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	07/02/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation relates to Intake 1302878. Based on observation, interview, and record review, the facility failed to ensure proper positioning to prevent an avoidable fall with injury for one Resident (R703) of one resident reviewed for falls, which resulted in actual harm, with increased pain, emergent care, hospitalization, and fearfulness. Findings include: Review of a complaint intake received on 6/20/25 revealed R703 resided at the nursing facility with a diagnosis of stroke and limited range of motion in their extremities. The complaint showed R703 had a fall at night on 6/19/25 after warning the aide not to turn her, as she felt like there was not enough room on the bed. The aide reportedly proceeded to turn R703, and R703 hit their head on the floor. R703 was reportedly supposed to be a two-person assist at all times. R703 was subsequently taken to the hospital, and had no fractures or brain bleeds but did have increased pain and swelling of their right knee. The complaint stated, “(R703) is in a lot of pain is completely traumatized…” On 7/01/25 at 4:12 p.m., R703 was observed laying on their back in their hospital bed, wearing a gown. It was noted R703’s hands were closed in fists. R703 agreed to be interviewed. On 7/01/25 at 4:15 p.m. R703 was asked about their care, and responded, “The person (staff) was asked not to turn me in bed, and I said, ’I am a fall risk. I am supposed to have two people,’ and it was just one person. She (staff) turned me and I fell on the floor on my left side. I was to the ground. I hit my head really bad. They x-rayed me from head to toe, and they said that I didn’t have any broken bones. My head was hurting really bad. It is still going on and I am still having sharp shooting pain. I can’t move my arms well…” R703 reported they needed help feeding themselves and had pain in the back of their legs. R703 reported they fell a month ago directly onto the floor. R703 reported they went to the hospital, who kept them for a few days and said they had a head injury and pain in their legs and back which had worsened since their fall. R703 reported their pain was 8/10 (with 10 the highest pain) and said they needed more pain medication after the fall. R703 said they did not want to work with them ever again. R703 continued, “I am experiencing all the pain still and have a lot of fear (of moving and getting out of bed). Since then, I don’t want to be touched…” R703 confirmed they used a Hoyer lift to get out of bed. R703 was alert and oriented to their name, situation, and surroundings. Review of R703’s Minimum Data Set (MDS) assessment, dated 3/29/25, revealed R703 was admitted to the facility on [DATE] with diagnoses including heart failure, stroke, and epilepsy (a seizure disorder). The assessment revealed R703 required moderate assistance with eating and was dependent for bed mobility and transfers. The cognitive assessment revealed R703 was usually understood and could usually understand others. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/01/25 at 4:30 p.m., R703’s nurse, licensed practical nurse (LPN “K)”, was asked about their care and any pain. LPN “K” stated R703 had been requesting pain medication regularly, which was a change, as they had rarely asked for it prior to the recent fall. LPN “K” reported R703 was newly on scheduled Tramadol since the fall, however said they were not aware of her reporting fearfulness. LPN “K” stated R703’s routine was getting up out of bed with staff assistance before their fall in June (2025) every day and going to the dining room, attending activities, talking to the other residents, and watching television however since the fall they were in bed more often. LPN “K” reported R703 fed themselves with adaptive silverware. LPN “K” said R703’s affect was more solemn since their fall. On 7/02/25 at 12:37 p.m., LPN “N” was asked about R703’s fall on 6/19/25. LPN “N” said they were in another room taking care of another resident when the fall with injury occurred. LPN “N” reported there was only one aide in the room, and said they were a newer aide. The aide stated to them they were cleaning R703 (providing peri-care) and said the aide had the bed up and R703 fell out of bed. LPN “N” said the Kardex showed R703 was a two-person assist for bed mobility at the time of their fall. LPN “N” reported when they observed R703, they were laying on their back on the side of the bed, and said they hit their head, and their back was hurting. LPN “N” stated they called the doctor, EMS (emergency medical services) and the Director of Nursing (DON) and said, “(R703) was in pain in the neck, head, and on her back .” On 7/02/25 at approximately 1:20 p.m., R703’s guardian, Guardian “P”, stated in a phone interview LPN “N” called them on 6/20/25 and said they were sending R703 out (emergently) after a fall when staff were