

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/23/2025
NAME OF PROVIDER OR SUPPLIER  The Orchards at Three Rivers		STREET ADDRESS, CITY, STATE, ZIP CODE  55378 Wilbur Rd Three Rivers, MI 49093	

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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to Intake #2690782Based on interview, and record review, the facility failed to obtain informed consent for psychotropic medications for 1 (Resident #106) of 3 residents reviewed for notification of change resulting in lack of communication and/or education to the resident/resident representative for initiation and/or dose changes of psychotropic medications.Findings include:In an interview on 12/16/25 at 2:34 PM, Family Member HH reported she was not notified regarding changes to Resident #106's medications. Family Member HH stated .He has been put on medications that I knew nothing about . Family Member HH reported she recently learned that Resident #106 had been prescribed and was taking Seroquel (generic name quetiapine - an antipsychotic medication) and they are currently in the process of discontinuing that medication. Family Member HH reported Resident #106 did not take Seroquel prior to his admission to the facility, and stated .I did not know he was on it . Family Member HH reported the facility recently gave her some paperwork with all his medications, and stated .I started going through (the medication list) and wondering what they were . Family Member HH reported she and her daughter began researching the medications and started to question why Resident #106 was on some of the psychotropic medications to begin with.</p> <p>Resident #106</p> <p>Review of an admission Record revealed Resident #106 was a male, originally admitted to the facility on [DATE], with pertinent diagnoses which included: psychotic disorder with delusions due to known physiological condition, depression unspecified, and unspecified dementia unspecified severity with agitation.</p> <p>Review of a Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed a BIMS score of 4 out of a total possible score of 15, which indicated Resident #106 was severely cognitively impaired. The BIMS assessment dated [DATE] revealed a BIMS score of 3 out of a total possible score of 15, which indicated Resident #106 was severely cognitively impaired. The BIMS assessment dated [DATE] revealed a BIMS score of 4 out of a total possible score of 15, which indicated Resident #106 was severely cognitively impaired. The BIMS assessment dated [DATE] revealed a BIMS score of 2 out of a total possible score of 15, which indicated Resident #106 was severely cognitively impaired.</p> <p>Review of a Discontinued Physician Order for Resident #106 revealed, DULoxetine HCl Capsule (an antidepressant) Delayed Release Particles 30 MG (milligrams) Give 1 capsule by mouth one time a day for depression Discontinued Start Date 5/23/2025 End Date 8/14/2025</p> <p>(continued on next page)</p>

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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Active Physician Order for Resident #106 revealed, DULoxetine HCl Capsule Delayed Release Particles 30 MG Give 1 capsule by mouth one time a day for depression related to DEPRESSION, UNSPECIFIED Active Start Date 8/15/2025</p> <p>Review of a Discontinued Physician Order for Resident #106 revealed, Mirtazapine 7.5 MG Give 1 tablet by mouth at bedtime for appetite. Start Date 5/23/2025 End Date 8/14/2025</p> <p>Review of a Discontinued Physician Order for Resident #106 revealed, Mirtazapine Tablet 7.5 MG Give 1 tablet by mouth at bedtime for appetite. Start Date 8/14/2025 End Date 9/25/2025:</p> <p>Review of an Active Physician Order for Resident #106 revealed, Mirtazapine Tablet 7.5 MG Give 1 tablet by mouth at bedtime related to DEPRESSION, UNSPECIFIED. Start Date 9/25/2025</p> <p>Review of a Discontinued Physician Order for Resident #106 revealed, OLANzapine Tablet (an antipsychotic) 5 MG Give 1 tablet by mouth one time a day for anxiety. Start Date 9/15/2025 End Date 10/23/2025</p> <p>Review of an Active Physician Order for Resident #106 revealed, OLANzapine Tablet 5 MG Give 1 tablet by mouth one time a day related to PSYCHOTIC DISORDER WITH DELUSIONS DUE TO KNOWN PHYSIOLOGICAL CONDITION. Start Date 10/24/2025</p> <p>Review of a Discontinued Physician Order for Resident #106 revealed, QUETiapine Fumarate Tablet (an antipsychotic) 25 MG Give 1 tablet by mouth at bedtime for aggression. Start Date 5/22/2025 End Date 8/14/2025</p> <p>Review of a Discontinued Physician Order for Resident #106 revealed, QUETiapine Fumarate Tablet 25 MG Give 1 tablet by mouth at bedtime for aggression. Start Date 8/14/2025 End Date 8/18/25</p> <p>Review of a Discontinued Physician Order for Resident #106 revealed, QUETiapine Fumarate Tablet 25 MG Give 1 tablet by mouth at bedtime related to UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH AGITATION. Start Date 8/18/2025 End Date 9/20/2025</p> <p>Review of a Discontinued Physician Order for Resident #106 revealed, QUETiapine Fumarate Tablet 25 MG Give 0.5 tablet by mouth at bedtime related to PSYCHOTIC DISORDER WITH DELUSIONS DUE TO KNOWN PHYSIOLOGICAL CONDITION Take 12.5 mg po (by mouth) QHS (every bedtime). Start Date 9/29/2025 End Date 12/10/2025</p> <p>In an interview on 12/22/25 at 10:13 AM, Social Worker (SW) J was requested to provide any evidence of signed consent forms for all prescribed doses of Duloxetine HCl, Mirtazapine, Olanzapine, Quetiapine Fumarate for Resident #106. SW J reported there had been a care conference with Resident #106's spouse on 12/4/25 during which the facility informed Resident #106's spouse/guardian about the psychotropic medications Resident #106 was on. SW J reported he didn't think Resident #106's spouse/guardian was fully aware of everything that Resident #106 was taking prior to the care conference meeting on 12/4/25. SW J reviewed Resident #106's electronic medical record and reported he did not see any evidence of signed consent forms for all prescribed doses of Duloxetine HCl, Mirtazapine, Olanzapine, Quetiapine Fumarate for Resident #106 other than the discussion with Resident #106's spouse on 12/4/25.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a follow-up interview on 12/22/25 at 12:30 PM, SW J reported Resident #106 was deemed incompetent on 10/15/25. SW J reported if Resident #106 was severely cognitively impaired at the time he was prescribed psychotropic medications regardless of when he was deemed incompetent, SW J didn't believe Resident #106 should have been able to sign his own consent forms and felt that the facility should have at least discussed his medications with the spouse/guardian so she was aware of what medications Resident #106 was on.</p> <p>In electronic correspondence on 12/22/25 at 11:07 AM, Nursing Home Administrator (NHA) A was requested to provide any and all medication consent forms available for Resident #106 for Olanzapine, Duloxetine, Mirtazapine, and Seroquel (Quetiapine Fumarate).</p> <p>In an interview on 12/22/25 at 3:26 PM, NHA A reported the facility could not find any consents for Resident #106 for the psychotropic medications Duloxetine HCl, Mirtazapine, Olanzapine, Quetiapine Fumarate he was prescribed. NHA A reported the facility had the verbal consent documentation from the care conference held with Resident #106's spouse in December 2025 but that was all.</p> <p>In an interview on 12/22/25 at 3:28 PM, Director of Nursing (DON) B reported any psychotropic medication that is administered should have a consent.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>This citation pertains to Intake # 2670974, 2689916, &amp; 2646054. Based on observation, interview, and record review, the facility failed to ensure a clean, comfortable, homelike environment in 3 of 5 residents (Resident #102, #103, &amp; #108) reviewed for a safe/clean environment, resulting in refusal of care due to uncomfortable water temperatures and dissatisfaction with the living conditions. Findings include: Resident #102</p> <p>Review of an admission Record revealed Resident #102 was a male, with pertinent diagnoses which included Parkinson's disease (a progressive brain disorder affecting movement), major depression, legal blindness, need for assistance with personal care, dementia, and anxiety.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 11/7/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, indicating he was cognitively intact.