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	04/03/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 This citation relates to Intake #MI00151265. Based on observation, interview, and record review, the facility failed to provide adequate staffing to adequately meet the care needs of three Residents (R101, R102, and R105) of five residents reviewed for staffing, with the potential to affect all facility residents. Findings include: Review of a complaint received by the State Agency on 3/17/25 revealed resident-centered concerns related to not enough nursing aides with an increasing census. This reportedly resulted in residents not being gotten out of bed timely, with additional concerns about resident safety and comfort. The complaint described limited management oversight and problem solving given recent management staff turnover. On 4/03/25 at 9:31 a.m., Certified Nurse Aide (CNA) B reported they felt there should be two aides on Unit 4, which they described as primarily rehabilitation (skilled) residents when there was higher acuity on their unit, as many residents coming in required full care and full body mechanical lifts for transfers. CNA B stated the unit was typically staffed with one aide, which was not enough to meet the care needs of the residents. CNA B explained when there were residents on the unit with behaviors, they could not manage the higher acuity (resident care) needs of the incoming rehab residents when a resident needed increased supervision. CNA B reported there was typically only one nurse on the unit, and some helped with care, and some would not assist them when they were the only aide. CNA B reported it was difficult to find assistance for residents needing two-person assistance or full body mechanical lifts for transfers, as the other units were located on the second floor of the facility, which was verified. CNA B clarified they had shared their concerns with facility management. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER: Lakeland Center (the)		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/03/25 at approximately 9:55 a.m., Licensed Practical Nurse (LPN) A, who worked on Unit 1 regularly, reported when there were only two aides on their unit, it was more difficult for the aides to meet the care needs of their residents, as each aide often had 14 to 15 residents, who were dependent on staff assistance for their care. LPN A explained some family members insisted on residents being up earlier, and this delayed the care of other facility residents, who expressed frustration. LPN A reported they assisted the CNA's when they could but had to complete their medication passes and nursing tasks first in the morning. LPN A explained the aides often waited to get the residents up after the breakfast trays arrived. LPN A described the trays were supposed to arrive at 8:00 p.m., but sometimes the trays arrived at 8:30 a.m. or 8:40 a.m., as occurred on 4/03/25, which held up resident care, and getting residents out of bed. LPN A stated care delays were also related to lack of consistent staff on their unit, as the staff in the building liked to float, and then did not know the care needs of their residents. LPN A stated this caused care delays, as they had to keep telling newer staff the same things (about the care needs of the residents). LPN A reported the aides were responsible for residents' showers for their assigned rooms, and there was a higher acuity on Unit 1, with many residents requiring lifts or full care. This Surveyor reviewed the Unit 1 floor plan with LPN A, which showed 17 residents on Unit 1 required full body mechanical lifts for transfers and were maximum assistance to dependent for toileting. R105 Review of the Minimum Data Set (MDS) assessment, dated 3/06/25, revealed R105 was admitted to the facility on [DATE], with diagnoses including heart failure, renal failure, anxiety, and depression. The assessment showed R105 was dependent for bed mobility, toileting, and transfers, and was frequently incontinent of bladder and bowel. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, which showed R105 was cognitively intact. Review of the Electronic Medical Record (EMR) showed R105 was their own responsible party. On 4/03/25 at 10:14 a.m., R105 was observed laying in their bed, wearing a house dress. R105 resided on Unit 1 in the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Lakeland Center (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/03/25 at 10:16 a.m., R105 reported when there were only two aides on the floor, they waited a longer time for assistance, stating, Sometimes it's (the wait) about 1 hour. R105 explained they were frustrated as they often waited one hour to be put to bed after dialysis, which was between 2:30 p.m. and 3:00 p.m., three days a week. R105 reported some of the aides would