trying to change their (briefs) and rolled them out of bed and told them R703 landed on her back and hit their head on the floor. R703’s guardian stated R703 was a two-person assist at all times for care, and reported R703 was traumatized and kept saying at the hospital, “I’m falling; I’m falling…” Guardian “P” said they got R703’s pain under control at the hospital but the next day the facility staff sent R703 back to the hospital with increased leg pain and said R703 was diagnosed with a pelvic fracture. Guardian “P” stated, “Why would you try to roll them if they (resident) say not to roll them? R703 is a two-person assist at all times. There is signage in the room. That I don’t understand…” Guardian “P” reported prior to their fall R703 went to the dining room to eat and attended activities but since the fall had not gone much as R703 felt scared. Review of R703’s Accident and Incident report, dated 6/19/25 at 10:00 a.m., revealed, “Writer was in hallway and heard resident yelling for help. Upon entering room, resident was on the floor on her back accompanied with assigned CNA (Certified Nurse Assistant/CNA “Q”). CNA stated, “’The resident fell during patient care.’” RCA (Root Cause Analysis): Improper positioning in bed. Staff to ensure resident is positioned in the center of bed. Resident stated, “’I fell out of bed.’” …Resident complained of pain to hand, neck, and back…Resident sent to hospital via EMS accompanied by two CNAs…” The report showed R703 was alert and oriented x 3 (3 spheres of 4). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R703’s facility investigation report showed on 6/19/25 at 9:45 p.m., CNA “Q” rolled R703 out of bed the opposite way (of CNA “Q”) and rolled them completely out of bed and onto the floor. R703 reportedly hit her head and was found between two nightstands. R703 stated they were being changed (brief) and told the CNA they needed two staff to take care of her, but the CNA did it anyways and they fell out of bed. R703 explained they hit their head and said they were having headaches. CNA “Q” confirmed R703 fell between two nightstands and hit their head. The conclusion showed the staff member (CNA “Q”) did not use proper positioning techniques, resulting in the fall. The report revealed R703 was sent to the ER (emergency room) and said their CT scan and x-rays were negative (with no fracture). The resident returned with orders for Tylenol and Robaxin (a muscle relaxant which was newly ordered). Review of R703’s nursing progress note dated 6/21/25 at 4:20 a.m. (second note) showed R703 experienced pain during the night shift hours between 3:00 a.m. and 3:30 a.m. and they requested to go out to the hospital. Nurse assessed to see where the pain was coming from and patient stated their legs were in “so much pain”. The note when the EMT’s (emergency medical technician) arrived and were transferring R703 to the stretcher R703 screamed out in pain. Review of R703’s progress note, dated 6/26/25 at 12:08 p.m., revealed, “Wellness check completed. (R703) states she feels safe being at the facility however c/o (complains of) pain and that her pelvis is broken. Says she is anxious and agreed to see psych services…Spoke to case manager regarding resident asking for something (medication/intervention) to help her calm down…” Review of R703’s progress note dated 6/25/25 at 1:37 p.m. revealed, “Writer notified by SW (social worker) of residents’ increased anxiety/pain. NP (Nurse Practitioner) notified. New orders received for Tramadol (controlled pain medication) 50 mg every six hours as needed for pain, and a one-time dose of Zyprexa for increased anxiety, with psych service consult ordered…” Review of R703’s nursing progress note, dated 6/29/25 at 17:34 (p.m.), by LPN “K”, revealed, “(R703) reported to writer that current pain medication was not helping to alleviate pain…stating, “…I’m still in a lot of pain .” Writer notified on-call provider, awaiting new pain medication order…” Review of R703’s nursing progress note, dated 6/30/25 at 10:19 a.m., revealed, “Primary NP (Nurse Practitioner) in house, new orders given to change Tramadol 50 mg prn (as needed) to Tramadol 50 mg (scheduled) every 6 hours. On coming nurse notified.” Review of R703’s psychiatric progress note, dated 6/30/25 at 11:15 a.m., revealed the provider was seeing R703 for restlessness and agitation post hospitalization, with no new interventions or medications added. R703’s mood was stable, and pain was found managed by the visit. