the Administrator who was also the facility's Abuse Coordinator. Upon review of the grievance form dated 11/17/22, when asked if the allegation of misappropriation of personal items should have been reported to the State Agency, the Administrator reported it should have, but they were not able to offer any further explanation since they were not employed with the facility at that time. The Administrator was asked if there was any other investigation completed for this, they reported they provided what they had available. Staff 'KK' was attempted to be contacted by phone, but there was no return call by the end of the survey.			
F0610 SS= E	Investigate/Prevent/Correct Alleged Violatio §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have	F0610	F 610 Element 1 It is the practice of the facility to ensure that	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #: MI00135117. Based on interview and record review, the facility failed to ensure that allegations and instances of misappropriation were fully investigated for one (R52) of four residents reviewed for abuse. Findings include: According to the facility's policy titled, "Abuse Program: Elder Justice Act (Abuse, Neglect, Mistreatment, Misappropriation, Suspicion of Crime, Investigation and Reporting) dated 4/13/2022: "...An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect of exploitation occur...Investigating different		allegations and instances of misappropriation are fully investigated. Resident 52 allegations of misappropriation has been investigated and reported. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Those residents have been interviewed for any misappropriation. No other misappropriation have been noted. Element 3 The Interdisciplinary Team reviewed the policy and procedure Abuse Program: Elder Justice Act (Abuse, Neglect, Mistreatment, Misappropriation, Suspicion of Crime, Investigation and reporting) and deemed it appropriate. IDT, including the Administrator, have been educated on the abuse program and thoroughly investigating allegations of misappropriation and timely reporting to the state agency. Element 4 The Administrator/designee will complete audits on 5 residents weekly for 2 months, then every other week for 2 months to ensure any allegations of misappropriation have been reported in a timely manner to the state agency. Any deficient practice will be corrected immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

types of alleged violations...Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations..Focusing the investigation on determiningn if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause...Providing complete and thorough documentation of the investigation..."

R52

Review of R52's grievance/concern documentation provided by the facility included a document dated 11/17/22 which alleged "...Resident stated she's missing dove body wash, body spray, powder, and a wedding ring..." This form had been completed by former Activity Director (Staff 'I').

The investigation portion of this document read, "...room search conducted staff & resident interviews. Resident account of when missing items varies. Resident declines police report or wanting reimbursement or replacement. She denies theft & simply states they are missing. Denies anyone was in room that was not assigned or should not have been there. (This was signed on 11/28/22 by the former Administrator (Staff 'KK').

The remaining sections for "ACTION TAKEN", "FOLLOW UP", AND "QUALITY ASSURANCE COMMITTED - PEER REVIEW ONLY" including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	signature from administrator were left incomplete (blank). Review of the additional documentation included three witness statements. There was no documented evidence that staff assigned to R52 or other residents were interviewed as part of this investigation. Review of the clinical record revealed R52 was admitted into the facility on 6/4/22, readmitted on 2/28/23 with diagnoses that included: encounter for orthopedic aftercare following surgical amputation, type 2 diabetes mellitus with diabetic peripheral angiopathy and hyperglycemia, acquired absence of right leg above knee, acquired absence of left leg below knee, acute kidney failure, hyperkalemia, major depressive disorder recurrent, other pericardial effusion and rhabdomyolysis. According to the Minimum Data Set (MDS) assessment dated 12/9/22, R52 had no communication concerns, and had intact cognition. On 3/30/23 at 10:30 AM, an interview was conducted with the Administrator who was also the facility's Abuse Coordinator. Upon review of the grievance form dated 11/17/22, when asked if there was any other investigation completed for this, they reported they provided what they had available. Staff 'KK' was attempted to be contacted by phone, but there was no return			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	call by the end of the survey.			
F0622 SS= D	Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility.	F0622	F 622 Element 1 It is the practice of the facility to ensure necessary documentation is completed and provided to support a transfer to another facility and evidence of communication to the receiving facility. Resident 19 has returned to the facility with no concerns. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Nursing staff has been educated that documentation needs to be completed to support a transfer to another facility and evidence of communication to the receiving facility. Element 3 The Interdisciplinary Team reviewed the policy and procedure Transfer and Discharge (Including AMA) and deemed it appropriate. The Nursing department has been educated on the Transfer and Discharge (including AMA) process including documentation is completed and provided to support a transfer to another facility with evidence of communication to the receiving facility. Element 4 The DON/designee will complete random audits on 5 residents discharged/transferred to an outside facility weekly for 2 months, then every other week for 2 months to ensure documentation is complete and provided to support a transfer to another facility with evidence of communication to the receiving facility. Any deficient practice will be	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need (s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.		corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The DON is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00132913. Based on interview and record review, the facility failed to ensure necessary documentation was completed and provided to support a transfer to another facility and evidence of communication to the receiving facility for one (R19) of residents reviewed for transfers and discharges. Findings include: Review of a complaint filed with the State Agency read, "...on 11/28/2022 the resident had a breathing attack while in the activities room so staff took her back to her room to try to get her breathing under control...The complainant states she and her sister left the facility thinking everything was okay with the resident. The complainant states she received a call after leaving stating the resident was being transferred to the hospital because her breathing was irregular...". Review of the clinical record revealed R19 was admitted into the facility on 9/13/21 and readmitted on 11/28/22 with diagnoses that included: longstanding persistent atrial fibrillation, acute on chronic combined systolic and diastolic heart failure, acute respiratory failure with hypoxia, pulmonary hypertension, old myocardial infarction,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

typical atrial flutter, cardiomyopathy, hypertensive heart and chronic kidney disease without heart failure, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dependence on supplemental oxygen, generalized anxiety disorder, depression, and encephalopathy.

Review of the progress notes revealed there were only two entries on 11/28/22 and 12/21/22 from practitioners that mentioned R19's reason for transfer to the hospital on 11/28/22. There was no documentation from the facility's nursing staff as to the change in status and/or reason for transfer.

The physician/practitioner entries included:

On 11/28/22 at 2:16 PM, an entry from Nurse Practitioner (NP 'R') read, "Patient was seen for follow up of her episode of panic attack with sob (shortness of breath) earlier today . On encounter she was sitting in the dining room eating lunch. She denied feeling SOB at this time. She stated that she started feeling sob all of a sudden. She denied any palpitations or chest pain...".

On 12/21/22 at 12:47 PM, an entry from Physician 'Q' read, "Patient is seen and examined for follow up. Patient had recent episode of AFivb <sic> (Atrial Fibrillation) with RVR (Rapid Ventricular Response) with SOB. She had to be transferred to the ER (Emergency Room). She returned back same

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	day after stabilizing...". On 3/29/23 at 10:00 AM, review of R19's census details documented the resident had been transferred out to a hospital on 11/28/22 and transferred back into the facility on 11/28/22. Further review of the resident's clinical record revealed there was no other information about the resident's clinical rationale for transfer, assessment at the time of the transfer, or what documentation had been provided to the receiving hospital. There was no transfer form, physician's order for hospitalization/transfer, or any progress notes and/or change of condition documentation from nursing. The assessment tab contained only three previous hospital transfer forms dated 3/7/22, 1/2/22 and 10/21/21. On 3/29/23 at 10:35 AM, an interview was conducted with the Director of Nursing (DON). When asked about what should occur by nursing staff when a resident transfers to the hospital, the DON reported there should be an "einteract" form filled out by the nurse and that information should be maintained under the assessment tab. Further review of the resident's clinical record revealed there was no documentation about R19's transfer or return from the hospital on 11/28/22. The DON further reported the nursing staff should've also assessed and documented the resident's status upon their return to the facility and confirmed that had not occurred			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	either.			
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00132711. Based on observation, interview, and record review, the facility failed to ensure activity of daily living care (personal hygiene, incontinence care, nail care) was provided for one resident, (R30) of eight residents reviewed for activities of daily living. Findings include: A review of a facility provided policy titled, "Activities of Daily Living" dated 4/1/22 was conducted and read, "...Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care...". On 3/28/23 at 10:44 AM, R30 was observed in their bed asleep. A strong urine odor was present at that time. It was further observed their gown had food crumbs and liquid from breakfast spilled down the front. The corner of R30's eyes appeared with crust accumulation and R30's fingernails were	F0677	F 677 Element 1 It is the practice of the facility to ensure activity of daily living care (personal hygiene, incontinence care, nail care) is provided. Resident 30 personal hygiene has been completed including shower, incontinence care and nail care. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Those residents' have been reviewed to ensure activity of daily living care (personal hygiene, incontinence care, nail care) has been provided. Any residents that required activity of daily living care as completed immediately. Element 3 The Interdisciplinary Team reviewed the policy and procedure Assisting with Activity of Daily Living and deemed it appropriate. The nurses and CNA's have been educated on the Assisting with Activity of Daily Living including personal hygiene, incontinence care, and nail care. Element 4 The DON/designee will complete random audits on 5 residents weekly for 2 months, then every other week for 2 months to ensure residents are receiving activities of daily living care including personal hygiene, incontinence care, and nail care. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting.	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observed with a visible accumulation of brownish debris under the nail beds. On 3/28/23 at 12:23 PM, R30 was observed in bed asleep. It was noted their gown had been changed, however; the crust remained in the corner of their eyes and their fingernails remained with the visible accumulation of debris under the nail beds. On 3/28/23 at 2:44 PM, R30's room presented with a strong urine odor. R30 remained with crust in the corner of their eyes and long fingernails with visible accumulation of debris under the nail beds. On 3/29/23 at 11:33 AM, R30 was observed up in their wheelchair in the dining room. At that time, R30's fingernails remained with a visible accumulation of brown debris under the nail beds. R30 was asked about their nails and said, "I do need my nails done." A review of R30's clinical record revealed they most recently re-admitted to the facility on 3/31/21 with diagnoses that included: dementia, diabetes, major depressive disorder, morbid obesity, and pressure ulcers. R30's most recent Minimum Data Set assessment revealed they required extensive assistance from one to two staff members for hygiene and bathing. On 3/3/1/23 at 12:30 PM, an interview with the facility's Director of Nursing (DON) was conducted and they reported resident's		The DON is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	should be assisted with personal hygiene tasks daily and nail care should be provided as needed.			
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify and provide care for a peripheral intravenous (IV) for one resident (R44) of one resident reviewed for peripheral IV's. Findings include: On 3/28/23 at 11:17 AM, R44 was observed in their bed, awake and alert but did not participate in attempts at verbal communication. At that time, it was observed R44 had a peripheral IV inserted on the outer aspect of their left upper arm. The IV was covered with a transparent dressing that was dated 3/13/23. On 3/29/23 at 11:30 AM, and 3/30/23 at 8:10 AM, R44 was observed in bed. It was further observed R44's left arm remained with the IV in place, and the dressing dated 3/13/23.	F0684	F 684 Element 1 It is the practice of the facility to ensure to identify and provide care for a peripheral intravenous (IV). Resident 44 peripheral intravenous has been discontinued. Element 2 Residents that currently reside in the facility that have peripheral intravenous (IV) have the potential to be affected by this cited practice. An audit was conducted of those residents to ensure care for the peripheral intravenous was in place with a doctor's order. No concerns were found. Element 3 The Interdisciplinary Team reviewed the policy and procedure IV (intravenous) dressing change and the IV (intravenous) flushing policy and deemed it appropriate. Nursing staff have been educated on IV (intravenous) dressing change and the IV (intravenous) flushing policy with emphasis on assessment or monitoring of peripheral intravenous and changing of the dressing. Element 4 The DON/designee will audit 5 residents weekly for 2 months, then every other week for 2 months to ensure peripheral intravenous (IV) have the correct orders in place for assessment or monitoring of peripheral and changing of the dressing. Any deficient practice will be corrected/updated immediately. The results will also be taken to	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A review of R44's clinical record was conducted and revealed they admitted to the facility on 2/16/22. R44 discharged to the hospital on 3/13/23 and re-admitted to the facility on 3/27/23. R44's diagnoses included: traumatic brain injury, stroke, quadriplegia, aphasia, moderate protein calorie malnutrition, pressure ulcers, and contractures. R44' most recent minimum data set dated 2/24/23 revealed R44 had severe cognitive impairment, was non-ambulatory, and required total assistance from one to two staff members for all activities of daily living. A review of R44's orders revealed no order for insertion, assessment or monitoring of a peripheral IV, or intravenous therapy. A review of a re-admission progress note dated 3/27/23 did not reveal any documentation of the presence of a peripheral IV. A, "Nursing-Skin/Wound Note", dated 3/29/23 at 2:11 PM entered into the record by Wound Care Nurse 'QQ' was reviewed and read, "(R44) was re-admitted to the facility...(R44) is being seen regarding skin integrity, head to toe assessment reveals <sic> finding of hemorrhagic blisters to bilateral abdominal/flanks, open area to the left posterior calf, bilateral feet observed with multiple intact lesions, which appears to relate to his history of venous ulcers. All wound <sic> cleansed and treatments applied. MD (Medical Doctor) aware. message <sic> left for (R44) sister for skin integrity updates. Wound care team to follow		the Quality Assurance and performance review meeting. The DON is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