leave at 3:00 p.m. instead of staying until 7:00 p.m. through their 12-hour shift for personal reasons. R105 stated, There should be three staff (on their hall) at all times, as there are so many people (residents) that are in diapers (briefs), cannot feed themselves, and sometimes they (management) take an aide (to another unit) who is over here. When asked how they knew this information, R105 reported the aides told them, as they expressed frustration to them, as they sometimes could not adequately meet the care needs of their residents on the unit. R105 explained, They are losing good aides because they are overloading them, and they gotta do (care) for all these patients, and you have how many who are bedridden. Yesterday, no one gave us (residents) any water, and we are supposed to get on the day shift, and the night shift, and we didn't get either (water pass). I called three times (to the kitchen), and they said they would bring water, and I called the receptionist twice, and no one answered. Surveyor asked R105 if they could read their clock, and they repeated the time. R105 was alert and oriented times four (to person, place, time, and situation). R105 pointed to a pile of unfolded clothes on their wheelchair and reported they had asked staff to hang them up, but it had already been three days since their request (on 3/31/24). On 4/03/25 at 10:25 a.m., R105's manual wheelchair was observed at the foot of their bed, filled with a large pile of unfolded clothes. On 4/03/25 at 10:25 a.m., R105 continued, We (residents) like familiar people (consistent staff), and most of the time they (staff) are not because the aides are quitting or being fired .Some (aides) have an attitude and say, 'What do you want? R105 reported this made them feel tired after dialysis when they waited an hour to lay down, as their neck and shoulders hurt, and their wheelchair was uncomfortable. R105 added, I hate to go out (of the facility) with my clothes not being hung up (wrinkled). I missed my bed bath for two weeks (a few weeks prior). I am told I cannot get a bath as they don't have enough linen, towels and washcloths, and I have to wait a long time to be cleaned up at night, as there are only two aides . R105 reported this made them feel neglected and angry, and stated their family member tried to complain but they could not get a hold of staff on the phone. R105 was asked if they reported their concerns to the facility management. R105 responded they had called the Nursing Home Administrator (NHA) and the Unit Manager, LPN G, and they had not responded, and they had told their nurses, aides, and their family. R102 Review of R102's MDS assessment dated [DATE], revealed R102 was admitted to the facility on [DATE], with diagnoses including stroke, hemiplegia (paralysis), and adjustment disorder with mixed mood. R102 was dependent for toileting, bed mobility (rolling), and transfers, and was always incontinent of bladder and bowel. The sensory assessment revealed R102 had clear speech and was able to understand and be understood by others. The preferences assessment showed it was very important for R102 to have their daily preferences honored, including related to their care, daily schedule, and being involved in care decisions. On 4/03/25 at 11:29 a.m., R102 was observed in their bed, wearing a hospital gown and a splint on their left arm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Lakeland Center (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/03/25 at 11:31 a.m., R102 reported they wanted to get up (out of bed) earlier on most days, and stated, I asked for water (today), and I don't ever get it (several days). Icewater . R102 reported they pushed their call light for water, staff said 'ok' and never brought it. R102 stated, I never got water today . R102 was able to read their room clock and was alert and oriented to themselves, the time, and their surroundings. On 4/03/25 at 11:34 a.m., R102's water cup was observed on their bedside table. The cup was dated in pen 4/02/25 and showed 7:00 p.m. to 7:00 p.m, with an empty cup. R102 was observed pushing their call light for water with this Surveyor present. On 4/03/25 at 11:35 a.m., CNA C came into R102's room, viewed the date on R102's water cup, and stated, It (the water) should be passed by 7 (a.m) normally. CNA C stated, It was late as we (staff) had to change everyone from the midnight shift. When asked about this privately, CNA C stated the residents' waters were late every day as they could not pass them at 7:00 a.m. due to residents' care needs being the priority. On 4/03/25 at 11:36 a.m., the Unit Manager, LPN G arrived, viewed the date on R102's cup, and stated, It (the residents' waters) should have been passed this morning. On 4/03/25 at 11:37 a.m., R102 was asked how this made them feel. R102 responded, I feel neglected. R102 