STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235266	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Southgate	15400 Trenton Road Southgate, MI 48195

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2732359. Based on observation, interview and record review, the facility failed to verify tube placement and assess gastric residual prior to administering medication one resident (R402) of one resident observed receiving medications via peg tube resulting in the potential for aspiration respiratory compromise.Findings include:On 2/18/26 at 3:55 PM, the surveyor observed Licensed Practical Nurse (LPN) B crush and administer oxycodone 5mg one tab via peg tube to R402.Prior to administering the medication, LPN B did not check for tube placement and did not assess gastric residual.On 2/18/26 at 4:05 PM, LPN B was interviewed about PEG tube protocol. LPN B said they did not check placement or residual at that time because they had checked it earlier in the day and did not believe it needed to be rechecked.On 2/18/26 at 4:20 PM, the Director of Nursing (DON) was interviewed and said that tube placement and residual should be checked every time prior to using the PEG tube for medication or feeding administration. Record review of electronic medical record (EMR) indicated R402 was initially admitted on [DATE] with diagnosis including cerebral infarction (stroke), type II diabetes mellitus, pneumonia, tracheostomy, gastrostomy and adjustment disorder with depression.Review of the 1/2/2026 Minimum Data Set (MDS) assessment indicated R402 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment.Review of facility document titled, Medication VIA Gastrostomy Tube (undated) indicated that tube placement should be checked via auscultation or aspiration.

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
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2732359.Based on observation, interview and record review, the facility failed to ensure staff performed hand hygiene after removal of soiled gloves and prior to donning clean gloves during wound related care for one resident (R402) of three residents observed receiving wound care. This deficient practice had the potential to increase the risk of cross-contamination and infection transmission.Findings include:On 2/18/2026 at 11:20AM, during an observation, Wound Care Nurse (WCN) A cleansed the wound in R402 perineal area. WCN A removed the soiled gloves, applied a clean pair of gloves, and then applied cream to R402's perineal area.No handwashing or use of alcohol-based hand rub (hand hygiene) was observed between glove removal and the application of new gloves.On 2/18/2026 at 12:05 PM, WCN A was interviewed and acknowledged they did not perform hand hygiene after removing the soiled gloves and prior to donning clean gloves to continue wound care.On 2/18/2026 at 12:30 PM, the Director of Nursing (DON) was interviewed and said staff are expected to follow facility policy and perform hand hygiene when providing care. The DON further said the facility policy may need to be more detailed regarding performing hand hygiene more frequently during wound care.Record review of electronic medical record (EMR) indicated R402 was initially admitted on [DATE] with diagnosis including cerebral infarction (stroke), type II diabetes mellitus, pneumonia, tracheostomy, gastrostomy and adjustment disorder with depression.Review of the 1/2/2026 Minimum Data Set (MDS) assessment indicated R402 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment.Policy review of facility policy titled, Hand Hygiene (undated) indicated hand hygiene is the single most important means of preventing the spread of infections. The policy further noted that the use of gloves does not replace handwashing.