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	06/29/2026

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation relates to Intake 3047919. Based on observation, interview, and record review, the facility failed to protect the residents' rights to be right to be free from physical abuse for three Residents (R902, R903, R904) of four residents reviewed for abuse, which resulted in injuries for R902, R903, and R904. Findings include: R902 and R903: On 6/29/26 at 9:38 a.m., R902 reported during an interview in their room they and R903 had a physical incident between them in April (2026), after R903 backed their wheelchair into them earlier, which had occurred on multiple prior occasions. R902 stated they punched R903 in the head, as this upset them. R902 clarified it upset other residents as well, when R903 was aggressive towards them with their wheelchair. R902 said the facility management told them they had the incident on their video cameras and saw them strike R903. R902 explained they had been told R903 had a prior head injury and never to do this again. R903 said they regretted their action and this would not recur. R902 was alert and oriented to their situation, surroundings, place, and time. Review of R902's psychiatric provider progress note, dated 4/10/26 at 14:41 (2:41p.m.), revealed, .Resident (R902) discusses recent incident with another resident (R903) at the facility. (R902) states other resident kept running into his wheelchair and then this other resident grabbed his arm and wouldn't let go. (R902) admits to reacting by hitting other resident but reports he knows he should not have done this. (R902) states has been keeping his distance (from R903) since the incident. If he (R902) sees the resident (R903) he just goes the other way. He (R903) reports feeling safe at the facility. He (R902) reports understanding that he should not have reacted in this way and we discussed other healthy ways to deal with situations in the future. He is at his psycho-social baseline. The note also showed R902 denied need for medication adjustments and was on Cymbalta 30 mg twice daily (an antidepressant medication). Review of R902's physician team note, dated 4/09/26 at 16:00 (4:00 p.m.) revealed, .Mild wrist pain s/p (status post) altercation x1 day. HPI (History of Present Illness): Pt (R902) involved in altercation with another resident yesterday. Reports mild right wrist pain. R902 was noted as alert and oriented x 3 - 4 (spheres) during the visit. Review of R902's progress note, dated 4/13/26 at 13:34 revealed, Reviewed resident's x-ray post incident; no fractures or other injury noted. Review of R902's profile revealed they were their own responsible party. Review of R902's Minimum Data Set (MDS) assessment, dated 4/24/26, revealed R902 was admitted to the facility on [DATE], with diagnoses including heart failure, stroke, depression, and malnutrition. The assessment showed R902 was independent with eating and dependent for transfers. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, which showed R902 was cognitively intact. The behavior assessment showed no signs of psychosis or behaviors. Review of R903's investigation incident file revealed R902's prior BIMS score on 1/22/26 was 14/15, which showed R902 was cognitively intact at that time, prior to the incident. Review of R903's MDS assessment, dated 5/15/26, showed R903 was admitted to the facility on [DATE], with diagnoses including head injury, seizure disorder, anxiety, and depression. R903 was able to feed themselves with set up and was dependent for transfers. The cognitive assessment showed R903 was severely cognitively impaired. The assessment showed no psychosis or behaviors. On 6/29/26 at 12:55 p.m., (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse (LPN) A acknowledged they were working on 4/08/26 when the incident occurred between R902 and R903. LPN A said they were at the nurse's station when they overheard R902 say, If you touch me, I will hit you. and then they saw R903 close and trying to reach out so they separated them and took them back to their rooms. LPN A said R902 denied touching R903 at that time and they could not ask R903 as they were nonverbal. LPN A said when they returned to work a few days later they heard there was a physical confrontation between R902 and R903. LPN A said neither resident appeared injured. LPN A clarified when asked there were no staff present when they intervened.On 6/29/26 at approximately 1:10 p.m., LPN B was asked about any incident between R902 and R903. LPN B said they were doing medication pass with LPN A on 4/08/26, when the incident occurred and said they did not see anything happen. LPN B said R903 was capable of understanding and could answer yes and no questions accurately but was nonverbal essentially. LPN B said when asked R903 bumped their wheelchair into everything, and R903 had the ability to be intentional in their actions. On 6/29/26 at 2:05 p.m., R903 was observed dressed in their power wheelchair in the dining room on the second floor, watching television while other residents were engaged in an activity. R903 had no bruising observed and was wearing a right elbow orthopedic brace (longstanding). When asked how they were doing, R903 was alert, made eye contact, and nodded yes. R903 was unable to answer any additional questions.On 6/29/26 at 2:13 p.m., R902 was observed seated in their power wheelchair on their unit; it was noted they had above knee amputations of both their legs. R902 reclarified the incident, and said R903 backed into their wheelchair three times earlier and said they clocked him in the head, and said staff told them the camera told the story. R902 reported they did this intentionally, as they had become tired of R903 wheeling their wheelchair into them and the other residents, and said they believed R903 backed into them on purpose. On 6/29/26 at approximately 3:00 p.m., Social Worker (SW) C was asked about the incident between R902 and R903 on 4/08/26. SW C reported R902 said R903 was antagonizing him and they made physical contact. SW C said they only saw part of the camera footage and saw swatting but did not elaborate when asked. SW C was asked about any additional interventions put in place as R902 and R903's care plans showed none. SW C said they reached out to psychiatry services and confirmed that there were no medication changes or other interventions added after this first incident. SW C confirmed there was no consistent increased supervision of R903 care planned. SW C acknowledged R903 had been observed taking the elevator up and down independently and with a BIMS of 0 (severe cognitive impairment) would benefit from increased supervision when on the