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	11/03/2021

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 This Citation Pertains to Intake Number MI00123165. Based on interview and record review, the facility failed to report an injury of unknown origin (alleged abuse) for one Resident (#13) out of three residents reviewed for abuse reporting to the State Agency (SA). This deficient practice resulted in the potential for ongoing abuse. Findings include: A review of Resident #13's medical record revealed an admitted [DATE] with diagnoses including dementia, anxiety, bipolar disorder, schizophrenia, acute respiratory failure and encephalopathy (brain disorder). The Minimum Data Set assessment dated [DATE] revealed Resident #13 was moderately cognitively impaired. On 9/30/21 a complaint was filed with the SA, which read in part: . the resident (#13) fell and hurt herself . was trying to go to the restroom at the time of her fall . resident had a previous fall that did not produce injury but during this fall the resident broke 3 ribs, her clavicle, and fractured her pelvis .resident was in the hospital for a while then returned to the facility . The nursing progress notes for Resident #13 revealed: 09/11/2021 05:05 AM .at about 11:40 pm (09/10/21) resident was observed on the ground next to bed on (sic) laying on her right side. Unaware that she had fallen. Resident c/o (complaint of) chest pain while holding chest .911 arrived within 5 minutes and resident was taken to [hospital] .NP (Nurse Practitioner), DON (Director of Nursing) along with daughter aware of situation. Physician progress notes for Resident #13 revealed: 09/24/21 10:05 AM .(Resident #13 was) at [hospital name] following an unwitnessed fall in the nursing home . In the facility, pelvic x-ray was normal. Patient was ultimately sent to hospital for mental status change. Patient was found to have a left rib fracture, left clavical (sic) fracture, right superior and inferior pubic rami fracture (pelvis fractures) . (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

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	11/03/2021

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/3/21 at 11:40 AM, previous DON I stated she did her own investigation of Resident #13's fracture injuries. She stated, I was thinking we reported it (the unwitnessed fall with injuries to the State Agency). The previous DON I explained she thought the fall with injuries was reported at the same time a different Facility Reported Incident (FRI) was made. She stated, I was mistaken. We didn't report the injury of unknown origin. The facility policy Resident Abuse/Neglect dated 1/30/19 read in part, Other signs and symptoms or actual abuse/neglect may be apparent. When in doubt, report it. Signs of/Actual Physical Abuse .(3) Fractures, dislocations or sprains of questionable origin .Incidents involving alleged, suspected or actual abuse (including misappropriation or exploitation) or resulting in serious bodily injury to the patient (including injuries of unknown origin), shall be reported to the state immediately, but not more than 2 hours after forming the suspicion . The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency .

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	11/03/2021

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 This Citation Pertains to Intake Number MI00123165. Based on interview and record review, the facility failed to fully investigate an injury of unknown origin (alleged abuse) for one Resident (#13) out of three residents reviewed for abuse. This deficient practice resulted in the potential for ongoing unidentified abuse. Findings include: A review of Resident #13's medical record revealed an admitted [DATE] with diagnoses including dementia, anxiety, bipolar disorder, schizophrenia, acute respiratory failure and encephalopathy (brain disorder). The Minimum Data Set assessment dated [DATE] revealed Resident #13 was moderately cognitively impaired. On 9/30/21, a complaint was filed with the State Agency (SA) which read in part: . the resident (#13) fell and hurt herself .was trying to go to the restroom at the time of her fall .resident had a previous fall that did not produce injury but during this fall the resident broke 3 ribs, her clavicle, and fractured her pelvis .resident was in the hospital for a while then returned to the facility . During a phone interview on 11/2/21 at 8:07 AM, Family Member M stated Resident #13 fell at least four times at the facility. During a follow up phone interview on 11/4/21 at 3:45 PM, Family Member M recalled the hospitalization of 9/11/21, I did not know anything until I went to the hospital, and they told me about all of the fractures. Family Member M stated she spoke with the previous DON (Director of Nursing) I who said, Resident #13 fell in the bathroom. The nursing progress notes revealed: 09/09/2021 06:39 AM .I reached out to redirect [Resident #13] to bed and pt (patient) attemped (sic) to slide along bed rm (room) wall, writer assisted res (Resident) to floor writer and staff assisted [Resident #13] to bed. Resident denied any pain or discomfort at that time, resident did not hit her head. Skin assessed and ROM (Range of Motion) performed no abnormalities noted. Resident's RP (Responsible party) and NP (Nurse practitioner) notified. 09/09/2021 06:42 AM Resident closely monitored throughout MN (midnight) shift . Resident got up throughout night ambulating in her room and to nurses station. Re-directed when needed. Provider Nurse Practitioner progress note revealed: 09/09/2021 9:10 AM .evaluated in bed, calm, comfortable answered questions appropriately, denies pain and discomfort . pleasant, calm. Further nurse progress notes revealed: 09/09/2021 04:49 PM at approx. 245pm (2:45 PM) this afternoon resident complained of pain to right hip/pelvis area .orders received for stat xray . 09/09/2021 05:35 PM .resident (#13) seated up at nurses station in wheelchair, has multiple attempts to stand and self transfer and walk up to nurses station . (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	11/03/2021

