

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235719	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER Lakeside Manor Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13990 Lakeside Circle Sterling Heights, MI 48313	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220</p> <p>This citation pertains to Intakes MI00150910 and MI00150259.</p> <p>Based on interview and record review, the facility failed to prevent staff to resident verbal abuse for one sampled resident (R906) from a total of four residents reviewed for abuse resulting in feelings of being disrespected. Findings include:</p> <p>A review of the Facility Reported Incident dated 02/23/25 documented, Resident (R906) and Aide (Certified Nurse Assistant (CNA) C) got into a verbal altercation. Both became threatening to each other. The Administrator was contacted immediately, and the aide was sent home with the instructions that (they) will be contacted.</p> <p>On 03/03/25 at 10:11 AM and 1:22 PM, Staff D was interviewed. Staff D reported they had witnessed the incident between CNA C and R906. Staff D reported the incident started with CNA C asking if R906 wanted a shower and subsequently a verbal exchange began. CNA C was telling R906 they would need to have the shower then (at that time) and was not going to help R906 later. There was profanity from R906 and during the verbal exchange CNA C said they were going to get their friend to come and kill (R906). Staff D reported they intervened and had told CNA C they needed to go (leave the area). Staff D also noted CNA C should have let the resident be after they refused the shower.</p> <p>On 3/3/25 at 3:39 PM, CNA C was asked about the incident with R906. CNA C explained during their shift they asked R906 if they were going to take a shower. R906 said no and at that point CNA C said they asked R906 again to verify, R906 became upset and aggressively said 'no' and then the CNA became verbally aggressive towards them.</p> <p>On 3/3/25 at 3:52 PM, an attempt was made to interview LPN F who was reported to have witnessed the incident, a voice message was left with no return call by the end of the survey.</p> <p>On 03/03/25 at 3:30 PM, R906 reported they did not feel threatened by the words of CNA C because they were just 'talk', but if they had seen them return with a gun then it would have been real and they were not just 'playing'. R906 confirmed the incident started with the aide saying R906 was going to take a shower 'now' and they argued back and forth. R906 reported that during this exchange CNA C said I got something for you and R906 reported they were not scared with just words. R906 reported they felt disrespected by a comment during the back and forth about them being in a wheelchair.</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
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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>On 03/03/25 at 3:56 PM, the Administrator reported they had spoken with CNA C and summarized the incident confirming the CNA wanting to give R906 a shower, R906 refused, and the CNA said, 'then don't come back to me later'. The Administrator further reported, CNA C had said to R906 'I've got something for you' which the Administrator reported they had found out, was street talk meaning, 'I am going to kill you'. The Administrator confirmed, CNA C suspected they were going to be terminated and voluntarily resigned.</p> <p>Further review of the Facility Reported Incident, revealed, On 2/24 Spoke to resident about incident that occurred with (CNA C) over the weekend (2/24/25). (R906) said (they) was no longer upset but didn't want (CNA C) to take care of (them) any longer. When I asked what happened (R906) said that (CNA C) had wanted to give (R906) a shower at app (approximately) 11:00 PM and (they) declined. Then (CNA C) got upset about (their) refusal and they exchanged words. I asked if anyone had threatened anyone and (R906) said that (CNA C) told (them) I have something for you and something about (their friend) I asked if he was afraid and he said 'I am not afraid of anything.'</p> <p>A review of the medical record revealed R906 was admitted into the facility 10/11/24. Diagnoses included Traumatic Brain Injury and Multiples Bone Fractures. The Minimum Data Set (MDS) assessment dated [DATE] indicated intact cognition.</p> <p>A review of the facility policy titled, Abuse, Neglect and Exploitation with date implemented of 11/01/2022 revealed, Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability .</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34851</p> <p>This citation pertains to Intake MI00150377.</p> <p>Based on interview and record review, the facility failed to monitor, timely initiate and complete treatment orders for a new wound, for one sampled resident (R902) of four reviewed for wounds, resulting in the potential for wound deterioration. Findings include:</p> <p>A review of an Intake noted the allegation, It was alleged the facility failed to monitor a blister for infection leading to toe amputation.