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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to maintain the exterior trash refuse area in a sanitary manner. This deficient practice had the potential to affect all residents, staff and visitors. Findings include:On 08/04/2025 at 9:00 AM, the exterior trash refuse area was observed. There were 2 dumpsters, and both doors on each dumpster were observed to be in the open position. There was a greasy liquid observed leaking from the bottom corner of one of the dumpsters. A large area of a greasy liquid was pooled on the concrete near the dumpsters. There was a strong garbage odor present in the area. On 08/04/2025 at 10:30 AM, Dietary Manager R was queried about the dumpster area, and stated that Maintenance was responsible for cleaning that area. The policy for maintaining the exterior trash refuse area was requested from the Administrator on 08/04/25 at 11:00 AM, but was not provided by the end of the survey.According to the 2022 FDA Food Code section 5-501.115 Maintaining Refuse Areas and Enclosures, A storage area and enclosure for refuse, recyclables, or returnables shall be maintained free of unnecessary items, as specified under S 6-501.114, and clean.

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure quarterly Quality Assurance (QA) meetings (for identification of any deficiencies and for performance improvement) were held in 2024 for 59 residents in a census of 59. Findings include:On 08/06/2025 at 1:01 PM, a review of the facility QA program was conducted with the Administrator. The quarterly QA meeting sign in and evidence of an active QA committee for 2024 was requested. The Administrator reported they did not have and could not find evidence of the required quarterly meetings for 2024. No performance improvement plans or projects (PIPs) were identified for 2024. The Administrator reported they had taken the role in March of 2025 and no hand off of facility QA projects or quality improvement plans were provided by the previous Administrator. The Administrator was also asked about ongoing PIPs from 2025 and reported no action plans had been developed. Current survey concerns included infection control, falls, physician order implementation and daily care needs for residents. A review of the Facility assessment dated [DATE] documented the Administrator, .Oversees all activities of a nursing home in accordance with established policies and federal and state guidelines. Develops strategic plans for profitability and is accountable for all operations and programs. Being a Nursing Home Administrator administers, directs and coordinates the business.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident rooms, and the north and south resident hallway carpets were clean and in good repair for four residents (R17, R47, R9, R1) in a census of 59. Findings include: On 08/04/2025 at 9:59 AM, a pillow was observed on the seat of an armchair in room [ROOM NUMBER]. The uncased pillow had multiple (greater than three linear cracks with multiple splintered cracks in the plastic covering of the pillow. On 08/06/25 the resident was observed seated on the uncased pillow in their wheelchair. On 08/04/25 at 8:30 AM, during the initial screening of residents and on 08/05/2025 at 9:14 AM, the south hall carpet was observed and revealed: An irregular pink/red stain/dried spill outside room [ROOM NUMBER], three areas of irregular red spots/dried spills between rooms [ROOM NUMBERS], the area from room [ROOM NUMBER] to room [ROOM NUMBER], appeared as the most soiled with solid blackened and gray area appearing carpet along the length of carpet in front of the nurse's station and around the corner into the center hall where ripples (raised, longitudinal areas) in the carpet were noted; an approximate 12x12 inch stain in the middle of the hall outside room [ROOM NUMBER]; additional faded pink/red areas of