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/09/2021 10:08 PM Resident is up in wheel chair at nurses station. She states that she has no pain or discomfort. Resident was observed walking at nurses station with attending nursing aide .X ray completed . 09/10/2021 12:26 AM X-ray results negative. No evidence of acute fracture or dislocation. The radiology report of 09/09/2021 at 10:44 PM read in part: Findings: There is no radiographic evidence of acute fracture or dislocation. The ischiopubic lines are intact. Further nursing progress notes revealed: 09/11/2021 05:05 AM .at about 11:40 pm (09/10/21) resident was observed on the ground next to bed on laying on her right side. Unaware that she had fallen. Resident c/o (complaint of) chest pain while holding chest .911 arrived within 5 minutes and resident was taken to [hospital] .NP, DON along with daughter aware of situation. The Hospital Physician Note dated 9/11/21 at 12:50 AM, read in part: (Resident #13) who presents to [hospital name] .after fall on (blood thinner medication) that happened two days ago. This was unwitnessed fall, patient did hit her head and lose (sic) consciousness. Patient was found in her bathroom at her residential living facility. At that time the facility ordered in pelvic x-ray which was reportedly normal, no further workup was done. Per EMS (Emergency Medical Services) the patient was brought into the ED (Emergency Department) today for concerns of changes in mental status over the last 2 days . Facility Physician progress notes for Resident #13 revealed: 09/24/21 10:05 AM .admitted at (hospital name on 9/11/21) following an unwitnessed fall in the nursing home .In the facility pelvic x-ray was normal. Patient was ultimately sent to hospital for mental status change. Patient was found to have a left rib fracture, left clavical (sic) fracture, right superior and inferior pubic rami fracture (pelvis fractures) . During a phone interview on 11/3/21 at 3:10 PM, LPN L stated she remembered Resident #13's fall on 9/10/21 and stated the Resident was always confused .I knew she had a fall prior a day or two before and her pain site always changed around, we were getting x-rays of all her extremities .I was doing med pass and I left the light on. Later I found her on the floor next to her bed . LPN L said Resident #13, due to her complaints of chest pain, was sent to the hospital. LPN L stated, We usually do an incident report, and we do neuros (neurologic assessments), but we could not do it as she was sent out .I reported it to the facility. Following multiple requests to the facility for all incident reports and investigation files for Resident #13, the only documents for four of the six falls (9/9/21, 9/10/21, 9/22/21, 9/27/21, 9/29/21 and 10/6/21) provided were: Safety Events - Fall dated 9/9/2021 and revealed Interventions Ineffective. (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	11/03/2021

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safety Events - Fall- Post Fall assessment dated [DATE] Incident occurred 9/10/21 and read in part: .Was Fall Witnessed? No .Stated chest hurts .Resident UNABLE to rate pain .Verbalization/vocalization: Sighing, moaning, calling out, cries, grunts, moans, gasps .Reddened Abrasion .behind right shoulder .No Injury Noted to head, extremities, or trunk . Care Plan Reviewed: No . Safety Events - Fall dated 9/22/2021 and read in part: .Was Fall Witnessed? No .Outcomes of Interventions: not completed. Care Plan Reviewed: No . Safety Events - Fall dated 9/28/2021 and read in part: .Fall actually occurred on 9/27 .Was Fall Witnessed? No . Outcomes of Interventions: not completed. All four documents listed above had a status of open and were not completed. During an interview with the DON on 11/3/21 at 10:40 AM, the falls of Resident #13 were reviewed. The facility did not have documentation of investigations following the Resident's falls to prevent recurrence. The DON stated, All falls should have a (Safety) Event report and a Post Fall Assessment completed by the nurse and full investigations should have been started. The DON confirmed the four fall safety event reports (of the six documented falls) were incomplete at the time and date of this interview and were marked as still open at the time of this interview. During an interview on 11/3/21 at 11:40 AM, previous DON I stated she did her own investigation of Resident #13's fracture injuries (of 9/10/21). She stated, I interviewed the staff. When asked to review the investigation and interviews, previous DON I confirmed none were documented. When asked about the unfinished open status of the Safety Events Fall documents from Resident #13's falls on 9/9/21, 9/10/21, 9/22/21, and 9/27/21, the previous DON I confirmed the documents remained opened. The previous DON I stated she could close the reports, but they never were closed. The Care Plan for Resident #13 included a Problem Start date: 08/11/21 Category: Falls .Resident at risk for falling R/T (related to): mobility limits, assist with transitions, fall risk at 18 (over 10 indicated fall risk) . The only updated intervention added to the Fall Care Plan following the fall of 9/9/21 were labs ordered. After the fall on 9/10/21, upon return from the hospital on 9/21/21, no additional interventions were put in place in Resident #13's Fall Care Plan and a fall was documented on 9/22/21. The facility policy Falls and Falls Risk, Managing dated 9/21/21 read in part, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling .The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls .The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling .If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant .If the resident continues to fall, staff will re-evaluate the situation, conditions or circumstances and whether it is appropriate to continue or change current interventions. This policy was absent any information regarding protocol for investigations including interviews, record review of incident reports etc. following falls. (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	11/03/2021

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Resident Abuse/Neglect dated 1/30/19 read in part, .Should an actual, suspected or alleged incident resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designee, will initiate investigation of, or appoint a member of the management team to investigate the incident . A completed copy of documentation forms and written statements from witnesses, if any, must be provided to the Administrator within 2 - 4 hours of the occurrence of an incident of suspected abuse .Witness statements will be obtained in writing. Witnesses will be required to sign and date such reports .The results of the investigation will be recorded on approved documentation forms .The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency .

