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	03/05/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to A.) operationalize an effective infection control program B.) have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP) C.) follow transmission-based precaution (TBP) and enhanced barrier precautions (EBP) guidelines for 4 (Resident #7, #54, #35, and #87) residents resulting in the potential for the development and transmission of communicable diseases and infections. Findings include: Resident #7 Review of an admission Record revealed Resident #7 was originally admitted to the facility on [DATE] with pertinent diagnoses which included need for assistance with personal care and muscle weakness. Review of Resident #7' Orders revealed, Enhanced Barrier Precautions r/t (related to) tube feeding (delivery of nutrients directly into the gastrointestinal tract through a feeding tube). Start date: 3/3/26. Review of Resident #7's February Treatment Administration Record (TAR) revealed, Enhanced barrier precautions: Providers and staff must wear gown and gloves for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, Device care: central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring dressing. every shift for PU (Pressure ulcer) . During a care observation on 3/05/2026 at 10:33 AM, Registered Nurse (RN) M entered Resident #7's room to provide wound care. RN M washed her hands, and donned (put on) gloves. RN M then cleaned Resident #7's left heel with a gauze and saline, let the heel dry and applied betadine (antiseptic solution) to Resident #7's heel. After completing wound care treatment, RN M repositioned Resident #7 in bed, assessed his oxygen saturation, and placed socks on Resident #7's feet. Noted that RN M was not wearing a gown as she provided the care to Resident #7. During an interview on 3/05/2026 at 11:22 AM, RN M reported Resident #7 was on enhanced barrier precautions, and that she did not think she needed to wear a gown to provide care to Resident #7 if she was not providing care related to his feeding tube. RN M then reported that she probably should have donned a gown either way. RN M reported that over the past weekend, she had sent Certified Nursing Assistant (CNA) DD home because she had come to the facility ill and had been vomiting at work. During an interview on 3/04/2026 at 1:35 PM, Infection Preventionist (IP) D reported that she had (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	been overseeing the Infection Control program at the facility for the last month. IP D provided the facility's Line Listings (List of residents with potential infections) for January 2026, and some of February 2026, and reported she had not yet completed the facility's line listings for the month of February 2026. IP D reported that her process for providing infection surveillance for the facility was to review resident progress notes daily to oversee potential resident infections, but she was not always able to as she was also working as the facility's Director of Nursing (DON) and Unit Manager (UM). IP D was unable to provide any verification of staff education that had been completed in the last year related to infection control. IP D was unable to provide any verification that the facility had been conducting infection control audits that the facility had completed. IP D reported that she had been in the process of trying to educate staff on following transmission based and enhanced barrier precautions but was not able to provide verification of this education. IP D reported that staff were educated on signs/symptoms of illness that would prohibit them from working during orientation. IP D reported if staff were to call in due to illness, the staff member taking the call in was supposed to document the symptoms of the illness so the facility could monitor for potential illness outbreaks at the facility. IP D reported that she thought that Medical Records (MR) C was tracking staff illnesses, and that she had not been overseeing staff call ins when they were sick. IP D reported that she was not sure how often the facility was reviewing the infection control policies or the program. IP D was unable to report which communicable diseases were supposed to be reported to the local/state health authorities, or what the communication protocol for reporting communicable diseases was. IP D was not able to report how the facility's infection control program monitored for early detection of potential infections, how infections were monitored after identification, or how the facility was currently monitoring immunizations of residents. IP D reported the facility had several staff members overseeing the infection control program over the last few months, so there were multiple changes in how the facility had been monitoring and tracking of infections, and the facility was still working on a new process with corporate. During an interview on 3/05/2026 at 11:35 AM, MR C reported that she did monitor staff call ins, but that staff never really tell a reason that they are calling in. MR C reported that if a staff member called in due to an illness, she would let the nursing managers know. MR C reported that she was unaware that CNA DD had been sent home over the past weekend because she was ill. During a follow up interview on 3/05/2026 at 11:36 AM, IP D reported that she had heard that CNA DD had been sent home over the past weekend because she was ill. IP D reported that she had kept an eye on the residents that CNA DD had cared for, but she did not have any documentation regarding this because she was just watching out to see if any residents got sick. Resident #54: Review of Resident #54's admission Record, undated, revealed she was admitted on [DATE] with pertinent diagnoses that included enterocolitis (inflammation of the intestines) due to clostridium difficile (bacteria) and immunodeficiency (immune system is unable to function properly). Review of Resident #54's brief interview for mental status, dated 2/3/26, was scored 9 which reflected she had moderate cognitive impairment. Review of Resident #54's physician orders included an order for Contact Precautions with a start date of 3/2/26 and an end date of 3/4/26. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 03/03/2026 at 10:35 AM, Resident #54's room had a Centers for Disease Control and Prevention (CDC) sign posted on the door that stated, CONTACT PRECAUTIONS (specific precautions intended to prevent the transmission of infectious agents) EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit . Resident #54 reported she was on contact precautions because she had a clostridium difficile infection. During an observation on 03/03/2026 at 11:40 AM, Housekeeping Aide (HA) LL was in Resident #54's room without any personal protective equipment (PPE) on (no gown or gloves) and the contact precaution signage was posted on the entry door of the room. HA LL proceeded to clean throughout the room and in the process HA LL's clothing/body had contacted the resident living environment including Resident #54's bed and trash bin. HA LL with bare hands removed the trash bag from Resident #54's trash bin, placed it in the trash on her cart just outside the resident's room, grabbed a new empty trash bag, reentered the room, replaced the trash bag, exited the room, and started heading down the hall. No gown or gloves were worn by HA LL while in Resident #54's room and upon exiting no hand hygiene was completed. During an observation on 03/03/2026 at 12:55 PM, HA LL entered Resident #54's room that had contact precaution signage posted without putting on any PPE. There was a bin outside the room as well that contained PPE to use before room entry. HA LL proceeded to do various cleaning and contact of room items that included a medical basin, bedding, bedside table, bedside commode, and trash bin. At 1:04 PM HA LL coughed into her right hand inside the resident's room, exited the room, and started pushing the cart down the hall. No gown or gloves were worn by HA LL while in Resident #54's room and upon exiting no hand hygiene was completed. During an observation on 03/03/2026 at 1:05 PM, in the hallway outside of Resident #54's room HA LL was overheard telling another staff member that she didn't know Resident #54 was on contact precautions. Resident #35: Review of Resident #35's physician orders revealed an order dated 3/3/26 that stated, Contact precaution r/t (related to) MRSA (Methicillin-resistant Staphylococcus aureus; a type of bacteria) in urine. Review of Resident #35's urinary tract infection care plan, included an intervention of Contact precautions, dated 3/3/26. During an observation and interview on 03/04/2026 at 8:50 AM, Social Services Staff OO was inside Resident #35's room standing near the foot of the bed. There was contact precaution signage on Resident #35's door which stated, .Put on gloves before room entry.Put on gown before room entry. Social Services Staff OO proceeded to exit the room and reported he didn't put on gown or gloves before entering the room because he didn't touch or provide cares to the resident. Resident #87: Review of Resident #87's physician orders included an order of Enhanced barrier precautions r/t (related to) peritoneal dialysis (a form of dialysis using the abdominal lining to filter and remove (continued on next page)