</p> <p>In an interview on 12/16/25 at 12:50 PM, Resident #102 reported he does not receive his showers as scheduled, partly due to issues with the facility not having enough hot water. Resident #102 reported the issue with the hot water has been going on for .months . Resident #102 reported he is supposed to get a shower twice a week, on Mondays and Fridays. Resident #102 reported he missed one last Friday (12/12/25) because there was no hot water. Resident #102 reported he did receive a shower yesterday, but the water started to get cold about halfway through the shower.</p> <p>Resident #103</p> <p>Review of an admission Record revealed Resident #103 was a female, with pertinent diagnoses which included cerebral palsy (a neurological disorder affecting movement, posture, and coordination), major depression, muscle weakness, and need for assistance with personal care.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 12/3/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, indicating she was cognitively intact.</p> <p>In an observation and interview on 12/16/25 at 12:09 PM, Resident #103 was in bed in her room. Noted significant peeling paint on the wall near her headboard, with a pile of chipped/flaked paint on the floor along the wall behind her bed. Resident #103 reported the facility often does not have hot water in the shower room, or the hot water will run out partway through the shower.</p> <p>In an observation on 12/22/25 at 11:20 AM, Resident #103 was noted in bed in her room. Observed significant amounts of peeling paint on the wall behind Resident #103's headboard, with a visible pile of paint chips and debris on the floor along the wall behind Resident #103's bed.</p> <p>Resident #108</p> <p>Review of an admission Record revealed Resident #108 was a male, with pertinent diagnoses which included diabetes (a chronic condition where blood sugar levels are too high), high blood pressure, and debility (physical weakness).</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of an admission Note for Resident #108, dated 10/16/25 at 7:59 PM, revealed .patient arrived to facility .assisted from car to wheelchair and into room .alert and oriented x 3 .</p> <p>In an interview on 12/16/25 at 3:28 PM, Resident #108 reported concerns with the physical environment while at the facility. Resident #108 reported significant amounts of chipped paint on the walls of his room. Resident #108 reported his room was dirty, and there was a dirty pillow on the floor under his bed when he first admitted .</p> <p>In an observation on 12/17/25 at 1:54 PM, noted the door was open to the Meadow Lane Spa room. Observed the left side of the door frame (near the base) was rusted out with visible pieces of rust and debris on the floor. Observed chipped tile along the wall. Noted a foul odor coming from the spa room and observed a three-compartment hopper which contained bags of trash.</p> <p>In an observation on 12/23/25 at 8:18 AM, noted a flagpole in the front parking area near the main entrance to the facility. Noted the American flag was in poor condition, visibly faded with multiple rips/tears in the fabric of the flag. Observed several discarded rubber gloves laying on the driveway.</p> <p>On 12/22/25 at 10:28 AM, an interview with LPN X found that the 100-hall shower room has shown some hot water issues within the last couple months.</p> <p>On 12/22/25, at 10:53 AM, an interview with Maintenance Director (MD) RR found that there should be enough hot water to maintain shower temperatures. When asked why the complaints regarding hot water are being heard, MD RR stated that he has trained staff that they need to let the water warm up for one minute.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to Intake # 2670974 &amp; 2689916. Based on interview, and record review, the facility failed to ensure showers/baths were provided per resident preference and plan of care in in 4 of 7 residents (Resident #101, #102, #103, &amp; #113) reviewed for showers/bathing, resulting in dissatisfaction with the care provided and the potential for discomfort and feelings of impaired self-worth. Findings include: Personal hygiene affects patients' comfort, safety, and well-being. Hygiene care includes cleaning and grooming activities that maintain personal body cleanliness and appearance. Personal hygiene activities such as taking a bath or shower and brushing and flossing the teeth also promote comfort and relaxation, foster a positive self-image, promote healthy skin, and help prevent infection and disease. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 50742-50744). Elsevier Health Sciences. Kindle Edition. Resident #101 Review of an admission Record revealed Resident #101 was a male, with pertinent diagnoses which included stroke, aphasia (a language disorder that impairs speaking, understanding, reading, and writing), need for assistance with personal care, and muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #101, dated 9/20/25, revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, indicating he had moderate cognitive impairment. Review of a current Care Plan for Resident #101 revealed the focus . The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Right sided hemiplegia (paralysis affecting one side of the body) d/t (due to) CVA (stroke), Right foot drop, Seizures, Impaired Mobility, Right hand contracture . revised 12/19/23, with interventions which included . BATHING/SHOWERING: assist x1 . revised 12/2/25. In an interview on 12/22/25 at 3:27 PM, Resident #101 reported he did not receive his showers as scheduled. Resident #101 reported he did not get two showers per week, which was his preference. Review of a Concern Form for Resident #101, dated 11/12/25, revealed . Resident is not getting his showers in a timely manner. Resident wants his showers on his preferred shower days . Noted the form indicated that the problem was . ongoing . Under the section Facility Response, noted Resident #101 was interviewed about his shower preferences, had his shower schedule updated, and was offered a shower on 11/14/25. Review of an Order Summary Report for Resident #101 revealed the active physician order . SHOWER DAYS: Document in Progress note completed shower/bed bath/refusal and complete weekly skin assessment in (electronic medical record) . every evening shift every Wed (Wednesday), Sat (Saturday) for Shower . with a start date of 4/5/25. Review of the unit Bath Schedule revealed Resident #101 was scheduled to receive baths/showers on Wednesdays and Saturdays, on second shift. Reviewed provided shower documentation for Resident #101 from 11/15/25 to 12/22/25. Noted missed showers (no documentation) on Wednesday 11/26/25, Saturday 12/13/25, and Wednesday 12/17/25. Resident #102 Review of an admission Record revealed Resident #102 was a male, with pertinent diagnoses which included Parkinson's disease, major depression, legal blindness, need for assistance with personal care, dementia, and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 11/7/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, indicating he was cognitively intact. Review of a current Care Plan for Resident #102 revealed the focus . The resident has an ADL (Activities of Daily Living) self-care performance deficit . revised 11/14/25, with interventions which included . BATHING/SHOWERING: Usual performance supervision/touching assistance . revised 12/2/25. In an interview on 12/16/25 at 12:50 PM, Resident #102 reported he does not receive his showers as scheduled, partly due to issues with the facility not having enough hot water. Resident #102 reported the issue with the hot water has been going on for . months . Resident #102 reported he is supposed to get a shower twice a week, on Mondays and Fridays. Resident #102 reported he missed one last Friday (12/12/25) because there was no hot water. Resident #102 reported he did receive a shower yesterday, but the water started to get cold about halfway through the shower. Resident #102 reported he is very particular about his hygiene and doesn't want anyone to think he smells bad. Resident #102 reported the combination of short-staffing, and the lack of hot water has made getting showers as scheduled . difficult . In an interview on 12/17/25 at 10:44 AM, Family Member DD reported Resident #102 does not receive his showers as scheduled. Family Member DD reported they often pick Resident #102 up on Sundays and stated . It's nothing for him to smell nasty and greasy like he hasn't been bathed in days . Family Member DD described an instance where the family gave Resident #102 a shower at</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to Intake # 2677000 &amp; 2693899. Based on interview, and record review, the facility failed to ensure ordered medications were administered timely per physician orders in 2 of 8 residents (Resident #107 &amp; #114) reviewed for quality of care, resulting in a delay of care, and the potential for worsened infection, increased seizure activity, and impaired health status. Findings include: Review of the policy/procedure Medication Administration and General Guidelines, dated 11/2022, revealed .Medications are administered in accordance with written orders of the attending physician .Resident #107 Review of an admission Record revealed Resident #107 was a male, admitted to the facility on [DATE], with pertinent diagnoses which included peripheral vascular disease (a circulatory problem resulting in reduced blood flow to the limbs), heart failure, left foot ulcer, bacteremia (presence of bacteria in the bloodstream), chronic pain, high blood pressure, left leg atherosclerosis (plaque buildup inside the arteries), diabetes, MRSA (methicillin resistant staphylococcus aureus) infection, left lower limb cellulitis (a bacterial skin infection), and sepsis (a serious condition in which the body responds improperly to an infection resulting in potential tissue and organ damage). Noted Resident #107 discharged to the hospital on [DATE]. Review of a Care Plan for Resident #107 revealed the focus .