reported not getting their water timely made them feel dry and thirsty at times, and they explained sometimes waited on hour to be changed (their brief). R102 stated they would like to have been up already in their chair, not in bed, as lunch came around noon. R102 reported they had told the nurses their concerns, and this had been happening for over a month. On 4/03/25 at approximately 11:53 a.m., CNA C was observed passing water on Unit 100. On 4/03/25 at 12:12 p.m., CNA C was asked further about the water being passed at that time, as receiving water was a basic need. CNA C reported the expectation was for the water to be passed to residents at the beginning of the day shift, and they were running late on this date. When asked why, CNA C reported they felt they needed to prioritize the care needs of their residents, which were extensive on the unit, as many of the residents used a full body mechanical lift for transfers. CNA C explained, I just started doing my patients (providing care) and getting them up and making sure they were clean and not waiting. The expectation is a 7 (7:00) a.m. water pass, and a second water pass at lunch, so the first one got missed today. (R102) is the only one (resident) who said anything . CNA C stated they found several residents soaked this morning, and stated, From what I heard, they (the night shift aides) did their last check and change at 4:00 a.m., and I personally think they should have done it at 5 or 6 (5:00 a.m. or 6:00 a.m.). Some beds were soiled, and residents were soaked . So, they had to do complete changes (bedding and briefs) verses providing the water pass. When asked about staffing on the unit, CNA C stated, If there is two aides, we usually just work together, and it was sloppy this morning (the team care provision) . CNA C reported they had only worked at the facility a month or two. R101 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER: Lakeland Center (the)		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R101's MDS assessment, dated 2/14/25, revealed R101 was admitted to the facility on [DATE], with diagnoses including peripheral vascular disease (circulatory disease), depression, and arthritis. The assessment showed they were dependent for bed mobility, transfers, and toileting, and were frequently incontinent of bowel. The BIMS assessment revealed a score of 15/15, which showed they were cognitively intact. Review of the EMR revealed R101 was their own responsible party. On 12:20 p.m., R101 was observed in the facility dining room, fully dressed, seated in their manual wheelchair. R101 asked to speak with this Surveyor. On 12:24 p.m., R101 reported they were not always gotten out of bed in time, stating, Sometimes yes; sometimes no . R101 reported the latest they wanted to be out of bed was 11:00 a.m., and said, Quite frequently, that doesn't happen as the people who are giving us the care are giving us a shower. It's very difficult. When they don't give us three aides, it's horrific. A lot of us (the residents) are getting mad as we are still in bed, not getting the (proper) care . R101 explained they and other facility residents sometimes missed their shower due to staffing shortages, and reported they shared their concerns with the facility administrator. R101 clarified they would want to be up and out of their bed by 10:00 a.m., and they had been gotten up on some occasions after lunch, which upset them. R101 reported they sometimes waited for water, stating, We don't get fresh water . and said they stopped at the nurse's station to get fresh water frequently, since it was not consistently passed to their room on the day shift. R101 described they were frustrated when they were waiting to get up and their call light was not answered, and said, We (the residents) say this place is not organized, and we get frustrated. We tell the administrator and (they do) not take action, and it is very frustrating . R101 reported they shared their concerns in the Resident Council group meetings, which they attended regularly, but nothing changed. R101's lunch arrived, and they asked to continue the interview after they ate their lunch. On 4/03/25 at 12:36 p.m., CNA C was asked about R101's concerns. CNA C reported, (They are) right. Residents come down on us because things are not going the way they want it to go. (Showers) are being missed sometimes so they (staff) at least do a bed bath . On 4/03/25 at 12:45 p.m., Housekeeping staff, Staff I was asked about the missing towels and washcloths per resident reports. Staff I reported there was adequate supply, and explained one of the main reasons residents were not getting showers timely was nursing aides were hiding linens in residents' room so they did not have to run back and forth (to the linen rooms), and then the linens were less available on the linen cart. On 