</p> <p>A review of R902's medical record revealed, R902 was admitted to the facility on [DATE] and discharged to the hospital on 1/18/25. An admission Minimum Data Set (MDS) assessment dated [DATE] and quarterly MDS dated [DATE] documented, R902 with an intact cognition, skin at risk for breakdown, one unhealed, present on admission, right heel pressure ulcer stage 3 (full thickness tissue loss) and moisture associated skin damaged.</p> <p>Nursing progress note dated 01/03/25 at 5:00 PM revealed, Resident received full bed bath today by assigned aide, no new skin issues .</p> <p>Further review revealed a progress note by LPN F, 01/07/2025 06:01 PM, resident had skin assessment done today wound was noticed on left baby toe and a second wound beneath the baby toe area was cleaned and a gauze and kerlix was applied. Unit Manager notified. Resident was put on wound care nurse list . The note did not indicate the physician or medical staff was contacted or if wound care treatment orders were obtained.</p> <p>A review of R902's January 2025 Medication Administration Record (MAR) and Treatment Administration Records (TAR) did not reveal documentation for treatment of the left baby toe or foot.</p> <p>On 03/03/25 at 2:58 PM, Licensed Practical Nurse (LPN) B reported they had provided wound care for a right heel wound for R902, but did not recall a wound to the left foot or pinky toe.</p> <p>A review of R902's care plan noted, Keep heels off bed at all times. (name of) specialty boots or float heels. The care plan did not reveal a plan of care that addressed R902's left baby toe and foot.</p> <p>A review of the Nurse Practitioner's progress note dated, 1/7/2025 at 6:13 PM, was reviewed and did not reveal the Nurse Practitioner documented an assessment of R902's left baby toe or foot.</p> <p>Further review of R902's progress notes, 01/08/2025 05:02 PM [Recorded as Late Entry on 01/17/2025 05:02 PM] Resident not been seen today by wound care np (Nurse Practitioner) because [R902] was on an appointment outside the facility.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a progress note by the wound care nurse practitioner revealed, Encounter Date: 01/15/2025, Chief Complaint: Re-evaluation of stage III pressure ulcer of the right heel and diabetic ulcer to the left lateral foot on pinky toe . [R902] is being seen by wound care for assessment and evaluation of right heel wound. Pressure offloading interventions were implemented prior . 1/15/25: new diabetic ulcer on left lateral foot, new treatment plan implemented, patient not seen last week due to being out on/at appointment. Physical Exam: . Wound #2: diabetic ulcer to the lower left lateral foot, pinky toe, current measurements 1 cm (centimeter) x 1 cm by UTD (Unstageable Deep Tissue Injury), surrounding tissue dry, no odor, no signs or symptoms of infection or cellulitis, scant serosanguinous drainage, base with necrotic slough (dead, non-viable skin tissue) and necrotic black tissue (dead skin tissue) . Assessments/Plans: . Continue medical management per primary team wound care recommendations to left lateral lower foot: Clean with normal saline, pat dry with gauze, apply Medihoney to wound bed, apply (name of) bandage, change daily and as needed.</p> <p>A review of the physician orders revealed no wound care orders were initiated until after R902 was seen by the wound care NP on 1/15/25 (8 days after wound was identified).</p> <p>R902's progress note dated, 01/17/25 5:07 PM, confirmed .Wound no. (number) 2 - diabetic ulcer to the lower left lateral foot, pinky toe, current measurements 1 cm x 1 cm by UTD, surrounding tissue dry, no odor, no s/s (signs or symptoms) of infection or cellulitis, scant serosanguineous drainage, base with necrotic slough and necrotic black tissue .</p> <p>On 03/03/25 at 3:40 PM and 4:12 PM the care of R902 was reviewed with the Director of Nursing (DON). The DON provided a nurse progress note dated 01/07/25 of an initial assessment of the left pinky toe, an order to consult the wound NP and an order for wound care dated 01/17/25 to clean the left lower lateral foot, with NS (normal saline) pat dry with gauze, apply Medi-honey then (name of) gauze, and to change daily, and as needed. The DON further reported on review the order was in the nurse note from 01/07/25 but no order or treatment was added into the physician orders or onto the January MAR or TAR.</p> <p>The DON reported the nurse should have entered the order into the record and confirmed there was no documented ongoing monitoring or treatment of the left toe and foot until R902 was seen by the wound care NP on 1/15/25.</p> <p>A review of the facility's policy titled, Documentation of Wound Treatments dated 10/09/2024 noted, Policy: The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment. Policy Explanation and Compliance Guidelines: 1. Wound assessments are documented up admission, weekly, and as needed if the resident or wound condition deteriorates . 3. Wound treatments are documented at the time of each treatment .</p>		