(Resident #107) has a MDRO (Multidrug-Resistant Organism) MRSA (positive) . initiated 10/30/25, with interventions which included .Give antibiotic therapy as ordered . initiated 10/30/25. In an interview on 12/17/25 at 3:52 PM, Licensed Practical Nurse (LPN) E reported she initiated Resident #107's hospital transfer on 10/31/25. LPN E reported Resident #107 complained of severe toe pain, and when she went to assess his foot noted the entire top of his left foot was discolored, and two of his toes had turned black (with the rest being purple). LPN E reported she checked with his admitting nurse from a few days prior, and the discoloration and blackened toes were not present at the time of admission. LPN E reported he had a dose of intravenous (IV) antibiotics scheduled on her shift, but she never administered them because the prescription was never filled by the pharmacy, therefore the medication was not available. Review of an Order Summary Report for Resident #107 revealed the physician order .Ceftaroline Fosamil (antibiotic) Intravenous Solution Reconstituted 600 MG (Ceftaroline Fosamil) Use 600 mg intravenously every 8 hours for MRSA until 11/25/2025 . with a start date of 10/30/25. Review of the October 2025 Medication Administration Record (MAR) for Resident #107 revealed the physician order .Ceftaroline Fosamil Intravenous Solution Reconstituted 600 MG (Ceftaroline Fosamil) Use 600 mg intravenously every 8 hours for MRSA until 11/25/2025 . had missed doses (medication was documented as not given) on 10/30/25 at 11:00 PM, 10/31/25 at 7:00 AM, and 10/31/25 at 3:00 PM (with documentation to see the progress notes). Review of a Nurses Note for Resident #107, dated 10/30/25 at 11:08 AM, revealed .(patient) is on 2 IV antibiotics for MRSA and (left leg) cellulitis .awaiting one from pharmacy .Review of an Orders - Administration Note for Resident #107, dated 10/30/25 at 11:52 PM, revealed Ceftaroline Fosamil Intravenous Solution .Use 600 mg intravenously every 8 hours for MRSA until 11/25/2025 .(pharmacy) stated needs (authorization) due to cost .Review of an Orders - Administration Note for Resident #107, dated 10/31/25 at 6:09 AM, revealed Ceftaroline Fosamil Intravenous Solution .Use 600 mg intravenously every 8 hours for MRSA until 11/25/2025 .(pharmacy) stated they sent cost (authorization) to DON and awaiting response .Review of an Orders - Administration Note for Resident #107, dated 10/31/25 at 3:19 PM, revealed Ceftaroline Fosamil Intravenous Solution .Use 600 mg intravenously every 8 hours for MRSA until 11/25/2025 .on order .Review of a Nurses Note for Resident #107, dated 10/31/25 at 6:20 PM, revealed . Resident c/o (complained of) left foot pain 10/10 pain scale. Upon evaluation the left toes had purple discoloration to 1-4 toes. (Toes) 1 and 3 are turning black. This is advanced discoloration since admission. (Nurse Practitioner) notified and new orders to send to hospital for evaluation .In an interview on 12/18/25 at 9:13 AM, Registered Nurse (RN) V reported Resident #107 was only at the facility for a few days, but during that time frame did not receive any doses of one of his two ordered IV antibiotics (Ceftaroline Fosamil). RN V reported the medication was expensive, and stated, Director of Nursing (DON) B .refused to pay for it . RN V reported after three days of missed IV antibiotics, the nurses began to express concerns that the facility was delaying treatment. RN V stated .You can't admit someone and then refuse to not pay for it (the ordered IV antibiotics) . RN V reported at that point, Administrator A contacted corporate and the facility agreed to pay for the medication. RN V reported the day the IV antibiotics were delivered from the pharmacy, Resident #107 had a change in condition his toes became purple/black and he was sent to the hospital RN V</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/23/2025
NAME OF PROVIDER OR SUPPLIER  The Orchards at Three Rivers		STREET ADDRESS, CITY, STATE, ZIP CODE  55378 Wilbur Rd Three Rivers, MI 49093	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>This citation pertains to Intake # 2670974, 2689916, 2646054, 2639254, &amp; 2693899. Based on interview, and record review, the facility failed to ensure sufficient staffing to meet resident needs in 4 of 6 residents (Resident #102, #103, #108, &amp; #109) reviewed for sufficient staffing and timely response to resident needs, resulting in long call light wait times, missed showers, and the potential for unmet needs. Findings include: Resident #102 Review of an admission Record revealed Resident #102 was a male, with pertinent diagnoses which included Parkinson's disease, major depression, legal blindness, need for assistance with personal care, dementia, and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 11/7/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, indicating he was cognitively intact. In an interview on 12/16/25 at 12:50 PM, Resident #102 reported he does not receive his showers as scheduled, partly due to issues with the facility not having enough hot water. Resident #102 reported he is supposed to get a shower twice a week, on Mondays and Fridays. Resident #102 reported he is very particular about his hygiene and doesn't want anyone to think he smells bad. Resident #102 reported the combination of short-staffing, and the lack of hot water has made getting showers as scheduled difficult. Reviewed provided shower documentation for Resident #102 from 11/15/25 to 12/22/25. Noted a missed shower (no documentation) on Friday 12/5/25. Also, noted Resident #102 did not receive his scheduled shower on Friday 12/12/25 due to a lack of hot water. Resident #103 Review of an admission Record revealed Resident #103 was a female, with pertinent diagnoses which included cerebral palsy (a neurological disorder affecting movement, posture, and coordination), major depression, muscle weakness, and need for assistance with personal care. Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 12/3/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, indicating she was cognitively intact. In an interview on 12/16/25 at 12:09 PM, Resident #103 stated in regard to staffing we have no help in here at all. The aides are great, but they are overworked. Resident #103 reported she experienced long call light wait times, especially on third shift. Resident #103 reported staff will often respond to the call light and turn the light off, saying they will be back later, but they don't come back. Resident #103 reported call light wait times as long as an hour. Resident #103 reported some days she was unable to get up in her power chair because there were not enough staff to assist with the transfer/care. Resident #103 reported there often is not enough staff to get her shower on Tuesday afternoon. Resident #103 reported Administration is aware of the staffing concerns, and stated nothing is being done. In an interview on 12/17/25 at 10:59 AM, Resident #103 reported she did not get her scheduled shower yesterday (Tuesday afternoon) because there were only two aides on the hall. Resident #103 stated Now I have to wait until Saturday. They won't do it today. (If) you miss your shower day you have to wait for the next one. Reviewed provided shower documentation for Resident #103 from 11/15/25 to 12/22/25. Noted missed showers (no documentation) on Saturday 11/29/25 and Tuesday 12/16/25. Resident #108 Review of an admission Record revealed Resident #108 was a male, with pertinent diagnoses which included diabetes, high blood pressure, and debility (physical weakness). Review of an admission Note for Resident #108, dated 10/16/25 at 7:59 PM, revealed patient arrived to facility assisted from car to wheelchair and into room alert and oriented x 3. In an interview on 12/16/25 at 3:28 PM, Resident #108 reported concerns with staffing at the facility. Resident #108 reported concerns with long call light wait times, up to 45 minutes. Resident #109 Review of an admission Record revealed Resident #109 was a female, with pertinent diagnoses which included depression, obesity, high blood pressure, obstructive lung disease, and heart failure. Review of a Minimum Data Set (MDS) assessment for Resident #109, with a reference date of 10/3/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, indicating she was cognitively intact. In an interview on 12/16/25 at 2:18 PM, Family Member II reported the facility was short-staffed and stated They put (Resident #109) in a diaper and told her to go in that. Family Member II reported staff told Resident #109 they were short-handed, and that they would get to her when they could. Family Member II reported Resident #109 often experienced long call light wait times, up to 45 minutes. In an interview on 12/17/25 at 1:46 PM, Registered Nurse (RN) C reported when she arrived for her shift this morning, it was just her and two Certified Nursing Assistants (CNAs) on the hall for the View Unit. RN C reported one of the CNAs was on light duty and could only assist with waters and vital signs. RN C reported the Unit Manager came in around 8:45 AM to cover as a floor nurse. RN C reported there should be a minimum of two nurses and two</p>		

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NAME OF PROVIDER OR SUPPLIER  The Orchards at Three Rivers		STREET ADDRESS, CITY, STATE, ZIP CODE  55378 Wilbur Rd Three Rivers, MI 49093	
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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>This citation pertains to Intake # 2689916. Based on observation, interview, and record review, the facility failed to follow the menu and serve food items from the menu as scheduled, post the current menu for residents to review, and update the menu with changes when they occurred, in 1 of 8 residents (Resident #103) reviewed for food, with the potential to affect all residents who receive meals from the kitchen, resulting in frustration with the food service process and the potential for decreased intake. Findings include: Resident #103</p> <p>Review of an admission Record revealed Resident #103 was a female, with pertinent diagnoses which included cerebral palsy (a neurological disorder affecting movement, posture, and coordination), major depression, muscle weakness, and need for assistance with personal care.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 12/3/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, indicating she was cognitively intact.</p> <p>In an interview on 12/16/25 at 12:09 PM, Resident #103 reported the food served is often inconsistent with the menu posted in the main dining room. Resident #103 reported she often doesn't know what will be served until the meal tray arrives.</p> <p>In an observation on 12/16/25 at 1:26 PM, noted two pages of menus (double-sided copies) posted on the wall of the main dining room. The menu visible on the outside was for Week 4. Note the pages were stapled together and would require a person to flip through the remaining pages to view the menus for Week 1 through Week 3. No dates on menu to indicate if Week 4 was the current week for the menu cycle.</p> <p>In an observation on 12/17/25 at 11:34 AM, noted two pages of menus (double-sided copies) posted on the wall of the main dining room. The menu visible on the outside was for Week 4. Note the pages were stapled together and would require a person to flip through the remaining pages to view the menus for Week 1 through Week 3. No dates on menu to indicate if Week 4 was the current week for the menu cycle.</p> <p>In an observation and interview on 12/17/25 at 11:43 AM, within the main kitchen, Dietary Services Aide MM reported the lunch today was fried chicken, mashed potatoes and gravy and carrots, with rice and pork (leftover from 12/16/25) available as alternate menu items. Observed the stated food items were present in trays on the steam table.</p> <p>In an interview on 12/17/25 at 11:49 AM, Dietary Services Aide MM reported they were currently on the Week 1 menu cycle. The scheduled Week 1 meal for Wednesday (12/17/25) included pork as the main entree. Dietary Services Aide MM reported they served pork yesterday (12/16/25) because they didn't have the chicken that was scheduled for Tuesday (12/16/25). Noted the chicken scheduled to be served on 12/16/25 was supposed to be teriyaki chicken. Dietary Services Aide MM reported they served fried chicken today (12/17/25) because they didn't have any teriyaki sauce.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation on 12/18/25 at 10:50 AM, noted two pages of menus (double-sided copies) posted on the wall of the main dining room. The menu visible on the outside was for Week 4. Note the pages were stapled together and would require a person to flip through the remaining pages to view the menus for Week 1 through Week 3. No dates on menu to indicate if Week 4 was the current week for the menu cycle.</p> <p>In an observation on 12/22/25 at 11:05 AM, noted two pages of menus (double-sided copies) posted on the wall of the main dining room. The menu visible on the outside was for Week 4. Note the pages were stapled together and would require a person to flip through the remaining pages to view the menus for Week 1 through Week 3. No dates on menu to indicate if Week 4 was the current week for the menu cycle.</p> <p>On 12/22/25 at 9:31 AM, an interview with Assistant Manager of Dietary Services (AMDS) PP, regarding menu inconsistency, found that some newer staff have had issues following which week of the menu the facility has been on, and instead have made meals from different weeks. This not only doesn't follow the menu but can change what the kitchen has available to make for the meals on the menu that week.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>This citation pertains to Intake # 2670974, 2689916, 2671774, 2667436, 2646054, 2639254, 2599079, 2693899, &amp; 2693872. Based on observation, interview, and record review, the facility failed to provide adequate portions of palatable food, served at an appetizing temperature in 8 of 9 residents (Resident #102, #103, #105, #108, #109, #110, #111, &amp; #113) reviewed for food quality, resulting in dissatisfaction with the meals served, frustration with the food service process, and the potential for decreased meal intake and weight loss. Findings include: In an interview on 12/17/25 at 10:03 AM, Ombudsman FF reported she had received many complaints from residents and family members regarding the quality of the food served at the facility and small portion sizes.</p> <p>Resident #102</p> <p>Review of an admission Record revealed Resident #102 was a male, with pertinent diagnoses which included Parkinson's disease (a progressive brain disorder affecting movement), major depression, legal blindness, need for assistance with personal care, dementia, and anxiety.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 11/7/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, indicating he was cognitively intact.</p> <p>In an interview on 12/16/25 at 12:50 PM, Resident #102 reported the food served from the kitchen is .terrible . Resident #102 stated .They tried to serve some soup last night that was green . which he refused to eat. Resident #102 reported staff will serve the food and when he asks what it is (because he is visually impaired) the staff don't know what is being served. Resident #102 stated .If they don't know what it is, I'm not going to eat it . Resident #102 the food is often bland and flavorless, and served lukewarm. Resident #102 reported he believes a menu is posted in the dining room, but due to his visual impairment he is unable to read it.</p> <p>In an interview on 12/17/25 at 10:44 AM, Family Member DD reported the food served at the facility is .horrendous . Family Member DD reported at times, the facility serves whatever they have left, describing one time Resident #102 was served Brussel sprouts mixed with black-eyed peas. Family Member DD reported recently Resident #102 was served .something green to eat . and when he asked what it was staff told him they didn't know and to just eat it. Family Member DD reported luckily that day, the facility had hot dogs, so the resident was able to get an alternative food item. Family Member DD stated .Half the time they don't have peanut butter when residents ask for a sandwich. The food is awful .