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	235354	A. Building B. Wing	03/05/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	waste) dated 2/23/26. Review of Resident #87's dialysis care plan, included an intervention, dated 1/22/26, that stated, Enhanced barrier precautions. During an observation and interview on 03/04/2026 at 11:19 AM, Certified Nurse Aide (CNA) AA pushed Resident #87 in her wheelchair from the hallway into her room. Resident #87's room had enhanced barrier precaution (EBP; an infection control strategy used during high-contact care activities) signage posted. No gown or gloves were put on by CNA AA, and she proceeded to transfer Resident #87 from her wheelchair to her bed. CNA AA handled Resident #87's oxygen supplies and switched the resident from her portable oxygen tank to her bedside oxygen concentrator. CNA AA confirmed Resident #87 was on enhanced barrier precautions, she did not wear any gown or gloves during the transfer for Resident #87 and reported nobody did. The posted CDC EBP signage on Resident #87's room entry stated, ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities .Transferring. During an interview on 03/05/2026 at 9:44 AM, Interim DON (IDON) D confirmed if staff entered a contact precaution room they needed to put on a gown and gloves. IDON D confirmed staff would need to put on a gown and gloves before transferring a resident who was on EBP. Review of the Centers for Disease Control and Prevention's resource (www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html), dated 4/2/2024, stated, Contact Precautions require the use of gown and gloves on every entry into a resident's room . Review of the facility's Enhanced Barrier Precautions (EBP) policy, undated, stated, The EBP requires the use of gowns and gloves during high-contact resident care activities .Examples of high-contact resident care activities requiring gown and glove use among residents that trigger EBP use include: .Transferring . The policy also stated, What are the differences between Enhanced Barier Precautions and Contact Precautions? Contact Precautions require the use of gown and gloves on every entry into a resident's room, regardless of the level of care being provided to the resident . During an observation and interview on 3/3/26 at 10:40 AM, Certified Nursing Assistant (CNA) GG sat at a table in the common area while 12 residents were participating with activities. CNA GG was wearing a pink-colored surgical mask below her nose and was coughing. During an interview on 3/03/2026 at 11:07 AM, CNA GG stated, I do not feel good. I feel heavy in my head, my nose is stuffy like a head cold, and I have a sore throat. I did not do a Covid-19 test before I came in or when I came in today. I cannot afford not to be here. I do have sick time I can use. I am working with the residents today. The facility provides masks and I put this one on when I got here today. I have been educated on how to wear the mask. I have never asked the facility what to do if I feel sick and come to work, and the facility has never said what to do if I feel sick and come to work. CNA GG was clearing her throat of phlegm and sniffing her nose. Observed on 3/3/26 at 12:31 PM, CNA GG assisting residents in Meadows (locked unit) dining room/common area eating lunch. CNA GG was wearing a mask and coughing. Observed on 3/3/26 at 12:35 PM, CNA GG was assisting a resident with eating lunch. CNA GG had a mask on and coughing while standing over the resident. (continued on next page)

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	235354	A. Building B. Wing	03/05/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/3/26 at 12:36 PM, Laundry Aide QQ stated she has received information on what to do if she feels sick by contacting the facility and be willing to test for Covid-19 if asked. During an interview on 3/3/26 at 12:39 AM, Nursing Home Administrator (NHA) A stated, If a staff feels sick, they are to notify the nurse manager or DON (Director of Nursing). They are not to come to work if they feel sick or show signs and symptoms of being sick. On 3/3/26 at 1:35 PM, an interview with Maintenance (M) PP found that he flushes the facilities hot water supply weekly by running the fixtures at the end of the loop for a few minutes but does not run the cold. When asked if there is any disinfection sampling that is performed on the water supply, M PP stated there was no sampling being done. On 3/3/26 at 2:33 PM, observation of the View Court Shower room found a spa tub with an accumulation of dust and dead bugs in the bottom of the unit, indicating stagnant water for the hot and cold-water lines feeding the spa. On 3/3/26 at 2:55 PM, an interview with Environmental Services and Dietary Manager (ESDM) R found that the tub is not regularly used. On 3/5/26 at 9:19 AM, observation of the janitors' closet, near the administrator's office, found that the mop sink basin was filled with bags of pop bottles and containers of cleaning products. At this time, an interview with ESDM R found that staff do not use the mop sink and only use the one in the main housekeeping closet. When asked how long that has been going on, ESDM R stated about November. A record review of the provided document entitled Water Management Plan dated March 1, 2024, found that no evidence of an annual review had been performed on the plan and additional review found that the plan states it expires on 03/01/2025. Further review of the document found a page titled General Requirements that states the Water Management Plan (WMP) should have a Program Team to help oversee and carry out the WMP. No documentation of an updated team or meeting minutes were available. A review of page 26 found Control Measures: Hot and Cold Water Systems. The page states under Monitoring: that the facility should Identify dead legs and either remove or drain (identification is key). A review of page 33 found that the facility should Check for Residual (Free) Disinfection (Chlorine) Levels On 3/3/26 at 2:34 PM, observation of the half wall next to the shower found two towels stored on the wall, open and exposed to contamination. On 3/3/26 at 2:47 PM, observation of the Meadow Lane spa room found three towels stored out in the open next to the shower. On 3/3/26 at 2:55 PM, an interview with Environmental Services and Dietary Manager R found that when her or her staff find towels stored open and exposed, they put them in the soiled laundry. On 3/3/26 at 3:32 PM, observation of the basement storage found clean sanitary supplies stored under wastewater lines int he basement. These items were disposable cups and bath tissue.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure an orderly and clean living environment was maintained for 8 (Residents #30, 74, 87, 50, 70, 40, 41, and 2) of 8 residents reviewed for environment resulting in a dirty living environment and being dissatisfied with the level of cleanliness and order.Findings include: Resident #30: Review of Resident #30's Minimum Data Set, dated [DATE], indicated Resident #30 was admitted on [DATE] and her brief interview for mental status score was 13 which indicated she was cognitively intact. During an observation and interview on 03/03/2026 at 10:40 AM, Resident #30 reported that she thought her window glass was cracked and covered in tape. The window glass had an approximately 55-inch-long streak of old dried-up tape and tape residue extending from the top of the window down towards the bottom. Resident #30 reported the tape had been on the window since she was admitted . The window was not shattered but was partially covered in old tape and tape residue.During an observation on 03/04/2026 at 9:29 AM, Resident #30's window presented the same as it did on 3/3/26 at 10:40 AM. Resident #74: During an observation and interview on 03/03/2026 at 10:45 AM, Resident #74's room had a visibly soiled floor. There was paper debris, an unknown dime sized clear plastic lid, what appeared to be food debris of various colors and sizes, and lots of dust and debris heavily located under the bed and on the floor surrounding the bed. The bedside table had white debris across the top left side. Resident #74 appeared somewhat confused and was unable to report the last time the facility had cleaned her room and/or how it made her feel. During an observation on 03/03/2026 at 12:44 PM, Resident #74 was asleep in her room, and the room presented the same as it had on 3/3/26 at 10:45 AM. Resident #87: During an observation and interview on 03/03/2026 at 11:17 AM, Resident #87 was lying in bed in her room. Resident #87 appeared slightly confused and was unable to answer questions about the cleanliness of her room. There was trash/debris on the floor in various areas throughout the room that included in front of dressers, the television, and under the bed. Under Resident #87's bed was a large white crumpled up tissue/wipe along with white and brown debris accumulation. The floor mat next to the bed was visibly soiled with dried stains. There was a large, approximately 10 inches by 5 inches dried-up spill/stain on the floor in front and under the rack holding Resident #87's dialysis (filter blood when the kidneys are no longer able to function properly) equipment. There were trash, dust, and debris under the bed next to hers, but no other resident resided in the room at that time. There was a large gouge on the wall next to Resident #87's bed which measured approximately 5 inches tall and 1 inch wide. (continued on next page)

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	235354	A. Building B. Wing	03/05/2026

