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	11/23/2021

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** 38207 This citation pertains to intake number MI00124304. Based on interview and record review the facility failed to fully investigate a bruise to a resident's knee for an injury of unknown origin for one sampled Resident (R706) of four residents reviewed for potential abuse, resulting in the potential for physical abuse and an incomplete investigation of abuse. Findings include: On 11/22/21 at 9:45 AM, a review of R706's electronic medical record (EMR) revealed that R706 was most recently admitted to the facility on [DATE] with diagnoses that included Osteoarthritis and Generalized Anxiety Disorder. R706's most recent minimum data set (MDS) assessment revealed that R706 had a severely impaired cognition. R706 was discharged from the facility on 11/2/21. On 11/22/21 at 10:00 AM, a review of a facility reported incident (FRI) which was reported to the State Agency (SA) indicated the following, It was reported that the resident received an injury of unknown origin. On 11/22/21 at 10:15 AM, an incident and accident report (I/A) was reviewed involving R706 which stated the following, Type of Alleged Incident: Injury of Unknown Source .Date/Time Incident Discovered: 11/3/2021 2:00 PM .Date/Time Incident Occurred: 11/1/2021 7:00 PM .Incident Summary: Resident observed with discoloration to right medial knee. On 11/22/21 at 10:30 AM, a review of R706's progress notes located in their EMR revealed the following, 11/1/21 6:46 PM, .Upon skin assessment, writer observed discoloration to right medial knee . On 11/22/21 at 12:12 PM, Nurse H was interviewed regarding any knowledge they had involving R706's injury of unknown origin. Nurse H stated, I heard [Resident] had some bruising. I'm not sure what happened. On 11/22/21 at 12:15 PM, Agency Certified Nursing Assistant (CNA) C was interviewed regarding any knowledge they had involving R706's injury of unknown origin. CNA C indicated that they were unaware of any injury which occurred to R706. On 11/22/21 at 12:20 PM, Agency CNA B was interviewed regarding any knowledge they had involving R706's injury of unknown origin. CNA B stated, I know [Resident] had a fall around that time. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/22/21 at 2:09 PM, Nurse I was interviewed by phone regarding any knowledge they had involving R706's injury of unknown origin. Nurse I stated, I completed a skin assessment on [Resident] on 11/1/21 and noticed discoloration to [Resident's] right knee. I documented it and reported it. Nurse I was asked if they had any idea how the discoloration to R706's right knee occurred. Nurse I responded, No. On 11/22/21 at 2:15 PM, the facility investigation pertaining to the FRI was reviewed and revealed that two facility staff member's written statements/interviews regarding R706's injury of unknown origin were included in the investigation of the FRI. Neither staff interviewed provided care and/or clinical services to R706. There were no other staff statements/interviews included in the facility investigation. On 11/22/21 at 3:10 PM, the Administrator/Abuse Coordinator (NHA) was interviewed regarding their investigation of R706's injury of unknown and asked where the other facility staff interviews were located regarding the investigation. The NHA/Abuse Coordinator had no response to the question. The NHA/Abuse Coordinator indicated that the Director of Nursing (DON) had resigned recently. On 11/22/21 at 4:00 PM, the facility's policy regarding investigation of abuse/injury of unknown origin was requested. However, it was never provided by the facility, prior to the conclusion of the survey.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34911 This citation pertains to Intake numbers, MI00124165, MI00124185, MI00122598, MI00122744, and MI00122848. Based on observation, interview, and record review the facility failed to provide incontinence care in a timely manner and ensure an adequate supply of linen was provided for residents affecting two residents, (R704 and R705) of 12 residents reviewed for Activities of Daily Living (ADLs) resulting in the likelihood of resident discomfort and dissatisfaction with care received at the facility. Findings include: Resident #704 (R704) On 11/22/2021 at 9:00 AM, an interview was conducted with R704 regarding the care at the facility. During the interview R704 stated, I've been here since June and if they aren't short of staff they are out of linen. A weekend ago or two I stayed wet for the entire weekend because there was no linen. They said the linen people called in sick and there was no linen and I'd have to be understanding. R704 was asked if they were clean and dry during the interview and stated, No. R704 pulled back the covers and revealed the bottom sheet was wet with a dry brown margin around the wetness. R704 was asked how long they had been wet and stated, Since last night. Record review of R704's Electronic Health