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	11/03/2021

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 This Citation Pertains to Intake Numbers MI00123561 and MI00123431 Based on observation, interview and record review, the facility failed to: 1) Ensure complete and accurate documentation of wound care and assessments of pressure injuries according to facility policy and professional standards of practice for one Resident (#11); 2) Ensure weekly skin assessments were completed according to physician order for one Resident (#10), and; 3) Ensure care planned interventions were implemented to prevent development of new pressure injuries for two Residents (#10 and #12) of four Residents reviewed for pressure injuries. This deficient practice resulted in the potential for the development of new pressure injuries, unrecognized worsening of existing wounds and infection. Findings include: Resident #11 Resident #11 was admitted to the facility on [DATE] and had diagnoses including: sepsis (life-threatening, full-body response to infection), multiple decubitus ulcers (pressure injuries), and quadriplegia (paralysis of all four limbs). A review of Resident #11's electronic medical record (EMR) revealed Resident #11 was hospitalized on [DATE] and returned to the facility on [DATE]. A review of Resident #11's hospital discharge summary, dated 10/25/2021, revealed the following, in part: Wound Care: Stage 4 (full-thickness tissue loss with visible bone) coccyx pressure injury. Left ischium (buttock) unstageable (wound bed not visible due to being covered with dead tissue that if removed would reveal a full-thickness wound) pressure injury. Right buttocks unstageable pressure injury. Right hip Stage 4 pressure injury. Right knee necrotic (dead tissue) wound with erythema (redness). Upper, mid-spine Stage 1 (reddened, non-blanchable area) pressure injury. Stable dry, scabbed wounds to the lower extremity. A review of Resident #11's Admission Skin Assessment, dated 10/26/2021 at 1:41 a.m., revealed the following, in part: Areas identified on the body must be explain(ed) in detail, in nurses' notes and treatments (initiated if) indicated . Body: Indicate location on the body: Reddened - Lt (left) knee, red scabs, mid-back . Other: open areas to RT (right) buttock, LT (left) buttock, LT (left) side buttock. Further review of Resident #11's EMR, including all progress notes, skilled nursing notes, skin assessments, skin monitoring sheets (shower sheets) and treatment administration records on 11/1/2021, revealed no assessments of Resident #11's wounds had been documented from the Resident's readmission on 10/26/2021 through the date of review on 11/1/2021. On 11/2/2021 at 8:24 a.m., a request was made to the Director of Nursing (DON) for this Surveyor to be present during Resident #12's wound care. The DON stated understanding and reported she would alert the Wound Care Nurse to the request. An observation on 11/2/2021 at 11:18 a.m., revealed Resident #11 alone in his room, sitting in bed with his heels floated by pillows that had been placed under his lower legs. During an interview at the time of the observation, Resident #11 reported he had not yet received wound care that morning. (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	11/03/2021