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R703’s hospital History and Physical report (H & P), dated 6/21/25, revealed R703 was a [AGE] year-old patient with prior stroke with right side hemiparesis (weakness) and seizure disorder who fell out of bed while being changed. Her acute diagnoses was intractable pain and UTI (urinary traction infection) symptoms. The report showed R703 reported hitting their head when they fell. The report diagnoses showed CT of their pelvis yielded, “Impression: focal defect (localized area of irregularity or damage) and cortical irregularity (causing pain or instability) involving the right inferior pelvic ramus (pelvic bone). No adjacent infiltration or hematoma. Findings may represent subacute injury however no callus formation is present (indicating bone growth)…” This report did not confirm or deny the presence of a pelvic fracture. Review of R703’s hospital occupational therapy evaluation, dated 6/22/25, revealed R703 had fair participation in the assessment due to severe back pain and muscle spasms. Review of R703’s hospital palliative report, dated 6/22/25, showed R703 had no acute fractures or dislocations, including right knee imaging, and showed they were not choosing palliative care at that time. On 7/03/25 at approximately 2:35 p.m., CNA “Q” was called about R703’s fall on 6/19/25. No call was returned by the end of survey. On 7/02/25 at approximately 3:00 p.m., Physical Therapist “R” reviewed R703’s pelvic scan report with Surveyor and said they had prior reviewed the scan. PT “R” reported the report did not clearly show a pelvic fracture and there was no bone growth which would have likely showed healing (if there was a fracture). PT “R” clarified there would be no different treatment for a pelvic fracture or injury, as the goal would be pain management. PT “R” confirmed R703 was currently receiving treatment for pain management in PT after their fall with injury. On 7/02/25 at approximately 3:30 p.m., the Director of Nursing (DON), along with Infection Preventionist (IP) Nurse “T”, reviewed the Electronic Medical Record (EMR) with Surveyor. Both confirmed R703’s Kardex at the time of their fall should not have shown 1–2-person assistance with ADL’s (activities of daily living), as then the aides had to choose the level, when this should have been specified by therapy. Both confirmed CNA “Q” had been newly hired on 5/28/25 and said they reeducated CNA “Q” on safe transfers. Both explained CNA “Q” was reportedly trying to change R703 and had been rushing, so no abuse or intent was found. Review of CNA “Q”’s personnel file showed they received bed mobility training during their orientation. Review of CNA “Q”’s reeducation regarding bed mobility respective to the incident read a follows: “…1st written warning: Patient Care:…During ADL care employee pushed (R703)…away from her, instead of towards her, for proper body alignment, resulting in resident injury…” Signed by the DON, and LPN “I”, delivered via phone to CNA “Q” on 6/20/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R703’s PT evaluation, dated 6/26/25 (after their fall), revealed R703 struggled with pain during the assessment in their legs with slightest movement at 10/10. The assessment revealed, “…Writer noticed patient screaming in pain while actively attempting to move her legs…” The assessment revealed a goal of 3/10 pain with modalities including heat and cold, with prior level of function showing n/a (no) pain, and a caregiver goal of safe patient handling to not aggravate pain. Review of the policy, “Fall Management Guidelines”, issued 12/13/23, revealed, “The purpose of this policy is to provide guidelines to assist with fall risk identification and fall management of residents in the facility…Intrinsic factors that may increase the risk of falls include…cognitive impairment, CVA/TIA…Evaluate for signs and symptoms and complaints of pain…Attempt to determine the root cause of the event…The interdisciplinary team (IDT) will review the resident’s fall including: the circumstances surrounding the resident’s fall and any changes in the resident’s risk factors, condition, and/or functional status to validate or determine the root cause of the fall, the interdisciplinary team will review the resident’s current plan of care and interventions to ensure that the interventions are appropriate and the resident’s post-fall interventions correlate to the root cause of the fall, in an attempt to prevent future fall, a progress note will be placed in (the EMR), documenting the IDT review and findings…”

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation relates to Intake MI00153706. Based on interview and record review, the facility failed to follow a physician order to ensure proper catheter care per standards of practice for one Resident (R702) of one resident reviewed for catheter care. Findings include: Review of a complaint intake received by the State Agency on 6/16/25 revealed R702 had quadriplegia (a form of paralysis affecting all four limbs) and needed a 20 (size diameter) French catheter, the facility ran out of supplies, and R702 was provided an 18 French catheter instead, which was leaking urine. The complaint further alleged R702 was not kept updated when a new catheter was available. On 7/01/25 at 11:33 a.m., Licensed Practical Nurse (LPN) “E” was asked about R702’s stay. LPN “E” confirmed an incident