STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235354	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Three Rivers	55378 Wilbur Rd Three Rivers, MI 49093

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes #2663418Based on interview and record review, the facility failed to operationalize its abuse policy and procedure for 1 resident (Resident #100) of 5 residents reviewed for abuse, resulting in potential abuse not being reported to the Nursing Home Administrator (NHA) immediately.Findings include:Resident #100Review of an admission Record revealed Resident #100 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease (disease causing progressive decline in cognitive skills), cognitive communication deficit (communication challenge caused by impaired thinking skills), and fracture of nasal bones.Review of a Minimum Data Set (MDS) assessment for Resident #100 with a reference date of 10/29/25, revealed Resident #100 was rarely to never understood and a Brief Interview for Mental Status (BIMS) could not be conducted. Section GG revealed Resident #100 was dependent for rolling in bed and transferring from bed to wheelchair.Review of a Care Plan for Resident #100 with a reference date of 9/18/25 revealed the following focus/goal/interventions: Focus: (Resident #100) is at risk for falls/injury r/t (related to) confusion.h/o (history of) falls, places head on surfaces.intentionally bumping head against dining room table. Goal: (Resident #100) will not sustain serious injury. Interventions: fall mat to floor beside bed.padding on right assist bar on bed.when resident is sitting at table, place an activity pad on table in front of resident.In an interview on 11/17/25 at 11:48am, Registered Nurse (RN) GG reported on 9/10/25 in the morning hours, she noticed a hematoma on Resident #100's forehead, approximately 2x2, and immediately called Unit Manager (UM) U to report the injury of unknown origin. RN GG reported UM U told her the injury was from a fall the resident had approximately 3 weeks earlier. RN GG reported UM U did not come view the injury but based on the telephone conversation, assumed the injury was not new.In an interview on 11/24/25 at 3:15pm, Director of Nursing (DON) B and Nursing Home Administrator (NHA) A reported Resident #100's hematoma reported on 9/10/25, was mistakenly thought to have been from her fall that occurred a few weeks prior. DON B and NHA A confirmed this was an injury of unknown origin that should have been reported NHA A immediately as a potential situation of resident abuse.In an interview on 11/24/25 at 2:24pm UM U reported she received a call regarding a hematoma on Resident #100's forehead but she assumed the injury was from a fall the resident had 3 weeks prior to the call on 9/10/25 and did not go assess the resident. UM U confirmed days later she saw the injury and realized it was new and should have been reported to NHA A immediately as an injury of unknown origin/potential abuse.Review of an Abuse and Neglect Prohibition policy with a reference date of 11/9/24 revealed Policy: Each resident has the right to be free from abuse, mistreatment.G. Reporting and Response: 1. The staff will report all allegations of abuse.to the Administrator immediately.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** This citation pertains to intake #2663418Based on interview, and record review, the facility failed to report injuries of unknown origin to the State Agency in a timely manner for 1 (Resident #100) of 5 residents reviewed for abuse and reporting, resulting in the potential for ongoing mistreatment to go unrecognized.Findings include:Resident #100Review of an admission Record revealed Resident #100 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease (disease causing progressive decline in cognitive skills), cognitive communication deficit (communication challenge caused by impaired thinking skills), and fracture of nasal bones.Review of a Minimum Data Set (MDS) assessment for Resident #100 with a reference date of 10/29/25, revealed Resident #100 was rarely to never understood and a Brief Interview for Mental Status (BIMS) could not be conducted. Section GG revealed Resident #100 was dependent for rolling in bed and transferring from bed to wheelchair.Review of a Care Plan for Resident #100 with a reference date of 9/18/25 revealed the following focus/goal/interventions: Focus: (Resident #100) is at risk for falls/injury r/t (related to) confusion.h/o (history of) falls, places head on surfaces.intentionally bumping head against dining room table. Goal: (Resident #100) will not sustain serious injury. Interventions: fall mat to floor beside bed.padding on right assist bar on bed.when resident is sitting at table, place an activity pad on table in front of resident.In an interview on 11/17/25 at 11:48am, Registered Nurse (RN) GG reported on 9/10/25 in the morning hours, she noticed a hematoma on Resident #100's forehead, approximately 2x2, and called Unit Manager (UM) U to report the injury of unknown origin. RN GG reported UM U told her the injury was from a fall the resident had approximately 2 weeks earlier. RN GG reported UM U did not come view the injury but based on the telephone conversation, assumed the injury was not new.In an interview on 11/17/25 at 11:50am, Certified Nursing Assistant (CNA) N reported she also saw the hematoma on Resident #100's forehead on 9/10/25. CNA N reported she regularly cared for Resident #100 and at times saw her put her forehead down on the table in the dining room but had never seen her do with the degree of force that would be needed to cause that type of injury she had. CNA N reported the hematoma was initially fairly small on 9/10/25 but became more elevated as the day went progressed. CNA N reported she cared for Resident #100 the previous day and did not see any injuries on the resident at that time.In an interview on 11/24/25 at 3:15pm, Director of Nursing (DON) B and Nursing Home Administrator (NHA) A reported Resident #100's hematoma reported on 9/10/25, was mistakenly thought to have been