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This Surveyor had not been alerted to observe Resident #11's wound care as previously requested, prior to end of day on 11/2/2021 at 4:45 p.m. A review of Resident #11's progress notes on 11/3/2021 at 8:10 a.m., revealed a Nurses' Note dated and signed by Licensed Practical Nurse (LPN) D on 11/2/2021 at 11:46 a.m. Further review of the note revealed the following, in part: 11/2/2021 11:46 a.m.: Wound Care: Wound care completed to the following wounds: Wound #1 - Sacro-coccyx, bl (bilateral) buttocks (L [length] 6.7 cm (centimeters) x W [width] 7 cm and 0.5 cm deep), has a large amount of sero-sang (serosanguinous) drainage with no odor noted. Wound #2 - Right hip (2 cm x 1.5 cm, 0.5 cm deep) wound has a moderate amount of sero-sang drainage with no odor. Wound #3 - Right Gluteal Fold (6 cm x 2.5 cm) wound has a moderate amount of drainage with no odor. Wound #4 - Left hip (1.5 cm x 1.3 cm) minimal serosanguinous drainage with no odor noted. Wound #5 - 4.5 cm x 4 cm, moderate serosang drainage noted with no odor. It was noted that the Wound Care Note did not contain detailed descriptions of the wound beds, wound edges, or the stages of the individual wounds, nor any indication of how Resident #11 tolerated the procedure. In addition, Wound #5 as listed in the Wound Care Note, did not list a location of the wound on Resident #11's body. An observation of Resident #11's wound care provided by LPN D on 11/3/2021 at 11:40 a.m., revealed the following pressure injuries: 1) Coccyx (tailbone area) - Stage 4, approximately six and one half centimeters long by seven and one half centimeters wide (6.5cm x 7.5cm) with a beefy red wound bed, indurated (raised) edges and undermining (erosion underneath the outward wound edges) at the distal (bottom) end of the wound; 2) Right ischium (buttock) - unstageable, approximately seven and one half centimeters long by six and one half centimeters wide (7.5cm x 6.5 cm) with slough (tan-colored, dead tissue) covering approximately 80% of the wound bed and flat wound edges; 3) Left ischium - unstageable, approximately eight and one half centimeters long by six and one half centimeters wide (8.5cm x 6.5cm) with 100% of the wound bed covered in eschar (black, dead tissue) and indurated wound edges; 4: Right hip - Stage 4, approximately two and one half centimeters long by two centimeters wide (2.5cm x 2cm) with bone visible in the wound bed and flat wound edges; 5) Left hip - Stage 4, approximately one and one half centimeters long by one and one half centimeters wide (1.5cm x 1.5cm) with bone visible, indurated wound edges with undermining at the proximal (top) edge of the wound and slough forming at the distal (bottom) edge of the wound; 6) Right inner knee - Unstageable, approximately one centimeter long by one centimeter wide (1cm x 1 cm) with the 100% of the wound bed covered in slough and indurated edges; and 7) Right gluteal fold (where the buttock meets the thigh) - Stage 2, approximately one-half centimeter long by four centimeters wide (0.5cm x 4cm), granulated (red, healing) wound bed with flat edges, and 8) Left heel had an oval shaped dark purple area approximately two centimeters wide by one centimeter long (2cm x 1 cm). In an interview immediately following the observation, LPN D reported she documented all wound care in the EMR and had no paper documentation of resident's wound care. LPN D reported she completed all day-shift wound care for all residents with extensive wounds, including Resident #11. When asked why there was no detailed documentation of Resident #11's wounds or wound care since his return from the hospital on 10/26/21, LPN D reported the documentation was, just too much to do. LPN D reported Resident #11 was seen by the Wound Clinic Nurse every Friday. All wound care notes for Resident #11 were requested at the time of the interview. (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	11/03/2021

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/3/21 at 1:30 p.m., LPN D presented the wound care documentation for Resident #11. A review of the documentation with LPN D at that time, revealed Resident #11 had not been evaluated by the wound care nurse since his readmission to the facility on [DATE]. LPN D confirmed there were no documented assessments of Resident #11's wounds after Resident #11 returned from the hospital on 10/26/21 and prior to her documentation on 11/2/2021. In an interview on 11/3/2021 at 2:05 p.m., the DON reported all wound care should be documented in detail in the EMR. The DON reported upon admission or readmission to the facility, residents should be thoroughly assessed for wounds with detailed documentation of any wounds recorded in the resident's EMR. The DON confirmed wound assessments were necessary to track wound healing or worsening, and to determine the need for changes in treatment. A review of Resident #11's EMR, with the DON, revealed no wound care documentation to correspond with the wound care recorded as delivered on Resident #11's October and November Treatment Administration Records (TARs). In addition, the DON stated all physician ordered, Weekly Skin Assessments, should be conducted by licensed nursing staff and documented under Observations, in the EMR. A review of Resident #11's Treatment Administration Records (TARs) for October 2021 and November 2021, revealed wound care recorded as completed on 11 occasions. Further review of the TARs revealed no documented assessments of Resident #11's wounds to correspond with the wound care provided by licensed nursing staff. A review of the facility policy titled, Pressure Ulcer Treatment Level III, dated 9/16/2021, revealed the following, in part: The purpose of this procedure is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers . Documentation: The following information should be recorded in the resident's medical record: 1. The type of treatment and resident response, 2. The date and time the wound care was given, 3. The position in which the resident was placed, 4. The name and title of the individual performing the care, 5. Any change in the resident's condition, 6. All assessment data (i.e., color, size, pain, drainage, etc.) when inspecting the wound, 7. Resident tolerance to procedure, 8. Any problems or complaints made by the resident related to the procedure, 9. Resident refusal of treatment and the reason(s) why . 10. The signature and title of the person recording the data. Resident #10 Resident #10 was admitted to the facility on [DATE] and had diagnoses including: cerebral infarction (stroke), aphasia (inability to express or understand speech), tracheostomy (surgical opening in the neck with insertion of a tube to allow for breathing) and gastrostomy (insertion of a feeding tub through the abdominal wall into the stomach). A review of Resident #10's most recent Minimum Data Set (MDS) assessment, dated 10/22/2021, revealed Resident #10 was totally dependent on staff for all care, bed mobility and transfers. Resident #10 had severely impaired cognition. An observation on 11/2/2021 at 3:52 p.m., revealed Resident #10 lying in bed. Resident #10 was not wearing any type of heel protection and there were no pillows present under the Resident's feet or lower legs. Resident #10's heels were observed to be resting directly on the bed. A review of Resident #10's most recent Braden Scale Assessment (assessment used to determine risk of developing pressure injuries), dated 8/18/2021 revealed Resident #10 was assessed as being at high risk for the development of pressure injuries. (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	11/03/2021