up." It was noted this note did not indicate any presence of the peripheral IV in R44's left upper arm.

On 3/30/23 at 11:36 AM, an interview as conducted with Wound Nurse 'QQ'. They were asked if they performed a skin assessment on R44 on 3/29/23, and reported they did. They were asked if they noticed the peripheral IV in R44's left arm and said they did not remember. They were then asked if the presence of the IV should have been documented and said it should have. Lastly, they were asked if the dressing dated 3/13/23 was appropriate and said it was not.

On 3/31/23 at 12:30 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding R44's IV. They were asked if staff were expected to perform thorough, accurate skin assessments and document their findings including the presence of peripheral IV's and said they should.

A review of a facility provided policy titled, "Intravenous Therapy -Heparin Lock/Peripheral Catheter (Short) Insertion, Flushing, and Discontinuation" issued 9/26/17 was conducted and read, "...Heparin locks/Peripheral Catheter (Short) must be ordered by a physician...Heparin lock is flushed by a nurse on each shift...Assessment of short peripheral catheter site is performed:...At least once a shift when not in use...Specific flush orders must be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documented...Discontinuation...Short peripheral catheters are removed/replaced: At the completion of therapy...".			
F0688 SS= D	Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure restorative program services were provided to two residents (R#'s 30 and 44) of four residents reviewed for restorative services. Findings include: A review of a facility provided policy titled, "Restorative Nursing Programs" revised 1/23 was conducted and read, "It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest	F0688	F 688 Element 1 It is the practice of the facility to ensure restorative program services are provided. Resident 30 and Resident 44 have been evaluated and a restorative program put in place. Element 2 Residents that currently reside in the facility that require a restorative program have the potential to be affected by this cited practice. An audit was conducted on those residents to ensure an appropriate restorative program is in place. Restorative programs have been updated as needed. Element 3 The Interdisciplinary Team reviewed the Restorative program policy and procedure and deemed it appropriate. The Nurses and CNA's have been educated on the restorative program. Element 4 The DON/designee will complete random audits on 5 residents weekly for 2 months, then every other week for 2 months to ensure residents have restorative program in place and completed as ordered. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The DON is responsible for compliance.	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	practicable level...". R30 On 3/28/23 at 10:45 AM and 2:44 PM, R30 was observed in their bed. At those times, orthopedic boots were observed on R30's legs. It was observed the boot on the left leg was labeled "Right" and the boot on the right leg was labeled "Left". A review of R30's clinical record was conducted and revealed they most recently admitted to the facility on 3/31/21 with diagnoses that included: dementia, diabetes, epilepsy, morbid obesity, and pressure ulcers. R30's most recent Minimum Data Set (MDS) assessment revealed R30 had severely impaired cognition, was non-ambulatory, and required extensive to total assist from one to two staff members for most activities of daily living. A review of R30's orders was conducted and revealed the following: An order dated 6/4/21 that read, "Orthosis/Splint to be applied to: bilateral ankles. Assist with the application of Splints, braces or prosthetics. Patient has bilateral PRAFOs (orthotic boots) which are specific to left and right side and have been labeled. To be donned every day for 4 hours as tolerated...". An order dated 1/31/21 that indicated R30 was to receive upper extremity range of motion (ROM) three times a week for 12		Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

weeks.

An order dated 2/28/23 that indicated R30 was to receive lower extremity range of motion (ROM) three times a week for 12 weeks.

On 3/29/23 at 2:27 PM, a review of facility provided documentation for restorative services was conducted. R30 had one "Restorative Nursing Flow Sheet" dated March 2023 and indicated the only services provided were lower extremity range of motion exercises, despite having orders for upper extremity ROM effective 1/2023 and application of ankle orthotics effective 6/2021. It was further noted R30 did not receive any services during the first week of March, and had received no services from 3/24/23 thru 3/29/23.

R44

On 3/29/23 at 3:28 PM, a review of R44's clinical record revealed they admitted to the facility on 2/16/22 with diagnoses that included: traumatic brain injury, stroke, quadriplegia, aphasia, epilepsy, moderate protein calorie malnutrition, pressure ulcers, and contractures of the feet. R44's most recent MDS indicated they had severe cognitive impairment, were non-ambulatory, and required total assistance from one to two staff members for all activities of daily living.

A review of R44's orders was conducted and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	revealed the following: An order dated 12/8/22 for lower extremity ROM three times a week for twelve weeks. An order dated 12/29/22 for upper extremity ROM three times a week for twelve weeks. And two orders dated 2/7/23 for upper extremity ROM and lower extremity ROM three times a week for twelve weeks. On 3/29/23 at 4:37 PM, a review of facility provided restorative documentation was conducted and revealed only two "Restorative Nursing Flow Sheets", one for February 2023 and one for March 2023. The February flow sheet documented R44 received services only five times during the month, and the March flow sheet documented R44 only received services on 3/2/23, 3/3/23, 3/7/23, 3/8/32, and 3/9/23. On 3/30/23 at 11:22 AM, the Director of Nursing (DON) reported there had not been a restorative nursing program in place prior to their employment at the facility in October 2022 and they were in the process of starting one.			
F0689 SS= D	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident	F0689	F 689 Element 1 It is the practice of the facility to ensure adequate supervision per plan of care. Resident 12 and Resident 29 care plans have	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate supervision per plan of care for two (R12 and R29) of five residents reviewed for accidents. Findings include: R12 On 3/29/23 from 8:02 AM to 8:27 AM, R12 was observed in the Unit 3 activity lounge area seated in a wheelchair at a table, eating breakfast with their right hand. The left hand was observed to have a left wrist/hand splint. The door to this lounge area was closed and there were no staff present, or periodically checking on R12 during this observation. On 3/29/23 at 8:07 AM, R12 reported they had eaten most of their breakfast. When asked if staff was usually present when eating, they shook their head yes. When asked if anyone had today, they shook their head no. On 3/29/23 at 8:27 AM, a staff member was observed entering the activity lounge and asking R12 if they were done with their meal. On 3/30/23 at 8:18 AM, R12 was observed in the Unit 3 activity lounge area seated in a		been reviewed and updated as needed. Resident 12 and Resident 29 were both assessed by nursing and no concerns were noted. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. An audit was conducted on current residents to ensure adequate supervision is being provided per the plan of care. Any concerns were addressed immediately. Element 3 The Interdisciplinary Team reviewed the comprehensive Person-Centered Care Planning Process and deemed it appropriate. Nursing staff have been educated on following the Comprehensive Person-Centered Care Planning Process. Element 4 The DON/designee will complete random audits on 5 residents for 2 months, then every other week for 2 months to ensure staff is providing adequate supervision per the plan of care. Results will also be taken to the Quality Assurance and performance review meeting. The DON is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wheelchair facing out the window, eating their breakfast. There were three staff observed at the desk and upon approach, Nurse Supervisor 'A' directed Certified Nursing Assistant (CNA 'B') to go to into the dining room with R12 and further stated "Someone's gotta sit in there. He can't be isolated behind the door alone." On 3/30/23 at 8:24 AM, an interview was conducted with Nurse Supervisor 'A'. When asked about the observation of lack of supervision while eating, Nurse Supervisor 'A' reported R12 liked to eat in the activity lounge but should have someone supervising. Nurse Supervisor 'A' was informed of the concern with lack of staff supervision during multiple observations and they acknowledged the same concern. Review of the clinical record revealed R12 was admitted into the facility on 1/22/17 and readmitted on 6/15/22 with diagnoses that included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, aphasia, dysphonia, unspecified protein-calorie malnutrition, chronic respiratory failure and juvenile cataract left eye. According to the quarterly Minimum Data Set (MDS) assessment dated 12/21/22, R12 had moderately impaired cognition (scored 12/15 on brief mental status exam), and required supervision with eating.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the Kardex and Activities of Daily Living (ADL) care plan initiated 2/12/21 directed staff to: "Monitor for difficulty chewing or swallowing" "upright posture, small bites/sips, slow rate, alternate liquids/solids, assistance as needed" "set-up with meals supervise PRN (as needed)". R29 R29 was initially admitted to facility on 2/10/22, with diagnoses that included metastatic prostate cancer, dementia, psychotic disturbance, mood disturbance, history of falls, and obstructive uropathy. R29 was recently hospitalized on 2/22/23 due to aggressive behaviors based on the physician note dated 2/28/23. R29 was readmitted back to the facility on 2/27/23. An initial observation of R29 was completed on 3/28/23, at approximately 2:40 PM, in their room. R29 was observed in their bed with eyes closed. R29's bed was positioned against the wall on their right side. A bed bolster (long cushion, measured approximately 3 feet in length), was secured to the left side of R29's bed along the perimeter of the mattress. R29 had a mattress with built up perimeter (concaved mattress) on their bed. There was no staff member/sitter in the room during this observation. A wheelchair was observed in the room. A subsequent observation was completed later that day at approximately 4:30 PM. R29 was observed in their bed during this 2nd observation,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