from her fall that occurred a few weeks prior. DON B and NHA A confirmed this was an injury of unknown origin that should have been reported within 24 hours to the State Agency.Review of a Incident Report revealed Resident #100's injury of unknown origin which was first identified on 9/10/25, was reported to the State Agency on 9/15/25 at 1:44pm.Review of an Abuse and Neglect Prohibition Policy with a reference date of 11/9/24 revealed Procedure.G. Reporting and Response.3. The Administrator or designee is responsible for reporting to the State Agency ALL alleged violations .including injuries of unknown origin.b. not later than 24 hours if the events that cause the allegation do not involve abuse or serious injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes #2663418, # 2648487, 2648458, 2645961, and #2671459Based on interview and record review, the facility failed to thoroughly investigate an incident of potential mistreatment for 4 (Resident #100, Resident #102, Resident #104, and Resident #109) of 5 residents reviewed for abuse resulting in the potential for mistreatment to go unrecognized and resolved.Findings include:Resident #100Review of an admission Record revealed Resident #100 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease (disease causing progressive decline in cognitive skills), cognitive communication deficit (communication challenge caused by impaired thinking skills), and fracture of nasal bones (9/18/25).Review of a Minimum Data Set (MDS) assessment for Resident #100 with a reference date of 10/29/25, revealed Resident #100 was rarely to never understood and a Brief Interview for Mental Status (BIMS) could not be conducted. Section GG revealed Resident #100 was dependent for rolling in bed and transferring from bed to wheelchair.Review of a Care Plan for Resident #100 with a reference date of 9/18/25 revealed the following focus/goal/interventions: Focus: (Resident #100) is at risk for falls/injury r/t (related to) confusion.h/o (history of) falls, places head on surfaces.intentionally bumping head against dining room table. Goal: (Resident #100) will not sustain serious injury. Interventions: fall mat to floor beside bed.padding on right assist bar on bed.when resident is sitting at table, place an activity pad on table in front of resident.In an interview on 11/17/25 at 11:48am, Registered Nurse (RN) GG reported on 9/10/25 in the morning hours, she noticed a hematoma on Resident #100's forehead, approximately 2x2, and called Unit Manager (UM) U to report the injury of unknown origin. RN GG reported UM U told her the injury was from a fall the resident had approximately 2 weeks earlier. RN GG reported UM U did not come view the injury but based on the telephone conversation, assumed the injury was not new. RN GG reported it was later determined that Resident #100's hematoma was a new injury, and an investigation was initiated but she was not interviewed.In an interview on 11/17/25 at 11:50am, Certified Nursing Assistant (CNA) N reported she also saw the hematoma on Resident #100's forehead on 9/10/25. CNA N reported she regularly cared for Resident #100 and at times saw her put her forehead down on the table in the dining room but had never seen her do with the degree of force that would be needed to cause that type of injury she had. CNA N reported the hematoma was initially small on 9/10/25 but became more elevated as the day went progressed. CNA N reported she cared for Resident #100 the previous day and did not see any injuries on the resident at that time. CNA N reported she was not interviewed during the investigation.Review of a Provider Progress Note for Resident #100 with a reference date of 9/15/25 revealed .bruising on temporal area up to top of her head where there is a hematoma.this in the stages of healing and is green, purple and an ashen gray in color. The hematoma is approximately 2cm (centimeters) x 1cm in size. Unsure when and how this hematoma formed.In an interview on 11/24/25 at 1:45pm Nurse Practitioner (NP) NN reported Resident #100 had quite a bump on her head when she assessed the resident on 9/15/25. When queried about the injury, NP NN stated we speculated she hit her head on the table because she put her head on the table regularly.Review of a emergency room Physician note for Resident #100 with a reference date of 9/16/25 revealed Chief Complaint: Pt (patient) noted to have large bruise on right side of head. Unknow injury or fall. Also(sic) deformity noted to nose that RN says is not normal.Large, 10cm (centimeter) bruise and contusion on the right-side parietal area into the forehead. There is a 3cm hematoma on the superior edge of the bruise without bogginess. There is a contusion at the bridge of the nose.there is a small nose bone fracture.Resident #102Review of an admission Record revealed Resident #102 was originally admitted to the facility on [DATE] with pertinent diagnosis of: alzheimer's disease (disease causing progressive decline in cognitive skills).Review of a Care Plan for Resident #102 with a reference date of 9/21/25 revealed the following focus/goal/interventions: The resident has a potential (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	communication problem r/t (related to) alzheimer's disease .Goal: The resident will be able to make basic needs known.Interventions: .provide a safe environment.Review of an Incident Report for Resident #102 with a reference date of 9/28/25 revealed Nursing Description: CNA notified this nurse resident had a bruise on left hand middle finger, bruise is 2cm in diameter.Review of a Nursing Note with a reference date of 10/3/25 at 4:38pm revealed Noted bruise to right hand, .Bruise is over the whole backside of right hand.Review of an Incident Report for Resident #102 with a reference date of 10/3/25 revealed Incident Summary: Nurse (name omitted) reported a new bruise on the residents right back of hand to administrator on 10/3/25. It is noted to be suspected new of today.Resident #104Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnosis of: vascular dementia (decline in cognitive function caused by reduced blood flow to the brain).Review of a Minimum Data Set (MDS) assessment for Resident #104 with a reference date of 11/6/25, revealed a Brief Interview for Mental Status (BIMS) assessment was not attempted because the resident was rarely/never understood. Review of a Care Plan for Resident #104 with a reference date of 10/6/25 revealed the following focus/goal/interventions: Focus: The resident has a skin tear of the right forearm. Goal: The resident's skin tear of RFA (right forearm) will be healed.Interventions.Identify potential causative factors and eliminate/resolve when possible.Review of an Incident Report for Resident #104 with a reference date of 10/2/25 revealed Incident Summary: Nurse (name omitted) reported to abuse coordinator a dressing on resident with no orders. Nurse noted dressing to resident's right forearm. No documentation noted in resident's record. Res (resident) has skin tear to right forearm 1.5cm x 2cm.In an interview on 11/20/25 at 7:53am, CNA JJ reported Resident #104 was never physically aggressive during cares and she did not know how the resident received a skin tear on her right forearm.Resident #109Review of an admission Record revealed Resident # 109 was originally admitted to the facility on [DATE] with pertinent diagnosis of: other frontotemporal neurocognitive disorder (a group of brain disorders that cause the gradual deterioration of nerve cells leading to personality, behavior, and language deficits).Review of a Minimum Data Set (MDS) assessment for Resident #109 with a reference date of 10/15/25, revealed a Brief Interview for Mental Status (BIMS) was not completed because the resident was rarely/never understood. Section E revealed the resident displayed no behaviors during the assessment period.Review of a Care Plan for Resident # with a reference date of 10/14/25 revealed the following focus/goal/interventions: Focus The resident has actual impairment of skin integrity of the left hand r/t (related to) bruises.bruises to right eye, bilateral knees and lower extremities, left hip, left hand, right antecubital area (front surface of elbow).Review of a Risk Assessment for Resident #109 with a reference date of 11/2/25 revealed Nursing Description: while changing the pt (patient) CNA saw the swelling and purple eye .unwitnessed injury.In an interview on 11/19/25 at 3:24pm, CNA F reported she cared for Resident #109 during the period in which the resident was discovered to have a bruise around her right eye. CNA F reported the bruises were initially thought be from a fall but that was later found to be incorrect. CNA F reported she was not interviewed if an investigation was conducted regarding the injuries of unknown origin for Resident #109. CNA F reported she had concerns about some staff members handling residents roughly.In an interview on 11/21/25 at 8:24am, CNA Z reported he worked in the memory care area, where Resident's #100, #102 and #109 resided. CNA Z reported he noticed an increased number of resident's with injuries of unknown origin on that unit in recent months. CNA Z reported he had concerns about potential mistreatment and that Resident #100's injury on 9/10/25 was consistent with her falling out of bed and hitting her head. CNA Z stated I wonder if she fell and someone just picked her back up?. CNA Z reported he did not believe the injury she sustained would have happened as the result of the resident hitting her head on the table. CNA Z added that he felt some of the staff who were less familiar with the residents in memory care were struggling to properly care for them. CNA Z reported he was never interviewed about any of the recent injuries of unknown origin.In an interview on 11/24/25 at 10:21am CNA JJ reported she regularly worked on the memory care unit. When queried, CNA JJ reported NHA A did not interview her (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regarding any of the recent resident injuries of unknown origin.In an interview on 11/24/25 at 3:32pm, NHA A reported the facility had 6 instances in which residents suffered injuries of unknown origin between 9/10-11/2/25. When queried regarding the investigation process for these incidents, NHA A reported he took 5 random witness statements for the incident involving Resident #100 but did not interview any staff from the 3rd shift. NHA A reported he had no witness statements regarding the 5 remaining incidents in which residents suffered injuries of unknown origin. NHA A confirmed that the facility did not monitor staff interactions with the residents after the injuries were discovered and no protective measures such as unannounced management visits were provided. When further queried, NHA A reported he did not know if there were any patterns involved in the incidents i.e. the day of week in which they were identified, the time of day they were reported, if the same staff members worked prior to the discovery of the injuries, or if the residents who were injured were on the same staffing assignments.Review of the incidents in which residents suffered injuries of unknown origin between 9/10-11/2/25 revealed: 5 of the 6 incidents occurred on the memory care unit, all residents were severely cognitively impaired, 4 of the 6 incidents occurred on weekend shifts, 5 of the injuries were identified during morning cares.Review of an Abuse and Neglect Prohibition policy with a reference date of 11/6/24 revealed .D. The facility will monitor residents for.bruises/injuries of unknown origin.and trends that may constitute potential abuse and investigate such situations.5. The facility will investigate all patterns, trends or incidents that suggest the possible presence of abuse, neglect.