</p> <p>Resident #103</p> <p>Review of an admission Record revealed Resident #103 was a female, with pertinent diagnoses which included cerebral palsy (a neurological disorder affecting movement, posture, and coordination), major depression, muscle weakness, and need for assistance with personal care.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 12/3/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, indicating she was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 12/16/25 at 12:09 PM, Resident #103 reported the portion sizes at the facility are too small and described them as .toddler portions . Resident #103 reported the food is often unrecognizable and described a green soup that was served the night before. Resident #103 reported she refused to eat the soup, and instead requested a peanut butter and jelly sandwich, but was told the kitchen was out of bread. Resident #103 reported the kitchen ended up making her the sandwich using a hamburger bun. Resident #103 reported she was served waffles recently with no syrup .because they didn't have any .</p> <p>In an interview on 12/17/25 at 10:59 AM, Resident #103 reported she was served a pork chop yesterday (Tuesday) for lunch that was dry and tough. Resident #103 reported the lunch was .barely warm . by the time it was served, and stated .but everything is barely warm by the time we get it because we are the last ones served .</p> <p>In an interview on 12/22/25 at 11:20 AM, Resident #103 reported for breakfast that morning she received one piece of French toast and one piece of sausage. Resident #103 reported yesterday they couldn't get coffee at breakfast time, and when she asked about it was told .they didn't make any .</p> <p>In an observation on 12/23/25 at 11:37 AM, a test tray was obtained from the main facility kitchen. Noted the main entree consisted of a breaded pork chop, cheese rice, and spinach and onions, with what appeared to be a chocolate brownie for dessert. Noted the rice was dry/hard and undercooked, and lukewarm. Observed the pork chop was breaded but lacked flavor/seasoning. Observed the brownie was crumbled/dry and served as a pile of broken pieces on the same plate as the main entree.</p> <p>In an observation and interview on 12/23/25 at 12:50 PM, Resident #103 was noted in bed in her room, with her lunch tray on the table in front of her. Resident #103 reported she was unsure what type of meat was served and initially believed it to be chicken. Noted Resident #103's brownie was served on the same plate as the rest of her food, and Resident #103 reported the brownie was dry. Observed Resident #103 had been served mixed vegetables instead of spinach and onions. Resident #103 reported she generally likes spinach when cooked correctly. Observed Resident #103's tray ticket and noted spinach was not listed as a dislike. Resident #103 reported she would have liked to try the spinach and onions, stating .That would have been good . Resident #103 stated her food was .barely warm . Resident #103 reported the meat .doesn't really have much taste . and the rice .is kind of dry but that is the way we usually get it .</p> <p>Resident #105</p> <p>Review of an admission Record revealed Resident #105 was a male, with pertinent diagnoses which included diabetes (a chronic condition where blood sugar levels are too high), heart disease, major depression, anxiety, anemia (a blood disorder resulting in fatigue, weakness, pale skin, and dizziness), kidney disease, and muscle weakness.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 11/17/25, revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, indicating he was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation and interview on 12/16/25 at 12:33 PM, Resident #105 was noted in bed with his lunch tray on the table in front of him. Resident #105 reported the food served .is usually something that you can't recognize . Noted he was served two vegetable burgers and a bowl of soup. Resident #105 stated .It would be nice to have ketchup or something (for the burgers) . No condiments or toppings served with the burgers. Resident #105 ate a spoonful of the soup and stated it was terrible and described the flavor as bitter. Resident #105 reported the portion sizes for the meals are often too small.</p> <p>Resident #108</p> <p>Review of an admission Record revealed Resident #108 was a male, with pertinent diagnoses which included diabetes (a chronic condition where blood sugar levels are too high), high blood pressure, and debility (physical weakness).</p> <p>Review of an admission Note for Resident #108, dated 10/16/25 at 7:59 PM, revealed .patient arrived to facility .assisted from car to wheelchair and into room .alert and oriented x 3 .</p> <p>In an interview on 12/16/25 at 3:28 PM, Resident #108 reported he admitted to the facility around dinner time, and the meal served was .The worst that I have ever eaten . Resident #108 reported he could not finish the meal because .it was terrible . Resident #108 reported the meal served was .some kind of hash that they put together . with poor consistency and no flavor.</p> <p>Resident #109</p> <p>Review of an admission Record revealed Resident #109 was a female, with pertinent diagnoses which included depression, obesity, high blood pressure, obstructive lung disease, and heart failure.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #109, with a reference date of 10/3/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, indicating she was cognitively intact.</p> <p>In an interview on 12/16/25 at 2:18 PM, Family Member II reported the portion sizes for meals were too small, and one day for breakfast Resident #109 was served half a glass of orange juice, a hard-boiled egg, and a piece of toast. Family Member II stated .That is not even enough for a bird . Family Member II reported they questioned the portion sizes and were told that was what was served.</p> <p>Resident #110</p> <p>Review of an admission Record revealed Resident #110 was a female, with pertinent diagnoses which included major depression, anxiety, chronic respiratory failure, diabetes (a chronic condition where blood sugar levels are too high), heart disease, and high blood pressure.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #110, with a reference date of 12/10/25, revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, indicating she had moderate cognitive impairment.</p> <p>In an interview on 12/16/25 at 2:47 PM, Family Member JJ reported the portion sizes for the meals served at the facility are too small, and stated Resident #110 .likes to eat and she needs to eat .</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #111</p> <p>Review of an admission Record revealed Resident #111 was a male, with pertinent diagnoses which included diabetes (a chronic condition where blood sugar levels are too high), high blood pressure, and heart disease.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #111, with a reference date of 12/9/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, indicating he was cognitively intact.</p> <p>In an interview on 12/17/25 at 2:17 PM, Resident #111 reported the food served at the facility is not good and the portion sizes are too small.</p> <p>Resident #113</p> <p>Review of an admission Record revealed Resident #113 was a male, with pertinent diagnoses which included Huntington's disease (a brain disorder causing nerve cells to break down, leading to uncontrolled movements, cognitive decline, and psychiatric issues), dysphagia (difficulty swallowing), anxiety, depression, high blood pressure, muscle weakness, difficulty walking, and need for assistance with personal care.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #113, with a reference date of 11/25/25, revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, indicating he had moderate cognitive impairment.