with bed positioned against the wall, and a bed bolster attached to the left side of their bed. No staff member/sitter was observed in the room.

On 3/29/23, at approximately 9:20AM, a 3rd observation was completed. R29 was in their bed with their eyes closed. Staff member "III" was observed sitting in the room. R29's bed was positioned against the wall on their right side. Bed bolster-cushion was observed laying on the sofa behind the bed, by the window.

Based on the Minimum Data Set Assessment (MDS), dated 2/16/23, R29 had a Brief Interview of Mental Status (BIMS) score of 00, indicative of severe cognitive impairment. R29 needed limited assistance from staff for their mobility in bed and to get in and out of bed. R29 was able walk in the room with limited assistance from the staff.

A review of R29's EMR (electronic medical record) did not reveal any assessment for use of the bolster cushion in bed. There was no documented clinical rationale for using a bolster-cushion in bed and positioning R29's bed against the wall.

A review of R29's fall risk care plan revealed that one-on-one sitter was initiated on 3/7/23 due to "resident at high risk for falls and potential for injury r/t: (related to) confusion, gait/balance problems, incontinence, poor communication/comprehension, unaware of safety needs, wandering, history of aggressive behaviors, hitting, kicking staff d/t (due to) dementia, and metastatic CA (cancer) of prostate". Further review R29's care plan revealed that one on one sitter was initiated on 2/22/23 due to "R29 has behaviors of kicking at the staff, trying to get up out of bed on own, agitated, and starts arguing, stating wants to leave". R29's care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

plan did not reflect the use of concaved mattress.

Review of R29's nurses progress notes revealed documentation on one-to-one sitter only for the following dates since the start date of 2/22/23: 2/27/23, 3/4/23, 3/5/23, 3/6/23, 3/11/23, 3/13/23, 3/18/23, 3/19/23, 3/20/23, 3/21/23, 3/24/23, 3/25/23, and 3/27/23. R29's EMR did not have any other documentation to verify that they had 1:1 supervision every day from 2/22/23 as recommended on the fall care plan. Review of a nursing progress note dated 2/12/23 revealed that R29 was observed on the floor in their room and 1:1 supervision was initiated. There was no record on R29's EMR to verify if R29 had 1:1 supervision between 2/12/23 and 2/22/23 and from 2/22/23 to current date.

An interview with the Director of Nursing (DON) was completed on 3/29/23, at approximately 2:20 PM. The DON was queried regarding one-to-one supervision for R29's and the observations that were made on 3/28/23, when no staff member was in R29's room. The DON reviewed the EMR and reported that R29 had been on 1:1 from 2/22/23. The DON also reported that R29 was very anxious and needed 1:1 supervision at all times and they would check why there was no one to one supervision/sitter during the 3/28/23 observations. When queried on the documentation on one-to-one supervision under EMR, the DON reported that they were under progress note.

An interview with staff member "L" was completed on 3/30/23, at approximately 8:50 AM. Staff member "L" was in R29's room during the interview and reported that they were the assigned sitter for R29. Staff member "L" was queried on their shift start time and sitter from the previous shift. Staff member "L" reported that their shift started at 7 AM and the nurse was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	watching R29 when they came on shift. Staff member reported that R29 was in the dining room and they did not meet the sitter from previous shift. An interview with Staff member "LLL" was completed on 3/30/23, at approximately 9:15 AM. Asked the staff member on the process of 1:1 sitter assignment on the staff schedule. Staff member "LLL" reported that sitters were assigned on the daily staff schedule. Staff member "LLL" reported that they had agency staff assigned as sitters at times. When reviewed the staff schedule it was as listed agency on some their schedule sheets. When queried on the observations with no sitter in the room, Staff member "LLL" reported that the nurses were watching R29 when sitters were on their breaks. A facility policy titled "Accident and Incident Report" revised on 6/22/22 read in part, "The purpose of this policy is to .... e. to properly care plan for residents. f. to prevent reoccurrence of a similar incident. g. to provide timely follow up of corrective measures ....".			
F0728 SS= E	Facility Hiring and Use of Nurse Aide §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program,	F0728	F 728 Element 1 It is the practice of the facility to ensure Non-Certified Nurse Aide 1) became certified within four months of nurse aide training, and 2) demonstrated proficiency and is determined to be proficient for the tasks they were assigned before continuing to provide resident care. NCNA K has been removed	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00131469. Based on interview and record review, the facility failed to ensure one (Non-Certified Nurse Aide/NCNA 'K') of eight nurse non-certified nurse aides reviewed for nurse aide certification 1) became certified within four months of nurse aide training, and 2) demonstrated proficiency and was determined to be proficient for the tasks they were assigned before continuing to provide resident care, resulting in the potential for		from the schedule. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Those residents have been interviewed for any concerns to ensure care has been provided with no concerns. Current Non-Certified Nurse Aides employee files have been reviewed to ensure they have become certified within four months of nurse aide training and are able demonstrate proficiency for the tasks they are assigned to provide resident care. Those that have not become certified within four months of nurse-aide training and are unable demonstrate proficiency for the tasks they are assigned to provide resident care have been removed from the schedule. Element 3 The Interdisciplinary Team reviewed the State's Nurse Aide Registry to obtain a certificate of registration as a new nurse aide in the state of Michigan and deemed it appropriate. HR director, Scheduler, and Staff development have been educated on the State's Nurse Aide Registry. Element 4 The Administrator/designee will complete audits on 5 Non-Certified Nurse Aides weekly for 2 months, then every other week for 2 months to ensure Non-Certified Nurse Aide 1) became certified within four months of nurse aide training, and 2) demonstrated proficiency and is determined to be proficient for the tasks they were assigned before continuing to provide resident care. Any deficient practice will be corrected immediately. The results will also be taken to the Quality Assurance and performance review meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	inadequate or inappropriate resident care. This deficient practice had the potential to affect all residents that reside within the facility. Findings include: According to the job description "Temporary Nursing Assistant" dated 3/29/2022: " ...Must have completed an 8-hour training course and successfully completed a competency evaluation to assure competent to provide hands on care ...Employees signature below indicates the employee's understanding of the requirements, essential functions and duties of the position." According to the state's Nurse Aide Registry, "...To obtain a certificate of registration as a nurse aide in the state of Michigan, new candidates must...After successful completion of a state approved nurse aide training program, a candidate must sign in with Headmaster to schedule a written/oral exam and clinical skills demonstration exam. Upon successful completion of both the written/oral and clinical exam, Headmaster will issue the applicant a certificate of registration that is valid for 2 years. A graduate nurse aide awaiting an exam from Headmaster can work in a facility as a temporary nurse aide for up to four months if they have graduated from a state permitted nurse aide training program. If they have not passed testing with Headmaster within four		The Administrator is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

months, the individual is no longer eligible to work in a facility as a nurse aide...".

On 3/30/23 at 2:16 PM, Human Resource Director (Staff 'A') was asked to provide the license/certification for all nursing staff as part of the extended survey task.

On 3/31/23 at 12:05 PM, Staff 'A' was requested to provide the license/certification which included NCNA 'K' as this was not included in the binder of licenses and certifications provided for review. NCNA 'K's' hire date was 3/7/23 and their training certificate was from 4/11/22.

Review of the time punch details revealed NCNA 'K' began working at the facility on 3/7/23. NCNA 'K's time punch data documented they worked:

On 3/7/23 from 9:35 AM - 2:30 PM; On 3/8/23 from 9:10 AM - 2:30 PM; On 3/11/23 for 1 hour (no time details noted); On 3/14/23 from 8:00 AM - 3:00 PM; On 3/15/23 from 7:59 AM - 3:01 PM; On 3/17/23 from 8:06 AM - 2:22 PM; and on 3/29/23 7:00 PM (this entry was noted as a "missed punch".