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 03/04/2026 at 9:05 AM, Resident #87's room presented the same as it had on 3/3/26 at 11:17 AM with each dirty and/or unorderly area unchanged. During an observation on 03/05/2026 at 9:16 AM, Resident #87's room still had the dried stain on the floor near the dialysis machine, there was debris on the floor, and the floor mat next to the bed was still soiled. Resident #50:Review of Resident #50's brief interview for mental status, dated 2/6/26, was scored 15 which reflected she was cognitively intact.During an observation and interview on 03/03/2026 at 11:54 AM, between Resident #50's window and the bed were three clear plastic bags tied up and on the floor. Resident #50 reported one contained soiled linens and the other two contained trash. Resident #50 reported it bothered her that the trash was still near her bed. On the floor near the trash bags and under the wall vent there was an old paper meal ticket with the date 3/1/2026 on it. There was trash on the floor under the bed, the area surrounding the bed, and in various areas throughout her half of the room. Resident #50 reported the staff would visit her room once a day for cleaning, but felt it required more attention. Resident #50 reported she wished they'd give her a broom so she could take care of it herself. Under Resident #50's roommate's bed there was trash that included a crumpled up used tissue/wipe and other miscellaneous trash and debris. During an interview on 03/04/2026 at 9:32 AM, Resident #50 was in her bed. Resident #50 reported last night staff removed the bagged trash and linens but didn't clean her floors until this morning. Resident #70: During an observation on 03/03/2026 at 12:29 PM, Resident #70's room had trash on the floor in various areas throughout the room. There were broken pieces of grey plastic between the door and his bed. There was white and grey debris on the floor next to the bed, in the middle of the room, and along the walls on the floor. When exiting Resident #70's room, in the hallway outside the room, there was trash on the floor which included brown debris, a hard grey plastic piece approximately the size of a dime, and various other debris. Proceeding down the 200s hall there was a large bundle of dust and debris built up to the size of approximately a golf ball outside of room [ROOM NUMBER]. Further down the hall, at the double doors just past room [ROOM NUMBER] were pieces of shattered grey plastic, small pieces of trash, dust, and debris of various sizes and colors, and a two-inch-long ball of dust/debris. Resident #40:During an observation on 03/04/2026 at 9:41 AM, Resident #40's floor in her room was soiled with spills, trash, and debris. The bedside floor mat was soiled with dried up material and white/brown debris accumulation. One dried up spill on the mat was approximately 3 inches in diameter. Under the bed there was an accumulation of dust and debris, a small disposable plastic medication cup, and what appeared to be a plastic cap. There were trash and debris on the floor in areas along the wall in various areas of the room. During an observation on 03/05/2026 at 9:27 AM, Resident #40 was asleep in bed with the floor mat next to the bed. The floor mat presented the same as it did on 3/4/2026 and remained dirty. The dust, debris and trash remained on the floor mat and under the bed with the exception that the medication cup was no longer present under the bed. Memory Care Unit: (continued on next page)

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	235354	A. Building B. Wing	03/05/2026

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 03/04/2026 at 9:39 AM, in the locked memory care unit at the double doors just before the dining room there was a heavy accumulation of dust and debris on the floor with one dust and debris ball measuring approximately 3 inches long and 1 inch wide. During an observation on 03/05/2026 at 9:24 AM, in the locked memory care unit at the double doors just before the dining room dust and debris accumulation remained as it had on 3/4/2026 at 9:39 AM. During an observation on 03/04/2026 at 9:47 AM, the dining room of the memory care unit had a heavy accumulation of dust, trash and debris in the corner behind the decorative tree. In various areas, along the floor and wall, there were areas of debris accumulation. During an observation on 03/05/2026 at 9:26 AM, the dining room of the memory care unit had a heavy accumulation of dust, trash and debris in the corner behind the decorative tree. In various areas, along the floor and wall, there were areas of debris accumulation. During an observation on 03/04/2026 at 9:54 AM, the two wall mounted fans in the hallway of the memory care unit with the resident's rooms had built up grey dust/debris on the fans' blade guards. In various areas of the hallway there was dust and debris accumulation on the floor in the areas closest to the walls. During an observation on 03/05/2026 at 9:29 AM, the wall mounted fans in the hallways of the memory care unit still had heavy accumulation of grey dust/debris on the fans' blade guards. During a confidential resident council meeting on 03/04/2026 at 1:10 PM, 3 out of 5 residents in attendance voiced their rooms and shared spaces weren't consistently kept clean. 2 out of 5 residents reported their bedding wasn't changed frequently enough. During an interview on 3/5/2026 at 10:56 AM, Ombudsman V reported facility cleanliness has been an ongoing concern that she has received complaints on. Ombudsman V reported in September 2025, October 2025, December 2025, and February 2026 she had received concerns submitted by both residents and families about facility cleanliness. Review of the facility's Daily Cleaning Procedures policy, undated, stated, Routine cleaning for each housekeeper and included a map which indicated one housekeeper was responsible for approximately half the building and the other housekeeper was responsible for the other half.Applying the reasonable person concept, an individual living at the nursing home would not want to live in a dirty environment. Many residents due to medical condition and/or impaired cognition were unable to respond with how the facility's state of uncleanliness impacted them. Resident #41 Review of an admission Record revealed Resident #41 was a female, with pertinent diagnoses which included dementia, need for assistance with personal care, depression, cognitive communication deficit (impaired communication due to underlying cognitive issues), and muscle weakness. Noted Family Member U was Resident #41's Power of Attorney (POA) for care, first emergency contact, and responsible party. In an interview on 3/3/26 at 8:00 AM, Family Member U reported concerns with housekeeping services at the facility and dirty resident rooms. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 3/3/26 at 2:07 PM, Resident #41 was sitting on the edge of her bed, in her room. Noted a padded floor mat along the right side of Resident #41's bed, with visible crumbs/debris in the cracks/seams of the mat. Noted a trash can nearby with several pieces of trash on the floor (including a plastic beverage cup and two empty medication cups). In an observation on 3/4/26 at 1:03 PM, Resident #41 was lying in her bed in her room. Noted a padded floor mat along the right side of Resident #41's bed, with visible crumbs/debris in the cracks/seams of the mat. Resident #2 Review of an admission Record revealed Resident #2 was a female, with pertinent diagnoses which included neurocognitive disorder (a brain condition involving a decline in cognitive function), anxiety, depression, aphasia (impaired ability to understand or produce speech), dementia, cognitive communication deficit (impaired communication due to underlying cognitive issues), and muscle weakness. In an observation on 3/4/26 at 12:26 PM, Resident #2 was noted in her bed in her room, with her head of bed elevated, eating her lunch meal. Noted that the right side of Resident #2's bed was positioned along the wall. Observed several small, brown stains/spots on the wall alongside Resident #2's bed. In an observation on 3/4/26 at 12:19 PM, observed the shared bathroom between room [ROOM NUMBER] and room [ROOM NUMBER]. Noted urine in the toilet bowl (unflushed). Observed a splattered brown substance on the back surface of the toilet bowl and the backside of the toilet seat. Observed dust/debris around the perimeter of the bathroom and noted that the bathroom floors appeared sticky/tacky when walked on. Observed grip strips on the floor in front of the toilet in poor condition, with sections torn and peeling off of the floor. Noted the caulk around the base of the toilet was in poor condition, with some sections of caulk peeling up and some missing altogether. No staff or residents present at this time. In an observation on 3/4/26 at 12:22 PM, observed room [ROOM NUMBER]. Noted grip strips along the side of bed two (near the window) which were in poor condition with sections visibly torn and peeling away from the floor. Observed a dried spill on the floor in front of the dresser near the foot of bed two. Noted visible dust/debris around the perimeter of the room and under bed two, along with multiple small pieces of trash/paper. No staff or residents present at this time. In an observation on 3/4/26 at 12:23 PM, observed the shared bathroom between room [ROOM NUMBER] and room [ROOM NUMBER]. Noted urine and some toilet paper in the toilet bowl (unflushed). Observed a brown smear on the front of the toilet seat, with additional brown splatter visible within the toilet bowl. Observed dust/debris around the perimeter of the bathroom and noted that the bathroom floors appeared sticky/tacky when walked on. Observed grip strips on the floor in front of the toilet in poor condition, with sections torn and peeling off of the floor. Noted darkened buildup around the base of the toilet. No staff or residents present in bathroom at this time. During an observation on 3/03/2026 at 11:30 AM, the resident shared bathroom between rooms [ROOM NUMBERS] had splatters of brown substances resembling fecal matter on toilet seat, floor, and toilet bowl. During an observation on 3/03/2026 at 11:35 AM, the resident shared bathroom for rooms [ROOM (continued on next page)

