

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  02/11/2026
NAME OF PROVIDER OR SUPPLIER  The Lakeland Center		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)		
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>This citation pertains to intake #2615522. Based on observation, interview, and record review, the facility failed to promote resident self-determination through support of resident choice for two residents (R72 and R96) of two residents reviewed for self-determination and resident choice resulting in frustration, verbalized complaints, and the withholding of occupational therapy rehab services. Findings include:R72 On 2/10/26 at 10:09 AM, R72 was observed in their room. At that time, an interview was conducted regarding an allegation lodged with the State Agency regarding the facility's refusal to apply a seat belt to R72's wheelchair. They explained that when they used to go to their outpatient day program, they were allowed to have a seatbelt in their wheelchair, which gave them a sense of security and safety. They continued to explain that since they stopped attending the outpatient day program (in the summer of 2025) they had been given a different wheelchair and the facility repeatedly refused to equip it with a seatbelt upon their request. They continued to say they were physically able to unbuckle the seatbelt on their own free will and did not understand why they were no longer allowed to have one. They were asked who in the facility they requested the application of the seatbelt on their new wheelchair and said they inquired with both Rehab Director 'I' and Maintenance Staff 'N'. They were asked what the facility's reply was when they were told they could not have seatbelt and said, They told me the State doesn't allow it, but I know that's a lie. On 2/10/25 11:05 AM, an interview was conducted with Rehab Director 'I'. They were asked if they were aware of R72's request for the application of a seatbelt on their new wheelchair and they denied any knowledge of R72's request. Rehab Director 'I' said they would look into R72's request and perform an assessment. On 2/11/26 at 12:15 PM, an interview was conducted with the facility's Administrator, and they were made aware R72 had been told by staff they could not have a seatbelt in their wheelchair because, The State doesn't allow it. The Administrator indicated this was an inappropriate response to R72's request and said they had been made aware of R72's request from Rehab Director 'I' on 2/10/26 and they were going to have R72 assessed for the proper use of a seatbelt in their wheelchair. R96 On 2/11/26 at 1:04 PM, an interview was conducted with R96. R96 verbalized complaints about rehabilitation services. They said they have frequent transfers out to the hospital and when they return to the facility from an admission at the hospital, Physical Therapy (PT) comes to assess them, but they refuse the Occupational Therapy (OT) assessment. They continued to say they don't want PT services, but they would like OT services. When queried why they were not getting OT services they said they did not like Certified Occupational Therapist Assistant (COTA) 'DD' and refused treatment from them but would be willing to work with another therapist. They said they were told by Rehab Director 'I' COTA 'DD' was the only COTA on staff. The further said, Rehab Director 'I' said they would come in and supervise COTA 'DD' when working with them, but it didn't matter because they (R96) still did not want COTA 'DD' performing the therapy. On 2/11/26 at approximately 1:30 PM, a facility provided Concern Form initiated by R96 on 9/3/25 was reviewed and read,</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235589
		If continuation sheet Page 1 of 22

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>.Describe the concern using factual terms: Reports that he would like a different OT for his therapy .Action taken regarding the concern: Spoke with Resident &amp; COTA separately. Plan to have Therapist and DOT (Director of Therapy, Rehab Director 'I') attend next OT tx (treatment) &amp; determine if common ground can be found to continue with OT tx . A review of R96's progress notes revealed the following:A note entered into the record on 10/7/25 from COTA 'DD' that read, .Ot {sic} attempted OT evaluation as pt (patient) has returned from the hospital. Pt refused ot {sic} evaluation .Pt stated when the department hires a new therapist then let him know . A note entered into the record by Rehab Director 'I' on 2/10/26 that read, Attempted OT eval on this date with resident declining, stating, I'm not feeling up to it and I want to wait till you get a new (OT). Suggested to resident to agree to OT assessment and trial treatment with the current OT team. Resident again declined.On 2/10/26 at 2:19 PM, an interview was conducted with Rehab Director 'I'. They were asked why R96 was refusing OT services and said R96 did not like COTA 'DD'. They were asked what they were doing to accommodate R96's preferences for an OT service provider and said they (Rehab Director 'I') offered to be present with COTA 'DD' during the therapy sessions, however; R96 continued to decline services provided by COTA 'DD'. Rehab Director 'I' was asked if they could provide the therapy services since they were a licensed OT and said they could not promise to do all sessions as the role of Rehab Director had too many other things going on. They were then asked if the Rehabilitation Contract Company could send another COTA that worked for the company and said they didn't think they would send someone out for one resident. On 2/11/26 at 12:15 PM an interview was conducted with the facility's Administrator. They were asked if they were aware of R96's ongoing concerns with OT services, particularly with COTA 'DD' and said they said they were not, but they should have been made aware, and something should have been done to accommodate his preferences. A review of a facility provided policy titled, Accommodation of Needs reviewed 2/2026 was conducted and read, The facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preference of a resident .The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis .</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intakes 2603176, 2610188 and 2671721. Based on observation, interview and record review, the facility failed to maintain a clean, comfortable, safe, and homelike environment, affecting all residents that reside on the second floor, including R20, R23, R24, R39, R51, R72, R96, and R103 and residents that utilize the shower rooms on all units. Findings include: Review of the complaints reported to the State Agency included multiple concerns regarding the facility's environment, including safety, cleanliness, and lingering odors.</p> <p>On 2/9/26, during a building tour with the Director of Housekeeping &amp; Laundry (Staff 'H') the following observations were made:</p> <p>On 2/9/26 at 10:45 AM, in the Unit 4 first floor shower room observed a vinyl fabric liner attached under the shower bed full of cloudy liquid with odor of urine; HM H tipped the bed over the shower floor drain to drain away the waste liquid through the liner drain hole with attached tubing. The vinyl liner was then observed to be visibly soiled/stained with brown staining. During this observation, when asked if this liner was laundered, he indicated is not a laundered item and that housekeeping doesn't clean this item, it is the responsibility of the CNA (Certified Nursing Assistant) to clean this item.