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2671515Based on interview and record review the facility failed to provide appropriate first aid care for a burn for 1 (Resident #103) of 3 residents reviewed for professional standards, resulting in Resident #103 (who suffered a second-degree burn) receiving inappropriate treatment and a potential for worsening of the injury because of the care provided. Findings include:Resident #103Review of an admission Record revealed Resident #103 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: altered mental status (a change in a person's cognitive status), muscle weakness, and cognitive communication deficit (communication challenge caused by impaired thinking skills), and type 2 diabetes mellitus (condition in which the body does not produce enough insulin resulting in high blood sugar levels).Review of a Minimum Data Set (MDS) assessment for Resident #103 with a reference date of 10/1/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 12 /15, which indicated the resident was moderately cognitively impaired.Review of a Care Plan for Resident #103 with a reference date of 11/13/25 revealed the following focus/goal/interventions: Focus: (Resident #103) is at risk for injury from spills of hot liquids r/t (related to) weakness, Goal: (Resident #103) will remain free from complications related to hot liquids through next review. Interventions: Encourage resident to allow staff assistance with hot liquids.Encourage resident to wear clothing protector.treatment to affected area on chest as ordered 11/13/25.Review of an Incident Report for Resident #103 with a reference date of 11/13/25 at 8:00am, revealed Nursing Description: Resident heard yelling oww(sic), I'm in pain.resident had spilled hot coffee on herself.clothing removed and the affected area was rinsed with cold water, aloe burn gel applied to wound.injury type: burn, injury location: chest, 1.3 open injury to chest.In an interview on 11/18/25 at 10:11am, Licensed Practical Nurse (LPN) C reported on 11/13/25 at approximately 8:00am, she was standing at the medication cart, outside Resident #103's room when she heard the resident yelling it hurts, it hurts. LPN C ran into Resident #103's room and found the resident has spilled an entire cup of hot coffee on her chest. While assessing Resident #103, LPN C noted and hand sized reddened area of skin on Resident #103's torso and an open burn approximately the size of a quarter. LPN C reported she removed the residents gown and poured 16oz of cold water on the burn, then left the room and returned with an aloe burn gel that she applied to the affected area before contacting the physician.According to the Burn Institute, first aid for burns includes the following steps, stop the burning process, remove the source of heat .remove all burned clothing .pour cool water over burned area, keep pouring the cool water for at least 3-5 minutes, never put ice or cold water on a burn as it lowers the body temperature and can make the burn worse .do not apply ointments, creams, or salves to wound .cover burn with a soft, clean, dry dressing, bandage or sheet. Seek medical attention as soon as possible. (www.burninstitue.org/fbp/factsheets/firstaid.html) In an interview on 11/18/25 at 3:21pm, Medical Director (MD) MM reported LPN C did not contact him for direction before she applied an aloe burn gel to Resident #103's injury on 11/13/25. MD MM reported he would not have recommended a gel to treat the burn.In an interview on 11/25/25 at 10:24am, Director of Nursing (DON) B reported a nurse should not apply any treatment to an injury without a physician's order to do so, including the burn gel that LPN C applied to Resident #103's injury on 11/13/25.Review of the American Red Cross Burns: How to Help, https://www.redcross.org/take-a-class/resources/learn-first-aid/burns, revealed A burn is a traumatic injury to the skin caused by contact with extreme heat.Thermal (Heat) Burns: 1. Remove any clothing that is not stuck to the burn site. 2. Cool the burn as soon as possible under clean, cool, running water for 20 minutes.5. Leave the burn uncovered.Burn FAQs Should I put butter or cream on a burn? No.Using a greasy substance can seal in the heat and make the burn worse.The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care providers' orders unless they believe that the orders are in error, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	violate agency policy, or are harmful to the patient. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 20717-20719). Elsevier Health Sciences. Kindle Edition.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2663418Based on interview and record review the facility failed to promptly recognize and assess 1 resident (Resident #100) of 3 reviewed for quality of care, resulting in Resident #100, who had new symptoms of unknown head trauma, not being properly assessed for 5 days, and a potential for care needs to go unmet. Findings include:Resident #100Review of an admission Record revealed Resident #100 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease (disease causing progressive decline in cognitive skills), cognitive communication deficit (communication challenge caused by impaired thinking skills), and fracture of nasal bones (9/18/25).Review of a Minimum Data Set (MDS) assessment for Resident #100 with a reference date of 10/29/25, revealed Resident #100 was rarely to never understood and a Brief Interview for Mental Status (BIMS) could not be conducted.Review of a Care Plan for Resident #100 with a reference date of 9/18/25 revealed the following focus/goal/interventions: Focus: (Resident #100) is at risk for falls/injury r/t (related to) confusion.h/o (history of) falls, places head on surfaces.intentionally bumping head against dining room table. Goal: (Resident #100) will not sustain serious injury. Interventions: fall mat to floor beside bed.padding on right assist bar on bed.when resident is sitting at table, place an activity pad on table in front of resident.In an interview on 11/17/25 at 11:48am, Registered Nurse (RN) GG reported on 9/10/25 in the morning hours, she noticed a hematoma on Resident #100's forehead, that was approximately 2x2 in size. RN GG called Unit Manager (UM) U to report it as an injury of unknown origin. RN GG reported UM U told her the injury was from a fall the resident had approximately 3 weeks earlier. RN GG