elevator and in the lobby.Review of R903's investigation summary, provided by management, revealed on 4/08/26, .Watching TV while seated in his wheelchair Res (R902) approached (R903), stated words and then reached toward him, making contact with his open-handed finger (to) resident's (R903) head; no deficient practice was identified.No pain.Review of R902's investigation summary, dated 4/08/26 at 3:14 p.m., .Staff reported (R902) bragging about hitting (R903). This was reported to Admin (administration). Investigation began. Statements were obtained. A review of video surveillance separate.Review of a typed investigation summary, undated, showed, On 4/09/26, (R902) reported to staff that an incident occurred between (R903) and himself. Investigation initiated.A review of the facilities video surveillance system of April 8, 2026, revealed that (R903) was seated in his wheelchair in the dining room at approximately 9:30 a.m. watching television. At approximately 9:37 a.m. on April 8, 2026, (R902) enters the dining room near the location where (R903) was sitting. (R903) could see (R902) from his peripheral; (R902) began speaking to (R903); (R902) turned his head slightly to acknowledge (R903) then quickly turned his head away towards the television. (R902) continued to speak to (R903). (R902) began to navigate his wheelchair closer to (R903) until he was within his arms reach. (R902) then reached out towards (R903)'s head, making contact to (R903's) head with the tip of his four fingers of his right hand. (R903) then reached for (R902's) wheelchair, striking it a few times. (R902) grabbed (R903's) left hand in an effort to stop him from striking his chair. (LPN A) attests to hearing (R902) yell and quickly intervened. Review of findings showed physical contact was substantiated (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and abuse was denied, and the police were contacted. Surveyor requested to review video footage of the incident and was informed by management the video footage was no longer available.Review of R902 and R903's care plans showed no new interventions to address R902 and R903's behaviors were put in place after the resident-to-resident incident on 4/08/26, until a second resident-to-resident incident occurred with R903 and another resident, on 5/29/26. R903 and R904On 6/29/26 at approximately 9:50 a.m., R902 stated there was a second physical altercation between R903 and R904 in the facility elevator in May (2026), when they punched each other. R902 said R903 went up and down the elevator unsupervised frequently and had a third resident-to-resident physical incident last year in November (2025). R902 said they felt safe however believed R903 needed to be supervised more closely, as R903 often rode up and down the elevator alone, and kept backing their wheelchair into residents and striking them intentionally. Review of a typed investigation summary, undated, showed, On 5/29/26 at approximately 9:10 a.m., the Administrator was notified there was a physical altercation between (R903) to (R904). MN (midnight) nurse reported being on the elevator with (R904) and (R903) to assist them getting on the bus for Work Day, when (R903) grabbed (R904's) coat and (R904) took a swing at (R903) .causing him to lose his balance and stumble over. MN nurse continued to intervene with elevator reaching the 1st floor. Therapy (staff) and a Day Shift Nurse was awaiting and observed the incident, immediately assisted with intervention and separated residents successfully.The investigation report further revealed, .According to the MN nurse that was on the elevator, (R903) mumbled something to (R904) while grabbing his coat, when (R904) took a swing at (R903), . attempted to stop them but .couldn't. The elevator (door) came open and therapy and day shift nurse helped. The report showed the intervention after the incident was to change R903 and R904's rooms to ensure no contact between them on separate units and halls. R903 was found to test positive for a UTI (urinary tract infection) and placed on an antibiotic and found to have cognitive impairment. The report showed the conclusion was that abuse was unable to be substantiated.Review of R904's Accident and Incident report, dated 5/29/26 at 8:00 a.m. revealed, Altercation with another resident (R903) witnessed by other staff members. Staff alerted nurse of altercation. During altercation resident (R904) had a fall after residents were seen grabbing and hitting each other. Another resident (R903) had gotten on the elevator and used his wheelchair to hit (R904). Resident (R904) tried to move resident and that (sic) grabbed at his shirt aggressively. After getting off elevator, (R903) swung and (R904) threw a punch and then fell to the floor. Then staff came to break up the altercation. (R903) placed in his room and an assessment was done. (R904) reported no pain or discomfort, although (R904) had a skin tear on her index finger and a layer of skin removed under elbow. The assessment showed R904 was alert and oriented x 4 and sustained a left-hand abrasion and bruise (to) left elbow.Review of R903's Accident and Incident report, dated 5/29/26 at 8:00 a.m., revealed, .During altercation, (R903) had become aggressive with another resident (R904) and hit him with wheelchair, then both resident (sic) was seen hitting and grabbing at each other.Resident had a bruise under left eye.Other info: Resident was involved in an altercation with another resident. Per the report, R903 was only oriented to themselves. Review of LPN E's witness statement, dated 6/04/26, revealed, Noticed x 2 nurses coming in and out of elevator yelling, Stop (R903), Stop. Writer proceed to elevator to find (R904) on the floor against L (left) wall and (R903) in wheelchair. (R904) proceeded to pull self towards rail and struck (R903). Writer proceed to remove (R903) hand from rail and separated (R903) from situation. (R903) was placed safety distance aware from elevator and remained with him (R903) until all clear.Review of LPN F's witness statement, dated 5/29/26, revealed, I (LPN F) was in the elevator with (R903) when (R904) entered. As (R904) stepped in, he remarked that (R903) needed a jacket and then accused him of being aggressive and tripping (him) yesterday. (R903) then grabbed (R904's) shirt, and they began hitting each other in the head. They were arguing intensely. I quickly tried to separate them, urging them to stop and not to hit each other. When the elevator doors opened, staff were present to assist me in breaking up the altercation.Review of LPN G's witness statement, signed by LPN G, dated 6/05/26, revealed, I (LPN (continued on next page)

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