STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235719	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Manor Nursing and Rehabilitation Center	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)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2589351.Based on observation, interview and record review, the facility failed to ensure the resident's incontinence brief preference was honored for one resident (R11) of three residents reviewed for choices. Findings include:On 08/04/2025 at 10:12 AM, R11 expressed concerns about needing something to have a bowel movement. R11 reported they felt the brief staff had put on was too small and too tight and felt like it was keeping them from having a bowel movement. R11 noted they required a larger brief. The brief was observed to not cover the thigh area nor wrap around the buttocks area. R11 noted they only had two brief changes in 12 hours and waits for a least an hour and reported the urine forgets to stop. The brief observed was white and the tabs to hold the front and back together at the sides was stretched thin (narrow) and R11 reported it was uncomfortable and dug into their sides. R11 further reported they had told the aide the brief was too small, but it was reported it was all they had. On 08/05/2025 at 8:36 AM, R11 was observed Licensed Practical Nurse (LPN) M. R11 reported that were again in a brief that was too small and tight and did not cover their rear end. The straps for the brief appeared to be stretched taut and pressed into the hip area of R11. The attach point of the brief to the strap was wrinkled and narrowed. LPN M acknowledged the brief appeared tight and would ask an aide to change it. 08/05/2025 9:06 AM, the supply of briefs was observed in the storage room with Licensed Practical nurse (LPN) M. One pack of 2xl 60-70-inch green briefs, seven full and one partial back of 2xl white underwear (pull up) briefs and one pack of large 44-56-inch blue briefs were observed. A review of the linen cart on the hall of R11 revealed, an open pack of white medium sized briefs on top of the cart and a stack of blue and a stack of green briefs on the inside of the cart. A larger white brief was not observed. R55 reported the larger white brief covers the hip area. It appeared the medium sized brief had been placed on R11. On 08/06/2025 at 7:55 AM, R11 verbalized they still did not have the right brief on. A green brief was observed. The tabs appeared less stretched, but R2 reported in was still too tight. R2 reported they wore a white brief that was a 4X and that it fit down onto the hip and covered the hip area. The observed brief did not cover the hip and thigh area for R2. It appeared to be the 2XL brief. R11 was not observed to be placed into a larger brief. On 08/06/2025 at 1:51 PM, the Director of Nursing (DON) was asked about preferences for brief size and noted the issue had not come up and the there was a bariatric brief that was for the larger residents. The DON noted normally they had shipments every Friday but the shipment was late and did not come until yesterday and staff had purchased appropriate size briefs as needed. Upon review of the currently available briefs in the storeroom there was a white brief noted as 3XL which the DON indicated as the bariatric brief. Additional brief sizes were present that had not been seen the day prior. A review of the record for R11 revealed, R11 was admitted into the facility on [DATE]. Diagnoses included Schizoaffective Disorder and Alzheimer's. The Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition with a 15/15 Brief Interview for Mental Status score and the need for partial to moderate assistance for most activities of daily living. The active care plan documented the use of a water pill and the need for assistance with incontinence care. A review of the Resident Rights included in the facility admission contract revealed, .Federal and State laws guarantee certain basic rights to all residents of this facility. These include the following resident's rights: .to reside and receive services in the facility with reasonable accommodation of resident needs and preferences .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2580294.Based on interview, and record review, the facility failed to ensure Heparin (blood thinner) was administered per physician order, hospital discharge orders were accurately transcribed, and vital signs completed for three residents (R14, R17, and R55) out of five residents reviewed for following physician orders. Findings include: R17 On 08/04/2025 at 9:59 AM, an interview was conducted with R17, during which the resident expressed concerns that the facility runs out of Heparin doses at least two to three times per week. A review of Medication Administration Records (MAR) for June 1, 2025, through July 30, 2025, revealed 18 times Heparin was not administered as ordered on 18 occasions. The documented for each missed dose was (Not administered: Drug/item Unavailable). On 08/05/2025 at 11:32 AM, identified concerns were reviewed with Director of Nursing (DON) and the Unit Manager Registered Nurse (RN) A. The DON and RN A reviewed the MARs for June and July 2025 and confirmed missed Heparin doses. The DON indicated Heparin is available in the facility's emergency backup medication box, and