reported UM U did not come assess the injury but based on the telephone conversation, assumed the injury was not new. RN GG reported Resident #100 was not assessed because she was told the injury was not new. RN GG reported it was later determined that Resident #100's hematoma was a new injury.In an interview on 11/24/25 at 2:24pm UM U reported she received a call on 9/10/25 regarding a hematoma on Resident #100's forehead but she assumed the injury was from a fall the resident had 3 weeks prior. In an interview on 11/17/25 at 11:50am, Certified Nursing Assistant (CNA) N reported she also saw the hematoma on Resident #100's forehead on 9/10/25. CNA N reported the hematoma was initially small on 9/10/25 but became more elevated as the day went progressed. CNA N reported she cared for Resident #100 the previous day and did not see any injuries on the resident at that time.Review on an Incident Report for Resident #100 with a reference date of 9/15/25 revealed 9/15/25, 1pm, DON (Director of Nursing) assessed resident and noted a yellow and green bruise to the forehead and rt (right) temple. A raised area at the top of the rt side of head. Nursing and CNA interviews revealed timeline was outside of time related to the fall as previously reports (sic) in correlation with the bruise. Bruise origin unknown and reported to Administrator.Review of a Provider Progress Note for Resident #100 with a reference date of 9/15/25 revealed .bruising on temporal area up to top of her head where there is a hematoma.this in the stages of healing and is green, purple and an ashen gray in color. The hematoma is approximately 2cm (centimeters) x 1cm in size. Unsure when and how this hematoma formed.Review of Provider Progress Notes for Resident #100 revealed no provider assessed the resident between 9/10/25-9/15/25.In an interview on 11/24/25 at 1:45pm Nurse Practitioner (NP) NN reported Resident #100 had quite a bump on her head when she assessed the resident on 9/15/25. NP NN reported at the time, Resident #100 was on a blood thinner. NP NN reported she was not aware of the injury until 9/15/25, 5 days after the injury as first identified. NP NN reported Resident #100 was sent to the emergency room on 9/16/25 for further evaluation after some staff reported the resident was more difficult to arouse.Review of a emergency room Physician note for Resident #100 with a reference date of 9/16/25 revealed Chief Complaint: Pt (patient) noted to have large bruise on right side of head. Unknow injury or fall. Also(sic) deformity noted to nose that RN says is not normal.Large, 10cm (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Three Rivers	55378 Wilbur Rd Three Rivers, MI 49093

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(centimeter) bruise and contusion on the right-side parietal area into the forehead. There is a 3cm hematoma on the superior edge of the bruise without bogginess. There is a contusion at the bridge of the nose.there is a small nose bone fracture.Review of an Unusual Occurrences policy with a reference date of 6/10/21 revealed OVERVIEW: The facility will take the measures necessary to provide residents.with a safe and incident free environment. An incident is an unusual occurrence that happens within the facility that results in.resident harm. Examples of Unusual Occurrences include bruises, hematomas.3. If an unusual occurrence occurs a. immediately assess and treat the resident. b. notify the following individuals as soon as practicable after the incident occurs: i. Physician.

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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 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** This citation pertains to intakes #2658740, #2635653 and #2671515Based on observation, interview, and record review, the facility failed to implement interventions to reduce hazards for 5 residents (Resident #103, Resident #106, Resident #107, Resident #108, and Resident #101) of 5 residents reviewed for accidents, resulting in: 1. Resident #103 suffering a second degree burn when she was provided hot coffee without being assessed for her ability to manage a hot beverage and Resident #106, #107 and #108 being given a hot beverage without being assessed for their ability to safety handle it. 2. Resident #101 experiencing multiple falls due to a lack of monitoring for effectiveness of interventions and modification of interventions.Findings include:Resident #103Review of an admission Record revealed Resident #103 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: altered mental status (a change in a person's cognitive status), muscle weakness, and cognitive communication deficit (communication challenge caused by impaired thinking skills).Review of a Minimum Data Set (MDS) assessment for Resident #103 with a reference date of 10/1/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 12 /15, which indicated the resident was moderately cognitively impaired.Review of a Care Plan for Resident # with a reference date of 11/13/25 revealed the following focus/goal/interventions: Focus: (Resident #103) is at risk for injury from spills of hot liquids r/t (related to) weakness, Goal: (Resident #103) will remain free from complications related to hot liquids through next review. Interventions: Encourage resident to allow staff assistance with hot liquids.Encourage resident to wear clothing protector.Review of a Hot Liquids Guidelines policy with a reference date of 11/13/25 revealed .Initial and Ongoing Assessments: Each resident will be assessed for their ability to handle hot liquids by the admitting nurse during the nursing assessment.MDS Nurse will reassess the resident every quarter and upon any significant change.Determination Categories: Based on these assessments, resident will be categorized as follows:.Clothing Protector- Resident should use a vinyl-backed clothing protector when consuming hot liquids and should have lid for their cup.Review of Hot Liquids Safety Assessments for Resident #103 revealed the resident was assessed on 4/1/25 and again on 