</p> <p>On 2/9/26 at 11:00 AM, in the Unit 3 shower room (room [ROOM NUMBER]) observed a therapy tub connected to the water supply. The floor was visibly soiled with buildup under and around the therapy tub. At the floor/wall juncture around the perimeter of the tiled shower observed torn and missing caulk seal and visibly soiled with black substance. The shower bed liner (catchment beneath the bed) also observed soiled/stained with a large brown area around the drain hole area connected to tubing. During this observation, when asked, HM H indicated he had not seen the tub be used. HM H also observed the soiled shower area and confirmed that it needed re-caulking and cleaning to remove the staining. When asked about the frequency of cleaning of shower rooms, he indicated that housekeeping staff cleaned all shower rooms daily with a deep/detail cleaning monthly.</p> <p>On 2/9/26 at 11:10 AM, in the Unit 2 shower room observed the floor visibly soiled with buildup under and around therapy tub. At the floor/wall juncture around the perimeter of the tiled shower observed torn and missing caulk seal and visibly soiled with black substance. During this observation, when asked, HM H indicated he had not seen this tub be used either. He also observed this soiled shower area and confirmed that it needed re-caulking and cleaning to remove the staining.</p> <p>On 2/9/26 at 11:20 AM, in the Unit 1 shower room observed the vinyl fabric liner attached under the shower bed full of cloudy liquid with odor of urine; HM H tipped the bed over the shower drain to drain away the waste liquid. This vinyl liner was also visibly soiled/stained with brown staining. Floor area at floor/wall juncture around perimeter of shower room also observed with soil build up.</p> <p>Additional observations included:</p> <p>On 2/9/26 at 9:27 AM, R96's room was observed. The floor in the room was littered with debris and numerous stains near the head of the bed and around the nightstand.</p> <p>On 2/9/26 at 9:35 AM and 2/10/26 at 1:25 PM, R24's room was observed. The closet door, the wall</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>adjacent to the closet door, and the wall adjacent to the room door were observed with a dried purple substance in streaks down the surfaces.</p> <p>On 2/9/26 at 10:31 AM, R91's room was observed to be cluttered. The floor was sticky with debris scattered throughout the floor and appeared as if it had not been mopped.</p> <p>On 2/9/26 at approximately 10:40 PM, R23 and R39's room was observed with a dirty floor. Food crumbs, including scrambled eggs were observed around R39's bed. Food crumbs and trash were observed on the floor beside R23's bed. The floor appeared as if it had not been mopped and was sticky.</p> <p>On 2/9/26 at 12:15 PM, observations of the second floor revealed upon exiting the elevator there were very strong urine and bowel movement odors present throughout the hallways on Unit 1 and Unit 2. The flooring in the hallway just outside of the room occupied by R20 was observed soiled with a clear, sticky substance.</p> <p>On 2/9/26 at 12:21 PM, R20's room was observed to have a strong urine odor. The resident was not in the room at this time, and the bed linens were removed from the bed. The wall near the door was observed to be heavily damaged with deep grooves and the floor molding just on the inside of the room, near the door was observed peeling back with exposed debris. There was various food debris and trash scattered on the flooring throughout the room.</p> <p>On 2/9/26 at 12:40 PM, R51's room was observed to have debris and trash on the flooring scattered throughout the room. When asked about housekeeping, R51 reported housekeeping came into the rooms but lately there was a lot of housekeeping turnover with the housekeepers and supervisor.</p> <p>On 2/9/26 at 1:04 PM the handrail observed across from the housekeeping closet was observed separated, with sharp metal and plastic edges exposed. The handrail near the main lounge on Unit 1 was observed to have a missing end cap which exposed sharp metal and plastic edges. A resident was observed trying to propel their wheelchair throughout the hallway and used their hand to pull along the area of the handrail that was exposed.</p> <p>On 2/10/26 at 9:02 AM, observation of the entire hallway for rooms 215-225 revealed a very strong urine odor that was pervasive throughout the hallway, including in the central shower room. Upon further observation of the central shower room, there was no evidence of the source of the urine odor.</p> <p>The wallpaper throughout the hallways were observed heavily soiled with purple and brown colored debris splattered throughout and some sections were peeled away from the wall.</p> <p>The flooring outside and inside R20's room remained covered with a clear, sticky substance and a mechanical lift was stored directly over the substance. The floor molding in R20's room remained peeled away from the wall.</p> <p>On 2/10/26 at 10:09 AM, an observation of R72's room was conducted. Food and litter debris were observed on the floor and under R72's bed. A pedestal fan was observed at the foot of R72's bed and the cage around the fan and the fan blades were observed with a large accumulation of gray dust and debris. At that time, an interview was conducted with R72. During the interview, R72 expressed complaints with the facility's housekeeping. They said when they first admitted a couple of years ago the housekeeping staff would sweep and mop the floor daily and lately, they have only been coming in once a week. R72, said It's not sanitary. R72 then said the facility frequently has unpleasant odors.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>They said they usually refuse to go out to dialysis on Wednesdays but sometimes they go just to get away from the smell in the building.</p> <p>On 2/10/2026 at 1:09 PM, the housekeeping closet 212 door was observed opened and not secured. There were several containers of cleaning chemicals stored in the room. There was no housekeeping staff observed in the hallways nearby.</p> <p>On 2/10/26 at 1:11 PM, Housekeeper 'E' was observed walking to the unlocked closet and when asked about the closet being unsecured, they reported that should've been locked.</p> <p>On 2/10/26 at 1:16 PM, the handrail end caps and peeling, soiled wallpaper remained. The floor molding inside room [ROOM NUMBER] remained peeled away.</p> <p>On 2/10/26 at 1:17 PM, R96's room was observed. R96 was not in the room, nor were there staff present. The bed was stripped of the linens, and the linens were thrown on the floor under the window. At the foot of the bed, the floor was observed with copious amounts of skin flakes, and the floor near the nightstand was soiled with light brown, sticky stains.</p> <p>On 2/10/26 at 1:40 PM, R23 and R39's room remained in the same condition as mentioned above. The floor was dirty with food crumbs and scrambled eggs alongside R39's bed. A plastic spoon, medication cup, and food crumbs were on the floor beside R23's bed. At that time R23 was interviewed and asked how often the room was cleaned. R23 said they did not know but mentioned a nurse aide thought staff members were using the toilet in their room. At that time, an observation of R23 and R39's bathroom was conducted. Two wheelchairs were stored in the bathroom. A pink stain was observed on the toilet seat. The water in the toilet bowl appeared to have a film on the top and was discolored. The toilet bowl had black stains on it.