</p> <p>In an interview on 12/17/25 at 4:07 PM, Family Member KK reported concerns with the food served at the facility. Family Member KK reported she has been present when Resident #113 was served his meals, and his portion sizes are too small. Family Member KK reported they specifically requested extra portions because Resident #113 needed the extra food due to his medical conditions, but the kitchen is inconsistent with serving the additional portions. Family Member KK reported at times the kitchen served Resident #113 food that was inconsistent with his ordered diet. Family Member KK reported she is concerned the kitchen is not reading instructions before serving residents and stated .They are just dishing up food and sending it out and it's up to the nursing staff to make sure (Resident #113) is getting what he should get . Family Member KK reported there have been times he was served ground meat for a sandwich with no gravy or sauce (indicating the meat was too dry). Family Member KK reported she requested gravy from the kitchen for Resident #113 and was told they had run out, so she had to moisten the meat with mayonnaise packets.</p> <p>In an interview on 12/17/25 at 12:17 PM, Dietary Services Aide MM reported they are currently out of Magic Cups (a fortified, high-protein frozen dessert) and yogurt. Dietary Services Aide MM reported they are waiting on those items with the next food order.</p> <p>In an interview on 12/18/25 at 9:13 AM, Registered Nurse (RN) V reported concerns with the food at the facility and stated .It's only gotten worse . since the change in facility ownership. RN V reported residents often do not receive ordered diets, supplements are not provided, the food is cold, the portion sizes are small, and the food is sometimes not edible. RN V stated .There will be no magic cups (for days), so supplements are not provided .</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/22/25 at 11:52 AM, an interview with Assistant Manager of Dietary Services (AMDS) PP, found that no residents requested items off the always available menu today for lunch service. When asked what temperatures she would like to see for hot food on the steam table, AMDS PP stated 160 to 180 degrees.</p> <p>On 12/22/25 at 12:46 PM, a regular test tray was plated and placed as one of the first trays on a meal cart going as the last cart to the River unit.</p> <p>On 12/22/25 at 12:52 PM, the meal cart was delivered to the River unit and trays were being passed.</p> <p>On 12/22/25 at 1:06 PM, all trays on the meal cart were passed and the test tray was back in the conference room with the following temperatures noted using a rapid read thermometer: Chicken tenders 104F, Green Beans 113F, and the stuffing was 128F.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to maintain best practices in accordance with professional standards of food service safety. The deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: In an observation and interview on 12/17/25 at 11:43 AM, within the main kitchen, noted Dietary Services Aide MM standing beside the tray line (with lunch service in progress) with no hair net or hair restraint worn. Dietary Services Aide MM reported the lunch today was fried chicken, mashed potatoes and gravy and carrots, with rice and pork (leftover from 12/16/25) available as alternate menu items. Observed the stated food items were present in trays on the steam table.</p> <p>In an observation and interview on 12/17/25 at 11:53 AM, lunch service was in progress for the main dining room. Noted the leftover pork that had been reheated and placed in a tray on the steam table to serve as an alternative menu item. Dietary Services Aide NN reported she was unaware if the leftover pork was properly cooled the day before (12/16/25) and could not provide information related to a cooling log or confirm that temperatures were checked to ensure the pork was cooled properly. Dietary Services Aide MM reported she was not aware of a cooling log or the need to check temperatures when cooling/saving leftover food items. Observed a large puddle of water below a shelf in the dry storage area of the kitchen, along with a bed blanket covering a puddle of water on the floor outside the utility closet (within the kitchen). Dietary Services Aide MM reported there was a leak coming from the utility closet and maintenance staff were notified.</p> <p>In an interview on 12/17/25 at 12:17 PM, Dietary Services Aide MM reported they are currently out of Magic Cups (a fortified, high-protein frozen dessert) and yogurt. Dietary Services Aide MM reported they are waiting on those items with the next food order. Dietary Services Aide MM reported food deliveries are on Tuesdays and Fridays.</p> <p>During a tour of the kitchen on 12/18/25 with Assistant Manager Dietary Services (AMDS) PP the following observations/interviews were conducted:</p> <p>General Cleanliness of the Kitchen</p> <p>At 2:20 PM in the pantry area, it was noted that there was water on the pantry floor underneath the storage racks. AMDS PP reported the water was leaking from the supply closet and maintenance had been notified.</p> <p>At 2:36 PM in the pantry area, it was noted that the leaking water was also now in the middle of the pantry floor.</p> <p>At 2:57 PM in the River Drive nourishment room refrigerator, noted an opened container of honey thickened water that was placed on its side not securely sealed such that the beverage was leaking out onto the bottom shelf of the refrigerator. AMDS PP reported housekeeping or whoever noticed the spillage should have cleaned it up.</p> <p>Handwashing</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In an observation and interview on 2/18/25 at 2:38 PM, observed AMDS PP mop up some of the water on the floor in the pantry area with a mop. She then walked over to the handwashing sink next to the freezer and rinsed her hands for approximately 5 seconds. She did not use soap. AMDS PP reported staff should wash their hands with soap and water for 20 seconds.</p> <p>In an observation on 2/18/25 at 3:16 PM, observed AMDS PP touch her face mask with her hand. She then retrieved some clean trays from the clean side of the dish area and stacked the trays with other clean trays in the clean tray area. AMDS PP did not perform hand hygiene after touching her mask before touching the clean trays.</p> <p>Labeling and Dating of Food Product</p> <p>At 2:20 PM in the pantry area, observed the following items that were opened but were not labeled with an opened or discard date: a box of cornstarch, a bottle of vegetable salad oil, and a container of teriyaki sauce. There was a bag of baking powder that was opened but not securely sealed; the opened and discard dates were rubbed off the label and were illegible. AMDS PP reported opened items should be labeled with an opened and discard date.</p> <p>At 2:32 PM in the freezer, there was a container of a brown frozen product that was not labeled with product identification or a prepared or discard date. AMDS PP reported the item should have been labeled with product identification information as well as the prepared and discard dates. AMDS PP discarded the item.</p> <p>At 2:39 PM in the walk-in cooler, observed the following items that were opened but were not labeled with an opened or discard date: a jar of pickle chips, a jar of enchilada sauce, a container of vinaigrette dressing, a container of coleslaw dressing, a container of mayonnaise, and cooked spinach in serving bowls. There was a container of Worcestershire sauce labeled with a use by date of 10/2025. There was a container of soy sauce that was not securely stored with a lid. There was a container of thawed frozen strawberries with an opened date of 12/7/25 and a use by date of 12/12/25. There was a container of applesauce with an opened date of 12/10/25 and a discard date of 12/16/25. AMDS PP reported opened items should be labeled with an opened and discard date. AMDS PP reported items outside of the use by date should have already been discarded.</p> <p>At 2:57 PM in the River Drive nourishment room, observed the following items that were opened but not labeled with an opened or discard date: an opened container of (beverage brand omitted), an opened container of nectar thickened apple juice and an opened container of honey thickened water. There were portioned cups of chocolate pudding and a fruit fluff dessert that were not labeled with prepared or discard dates. There were several peanut butter and jelly sandwiches that were not labeled with prepared or discard dates.</p> <p>At 3:06 PM in the Meadow nourishment room, noted portioned cups of applesauce and fruit fluff dessert that were not labeled with prepared or discard dates. There were several cheese sandwiches that were not labeled with prepared or discard dates. There was an opened box of nectar thickened fruit punch that was not labeled with an opened or discard date.