On 3/31/23 at approximately 2:45 PM, Staff 'A' was asked about the facility's hiring process and ensuring nurse aides became certified within four months of completing a state approved training. Staff 'A' reported they were not able to answer that, and deferred that question to either the Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of Nursing (DON) or Assistant DON (ADON) for further details. On 3/31/23 03:05 PM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's process for ensuring nurse aides became certified within four months of completing a state approved training, the DON reported they were aware as they currently owned their own nurse aide training program that was nearby. When asked about NCNA 'K', the DON reported NCNA 'K' and other employees had been taken off the schedule pending taking the certified nursing assistant exam. When asked about when the non-certified nurse aides were expected to obtain their cna exam upon hire, they reported I tell them asap (as soon as possible) but within four months. When asked about NCNA 'K', the DON reported they had been taken off the schedule recently when it was discovered their training program was from 4/11/22. When asked who was responsible for verification of certification and/or license requirements prior to or upon employment, the DON acknowledged that was a problem but was unable to explain who was responsible. When informed that Staff 'A' had deferred to the DON or ADON (assistant DON) for clarification, the DON was unable to offer any further explanation. On 3/31/23 at 3:56 PM, Staff 'A' responded			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	via email that NCNA 'K's missed punch detail for 3/29/23 was an error as the facility has been having issues with the time clock and further reported, "Sometimes in a haste when other employees punch in it sometimes pulls up another employee's name and the punch will go under that person and then the scheduler or myself will have to fix it. But since this is a new pay period and our time cards are not due yet no one has gone in to correct it." On 3/31/23 at 4:35 PM, Staff 'A' was asked to provide NCNA 'K's signed job description and competency evaluation provided by the facility upon hire. At 4:58 PM, Staff 'A' responded via email that they had checked with the ADON (who was responsible for skills/competency evaluations) and was told NCNA 'K' doesn't have any completed.			
F0755 SS= E	Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the	F0755	F 755 Element 1 It is the practice of the facility to ensure that accurate documentation of administration of controlled substances is completed. Resident 4 has been assessed by nursing to ensure accurate documentation of her controlled substance has been completed. Resident 4 is stable and denies any pain/discomfort. Element 2 Residents that currently reside in the facility that currently receive controlled substances have the potential to be affected by this cited practice. Those residents have been audited to ensure that accurate documentation of	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	services of a licensed pharmacist who-§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure accurate documentation of administration of controlled substances for one (R4) resident. Findings include: Review of a facility policy titled, "Controlled Medications - Storage of Controlled Substances" dated 3/1/18, revealed, in part, the following: "Medication including in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations...At each shift change, a physical inventory of all controlled medications, including the emergency supply, is conducted by two licensed nurses and is documented on the controlled medication accountability record...Any discrepancy in controlled substance medication count is reported to the director of nursing		administration of controlled substances is completed. Element 3 The Interdisciplinary Team reviewed the policy and procedure Controlled Medications-Storage of Controlled Substances and deemed it appropriate. Nurses have been educated on the Controlled Medications-Storage of Controlled Substances. Element 4 The DON/designee will randomly audit 5 residents weekly for 2 months, then every other week for 2 months to ensure accurate documentation of controlled substances has been completed. Any deficient practice will be corrected immediately. The results will also be taken to the Quality Assurance and performance review meeting. The DON is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

immediately. The director or designee investigates and makes every reasonable effort to reconcile all reported discrepancies. The director of nursing documents irreconcilable discrepancies in a report to the administrator..."

Review of Nurse 'FF's personnel file revealed a typed statement written by Nurse 'EE', former weekend supervisor, and signed off by the Director of Nursing (DON) that read, "...While I was counting narcotic boxes with Unit 1 nurse (Nurse 'FF') none of her narcotics were signed off that she had given earlier in shift. I had to wait until she signed off narcotics to count. I did inform (Nurse 'FF') that narcotics have to be signed off in real time when she pops a narcotic out of the blister packet that is when she signed off the narcotic in narc book."

On 3/29/23 at 2:44 PM, a telephone interview was conducted with Nurse 'EE'. When queried about the typed statement in Nurse 'FF's personnel file, Nurse 'EE' explained Nurse 'FF' did not sign out the narcotics they gave on the controlled substance log. Nurse 'EE' explained on the day in question, Nurse 'FF' wanted to leave without counting the controlled substances because the oncoming nurse had not yet showed up so the count was done by Nurse 'EE' and Nurse 'FF'. Nurse 'EE' reported the count of the cartridges in the narcotic box in the medication cart did not match what was documented on the count sheet. Nurse 'FF' explained there was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

another narcotic stored in the refrigerator so they went to the refrigerator and the box was empty. Nurse 'EE' reported that all the nurses kept writing down the same number even though there was no actual medication in the refrigerator. Nurse 'EE' reported the medication was for Marinol and was for R4. The DON and Administrator were notified by Nurse 'EE'. Nurse 'EE' explained that when they reviewed the Medication Administration Record there were doses that were documented as given but when they contacted the pharmacy they reported they had not refilled the medication in over two months.

Review of R4's clinical record revealed R4 was admitted into the facility on 6/11/21 with diagnoses that included: Alzheimer's Disease, bipolar disorder, and major depressive disorder. Review of a Minimum Data Set (MDS) assessment dated 3/17/23 revealed R4 had severely impaired cognition, rejected care, and required extensive to total physical assistance with transfers, bed mobility, and activities of daily living.

On 3/29/23 at 3:08 PM, an interview was conducted with the DON. When queried about the disciplinary note in Nurse 'FF's personnel file regarding narcotics, the DON reported Nurse 'FF' and other nurses were not "charting appropriately" for Marinol. They were signing out that the medication was given on the MAR, but the medication was not available to give. At that time, the DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

was asked if there was an investigation into this concern. The DON reported she would look into it.

On 3/29/23 at 3:39 PM, the DON provided a folder with their "investigation". Review of the investigation revealed the following:

Review of a "Controlled Substance Shift Inventory" forms (explained by the DON to be from the Unit 1 medication cart) revealed the following:

On 11/22/22, the 7:00 PM count did not match the previous shift's total at the end of the shift. "7" was documented for the total at the end of the 7:00 AM to 7:00 PM shift and "6" was documented for the total at the start of the 7:00 PM to 7:00 AM shift.

On 11/28/22 (7:00 AM shift), it was documented that one container was emptied or given to the DON, but the end count remained the same as the count at the beginning of the shift, which was "6" instead of "5".

On 11/30/22 (7:00 AM shift), it was documented that one container was received from the pharmacy which would have made the count "5" at the end of the shift (It was "4" at the beginning of the shift). However, the "5" was crossed out and "4" was written in for that date for the end count.

On 12/9/22 7:00 PM count documented there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

were seven containers in the cart at the start of the shift, none were received from pharmacy, and none were emptied from the cart. The end count was documented as seven and crossed out and six was written. The oncoming nurse's signature was scribbled out.

On 12/10/22, the 7:00 AM count indicated there were 10 containers in the cart at the start of the shift, but that number was crossed out and a "6" and a "7" were written in. The end of the shift count was 6 containers.

Review of R4's MAR and the "Controlled Drug Receipt/Record/Disposition Form" for dronabinol (Marinol) 2.5 milligrams take 1 capsule by mouth twice a day delivered and received on 10/10/22 revealed the following inaccuracies:

On 10/14/22 at 12:00 AM, the count was one less than what was documented when the last dose was pulled on 10/12/22. The medication was recounted and it was confirmed that the actual count was "23" and not "24" which does not account for one dose between 10/11/22 and 10/12/22. It was documented on the MAR that both the 12:00 PM and 5:00 PM doses were administered on 10/13/22. However, there were no doses documented as pulled on the controlled drug form.

