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	02/06/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings include:On 02/04/2026 at 9:45am-10:15am during the initial kitchen tour with Dietary Supervisor J, observed an opened bag of turkey dated 2/3 with a discard date of 2/10 and an opened bag of salami dated 2/3 with a discard date of 2/10, located in the walk-in refrigerator. During this observation, Dietary Supervisor J was asked how long they hold onto food and stated food is kept for 7 days.According to the facility's date marking policy, Refrigerated, ready-to-eat, time/temperature control for safety food (i.e. perishable food) shall be held at a temperature of 41 F or less for a maximum of 7 days.According to the 2022 Food Code, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.On 02/04/2026 at 9:45am-10:15am observed a dark brown residue on the interior walls of the ice machine located in the kitchen. During this observation, Dietary Supervisor J was asked how often the ice machine is cleaned and stated it's cleaned every month. On 02/04/2026 at 9:45am-10:15am observed utility sink with an attached hose to a chemical feeder downstream of an atmospheric vacuum breaker (AVB). According to the 2008 Cross Connection Manual on chemical feeder backflow prevention, Another concern with a hose being run from a faucet to the dispenser is that many times a valve is installed on the hose downstream of an AVB, which is not allowed since AVBs cannot be subject to continuous pressure.On 02/04/2026 at 10:22am observed a strong odor coming from refrigerator with a black box of leftovers and a cup of yogurt that was warm to the touch, located in the cafe. During this observation, Housekeeping Supervisor C was asked how long the refrigerator has been off and stated the refrigerator has been off for several months. According to the 2022 Food Code, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, Except during preparation, cooking, or cooling, or when time is used as the public health control, time/temperature control for safety food shall be maintained: .at 5 C (41 F) or less.According to the 2022 Food Code, 4-301.11 Cooling, Heating, and Holding Capacities, Equipment for cooling and heating food, and holding cold and hot food, shall be sufficient in number and capacity to provide food temperatures as specified under Chapter 3.On 02/04/2026 at 10:29am observed yellow residue on the interior wall of the ice machine, located in the nourishment room. On 02/05/2026 at approximately 2:00pm during interview with Director of Facilities K on how often the ice machine is cleaned in the nourishment room, he stated it's cleaned and sanitized monthly. According to the 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.

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 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 2/4/26 at 10:45 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. Garbage was observed spilling onto the ground surface including several used disposable gloves. Also observed on the ground in the enclosure were 2 large empty boxes, a grill unit, a wood pallet. On 2/4/26 at 10:15 AM, prior to the observation of the garbage area, Dietary Manager J was queried about maintenance of the outside garbage area and stated that the responsibility was shared among Maintenance, Housekeeping, and Dietary for maintaining that area. Record review of the facility policy Disposal of Garbage and Refuse Policy dated 11/1/2022 indicates: Refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors, or covers. Containers and dumpsters shall be kept covered when not being loaded. Surrounding area shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to put on and take off personal protection equipment for one (R5) of eight residents with an Enhanced Barrier Precaution (EBP) sign on room door and did not provide adequate Personal Protection Equipment (PPE) for four resident rooms with PPE equipment located in resident rooms; and failed to have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). 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 all residents in the facility. Findings include: On 02/04/2026 at 10:29am observed filter to the ice machine dated 8/14/2023 as the installment date, located in the nourishment room. On 02/04/2026 at 11:01am observed an unused fountain pop machine wrapped in plastic and plumbed into the wall with an attached carbonator, located in the dining area. On 02/04/2026 at approximately 11:30am during interview with Dietary Supervisor J on the unused fountain pop machine in the dining area, she stated the fountain pop machine has been wrapped in plastic and unused for as long as she's been working there, and she's been working at the facility for about a year and four months. According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Eliminate dead legs, which are sections of no- or low-water flow. On 02/04/2026 at 1:35pm during the environmental tour with Director