stain/dried spills were between rooms [ROOM NUMBERS]; an 18-24 inch long horizontal raised area at the seam between the bathing area and the opposite room; three longitudinal ripples about three feet long stemmed from the seam; an irregularly bleached out area around four feet by 8 inches along the edge of the wall outside room [ROOM NUMBER]; Observation of the north hall carpet revealed: spotty darkened areas along the length of the hallway with an area of darker/blackened/gray soil at the double doors prior to the nurse's station; three pink/red stain/dried spills were beyond the doors between the nurse station and the doorway; a ripple on entry to the 100 hall from the main hallway; a bleached out area outside room [ROOM NUMBER]; orange color/discoloration of various sizes (from a few inches to a couple of feet) under the hand sanitizer dispensers along the length of the hallway; a red stain/dried spill outside room [ROOM NUMBER], darker/blackened soil outside room [ROOM NUMBER], with greater than ten quarter size white/gray spots in the area of hall between the rooms; soil around the carpet medallion outside room [ROOM NUMBER]; a raised area at metal floor cover for the electrical off corner of the nurse station; four bleached spots along wall at entry to nurse station; red stain/dried spills outside room [ROOM NUMBER]; and a ripple in the carpet outside room [ROOM NUMBER]. In room [ROOM NUMBER] the wall behind the head of the bed had three linear gouges in the wallboard about one to four inches wide. The opposite wall had three or more holes that had been patched but not painted. On 08/05/25 at 11:00 AM, in the multipurpose room: a red/dried spill about around 12 inches wide was observed in front of the trash can; a pink/red stain/dried spill around 24 by nine inches was observed in the center area of the carpet in the multipurpose room, and the wallpaper was peeled away at one corner under the first window from the doorway. On 08/05/25 at 2:45 PM, the Life Safety Director F reported on query that the carpet area on the south hall was not cleanable, and the red areas would not come up. The Maintenance Director acknowledged the need for additional carpet repairs. On 08/04/2025 at 9:58AM, and 08/05/2025 at 8:58 AM, observed the bottom drawer of R47's dresser was missing. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/04/2025 at 9:58 AM, and 08/05/2025 at 8:58 AM, observed the of second and bottom drawer of R9's dresser were missing. On 08/04/2025 at 9:15 AM, and 08/05/2025 at 9:55 AM, observed R17's wall thermostat had been removed which left a hole with wires hanging out, and a canister, for wound drainage, was observed sitting on the dresser with a brown and white crystalized substance in it. R17 stated it had been sitting there for a while. On 08/04/2025 at 9:30 AM, and 08/05/2025 at 8:41 AM, observation of R1's room revealed, dried tube feeding residue on the feeding pump and on the base (feet) of the tube feeding pole. On 08/05/2025 at 8:59 AM, the Director of Nursing (DON), and Unit Manager Registered Nurse (RN) A, reported their expectation was the used wound drainage canister would not be left on the resident's dresser and should have been properly disposed of. On 08/05/2025 at 9:05 AM, interview with Wound Care Nurse RN O confirmed wound closure system was discontinued on June 11, 2025. On 08/05/2025 at 11:43 AM, the DON and the Unit Manager RN A accompanied writer to R1's room and observed the dried tube feeding on tube feeding pole and base of the pole. Their expectation was for either housekeeping or the nurse to clean the tube feeding pump and pole. On 08/05/2025 at 2:40 PM, the Life Safety Director F looked at the missing dresser drawers and the hole in the wall with wires hanging out. Corporate Life Safey Director F took notes on the dresser draws missing, and the hole in the wall and commented the hole in the wall needs to be fixed right away.