Record (EHR) revealed R704 was admitted into the facility on [DATE] with diagnoses that included: Bipolar Disorder, Secondary Osteoarthritis, Schizoaffective Disorder, Essential Hypertension, and Obesity. The most recent Minimum Data Set (MDS) assessment dated , 10/30/2021 revealed R704 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating an intact cognition and needed limited assistance with ADLs. Resident #705 (R705) On 11/22/2021 at 9:41 AM, and interview was conducted with R705 regarding the care received at the facility. During the interview R705 stated, I've been here for a year in September. I've been wet since three or four in the morning. Sometimes they don't have linen, I talked to the DON (Director of Nursing) and the DON said they are working on it. They don't have any aides, they burn the good ones out and they leave. We all lay in wet beds for hours. Record review of R705's EHR revealed R705 was admitted into the facility on [DATE] with diagnoses that included: Muscular Dystrophy, Hidradenitis Suppurativa (skin disease), and Type-2 Diabetes. The most recent MDS assessment dated [DATE] revealed R705 had a BIMS score of 15 indicating an intact cognition and was totally dependent on staff for ADLs. On 11/22/2021 at 9:58 AM, a skin care observation was conducted on R705 with Certified Nurses Aide (CNAB) and Nurse G During the observation it was noted that R705 was wearing two briefs and the inner brief was saturated with urine and there was a small amount of stool in the brief. R705's scrotal area and buttocks were excoriated and swollen. Nurse G and CNA B completed R705's skin care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/22/2021 at 10:09 AM, a tour of the facility revealed, there was no linen in the linen room in the hallway between the North and South hallways. The North hallway linen cart had five towels, four flat sheets, three fitted sheets, and a few wash cloths. A cart in the 200 hall cart was empty. On 11/22/2021 at 1:39 PM, an interview was conducted with CNA B regarding the ability to care for residents at the facility and CNA B stated, I have 11 residents today but usually I have 18. CNA B was asked if they were able to give all of the assigned bed baths and showers and stated, Not always, I go from room to room. When I'm done with one resident, I go to the next. CNA B was asked if staffing shortages occurred regularly and stated, Having 18 happens a lot. I must tell you that I have had this whole hall all by myself. CNA B was asked about the supply of linen and stated, We run out of linen a lot. CNA B was asked what would be done if a resident needed a linen change and linen was not available and stated, We do the best that we can. On 11/22/2021 at 1:49 PM, a tour of the facility's laundry room was conducted. During the tour Laundry Staff (LS D) was asked about the ability to supply linen for the residents and stated, One problem is that we only have one washer and one drier. There are three of us and we all work day shift. LS D was asked about the afternoon and night shift running out of linen and stated, They have to wait. On 11/22/2021 at 2:12 PM, an interview was conducted with CNA C regarding the ability to provide adequate care to the residents and stated, Staffing here is terrible. I usually have 12-13 residents, that's when there are three of us, but usually there are only two of us. CNA C was asked about the availability of linen and stated, Linen here is terrible. We run out frequently. I work at other facilities and this place is the worst for running out of linen. CNA C was asked, what did they do when a resident has been incontinent of urine and feces and needs a linen change and stated, We do the best we can do. On 11/23/2021 at 8:31 AM, an interview was conducted with midnight shift Nurse E regarding the availability of clean linen for incontinent residents and stated, Linen is a big problem. On 11/23/2021 at 10:47 AM, an interview was conducted with the Nursing Home Administrator (NHA) and a Corporate Advisor (CA J). They were asked about the expectations of caring for incontinent residents and CA J stated, Our expectation is if the resident needs to be changed that they get changed. But if a resident is a two person assist then they have to wait until someone is available to help. The NHA and CA J were asked about the availability of linen at the facility and the NHA stated, Our house keeping supervisor abruptly quit and we told them to fill the two linen rooms and they (the staff) have access to the bigger laundry room that has more shelves. The NHA and CA J was asked about the facility's staffing levels and CA J stated, We offer bonuses for our staff to come in, one of the housekeepers came in this weekend and did laundry all day, I know because I was here. Review of the facility's policy and procedure titled, Urinary Incontinence dated, Revised 11/23/2021 revealed, the timeliness of incontinence care was not addressed.