</p> <p>On 2/11/26 at 8:10 AM, an interview was conducted with the Maintenance Director (Staff 'G') who reported they had started working at the facility in September 2025. When asked about how the facility staff notified maintenance of any items that might need to be addressed, Staff 'G' reported the facility staff utilized an electronic reporting system. At that time, Staff 'G' was asked to observe the environment on Unit 1 and Unit 2 and confirmed the same findings with the sharp handrails and missing end caps, floor molding, and peeling wallpaper. Upon observing the Unit 1 shower room, the shower bed was observed to have a lower white plastic shelf layer under the shower bed that was visibly soiled. Staff 'G' reported they had identified that yesterday and would be removed today. Upon further inspection of the shower bed, there was a metal object on the tile floor directly under the shower bed and a broken black zip tie to the left side of the shower bed. When asked about the metal object and broken zip tie, Staff 'G' reported that was a broken pin which secured the railing to one side of the shower bed rails. When asked if staff were aware it was broken, why was the shower bed still available for use, and further asked if Staff 'G' had been notified it needed repairs, Staff 'G' reported they were not aware of that, it should've been reported and not been available for use.</p> <p>When asked about the floor molding for room [ROOM NUMBER], Staff 'G' reported they had just seen that yesterday and had not been reported by any staff.</p> <p>On 2/11/26 at 8:26 AM, an interview was conducted with the Director of Housekeeping and Laundry (Staff 'H'). They reported they had been in their role for about a month. When asked about their staffing for the department, Staff 'H' reported there were several openings that needed to be filled. They further reported their housekeepers were assigned seven days a week from 7:00 AM to 3:30PM and they</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>also had a night housekeeper who worked seven days a week from 3:00 PM to 11:00 PM. When asked about to explain their process of ensuring resident rooms and environment were adequately cleaned, Staff 'H' reported their staff used a checklist and cleaned all rooms daily. When asked about the earlier observations of housekeeping concerns as well as the multiple complaints from residents and families, Staff 'H' acknowledged there were concerns with housekeeping.</p> <p>When asked about the stains throughout the hallway on Unit 1 and 2, Staff 'H' confirmed the areas of concern and proceeded to use their nail on the brown stain on the wall and handrail across from the nursing station and stated that could be tube feeding residue. When asked why no one had addressed the areas since these were evident since the survey began on 2/9/26, Staff 'H' offered no further explanation.</p> <p>When asked about the storage of chemicals and informed of the observation with Housekeeper 'E', Staff 'H' reported that should not have occurred and the housekeeping closet should be locked at all times.</p> <p>On 2/11/26 at 2:25 PM, review of the electronic reporting documentation provided by the facility included four pages with dates from 9/23/25 - 2/9/26. None of the concerns mentioned above were included within this documentation.</p> <p>According to the policy titled, Homelike Environment dated 2/3/2026:</p> <p>.Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences .The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: clean, sanitary, and orderly environment .pleasant, neutral scents .Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment .Staff may assist in providing a safe and homelike environment by .reporting lingering odors and bathrooms needing cleaning to the housekeeping department .Reporting any unresolved environmental concerns to the administrator.</p> <p>According to the policy titled, Chemical Storage dated 5/7/2013:</p> <p>.It is the Center's Policy to store chemicals in a safe manner .</p> <p>On 2/9/26 at 9:27 AM, R96's room was observed. The floor in the room was littered with debris and numerous stains near the head of the bed and around the nightstand.</p> <p>On 2/9/26 at 9:35 AM and 2/10/26 at 1:25 PM, R24's room was observed. The closet door, the wall adjacent to the closet door, and the wall adjacent to the room door were observed with a dried purple substance in streaks down the surfaces.</p> <p>On 2/10/26 at 10:09 AM, an observation of R72's room was conducted. Food and litter debris were observed on the floor and under R72's bed. A pedestal fan was observed at the foot of R72's bed and the cage around the fan and the fan blades were observed with a large accumulation of gray dust and debris. At that time, an interview was conducted with R72. During the interview, R72 expressed complaints with the facility's housekeeping. The said when they first admitted a couple of years ago the housekeeping staff would sweep and mop the floor daily and lately, they have only been coming in once a week. R72, said It's not sanitary. R72 then said the facility frequently has unpleasant odors. They</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>said they usually refuse to go out to dialysis on Wednesdays but sometimes they go just to get away from the smell in the building.</p> <p>On 2/10/26 at 1:17 PM, R96's room was observed. R96 was not in the room, nor were there staff present. The bed was stripped of the linens, and the linens were thrown on the floor under the window. At the foot of the bed, the floor was observed with copious amounts of skin flakes, and the floor near the nightstand was soiled with light brown, sticky stains.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake #2671721. Based on observation, interview and record review, the facility failed to ensure freedom from neglect for one resident (R96), of four residents reviewed for neglect resulting in R96's frustration and complaints that staff do not tend to their needs/requests when they activate their call light. Findings include: On 2/10/26 at 1:30 PM, a review of facility provided, Concern Form dated 8/4/25 reported from R96 was interviewed and read. Describe concern using factual terms: Resident alleges when call light is pressed staff turn of {sic} call light from desk without completing the task .[NAME] taken regarding concern: Verbal statement from nurse during Admin (Administrator) investigation: Nurse admitted to turning off call light without addressing issues. Staff educated on call light response .Nurse provided one-on-one . On 2/11/26 at 12:15 PM, an interview was conducted with the facility's Administrator regarding R96's concern form. They were asked if they recalled the incident and to identify the nurse that admitted to turning off R96's call light without tending to their needs/request. The Administrator indicated they remembered the incident and identified Nurse 'O'; who admitted to turning off the call light from the nursing station without going to check why R96 activated the call light. On 2/11/26 at 12:36 PM, R96 was observed in their bed with a specialized, breath activated call light designed for patients with limited or no motor skills, such as quadriplegia. A that time, an interview was conducted with R96 regarding staff turning off the call light from the nursing station desk without tending to their needs/request and reported staff were still doing it. When they were asked how they knew the call light was deactivated from the nursing desk they explained that when the light is activated a bell sounds in the hallway, and when the bell stops sounding, and no one comes to their room the light was deactivated from the nursing station. R96 further reported, in the past the Administrator had been in their room, activated the call light and witnessed staff deactivating it without coming into the room to check why it was activated. A review of R96's clinical record revealed they admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnoses that included: quadriplegia, peripheral vascular disease, chronic pain, pressure ulcers, neuromuscular dysfunction of the bladder, presence of a suprapubic catheter, and urinary tract infections. A review of a facility provided policy titled, Abuse updated 5/2023 was conducted and read, .Residents have the right to be free from abuse, neglect, exploitation, mistreatment .Definitions: Neglect .Failure of the facility, it's 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 .