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	03/05/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NUMBERS] had dried and partially wet brown substance resembling fecal matter on toilet bowl. During an interview on 3/03/2026 11:41 AM, Certified Nursing Assistant (CNA) Z reported the resident in room [ROOM NUMBER] had to be supervised to use the bathroom. CNA Z reported earlier that morning she had walked the resident in room [ROOM NUMBER] into the bathroom and helped him sit down on toilet then left him there to give him privacy. CNA Z further reported she did not go back in to help him clean up, pull his pants up, or walk out of bathroom, stating, He did that on his own. During an interview on 3/3/26 at 11:50 AM, Housekeeping MM stated, Me and my coworker (Housekeeping LL) work for an environmental cleaning agency The two of us clean all the rooms here at the facility daily (census 3/3/26 97 residents). The two of us clean all the rooms then go to Meadows (locked unit) to clean. We split that unit. Neither one of us have been to the locked unit yet today. I don't know when we will get there today or if we will. When a resident has a bowel movement or urine that goes on the floor or all over the toilet, the CNAs are to clean it and then housekeeping is to disinfect it. If the toilet has bowel movement on it or urine on the floor, we tell the CNAs and wait for them to wipe it up then we go behind them to disinfect the area. During an observation on 3/5/26 at 10:16 AM, the shared bathroom serving rooms [ROOM NUMBERS] revealed dirt and debris around the base of the toilet and along the baseboard of the room. The room smelled of stale urine and the floor was sticky. On the outside of the toilet seat, on the wall behind the toilet and immediately next to the toilet was a splattering of dried brown substances resembling fecal matter. During an observation on 3/25/26 at 10:19 AM, the shared bathroom serving rooms 121-123 revealed dirt and debris around the base of the toilet and along the baseboard of the room. The room smelled of stale urine and the floor was sticky. On the inside of the toilet bowl, on the wall behind the toilet and immediately next to the toilet was a splattering of dried brown substances resembling fecal matter. Two of the three grip strips on the floor immediately to the front of the toilet were peeled off leaving a residue and no grip. The toilet tank was cracked and the substance used to repair it was dirty and peeling. The nightlight that was recessed in the wall had flakes of rust and paint along with dirt and debris. On 3/3/26 at 2:32 PM, observation of the View Court Spa room found dust and dead bugs in the bottom the spa tub and an accumulation of brown crusted debris on the seat of the shower chair. Further review of the room found dozens of small slab ants on the floor of the spa room coming from behind the toilet and the floor juncture near the shower. On 3/3/26 at 2:46 PM, observation of the Meadow Lane shower room found an accumulation of white wet debris on the top of the shower chair resembling toilet paper. On 3/5/26 at 9:07 AM, an interview with Environmental Services and Dietary Manger R found that housekeeping does a deep clean of the spa rooms daily, while nursing staff should keep the spa rooms tidy between residents.

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	235354	A. Building B. Wing	03/05/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% in 2 of 4 residents (Resident #33 and #54) reviewed for medication administration, when wrong dosages of medications were administered, and medications that were not to be crushed were administered crushed, resulting in the potential for adverse medication side effects. Findings include:Resident #33 Review of an admission Record revealed Resident #33 was a female, with pertinent diagnoses which included heart failure, diabetes, heart disease, cognitive communication deficit (impaired communication due to underlying cognitive issues), anemia (a deficiency of healthy red blood cells or hemoglobin), depression, high blood pressure, kidney failure, and muscle weakness. In an observation and interview on 3/4/26 at 9:03 AM, Licensed Practical Nurse (LPN) I prepared scheduled medications for Resident #33. LPN I reported Resident #33 takes all her medications crushed in pudding due to difficulty swallowing pills. Observed LPN I prepare one tablet of Vitamin D3 125 mcg (micrograms) (which was equivalent to 5,000 International Units), one Metoprolol Succinate ER (Extended Release) 25 mg (milligrams) tablet, two Vitamin B-12 500 mcg tablets, one Imipramine HCl 50 mg tablet, and one Potassium Chloride ER 20 mEq (milliequivalent) tablet for Resident #33, crush the medications, mix the medications in pudding, and administer the medications to Resident #33 while she was seated in the dining area on the memory care unit. Review of an Order Summary Report for Resident #33 revealed the active physician order .Cholecalciferol (Vitamin D3) Tablet 1000 UNIT Give 2 tablet by mouth one time a day for supplement give 2000 units (50 mcg) TOTAL . with a start date of 12/27/25. Noted the Vitamin D3 administered to Resident #33 by LPN I on 3/4/26 at 9:03 AM was administered at the wrong dosage. Review of an Order Summary Report for Resident #33 revealed the active physician order .Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG Give 1 tablet by mouth one time a day for HTN (high blood pressure) . with a start date of 9/26/25. Review of an Order Summary Report for Resident #33 revealed the active physician order .Cyanocobalamin (Vitamin B-12) Tablet 500 MCG Give 1 tablet by mouth one time a day for supplement . with a start date of 1/9/26. Noted the Vitamin B-12 administered to Resident #33 by LPN I on 3/4/26 at 9:03 AM was administered at the wrong dosage. Review of an Order Summary Report for Resident #33 revealed the active physician order .Imipramine HCl Oral Tablet 50 MG (Imipramine HCl) Give 1 tablet by mouth one time a day for antidepressant related to DEPRESSION . with a start date of 9/26/25. Review of an Order Summary Report for Resident #33 revealed the active physician order .Potassium Chloride Crys (Crystals) ER Oral Tablet Extended Release 20 MEQ (Potassium Chloride Microencapsulated Crystals ER) Give 1 tablet by mouth one time a day for low potassium . with a start date of 10/11/25. Review of an Order Summary Report for Resident #33 revealed the active physician order .OK to crush allowable medications and administer together . dated 12/28/25. In an interview on 3/4/26 at 12:15 PM, Registered Nurse (RN) H reported nurses are to use their professional knowledge and judgement when deciding whether or not medications can be crushed. RN H reported residents have physician orders to crush allowable medications. RN H reported if the medication ordered is not able to be crushed, nurses should either leave those medications to the side and administer them whole or contact the physician to change the order or get a different version of the medication. RN H reported both Metoprolol ER and Potassium Chloride ER should not be crushed for administration. RN H reported there is a powdered (immediate-release) form of Potassium Chloride available if a resident is unable to swallow the extended-release tablet. In an interview on 3/5/26 at 8:31 AM, LPN I reported extended-release medications should not be crushed for administration. LPN I reported Resident #33's medications (including the extended-release medications) are crushed for administration due to difficulty swallowing pills. LPN I reported the physician was previously notified and gave orders to crush all of Resident #33's medications, even those that should not be crushed per pharmacy recommendations. In an interview on 3/5/26 at 8:48 AM, requested information from Unit Manager F regarding Resident #33's medication orders and any (continued on next page)

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	235354	A. Building B. Wing	03/05/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation that the physician was notified and gave orders/approval to crush Resident #33's medications (including those that should not be crushed per pharmacy recommendations). No documentation provided prior to survey exit that the physician gave orders/approval to crush Resident #33's extended-release medications. In an interview on 3/5/26 at 9:11 AM, Unit Manager F reported he spoke with the physician regarding the crushed extended-release medications for Resident #33, with new orders obtained to discontinue the Metoprolol ER 25 mg tablet and dissolve the Potassium Chloride ER in water prior to administration. In an interview on 3/5/26 at 11:44 AM, Pharmacist T reported the general rule of thumb is that extended-release medications should not be crushed prior to administration. Pharmacist T verified Metoprolol ER should not be crushed, and that there is an alternative form available (Metoprolol Tartrate) that would be able to be crushed. Pharmacist T verified Potassium Chloride ER should not be crushed, and that there is an alternative form available (dissolvable packet). Pharmacist T reported Imipramine HCl 50 mg tablets are also not recommended to be crushed, and that there is an alternative liquid formulation available. Resident #54 Review of an admission Record revealed Resident #54 was a female, with pertinent diagnoses which included protein-calorie malnutrition (a deficiency in caloric and/or protein intake leading to severe metabolic dysfunction, muscle wasting, and weakened immunity), kidney failure, and anemia. In an observation on 3/4/26 at 8:19 AM, LPN N prepared scheduled medications for Resident #54. Observed LPN N prepare one tablet of Ferrous Sulfate 325 mg (65 mg of elemental iron) and administer the medication to Resident #54 in the resident's room. Review of an Order Summary Report for Resident #54 revealed the active physician order .Ferrous Sulfate ER Oral Tablet Extended Release 45 MG (Ferrous Sulfate) Give 1 tablet by mouth one time a day for Supplement . with a start date of 1/31/26. Noted the Ferrous Sulfate administered to Resident #54 by LPN N on 3/4/26 at 8:19 AM was administered at the wrong dosage. A total of 32 opportunities for medication administration were observed, and 6 of the 32 medications were not administered in accordance with physician's orders and professional standards of practice, resulting in a medication error rate of 18.75%.