On 10/15/22, it was documented only one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	capsule was pulled from the supply at 5:00 PM. It was documented on the MAR, that R4 received their 12:00 PM dose. On 10/16/22, it was documented one capsule was pulled from the supply at 12:00 PM and 5:00 PM. It was documented on the MAR that R4 refused the 5:00 PM dose. However, there was no documentation that the dose was wasted after it was pulled. On 10/19/22, there were no doses documented as pulled from the supply for that date. It was documented on the MAR that R4 received the 12:00 PM and 5:00 PM doses. There were no documented doses pulled from the supply between 10/21/22 and 10/25/22. It was documented on the MAR that R4 received their 12:00 PM and 5:00 PM doses on 10/22/22, 10/23/22, and 10/24/22. On 10/25/22, it was documented one capsule was pulled from the supply at 12:00 PM only. It was documented on the MAR that R4 received the 5:00 PM dose as well. There were no documented doses pulled from the supply between 10/25/22 and 11/1/22. It was documented R4 received their 12:00 PM and 5:00 PM doses on 10/26/22, 10/28/22, 10/29/22, 10/30/22, and 10/31/22. It was documented R4 received their 12:00 PM dose on 10/27/22, but refused the 5:00 PM dose.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of R4's MAR and the "Controlled Drug Receipt/Record/Disposition Form" for dronabinol (Marinol) 2.5 milligrams take 1 capsule by mouth twice a day delivered and received on 10/23/22 revealed four capsules were received on that date and were pulled from the supply on 11/15/22 at 5:00 PM, 11/20/22 at 12:00 PM, 11/20/22 at 5:00 PM, and 11/21/22 at 12:00 PM. It was documented that dronabinol was not sent from the pharmacy again after it ran out on 11/21/22. Review of R4's MARs for November 2022 and December 2022 revealed it was documented that R4 received dronabinol on 11/28/22 at 12:00 PM, 11/30/22 at 12:00 PM and 5:00 PM, 12/2/22 at 12:00 PM and 5:00 PM, 12/3/22 at 12:00 PM and 5:00 PM, 12/4/22 at 12:00 PM and 5:00 PM, 12/5/22 at 12:00 PM, and 12/7/22 at 12:00 PM and 5:00 PM. It should be noted that no further dronabinol was delivered from the pharmacy for R4 after 11/21/22. On 3/31/23 at 12:25 PM, the DON was further interviewed. When queried about what further action was taken to ensure other residents were not affected by the inaccurate documentation of controlled substance administration. The DON reported the nurse involved were inserviced and one was terminated, but she did not look into any other residents or review any other controlled substance documentation. The DON			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	explained that any medication pulled from the controlled substance supply should be accurately documented and when administered, the MAR should match the time the medication was pulled. Nurses should not document on the MAR that a medication was given, if it was not.			
F0756 SS= F	Drug Regimen Review, Report Irregular, Act O §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen	F0756	F 756 Element 1 It is the practice of the facility to ensure medication regimen reviews are conducted by the consultant pharmacist monthly and maintained in the resident's clinical record with documentation of the physician's response. Resident 36, 68, and 4 medication regimen reviews have been conducted by the consultant pharmacist with documentation of the physicians response and maintained in the residents clinical record. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. A complete chart review has been completed of those residents to ensure the medication regimen reviews were conducted by the consultant pharmacist with documentation of the physician’s response and maintained in the residents clinical record. Element 3 The Interdisciplinary Team reviewed the policy and procedure Medication Regimen Reviews-Pharmacy Services and deemed it appropriate. The DON and Unit Managers have been educated on the Medication Regimen Reviews- Pharmacy Services with	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure medication regimen reviews were conducted by the consultant pharmacist monthly and maintained in the resident's clinical record with documentation of the physician's response for three residents (R#'s 36, 68 and 4) of five residents reviewed for medication regimen reviews. Findings include: A review of a facility provided policy titled, "Medication Regimen Reviews-Pharmacy Services" issued 10/8/2018 was conducted and read, 1. The Consultant Pharmacist will conduct MRRs (medication regimen reviews) on residents...monthly...5. When irregularities are noted during the MRR, these irregularities are documented on a separate report...6. The Consultant Pharmacist will provide copies of the MRR irregularities and recommendations...7. The Director of Nursing, attending physician, and Medical Director will be provided with copies of the MRR irregularities and recommendations...8. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR, and the Director of Nursing, to act upon the		emphasis on the reviews being completed monthly, maintained in the resident's clinical record with documentation of the physician response. Element 4 The DON/designee will complete random audits of 5 resident charts monthly to ensure mediation regimen reviews are conducted by the consultant pharmacist monthly and maintained in the resident's clinical record. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The DON is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	recommendations...a). For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to either, accept and act upon the recommendations contained within the MRR, or reject all or some of the recommendations...and provide an explanation as to why the recommendation was rejected. b). The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it..." R36 On 3/29/23 at 1:17 PM, a review of R36's clinical record revealed they admitted to the facility on 7/27/22 and most recently re-admitted on 11/21/22. R36's diagnoses included: chronic kidney disease, diabetes, sickle cell disease, and heart disease. R36's most recent Minimum Data Set (MDS) assessment revealed they had severely impaired cognition and required extensive assistance from one to two staff members for most activities of daily living. A review of the Pharmacist's monthly medication regimen reviews in the miscellaneous tab of the electronic medical record was conducted and revealed one pharmacy recommendation dated 11/8/22. R68			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/29/23 at 4:07 PM, a review of R68's clinical record revealed they admitted to the facility on 6/15/22 withe diagnoses that included: chronic obstructive pulmonary disease, major depressive disorder, chronic pain, and obesity. A review of R68's MDS assessment revealed R68 was cognitively intact and required set up assistance from one staff member for activities of daily living. A review of the Pharmacist's monthly medication regimen reviews in the miscellaneous tab of the electronic medical record was conducted and revealed two recommendations dated 11/8/22. R4 Review of R4's clinical record revealed R4 was admitted into the facility on 6/11/21 with diagnoses that included: Alzheimer's Disease, bipolar disorder, and major depressive disorder. Review of a Minimum Data Set (MDS) assessment dated 3/17/23 revealed R4 had severely impaired cognition and required extensive to total assistance with transfers, bed mobility, and most activities of daily living. Further review of R4's clinical record revealed no monthly medication regimen reviews since 4/14/22. On 3/30/23 at 9:52 AM, an interview was conducted with the Director of Nursing (DON) regarding the location of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pharmacist's monthly medication regimen reviews. The DON reported they were scanned into the miscellaneous tab of the electronic medical record. On 3/30/23 at 10:20 AM, the facility was requested to provide any additional pharmacy reviews for R36, R68 and R4, however; none were provided by the end of the survey. On 3/31/23 at 1:10 PM, an interview was conducted with Pharmacist 'SS'. They were asked about the facility's process for monthly medication regimen reviews and said they completed them offsite, and e-mailed them to both the Administrator and Director of Nursing. They said they did not know the facility's process after they made their recommendations. Pharmacist 'SS' further said they did not believe the attending physicians were addressing the recommendations as they were making the same recommendations for the same residents month after month.			
F0759 SS= D	Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a	F0759	F 759 Element 1 It is the practice of the facility to ensure a medication error rate of less than five percent. Resident 129 has been assessed by nursing and remains in stable condition with no ill effect related to the medication error. Element 2	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medication error rate less than five percent when two medication errors were observed from a total of 27 opportunities for one resident (R129) of five residents observed during medication administration, resulting in a medication error rate of 7.41%. Findings include: On 3/28/23 at 9:22 AM, Nurse 'DD' was observed preparing medications for administration to R129. Nurse 'DD' prepared multiple medications including a 10 mg (milligram) amlodipine (blood pressure medication) tablet. Nurse 'DD' entered R129's room and administered the medications. On 3/28/23 at 9:28 AM, Nurse 'DD' exited the room and signed the medications out as given on the eMAR (electronic medication administration record). Nurse 'DD' was asked if they administered all of R129's medications that were due at that time and indicated they did. On 3/30/23 at 1:19 PM, R129's medication orders and March 2023 eMAR were reviewed. During the review it was discovered R129's order for amlodipine 10 mg tablet had been discontinued on 3/27/23 and a new order for amlodipine 1 mg/1 ml (milliliter) liquid had been ordered to start on 3/28/23. It was further discovered Nurse 'DD' signed the MAR that they administered the liquid amlodipine medication. Continued review of R129's orders further revealed R129 had an order for Miralax (laxative medication) that		Residents that currently reside in the facility have the potential to be affected by this cited practice. Those residents have been audited to ensure medications are being administrated as order by the physician. No other concerns noted. Element 3 The Interdisciplinary Team reviewed the policy and procedure ADMINISTRATIVE PROCEDURES-MEDICATION ADMINISTRATION PROCEDURE and deemed it appropriate. The Nurses have been educated on the Administrative Procedures-Medication Administrative Procedure with emphasis on administrating medications as ordered by the physician, including the correct form of the medication. Element 4 The DON/designee will complete random medication administrative audits for 5 nurses weekly for 2 months, then every other week for 2 months to ensure medication error rate less than 5 percent. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The DON is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was not observed to be administered or offered on 3/28/23, but had been signed off on the MAR by Nurse 'DD' as given. On 3/31/23 at 12:31 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding medication administration and they indicated medications should be administered per the, "Five Rights", right resident, right medication, right time, right, dose, and right route. A review of a facility provided policy titled, "ADMINISTRATIVE PROCEDURES-MEDICATION ADMINISTRATION PROCEDURE" dated March 2018 was reviewed but did not address the utilizing the five rights of medication administration, nor did it include any information about ensuring the right type (liquid, pill, etc...) of medication is administered.			
F0761 SS= E	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide	F0761	F 761 Element 1 It is the practice of the facility to ensure medications are appropriately labeled and stored. The insulins, lidocaine cream, sanitizing wipes, fleets enema, tube feeding formula, arthritis cream have been discarded. The liquid medications bottles have been cleaned. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. An audit was conducted of each	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications were appropriately labeled and stored in three of four medications carts reviewed. Findings include: A request for a policy on medication storage and labeling was requested via e-mail on 3/30/23 at 12:45 PM, however; a policy was not received by the end of the survey. On 3/28/23 at 9:00 AM, a review of a medication cart on unit 1 was conducted with Nurse 'TT'. During the review of the drawers the following was discovered: a long acting insulin injection pen with no resident name, a vial of short acting insulin stored with no date of when it was opened, a second vial of short acting insulin with an open date on the vial of 2/28/23 and an open date on the box of 3/13/23. It was further observed a tube of lidocaine cream stored with oral medications, and an open container of sanitizing wipes and a fleet's enema stored on top of a bag of tube feeding formula.		medication cart and topical medications were removed. Expired, undated, and unlabeled medications have been discarded. Each medication cart has been cleaned to include liquid medication bottles. Element 3 The Interdisciplinary Team reviewed the policy and procedure Medication and Treatment cart storage and deemed it appropriate. Nursing staff have been educated on Medication and Treatment cart storage with emphasis on expired, undated, and unlabeled medications need to be discarded and liquid medication bottles need to be cleaned. Element 4 The DON/designee will randomly audit 5 medication carts weekly for 2 months, then every other week for 2 months to ensure medications carts are free of expired, undated, and unlabeled medications and liquid medications bottles are clean. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The DON is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/28/23 at 9:29 AM, a review of a medication cart on unit 2 was conducted with Nurse 'DD'. During the review of the cart it was discovered a tube of arthritis cream stored in a drawer with oral medications and inhaled medication. It was further noted the drawer that stored the liquid medications was heavily soiled with sticky stains. At that time, Nurse 'DD' was asked who was responsible for keeping the medication carts clean, and they said they did not know. On 3/30/22 at 12:05 PM, a review of a second medication cart on unit 1 was conducted with Nurse 'LLL'. During the review, a vial of novolog insulin was observed. The open date on the bottle was 2/15/23. It was noted the label on the indicated the medication indicated it was to be disposed of after 28 days. It was also observed an unopened vial of novalog insulin was also stored in the cart. The label on the unopened insulin was reviewed and indicated the vial was to be refrigerated until opened. Nurse 'LLL' was asked if they put the unopened vial of insulin in the cart and said they did not. On 3/31/23 at 12:30 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding the medication carts. The DON indicated they had been made aware of the observations and acknowledged the concern.			
F0812	Food Procurement,Store/Prepare/Serve-	F0812	F 812	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
SS= F	Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen and failed to ensure potentially hazardous food items were properly cooled. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 3/28/23 between 8:45-9:15 AM, during an initial tour of the kitchen with Dietary Manager (DM) "OO", the following items were observed: In the dry storage room, there was an opened bag of French fried onions that was dated 11/23-12/23. DM "OO" stated "I'll throw that out." The ice scoop holder had black debris on the inside bottom surface, and the ice scoop was resting on the black debris. According to the Food & Drug administration		Element 1 It is the practice of the facility to maintain sanitary conditions in the kitchen and to ensure potentially hazardous food items are properly cooled. The French-fried onions were discarded immediately. The Ice Scoop and its holder have been clean. The two sanitizer buckets with cloths have been cleaned and changed to have sanitizer in the bucket. Handwashing signage has been posted at the handwashing sink located near the dish machine room. The two whole pork loins were discarded. Element 2 Residents that currently reside in the facility that consume food from the kitchen have the potential to be affected by this cited practice. An audit was conducted to ensure the kitchen is in sanitary condition and potentially hazardous food items are properly cooled. No other concerns noted. Element 3 The Interdisciplinary Team reviewed the Cooling of Food and the Kitchen Sanitation to Prevent the Spread of Viral Illness policy and procedure and deemed it appropriate. The Dietary Department have been educated on the Cooling of Food and the Kitchen Sanitation to Prevent the Spread of Viral Illness policy and procedure with emphasis on expired food, clean Ice scoop, sanitizer in the sanitizer bucket, cooling of potentially hazardous food items, and the posting of handwashing signage. Element 4 The Food Service Director/designee will complete random audits weekly for 2 months, then every other week for 2 months to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(FDA) 2013 Model Food Code, Section 3-304.12 In-Use Utensils, Between-Use Storage, "During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: ...(E) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not potentially hazardous (time/temperature control for safety food)..." In the walk-in cooler, there was a covered pan with 2 whole cooked pork loins, that had been cooked in the morning on 3/28/23. . On 3/28/23 at 11:02 AM, the internal temperature of the 2 whole pork loins in the walk-in cooler were measured to be 74 degrees Fahrenheit and 82 degrees Fahrenheit. At 11:50 AM, DM "OO" was queried if they use cooling logs and stated, "No, because we don't save much". When queried about the pork loins that were in the walk-in cooler, she stated they were cooked this morning and if she had to guess, were put into the walk-in cooler around 8 am. DM "OO" stated her morning cook arrives around 4:30 am. According to the 2017 FDA Food Code section 3-501.14 Cooling, "(A) Cooked POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be cooled: (1) Within 2 hours from 57ºC (135ºF) to 21ºC (70°F); and (2) Within a total of 6 hours from 57ºC (135ºF) to 5ºC (41°F) or less." There were 2 sanitizer buckets with cloths that were tested by DM "OO" and noted to have no detectable sanitizer (quaternary ammonia test strip did not change color to denote the presence of sanitizer). DM "OO" stated that the water was		the kitchen is in sanitary condition and to ensure potentially hazardous food items are properly cooled. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	too hot, and that was the reason the strips were not able to detect any sanitizer. According to the 2017 FDA Food Code, Section 3-304.14 Wiping Cloths, Use Limitation, ..."(B) Cloths in-use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114;" There was no handwashing signage at the handwashing sink located near the dish machine room. According to the 2017 FDA Food Code section 6-301.14 Handwashing Signage, "A sign or poster that notifies food employees to wash their hands shall be provided at all handwashing sinks used by food employees and shall be clearly visible to food employees."			
F0842 SS= D	Resident Records - Identifiable Informatio §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of	F0842	F 842 Element 1 It is the practice of the facility to maintain complete and readily accessible medical records. Resident 12's information regarding the dental concerns have been documented/uploaded in Resident 12's medical record. Resident 279 no longer resides in the facility. Physician BBB was educated on late documentation. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. An audit was conducted on current residents to ensure residents have complete and readily accessible medical records. Element 3	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physicia's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain complete and		The Interdisciplinary Team reviewed the HIM-Medical Record Department and deemed it appropriate. Nursing staff, physicians, and Medical Records have been educated on the HIM-Medical Record Department with emphasis on documenting in the chart timely and uploading information into the chart timely. Element 4 The DON/designee will complete random audits on 5 residents weekly for 2 months, then every other week for 2 months to ensure medical records are maintained completely and readily accessible. Results will also be taken to the Quality Assurance and performance review meeting. The DON responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	readily accessible medical records for two (R12 and R279) of 28 residents reviewed for complete/accurate clinical records, resulting in the facility staff and providers not having access to all of the pertinent information to care for the residents, and the increased potential for providers not having an accurate picture of the resident's condition. Findings include: Review of the facility's policy titled, "Medical Records/Process for Scanning Document(s)" dated 2/12/2019 revealed there was no documentation of the facility's process to maintaining accurate/available clinical records. This document only identified the process on how to scan and file a document into the electronic record. R12 On 3/28/23 at 11:58 AM, R12 was observed seated in a high-backed wheelchair next to their bed. R12 was able to communicate via some verbal communication, hand gestures and use of an electronic tablet. During this interview, R12 reported severe, throbbing pain to their right upper teeth and further reported, "I can't sleep." When asked about if they had recently seen a dentist, R12 shook their head no. On 3/28/23 at 12:05 PM, an interview was conducted with R12's assigned nurse, Nurse 'M'. When asked about what they knew about			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