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review Resident #10's care plan revealed the following, in part: Problem Start Date: 7/16/2021. Risk for alteration in skin (related to): mobility limits . bed bound . Approach Start Date: 7/16/2021 Float heels when in bed using pillows or soft heel boots . Weekly skin assessments - Nursing. A review of a physician order for Resident #10, dated and signed on 7/17/2021 at 12:07 a.m., revealed the following, in part: Order Description: Weekly Skin Assessment. Frequency: Once A Day on Wed (Wednesday). Special Instructions: Record skin assessment under observations. Order class: Nursing Order. A review of Resident #10's EMR, for the time period of 9/24/2021 through 11/2/2021 revealed no documented weekly skin assessments for Resident #10 during the review period. A review of all, Skin Monitoring: Comprehensive CNA Shower Review(s) (shower sheets), from 9/24/2021 through 11/2/2021 for Resident #10, provided by the DON, revealed the following: perform a visual assessment of a resident's skin when giving the resident shower. Report any abnormal looking skin to the charge nurse immediately. Forward any problems to the DON for review. Use this form to show the exact location and description of the abnormality . Further review of the shower sheets for Resident #10 as provided by the DON revealed completion of the sheets by CNAs on 10/2/2021, 10/20/2021 and 10/30/2021. In an interview on 11/3/2021 at 2:05 p.m., the DON reported the process for completion of the shower sheets was for CNAs to document any observed skin abnormality, including pressure injuries. The sheets were then given to nursing for review. When asked if the shower sheets replaced the nursing, Weekly Skin Assessment, the DON confirmed the nursing assessments should be based on the nurses' observations and assessment of the resident's skin and not on the CNA observations. The DON acknowledged that residents at risk for developing pressure ulcers would have injuries go unrecognized when the Weekly Skin Assessments, were not completed and documented as ordered. The DON reported residents assessed for being at risk for development of pressure ulcers should have care planned interventions in place to aid in preventing skin breakdown. The DON confirmed all care planned interventions should be carried out unless the resident refuses. The DON stated all refusal of care should be documented in the EMR. Resident #12 Resident #12 was admitted to the facility on [DATE] and had diagnoses including: intracerebral hemorrhage (stroke), left-side hemiplegia (paralysis of the left-side of the body) and protein-calorie malnutrition. A review of Resident #12's most recent MDS assessment, dated 9/2/2021 revealed Resident #12 was totally dependent on staff for bed mobility, transfers, toilet use and personal hygiene. Resident #12 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating fully intact cognition. (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	11/03/2021

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 11/1/2021 at 4:10 p.m., revealed Resident #12 lying in bed. Further observation revealed two [NAME]-lined heel protection boots lying on the floor in the corner of the room approximately three feet from the end Resident #12's bed. During an interview at the time of the observation, Resident #12 reported she thought she was supposed to be wearing the heel protection boots when she was in bed because she could not reposition her legs on her own. Resident #12 then lifted the sheet from her lower legs revealing her heels were resting directly on the bed. Resident #12 reported the heel protectors had been removed during care overnight and had not been replaced. Resident #12 reported she sometimes forgot to remind staff to replace the heel protectors after they had been removed during care delivery. An observation on 11/2/2021 at 10:00 a.m., revealed CNA E enter Resident #12's room. CNA E reported Resident #12 was going to be transferred to the shower gurney to be transported to the shower room. CNA E removed the sheet that was covering Resident #12's legs at which time, Resident #12's heels were observed to be resting directly on the bed. When asked if Resident #12's heels should be resting directly on the bed, CNA E reported she was unsure. Further observation at that time revealed the heel protection boots on the floor in the corner of Resident #12's room, as previously observed by this Surveyor on 11/1/2021 at 4:10 p. m. CNA E reported she had not noticed the heel protection boots on the floor in the corner of the Resident's room and was unaware the Resident was care planned to have the boots applied when she was in bed. A review of Resident #12's care plan revealed the following, in part: Problem Start Date: 8/07/2020. Risk for alteration in skin (related to): mobility limits . Braden Scale is at 11 (high risk for pressure ulcers) . she has CVA (stroke) with left side hemiparesis, she requires assist with repositioning. Goal Target Date: 12/14/2021. Resident will be free of skin breakdown, unless unavoidable through the review date. Approach Start Date: 8/07/2020 . Float heels when in bed using pillows or soft heel boots . Weekly skin assessments - Nursing. A review of the facility policy titled, Prevention of Pressure Ulcers, dated 9/16/2021, revealed the following, in part: The purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors. 1. Review the resident's care plan t assess for any special needs of the residents. 2. The most common site of a pressure ulcer is where the bone is near the surface of the body including . heels, ankles, and toes. 5. Once a pressure ulcer develops, it can be extremely difficult to heel. Pressure ulcers are a serious skin condition for the resident. General Preventative Measures: 9. Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Residents with Risk Factors: 5. Risk Factor - Immobility. C. While in bed, every attempt should be made to float heels (keep heels off of the bed) by placing a pillow from knee to ankle or with other devices recommended by therapist and prescribed by the physician.