occurred in the past month on a Sunday (6/15/25), when R702’s suprapubic catheter (an abdominal urinary catheter to drain urine) became clogged. LPN “E” said the facility did not have a 20 sized French catheter (a type of catheter and size diameter) in the building, per R702’s physician orders, and reported the facility only had a 22 French (larger sized catheter) or an 18 French catheter (smaller sized catheter). LPN “E” stated they called R702’s physician, who ordered an 18 sized French catheter and said to order and change the catheter the next day back to a 20 French catheter. LPN “E” reported they entered this physician order in large print, so the next incoming nurses would see the catheter needed to be ordered and changed the next day, and requested central supply order the 20 French catheter. LPN “E” explained when they returned to work for their day shift the following Tuesday (two days later), R702 still had the 18 French catheter placed, and when they tried to put in the 20 French catheter, the stoma (opening in the body for waste to exit) closed. LPN “E” described then the 18 French catheter would not fit back in either, so they placed a foley indwelling (urethral) catheter and sent R702 to the hospital, per physician orders. Review of R702’s facility census revealed they were hospitalized on [DATE] (a Tuesday) and returned to the facility on 6/28/25. Review of R702’s Care Plan, accessed 7/01/25, revealed they had a suprapubic urinary catheter. Review of R702’s physician orders revealed an order for a suprapubic urinary catheter started on 5/05/25 and ended on 6/23/25. The order showed the French catheter size was designated but left blank. Review of R702’s Minimum Data Set (MDS) assessment, dated 6/12/25, revealed R702 was admitted to the facility on [DATE], with diagnoses including quadriplegia. The assessment showed R702 was dependent for transfers and bed mobility, and had a urinary catheter. The Brief Interview for Mental Status (BIMS) assessment showed a score of 15/15, which showed R702 was cognitively intact. Review of the electronic medical record (EMR) showed R702 was their own responsible party. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R702’s hospital record internal medicine physician note, dated 6/28/25, showed, “…Assessment/plan: .presenting with UTI (urinary tract infection) and misplaced SP (suprapubic catheter) tube now s/p (status post) urethral catheter placement…continue urethral catheter; ok for monthly exchanges with nursing or urology…” Review of R702’s hospital record internal medicine physician note, dated 6/26/25, revealed, “Assessment/plan:…Complicated acute UTI likely secondary to SPC (suprapubic urinary catheter) with sepsis…SPC dysfunction/clogged, unable to be replaced…” Review of R702’s hospital record history and physical, dated 6/18/25, revealed R702 was admitted to the hospital on [DATE]. The document showed, …neurogenic bladder s/p suprapubic catheter…Patient states his suprapubic catheter has been clogging at his nursing facility…approximately 3 days ago his suprapubic catheter was exchanged after clogging. He states he normally gets a 20 French but the facility did not carry that catheter size and it was exchanged for an 18 French. He states today when the facility tried to upsize his catheter to a 20 French suprapubic catheter however the catheter was unable to (sic - be) replaced. He states that he then had a 14 French urethral catheter placed and was then taken to the emergency department…His suprapubic catheter was removed likely over 12 hours ago…significant edema and bleeding from the (suprapubic) tract. Fourteen French Foley catheter in place draining pink tinged urine. Significant purulent (infected) appearing exudate (drainage) from around the catheter…Suprapubic catheter unable to be replaced…given significant amount of time since catheter was removed, tract appears to be permanently closed…Maintain urethral catheter. Patient with bladder spasms after placement. Some blood, purulent exudate and leaking around the catheter to be expected (sentence in bold print)…” The note further revealed R702 was to follow-up with urologist as an outpatient and was prescribed antibiotics. Review of R702’s physician order, dated 6/15/25, revealed, “Insert Foley catheter: for 24 hr (hour) until 20 Fr (catheter size). Catheter size/French: 18…one time only for Foley care for 1 day. Start date: 6/15/25 1858 (6:58 p.m.).” On 7/10/25 at 12:17 p.m., R702 was observed in their hospital bed, wearing a gown. R702 had a foley urinary catheter, which was draining clear yellow urine. On 7/01/25 at 12:19 p.m., R702 was asked about their care at the facility. R702 stated they had been at the hospital for two weeks as the facility ran out of the catheter size they needed and said they had subsequently developed “a bad UTI”, requiring hospitalization, and could not have surgery to replace their SPC until the infection was gone, so the hospital