R12's dental pain, Nurse 'M' reported they had given the resident pain medication this morning and the facility was having an issue with the current dentist and was trying to find another one.

Review of the clinical record revealed R12 was admitted into the facility on 1/22/17 and readmitted on 6/15/22 with diagnoses that included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, aphasia, unspecified protein-calorie malnutrition, type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, hypertensive heart disease with heart failure, chronic respiratory failure, obstructive sleep apnea, gallstone ileus, acute kidney failure, neuromuscular dysfunction of bladder, hypokalemia, hypomagnesemia, major depressive disorder single episode, localized edema, and juvenile cataract left eye.

According to the most recent completed Minimum Data Set (MDS) assessment dated 12/21/22, R12 had moderately impaired cognition (scored 12/15 on brief mental status exam), required supervision with eating, and had no dental concerns noted.

Review of the progress notes revealed one entry on 3/21/23 at 12:13 PM by R12's physician which read, "...He reports increased tooth and jaw pain right upper jaw. Staff reports that they are trying hard to find a dentist who would accept his insurance and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	office is wheelchair assessable...Tooth pain-acute on chronic-? root canal infection- A course of antibiotics- Augmentin x 7 days. Pending Dentist eval (evaluation). Orajel tid (three times a day) for pain control..." Additional review of the clinical record revealed there were no other progress notes about what had been attempted in regard to obtaining a dentist, or what had been attempted. On 3/28/23 at approximately 9:00 AM, an interview was conducted with R12's Social Worker (Staff 'F'). When asked about what had been done about R12's need to see a dentist, Staff 'F' deferred to the medical records/ward clerk (Staff 'N') for further details. When asked to clarify who was responsible for finding and/or coordinating services, Staff 'F' reported they only obtained consents for treatment and that Staff 'N' provided everything else. On 3/29/23 at 12:40 PM, an interview was conducted with Staff 'N'. When asked about what had been attempted for R12's dental concerns, Staff 'N' reported they had been trying to get him into the dentist for the past seven months. Staff 'N' discussed multiple hurdles and issue with current dental provider and was actively seeking another company utilized by their sister facilities. When asked where this information had been maintained as this was not available for review currently in R12's electronic medical			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

record, Staff 'N' acknowledged the concern and reported they also worked in medical records and that information had not been able to be uploaded to the electronic record yet.

R279

R279 was initially admitted to the facility on 5/11/22 with diagnosis that included: Multiple Sclerosis, paraplegia, muscle weakness, visual loss, major depressive disorder, neuromuscular dysfunction of bladder, and dependence on wheelchair.

A record review for R279 was completed on 3/29/23. Based on the most recent Minimum Data Set (MDS) assessment completed on 11/17/22, R279 had a Brief Interview of Mental Status (BIMS) score of 3, indicative of severe cognitive impairment. R279 needed extensive assistance from staff members to move or reposition in bed and totally dependent on staff assistance to get in and out of bed.