of Facilities K, observed an out of order toilet removed from the water line and the water line to the toilet was left open to the environment, located in the shower room in the 200 hallways. During this same observation, there appeared to be an unused hydrotherapy tub with dirt accumulation at the bottom of the tub. During this observation, Director of Facilities K was asked if the tub was flushed, and he answered the tub is flushed monthly. According to the facility's policy on Legionella/OPPP Flushing and Disinfection of fixtures/equipment, Resident showers, faucets, toilets, or other plumbing fixtures that are not in regular use must be flushed for at least 1 minute weekly, toilets flush twice. Upon review of the flushing logs given by the facility at the time of survey, there was not a record of the hydrotherapy tub being flushed. According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits. On 02/04/2026 at approximately 2:00pm during interview with Director of Facilities K on how often the ice machine filter is changed in the nourishment room, he stated it should be changed out quarterly. On 02/04/2026 at 3:12pm during interview with the Administrator on the hydrotherapy tub located in the 200 hallways, she stated the hydrotherapy tub hasn't been used the entire time she's been there (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and no residents are care planned to use the tub. On 2/4/2026 at 10:53 AM, a review of rooms with EBP signs on the room door revealed that four rooms (119, 203, 218, 226) had no gowns or masks available. On 2/4/2026 at 12:30 PM a CNA was observed delivering a tray and then moving resident bedding around without gloves or a gown on. On 2/4/26 at 1:30 PM, R5, a resident on EBP, was observed receiving morning care from Certified Nursing Assistant (CNA) A who did not have a gown on. CNA A stated, They never wear a gown when getting this resident out of bed. Gowns and masks were not available in the EBP cart at the door of R5's resident. CNA A revealed the scheduler fills the containers in the morning. On 2/4/26 at 1:44 PM, a review of the rooms with EBP signs on the room door revealed that four rooms had no gowns or masks available. On 2/5/2026 at 10:00 AM, an interview with the Infection Control Practitioner (ICP) and Director of Nursing (DON) revealed supplies should be in containers inside room with gowns. ICP further revealed that masks are not in drawers at this time because there are no residents with transmission-based precautions. ICP further revealed a supply person fills the containers on the night shift and is assisted by the night supervisor. The ICP further revealed that all of the care providing staff know where to obtain PPE if a container needs restocking. On 2/5/26 at 12:57 PM, Scheduler E revealed they restock any gloves that are needed in the rooms, but does not check the PPE carts. Scheduler E further revealed that they are in charge of orders for Central Supply and when stock is needed in that area, they reorder. Scheduler E further revealed masks are on order but masks are also available at the nurses' desk and the DON has some in their office. A review of the policy titled, Personal Protective Equipment implemented on date 11/1/2022 under the heading PPE supply management revealed a. the Central Supply Clerk is responsible for ordering and maintaining adequate PPE supplies and stocking in appropriate facility locations to ensure access to staff who need them .c. The charge nurses hall check isolation supply carts twice per shift and replenish as needed. The policy also revealed, All staff who have contact with residents and/or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely. In addition, the policy under Indications/considerations for PPE use: a. Gloves: i. Wear gloves when direct contact with .potentially contaminated surfaces or equipment is anticipated. b. Gowns: i. Wer gowns to protect arms, exposed body areas, and clothing from contamination with .other potentially infections material. A review of the policy titled, Enhanced Barrier Precautions revised on 2/26/25 under the heading Implentation of Enhanced Barrier Precautions revealed a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray. b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities .4. High-contact resident activities include: Dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to apply heel boots for three residents (R2, R4, and R13) out of four reviewed for skin conditions. Findings include:R2On 2/4/2026 at 1:15 PM, R2 was observed lying in bed. R2's bed was observed in a low position and their head of bed elevated. R2's heels were noted to be on the mattress, and heel boots were observed in a chair across the room.A review of the medical record revealed R2 was admitted into the facility on [DATE] with the following medical diagnoses, Retention of Urine and Adjustment Disorder. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 99, indicating R2 was unable to complete the assessment. R2 also required staff assistance with bed mobility and transfers.A review of the physician's orders revealed the following, Order: Apply soft heel protector boot when in bed, up to 12 hours a day. Status: Active.On 2/4/2026 at 10:21 AM and 11:467 AM, R2 was observed lying in bed. No heel boots were applied.On 2/5/2026 at 8:46 AM, 9:28 AM, and 1:32 PM, R2 was observed lying in bed. No heel boots were applied.On 2/6/2026 at 9:52 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that R2 does refuse to wear their heel boots. The DON reported the nurses should document when R2 refuses to wear heel boots.A review of the progress notes, treatment administration record (TAR) and care plan did not reveal any refusals for the application of R2's heel boots.R4On 2/4/2026 at 1:24PM, R4 was observed lying in bed. No heel boots were observed in the room.A review of the medical record revealed that R4 admitted into the facility on 1/21/2021 with the following medical diagnoses, Fracture of Left Femur and Dementia. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 15/15 indicating an intact cognition. R4 also required staff assistance with bed mobility and transfersA review of the physician's orders noted the following, Order: Resident to wear proactive heel boots while in bed up to 12 hours. Status: Active.On 2/5/2026 at 8:50 AM and 1:31 PM, R4 was observed lying in bed. No heel boots were applied.On 1/6/2026 at 9:57 AM, an interview was conducted with Unit Manager (UM) B. UM B reported R4 refuses to wear their boots and often kicks them off. UM B reported if R4 refuses application, or takes them off, then it should be documented.A review of the progress notes, treatment administration record (TAR) and care plan did not reveal any refusals for the application of R4's heel boots.On 2/6/2026 at 10:04 AM, R4 was observed lying in bed, no heel boots were applied.R13On 2/5/2026 at 8:59 AM, R13 was observed lying in bed. R13 was noted to have their oxygen cannula off and sitting next to them. Heel boots were observed to be in their wheelchair, and their heels on the mattress. R13 reported they took their O2 off, but no one offered to place heel boots in them. R13 reported they were unsure of the last time they had them on.A review of the medical record revealed R13 admitted into the facility on 5/3/2023 with the following medical diagnoses, Functional Quadriplegia and Chronic Venous Hypertension. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 15/15 indicating an intact cognition. R13 also required staff assistance with bed mobility and transfers. A review of the physician's orders noted the following, Order: Apply soft heel protectors when in bed for up to 12 hours. Status: Active.On 2/5/2026 at 12:27 PM and 1:31 PM, R13 was observed lying in bed. No heel boots were applied.On 2/6/2026 at 10:05 AM, R13 was observed lying in bed. No heel boots were applied.A review of the progress notes, treatment administration record (TAR) and care plan did not reveal any refusals for the application of R13's heel boots.A review of a facility policy titled, Physician and medication orders did not address following physician orders.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to implement fall interventions for one resident (R4) out of three reviewed for falls. Findings include:On 2/4/2026 at 10:09 AM, R4 was observed lying in bed. R4's bed was observed to be in an elevated position with the head of bed elevated. R4 reported they had a fall in the facility before and broke their hip. A review of the medical record revealed that R4 admitted into the facility on 1/21/2021 with the following medical diagnoses, Fracture of Left Femur and Dementia. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 15/15 indicating an intact cognition. R4 also required staff assistance with bed mobility and transfersFurther review of the fall care plan revealed the following intervention, Floor mats next to bed.On 2/4/2026 at 12:05PM, R4 was observed lying in bed. No fall mats were observed next to the bed.On 2/5/2026 at 12:16 PM, R4 was observed lying in bed. No fall mats were observed next to the bed.On 2/6/2025 at 9:55 AM, an interview was conducted with the Director of Nursing (DON). The DON reported that the fall mats should be in place for R4. The DON reported they were unsure why they were not in place, but anyone that has had a major fall should have fall mats in place.On 2/6/2026 at 10:02 AM, R4 was observed lying in bed. No fall mats were observed next to the bed.A review of a facility policy titled, Fall Prevention Program noted the following, .8. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. A. Interventions will be monitored for effectiveness. B. The plan of care will be revised as needed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise a care plan to reflect accurate transfer status for one resident (R2) out of three reviewed for falls. Findings include:On 2/4/2026 at 1:15 PM, R2 was observed lying in bed. R2's bed was observed in a low position and their head of bed elevated.A review of the medical record revealed R2 admitted into the facility on [DATE] with the following medical diagnoses, Retention of Urine and Adjustment Disorder. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 99, indicating R2 was unable to complete the assessment. R2 also required staff assistance with bed mobility and transfers.Further review of an incident and accident report dated 1/14/2026 noted the following, No injuries noted during fall.A review of R2's care plan noted the following intervention on the self-care deficit care plan, Transfer: One assist; pivot transfer.Further review of the fall care plan noted the following intervention, Transfer: Two person assist.On 2/5/2026 at 9:50 AM, Certified Nursing Assistant (CNA) L was asked how R2 transfers. CNA L reported that R2 used to be a one person assist and could help get to the chair. CNA L reported R2 does not get out of bed now, so they are unsure how they transfer.On 2/6/2026 at 1:15 PM, an interview was conducted with the Director of Nursing (DON). The DON reported that R2 was made a two-person assist for transfers, following their fall. The DON reported they will have to update the care plan to reflect their accurate transfer status. The DON reported R2 has refused to get out of bed lately, so they have not witnessed any recent transfers. A review of a facility policy titled, Fall Prevention Program noted the following, .8. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. A. Interventions will be monitored for effectiveness. B. The plan of care will be revised as needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This pertains to intakes 2723857 and 2717388 Based on interviews and record review, the facility failed to provide adequate monitoring and supervision for two residents (R38 and R44) of two residents reviewed for monitoring and supervision.R38On 2/06/2026 at 10:30 AM, R38 was observed ambulating in the hallway. R38 could not recall alleged incident or the name of the facility. A review of R38's medical record revealed that they were admitted into the facility on 9/26/23 and readmitted on [DATE] with diagnoses that included Dementia; Hypertension and Failure to Thrive. A review of R38's Minimum Data Set assessment revealed that the resident was cognitively impaired and required assistance for Activities of Daily Living.R44On 2/06/2026 at 11:30 AM, R44 was observed sitting in a chair in his room with his oxygen nasal cannula on. R44 thought they were in an apartment and would be leaving soon. R44 could not recall alleged incident.A review of R44's medical record revealed that they were admitted into the facility on 8/20/25 with diagnoses that included Vascular with Agitation, Anxiety and Chronic Obstructive Pulmonary Disease. A review of R44's Minimum Data Set assessment revealed that the resident was cognitively impaired and required extensive assistance for Activities of Daily Living. A review of R44's physician orders state 2 liters of continuous oxygen via nasal canula.A review of the medical record revealed the following nursing progress note dated on 1/10/2026 at 4:30 AM resident (R38) and another resident (R44) spent most of the night talking in the hallway in front of room114, writer educated both residents on the importance to go to sleep, but both residents continued talking to each other on the hallway of the north side of the facility.Further review of the medical record revealed the following note dated 1/10/2026 at 6:40 AM, During morning rounds, the writer entered room [ROOM NUMBER] and observed R38 seated on the bed facing the doorway without clothing. The other resident R44 from room [ROOM NUMBER] was observed standing approximately four feet away from R38 and was not wearing a shirt. The residents were engaged in conversation. The writer immediately escorted R44 back to their room. The writer then returned to room [ROOM NUMBER] to assess R38 and inquired as to why they were unclothed; the resident stated they were preparing to go to bed.On 2/7/2025 at 8:50 AM, a phone call was made to Registered Nurse (RN) M who was the nurse on duty for the day of incident. RN M stated that they noticed the residents were outside of their room talking most of the night. When preparing to round, RN M noticed that R44 was not in their room. R44 is on 2 liters of continuous oxygen. RN M was asked why the residents were not redirected or taken to their rooms during the first encounter of noticing them at 4:30 AM in the hallway. RN M stated that they were both outside their rooms. RN M went to get a nursing assistant and then went to R38's room and found both residents in there. RN M was asked why they went get a nursing assistant and they stated that just in case they needed additional assistance with a resident. RN M indicated that R38 and R44 could be in the room indicating the door was closed.On 2/7/2026 at 9:15 AM Certified Nursing Assistant (CNA) N was interviewed by phone and asked about the alleged incident. CNA N explained that they were busy with a resident when RN M came to her and stated the need to go with them to R38's room. CNA N revealed that they finished providing care and then followed RN M to R38's room. CNA N stated that upon opening the door and entering R38's room both residents were there. R38 was observed with their bra on and brief pulled down to their ankles. R44 was observed with their shirt off standing near the bed. The nurse immediately took R44 back to their room to and then came to assess R38.On 2/7/2026 at 12:30 PM, the Nursing Home Administrator (NHA) was interviewed and reported their expectation is that staff would provide adequate supervision and monitoring for all residents.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to empty a catheter drainage bag for one resident (R2) out of one reviewed for indwelling catheters. Findings include:On 2/4/2026 at 10:21 AM, R2 was observed lying in bed. R2 was noted to have an indwelling catheter in place, and the drainage bag (bag connected to indwelling catheter that collects urine) was full.A review of the medical record revealed R2 admitted into the facility on [DATE] with the following medical diagnoses, Retention of Urine and Adjustment Disorder. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 99, indicating R2 was unable to complete the assessment. R2 also required staff assistance with bed mobility and transfers.A review of the physician's orders revealed the following, Order: Change foley bag/tube/anchor as needed.On 2/4/2026 at 1:13 PM, R2 was observed lying in bed. The drainage bag was observed to be full.On 2/5/2026 at 8:45 AM and 9:28 AM, R2 was observed lying in bed. The drainage bag was observed to be full.On 2/5/2026 at 9:52 AM, R2 was observed lying in bed. The drainage bag was observed to be full. Licensed Practical Nurse (LPN) I was shown the drainage bag and stated that it was full and should have been emptied. LPN I reported the drainage bag should be emptied every two hours and as needed.On 2/5/2026 at 9:53 AM, an interview was conducted with Certified Nursing Assistant (CNA) L. CNA L stated they were unsure of the last time R2's drainage bag was emptied. CNA L reported they did not know if it was emptied on midnights and that they had not emptied it on their shift.On 2/6/2026 at 9:51 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the drainage bag should be emptied when the bag is half full and should be emptied no matter what at the end of a shift.A review of a policy titled Appropriate use of Indwelling Catheters noted the following, .Indwelling urinary catheters (urethral and suprapubic) will be utilized in accordance with current standards of practice, with interventions to prevent complications to the extent possible.

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	02/06/2026

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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, interview, and record review, the facility failed to provide assistive devices and utensils for eating for one resident (R4) out of two reviewed for limited range of motion. Findings include:A review of the medical record revealed that R4 admitted into the facility on 1/21/2021 with the following medical diagnoses, Fracture of Left Femur and Dementia. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 15/15 indicating an intact cognition. R4 also required staff assistance with bed mobility and transfers. Further review of R4's diet order revealed the following, Directions: Help with setting up meals, use padded foam utensils/divided plate w (with) guard.On 2/5/2026 at 12:15 PM, R4 was observed in their room with their lunch tray in front of them. R4 was noted to be on a pureed diet and had not eaten much. R4 stated they did not want anymore because their stomach was hurting.R4 was observed to have regular utensils and a regular plate.On 2/5/2026 at 12:24 PM, CNA O was shown the plate and utensils. CNA O stated that on the meal ticket it showed that R4 was supposed to have padded foam utensils, but the divided plate was not on there. CNA O reported that the utensils and plates come from the kitchen and they were unsure why R4 had a regular plate and utensils.On 2/6/2026 at 11:56 AM, an interview was conducted with Dietary Manager (DM) P. DM P reported they run out of padded utensils when the staff keep them in the rooms and don't put them back on the cart to be cleaned and reused. DM P reported the divided plate is not on the meal ticket which means they never received the order to update the ticket.On 2/6/2026 at 12:02 PM, an interview was conducted with the Director of Rehab (DOR). The DOR reported that R4 was on therapy and the order came from their department to increase R4s independence with eating.A review of a facility policy titled, Restorative Nursing Programs noted the following, It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level.