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>At 3:10 PM in the View nourishment room, noted several cheese sandwiches that were not labeled with prepared or discard dates. The following items were noted to be opened but were not labeled with opened or discard dates: an opened box of nectar thickened apple juice, a container of nutrition supplement (brand name omitted), and a bottle of apple juice.</p> <p>At 3:15 PM, AMDS PP reported everything should be labeled with an opened and a discard date.</p> <p>Nourishment Room Refrigerator Temperatures</p> <p>Review of the View nourishment refrigerator temperature log revealed recorded temperatures above 41 degrees in the AM on 12/4, 12/5, 12/7, 12/9, 12/10, 12/12, 12/13, 12/14, 12/17, 12/18 and in the PM on 12/3, 12/4, 12/6, 12/8, 12/9, 12/10, 12/11, 12/12, 12/13, 12/16, and 12/17.</p> <p>Review of the River nourishment refrigerator temperature log revealed recorded temperatures above 41 degrees in the AM on 12/6, 12/11, 12/12, 12/14 (with a remedy notation of turned down), 12/16, 12/17, 12/18 and in the PM on 12/1, 12/4, 12/5, 12/6, 12/7, 12/8, 12/9, 12/12.</p> <p>In an interview on 12/18/25 at 3:10 PM, AMDS PP reported if the nourishment room refrigerator temperature is above 41 degrees, staff are supposed to call maintenance to look at it. AMDS PP reported she also needed to know why it was so high (referring to above 41 degrees).</p> <p>In an interview on 12/23/25 at 1:04 PM, Maintenance Director (MD) RR reported maintenance did not have any involvement in maintaining the nourishment room refrigerators. MD RR reported maintenance did not get notified if the temperature of the nourishment room refrigerators are above what they should be or if the refrigerator freezes up. MD RR reported he was pretty sure housekeeping was responsible for the refrigerators.</p> <p>In an interview on 12/23/25 at 1:15 PM, Registered Nurse (RN) UU reported whoever remembers during the day and the night are responsible for recording the temp of the nourishment room fridge. RN UU reported if the temperature is above 41 degrees, maintenance should be called to come and check it out and fix it.</p> <p>In an interview on 12/23/25 at 1:22 PM, Dietary and Housekeeping Manager (DHM) VV reported housekeeping didn't do anything with the nourishment room refrigerators except clean them and defrost them. DHM VV reported housekeeping didn't have anything to do with managing the temperature of the nourishment room refrigerators. DHM VV reported if the temperature of the nourishment room refrigerator is too high, items in the refrigerator should be discarded and then the temperature would need to be reset after it was defrosted. DHM VV reported if items in the nourishment room refrigerator are discarded due to high temperature, the facility did not document that anywhere.</p> <p>On 12/22/25 starting at 9:27 AM, an interview with Assistant Manager of Dietary Services (AMDS) PP found that most food items are dated for a three-day discard date.</p> <p>On 12/22/25 at 9:36 AM, observation of the walk-in cooler found three egg salad sandwiches dated 12/16 to 12/18, two unopened bags of cabbage with best by dates of 12/19/25, a container of cooked macaroni dated 12/16 to 12/19, and an open bag of cubed potatoes dated 12/18-12/21. Further review of the walk-in cooler found a half full flat of shell eggs stored on the top shelf over blueberries and an open bag of green onions (that looked brown and slimy in texture).</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 12/22/25 at 9:50 AM, observation of the two-door reach in cooler found two boxes of nutritional shakes, one vanilla with 23 cartons and one chocolate with 20 cartons. A review of the supplements found that they are good for 14 days once thawed. At this time there was no date to indicate how long the vanilla box of shakes had been under refrigeration, however the chocolate box had the date 9-8 written in marker. A review of each box found that the vanilla was delivered on 9/23/25 and the chocolate was delivered on 8/26/25.</p> <p>On 12/22/25 at 10:06 AM, observation of the under-counter freezer found a box of frozen chocolate nutritional shakes with a delivery date of 9/23/25. No other nutritional supplements were observed frozen. The surveyor informed AMDS PP of the expired shakes.</p> <p>On 12/22/25 at 10:24 AM, observation of the River Pantry found a container of, what appeared to be, resident leftovers in a gelato container dated 12/15.</p> <p>According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5&amp;ordm;C (41&amp;ordm;F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety .</p> <p>According to the 2022 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) .</p> <p>On 12/22/25 at 9:38 AM, observation of the walk-in cooler floor found a quarter inch to three quarter inch gap running most of the back floor juncture leaving area for pests to enter and cold air to escape. Further review of the walk-in cooler found accumulation of dirt and debris on bottom wire storage racks and the floor of the unit. Food items such as onions and creamers were found among the debris. Upon leaving the walk-in cooler the handle latch was observed loose and not allowing for a tight seal of the door when held closed. As the surveyor ran their hand along the perimeter of the door, cool air was able to be felt.</p> <p>On 12/22/25 at 9:47 AM, observation of a storage rack at the end of the cooking line found stacked pots and pans. An interview with AMDS PP found that this is where clean pots and pans are stored. Further review of five sheet pans found them with encrusted grease deposits in the seams and corners.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 12/22/25 at 9:53 AM, observation of the kitchen wall, shared with the dining room, found three wall mounted A/C inverter units used to help maintain temperature in the kitchen. Using a flashlight, the inside of these three units were found to have heavy accumulation of black spotted debris. The three units were placed pointing at or near food preparation and serving areas when in operation.</p> <p>According to the 2022 FDA Food Code section 4-602.13 Nonfood-Contact Surfaces. NonFOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues.</p> <p>According to the 2022 FDA Food Code section 6-501.11 Repairing. PHYSICAL FACILITIES shall be maintained in good repair.</p> <p>According to the 2022 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean.</p> <p>On 12/22/25 at 9:58 AM, observation of the dish machine found that the pressure gauge was showing pressure exceeding the manufacture requirement of 15-25 pressure per square inch (psi), listed on the data plate. Unsure of the integrity of the gauge, and interview with Dietary Service Aide (DSA) TT, found that staff mainly look at the temperature gauges on the dish machine and not the pressure gauge in the back top of the machine. When asked if the kitchen had a dish machine thermometer, thermo-tape, or another way to ensure proper working temperatures of the dish machine, DSA TT was not aware of anything they use to test the dish machine to ensure accurate temperatures.</p> <p>According to the 2022 FDA Food Code section 4-302.13 Temperature Measuring Devices, Manual and Mechanical Warewashing. (B) In hot water mechanical WAREWASHING operations, an irreversible registering temperature indicator shall be provided and readily accessible for measuring the UTENSIL surface temperature.</p> <p>According to the 2022 FDA Food Code section 4-501.113 Mechanical Warewashing Equipment, Sanitization Pressure. The flow pressure of the fresh hot water SANITIZING rinse in a WAREWASHING machine, as measured in the water line immediately downstream or upstream from the fresh hot water SANITIZING rinse control valve, shall be within the range specified on the [NAME] ne manufacturer's data plate and may not be less than 35 kilopascals (5 pounds per square inch) or more than 200 kilopascals (30 pounds per square inch).</p> <p>On 12/22/25 at 10:02 AM, observation of the freezer found food stored open and exposed. Boxes of carrots, cookie dough, and spinach were found open to air with no observed covering, wrapping, or sealing of the containers between uses.</p> <p>According to the 2022 FDA Food Code section 3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (4) Except as specified under Subparagraph 3-501.15(B)(2) and in &amp;para; (B) of this section, storing the FOOD in packages, covered containers, or wrappings.</p> <p>On 12/22/25 at 10:12 AM, observation of the dry storage shelf found an open container of Teriyaki marinade, 1/3 gone, and a date of 12/15/25 as opened. Further review of the item found that it requires refrigeration after opening. The surveyor informed AMDS PP and the item was placed to the side.