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	235354	A. Building B. Wing	03/05/2026

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to designate an Infection Preventionist (IP) that had adequate time to perform infection prevention responsibilities and oversee the infection control program. This deficient practice resulted in the potential for the spread of infection, cross-contamination, and disease transmission for all residents residing in the facility. Findings include: During an interview on 3/04/2026 at 1:35 PM, Infection Preventionist (IP) D reported that she had been overseeing the Infection Control program at the facility for the last month. IP D provided the facility's Line Listings (List of residents with potential infections) for January 2026, and some of February 2026, and reported she had not yet completed the facility's line listings for the month of February 2026. IP D reported that her process for providing infection surveillance for the facility was to review resident progress notes daily to oversee potential resident infections, but she was not always able to as she was also working as the facility's Director of Nursing (DON) and Unit Manager (UM). IP D was unable to report how much time she spent every day or week working on the facility's infection control program tasks. IP D reported she was trying to keep track of all of the infection control tracking, but since she was working in three different roles, she was not able to manage all of the infection control tasks and oversight. IP D could not provide any verification of staff education that had been completed in the last year related to infection control. IP D could not provide any verification that the facility had been conducting infection control audits that the facility had completed. IP D confirmed that she had not been completing infection control audits over the last month because she had not had the time to do so. IP D reported that she had been in the process of trying to educate staff on following transmission based (TBP) and enhanced barrier precautions (EBP) but was not able to provide verification of this education. IP D confirmed that there were ongoing concerns that the facility staff were not following TBP and EBP, and that this was an area that all staff needed re-education on. IP D reported that staff were educated on signs/symptoms of illness that would prohibit them from working during orientation. IP D reported if staff were to call in due to illness, the staff member taking the call in was supposed to document the symptoms of the illness so the facility could monitor for potential illness outbreaks at the facility. IP D reported that she thought that Medical Records (MR) C was tracking staff illnesses, and that she had not been overseeing staff call ins when they were sick. IP D reported that she was not sure how often the facility was reviewing the infection control policies or the program. IP D was unable to report which communicable diseases were supposed to be reported to the local/state health authorities, or what the communication protocol for reporting communicable diseases was. IP D could not report how the facility's infection control program monitored early detection of potential infections, how infections were monitored after identification, or how the facility was currently monitoring immunizations of residents. IP D reported the facility had several staff members overseeing the infection control program over the last few months, so there were multiple changes in how the facility had been monitoring and tracking of infections, and the facility was still working on a new process with corporate. Review of the facility's Infection Control binder during the meeting with IP D on 3/4/26 at 1:35 PM revealed Line Listings for January 2026, and some of February 2026. Noted that the line listings only included residents that had been prescribed antibiotics. The Infection Control binder did not have audits, education, or other documentation to verify ongoing infection control surveillance. For further information, please see F880.

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	235354	A. Building B. Wing	03/05/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility to failed to ensure call lights were within reach for 1 (Resident #7) of18 residents reviewed for accommodation of needs, resulting in the potential for unmet care needs. Findings include: Resident #7 Review of an admission Record revealed Resident #7 was originally admitted to the facility on [DATE] with pertinent diagnoses which included need for assistance with personal care and muscle weakness. Review of Resident #7's Care Plan revealed, (Resident #7) is at risk for falls r/t (related to) impulsiveness, TBI (Traumatic Brain Injury), agitation, weakness, confusion, history of falls, poor judgement and lacks insight into limitations . Date initiated: 12/31/24 . Interventions: . Clip call light on resident when he is in bed as he allows (post fall 11/15/25). Date initiated: 11/17/25 .Replace call light clip (post fall 12/15/25). Date initiated:12/18/25 .soft touch (type of call light device) call light in reach. Date initiated: 1/6/25 . Review of Resident #7's Progress Note dated 12/18/25 revealed, IDT (Interdisciplinary Team) met to review recent fall on 12/15/25. Resident observed laying on floor mat next to bed .IDT intervention to have call light clip replaced and is working to ensure staff is (sic) able to clip to resident as he allows . In an observation on 3/05/2026 at 10:07 AM, Resident #7 was lying in his bed. It was noted that Resident #7's call light was on the floor and out of his reach. During an interview on 3/05/2026 at 10:13 AM, Certified Nursing Assistant (CNA) JJ reported Resident #7 did use his call light when he needed assistance from staff. During a care observation 3/05/2026 at 10:33 AM, Registered Nurse (RN) M entered Resident #7's room and provided wound care to Resident #7. After RN M completed wound care treatment on Resident #7, RN M exited his room. It was noted that Resident #7's call light was on the floor and out of his reach. When this writer queried RN M about Resident #7's call light, she reported that she didn't know if Resident #7 could use his call light, but that he would yell out if he needs us. RN M confirmed that Resident #7 was at risk for falls and had a history of attempting to get up on his own when he needed assistance. During an observation on 3/05/2026 at 1:01 PM, Resident #7 was sitting in his room in his chair. It was noted that his touch pad call light was in reach, and he turned it on to request assistance from staff.

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	235354	A. Building B. Wing	03/05/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. This citation pertains to Intake # 2749154. Based on interview, and record review, the facility failed to notify the responsible party of a change in resident condition in 1 of 1 resident (Resident #41) reviewed for notification of changes, resulting in the family/responsible party being unaware of a newly identified urinary tract infection and initiation of antibiotic treatment. Findings include:Resident #41 Review of an admission Record revealed Resident #41 was a female, with pertinent diagnoses which included dementia, need for assistance with personal care, depression, cognitive communication deficit (impaired communication due to underlying cognitive issues), and muscle weakness. Noted Family Member U was Resident #41's Power of Attorney (POA) for care, first emergency contact, and responsible party. Review of a Minimum Data Set (MDS) assessment for Resident #41, with a reference date of 12/4/25, revealed a Brief Interview for Mental Status (BIMS) of 4, out of a total possible score of 15, which indicated severe cognitive impairment. In an interview on 3/3/26 at 8:00 AM, Family Member U reported she was Resident #41's responsible party/POA, however, the facility has not been notifying her consistently with changes in Resident #41's condition. Family Member U reported during a recent visit with Resident #41, she discovered Resident #41 was being treated for a urinary tract infection (UTI) when the resident mentioned staff were .giving her shots . Review of a Physician Note for Resident #41, dated 2/12/26, revealed .REASON FOR EVALUATION: I am asked by the nursing staff to evaluate the patient's urine .LABS: The patient has pyuria (elevated number of white blood cells or pus in the urine indicating inflammation or infection in the urinary tract), bacteriuria (presence of bacteria in the urine), growth of greater than 100,000 organisms of proteus mirabilis (a type of bacteria), sensitive to Rocephin (a type of antibiotic) .ASSESSMENT: Pyuria, bacteriuria .PLAN: Rocephin 1 gram IM (intramuscular injection) with lidocaine one time a day . No documentation noted to indicate if the responsible party was notified of these lab findings or the new antibiotic orders. Review of an Order Summary Report for Resident #41 revealed the physician order .cefTRIAXone (Rocephin) Sodium Injection Solution Reconstituted 1 GM (gram) (Ceftriaxone Sodium) Inject 1 gram intramuscularly one time a day for (UTI) for 5 Days . with a start date of 2/13/26 and an end date of 2/18/26. Review of a Nurses Note for Resident #41, dated 2/14/26 at 11:07 AM, revealed .Resident on (IM) injection abx (antibiotics) r/t (related to) (UTI) gave in left trochanter (hip) no s/s (signs/symptoms) of adverse reaction to abx . Review of a Nurses Note for Resident #41, dated 2/16/26 at 10:55 AM, revealed .Resident on (IM) injection Rocephin, gave abx injection in right trochanter, no adverse reaction to abx therapy r/t (UTI) . Review of Resident #41's medical record revealed no documentation that Family Member U was notified of Resident #41's confirmed UTI on 2/12/26, or initiation of antibiotic therapy on 2/13/26. In an interview on 3/5/26 at 1:11 PM, Administrator A reported the facility was unable to locate documentation that Family Member U was notified of Resident #41's confirmed UTI and new antibiotic orders on 2/12/26. In an interview on 3/5/26 at 1:14 PM, Licensed Practical Nurse (LPN) RR reported when a resident is not their own responsible party, the resident representative should be notified for any newly identified infection. In an interview on 3/5/26 at 1:19 PM, Registered Nurse (RN) M reported for a cognitively impaired resident, the resident representative should be notified whenever there is a change in condition, with new physician orders, and with any abnormal lab results.