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 36897 This citation pertains to intake #MI00124307. Based on observation, interview and record review the facility failed to provide monitoring and/or supervision to prevent elopement and respond to an alarm sounding door for one Resident (Resident #708) of four residents reviewed for elopement, resulting in immediate jeopardy (IJ) due to the likelihood of serious injury, harm, impairment or death. On 11/12/2021 at approximately 06:31 AM, Resident #708 was witnessed by Resident #711 outside of the facility trying to get back in. Resident #708 had exited the facility from an emergency door, unbeknownst to the staff, dressed in flannel pajama bottoms, a T-shirt, and socks, with an approximate outdoor temperature of 39 degrees Fahrenheit. R708 was cognitively impaired with a known history of exit seeking behavior. At 06:41 AM, Resident #708 was observed by Housekeeper A walking slowly against the wall of the building outside and was brought back into the facility at approximately 06:58 AM. Findings include: On 11/22/2021 at 08:32 AM, Resident #708 was observed awake, lying-in bed. An attempt was made to interview Resident #708; however, they were unable to answer questions appropriately. A record review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #708 was most recently admitted to the facility on [DATE] with the diagnoses of: Cerebral Infarction, Parkinson's Disease and Dementia. Resident #708 required limited assistance with bed mobility, transfers and ambulation, and had a BIMS score of 06 out of 15 (00-07= severe cognitive impairment). A record review of the Progress Notes for Resident #708 revealed the following: 09/05/2021 05:51 PM Res (Resident) A/Ox1-2 (alert and oriented to person and/or place), makes needs known, staff continuously redirecting res to not attempt to stand and ambulate independently, or self transfer, d/t (due to) unsteady gait and weakness. Res continues to attempt to exit building verbalizing .has to get out of here. Res does not listen and is combative with staff when re-directed. Res placed at nurse station for monitoring. 09/14/2021 05:58 PM A/Ox1, able to make needs known. Res continues to wander into inappropriate places and exit seeking, res with undesired sexual behavior toward staff such as hitting staff members on their buttocks. Res consistently attempts to self transfer and/or ambulate independently with unsteady wobbly gait, re-educated res to ask for help when needed, res verbalized understanding. Staff continuously re-directing res to quiet place and to maintain safety, res continues to resist. Res with no pain or discomfort identified. SW (Social Worker) notified. DON (Director of Nursing)/Administer aware. 09/27/2021 01:01 PM SW followed up with resident regarding behaviors- per bx (behavioral) log, resident displayed inappropriate sexual bx and per nurse resident has exit seeking bx as well .Resident is confused and unable to recall what .did over the weekend. Resident is followed by psych services. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11/12/2021 06:54 AM Writer informed that patient was observed outside of the building by staff member (Housekeeper A). Patient was observed on north side believed to have used Emergency exit door to get out and was observed on sidewalk walking. Patient redirected back inside without injury. Writer informed by [Housekeeper A] that patient was seen by her approximately 06:40 am. Patient was wheeled back down to hall. Patient has been up throughout the shift. being directed to sit down throughout shift. Unable to give a time of how long patient was off the floor and outside. Patient was last seen by writer and changed proximately 6 am . DON .Notified. Writer informed to contact the administrator .and to have everyone write a statement and place under door. Patient currently sitting in w/c (wheelchair) up at south nursing station. No further assistance needed at this time. Authored by Nurse K. 11/12/2021 03:12 PM SW called POA (Power of Attorney) .to follow up with facilities . would like me to send referrals to for a transfer. It has been discussed that resident requires a locked unit/memory care facility. POA does not have a preference for facility to send referrals to. SW sent referrals to facilities. 11/15/2021 10:46 AM Res alert/verbal up in w/c self-propelling, exit seeking. Staff continues to re-direct resident to maintain safety . On 11/22/2021 at 11:02 AM, Resident #711 was observed to be dressed and groomed ambulating in the hallway just outside their room. Resident #711's room was located at the end of the north hall with a clear view of the emergency exit door on the north unit. Resident #711 was interviewed in regard to what they saw on the morning of 11/12/2021. Resident #711 had explained that they are a light sleeper and heard noises from outside their room. Resident #711 explained that they got out of bed, walked out of their room and looked across the hall (about 15 feet) and saw that Resident #708 was outside the building looking through the window. Resident #711 was asked what they did when they saw Resident #708 outside and explained that they think they told someone and then went to back to bed. A record review of the MDS dated [DATE] revealed that Resident #711 was admitted to the facility on [DATE] with diagnoses that include Cerebral Infarct and Dementia. The Resident had a BIMS of 03, indicating an impaired cognition and needed limited assistance with bed mobility and transfers. On 11/22/21 at 11:11 AM, the Nursing Home Administrator (NHA) was interviewed in regard to Resident #708 exiting the building on 11/12/2021. The NHA was asked to explain what happened and revealed that she was able to view camera footage of Resident #708 self-propelling themselves from the south unit, heading toward the north side, a Certified Nurse Assistant (CNA) brought the Resident back to the nurses station on the south unit and went to give care to other residents. The NHA further explained that the Resident then self-propelled towards the north unit and sat in front of north station for a couple of minutes, then went down back to the end of north hall where the door then subsequently was opened by Resident #708. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The NHA was asked if there was audio to the camera footage and explained there was not. The NHA stated, There was a red flashing light noticed on camera footage, indicating the door was sounding. The NHA was asked what the staff were doing at the time and explained that Resident #711 was observed to come out of their room, and then go to the north nurse's station (where there were four staff members sitting) to report that Resident #708 was outside. The NHA stated, I could see that [Resident #711] was frustrated that the staff wasn't listening to them. A staff member did get up to respond but then was waved to sit back down by the nurse. Another staff member was on their phone. They were agency staff. We reported their licenses to the board (state board of nursing) and will not allow them back in the building. A request was made to view the camera footage at this time, however the footage was not made available by the end of the survey. A review of the Facility Reported Incident (FRI) packet revealed the following: Incident Summary: Resident found outside the building by staff member. No physical injuries notes. Resident returned safely to building . Camera footage .on 11/12/2021 approximately 06:00 am, [Resident #708] was self propelling in .wheelchair in the facility. The resident is seen rolling .to the North side of the building, and was brought back by a CNA on the South side. Approximately 06:20 AM [Resident #708] is observed propelling .to the North side again. [Nurse L] from .agency, [Nurse M], from .agency and CNA N from . agency can be seen at the North nurses station for approximately 4 minutes before (Resident #708) self propelled down the back end of the North hall. At 06:30 AM [Resident #708] got to the emergency exit door located at the back end of the North hall. [Resident #708] got up from their wheelchair to open the door. The door has an alarm on it, and sounds immediately when attempted to open. The door will not release unless held for 15 seconds. The resident exited the building at 06:31 AM. The door alarm is sounding, which is evident by the red flashing light observed in the video. [Nurse L, Nurse M], and [CNA N] are still sitting behind the North nurses station .[Nurse L, Nurse M], and [CNA N] continue to sit at the North nurses station. Minutes later, [Housekeeper A] . is seen in the building bringing [Resident #708] back to the nurses station . A review of the witness statements revealed the following: Nurse K- .No one can give a clear time of how long patient was outside but that pt (patient) was observed outside approximately 06:40 AM. Nurse P- .observed [R708] being changed between 06:00-06:30 AM .was doing a safety watch on patient at south side nurses station .then observed a staff member wheeling [R708] into the building . CNA O- I was in 112A providing care I didn't see 212B. CNA N- I was walking down the hallway and another worker was bringing the patient back . Nurse M- Resident in room [ROOM NUMBER]-B was last seen by writer by nursing station on north side, after writer was in room [ROOM NUMBER]-A . Nurse L- I observed staff member pushing resident 212B down the hallway stating she observed the resident off the unit . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/22/2021 at 12:00 PM, Nurse K (assigned to Resident #708 on 11/12/2021) was interviewed via phone. Nurse K stated, (Resident #708) was my patient, (Resident #708) was on the south unit. We had three aides and two nurses down there that night. I gave (Resident #708) their 06:00 AM meds and had the aides change them. I had a 1:1 (another resident requiring one to one supervision) at the desk already. Then [Housekeeper A] brought them to me and said they were outside. I went down to the north side and asked them (the staff at the desk) what happened but none of them could tell me what happened. Just [Housekeeper A]. I couldn't hear any alarms because I was on the south unit. On 11/22/2021 at 12:45 PM, Nurse P was attempted to be contacted and interviewed via telephone. No return phone call was received by the end of the survey process. On 11/22/2021 at 12:49 PM, CNA O was attempted to be contacted and interviewed via telephone. No return phone call was received by the end of survey process. A record review of the Physician Orders for Resident #708 revealed the following: 11/12/2021-Elopement: Initiate Elopement Precautions - Take photo of resident and post at units, reception, and other exit areas, as appropriate; Make sure resident has name on band at all times; Check resident whereabouts Q (every) 30 minutes; Initiate wander protection device; etc. On 11/22/21 at 01:30 PM-Resident #708 was observed to be sitting up in their wheelchair in their room. Resident #708 was dressed and groomed. There was no wander device observed on the resident. On 11/22/2021 at 01:58 PM, the NHA was interviewed regarding Resident #708 exiting the building on 11/12/2021. The NHA was asked if the staff at the desk could hear the sounding alarms. The NHA stated, Yes, they just didn't respond. I was livid when I saw the video. Their statements were bogus, they didn't add up. They probably aren't going to talk to you because I reported all their licenses. One of them was on the phone, the other one just waved [Resident #711] off. The NHA was asked when Resident #708 was brought in the building and stated, Around 06:58 AM. The NHA was asked what Resident #708 was wearing and explained that Resident #708 was wearing gripper socks, and red flannel pajamas and a gray shirt. The NHA was asked to clarify the order written for a wander protection device and stated, We don't use a wander guard system (a system that utilizes bracelets to alarm when close to an alarmed door). On 11/22/2021 at 02:17 PM, Housekeeper A was interviewed via telephone and was asked to explain what happened on her way to work on 11/12/2021. Housekeeper A stated, I was pulling into work and saw (Resident #708) literally scaling the walls on the outside of the building. I immediately stopped my car and got out. (Resident #708) was probably seven feet away from the door. When I approached the Resident, they kept telling me, 'It's cold!' They had pajama pants on, a T-shirt and socks on. I walked with them around to the door and brought them in the building. A review of the care plans for Resident #708, revealed there were no care plan initiated for exit seeking behaviors until 11/12/2021. On 11/23/2021 at 10:01 AM a paper was taped to the window at the side of the north emergency exit door that read the following: Please ring doorbell for entry. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility policy titled Elopements (undated) revealed the following: .Staff shall report and investigate if need be all cases of missing residents .Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse .If an employee observes a resident leaving the premises, he/she should: a. Attempt and or to prevent the departure in a courteous manner; b. Get help from other staff members in the immediate vicinity . The Administrator was notified of Immediate Jeopardy on 11/22/21 at 04:01 PM and a plan of correction was requested to remove the immediacy that began on 11/12/2021. The facility provided the following removal plan. Immediate Jeopardy was removed on 11/22/2021 as validated by the team on 11/23/2021. Removal Plan: Issue Cited: The facility failed to provide monitoring and supervision to prevent the elopement of Resident #708 (R708) from an emergency door of the facility. Identification of Residents Affected or Likely to be Affected: While all residents have the potential to be affected, no other residents were identified. [Resident #708] was the only resident that exited the building. Beginning 11/12 - [Resident #708] was immediately put on a one on one. Beginning 11/12- Elopement books were updated. Beginning 11/12 - All residents had an elopement reassessment completed. The residents with high scores had their care plans were updated. Actions to Prevent Occurrence/Recurrence: All door alarms are checked twice daily to ensure the alarm is audible. All staff was in-serviced on elopements. Elopement drills will be done weekly x4, then monthly. Staff were educated on timely response to alarming doors and checking surrounding areas for possible elopement Charge nurse/individual overseeing facility at time of alleged incident will contact Administrator immediately and direct staff to do a head count to ensure all residents are in the building. Date Facility Asserts Likelihood for Serious Harm No Longer Exists: 11/22/2021. Although the immediate jeopardy was removed on 11/22/2021, the facility remained out of compliance at the scope of isolated and a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy, as sustained compliance could not be verified by the State Agency.