Further review of R279's EMR revealed a late entry nursing progress notes dated 1/9/23 for an event from 1/6/23, read in part, "while walking down the hall, writer observe the resident hanging on his mobile chair, holding onto arms rest, back laying on the chair seat, both feet touching the floor, mobile chair on the resting position with power off. When asked what happens, state" I ran out of power in my mobile chair, and I was trying to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	move the gear back and forth". Resident was repositioned back to his chair in a comfortable position, alert, and verbal, able to make needs known, denied any pain at this time around ...". On 1/7/23, R279 complained of pain on their left leg. R279 had swelling on left leg and left foot. The attending physician ordered left leg x-ray stat (immediately). The facility received x-ray results on 1/8/23. X-ray results revealed that R279 had sustained a fracture of the distal (lower) shaft of the left femur and R279 was transferred to the hospital. During record review on 3/29/23, there was no physician visit note following the event on 1/6/23. Follow up record review on 3/30/23 revealed a late entry physician note, completed on "3/29/23 at 9:49 AM" per EMR entry time, for a visit completed on 1/6/23, 82 days after the event. R279 was no longer residing at the facility. The late entry physician visit note indicated that resident was residing at a different facility. On 3/30/23, at approximately 9:15 AM, an interview was completed via phone with the attending physician, "BBB" regarding the documentation that was completed for R279, approximately 80 days after the event and discharge from the facility. Physician reported initially that they might have made an erroneous entry and would check. They had reported that they were checking their documentation during the interview. After			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	verification they reported that they the entry was correct. Also, reported that they had seen R279 after the event on 1/6/23 and they had missed to complete their note. When queried on the time frame to complete their documentation, Physician "BBB" reported that they had complete within 2-3 days. An interview with Director of Nursing (DON) was completed on 03/31/23, at approximately 01:49 PM. DON was queried on the late entry physician visit note completed on 3/29/23 for a visit from 1/6/23. DON verified and agreed that the documentation was late.			
F0867 SS= F	QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance	F0867	F 867 Element 1 It is the practice of the facility to implement an effective Quality Assurance & Performance Improvement (QAPI) program that identified systemic quality issues and implemented appropriate plans of action to correct quality deficiencies. It is also the practice of the facility to update the Abuse Policy and educate staff based on the most recent regulatory updates. QAPI meeting was conducted, and appropriate plan of action was implemented on identified systemic quality issues. Staff have been educated on the updated abuse policy. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. QAPI meeting was conducted, and appropriate plan of action was implemented on identified systemic quality issues. Staff	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident		have been educated on the updated abuse policy. Element 3 The Interdisciplinary Team reviewed the QAPI Quality Assurance Performance Improvement plan policy and deemed it appropriate. The IDT, including the Administrator and DON have been educated on the QAPI Quality Assurance Performance Improvement Plan Policy with emphasis on routine meetings and updated policies. Element 4 The Administrator/designee will complete audit every month for 6 months to ensure that an effective Quality Assurance & Performance Improvement (QAPI) program that identified systemic quality issues and implemented appropriate plans of action to correct quality deficiencies was completed and policies have been implemented with most recent regulatory updates. Any deficient practice will be corrected immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	**3/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	**26900 FRANKLIN ROAD SOUTHFIELD, MI 48034**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement an effective Quality Assurance & Performance Improvement (QAPI) program that identified			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	**3/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	**26900 FRANKLIN ROAD SOUTHFIELD, MI 48034**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	systemic quality issues and implemented appropriate plans of action to correct quality deficiencies, resulting in an immediate jeopardy (IJ) and substandard quality of care related to neglect. The facility also failed to update their Abuse Policy and educate staff based on the most recent regulatory updates. This deficient practice had the potential to affect all 71 residents who resided in the facility. Findings include: According to the facility's policy titled, "Quality Assessment & Assurance Plan" dated 10/15/2018, read in part, "...It is the policy of this facility to develop and maintain effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The QA committee shall be interdisciplinary and shall ...meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program. The facility will maintain documentation and demonstrate evidence of ongoing QAPI program. Documentation may include, but not limited to: The written QAPI Plan; Systems and reports demonstrating systematic identification, investigation, analysis; Documentation demonstrating performance improvement activities..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

Review of a facility policy titled, "Abuse Program: Elder Justice Act (Abuse, Neglect, Mistreatment, Misappropriation, Suspicion of Crime, Investigation and Reporting)", was dated for 4/13/22.

An annual recertification and an abbreviated survey were conducted from 3/28/23 through 3/31/23 and the following widespread deficiencies were identified:

The facility failed to protect residents' rights to be free from deprivation of goods and services by staff for nine (R28, R57, R14, R36, R45, R24, R68, R60, and R7) of 13 residents reviewed for neglect. This resulted in an Immediate Jeopardy (IJ) to the health and safety of the resident when these residents were not assigned a licensed or registered nurse for 12 hours (7:00 PM on 9/22/22 until 7:00 AM on 9/23/22) and did not receive multiple physician ordered medications needed to treat medical conditions, such as, pain, cardiac disease, blood clots, psychiatric disorders, diabetes, and post kidney transplant therapy; did not provide wound treatments and catheter care; complete nursing assessments for pain and blood sugar monitoring; provide supervision; and respond to potential crisis/medical complications. This resulted in R28 and R60 calling 911 due to unrelieved pain and experiencing anxiety due to nobody being available to check their vital signs when they experienced blurry vision because there was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	no nurse willing to provide nursing care to these residents, it increased the likelihood of serious harm, serious injury and/or death. On 3/31/23, at approximately 2:30 PM an interview was completed with the Administrator during the QAPI meeting. The Administrator was queried about the facility's QAPI plan and performance improvement project. The Administrator reported they were planning to do quarterly meetings for the year 2023 and they had been at the facility for a few months. The Adminstrator reported that the facility had a QAPI meeting in January 2023 and provided the sign-in sheet. The Administer reported that they had addressed staffing, medication issues and quality care of issues in the previous meetings. The Administrator did not indicate that they had identified or addressed abuse or neglect related concerns or review of their policies. The Administrator was asked to provide the evidence of QAPI meetings for 2022. The Administrator provided only 2 sign-in sheets for the QAPI meetings conducted in November-2022 and May-2022.			
F0868 SS= F	QAA Committee §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the	F0868	F 868 Element 1 It is the practice of the facility to meet the Quality Assessment and Assurance component of an effective Quality Assurance & Performance Improvement (QAPI) program, by meeting with their committee members at least quarterly. QAPI meeting was conducted.	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to meet the Quality Assessment and Assurance component of an effective Quality Assurance & Performance Improvement (QAPI) program, by not meeting with their committee members at least quarterly. This deficient practice had the potential to affect all 71 residents who resided in the facility.		Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. QAPI meeting was conducted to meet the requirements of at least quarterly. Element 3 The Interdisciplinary Team reviewed the QAPI Quality Assurance Performance Improvement plan policy and deemed it appropriate. The IDT, including the Administrator and DON have been educated on the QAPI Quality Assurance Performance Improvement Plan Policy with emphasis on meeting with their committee members at least quarterly. Element 4 The Administrator/designee will complete audit every month for 6 months to ensure that the facility meet the Quality Assessment and Assurance component of an effective Quality Assurance & Performance Improvement (QAPI) program, by meeting with their committee members at least quarterly. Any deficient practice will be corrected immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: According to the facility's policy titled, "Quality Assessment & Assurance Plan" dated 10/15/2018, read in part, "...It is the policy of this facility to develop and maintain effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The QA committee shall be interdisciplinary and shall ...meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program. The facility will maintain documentation and demonstrate evidence of ongoing QAPI program. Documentation may include, but not limited to: The written QAPI Plan; Systems and reports demonstrating systematic identification, investigation, analysis; Documentation demonstrating performance improvement activities...". An annual recertification and an abbreviated survey were conducted from 3/28/23 through 3/31/23 and the following widespread deficiencies were identified: On 3/31/23, at approximately 2:30 PM an interview was completed with the Administrator during the QAPI meeting. The Administrator was queried about QAPI plans and performance improvement project. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator reported they were planning to do quarterly meetings for 2023 and they had been at the facility for a few months. The Administrator provided the sign-in sheet with signatures of QAPI committee members for January 2023. The Administrator also reported that they had addressed staffing, medication issues, quality care of issues in the previous meetings. The Administrator was asked to provide the evidence of QAPI meetings for 2022. The Administrator provided only two sign-in sheets for the QAPI meetings conducted in November-2022 and May-2022 and meeting sign-in sheets were not available for the rest of the year.			
F0880 SS= F	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i)	F0880	F 880 DP 1 Element 1 It is the practice of the facility to ensure the infection control prevention program accurately documented signs and symptoms of infection, utilized pharmacy reports to identify prescribed antibiotics, utilized laboratory reports to identify types of infections, investigated trends, performed departmental surveillance, and documented education regarding infection control topics. The infection preventionist has been educated on this practice. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. All current residents have been audited to ensure that the infection control prevention program accurately documented signs and symptoms of infection, utilized pharmacy reports to identify prescribed	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: This citation has two deficient practices. Deficient Practice #1 Based on observation, interview, and record		antibiotics, utilized laboratory reports to identify types of infections, investigated trends, performed departmental surveillance, and documented education regarding infection control topics. Element 3 The Interdisciplinary Team reviewed the policy and procedure the Infection Prevention and Control Program and deemed it appropriate. The new Infection Control Preventionist has been educated on the infection control prevention program with emphasis on following the McGeer's criteria, utilizing pharmacy reports, lab reports, investigating trends, documenting education regarding infection control topics and surveillance. Element 4 The DON/designee will complete random audits on 5 residents weekly for 2 months then every other week for 2 months to ensure the facility maintained and infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The DON is responsible for compliance. Compliance Date: 04/26/2023 F 880 DP 2 Element 1 It is the practice of the facility to ensure appropriate hand hygiene and aseptic technique during medication administration. Resident 38 has	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	review, the facility failed to ensure the infection control prevention program accurately documented signs and symptoms of infection, utilized pharmacy reports to identify prescribed antibiotics, utilized laboratory reports to identify types of infections, investigated trends, performed departmental surveillance, and documented education regarding infection control topics resulting in the increased likelihood for inaccurate reporting of infections, unnecessary antibiotic usage and antibiotic resistance. Findings include: On 3/31/23 at 8:53 AM, a review of the facility's infection control program documentation was conducted. No documentation for the program prior to October 2022 was provided. The documentation provided revealed: October 2022 The facility documented two total infections for the entire month. The infections documented were a facility acquired urinary tract infection (UTI) with a catheter and a community acquired case of osteomyelitis (bone infection). The documentation did not indicate the UTI met McGeer's Criteria (a set of symptoms and diagnostic criteria that defines infections and justifies antibiotic use). The documentation did not include any pharmacy reports, laboratory reports, departmental surveillance, or education provided to staff.		been assessed to ensure no negative effective from lack of hand hygiene and aseptic technique during medication administration. No negative outcome noted. Nurse UU (agency) has been DNR'd from the facility. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Those residents have been audited to ensure appropriate hand hygiene and aseptic technique during medication administration was completed. No negative outcome. Element 3 The Interdisciplinary Team reviewed the policy and procedure of Hand Hygiene and deemed it appropriate. The Nurses have been educated on the Hand Hygiene Procedure and Aseptic Technique a with emphasis on performing hand hygiene before dispensing medications. Element 4n The DON/designee will complete random medication administrative audits on 5 residents weekly for 2 months, then every other week for 2 months to ensure appropriate hand hygiene and aseptic technique during medication administration. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Compliance Date: 04/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

November 2022

The facility map demonstrated a cluster of three urinary tract infections in three consecutive rooms next door to each other. The summary did not identify the cluster and there was no evidence on an investigation into the cluster. Five infections identified on the line listings did not show evidence of meeting the McGeer's criteria. It was further noted the monthly data provided did not include pharmacy reports, laboratory reports, departmental surveillance, or education provided to staff.