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	235354	A. Building B. Wing	03/05/2026

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Notice of Transfer and Bed Hold documentation was provided in writing prior to transfer from facility for 1 (Resident #3) of 2 residents reviewed for hospitalization, resulting in the potential for the resident or resident representative to be uninformed of rights related to transfer to hospital and bed hold policy.Findings include: Resident #3Review of an admission Record revealed Resident #3 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: end stage renal disease (the final stage of renal disease where the kidneys can no longer function to sustain life without treatment), dependence on renal dialysis (a medical treatment that removes waste products, excess fluids, and toxins from the blood when the kidneys are unable to perform these functions) and dementia (a syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities).Review of Progress Notes for Resident #3 revealed on 2/7/26 at 18:45 (6:45 PM) and 2/17/26 at 17:34 (5:34 PM) Resident #3 was transferred to (Name Redacted) local emergency department for evaluation of an acute change in condition.Review of Resident #3's medical record on 3/4/26 revealed no noted Notice of Transfer for either transfer to the local emergency department.Review of Resident #3's medical record on 3/4/26 revealed documentation no Bed Hold information was provided to Resident #3 or his resident representative when he was transferred to the local emergency room on 2/17/26.In an interview on 3/4/26 at 2:20 PM, Medical Records/Scheduler (MR/S) C reviewed Resident #3's medical record and reported if she had been given a copy of the Bed Hold and Notice of Transfer forms provided to Resident #3 when he was transferred to the hospital, they would be uploaded into his medical record. MR/S C reviewed Resident #3's electronic record and confirmed there was neither a Notice of Transfer nor a Bed Hold form in Resident #3's record for neither the transfer on 2/7/26 nor 2/17/26.In an interview on 3/4/26 at 2:33 PM, Director of Nursing (DON) B reported she was unable to locate documentation indicating a Notice of Transfer was provided to Resident #3 prior to his transfer to the emergency room on 2/7/26 and 2/17/26, and DON B was unable to locate documentation indicating Bed Hold information was provided to Resident #3 prior to his transfer from the facility on 2/17/26.In an interview on 3/4/26 at 3:19 PM, Nursing Home Administrator (NHA) A reported a Notice of Transfer and Bed Hold should be given to either the resident or the resident representative in writing prior to the resident's transfer from the facility. NHA A reported she was unable to find a Notice of Transfer for Resident #3 dated 2/7/26 or 2/17/26 and she was unable to find a Bed Hold information from 2/17/26.No Notice of Transfer for Resident #3 was provided for 2/7/26 and 2/17/26 prior to survey exit.No Bed Hold for Resident #3 was provided for 2/17/26 prior to survey exit.Review of facility policy Social Service SOP Transfers and Discharges with no date revealed .The copies of the transfer form.are retained in the medical record.provide orientation for transfer or discharge to minimized anxiety and to ensure a safe and orderly transfer or discharge. Provide in a form and manner that the resident can understand.Review of facility policy Bed Hold Policy with no date revealed .a bed hold will be offered to all other residents upon their unplanned discharge and/or leave to assure a bed is available upon the resident's desirable return to the facility.immediately upon discharge for any reason, the bed hold policy and agreement will be provided to the residents and/or their representative and documented in the medical record to whom the form was given.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. Based on observation, interview, and record review, the facility failed to follow professional standards of practice for medication administration in 1 of 4 residents (Resident #33) reviewed for medication administration, resulting in medications being crushed against pharmacy recommendations and the potential for adverse medication side effects. Findings include:Resident #33Review of an admission Record revealed Resident #33 was a female, with pertinent diagnoses which included heart failure, diabetes, heart disease, cognitive communication deficit (impaired communication due to underlying cognitive issues), anemia (a deficiency of healthy red blood cells or hemoglobin), depression, high blood pressure, kidney failure, and muscle weakness.In an observation and interview on 3/4/26 at 9:03 AM, Licensed Practical Nurse (LPN) I prepared scheduled medications for Resident #33. LPN I reported Resident #33 takes all her medications crushed in pudding due to difficulty swallowing pills. Observed LPN I prepare one Metoprolol Succinate ER (Extended Release) 25 mg (milligrams) tablet, one Imipramine HCl 50 mg tablet, and one Potassium Chloride ER 20 mEq (milliequivalent) tablet for Resident #33, crush the medications, mix the medications in pudding, and administer the medications to Resident #33 while she was seated in the dining area on the memory care unit.Review of an Order Summary Report for Resident #33 revealed the active physician order .Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG Give 1 tablet by mouth one time a day for HTN (high blood pressure) . with a start date of 9/26/25.Review of an Order Summary Report for Resident #33 revealed the active physician order .Imipramine HCl Oral Tablet 50 MG (Imipramine HCl) Give 1 tablet by mouth one time a day for antidepressant related to DEPRESSION . with a start date of 9/26/25.Review of an Order Summary Report for Resident #33 revealed the active physician order .Potassium Chloride Crys (Crystals) ER Oral Tablet Extended Release 20 MEQ (Potassium Chloride Microencapsulated Crystals ER) Give 1 tablet by mouth one time a day for low potassium . with a start date of 10/11/25.Review of an Order Summary Report for Resident #33 revealed the active physician order .OK to crush allowable medications and administer together . dated 12/28/25.In an interview on 3/4/26 at 12:15 PM, Registered Nurse (RN) H reported nurses are to use their professional knowledge and judgement when deciding whether or not medications can be crushed. RN H reported residents have physician orders to crush allowable medications. RN H reported if the medication ordered is not able to be crushed, nurses should either leave those medications to the side and administer them whole or contact the physician to change the order or get a different version of the medication. RN H reported both Metoprolol ER and Potassium Chloride ER should not be crushed for administration. RN H reported there is a powdered (immediate-release) form of Potassium Chloride available if a resident is unable to swallow the extended-release tablet.In an interview on 3/5/26 at 8:31 AM, LPN I reported extended-release medications should not be crushed for administration. LPN I reported Resident #33's medications (including the extended-release medications) are crushed for administration due to difficulty swallowing pills. LPN I reported the physician was previously notified and gave orders to crush all of Resident #33's medications, even those that should not be crushed per pharmacy recommendations.In an interview on 3/5/26 at 8:48 AM, requested information from Unit Manager F regarding Resident #33's medication orders and any documentation that the physician was notified and gave orders/approval to crush Resident #33's medications (including those that should not be crushed per pharmacy recommendations). No documentation provided prior to survey exit that the physician gave orders/approval to crush Resident #33's extended-release medications.In an interview on 3/5/26 at 9:11 AM, Unit Manager F reported he spoke with the physician regarding the crushed extended-release medications for Resident #33, with new orders obtained to discontinue the Metoprolol ER 25 mg tablet and dissolve the Potassium Chloride ER in water prior to administration.In an interview on 3/5/26 at 11:44 AM, Pharmacist T reported the general rule of thumb is that extended-release medications should not be crushed prior to administration. Pharmacist T verified Metoprolol ER should not be crushed, and that there is an alternative form available (Metoprolol (continued on next page)

