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	05/06/2026

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.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #'s 2998574, 2991736 and 3001096.Based on observation, interview and record review, the facility failed to ensure sufficient staffing to meet resident needs for three residents (R801, R804 and R805) of four residents reviewed for staffing. Findings include:On 5/6/26 multiple concerns that were submitted to the State Agency were reviewed which alleged the facility had insufficient staffing levels. On 5/6/26 a review of the facility resident council minutes for February and March 2026 revealed the following Nursing concerns: February- [Anonymous Resident] sits in her chair to long . March-Long wait time for help . Some days it takes too long to get out of bed. On 5/6/26 at approximately 12:21 p.m., Nurse A was queried regarding the facility staffing levels and they indicated that the facility does not have enough CNA's (Certified Nursing Assistants) Nurse A reported they have had one CNA that worked on Unit one many days of the week when three CNA's should be assigned to work. Nurse A was quired how the low level of CNA's assigned to the units affected resident care and they reported that call lights do not get answered on time and residents will have to wait for toileting care to be provided. Nurse A reported that Wednesday 4/22/26 only had one CNA and residents were delayed in getting out of bed until late in the morning due to many of the residents being a two-person assist. On 5/6/26 at approximately 1:03 p.m., CNA C was queried regarding the staffing levels in the facility. CNA C indicated that the staffing is bad and that the facility cannot keep CNA's employed. CNA C indicated that Unit one is supposed to have three aides working on the unit due to the acuity and lately they have been the only CNA on dayshift working the unit. CNA reported they typically work four shifts a week and of the four shifts, three of them they will be the only aide. CNA C was queried how the staffing levels affected resident care in the facility and they reported that the Residents do not get the care they deserve and it takes longer for incontinence care to be provided so residents will have to be wet/soiled longer. CNA C reported that some residents cannot be gotten up out of bed for the day because they are two-person assist and the Nurse is busy passing medication and cannot assist. CNA C reported that residents are missing showers because they do not have time to give them and it is taking a longer time to reposition residents who are supposed to be repositioned every 2 hours for wounds, but they cannot get to them. CNA C indicated that often times they will have 17-18 residents and they cannot give the care they deserve. On 5/6/26 a review of the April and March staffing assignments revealed Unit one was assigned one or two CNA's 9-10 times during the months with multiple call off's and staff being late on other units. On 5/6/26 at approximately 1:34 p.m., during a conversation with Nurse Manger I (NM I), NM I was (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	queried regarding the facility staffing challenges and they reported they had been doing the staffing assignments as the acting staffing coordinator and reported the facility does not have enough CNA's to fill out the schedule appropriately. NM I was queried regarding the CNA assignments for Unit 1 and they indicated they could only put on the schedule who they had available to work and lately they have had problems [NAME] staffing the unit. NM I reported the facility does not utilize staffing agencies to fill vacant holes in the schedule and will sometimes be able to use a Nurse as a CNA. NM I was queried how the lack of staffing has affected the residents and they reported they have heard that the residents experience longer wait times for their call button to be answered. NM I reported they had notified the Director of Nursing (DON) and Administrator regarding the staffing shortages, and they were working on hiring more staff. On 5/6/26 at approximately 1:57 p.m., the DON was queried regarding the staffing shortages in the facility, and they reported they were aware to it and were working to correct the issues. The DON indicated they were new to the facility in the last few weeks, and they had recently requested an increase in PPD's (total number of Nursing hours worked in a 24-hour period) to try to cover all of the no-shows and call-offs the facility had been experiencing. On 5/6/26 at approximately 2:55 p.m., the Administrator was queried regarding the staffing levels in the facility and if they had picked up the concern in their QAPI (Quality Assurance Performance Improvement) meetings. the Administrator indicated they were aware of the lack of staffing in the facility and had identified it through the staffing audits they had been doing. The Administrator indicated they were attempting to put a plan into action to try to hire more CNA's and implement retention programs to try to keep the CNA's working in the facility. R804 On 5/6/26 at approximately 2:32 pm., R804 was observed in their room up in their electric wheelchair. R804 was queried regarding the staffing levels in the facility. R804 reported that the staffing was horrible and that they have been left in bed for hours because nobody was available to get them up in the morning. R804 reported they usually get up in the early morning with the assistance of the midnight shift but sometimes the midnight shift could not get them up and they had to rely on the dayshift which stated at 7:00 AM. R804 indicated that in April there were many days in which they were left in bed the entire morning due to the dayshift being understaffed. R804 reported that the Nursing staff told him they had no help and could not get him up. R804 indicated that they require two staff members due to them needing a mechanical lift and nobody can help them. R804 also reported they have had to wait hours for staff to clean them up after having a bowel movement due to their being only one Certified Nursing Assistant (CNA) assigned to their hallway and they need two staff members to safely provide changing. R805 On 5/6/26 at approximately 2:39 p.m., R805 was observed in their room, laying in their bed. R805 was queried if they had any concerns regarding the staffing levels in the facility and they reported it was terrible. R805 reported there are not enough staff to help them meet their needs. R805 reported they were quadriplegic and that they have to wait for hours for their call button to be answered when they push it for help. R805 reported they do not get out of bed anymore because they get left in their wheelchair all day due to their not being enough staff to help put them back into their bed when they want to go back in it. R805 reported the Nursing staff tell them that there are no staff to get them out of bed and they cannot get fresh water in the morning because the only Nursing aide is trying to get (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be changed . missed a bed bath because there was not enough staff . there are six people on that Unit that staff have to hand feed breakfast, lunch and dinner . some CNA's tell her they will call in because having the whole Unit by themself is too hard and they are wiped out at the end of their 12 hour shift . when they have a new CNA they are supposed to work with somebody to learn how to do things, but they will have the new CNA do things alone and they do not know how to do things and then do not stay long. On 5/6/26 at 11:40 AM, an interview was conducted with Registered Nurse (RN) 'B'. RN 'B' reported the facility is often short on certified nursing assistants (CNAs) on most days. RN 'B' reported they worked as a CNA for 16 of 20 shifts since April 2026. RN 'B' reported only one CNA was often scheduled for Unit 1 where approximately 30 residents resided. When a nurse worked as a CNA that split up the residents, so they had 15 each. According to RN 'B', the CNA assigned to the unit followed the nurse which meant however many residents the nurse was assigned to, the CNA had the same amount. RN 'B' reported it was difficult to get all the required tasks completed unless their forfeited a break. At times, the midnight shift was short and if they did not get the residents up on their shift, the day shift had to do it, and often that resulted in residents not getting up according to their preferred times. RN 'B' reported CNAs call off, but there are not enough available to pick up shifts so only one is scheduled on Unit 1 a lot of the time, when there should be three. RN 'B' reported they have discussed the difficulty with staffing with Administration, and the new Director of Nursing was trying to advocate to get another CNA scheduled in, just in case of call ins.