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to Intake Numbers: 2671563, 2671721. Based on observation, interview and record review, the facility failed to report an injury of unknown origin and an allegation of neglect to the Abuse Coordinator and State Agency, and failed to report resident to resident physical abuse to the State Agency without misleading information that minimized the seriousness of the incident for three (R22, R76, and R96) of five residents reviewed for abuse and neglect. Findings include: R22 and R76</p> <p>A review of a Facility Reported Incident (FRI) revealed on 11/3/25, the facility reported the following to the State Agency: physical contact made by resident (R22) to resident (R76) .Resident (R22) placed on one-on-one supervision .Investigation initiated . The report did not document the type of physical contact that was made.</p> <p>A review of R76's progress notes revealed a Nursing-Progress Note dated 11/3/25 that documented, Writer called to the unit for an incident involving res (resident) and another resident from unit, staff CNA (Certified Nursing Assistant) stated res was in dining area in wheelchair when another res rolled up and grabbed res by the collar and pulled her to the floor, incident was witnessed .had pain in R (right) arm and hip area .</p> <p>A review of an investigation file provided by the facility into the resident-to-resident incident between R22 and R76 revealed the following:</p> <p>.Witnesses: CNA 'P' .</p> <p>Witnesses: Avion [NAME] .Investigation Summary .Incident Details: On 11/3/2025 at approximately 3:45pm the facility was notified of an allegation involving physical contact initiated by (R22) toward (R76). (R76) had a fall from the wheelchair related to the incident. The incident occurred in the dining room with one staff member present.</p> <p>Staff Witness Statement Summary:</p> <p>(R76) had just returned from (an outside appointment). She was placed by the window in the dining room. As she was being assisted, (R22) approached her from behind making physical contact that resulted in (R75) falling from the wheelchair . The statement was handwritten by the Director of Nursing (DON) and signed by CNA 'P'.</p> <p>On 2/10/26 at 10:08 AM, an interview was conducted with CNA 'P' via the telephone regarding the incident between R22 and R76 on 11/3/25. When queried about what happened, CNA 'P' explained R76 returned from an outside appointment in the afternoon and although she was not R76's assigned CNA that day, she brought R76 back up to the unit when she returned, took her coat off, placed her near the window in the dining room because she was warm, and got her situated. CNA 'P' was opening the window when R22, who was previously on the other side of the dining room, appeared by R76. R22 Grabbed her out of the chair by her shirt and would not let go. CNA 'P' said R76 fell out of the wheelchair onto the floor and R22, who was only able to use one arm, continued swinging at R76. CNA 'P' reported a nurse (Registered Nurse - RN 'Q') came into the dining room while it was happening and assisted CNA 'P' to separate the residents. CNA 'P' said she gave all of the details to the DON, she wrote them down, and then CNA 'P' signed off on the statement.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/10/26 at 10:20 AM, an interview with RN 'Q' was attempted via the telephone. RN 'Q' was not available for interview prior to the end of the survey.</p> <p>On 2/9/26 at approximately 10:00 AM, R76 was not in her room. At 1:14 PM, R76 was not in her room. Staff said she was at an outside appointment.</p> <p>On 2/10/26 at 9:19 AM, R76 was observed in the dining room, sleeping in a wheelchair. Was unable to interview R76 at that time.</p> <p>A review of R76's clinical record revealed R76 was admitted on [DATE] with diagnoses that included Lupus, anxiety disorder, major depressive disorder, auditory hallucinations, cerebral palsy, and legal blindness. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R76 had moderately impaired cognition.</p> <p>On 2/9/25 at 1:09 PM, R22 was observed in his room eating lunch. When spoken to, R22 did not make eye contact or respond verbally.</p> <p>On 2/10/26 at 9:17 AM, R22 was observed in the dining room, making grunting noises and watching television. R22 was unable to be interviewed.</p> <p>A review of R22's clinical record revealed R22 was admitted into the facility on 5/6/22 with diagnoses that included: brain injury and epilepsy. A review of an MDS assessment dated [DATE] revealed R22 had severely impaired cognition.</p> <p>On 2/11/26 at 8:55 AM, an interview was conducted with the Administrator who was the Abuse Coordinator for the facility. When queried about why only physical contact was reported to the State Agency and not exactly what happened according to the witness (CNA 'P') and what was documented in the clinical record, the Administrator reported she understood it should have more detail to explain what actually happened.</p> <p>R96</p> <p>On 2/10/26 at 1:30 PM, a review of facility provided, Concern Form dated 8/4/25 reported from R96 was conducted and read, Describe concern using factual terms: Resident alleges when call light is pressed staff turn of {sic} call light from desk without completing the task. [NAME] taken regarding concern: Verbal statement from nurse during Admin (Administrator) investigation: Nurse admitted to turning off call light without addressing issues. Staff educated on call light response .Nurse provided one-on-one .</p> <p>On 2/11/26 at 12:15 PM, an interview was conducted with the facility's Administrator regarding R96's concern form. They were asked if they recalled the incident and to identify the nurse that admitted to turning off R96's call light without tending to their needs/request. The Administrator indicated they remembered the incident and identified Nurse 'O'; who admitted to turning off the call light from the nursing station without going to check why R96 activated the call light. They were then asked if they reported R96's documented allegation of Nurse 'O' neglecting to answer their call light and turning it off from the nursing station and said they did not.</p> <p>On 2/11/26 at 12:36 PM, R96 was observed in their bed with a specialized, breath activated call light designed for patients with limited or no motor skills, such as quadriplegia. A that time, an</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>interview was conducted with R96 regarding staff turning off the call light from the nursing station desk without tending to their needs/request and reported staff were still doing it. When they were asked how they knew the call light was deactivated from the nursing desk they explained that when the light is activated a bell sounds in the hallway, and when the bell stops sounding, and no one comes to their room the light was deactivated from the nursing station.