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	11/03/2021

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 0689 Level of Harm - 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** 40383 This Citation Pertains to Intake Number MI00123165. Based on interview and record review, the facility failed to provide monitoring and supervision to prevent elopement and adequately investigate and implement interventions to prevent falls for one Resident (#13), from 3 residents reviewed for supervision and safety. This deficient practice resulted in Resident #13's elopement and repeated falls with injury,hospitalization s and multiple fractures. Findings include: A review of Resident #13's medical record revealed an admitted [DATE] with diagnoses including dementia, anxiety, bipolar disorder, schizophrenia, acute respiratory failure and encephalopathy (brain disorder). The Minimum Data Set assessment dated [DATE] revealed Resident #13 was moderately cognitively impaired. Nursing progress notes revealed: 08/10/2021 08:35 PM New admit day #1 .Resident wanders frequently in hallway, anxious, frequently redirected. Frequent checks . 08/12/2021 04:43 AM New admit day #2 .in bed at change of shift, alert x3, confused at times . Resident wandered throughout the night and had to be redirected multiple times. 09/02/2021 06:43 AM .alert and sitting by the nurses station at change of shift .At approximately 0200 am, resident was observed at back west entry facility door trying to exit. Resident redirected back towards nurses station Resident began to grab the hands of another resident and started tell (sic) resident, come on, lets go. Resident continued to pull at the other resident towards exit door. attempts made to distract resident, resident continued to exhibit exit seeking behaviors . 09/08/2021 04:41 PM Resident noted exiting the building and seen by maintenance and housekeeping supervisor and redirected back into the building. DON (Director of Nursing,) Administrator notified, unable to reach daughter . During an interview on 11/2/21 at 3:43 PM, the Nursing Home Administrator (NHA) revealed she was aware of Resident #13's elopement on 9/8/21. The NHA explained Resident #13 was at the exit door and held it long enough to release the lock. The NHA said there was not an elopement, but Resident #13 may have had one foot out the door. The NHA revealed there was no written investigation or incident report documenting the event or follow up. The NHA stated, I did not put it in a progress note .There should have been an incident report. The NHA said Resident #13 was exit seeking and was redirected. The NHA named two staff members (Staff J and Staff K) who redirected Resident #13 back into the building. (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	11/03/2021

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/3/21 at approximately 9:40 AM, the previous DON I stated she did recall Resident #13 was observed at the exit door. The previous DON I revealed she did not review the progress note of 9/8/21 until Friday 9/10/21. The previous DON I stated there was a discrepancy in the [progress] note and what was reported, and we discussed this. The previous DON I continued stating Licensed Practical Nurse (LPN) D, the author of the progress note dated 9/8/21, was asked to clarify the note. A copy of the clarified note was requested and was provided on plain paper (not printed from the medical record), and it was hand signed by LPN D. The clarified note read, While in another resident's room, writer heard alarm sounding and came out of resident's room and ran towards the alarming door. I was approached by Maintenance and Hsk (Housekeeping) supervisor with [Resident #13], they both stated that [Resident #13] had opened the exit door and was re-directed without difficulty. Immediately after resident was placed on one on one with sitter. The previous DON I revealed if Resident #13 exited the building it would be considered an elopement, we would have to report it and start an investigation. The previous DON I confirmed no other investigation documentation was available. On 11/3/21 at 8:27 AM Staff J was interviewed via telephone and recalled Resident #13's elopement on 9/8/21. Staff J revealed an exit door alarm was sounding as she walked in the hallway returning from a morning meeting. The Maintenance Director (Staff) K was near her and said, Why is that alarm going off? Staff J stated, I started running to the door. Staff J said no other nurses or aides were seen in the hallway. Staff J stated, I got to the door and found it was cracked open. I could not see anyone. Staff J explained, if the locked door was pushed and held, after a while it would open and alarm. Staff J stated, I ran out the door to the end of the sidewalk and turned left and saw [Resident #13] going to the back end of the parking lot where there are a lot of employees cars . [Resident #13] was a small lady and could move fast. Staff J said Resident #13 was repeating I just want to go home. Staff J was able to get Resident #13 to move back toward the building. By then, Staff K had arrived with a wheelchair for Resident #13 whose legs were getting weak and took her back into the building. The nurse (LPN D) wheeled Resident #13 back to her room and wrote a statement. When Staff J was asked about an investigation, she stated, They did not ask me about it . They did not ask me for a statement. On 11/3/21 at approximately 11:10 AM, during an interview regarding the elopement of Resident #13, LPN D stated she heard the alarm, went down the hall to the exit door, and saw Staff J and Staff K with Resident #13. LPN D took Resident #13 back to her room. LPN D said she did not see Resident #13 on the outside of the building. During a telephone interview on 11/3/21 at 12:05 PM, Staff K recalled walking back from the morning meeting and said the door at 1 north was chirping. We definitely heard it. It is quite loud. Staff K said he approached the door, and it was opened a crack. Staff K explained, When someone opens the door, it swings shut but not all the way. Staff K said, [Staff J] got there first and I went and grabbed a wheelchair . I went outside and [Staff J] was there walking [Resident #13] back toward the door. When asked where he saw Resident #13, Staff K said, six or seven steps out the door when I got there. Staff K said they got Resident #13 in, and LPN D took the Resident back to her room. When asked about the follow up to the event, Staff K said no one asked him what had happened or took a statement from him. (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	11/03/2021