11/13/25, which left a 7-month time span in which the resident was not assessed for safety while handling hot liquids.Review of a Hot Liquids Safety Assessment for Resident #103 with a reference date of 11/13/25 revealed 1. RISK FACTORS: a. COGNITION, b. MOOD, c. BEHAVIORS.f. STRENGTH.2. Is a Hot Liquids Safety intervention plan indicated for this resident? A. Yes, see intervention plan below.intervention: Encourage resident to allow staff assistance with hot liquids.Encourage resident to drink hot liquids while sitting at table.Encourage resident to wear clothing protector.Review of an Incident Report for Resident #103 with a reference date of 11/13/25 at 8:00am, revealed Nursing Description: Resident heard yelling oww(sic), I'm in pain.resident had spilled hot coffee on herself.clothing removed and the affected area was rinsed with cold water, aloe burn gel applied to wound.injury type: burn, injury location: chest, 1.3 open injury to chest.During an observation and interview on 11/18/25 at 10:34am, Resident #103 sat in her bed with the head of bed elevated to 30 degrees. A white bandage, approximately 2x2 was present on her upper chest. Resident #103 was alert but when spoken to, only responded by asking the writer's name several times.In an interview on 11/18/25 at 10:11am, Licensed Practical Nurse (LPN) C reported on 11/13/25 at approximately 8:00am, she was standing at the medication cart, outside Resident #103's room when she heard the resident yelling it hurts, it hurts. LPN C ran into Resident #103's room and found the resident has spilled an entire cup of hot coffee on her chest. While assessing Resident #103, LPN C noted and hand sized reddened area of skin on Resident #103's torso and an open burn approximately the size of a quarter. LPN C reported Resident #103 had fluctuating cognitive skills, at times was disoriented and unaware of her surroundings at her baseline.According to the Mayo Foundation for Medical Education (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and Research, 1998-2012, when the first layer of skin has been burned through and the second layer of skin (dermis) also is burned, the injury is called a second-degree burn, blisters develop, skin takes on an intensely reddened, splotchy appearance and there is severe pain and swelling. (www.mayoclinic.com/health/first-aid-burns) In an interview on 11/20/25 at 1:31pm, Registered Nurse (RN) RR reported the facility had zero vinyl backed clothing protectors and the kitchen continued to not provide cup lids on the food carts, despite both items being identified as interventions in the Hot Liquids Safety policy.In an interview on 11/24/25 at 11:46am, MDS Nurse KK reported she was unsure who completed Hot Liquid Assessments but it was not something she had been assigned.In an interview on 11/25/25 at 10:24am, Director of Nursing (DON) B reported it was the expectation that each resident be assessed using the Hot Liquids Safety Assessment upon admission, quarterly and with change of condition. DON B confirmed it was the responsibility of the MDS nurse to complete these assessments. DON B confirmed Resident #103 had not been assessed as required.Resident #106Review of an admission Record revealed Resident # 106 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis or loss of movement of dominant side after a stroke), and patient's noncompliance with other medical treatment and regimen for other reason.Review of Resident #106's care plan revealed no focus/goal/interventions related to his ability to safely manage hot liquids.During an observation and interview on 11/19/25 at 8:40am, Resident #106 sat alone in his room, wearing a hospital gown and no clothing protector, with a cup of hot coffee in front of him on his bedside table. There was no lid on the cup. When queried, Resident #106 reported the coffee was plenty hot. Resident #106 used his left hand to pick up the cup.Review of Resident #106's electronic health record (EHR) revealed no Hot Liquids Safety assessment had been completed at his admission, and none was present as of 11/20/25.Resident #107Review of an admission Record revealed Resident #107 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: Hypertensive Encephalopathy(diagnosed 11/14/25) (brain dysfunction caused by high blood pressure), muscle weakness, cerebral infarction (stroke), attention and concentration deficits following cerebral infarction, and unspecified dementia(diagnosed 11/14/25)(progressive or persistent loss of intellectual functioning).Review of Resident #107 care plan revealed no focus/goal/interventions related to her ability to safely manage hot liquids.During an observation on 11/19/25 at 8:44am, Resident #107 sat alone in her room with a hot beverage in front of her on her bedside table. There was no lid on the cup. Resident #107 was not wearing a clothing protector.Review of Hot Liquids Safety Assessments for Resident #107 revealed the resident had not been assessed for safety since 1/29/25.Resident #108Review of an admission Record revealed Resident # 108 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: traumatic subarachnoid hemorrhage (bleeding into the space around the brain caused by head trauma), and neuropathy (nerve damage that causes pain, numbness and muscle weakness).Review of a Care Plan for Resident #108 with a reference date of 11/15/25 revealed the following focus/goal/interventions: Focus: The resident has limited physical mobility r/t (related to) generalized weakness, intermittent dizziness. Goal: The resident will remain free from complications.Interventions: The resident requires assistance by staff as necessary.During an observation on 11/19/25 at 8:24am, Resident #108 sat alone in her room, wearing a hospital gown and no clothing protector as she sipped a hot beverage from a blue cup. There was no lid on the cup.Review of Resident #108's EHR revealed the resident had not been assessed for safety with hot liquids.Resident #101Review of an admission Record revealed Resident # 101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: traumatic