</p> <p>A review of R96's clinical record revealed they admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnoses that included: quadriplegia, peripheral vascular disease, chronic pain, pressure ulcers, neuromuscular dysfunction of the bladder, presence of a suprapubic catheter, and urinary tract infections.</p> <p>A review of a facility provided policy titled, Abuse updated 5/2023 was conducted and read, .Initial Reporting: The facility will ensure that all allegations involving abuse, neglect, exploitation .are reported immediately to the Administrator and: Reported to the State Survey Agency immediately but not later than two hours after the allegation is made if the allegation involves abuse .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intakes 2603176 and 2610478. Based on observation, interview and record review, the facility failed to implement interventions per plan of care following a resident to resident incident (between R51 and R16) for one (R51) of six residents reviewed for accidents. Findings include: Review of a complaint reported to the State Agency on 9/9/25 documented R51 reported an incident from 9/8/25 in which another resident (R16) came into their room with just a brief on and scared her. Review of the clinical record revealed R51 was initially admitted into the facility on 5/19/21, readmitted on [DATE] with diagnoses that included: generalized anxiety disorder, major depressive disorder recurrent moderate, adjustment disorder, other osteochondrodysplasia with defects of growth of tubular bones and spine, short stature due to endocrine disorder unspecified, and neuralgia and neuritis. According to the Minimum Data Set (MDS) assessment dated [DATE], R51 had intact cognition. Review of the care plans included, The resident expressed desire for enhanced safety and privacy measures in her room. This care and interventions had been initiated on 9/22/25 by Former MDS Coordinator (Nurse 'D') and had not been discontinued as of this survey. Interventions included: Place a red stop sign on the resident's door as a visual cue to discourage uninvited entry. Reinforce the residents' rights to privacy and safety. Observations during the survey on 2/9/26 at 12:39 PM, 2/10/26 at 8:50 AM, and 2/10/26 3:17 PM revealed there was no placement of any Velcro stop signs within R51's doorway. Throughout the survey, R16 was observed lying in bed in their room which was located directly across from R51's room. On 2/11/26 at 8:35 AM, an interview was conducted with Certified Nursing Assistant (CNA 'F') who was assigned to R51. When asked about whether they were aware there should be a Velcro stop sign for R51's room, according to the care plan, CNA 'F' reported they had worked at the facility for a year and had never seen anything like that for R51. On 2/11/26 at 8:43 AM, an interview was conducted with the Director of Nursing (DON). When asked to review R51's care plan following the concern from 9/8/25, the DON reported that was prior to their employment which began in October 2025 and was unable to offer any explanation, but reported if that was an intervention it should've been in place for R51. The DON further reported Nurse 'D' no longer worked at this facility. When asked if the facility had Velcro stop signs to utilize, the DON reported they definitely did and they just saw one at the nursing station today. According to the facility's policy titled, Care Plan - Comprehensive and Revision dated 2/2/2026: .Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to .Receive the services and/or items included in the plan .</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake # 2610188. Based on observation, interview, and record review, the facility failed to ensure activity of daily living care (personal hygiene, bathing, nail care) for four residents, (R's 72, 6, 20, and 51) of six residents reviewed for activities of daily living, resulting in poor hygiene, body odor, complaints of not receiving care, and the potential for embarrassment from poor hygiene. Findings include: R72</p> <p>On 2/10/26 at 10:09 AM, an interview was conducted with R72. R72 verbalized complaints that sometimes there were not enough aides on the unit. When queried why they thought the facility was short staffed they said, It takes a long time to get waited on, and further indicated they missed some of their scheduled bed baths. They said recently they went about a week without receiving a bed bath.</p> <p>On 2/10/26 at 10:12 AM, a review of R72's Certified Nurse Aide (CNA) task for bathing for a 30-day look-back period was conducted and revealed they received a bed bath on 1/21/26 and did not receive their next one until 1/28/26. The task form further revealed their last documented bed bath was completed on 2/3/26.</p> <p>R6</p> <p>On 2/9/26 at 9:27 AM, R6 was observed sleeping in their bed in a hospital gown. The fingers on R6's left and right hands were contracted in a fist into the palm of their hands. R6's fingernails that could be observed (not all could be observed due to contractures) were long in length approximately 1.25 inches beyond the tip of the finger with debris under the nails. It was noted R6 had an unpleasant, sour body odor.</p> <p>On 2/9/26 at 12:08 PM, R6 was observed in their bed awake, dressed in a hospital gown. R6 did not respond to attempts at an interview and made only non-sensical grunting noises. The foul, sour odor persisted about the room.</p> <p>On 2/10/26 at 10:45 AM, an observation of R6 was made with Unit Manager 'X'. R6 was observed in the same gown as observed on 2/9/26. At that time, Unit Manager 'X' was asked about the foul odor in the room and confirmed the room had an unpleasant odor. They further said R6 was scheduled to receive a shower later on in the day. They were then asked if an observation of R6's right palm could be made to check skin integrity and ensure no sores developed in the palm from the long nails on R6's contracted fingers. Unit Manager 'X' was only slightly able to uncurl R6's fingers from their palm given R6's contractures and resistance, but when they did a very strong, foul, bitter, sour odor emanated from R6's hand. Unit Manager 'X' confirmed the odor was coming from R6's hand. They were asked how staff ensured R6's cleanliness and hygiene and said about a month ago, the therapy department was able to work with R6 to clean the palm of their hand.</p> <p>On 2/10/26 at 11:05 AM, an interview was conducted with Rehab Director 'I' regarding R6's hand contractures and hygiene for the hand. They indicated R6 was resistive for opening their hands but thought if they took enough time with R6 he would eventually let them clean the palm of the hand.</p> <p>On 2/10/26 at approximately 3:00 PM, R6 was observed in their room, dressed in a long sleeve shirt and fleece pants seated in their geri-chair. R6's nails were observed to remain long in length. Though some of the strong odor had diminished in the room, the room and R6 remained with a sour, stale</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>odor.</p> <p>A review of R6's CNA task for bathing for a 30-day look-back period was conducted and revealed their last scheduled shower was documented on 2/3/26. R6's clinical record further revealed they had severely impaired cognition and was dependent of staff for all activities of daily living.</p> <p>R20</p> <p>Review of concern forms provided by the facility from R20's family included:</p> <p>9/19/25. Notified by administrator that family called and was very upset that resident had not been dressed and still in bed. Writer went to staff to address problem and instructions were given to get resident dressed and in chair. Writer notified a hour later tasks had not been done.