STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235589	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Center (the)	26900 Franklin Road Southfield, MI 48034

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 This citation pertains to intake #MI00145151 Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse was immediately reported to the abuse coordinator and reported to the State Agency for three residents, (R901, R902 and R903) of four residents reviewed for abuse/neglect/mistreatment. Findings include: On 7/1/24 a concern submitted to the State Agency was reviewed and alleged R902 hit R903. On 7/1/24 at approximately 10:30 a.m., during an observation and conversation with R901, R901 indicated they had had issues with R902 being aggressive and further said they witnessed R902 hit R903 in the dining room. R901 was queried if they informed any of the facility staff of what they witnessed, and said they had. They further said R902 now had someone, always watching them. R903 On 7/1/24 at approximately 10:46 a.m., R903 was observed dressed and up in their wheelchair. R903 was queried if they had any altercations with any other residents and they said R902 had previously hit them on the side of the face with a balled first and again on their arm in the dining room. R903 was queried if they remembered when the incident occurred and they said it happened a few weeks ago on on either a Thursday or Friday. R903 reported they told their Nurse about the incident and staff needed to watch R902. On 7/1/24 the medical record for R903 was reviewed and revealed the following: R903 was initially admitted to the facility on [DATE] and had diagnoses that included: dementia and adjustment disorder with anxiety. A review of R903's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/23/24 revealed R903 needed assistance from facility staff with most of their activities of daily living. R903's BIMS (Brief Interview for Mental Status) score was 11/15 and indicated moderately impaired cognition. A review of R903's progress notes revealed the following: A Nursing progress note dated 6/18/2024 at 5:12 PM that read, .The resident was involved in a physical altercation with another resident Managers and MD (medical doctor) notified. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Social Work progress note dated 6/19/2024 at 8:49 AM that read, .Writer completed wellness check on resident regarding the physical altercation was in <sic> yesterday per nursing note. Resident states that she feels safe now as resident is no longer in the facility R902 On 7/1/24 the medical record for R902 was reviewed and revealed the following: R902 was initially admitted to the facility on [DATE] and had diagnoses that included: Huntington's disease, dementia and bipolar disorder. A review of R902's MDS assessment with an ARD of 4/4/24 revealed R902 needed assistance from facility staff with most of their activities of daily living. R902's BIMS score was 1/15 and indicated R902 had severely impaired cognition. A review of R902's progress notes revealed the following: A nursing progress note on 6/18/2024 at 3:54 PM that read, .notified by staff, who was providing 1:1 care, that resident was escorted outside to patio for fresh air. Resident was then escorted back inside the building after requesting water. As staff was assisting the resident to get water, resident turned around and began ambulating towards the patio. Staff attempted to redirect resident by assuring her she could return to the patio after retrieving water. Resident then became agitated at <sic> began to hit staff and screaming. Another staff member came to assist and escorted resident activities. Resident appeared to have calmed down and the activities aid was assisting resident to her seat when she hit another resident on the arm. Resident was quickly removed from the dining room, maintaining 1:1 supervision. PRN (as needed) Ativan (anti-anxiety medication) admin (administered) per order. NP (Nurse Practitioner) notified of occurrence and new order to send and petition resident to [Local Crisis Center] On 7/1/24 a review of an Incident and Accident (I/A) report provided by the Administrator for R902 dated 6/18/24 was reviewed and read, .Physical Aggression Initiated .Agencies/People notified .POA Care (Power of attorney-healthcare) and Physician . Further review of the I/A report did not indicate the Administrator (abuse coordinator) had been notified of the allegation. On 7/1/24 a review of the State of Michigan Facility Reported Incidents (FRI) system did not reveal any facility reported allegations for R902 for 6/18/24. On 7/1/24 at approximately 12:26 p.m., an interview was conducted with the facility's Administrator. They were queried if they were aware of the documented physical altercation between R902 and R903 on 6/18/24 and if they investigated and reported it to the State Agency. They said they had not been made aware and they would begin the investigation and report the incident. On 7/1/24 at approximately 12:44 p.m., Nurse A was queried regarding their progress note on 6/18/24 pertaining to R903 having had a physical altercation with R902. Nurse A indicated R902 had gotten mad and grabbed R903's wrist really tight, and they notified the DON (Director of Nursing) and the Nurse manager at the time of the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/24 at approximately 12:55 p.m., Social Worker (SW) B was queried regarding the their wellness check documented in R903's record on 6/19/24. They indicated they performed the wellness check because R902 hit R903 on the wrist and that something was thrown at them. SW B was queried regarding R902's behaviors and said R902 has one-on-one staff supervision and staff try to redirect the resident. On 7/1/24 a facility document titled Abuse was reviewed and revealed the following: Residents have the right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of resident property. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint that is not required to treat the patient/resident's medical symptoms, e The facility will develop and implement written policies and procedures that include: Initial Reporting: The facility will ensure that all allegations involving abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, and crimes are reported immediately to the Administrator and: e Reported to the State Survey Agency immediately but not later than two hours after the allegation is made if the allegation involves abuse or results in serious bodily injury and to other officials (including adult protective services and/or law enforcement, when applicable OR Reported to the State Survey Agency no later than 24 hours if the allegation does not involve abuse and does not result in serious bodily injury to the State Survey Agency and to other officials (including adult protective services and/or law enforcement, when applicable). e Assuring that reporters are free from retaliation or reprisal