per facility policy, staff are expected to call the pharmaceutical backup number to obtain authorization to remove the Heparin and administer it as ordered. Per facility policy, the physician must be notified if a single dose of an anticoagulant is missed. The DON and RN A reviewed R17s progress notes and confirmed there was no documentation showing the physician had been notified of the missed Heparin doses. On 08/06/2025 at 9:23 AM, an interview with R17s Attending Physician E, his said his expectation is to be called when R17 misses a dose of Heparin. A review medical record for R17 revealed: R17 was admitted to the facility on [DATE]. Diagnoses included Traumatic Secondary Hemorrhage (recurrent bleeding after an injury), and Seroma (pocket of clear fluid that collects under the skin following surgery), status post-surgery for Neoplasm (abnormal tissue growth), and High Cholesterol. R14 On 08/04/2025 at 9:03 AM, an interview was conducted with R14, during which the resident expressed concerns regarding discontinuing an indwelling catheter after a recent discharge from hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of medical records revealed R14 was originally admitted to the facility on [DATE]. Diagnoses included Urinary Retention, Nephritis (inflammation of the kidneys) and Hypertension. Review of the hospital discharge records dated 07/07/2025 through 07/12/2025, R17 was re-admitted to the facility with diagnoses of Urinary Tract Infection (UTI), and Urinary Retention. The hospital discharge instructions indicated to discontinue indwelling catheter on 07/14/2025 and start a trial of voiding (process used to check whether a person can urinate on their own after having a catheter removed or after experiencing urinary retention) measure post void (urine) residual, have R17 urinate two times in a row, if R17 if unable then check bladder with bladder scan and record post void bladder scans time three and document clearly in intake and outputs (I/O). Document amount voided and amount of postvoid urine residual if greater than 350ccs of urine then straight catheterization, if urine residual is greater than 500cc then replace catheter. If the catheter needs to be replaced and repeat trial void again in three to five days. There is no documentation on the Medication Administration Summary (MAR) the discharge orders were followed. On 08/05/2025 at 9:44 AM, identified concerns from hospital discharge for R14 were reviewed with Director of Nursing (DON) and RN A. The DON and RN A reviewed the discharge hospital paperwork, MARs, and progress notes and agreed the hospital discharge paperwork was not complete and the order to discontinue the indwelling catheter and ordering bladder scans must have been overlooked. On 08/06/2025 at 9:23 AM, an interview with R17s Attending Physician E was notified the indwelling catheter was not discontinued as ordered, and the bladder scans were not completed. Attending Physician E said his expectations would to be notified when orders are not completed. On 08/06/2025 at 2:00PM, an interview with the DON regarding bladder scan revealed the facility does not have a bladder scan machine. On 08/06/2025 at 2:22PM, an interview with Licensed Practical Nurse (LPN) C indicated the bladder scan machine has been broken for months. A review of the facility policy titled Medication Reordering dated 11/01/2022, It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including routine and emergency medications in a timely manner to meet the needs of each resident. R55 On 08/06/2025 at 10:19 AM, a complaint called into the State Agency was reviewed for R55 related to vital signs not being completed for the resident. On 08/06/2025 at 10:58 AM, Licensed Practical Nurse (LPN) L was asked about the missing vital signs (blood pressure, temperature, pulse rate, respiratory rate) for R55. LPN L reviewed the record of R55 and noted the last vitals in the record were from 07/29/25 with no daily or weekly vitals before or after. The last vitals were noted to be on admission in March of 2025. An order dated 06/23/25 and discontinued 07/29/25 had indicated to complete vital signs every Monday. The new order dated, 07/29/25 and updated 07/31/25 indicated to complete vital signs every shift (two times a day). LPN L confirmed the orders had not been entered correctly and had not popped up in the electronic medical record for the nurse to complete. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/06/2025 at 11:19 AM, LPN D reported that R55's missed vitals had been discovered after a resident representative had come in and asked about R55's vital signs. LPN D reported at that time vitals were not done daily for all residents, but currently the facility completes vitals on everybody. On 08/06/2025 at 11:30 AM, R55 reported their vital signs were not taken daily. On 08/06/25 at 1:51 PM the Director of Nursing (DON) reported vitals should be done on admission for a baseline and per physician orders. The DON further reported if a resident was not on blood pressure medication vital signs should be done once a week and the nurse follows what the orders are. A review of the facility policy titled, Medication Administration revised 06/12/24, revealed, .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician’s prescribed parameters .