</p> <p>9/9/25. Son reports delay in personal care on 9/8/25. Son reports resident in same clothing (facility gown) per resident. Son also reports a strong urine smell from bed which suggests she hasn't had any change in linen .</p> <p>Review of the clinical record revealed R20 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses that included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, vascular dementia unspecified without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and epileptic seizures related to external causes no intractable without status epilepticus.</p> <p>According to the MDS assessment dated [DATE], R20 had intact cognition, had no behaviors, had impaired functional limitation in range of motion on both upper and lower extremities, and was dependent for shower/baths and personal hygiene.</p> <p>Review of the care plans included:</p> <p>[R20] has an ADL Self-care deficit related to diagnosis of vascular dementia, Hx (History) of CVA (Cerebrovascular accident) with residuals, Left Hemiparesis, upper and lower extremity ROM (Range of Motion) impairment. Date Initiated: 06/28/2024.</p> <p>Interventions included:</p> <p>Assist [R20] to bathe/shower as scheduled and as needed via gurney x2 person assist. Date initiated: 10/16/2025.</p> <p>Review of the available shower/bath documentation for the past 30 days revealed R20 only had one shower documented on 1/14/26 at 12:52 PM. There were no documented refusals.</p> <p>R51</p> <p>On 3/9/26 at 12:40 PM, an interview was conducted with R51 at bedside. When asked about whether they received their showers/baths as scheduled, the resident reported their preference was to get a shower but at times when there wasn't enough nursing staff, they received a bed bath or didn't get a shower.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the clinical record revealed R51 was initially admitted into the facility on 5/19/21, readmitted on [DATE] with diagnoses that included: generalized anxiety disorder, major depressive disorder recurrent moderate, adjustment disorder, other osteochondrodysplasia with defects of growth of tubular bones and spine, short stature due to endocrine disorder unspecified, and neuralgia and neuritis.</p> <p>According to the MDS assessment dated [DATE], R51 had intact cognition, was dependent on staff for assistance with toileting hygiene, required substantial/maximal assistance for shower/bathing, required partial/moderate assistance with upper body dressing, was dependent for lower body dressing, and was dependent for tub/shower transfers.</p> <p>Review of the resident's bathing/shower documentation in the electronic medical record revealed for the past 30 days, R51 received only three showers on 1/13/26, 1/20/26, and 1/30/26. There were no documented refusals.</p> <p>According to the ADL care plan initiated 5/19/21:</p> <p>SELF-CARE DEFICIT (ADLs): [R51] needs assistance with ADLs and bed mobility. [R51] is &lt;sic&gt; risk for ADL Decline related to [R51's] disease process. Performance deficit related to Activity Intolerance, Limited Mobility, and Limited ROM.</p> <p>Interventions/Tasks included:</p> <p>[R51] has a preference of shower chairs to be used as available. She prefers to use the gray shower chair. date initiated 5/7/25.</p> <p>On 2/10/26 at 2:02 PM and 4:40 PM and 2/11/26 at 8:16 AM, the facility was requested via email to provide the shower/bath schedules for all units. There was no further follow-up or documentation of this request provided by the end of the survey.</p> <p>On 2/11/26 at 8:43 AM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's process for documenting when shower/baths were provided, the DON reported the CNAs (Certified Nursing Assistants) were told everything should be documented in (electronic medical record). When asked if they used any other documents such as an actual shower forms, the DON reported they did not use additional forms and should be documented in (electronic medical record).</p> <p>A review of a facility provided policy titled, Activities of Daily Living (ADL) reviewed 2/2026 was conducted and read, .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal, and oral hygiene .</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intakes 2615522, 2645363, and 2671721. Based on observation, interview, and record review, the facility failed to ensure there was sufficient nursing staff to meet the needs of the residents, resulting in delayed and/or lack of activities of daily living (ADL) care including incontinence care, dressing and showers/baths for residents that reside on the second floor, including R17, 27, 51, 54, 72, 96 and nine residents who wished to remain anonymous that attended the resident council interview. Findings include: Review of complaints reported to the State Agency included multiple concerns from residents, families and staff that the facility was not adequately staffed to meet the residents' needs. According to the facility's documentation of their staffing guidelines within the facility assessment last updated 1/15/26, 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. Unit 1. Licensed Nurse 7a-7p .2 .7p-7a .1 .Nursing Assistant 7a-7p .3 .Unit 2 .Licensed Nurse 7a-7p .1-2 .7p-7a .1 .Nursing Assistant 7a-7p .2. Unit 3 .Licensed Nurse 7a-7p .1 .7p-7a .1-2 .Nursing Assistant 7a-7p .2. Review of the documentation provided by the facility which included assignment sheets with rooms assigned, census for each unit, as well as the time punch reports for all nursing staff that worked on 2/7/26 and 2/8/26 revealed there were multiple staff call-offs and the staffing assignments were not reflective of the above staffing levels identified in accordance with the facility assessment. On 2/9/26 at 9:50 AM, R54 was observed in their bed. They were asked about their stay in the facility and said the facility does not have enough staff. R54 said they have been left an entire shift without incontinence care. They further reported it was more prevalent on the night shift. They were asked if staff reported they were working short and R54 said, They always cry that. They further reported because of staffing they don't get their scheduled bed baths. On 2/9/26 at 10:02 AM, R17 was observed lying on their back and an interview was conducted with the resident at that time. R17 stated the facility did not have enough staff to provide care. R17 stated they missed therapy a lot because the facility did not have enough staff to get them ready for therapy. A review of R17's Physical Therapy notes revealed the following: 9/1/25 . could not be seen due to BM (bowel movement) and later dinner, team will follow up tomorrow. 