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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. **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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure timely delivery of the Medicare Notice of Non-Coverage (NOMNC-document that tells a resident and/or their representative that Medicare will no longer pay for their stay or services) for one resident (R55) of three residents reviewed for Medicare coverage and liability. Findings include: A review of the medical record revealed R55 was admitted to the facility on [DATE] with diagnoses included Heart Disease, Rheumatoid Arthritis, and High Blood Pressure. R55 was receiving Medicare Part A skilled services. The Notice of Medicare Non-Coverage (NOMNC) dated 05/30/2025 indicated services would end 06/04/2025, R55's guardian did not sign the notice until 06/09/2025. There was no documented evidence the guardian was notified at least two days prior to the end of skilled services. On 08/06/2025 at 2:00 PM, interview with Business Office Manager I reported the NOMNC was faxed to R55's guardian; however, they were unable to provide fax confirmation that the notice was successfully sent. They also confirmed that no follow-up call was made to the guardian to verify receipt of the NOMNC.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a 14 day stop date for a PRN (as needed) anti-psychotic medication for one (R7) of five residents reviewed for unnecessary medications.On 08/04/25 at 9:28 AM, R7 was observed in bed. They did not respond to verbal greetings or open their eyes. During subsequent observations the resident was primarily non-responsive and non-communicative. Review of the facility record for R7 revealed they were originally admitted into the facility on [DATE] and had current diagnoses that included Cerebral Infarction with Left Hemiplegia, Vascular Dementia, and Anxiety Disorder. The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 5/15 indicating severe cognitive impairment. Review of R7's physician orders revealed they were receiving hospice services and they had an active order for PRN Haloperidol for agitation with a start date of 05/13/25 and an end date stating open-ended. Additional review of R7's record revealed no documentation from the prescribing physician or the hospice service to indicate follow-up or ongoing monitoring of the medication's appropriateness or to support an extended order beyond 14 days. Review of R7's Medication Regimen Review (MRR) that coincided with the 05/13/25 Haloperidol order revealed the Pharmacist indication that the medication could be used for up to 60 days, however upon expiration of the 60-day period (07/13/25) there was no further documentation indicating review or monitoring to support extension of the medications use. On 08/06/2025 at 12:48 PM, the facility Director of Nursing (DON) was interviewed and reported the expectation is an anti-psychotic medication would have a 14 day stop date. The DON reported they discussed the concern with the hospice service who responded that the medication was the only thing that was effective and therefore they did not implement a 14 day stop date. Review of the facility policy Use of Psychotropic Medications dated 03/26/25 revealed the compliance guideline statement b. PRN orders for antipsychotic medications only, shall be limited to 14 days with no exceptions. If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure incontinence care was provided timely for one resident (R34) and bedding was changed timely for one resident (R46) of three reviewed for activities of daily living. Findings include: R34 On 08/04/2025 at 10:50 AM, R34 reported shortages of briefs, a concern with staff attitudes and being left wet and soiled for extended periods of time. R34 was asked if they were currently wet and reported they were. A yellow area was observed behind R34, and the sheet appeared yellow in spots. An odor of urine was also noted. The pillow R34 leaned on did not have a pillowcase. R34 reported they had been wet since the last shift and had overflowed the brief because the aide had left and had not come in to change them. R34 further noted they were served breakfast around 9:00 AM and was not changed at that time and denied they had refused any care. R34 then put their call light on. On 08/04/2025 at 5:08 PM, Certified Nursing Assistant (CNA) J, reported they had not yet changed R34 earlier in the morning prior to another staff who had changed R34 because the call light was on. CNA J reported their shift started at 7:00 AM. On 08/06/2025 at 8:00 AM, R34 reported the aide last night was terrible. R34 further reported they were only changed one time around 3:00 AM and believed there was only one aide on. R34 commented they needed to be changed again and was waiting on an aide. On 08/06/2025 at 1:51 PM, the Director of Nursing (DON) was asked about timely incontinences care and reported if a resident is wet, they should be changed and should be checked on at least every two hours. The DON confirmed only one aide was on the hall until 11:00 PM. A review of the record for R34 revealed R34 was admitted into the facility on [DATE]. Diagnoses included Diabetes and Intestinal Obstruction. A review of the active care plan documented R34 was on a water pill and required one person assistance for incontinence care. A review of the Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition with a 15/15 brief interview for mental status score and was dependent or required substantial/maximal assistance for most activities of daily living. 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 . On 08/04/2025 at 8:53 AM, the bed of R46 was observed to have a cloth draw sheet with light brown smears of what looked like bowel movement (BM) on it. An incontinence brief was turned inside out in the middle area of the linen draw sheet. CNA P walked in the room to deliver breakfast tray and left dirty linen and brief on the bed. On 08/05/2025 at 8:30 AM, the bed of R46 was observed to have a cloth draw sheet with light brown smears of what looked like BM at the lower right corner. On 08/05/2025 at 12:01 PM, the Unit Manager, RN A accompanied the surveyor to R46 room and showed them the dirty cloth draw sheet with brown smears on it that looked like BM. RN A replied (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that is not good. A review of the medical record for R46 revealed: R46 was admitted into the facility on [DATE]. Diagnoses included Dementia, Osteoarthritis, and heart disease. The Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) 03 (indicates severe cognitive impairment). The Activities of Daily Living (ADL) care plan identified R46 is one person assist as needed and episodes of incontinence of bowel and bladder at times and needs assistance with incontinence care.