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	03/05/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tartrate) that would be able to be crushed. Pharmacist T verified Potassium Chloride ER should not be crushed, and that there is an alternative form available (dissolvable packet). Pharmacist T reported Imipramine HCl 50 mg tablets are also not recommended to be crushed, and that there is an alternative liquid formulation available.Review of the policy/procedure Medication Administration - General Guidelines, dated May 2022, revealed .Tablet Crushing/Capsule Opening: Crushing tablets may require a physician's order, per facility policy. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines .An individualized approach should be used when altering dosage forms by crushing or opening capsules. Working with the resident or representative and appropriate clinicians (e.g., the consultant pharmacist, attending physician, medical director) the facility should determine the most appropriate method for administering medications which considers each resident's safety, needs, medication schedule, preferences, and functional ability .An order to crush medications may be required or preferred in accordance with State regulation (or) facility preference .Orders to crush medications should not be applied to medications which, if crushed, present a risk to the resident. For example: Long-acting or enteric-coated dosage forms should not be crushed; an alternative should be sought .The pharmacist should be contacted to review all medications being considered for crushing, whether a physician's order is present or not. The pharmacist can assist in finding appropriate alternatives to medications that should not be crushed. When identified, the prescriber shall be contacted for an order change .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess and implement pressure ulcer preventative care, consistent with professional standards of practice, for 1 (Resident #7) of 3 residents reviewed for pressure ulcer prevention and treatment, resulting in the potential for the development of an pressure ulcer and potential for worsening of pressure wounds, and overall deterioration in health status. Findings include:Resident #7Review of an admission Record revealed Resident #7 was originally admitted to the facility on [DATE] with pertinent diagnoses which included need for assistance with personal care and muscle weakness. Review of Resident #7's Braden Assessment (evidence-based tool used by healthcare professionals to assess a patient's risk of developing pressure injuries) dated 1/7/26 indicated that Resident #7 scored a 12 on the assessment, indicating that he was high risk for developing a pressure injury. Review of Resident #7's Progress Note dated 2/11/26 revealed, Left heel pressure wound, scant serosanguineous (thin, watery, light pink or pale red wound drainage). Applied skin prep (protective barrier that forms a breathable, transparent film on intact skin to reduce friction) and bordered foam dressing per wound nurse orders. Review of Resident #7's Skin and Wound Note dated 2/14/26 revealed, . Reason for visit: New skin and wound consult for resident . wound specialist re-consulted due to nursing concerns for bruising and possible DTI (deep tissue injury) to left heel .Wound assessment: Location: Left Heel Primary Etiology (cause): Pressure: Stage/Severity: DTI. Wound Status: new. Size: 2cm (centimeters) x2cm x0cm . Assessment: Pressure-induced deep tissue damage of left heel .f/u (follow up) in one week. Consider use of offloading boots when in chair and bed as tolerated . Review of Resident #7's Skin and Wound Note dated 2/18/26 revealed, .Wound assessment: Location: Left Heel. Etiology: Pressure. Stage/severity: Stage 2 . Size: 1.7 cmx0.7cmx0cm .Consider use of offloading boots when in chair and bed as tolerated . Review of Resident #7's Orders revealed, Left Heel: Apply BD (betadine antiseptic solution) two times daily for wound management. Start date: 2/25/26. Review of Resident #7's Orders revealed Left heel: Cleanse with wound wash, pat dry, apply a layer of xerofoam (type of dressing) and cover with comfort foam dressing daily and PRN (as needed). Every day shift for Wound Management. Start date: 2/19/25 (Noted missing documentation to indicate if the treatment had been completed on 2/19/26.) Review of Resident #7's Weekly Skin Assessments revealed that the last weekly skin assessment that had been documented for Resident #7 was 2/2/26. Review of Resident #7's Care Plan revealed, I (Resident #7) have impaired skin integrity on my left heel r/t (related to) pressure ulcer. Date initiated: 2/20/26. Inventions: Administer medications as ordered. Observe for side effects and effectiveness, administer my treatments as ordered and monitor for effectiveness, Assess/record/monitor my wound healing. Measure length, width and depth where possible. Assess and document status of my wound healing progress. Report my improvements to my Dr (Doctor), Assist in repositioning me frequently in my bed and chair, enhanced barrier precautions, I need a pressure reducing mattress, I need assistance to turn/reposition as least every 2 hours, more often as needed or requested, I need barrier cream applied to my skin, as needed , I require a pressure reducing device in my chair-including my geri chair (specialized chairs designed for patients with limited mobility), Observe and report any changes in skin status: appearance, color, wound healing, s/sx (signs and symptoms) of infection, wound size, stage . date initiated: 2/20/26. During an observation on 03/03/2026 11:14 AM, Resident #7 was lying in his bed with his feet directly on his bed without a pillow under his feet to reduce pressure. During an observation on 3/05/2026 at 10:33 AM, Registered Nurse (RN) M entered Resident #7's room to provide wound care. Resident #7 was lying in his bed. RN M removed the blanket covering Resident #7's feet. Noted that Resident #7's feet were lying directly on his bed without a pillow under his feet to reduce pressure. RN M reported Resident #7's wound had recently closed, and that it was important for staff to make sure that they were placing pillows under his feet to reduce pressure. RN M (continued on next page)

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	235354	A. Building B. Wing	03/05/2026

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed that Resident #7 was at risk for his left heel wound to deteriorate in healing, especially if there was not pressure reducing measures in place when Resident #7 was in bed. During an interview on 3/05/2026 at 10:28 AM, Interim Director of Nursing (IDON) D reported Resident #7 had developed a pressure ulcer on his left heel that the facility had discovered in February 2026. IDON D reported Resident #7's staff were supposed to prop Resident #7's feet with pillows when he was in bed to reduce pressure. When this writer queried about offloading boots that had been recommended by the facility's wound care provider, IDON D reported she was supposed to look into getting boots for Resident #7, but she had not done that yet. IDON D reported that nurses were supposed to complete weekly skin assessments for each resident. IDON D reviewed Resident #7's Weekly Skin Assessments and confirmed that Resident had not had a Weekly Skin Assessment documented since 2/2/26. Review of the facility's Skin Management Facility Guidelines revealed, The facility is committed to providing care and services to prevent the development of skin breakdown. The following guidelines are in place to reach that goal: .3. Residents admitted with skin impairments will have: appropriate interventions implemented to promote healing .7. Place each resident on weekly head to toe skin assessment on PCC (Medical Records Program) and indicate day and shift on which the check will be conducted .

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	235354	A. Building B. Wing	03/05/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate care for residents who received enteral nutrition (delivery of nutrients directly into the gastrointestinal tract through a feeding tube) in 1 (Resident #7) of 1 resident reviewed for tube feeding, resulting in the potential for aspiration pneumonia. Findings include: Resident #7 Review of an admission Record revealed Resident #7 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dysphagia following a cerebral infarction (difficulty swallowing after a stroke) and pneumonitis due to inhalation of food and vomit (lung inflammation caused by aspirating food, liquid, or gastric contents into the airways). Review of Resident #7's Orders revealed, Enteral Feed Order: Every shift for nutrition. Jevity (type of enteral feed formula) 1.5 continuous feed at 50ml/hr (milliliters per hour). Review of Resident #7's Care Plan revealed, (Resident #7) is dependent on tube feeding (device used to provide nutrition to someone that cannot eat by mouth) r/t (related to) dysphagia, swallowing problem. Date initiated: 12/31/25. Interventions: I need my HOB (head of bed) elevated to 45 degrees during and thirty minutes after tube feed. Date initiated: 12/31/25 . During an observation on 3/05/2026 at 10:07 AM, Resident #7 was in his room lying in his bed on his back. Resident #7's head of bed was not elevated to 45 degrees. Noted that Resident #7's enteral feeding was running at 50 mL/hr. During a care observation and interview on 3/05/2026 at 10:33 AM, Registered Nurse (RN) M entered Resident #7's room and adjusted the head of Resident #7's bed to 45 degrees. Noted that Resident #7 was coughing prior to RN M adjusting the head of his bed. RN M confirmed that Resident #7's head of bed needed to be elevated to at least 45 degrees when his enteral feed was running to prevent Resident #7 from aspirating. RN M confirmed that Resident #7's head of bed was not elevated to 45 degrees when she entered Resident #7's room. RN M reported that the aides at the facility were not good at ensuring that Resident #7's head of bed was elevated to 45 degrees when they would provide care for Resident #7, and that she was often reminding staff that Resident #7 could not lie flat when his enteral feed was running. Review of the facility's Enteral Nutrition Guidelines policy revealed, Procedure: . 8. The resident should be in semi-Fowlers (patient posture in which the head and upper body are elevated 30 to 45 degrees while lying on the back) position and for 30 minutes to one hour after to prevent aspiration .