December 2022

The facility map identified 13 infections and the monthly summary identified 15 infections. Six of the infections identified on the line listings did not show evidence of meeting the McGeer's criteria. It was noted the monthly data provided did not include pharmacy reports, laboratory reports, departmental surveillance, or education provided to staff.

January 2023

The facility map identified 17 infections and the monthly summary identified 14 infections. Three of the infections identified on the line listing did not show evidence of meeting McGeer's criteria. It was noted the data provided did not include pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reports, laboratory reports, departmental surveillance, or education provided to staff. February 2023 The facility map identified 15 total infections and the monthly summary identified 13 infections. Two of the infections identified on the line listing did not show evidence of meeting McGeer's criteria. It was further noted the data provided did not include pharmacy reports, laboratory reports, departmental surveillance, or education provided to staff. On 3/31/23 at approximately 10:00 AM, an interview was conducted with Infection Control Preventionist, Nurse 'RR'. They were asked how long they had been overseeing the infection control program and said they took over October of 2022. They were asked if they utilized any pharmacy reports, laboratory reports and said they hadn't. They were also asked if anyone conducted departmental surveillance or if they provided any types of education and said they had not. On 3/31/23 at 12:30 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding the facility's infection control program. The DON said they did not know a lot about infection control in a long-term care setting and they relied on Nurse 'RR'. Deficient Practice #2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, interview, and record review, the facility failed to ensure appropriate hand hygiene and aspetic technique during medication administration for one resident, (R38) of five residents reviewed during medication pass. Findings include: On 3/29/23 at 8:42 AM, Nurse 'UU' was observed preparing medications for administration to R38. R38 had long, pointy, artificial fingernails and was not observed to perform hand hygiene prior to the preparation of R38's medication. Nurse 'UU' placed a medication cup on top of the medication cart, dispensed a lisinopril (blood pressure medication) tablet from medication card into the palm of their bare hand and placed it in the medication cup. They were then observed to dispense an olanzapine (psychiatric medication) tablet from the medication card into the palm of their bare hand and place it in the medication cup. After Nurse 'UU' finished preparing all of R38's medications they entered R38's room and administered the medications. On 3/31/23 at 12:30 PM, an interview was conducted with the facility's Director of Nursing. They were asked if staff should be touching pills with their bare hands and said they should not.			
F0881 SS= E	Antibiotic Stewardship Program §483.80(a) Infection prevention and control program.	F0881	F 881	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to continuously implement an antibiotic stewardship program that included consistent implementation of protocols for appropriate antibiotic use for four (R's 85, 28, 59, & 70) of 25 sampled residents. Findings include: On 3/31/23 at 8:53 AM, a review of the facility's infection control program was conducted and revealed the following: October 2022 documented a facility urinary tract infection (UTI) treated with a course of antibiotics. The line listing for the infection did not demonstrate the infection met McGeer's Criteria, a set of symptoms and diagnostic testing (such as labs or imaging) to justify the appropriate use of antibiotics. November 2022 documented two facility acquired UTI's with a catheter and three facility acquired UTI's without a catheter, all treated with antibiotic therapy. The line listings for the infections did not demonstrate any of the infections met McGeer's criteria.		Element 1 It is the practice of the facility to continuously implement an antibiotic stewardship program that included consistent implementation of protocols for appropriate antibiotic use. Residents 59 and 70 no longer reside in the facility. Resident 28 has been assessed for appropriate antibiotic use. Element 2 Residents that currently reside in the facility have the potential to be affected. All residents receiving antibiotic treatment have been assessed to ensure the antibiotic prescribed is appropriate treatment. Element 3 The interdisciplinary Team reviewed the Antibiotic Stewardship Program and Policy and deemed it appropriate. The Infection Preventionist has been in-serviced on the Antibiotic Stewardship Program to ensure residents are receiving antibiotic treatments appropriately according to protocol. Element 4 The DON/Designee will complete audits on 5 residents receiving antibiotic treatment weekly for 2 months, then every other week for 2 months to ensure prescribed antibiotic treatments are appropriate and protocol is followed. Any deficient practice will be corrected immediately. Results will also be taken to the Quality Assurance and Performance review meeting. The Director of Nursing is responsible for compliance. Compliance date: 4/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	December 2022 documented a facility acquired "(R) elbow infection" treated with antibiotic therapy, the line listing did not indicate any McGeer's criteria were met for the infection. The documentation further revealed three facility acquired UTI's with catheters and two facility acquired UTI's without a catheter, all treated with antibiotic therapy. The line listings for the infections did not demonstrate any of the infections met McGeer's criteria. January 2023 documented a facility acquired skin infection treated with antibiotic therapy, the line listing did not indicate the infection met McGeer's criteria. The documentation further revealed a community acquired UTI with symptoms identified on 1/12/23, however; the resident had been admitted 10/2021 and had transferred out from the facility. The line listing for the UTI did not demonstrate it met McGeer's criteria but had been treated with two different antibiotics. February 2023 documented one facility acquired pneumonia infection and one facility acquired UTI, both treated with antibiotic therapy. The line listings for the infections did not demonstrate the infections met McGeer's criteria. On 3/31/23 at approximately 10:00 AM, an interview was conducted with Infection Control Preventionist, Nurse 'RR'. They were asked how long they had been overseeing the infection control program and said they			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	took over October of 2022. They were asked how they ensured antibiotics were appropriate for the treatment of infections and reported they used, "McGreer's" Criteria. At that time, it was pointed out that the criteria generally used in long term care was McGeer's, not McGreer's. At that time, it was further pointed out the line listing forms they had been utilizing were also labeled "McGreer's" and the bottom of the form where it listed additional criteria had been cut off, leaving out important information to determine whether an infection met criteria. They acknowledged the concern and indicated they would be doing further research into determining the appropriate use of antibiotics. On 3/31/23 at 12:30 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding the facility's infection control program and antibiotic stewardship. The DON said they did not know a lot about infection control in a long-term care setting and they relied on Nurse 'RR'. A review of a facility provided policy titled, "Antibiotic Stewardship" issued 10/17 was conducted and read, "Infection Control and Prevention Officer will monitor antibiotic usage and resident infection, per Infection Control Manual policies, and track data on whether the resident meets McGeer/SHEA (Society for Healthcare Epidemiology) (2012) criteria for a true infection..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0883 SS= D	Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or	F0883	F 883 Element 1 It is the practice of the facility to ensure the 2022-2023 seasonal influenza (flu) vaccine is offered in a timely. Resident 26, 44, and 45 received their influenza vaccine and was monitored for any adverse reactions. No negative outcome noted. Element 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. An audit was conducted to ensure current residents have received or was offered the influenza vaccine. Any deficient practice was corrected immediately. The infection preventionist was educated on offering the influenza vaccine in a timely manner. Element 3 The Interdisciplinary Team reviewed Influenza Vaccine Protocol policy and procedure and deemed it appropriate. The Infection preventionist have been educated on offering the seasonal influenza vaccine in a timely manner. Element 4 The DON/designee will complete random audits on 5 resident weekly 2 months, then every other week for 2 months to ensure the seasonal influenza vaccine is offered in a timely manner. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The DON is responsible for compliance.	4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:

Based on interview and record review the facility failed to ensure the 2022-2023 seasonal influenza (flu) vaccine was offered in a timely manner for three residents, (R#'s 26, 44, and 45) of five residents reviewed for the influenza vaccine. Findings include:

On 3/30/23 at 3:08 PM, a review of R26's clinical record was conducted and revealed they admitted to the facility on 10/31/16. A review of R26's vaccination tab and consent for the flu vaccine was conducted and revealed they consented to the 2022-2023 flu vaccine on 1/21/23 and the vaccine had been administered on 2/14/23.

On 3/30/23 at 3:25 PM, a review of R44's clinical record was conducted and revealed they admitted to the facility on 2/16/22. R44's vaccination tab in the record did not indicate they received a flu vaccine for the 2022-2023 flu season.

On 3/30/23 at 3:57 PM, a review of R25's clinical record was conducted and revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634510	A. BUILDING _____ B. WING _____	3/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND CENTER (THE)	26900 FRANKLIN ROAD SOUTHFIELD, MI 48034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	they admitted to the facility on 11/18/21. R25's vaccination tab and consent for the flu vaccine were reviewed and the consent was signed on 3/7/23 with the vaccine being administered on 3/23/23. On 3/31/23 at 8:24 AM, the facility provided a consent for R44 to receive the 2022-2023 flu vaccine dated 3/30/23. On 3/31/32 at 8:26 AM, an interview was conducted with the facility's infection control preventionist, Nurse 'RR' and the Director of Nursing regarding why the flu vaccine consents and administration of the flu vaccine were not done at the beginning of the flu season, or why consents were signed and there was a delay in administration; and they had no explanation. A review of a facility policy titled, "Influenza Vaccine Protocol" issued 9/2017 was conducted and read, "All residents and responsible parties will be given the opportunity to choose to have the influenza vaccine. Influenza Vaccine Authorization...will be given out during the admission paperwork process and sent to resident and/or responsible parties annually, as applicable, in anticipation of the flu season..."			