ended up leaving the (foley) urinary catheter (which drained from the bladder) in place. R702 explained the doctor ordered an 18 sized French catheter when the facility did not have the 20 sized French catheter they required for two days. R702 described when the nurse removed the 18 French catheter to put in the ordered 20, the opening (stoma) had healed around the 18 size, so they couldn’t insert the 20 French catheter size. R702 reported their nurse was LPN “E”, who did “everything they could do”. R702 stated they never saw any doctor when the incident occurred, which concerned them. R702 reported if the physician had seen them and prescribed an antibiotic they may not have required the hospitalization, as the catheter was clogged prior and smelled foul, and said they had asked the facility staff to see their physician for an antibiotic. R702 explained this made them feel angry and upset and said they were tired of feeling angry and just wanted appropriate care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R702’s nursing progress note dated 6/18/25 at 11:29 p.m. by LPN “I”, “(R702) complains of suprapubic pain on 6/15/25, NOD (nurse on duty) attempted to change foley (sic – SPC) and could not locate required supplies for 20Fr (French) catheter. NOD contacted neurologist…(who) ordered a 18F foley to be placed until supplies arrived. (Physician) further states to send resident to hospital if 20F is not available 6/17/25. 20 F still unavailable, resident request to be transferred (to hospital)…” Review of R702’s nursing progress note, dated 6/15/25 at 7:15 p.m., revealed, “Dr. notified of unavailability of 20 fr foley @ the moment r/t (related to) resident foley being clotted. New order for 24 hr 18 fr sp foley until made available. Send resident out to hospital if 20 fr does not become available per (physician).” On 7/01/25 at 3:00 p.m., LPN “I” was asked about R702’s catheter and subsequent hospitalization. LPN “I” confirmed the incident occurred per their progress note. LPN “I” was asked why there was no 20 French foley available. LPN “I” stated the 20 French foley should always have been stocked at the facility for R702, and said they had some hit or miss with supplies, as the staff member in charge of ordering supplies, Staff “L”, did not always understand how to order supplies. LPN “I” acknowledged there had been some communication gaps with Staff “L” who oversaw central supply ordering and said things had been improving. LPN “I” stated when the 20 French foley and then the 18 French foley would not go in (for R702), that was an emergency situation. LPN “I” reviewed the EMR (electronic medical record) with Surveyor and confirmed R702 should have been sent to the hospital on 6/16/25, instead of 6/17/25 per physician order when they did not have the 20 French foley. LPN “I” acknowledged this placed them at higher risk for infection. LPN “I” reported the physician had been notified on 6/15/25 and confirmed there was no physician visit documented when the incident occurred or after, between 6/15/25 and 6/17/25. On 7/02/25 at 8:04 a.m., Staff “L” reported they oversaw central supplies and ordering supplies. Staff “L” reported no staff let them know the Friday before they needed a 20 French foley, and they had been made aware on Monday (6/16/25) nursing staff needed a 20 French foley for R702, so they checked with their sister facilities and found none on Monday but found a 20 French foley on Tuesday (6/17/25). When asked whose responsibility it was to order supplies, Staff “L” reported it was their responsibility but also nursing staffs to bring it to their attention. Staff “L” was asked if there was a way to track facility supplies and when they were needed. Staff “L” reported they did more of a visual check and said they were not logging or keeping track of when supplies were needed. Staff “L” felt improved communication with nursing staff could help them to know when supplies were needed, and said R702 was the only resident using a 20 French foley when the incident occurred. On 7/02/25 at approximately 8:25 a.m., the DON was asked about the 20 French foley not being available for R702 on 6/15/25 and 6/16/25, and the supply ordering process. The DON explained they had not been made aware of any concerns, but their expectation would have been for Staff “L” to have been keeping track of the PAR (Periodic Automatic Replacement) level to prevent such an occurence, and said they would speak with Staff “L” about their ordering process and not just doing visual checks. The DON was shown the physician order not having any designation for the type of catheter size, and confirmed they understood the concern, as the size should be reflected in the physician orders and Care Plan. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/02/25 at 8:30 a.m., the Director of Nursing (DON) was asked about the incident and reviewed the EMR with this Surveyor. The DON shared they were not notified of the concern with R702’s catheter until 6/16/25 (a day after the incident), and stated their Nurse Practitioner (NP) “M” saw R702 on 6/16/25, and had said not to send R702 to the hospital and wait for the 20 French foley to come in. This surveyor noted a practitioner or physician note was not found in the EMR on 6/16/25, which the DON acknowledged. The DON reported the NP visit should have been documented in a progress note, and their expectation would have been for NP “M” to document the visit. The DON reported downsizing the catheter size would not have been a concern for them for one day, although they were aware R702 required a 20 French foley. The DON reported they came to the facility and saw the resident when the incident occurred on Tuesday (6/17/25) and were aware staff placed a smaller foley as they could not replace the 20 French or 18 French foley catheters, and said they sent R702 to the hospital. The DON reported they had not been made aware of R702 having any UTI symptoms, and review of the EMR showed no fevers or change in vitals or symptoms on the days prior and up to the incident. The DON reported if they had a 20 French foley it would have been placed at that time instead of the 18, and then they could have possibly treated R702’s (UTI) symptoms in house. The DON explained if they had been involved initially, they could have possibly sent R702 to the hospital when the incident occurred (on 6/15/25), and said they believed R702 was seen by the Nurse Practitioner (NP “M”) on 6/16/25. On 7/02/25 at 9:17 a.m., NP “M” was asked about R702’s catheter and their visit on 6/16/25, per the DON’s description. NP “M” said they spoke with the DON about R702’s catheter and were aware the on-call physician suggested R702 be sent to the hospital, but they understood R702 was not agreeable to going to the hospital. NP “M” said, “That is what I heard.” NP “M” was asked if they saw R702 on 6/15/25, 6/16/25, or 6/17/25 and confirmed they had no seen R702 or done a visit. NP “M” reported R702 was adamant about having the 20 French foley, but they felt the 18 French foley was fine to keep the (SP) tract open for 1-2 days. NP “M” reported they agreed for R702 to go to the hospital when their suprapubic catheter could not be replaced. On 7/02/25 at 11:16 a.m.,this Surveyor shared with the DON the concern regarding NP “M” reporting they did not do an in-person visit on 6/16/25 with R702. The DON acknowledged they understood the concern and said they would have expected NP “M” to have seen R702 when they were in the facility on 6/16/25. The DON reported R702 did not want to go to the hospital initially. The DON reported R702 had no pain when the incident occurred. The DON was asked about no designation in R702’s physician orders or Care Plan regarding the catheter size at the time of the incident, and currently. The DON reported they understood, and clarified the French foley catheter size should be designated. The DON reported the incident had a potential outcome, as a too large catheter size could have caused pain, and a too small catheter size could have caused leakage. Review of R702 Treatment Administration Record (TAR) showed R702 had pain of 6/10 on 6/15/25, when the incident occurred. Review of the policy, “Suprapubic Catheter Change”, revised 7/06/23, revealed no information respective to catheter sizing or availability. (continued on next page)

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	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lakeland Center	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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy, “Standards of Practice”, dated 8/15/24, revealed, “Residents at the facility will receive services, treatment, and care in accordance with professional standards of practice. Resident care policies are developed, revised, and updated as needed, to ensure they are consistent with current professional standards of care and implemented within the facility… Review of the policy “Catheter Care”, dated 8/24/24, revealed, “It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use…” Review of the job description, “Central Supply Clerk”, revealed, “The Central Supply Clerk is responsible for the procurement, storage, and distribution of medical and non-medical supplies in the facility. This role ensures all departments have access to necessary material to support daily operations and quality resident care. Essential Duties and Responsibilities: Order, receive and stock all supplies including medical ., monitor and maintain appropriate inventory levels, deliver supplies to nursing units and departments in a timely and organized manner, maintain organization and cleanliness of the central supply area, coordinate with vendors regarding delivery schedules and back-ordered items, assist with monthly inventory counts and supply cost tracking…, communicate effectively with department heads regarding supply needs…”