8/23/25 . Pt (patient) received supine in bed with gown on, stating. Last time they did the therapy in the room. I would like that today because I am not dressed yet. On 2/9/26 at 12:40 PM, R51 reported their roommate's family (R27) repeatedly asks staff to make sure she is up but everyday the staff leaves her in bed. R51 further reported the facility frequently had only one nurse and two aides for the whole hallway and frequently have to wait for assistance longer than a half hour. R51 was asked if they had missed any activities of daily living such as showers due to not having enough nursing staff and they reported they missed multiple showers and will get a bed bath at times, but their preference is a shower. R51 further reported that due to the low nursing staff this past weekend, None of us got out of bed and meals were brought to eat in our rooms. On 2/10/26 at 9:18 AM, review the staffing assignment sheets for second floor included some residents that were documented as early get up which included rooms 280 bed A and bed B. On 2/10/26 at 9:25 AM, both residents in room [ROOM NUMBER] were observed lying in bed, not dressed and wearing hospital gowns. According to the current assignment sheet, there were supposed to be three CNAs assigned to Unit 1 on the North and South side. However, on 2/10/26 at 9:25 AM, Nurse 'O' was asked about the assignment sheet and reported CNA 'W' was not in yet. When asked who was covering their assignments, Nurse 'O' offered no further explanation. On 2/10/26 at 9:32 AM, Nurse 'R' was asked about the residents still in bed that were scheduled to be on the early get up</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>list according to the assignment sheet and Nurse 'R' reported they had marked that on the assignment sheet so that the staff do get them up, but reported the CNAs typically do meals, get residents ready for appointments, then showers before they get residents out of bed. When asked what they considered as early, Nurse 'R' offered no further explanation. On 2/10/26 at 10:05 AM, an interview was conducted with the Director of Nursing (DON). When asked about who the facility's staffing scheduler was, the DON reported that person started yesterday. When asked who was handling it prior to that, they reported that was their Unit Manager (UM 'X'). On 2/10/26 at 10:09 AM an interview was conducted with R72 and expressed concerns regarding lack of staff. R72 was queried further and said sometimes there were not enough aides saying, It takes a long time to get waited on. They said sometimes there was only one CNA for all of unit one and part of unit two. R72 further reported last week they did not receive their scheduled shower or bed bath. On 2/10/26 at 11:00 AM, a Resident Council interview was conducted with nine residents who wished to remain anonymous. When queried about any concerns about care in the facility, the following concerns were expressed by five of the residents: One resident reported the staff did not answer the call lights in a timely manner. The same resident reported due to there not being enough staff, they are forced to receive a shower at whatever time the certified nursing assistants (CNA) give it to them rather than at their preferred time. A second resident reported there were only two CNAs and two nurses at times on the second floor, and they worked on multiple units. That resident reported the CNAs said, Be there in a minute. but they did not return for hours. That resident further reported last Saturday they had to take a shower at 6:00 AM due to short staff and that was not their preferred time. A third resident reported they were left in bed this past weekend from the time they were put in bed until 1:00 or 2:00 PM the following day. They required assistance from staff to get out of bed. They typically liked to spend their days out of bed and in their wheelchair. That same resident reported there was another weekend when they were left in bed for two whole days. A fourth resident stated, The midnight shift disappears and reported when they rang the buzzer it often took hours and hours to get help. A fifth resident reported they also experienced long call light response and felt there were not enough nursing staff. On 2/10/26 at 11:34 AM, an interview was conducted with the Human Resources / Payroll (Staff 'V'). When asked about the facility's open nursing positions, Staff 'V' reported they were constantly hiring and expressed challenges with three different staff in the scheduler position. On 2/10/26 at 12:01 PM, a phone interview was conducted with Certified Nursing Assistant (CNA 'S'). When asked about the staffing for this past weekend, they reported there were multiple call-offs on Sunday. When asked if anyone from management came in to assist, they reported sometimes that happened but that did not happen this past Sunday. When asked if they were able to complete all their tasks when they worked with less staff, CNA 'S' reported they were not. On 2/10/26 at 1:04 PM, an interview was conducted with R96. R96 said the facility was short nurses on the night shift. They further reported the facility has nurses on staff to pass the nighttime medications, but then most of them are sent home after the medications have been passed. On 2/11/2026 at 8:59 AM, an interview was conducted with the Administrator. When asked about the concerns reported by multiple residents, families and staff in regard to lack of adequate nurse staffing, the Administrator reported there were challenges and they've hired a lot of people. On 2/11/26 at 8:43 AM, an interview was conducted with the DON. When asked about the concerns with lack of adequate nursing staff, the DON reported they had the appropriate staff assigned, but the call offs were excessive. The DON reported their facility has been doing mass hirings and just had a new weekend supervisor start three days ago. When asked about the staffing ratios for Unit 1, the DON reported Should have three CNAs on day shift and acknowledged the staffing documentation they provided</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  The Lakeland Center		STREET ADDRESS, CITY, STATE, ZIP CODE  26900 Franklin Road Southfield, MI 48034	
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F 0725  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	to review confirmed there were not.According to the facility's policy titled, Staffing dated 4/18/2025: .Licensed nurses and nursing assistants are available 24 hours a day, ,seven days a week to provide competent resident care services including.Responding to resident needs.Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments, and the facility assessment.Inquiries or concerns related to the facility's staffing should be directed to the Administrator or their designee.		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>This citation pertains to intakes 2615522, 2645363, and 2671721. Based on interview and record review, the facility failed to ensure that nursing staff received the required skills/competencies/performance evaluations for five of five Certified Nursing Assistants (CNA Y, Z, AA, BB, and CC) reviewed for education/training. Findings include: On 2/11/26 at 8:06 AM, the facility was requested via email to provide the CNA (Certified Nursing Assistant) skills competencies for CNAs (Y, Z, AA, BB, and CC). Review of the documentation provided by the facility revealed: CNA 'Y's most recent skills competency evaluation was completed on 7/18/24. CNA 'Z's most recent skills competency evaluation was completed on 8/8/24. CNA 'AA's most recent skills competency evaluation was completed on 1/23/24. CNA 'BB's most recent skills competency evaluation was completed on 11/2/22. CNA 'CC's most recent skills competency evaluation was completed on 6/27/24. On 2/11/26 at 12:45 PM, an interview was conducted with the Infection Preventionist / Staff Development (Nurse 'C'). They reported they had been in their role as Staff Development since mid October (2025). When asked about the facility's process for ensuring nurse staffing skills competencies were completed, Nurse 'C' reported they did reconcile the skills competency were done upon hire. When asked if they completed annual skills competency evaluations to determine areas that might need improvement, Nurse 'C' reported they were not aware those needed to be completed annually. When asked if there was any oversight from corporate for support, Nurse 'C' reported they did and was unable to offer any further explanation. According to the policy titled, Skills Evaluations dated 2/9/2024: . The skills evaluation checklist(s) is completed during job-specific orientation, re-validated annually, and completed as needed .