subarachnoid hemorrhage (bleeding into the space around the brain caused by head trauma), difficulty walking, need for assistance with personal care and unspecified dementia (persistent or progressive loss of intellectual functioning).Review of a Minimum Data Set (MDS) assessment for Resident #101 with a reference date of 8/28/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	4/15, which indicated the resident was severely cognitively impaired.Review of a Care Plan for Resident #101 with a reference date of 5/22/25 revealed the following focus/goal/interventions: Focus: (Resident #101) is at risk for falls r/t (related to) cognitive impairment, frequently incontinent, hx (history) of falls, poor safety awareness.Goal: The resident's risk of serious injury will be minimized.Interventions: .bolters (bolsters) to bed to provide tactile border, bowel medication time moved to early in the day(10/3/25).Offer toileting upon rising, before and after meals, at hs (night time) and prn (as needed) in addition to 1-2hr (hour) toileting (10/7/25).Review of Incident Reports for Resident #101 revealed the resident fell 11 times between 8/24/25-11/20/25. 8 of the 11 incident descriptions reflected the resident experienced a fall while trying to complete toileting tasks without staff assistance.During an observation on 11/17/25 at 9:27am, Resident #101 sat alone at the edge of his bed. Resident #101's bed was parallel to an interior wall, to the right of the door, with the head of the bed facing the hallway. Resident #101's bathroom door was directly across from his bed on the opposite wall. The bathroom door opened toward the left, which was also toward the hallway. Upon entering the resident's bathroom, the toilet was to the right of the bathroom door. Entering the bathroom required a right turn.In an interview on 11/24/25 at 10:37am, Durable Power of Attorney (DPOA) PP of Resident #101 reported the resident suffered from longstanding urinary urgency that resulted in him needing to empty his bladder quickly to avoid being incontinent. DPOA PP reported prior to coming to the facility, Resident #101 kept a container nearby that he could use when he needed to empty his bladder because he wanted to avoid having incontinence accidents. DPOA PP reported she was frustrated when she came to visit Resident #101 because his urinal was often not left in reach and despite her telling the staff that he needed his supplies nearby, the issue persisted. When queried about Resident #101's falls, DPOA PP stated I've told them repeatedly that Resident #101 had a balance problem for decades and frequently lost his balance when he turned toward the right. DPOA PP reported she last told staff about Resident #101's balance problems at his care conference in September of this year. DPOA PP confirmed that Resident #101 had to turn right to access his bathroom and it would be worth considering moving him to another room. DPOA PP reported she spent time with Resident #101 several times a week and had witnessed incidents in which the staff didn't offer Resident #101 with assistance for toileting for 3-4 hours at a time.Review of a Care Conference Summary for Resident #101 with a reference date of 9/26/25 revealed Attendance at Meeting: .k. Family.During an observation on 11/24/25 at 2:15pm, Resident #101 was lying in bed with his belongings stored by the head of his bed. No urinal was within reach.In an interview on 11/24/25 at 2:24pm, Unit Manager (UM)/Licensed Practical Nurse (LPN) U reported an intervention for assist with toileting every 1-2 hours was added to Resident #101's care plan on 10/7/25. UM/LPN U confirmed there was no documentation that supported Resident #101 being offered assistance with toileting every hour. UM/LPN U reported she was aware that staff had not complied with this expectation when Resident #101 was visiting with DPOA PP. When queried, UM/LPN U reported she was not aware Resident #101 had a longstanding history of losing his balance when he turned toward the right or a history of urinary urgency. When queried regarding the development of fall prevention interventions, UM/LPN U reported the facility usually did not involve floor staff unless the Interdisciplinary Team (IDT) was struggling to develop ideas.In an interview on 11/24/25 at 12:08pm, Certified Nursing Assistant (CNA) G reported she worked 3rd shift and had noted that Resident #101 needed to use the restroom very frequently. CNA G reported Resident #101 was aware of the need to urinate/have a bowel movement and became upset when he soiled himself. CNA G reported when Resident #101 soiled himself, he would attempt to clean himself up but could not remember to activate the call light and wait for help. CNA G confirmed she was not involved in developing interventions to reduce Resident #101's fall risk.In an interview on 11/24/25 at 11:50am, CNA F reported Resident #101 became stressed when he soiled himself and would attempt to clean himself up. CNA F reported Resident #101 at times appeared to have difficulty urinating when he tried to do so while on the toilet. CNA F also reported she noticed Resident #101 consistently leaned to the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	left when sitting, standing and transferring.In an interview on 11/24/25 at 8:24am, CNA AA reported nursing assistants were not involved in developing care interventions but added that he felt could provide information that would benefit the residents if asked.In an interview on 11/24/25 at 10:21am, CNA JJ stated (Resident #101) does not like to be soiled. If he is wet, he takes off his brief and tries to walk to the bathroom.In an interview on 11/20/25 at 9:25am, CNA P confirmed Resident #101 displayed that it was important to him to be clean and dry because he expressed emotional distress when his brief was soiled.In an interview on 11/24/25 at 3:10pm RN BB reported Resident #101 frequently got up and tried to assist himself to the bathroom if his brief was soiled. RN BB reported sometimes the schedule for checking and changing Resident #101 ran late and he got up