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	235354	A. Building B. Wing	03/05/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain oxygen equipment in a sanitary manner and follow physician's oxygen orders for 1 (Resident #87) of 1 resident reviewed for respiratory care resulting in the potential for excessive oxygen levels and/or an infection.Findings include:Review of Resident #87's admission Record, print date 3/5/26, indicated she was readmitted on [DATE] and had a power of attorney (authorized person to make decisions for another individual) for medical care. The admission record included medical diagnoses of chronic respiratory failure, other disorders of lung, and other forms of dyspnea (shortness of breath). Review of Resident #87's physician order for oxygen, dated 2/23/26, stated, Oxygen @ 2L (at 2 Liters per minute) via NC (nasal cannula/oxygen tubing) .During an observation on 03/03/2026 at 11:17 AM, Resident #87 was in her bed receiving supplemental oxygen from the bedside oxygen concentrator at a flow rate of 2 liters per minute. Resident #87's wheelchair was positioned just past the privacy curtain (out of reach of the resident), had a portable oxygen tank on the back with separate oxygen tubing attached, and the tubing including the part that went into the nostrils was coiled up and resting directly on the wheelchair seat pad. During an observation on 03/04/2026 at 9:03 AM, Resident #87 was in her bed receiving supplemental oxygen from the bedside oxygen concentrator at a flow rate of 4 liters per minute. Resident #87's wheelchair was positioned just past the privacy curtain (out of reach of the resident), had a portable oxygen tank on the back with separate oxygen tubing attached, and the tubing including the part that went into the nostrils was coiled up and resting directly on the wheelchair seat pad. During an observation on 03/04/2026 at 9:05 AM, Registered Nurse (RN) H entered Resident #87's room, removed her meal tray, and then exited the room. No adjustment to the oxygen concentrator's flow rate or fixing the tubing on the wheelchair pad was done at that time. During an interview on 03/04/2026 at 11:01 AM, RN H confirmed Resident #87's oxygen order was for a flow rate of 2 liters per minute and reported she had observed her oxygen concentrator incorrectly set to 4 liters per minute at around 9:30 or 10:00 AM that morning. RN H reported the night staff from the shift prior had not made report about issues requiring a higher oxygen flow rate for Resident #87. RN H reported if a resident needed an increased oxygen flow rate, the nurse should call the doctor to discuss it, get a new oxygen order, and then increase the oxygen flow rate to meet resident need. RN H confirmed oxygen tubing should be stored in a bag between uses and it shouldn't be left on the resident's wheelchair seat pad. RN H reported Resident #87 required staff assistance transferring from wheelchair to bed and the staff would have been the one handling the oxygen tubing.During an interview on 03/05/2026 at 9:44 AM, Interim Director of Nursing (IDON) D (who also had infection preventionist certification) confirmed residents' oxygen tubing should be stored in a bag between uses when the tubing wasn't on the resident's face. IDON D reported if a nurse was to increase oxygen from 2 liters per minute to 4 liters per minute they could do so in an emergency, but they should be contacting the doctor and getting an order for the increased oxygen flow rate. IDON D confirmed Resident #87's physician order for oxygen was to be at 2 liters per minute and staff should not have been giving it at 4 liters per minute. IDON D confirmed there wasn't documentation present that addressed Resident #87 having their oxygen increased from 2 liters per minute to 4 liters per minute.During an interview on 03/05/2026 at 11:30 AM, Licensed Practical Nurse (LPN) K reported she had raised Resident #87's oxygen rate from 2 liters per minute to 4 liters per minute on 3/4/26 around approximately 3:50 AM. LPN K reported she thought Resident #87's oxygen order had parameters that would have allowed this and thought possibly she could have looked at the wrong order. Resident #87's oxygen order was reviewed with LPN K, and the order didn't include parameters that addressed increasing the flow rate. LPN K confirmed she did not contact a physician for a new oxygen order for Resident #87 and hadn't made a note addressing the change in oxygen flow rate or reasons for it. Review of Resident #87's respiratory care plan, revised 1/23/26, included an (continued on next page)

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	03/05/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervention of OXYGEN SETTINGS: O2 (oxygen) via nasal cannula as ordered. Review of Resident #87's O2 Sats (oxygen saturation; an indicator of how well oxygen is being delivered to the body) Summary, had noted the oxygen was running at 4L/Min (4 liters per minute) on 3/4/26 at 3:50 AM by LPN K. Review of the facility's Oxygen Administration policy, undated, stated, A resident will receive oxygen per physician's orders.Turn the unit on to the desired flow rate.

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	03/05/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to maintain complete and accurate medical records in 2 of 18 residents (Resident #61 & #7) reviewed for accuracy of medical records, resulting in inaccurate code status information within the electronic health record and missing documentation in the treatment record with the potential for advanced directive/code status preferences to not be honored and deterioration in resident status.Findings include:Resident #61 Review of an admission Record revealed Resident #61 was a female, with pertinent diagnoses which included high blood pressure, paraplegia (impairment or loss of motor and sensory function in the lower half of the body), muscle weakness, depression, anxiety, and chronic kidney disease. Noted Resident #61 was her own responsible party. Review of a Minimum Data Set (MDS) assessment for Resident #61, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, indicating she was cognitively intact. Review of a Medical Treatment Decisions/Advanced Directives form for Resident #61, signed by the resident on [DATE], revealed a check next to .I DO .Wish to have Cardiopulmonary Resuscitation (CPR) . Noted this form was also signed by two witnesses and the physician. Review of an Order Summary Report for Resident #61 revealed the active physician order .Do Not Resuscitate - DNR . dated [DATE]. Note these orders conflict with Resident #61's most recent preferences identified on her Medical Treatment Decisions/Advanced Directives form completed on [DATE]. Review of a current Care Plan for Resident #61 revealed the focus .Advance Directive - Resident and family have elected DNR . with interventions which included .Honor and respect resident and resident's family's wishes regarding code status . initiated [DATE]. Note the information within this Care Plan conflicts with Resident #61's most recent preferences identified on her Medical Treatment Decisions/Advanced Directives form completed on [DATE]. In an interview on [DATE] at 8:51 AM, Social Services Director OO reported advanced directives should be reviewed and updated upon admission, readmission, quarterly, and with any changes. Social Services Director OO reported when there is a change in code status, the physician orders should be updated to reflect the change. In an interview on [DATE] at 12:52 PM, Social Services Director OO reported he spoke with Resident #61 to confirm her wishes regarding her advanced directives/code status, and the orders have been updated to reflect her choice to be FULL CODE (receive CPR). Resident #7 Review of an admission Record revealed Resident #7 was originally admitted to the facility on [DATE] with pertinent diagnoses which included need for assistance with personal care and muscle weakness. (continued on next page)

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	235354	A. Building B. Wing	03/05/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's Weekly Skin Assessments revealed that the last weekly skin assessment that had been documented for Resident #7 was [DATE]. Review of Resident #7's February 2026 Treatment Administration Record (TAR) revealed, Left heel: Cleanse with wound wash . everyday shift for wound management. (Noted missing documentation to indicate if the treatment had been completed on [DATE].) Weekly Weight every day shift every Thurs (Thursday). (Noted missing documentation to indicate if the treatment had been completed on [DATE], and [DATE].) Weights: Weekly r/t (related to) weight loss.one time a day every Mon (Monday). (Noted missing documentation to indicate if the treatment had been completed on [DATE].) During an interview on [DATE] at 10:28 AM, Interim Director of Nursing (IDON) D reported nurses were supposed to complete weekly skin assessments for all residents and document their assessment findings under Weekly Skin Assessments in the resident's medical record. IDON D reviewed Resident #7's Weekly Skin Assessments with this writer and confirmed that Resident #7 had not had a documented weekly skin assessment since [DATE]. IDON D reported nurses were expected to document the completion or reason a treatment was missed in the TAR.

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	235354	A. Building B. Wing	03/05/2026

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure they educated, offered and administered COVID-19 vaccines or maintained valid declination in the medical record for 1(Resident #87) of 5 residents reviewed for Covid-19 immunizations resulting in the increased likelihood of severe infection and complications/death related to COVID-19. Findings include:Resident #87 Review of an admission Record revealed Resident #87 was originally admitted to the facility on [DATE] with pertinent diagnoses which included pneumonia (an infection that inflames the air sacs in one or both lungs) and pulmonary hypertension (condition characterized by high blood pressure in the lungs' arteries, causing the right side of the heart to work too hard, leading to weakening and potential failure). Review of Resident #87's Immunization Record revealed, SARS-COV-2 (COVID-19)-Dose 2. Date administered: (there was no date indicated). Status: Pending historical . During an interview on 3/04/2026 at 10:22 AM, Infection Preventionist (IP) D reported that Resident #87's immunization history should have been reviewed when she was admitted to the facility to determine if she was eligible for Covid-19 immunization, and if Resident #87 was eligible, the facility should have offered and administered the vaccine. IP D confirmed that the facility had not assessed Resident #87's vaccinations to determine if Resident #87 was eligible and wanted to receive the second dose of COVID-19 immunization. IP D was unable to report how the facility had missed assessing Resident #87's immunization record since Resident #87's admission.