</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>This citation pertains to intakes 2615522, 2645363, and 2671721. Based on interview and record review, the facility failed to ensure that one of five Certified Nursing Assistants (CNA 'AA') whose in-service training files were reviewed, had the required 12 hours of in-service training within the required time period. Findings include: On 2/11/26 at 8:06 AM, the facility was requested via email to provide the CNA (Certified Nursing Assistant) inservice/education training hours for five CNAs (Y, Z, AA, BB, and CC). Review of the documentation provided by the facility revealed CNA 'AA' only had 7.75 hours of education from 2024. On 2/11/26 at 12:45 PM, an interview was conducted with the Infection Preventionist / Staff Development (Nurse 'C'). They reported they had been in their role as Staff Development since mid-October (2025). When asked about the facility's process for ensuring annual education in-services were completed, Nurse 'C' reported they did reconcile of the hours and was not sure if the electronic system was glitching or not, but the documentation provided was what they were able to find. When asked about whether they received any assistance since they also performed the role as the Infection Preventionist, Nurse 'C' reported there was corporate oversight but was unable to offer any further explanation as to why the facility had not identified CNA 'AA's lack of education/training. They were requested if there was any additional documentation, they could provide by the survey exit but there was no additional documentation provided. According to the facility policy titled, In-Service Tracking dated 2/4/2024: .Each Center Administrator will appoint a Staff Development Nurse or Human Resources Representative to be responsible for tracking in-service education. The department manager will assure timely student in-service education completion.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>This citation pertains to Intake #'s 2615522 and 2610188. Based on observation, interview, and record review, the facility failed to ensure a medication error rate less than five percent when five errors were made from 25 opportunities for two residents (R#'s 57 and 92) of three residents reviewed during the medication administration task, resulting in a medication error rate of 19%. Findings include: R57 On 2/11/26 at 8:30 AM, Nurse 'EE' was observed preparing medications for R57. Among the medications prepared, Nurse EE prepared a magnesium oxide (supplement) 400 mg (milligram) tablet, a folic acid (supplement) 400 mcg (microgram) tablet, and a gabapentin (neuropathy medication) 100 mg capsule. Nurse 'EE' then crushed all the medications including the gabapentin capsule, mixed them with applesauce, entered R57's room and administered them. Upon the completion of the administration, Nurse 'EE' confirmed all medications due at that time were administered to R57. Nurse 'EE' was asked about crushing the gabapentin capsule as opposed to emptying the capsules content and discarding the outside capsule halves and said they did not see a warning in the electronic medical record that advised them it could not be crushed. On 2/11/26 at 9:40 AM, the medications administered by Nurse 'EE' to R57 were reconciled (compared) with the physician's orders. During the reconciliation it was discovered R57's order for magnesium oxide dated 6/26/25 was to administer 440 mg. It was further discovered R57's order for folic acid dated 6/26/25 was to administer 1 mg as opposed to the 400 mcg dose observed to be administered to R57. Continued review of the physician's orders revealed R57 had an order dated 6/26/25 for famotidine (for gastroesophageal reflux) 20 mg that was not observed to be prepared and administered to R57 during the observation. On 2/11/26 at 8:43 AM, Nurse 'FF' was observed preparing medications for administration to R92. Among the medications prepared was a sennosides (laxative) 8.6 mg tablet. After preparing the medications, Nurse 'FF' entered R92's room and administered the medications due at that time. On 2/11/26 at 9:30 AM, the medications administered by Nurse 'FF' to R92 were reconciled with the physician's orders. It was discovered R92 did not have an order for 8.6 mg of sennosides laxative, rather; they had an order dated 1/15/26 for Senna-S, a combination medication containing sennosides 8.6 mg combined with 50 mg of docusate sodium (stool softener). On 2/11/26 at 10:23 AM, an interview was conducted with the facility's Director of Nursing. They were asked about Nurse 'EE' crushing the gabapentin capsule and said it should not be crushed, rather the contents of the capsule should have been emptied from it. They were then asked about how, in general; nurses should administer medications and they reported medications should be administered per the 5-rights of medication administration (Right resident, Right medication, Right dose, Right Route, Right time). A review of a facility provided policy titled, Medication Administration reviewed 2/2026 was conducted and read, Policy Overview: To safely and accurately prepare and administer medication according to physician order, professional standards of practice and resident needs .Medications are administered in accordance with the following rights of medication administration: Right resident, Right medication, Right dose, Right route, Right time and frequency, Right documentation .Do not crush medication when contraindicated or without a physician's order .</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>This citation pertains to intakes 2615522, 2645363, and 2671721. Based on interview and record review, the facility failed to ensure that two of five Certified Nursing Assistants (CNAs 'AA' and 'CC') reviewed for required annual in-service education, had the required 12 hours of in-service training within the required time period which included abuse prevention and dementia care. Findings include: On 2/11/26 at 8:06 AM, the facility was requested via email to provide the CNA (Certified Nursing Assistant) in-service/education training hours for five CNAs (Y, Z, AA, BB, and CC). Review of the documentation provided by the facility revealed: CNA 'AA' last had abuse and dementia care education on 2/20/24. CNA 'CC' had no dementia care education. On 2/11/26 at 12:45 PM, an interview was conducted with the Infection Preventionist / Staff Development (Nurse 'C'). They reported they had been in their role as Staff Development since mid October (2025). When asked about the facility's process for ensuring annual education in-services were completed and included all the required components including abuse and dementia care, Nurse 'C' reported they did reconcile of the hours and was not sure if the electronic system was glitching or not, but the documentation provided was what they were able to find. When asked about whether they received any assistance since they also performed the role as the Infection Preventionist, Nurse 'C' reported there was corporate oversight but was unable to offer any further explanation as to why the facility had not identified CNA 'AA's lack of education/training. They were requested if there was any additional documentation, they could provide by the survey exit but there was no additional documentation provided. According to the facility policy titled, In-Service Tracking dated 2/4/2024: Each Center Administrator will appoint a Staff Development Nurse or Human Resources Representative to be responsible for tracking in-service education. The department manager will assure timely student in-service education completion.</p>