on his own.In an interview on 11/25/25 at 4:10pm, DON B reported the facility could not confirm Resident #101 was being assisted with toileting every 1-2 hours per his care plan because the staff had not been asked to document when they assisted him. DON B reported the IDT discussed changing the time Resident #101 received tamsulosin hydrochloride (medication used to treat urinary urgency by relaxing the muscles in the prostate and bladder), which was currently ordered to be given at 6:00pm, but had not done so. DON B reported the facility's pharmacist verified the medication could be given during the day if needed. DON B reported she had no knowledge of Resident #101 having urinary urgency or a longstanding history of losing his balance when he turned toward his right. DON B confirmed Resident #101 was still getting up several times a night to urinate. When further queried, DON B reported if Resident #101 has urinary urgency his care needs related to this issue should be included in his plan of care.Review of Physician Orders for Resident #101 with a reference date of 8/14/25 revealed Resident #101 was prescribed tamulosin HCl 4mg (milligrams) for benign prostatic hyperplasia (non-cancerous enlargement of the prostate causing difficulty starting urination .increased frequency and feeling of incomplete bladder emptying .).In an interview on 11/24/25 at 1:45pm, Nurse Practitioner (NP) NN reported she recently reviewed Resident #101's medications after he had multiple falls. NP NN she had not considered changing medication administration time of Resident #101's tamsulosin hydrochloride because she was unsure if the medication could only be given at night.In an interview on 11/24/25 at 1:17pm, Pharmacist QQ reported the peak time of effective for tamsulosin hydrochloride was 4-6 hours after it was given which would result in the resident feeling a strong urge to urinate. Pharmacist QQ reported if a resident was at high risk for falling, the facility should consider giving the medication during the day.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. Based on interview and record review, the facility failed to ensure 6 staff members (Certified Nursing Assistant (CNA) G, CNA TT, CNA Z, CNA G, CNA UU and Registered Nurse (RN) BB) of 6 staff reviewed for behavioral competency, had the appropriate skills needed to provide care in a manner that supported each resident's psychosocial wellness, resulting in the potential for inappropriate staff to resident interactions, inability of staff to appropriately address residents in psychological distress, unmet care needs, and resident not maintaining or achieving highest practical psycho-social wellbeing. Findings include:In an interview on 11/20/25 at 9:24am, CNA P reported she struggled to successfully care for several residents in the memory care unit of the facility. CNA P reported working in memory care was her least favorite hall because she did not know how to care for the resident's without triggering their stress responses. CNA P stated I say I'm sorry to residents back there more than anywhere else in the building because they get so upset.In an interview on 11/20/25 at 1:58pm, CNA E reported she has worked in memory care for many years. CNA E reported some of the staff did not know how to approach residents in the memory care unit. CNA E reported she regularly saw some staff members triggering residents' stress responses, the resident responding by flailing their arms, banging against things, and she wondered if that was why more residents were being found with injuries of unknown origin.In an interview on 11/21/25 at 8:29am, CNA Z reported several staff members did not seem to have the skills needed to avoid triggering psychological stress responses from the residents. CNA Z reported it was not uncommon for other CNA's to say they were unable to complete personal care for certain residents because the resident became too upset when approached.In an interview on 11/19/25 at 11:32pm, Registered Nurse (RN) GG reported some staff members did not know how to effectively care for residents who were prone to bouts of psychological distress. RN GG reported she witness staff approaching residents in a manner that led to unnecessary emotional distress. RN GG reported the staff members were not acting maliciously, they simple just did not understand how to approach the resident.In an interview on 11/24/25 at 4:10pm, Director of Nursing (DON) B reported staff were expected to have the skills they needed to successfully work in any area of the facility, at any time, including in the memory care unit.In an email on 11/25/25 at 9:17am, verification of staff competencies completed in the last 12 months was requested for 5 staff members, including CNA P, CNA TT and RN BB.In an interview on 11/25/25 at 10:16am, DON B reported it was determined that RN BB, CNA P, and CNA TT had not completed nursing competencies in the last 12 months, including a behavioral health competency. DON B reported CNA Z, CNA UU and RN BB had completed nursing competencies in the last 12 months.Review of the competencies provided for CNA Z, CNA UU and RN BB, revealed the nursing competencies evaluated for these staff members were completed greater than 12 months ago.Review of staffing schedules revealed RN BB, CNA P, CNA G, CNA TT, CNA UU and CNA Z remained actively employed at the facility and provided care throughout the building.Review of a Facility Assessment with a reference date of 8/1/25 revealed INFORMATION ABOUT OUR RESIDENTS:.Severely impairment of cognition=43.5%, .CARE WE OFFER BASED ON OUR RESIDENT'S NEEDS: .care of someone with cognitive impairments, care of individuals with.trauma/PTSD (post-traumatic stress disorder), other psychiatric diagnoses.Training Program Evaluation:.We develop a curriculum and training plan on staff need and resident characteristics. The content at a minimum includes: .dementia management, special needs of residents, caring for resident who are cognitively impaired.cultural competency/trauma informed care.See F610 for additional information.