4/03/25 at 1:20 p.m., the linen carts on Unit 1, Unit 2, and Unit 3, were observed absent of clean towels and washcloths with housekeeping Staff I and a second housekeeping staff member. On 4/03/25 at 1:31 p.m., R101 stated, Several mornings they (aides) say they can't get us up as they have to wait for the linens to come up. They do come up (eventually) . R101 reported this caused them to get up late out of bed sometimes or caused their shower to be rescheduled later or on a different day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER: Lakeland Center (the)		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/03/25 at approximately 1:50 p.m., LPN A on Unit 1 confirmed sometimes the residents' waited longer than 30 minutes for their call light to be answered, and the water pass was sometimes late on the Unit 1 by a few hours. LPN A confirmed sometimes R105 waited an hour to be put back in bed after dialysis. LPN A also confirmed sometimes the aides reported the facility linens were short, which they understood may impact timely resident care. LPN A reported these were ongoing current concerns on the Unit 1, occurring in the past few months. On 4/03/25 at 2:09 p.m., CNA D reported they had only been working on Unit 1 a couple of weeks, and confirmed residents were waiting to get up (out of bed) a long time, up to a few hours. CNA D stated, This is a high acuity (resident care needs) unit; we have patients who need showers, we have therapy patients, and family members who want them (residents) up early . When it is (sic) two aides, it is very hectic, with the very high acuity. There is so many moving parts, and people with (full body mechanical) lifts, and a lot of people and families who have specific requests . When asked about the water pass, CNA D reported they tried to prioritize passing the waters before breakfast and explained this may be delayed when care was hectic on the unit. CNA D indicated the linens were sometimes short on the hall, which may cause delayed resident care, as they had to go on another hall or downstairs (to laundry) to get linens. CNA D explained when they were behind, everyone gets behind and it bothered the residents. CNA D stated, Nobody wants to be left wet and soiled, and the first thing you want (as staff) is to make sure the people (residents) are nice, clean, and dry. When asked when this occurred, CNA D clarified, This happened on Tuesday (4/01/24). On 4/03/25 at 2:28 p.m., LPN E, the other nurse on Unit 1, confirmed there were residents who were waiting to be gotten out of bed regularly. LPN E explained there needed to be three aides on unit one, and their residents' care needs could not be met if there was not enough staff on all the three units, as the acuity changed frequently. LPN E added the units needed to be more organized to spread out to the workload more equally, as they had 10 residents who needed total care on their section of Unit 1. LPN E reported a viable solution would be to schedule a back-up aide, as there were frequently call offs, and to have more continuity of staff. LPN E reported they understood the residents' concerns related to staffing and how this affected their care. LPN E acknowledged staff's reported concerns regarding residents being found wet on 4/03/25, and they believed residents were not being changed timely on the night shift sometimes. LPN E confirmed they ran short on linens sometimes, and this affected the care timeliness for the residents. LPN E reported they had made the Unit Manger aware of their concerns with staffing on their unit. LPN E clarified the staffing concerns were across the other units in the building as well. On 4/03/25 at 2:49 p.m., the Director of Nursing (DON) was asked if they had call light logs to show call light wait times for Unit 1 residents. The DON reported there was no way to show the call light wait times from their call light system. They reported they were newer to their position and were addressing the staffing concerns and scheduling. On 4/03/25 at 3:00 p.m., the DON was asked about facility staffing and residents' concerns. The DON reported they had increased staffing since they started their position, and reported they did take resident acuity into account when staffing. The DON reported they planned to staff higher on the rehab unit, due to their higher acuity of residents' care needs. The DON explained the Unit 1 Unit Manager, LPN G, had only worked at the facility on Unit 1 about seven months. The DON explained when many of the managers quit to become floor staff, LPN G stayed on and assumed extra job duties, and had a great deal of areas they were overseeing. The DON acknowledged the concerns. The DON reported their staffing expectations with the current census were as follows: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Unit 1: 3 CNAs on day shift. 