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>According to the 2022 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under &amp;para; (B) and in &amp;para; (C ) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above, except that roasts cooked to a temperature and for a time specified in &amp;para; 3-401.11(B) or reheated as specified in &amp;para; 3-403.11(E) may be held at a temperature of 54C (130F) or above; or (2) At 5C (41F) or less.</p> <p>On 12/22/25 at 9:25 AM, An interview with AMDS PP found that the kitchen was having some plumbing issues the last few days and that they are in the middle of a repair, but currently the water is shut off to the mop sink and one of the two hand sinks in the kitchen. The surveyor was able to observe the hand sink near the cook line and preparation area was currently out of order and not working. Only one hand sink was available for use, near the back dish area. No other alternative means for easily accessible hand washing was set up.</p> <p>On 12/22/25 at 11:32 AM, observation of the only hand sink available for use by kitchen staff found it blocked by wheeled carts. The surveyor moved three carts out of the way to reach the hand sink.</p> <p>On 12/22/25 at 11:59 AM, observation of DSA SS found the staff member wearing artificial nails with no gloves. During tray line DSA SS was observed getting ice, opening cans of pop, and placing drinks for trays as they pass.</p> <p>On 12/22/25 at 12:19 PM, observation of AMDS PP found that she stepped off the serving line, took her gloves off, went to the cook line to help fill items back up on the serving line, put gloves back on, and was not observed washing her hands in between glove changes.</p> <p>On 12/22/25 at 12:30 PM, observation of DSA MM, who was loading trays with desserts onto the steam table so that they could be plated, was observed checking her phone in the kitchen, leaving to go into the dining room, coming back into the kitchen and continuing to load and pass trays without washing her hands.</p> <p>On 12/22/25 at 12:41 PM, DSA MM, was observed running tasks off the line for staff in the dining room and answering her cell phone while on the tray line. No hand washing was observed after these changes in tasks.</p> <p>According to the 2022 FDA Food Code section 2-301.14 When to Wash.FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco products, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>According to the 2022 FDA Food Code section 2-302.11 Maintenance of Fingernails (A) FOOD EMPLOYEES shall keep their fingernails trimmed, filed, and maintained so the edges and surfaces are cleanable and not rough. (B) Unless wearing intact gloves in good repair, a FOOD EMPLOYEE may not wear fingernail polish or artificial fingernails when working with exposed FOOD.</p> <p>According to the 2022 FDA Food Code section 5-205.11 Using a Handwashing Sink. (A) A HANDWASHING SINK shall be maintained so that it is accessible at all times for EMPLOYEE use.(B) A HANDWASHING SINK may not be used for purposes other than handwashing. (C) An automatic handwashing facility shall be used in accordance with manufacturer's instructions.</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>(continued on next page)</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>This citation pertains to intake 2689916. Based on interview, and record review, the facility failed to be administered in a manner that enabled it to use its resources effectively and failed to implement effective corrective interventions for known issues involving staffing and meal service, with the potential to impact all residents who reside at the facility, resulting in insufficient staff to meet resident needs and poor food quality. Findings include: Refer to noncompliance cited at F677, F725, and F804. In an interview on 12/16/25 at 12:09 PM, Resident #103 stated in regard to staffing .we have no help in here at all. The aides are great, but they are overworked . Resident #103 reported she experienced long call light wait times, especially on third shift. Resident #103 reported staff will often respond to the call light and turn the light off, saying they will be back later, but .they don't come back . Resident #103 reported call light wait times as long as an hour. Resident #103 reported some days she was unable to get up in her power chair because there were not enough staff to assist with the transfer/care. Resident #103 reported there often is not enough staff to get her shower on Tuesday afternoon. Resident #103 reported Administration is aware of the staffing concerns and stated . nothing is being done . Resident #103 reported the portion sizes at the facility are too small and described them as .toddler portions . Resident #103 reported the food is often unrecognizable and described a green soup that was served the night before. Resident #103 reported she refused to eat the soup, and instead requested a peanut butter and jelly sandwich, but was told the kitchen was out of bread. Resident #103 reported the kitchen ended up making her the sandwich using a hamburger bun. Resident #103 reported she was served waffles recently with no syrup .because they didn't have any . Resident #103 reported the food served is often inconsistent with the menu posted in the main dining room. Resident #103 reported that she has discussed her concerns with management staff, and nothing has improved. In an interview on 12/17/25 at 10:03 AM, Ombudsman FF reported she had received many complaints from residents and family members regarding the quality of the food served at the facility and small portion sizes. Ombudsman FF reported concerns with staffing and call light response. Ombudsman FF reported issues locating staff when onsite and stated .I've had staff members call and say staffing is an issue . Ombudsman FF reported she has expressed her concerns to the management/administrative staff, and nothing has changed. In an interview on 12/17/25 at 3:52 PM, Licensed Practical Nurse (LPN) E reported concerns with staffing and scheduling at the facility. LPN E reported holes in the schedule often go unfilled. LPN E reported there were times on night shift where there were only two nurses for the entire building. LPN E reported staff were directed not to contact Director of Nursing (DON) B for staffing concerns. LPN E reported on night shift there were times with one nurse covering both the View Unit and the Memory Care Unit, assigned to more than 50 residents. LPN E reported the Memory Care Unit has many residents at risk for falls and often residents with different sleep schedules and stated .It's pretty scary . LPN E reported showers are not completed on a regular basis and stated on the View Unit .Any time we had only two CNAs showers were never done. It is too much . LPN E reported Administrator A and DON B do not put forth an effort to fill open positions on the schedule and expect staff to work short. LPN E stated .They only fill (a hole in the schedule) if they absolutely have to . In an interview on 12/18/25 at 9:13 AM, Registered Nurse (RN) V reported concerns with the food at the facility and stated .It's only gotten worse . since the change in facility ownership. RN V reported residents often do not receive ordered diets, supplements are not provided, the food is cold, the portion sizes are small, and the food is sometimes not edible. RN V reported Administrator A is aware of the food concerns, however, there has been no improvement. RN V stated .There will be no magic cups (for days), so supplements are not provided . In an interview on 12/23/25 at 1:26 PM, Administrator A and DON B reported they were aware of concerns regarding missed showers and were in the process of addressing the issue. Administrator A reported he was aware of the expressed food concerns and reported he fills out concern forms and takes the concerns directly to Dietary Manager VV and her supervisor. Administrator A reported the kitchen (dietary services) was outsourced (contracted with a separate company) on 11/1/25. Administrator A and DON B reported they were aware of the staffing concerns and in the process of addressing the issue. Administrator A reported they are monitoring staffing levels to ensure that they are meeting the required state minimums. Administrator A and DON B reported the lowest staffing they would deem acceptable for day shift would be two CNAs on each unit. DON B reported they did a review of their staffing and acuity and determined the River Unit should have three CNAs, as it has a higher acuity of residents. Inquired about the staffing levels for the River Unit yesterday (12/22/25) on day shift as there was only one CNA on the unit for a period of</p>		