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 0689 Level of Harm - Actual harm Residents Affected - Few	Nursing progress notes dated 8/10/21, 8/12/21, and 9/2/21 recorded Resident #13's wandering behavior. Resident #13's Care Plan dated 9/2/21 revealed, Resident experiences wandering and exit seeking behaviors (moves with no rational purpose, seemingly oblivious to needs or safety). The only intervention listed for the problem read: Place resident in a secure environment. No updates were listed after the elopement of 9/8/21. The facility policy and procedure Elopements dated 10/24/21 read in part: Staff shall promptly report any resident who tries to leave the premises .5. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall: .Complete and file an incident report; and Document relevant information in the resident's medical record. The policy was absent any information regarding protocol for investigation, evaluation, and analysis following elopements. On 9/30/21 a complaint was filed with the State Agency (SA), which read in part: . the resident (#13) fell and hurt herself .was trying to go to the restroom at the time of her fall . resident had a previous fall that did not produce injury but during this fall the resident broke 3 ribs, her clavicle, and fractured her pelvis .resident was in the hospital for a while then returned to the facility .on 9/29/21 .the resident fell yet again .concerned the facility does not have the appropriate fall precautions in place for the resident .[concerned] the resident is [not] being monitored appropriately. During a phone interview on 11/2/21 at 8:07 AM, Family Member M stated Resident #13 fell at least four times at the facility. During a follow up phone interview on 11/4/21 at 3:45 PM, Family Member M recalled the hospitalization of 9/11/21, I did not know anything until I went to the hospital, and they told me about all of the fractures. Family Member M stated she spoke with the previous DON I who said, Resident #13 fell in the bathroom. The nursing progress notes revealed: 09/09/2021 06:39 AM .I reached out to redirect [Resident #13] to bed and pt (patient) attemped (sic) to slide along bed rm (room) wall, writer assisted res (Resident) to floor writer and staff assisted [Resident #13] to bed. Resident denied any pain or discomfort at that time, resident did not hit her head. Skin assessed and ROM (Range of Motion) performed no abnormalities noted. Resident's RP (Responsible party) and NP (Nurse practitioner) notified. 09/09/2021 06:42 AM Resident closely monitored throughout MN (midnight) shift . Resident got up throughout night ambulating in her room and to nurses station. Re-directed when needed. Provider Nurse Practitioner progress note revealed: 09/09/2021 9:10 AM .evaluated in bed, calm, comfortable answered questions appropriately, denies pain and discomfort . pleasant, calm. Further nurse progress notes revealed: 09/09/2021 04:49 PM at approx. 245pm (2:45 PM) this afternoon resident complained of pain to right hip/pelvis area . orders received for stat xray . 09/09/2021 05:35 PM .resident (#13) seated up at nurses station in wheelchair, has multiple attempts to stand and self transfer and walk up to nurses station . (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	11/03/2021

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 0689 Level of Harm - Actual harm Residents Affected - Few	09/09/2021 10:08 PM Resident is up in wheel chair at nurses station. She states that she has no pain or discomfort. Resident was observed walking at nurses station with attending nursing aide .X ray completed . 09/10/2021 12:26 AM X-ray results negative. No evidence of acute fracture or dislocation. The radiology report of 09/09/2021 at 10:44 PM read in part: Findings: There is no radiographic evidence of acute fracture or dislocation. The ischiopubic lines are intact. Further nursing progress notes revealed: 09/11/2021 05:05 AM .at about 11:40 pm (09/10/21) resident was observed on the ground next to bed on laying on her right side. Unaware that she had fallen. Resident c/o (complaint of) chest pain while holding chest .911 arrived within 5 minutes and resident was taken to [hospital] .NP, DON along with daughter aware of situation. 09/21/21 7:28 PM .patient (readmitted) at 6:40pm from (name of) Hospital . The Hospital Physician Note dated 9/11/21 at 12:50 AM, read in part: (Resident #13) who presents to (hospital name) .after fall on (blood thinner medication) that happened two days ago. This was unwitnessed fall; patient did hit her head and lose consciousness. Patient was found in her bathroom at her residential living facility. At that time the facility ordered pelvic x-ray which was reportedly normal, no further workup was done . Facility physician progress note following readmission revealed: 09/24/21 10:05 AM .(Resident #13 was) at (hospital name) following an unwitnessed fall in the nursing home . In the facility, pelvic x-ray was normal. Patient was ultimately sent to hospital for mental status change. Patient was found to have a left rib fracture, left clavical (sic) fracture, right superior and inferior pubic rami fracture (pelvis fractures) . Further nursing progress notes revealed: 09/22/2021 06:15 PM Resident observed sitting on the floor next to her bed .Resident stated that she was trying to get to the bathroom . 09/27/2021 03:53 PM .placed in chair after breakfast. Resident was observed on her knees in front of w/c (wheelchair) . 09/29/2021 08:00 PM Nurse was informed that resident had a fall that was unwitnessed. Resident has history of self transferring despite staff encouraging her to call when needing assistance. Nurse went into resident room observed resident with blood all over face, and blood on sheets. Clots observed on shirt and sheets. Nurse got report that resident has been saying I want to go to the hospital earlier, and also has been speaking of falling repeatedly today .NP and Daughter notified, Emt (Emergency Medical Transport) called immediately arrived in approximately 6 minutes. 09/30/2021 11:30 AM .resident (arrived) at 10:15am from hospital by ambulance. Resident had fall unwitnessed on September 29,2021 . (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	11/03/2021