2 CNAs on night shift. Unit 2: 2-3 CNAs on day shift. 2 CNAs on night shift. Unit 3: 2 CNAs on day shift. 2 CNAs on night shift. Unit 4: 1-2 CNAs on day shift. 1-2 CNAs on night shift. This reflected a minimal number of 8 CNA's expected by the DON on the day shifts. Review of the facility floor plan with the DON confirmed there were at least 17 residents on Unit 1 who were dependent on mechanical lifts and for their toileting needs, as earlier reported by LPN A. There were additional residents who needed total care who were bedbound. Review of the following staff postings below showed less than 8 CNA's present on: 3/17/25: 6 CNAs on the day shift. Census: 86. 3/25/25: 6 CNAs on the day shift. Census: 88. 3/27/25: 7 CNAs on the day shift. Census: 89. 4/02/25: 7 CNAs on the day shift. Census: 86. On 4/03/25 at 4:26 p.m., the Housekeeping and Laundry Manager, Staff H was asked about observations and multiple staff interviews reporting shortages of linen on the Unit 1, Unit 2, and Unit 3 during the survey. Staff H reported they had been made aware of the concern, and the facility had been addressing. Staff H denied the concern was related to laundry or supply and reported this had been audited. Staff H understood the concern and believed it may have been related to nursing aides removing the towels and washcloths from the linen carts, placing them in resident's rooms and closets, sending clean linen down to laundry, as their staff sometimes found soiled linens in the garbage, which could have been rewashed. Staff H reported they would continue to work with the facility to come up with a plan to ensure the towels and washcloths were always available as needed for residents' care needs. On 4/03/25 at approximately 4:39 p.m., Unit Manger, LPN G, was asked about staffing concerns on Unit 1. LPN G acknowledged and understood the staffing concerns on their unit. LPN G clarified when there were only two aides to provide care verses three aides there were extended wait times for care. On 4/03/25 at approximately 4:44 p.m., the NHA was asked about the staffing concerns. The NHA reported they understood the staffing concerns and were hiring staff. The NHA clarified they expected more teamwork on the units and confirmed it would be reasonable for a resident to expect to wait less than an hour for their care needs to be met. The NHA had no comment initially on concerns brought forward related to linen shortages, and the reported impact on the residents. The NHA reported they would work with Staff H to follow-up on any concerns, given their report of staff storing some of the facility linens in residents' rooms, verses being available to all staff on the linen carts. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the policy, Staffing, issued 11/03/23, revealed, POLICY OVERVIEW: The facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for the residents in accordance with the resident's plan of care. GUIDELINES: Licensed nurses and nursing assistants are available 24 hours a day, 7 days a week to provide direct resident care services. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on their plan of care . Review of the facility assessment, dated 7/23/24, revealed, .The number of residents the facility is licensed to provide care for (number of beds): 91. The average daily census for the previous 12 months: 66.10 (average number of residents in the facility per day) .The facility's population is sub-divided into 4 units. The unit names and type of care provided are: Unit 1. (Checked) Skilled. Long Term. Unit 2: Skilled. Unit 3: Long Term. Unit 4. Skilled .Resident Acuity is determined by a review of major RUG (MDS) categories/PDPM (Patient Driven Payment Model - resident classification system) and MDS (resident assessment) data from the time of the last assessment over the last 12 months: Category: Extensive Services: 4%. Special Care High: 40.67%. Special Care Low: 18%. Clinically Complex: 14%. Behavior Symptom and Cognitive Performance: 2%. Reduced Physical Function: 21.33%. Cognitive Impairment: 46.5% .Staffing Guidelines: The facility's staffing is based on resident population and acuity. The following generally represents the daily staffing at the facility utilizing the number of employees. Position: Nursing Assistants: 12 hours (scheduled for 12 hour shifts regularly) .Shifts: 12 hour (each shift). Unit 1: .Nursing Assistant: 2 (aides). Unit 2 .1 (aide). Unit 3 .2 (aides) Unit 4 .0 (no aides) . It appeared there were 5 aides scheduled per day with an average census of 66 residents, with no available data for Unit 4. There were no staff (nurses or aide) marked for Unit 4, the rehabilitation unit. The boxes were blank. The current resident census was 88 residents on 4/03/25. It was unclear how Unit 4 was staffed on the facility assessment and given the current increased census.