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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. 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 (continued on next page)

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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician’s prescribed parameters .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure resident inhalers were dated when opened in one of four medication carts. Findings include:On 08/05/2025 at 9:10 AM, an observation of the 200-back medication cart with Licensed Practical Nurse (LPN) M, revealed a Fluticasone Furoate/Vilanterol (generic name) inhaler not dated when opened (new admit not added to sample), a fluticasone/salmeterol 250/50 (name for generic) inhaler for R18 not dated when opened, and a Fluticasone/Salmeterol 250/50 inhaler for R56 dated opened 04/14. On 08/06/2025 at 1:51 PM, the Director of Nursing (DON) reported the reported inhalers should be dated as soon as they are opened. A review of the facility policy titled, Labeling of Medications and Biologicals implemented 11/01/2022, revealed, Policy: All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications . 9. Labels for medications designed for multiple administrations (such as inhalers, eye drops), the label will identify the specific resident for whom it was prescribed . A review of the prescribing information for the Fluticasone/Salmeterol inhaler revealed, .should be stored inside the unopened moisture-protective foil pouch and only removed from the pouch immediately before initial use. Discard (brand name) 1 month after opening the foil pouch or when the counter reads 0 (after all blisters have been used), whichever comes first . A review of the prescribing information for the Fluticasone Furoate/Vilanterol inhaler revealed, .Safely throw away (brand name) in the trash 6 weeks after you open the tray or when the counter reads 0, whichever comes first. Write the date you open the tray on the label on the inhaler .

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

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Lakeside Manor Nursing and Rehabilitation Center	13990 Lakeside Circle Sterling Heights, MI 48313

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP) and failed to ensure nursing staff used appropriate Personal Protective Equipment (PPE) for Enhanced Barrier Precautions (EBP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility. Findings include:On 08/04/2025 at 10:00 AM, Corporate Life Safety Director F was queried about the Water Management Program (WMP) and stated that the building Maintenance Supervisor had resigned last week suddenly. Corporate Life Safety Director F stated he was trying to find any documents related to the facility's WMP. Corporate Life Safety Director F produced a binder with a policy dated 2022, and some blank monitoring forms. Further review of the binder noted there was no diagram of the building water system, and no text description of the water system. There was no risk assessment. There were no identified areas where Legionella could grow and spread. There were no listed control points, measures and limits. There was no evidence of control point monitoring. There was no evidence that the water management team was meeting routinely. The last water temperatures noted in book were from 8/2/24. On 08/04/2025 at 10:30 AM, the facility's policy Water Management Program, with a Copyright date of 2022 was reviewed. The policy noted, 1. Conduct an infection control risk assessment of the facility to determine if residents at risk or severely immunocompromised are present. 2. Establishment of a Water Management Team. The Team will meet routinely on a quarterly basis.3. Identification of potentially hazardous areas or devices where Legionella could grow and spread. 4. Establishment of control points, measures and limits for identified potentially hazardous areas or devices.8. Documenting in the minutes all activities and corrective actions that were initiated and their effectiveness.10. Conducting an annual review of the water management program and updating as necessary. The Water Management Team may be/is compromised of the following persons: Building Administrator, Maintenance, Chief Nursing Officer, Infection Control Designee, Risk Manager.On 08/04/2025 at 11:00 AM, the Administrator was queried regarding her involvement in the WMP and stated that only Maintenance was on the team. The Administrator further stated that she has been here since March, and that they have not met to discuss the WMP. On 08/04/2025 at 11:10 AM the facility's Infection Preventionist was queried regarding her involvement in the WMP and stated she has no involvement other than assessing residents for signs and symptoms.