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 0689 Level of Harm - Actual harm Residents Affected - Few	10/06/2021 06:54 PM writer summoned to residents room, upon entering, writer observed resident on floor, knee down at bedside [with] wheelchair in front of her. when asked what happened, resident stated, I want my daughter. 10/8/21 03:50 PM .taken to [hospital] . No further progress notes recorded. Resident did not return to the facility. During a phone interview on 11/3/21 at 3:10 PM, LPN L stated she remembered Resident #13's fall on 9/10/21 and stated the Resident was always confused .I knew she had a fall prior a day or two before and her pain site always changed around, we were getting x-rays of all her extremities .I was doing med pass and I left the light on. Later I found her on the floor next to her bed . LPN L said Resident #13, due to her complaints of chest pain, was sent to the hospital. LPN L stated, We usually do an incident report, and we do neuros (neurologic assessments), but we could not do it as she was sent out .I reported it to the facility. Following multiple requests to the facility for all incident reports and investigation files for Resident #13, the only four documents for the six falls (9/9/21, 9/10/21, 9/22/21, 9/27/21, 9/29/21 and 10/6/21) provided were: Safety Events - Fall dated 9/9/2021 Safety Events - Fall- Post Fall assessment dated [DATE] which included Incident occurred 9/10/21 Safety Events - Fall dated 9/22/2021 Safety Events - Fall dated 9/28/2021 included Fall actually occurred on 9/27 All documents listed above had a status of open and were not completed. The Safety Event dated 9/9/21 revealed Interventions Ineffective. The Safety Event dated 9/12/21 for fall on 9/10/21 at 11:40 PM was written by LPN L and read in part: .Was Fall Witnessed? No .Stated chest hurts .Resident UNABLE to rate pain .Verbalization/vocalization: Sighing, moaning, calling out, cries, grunts, moans, gasps .Reddened Abrasion .behind right shoulder .No Injury Noted to head, extremities, or trunk .Care Plan Reviewed: No . The Safety Event dated 9/22/21 read in part: .Was Fall Witnessed? No .Outcomes of Interventions: not completed .Care Plan Reviewed: No . The Safety Event dated 9/28/21 read in part: .Fall actually occurred on 9/27 .Was Fall Witnessed? No . Outcomes of Interventions: not completed. (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	11/03/2021

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with the DON on 11/3/21 at 10:40 AM, the falls of Resident #13's were reviewed. The facility did not have documentation of investigations following the Resident's falls to prevent recurrence. The DON stated, All falls should have a (Safety) Event report and a Post Fall Assessment completed by the nurse and full investigations should have been started. The DON confirmed all four fall documents were incomplete at the time and date of this interview and were marked as still open. During an interview on 11/3/21 at 11:40 AM, previous DON I stated she did her own investigation of Resident #13's fracture injuries. She stated, I interviewed the staff. When asked to review the investigation and interviews, previous DON I confirmed none were documented. When asked about the unfinished open status of the Safety Events Fall documents from Resident #13's falls on 9/9/21, 9/10/21, 9/22/21, and 9/27/21, previous DON I confirmed these documents remained opened. The previous DON I stated she could close the reports, but they never were closed. The Care Plan for Resident #13 included a Problem Start date: 08/11/21 Category: Falls .Resident at risk for falling R/T (related to): mobility limits, assist with transitions, fall risk at 18 (over 10 indicated fall risk) . The only updated intervention added to the Fall Care Plan following the fall of 9/9/21 were labs ordered. After the fall on 9/10/21, and upon return from the hospital on 9/21/21, no additional interventions were put in place for Resident #13's Fall Care Plan, and a fall was documented on 9/22/21. After the fall on 9/29/21, upon return from the hospital on 9/30/21, no additional interventions were put in place in Resident #13's Fall Care Plan. The facility policy Falls and Falls Risk, Managing dated 9/21/21 read in part, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling .The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls .The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling .If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant .If the resident continues to fall, staff will re-evaluate the situation, conditions or circumstances and whether it is appropriate to continue or change current interventions. This policy was absent any information regarding protocol for investigation, evaluation, and analysis following falls.