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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235447 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/05/2026 |
| NAME OF PROVIDER OR SUPPLIER The Orchards at Douglas Cove | | STREET ADDRESS, CITY, STATE, ZIP CODE 243 Wiley Road Douglas, MI 49406 | |
| 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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician of a significant change in 1 (Resident #102) of 3 residents reviewed for notification, resulting in the physician not evaluating Resident #102 when she experienced a significant weight gain, swelling of her legs, decreased functional abilities, and hospitalization. Findings include: Review of an admission Record revealed Resident #102 was a [AGE] year-old female who was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified atrial fibrillation (a common, often rapid irregular heart rhythm where the heart's upper chambers beat chaotically which can cause blood clots, stroke and heart failure). Review of a Minimum Data Set (MDS) assessment for Resident #102 with a reference date of 1/23/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. In an interview on 3/4/26 at 3:09pm, Resident #102 reported on 2/10/26 she insisted on going to the emergency room because she had experienced unresolved pain, swelling in both lower extremities and a loss of functional ability for more than a week. Resident #102 reported she told several staff members she wanted to be seen by the physician but was not evaluated. Resident #102 she became increasingly worried and frustrated when she lost the ability to transfer herself to her wheelchair and to the toilet. When further queried, Resident #102 reported she could tolerate a pain level of 5 on the pain scale of 0-10 and felt she could function as well as she'd like at that level. Resident #102 stated My pain was at an 8 before I went to the hospital and it was too much for me to handle. In an interview on 3/3/26 at 1:43pm, Family Member (FM) W reported Resident #102 struggled with swelling in her legs, pain and decreased mobility for more than a week when she went to the hospital on 2/10/26. FM W confirmed they spoke with a floor nurse on 2/2/26 and requested that a provider evaluate the resident. FM W reported they were told the resident (Resident #102) would be evaluated by a provider on 2/3/26 but that never happened. FM W reported when she asked the nurse what could be done to address Resident #102's severe pain, the nurse offered to provide the resident (Resident #102) with more over the counter pain medication but did not offer to contact a provider. FM W reported she witnessed Resident #102 crying from the pain she experienced. FM W reported during the week of 2/2/26, the staff began offering Resident #102 an over-the-counter cream for her pain, but the application of the cream intensified the pain in her legs, and she could not tolerate it. In an interview on 3/3/26 at 2:58pm, Certified Nursing Assistant (CNA) BB reported on 2/3/26 and 2/4/26 Resident #102 exhibited swelling in her legs, the left leg slightly more so than the right, complained of increased pain and needed more help getting her feet into bed and with transferring from one surface to another. CNA BB reported she told the nurse and therapy staff that something was off with Resident #102 because she felt Resident #102 needed to be evaluated. In an interview on 3/3/26 at 3:42pm, CNA K reported between 2/3-2/9/26 Resident #102 yelled out during cares and asked for pain medication. CNA K confirmed it was unusual for Resident #102 to complain of pain or request medication. In an interview on 3/4/26 at 3:50pm, CNA L reported between 2/3-2/9/26 she observed Resident #102's legs were swollen and painful. CNA L reported Resident #102 tried to be as independent as possible but during that time the resident (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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>needed physical assistance to lift her legs and for all transfers. CNA L reported Resident #102 yelled OHHH! and grabbed her legs as she was being assisted with moving them onto the bed. CNA L reported Resident #102's socks left indentations in her calves after they were removed. CNA L confirmed she reported Resident #102's swelling, increased pain and loss of functional abilities to the nurse. CNA L stated I told the nurse I thought the resident was retaining fluid. Review of a Weight Summary for Resident #102 revealed the resident gained 9 pounds from 12/30/25-2/1/26, a period of 32 days. Weight increase was documented by Licensed Practical Nurse (LPN) I. A weight gain of 4 pounds was documented by LPN I on 2/6/26. Review of a Weight Change Note for Resident #102 with a reference date of 2/5/26 revealed WEIGHT WARNING: .+7.5% (increase 7.5 percent) change.sig (significant) wt (weight) gain noted, resident has daily weights x7 days in place to monitor. No diuretics on board. In an interview on 3/4/26 at 1:54pm Director of Nursing (DON) B reported Resident #102 was supposed to have daily weights for 7 days because of her significant weight gain between 12/30/25-2/1/26. DON B confirmed Resident #102 continued to experience weight gain on 2/4-2/6/26. DON B confirmed the physician was not notified of the weight gain and Resident #102 was not evaluated by a provider between 2/1/26-2/10/26. Review of an Assessments listing revealed no nursing or physician assessments were completed on Resident #102 between 1/27/26-2/8/26. Review of progress notes revealed no documentation of a nurse contacting the provider regarding Resident #102's unexplained weight gain. In an interview on 3/6/26 at 7:15am, LPN J reported Resident #102 suddenly started complaining of leg pain in early February and had never previously had pain issues. LPN J reported she noticed swelling in Resident #102's left leg and was aware the resident was requiring additional physical assistance for mobility. LPN J reported she was not aware Resident #102 had gained 9 pounds in a little more than a month. LPN J confirmed a significant unexplained weight gain like the one Resident #102 experienced, along with her other symptoms were indicative of a need for further medical assessment and the physician should have been notified. When queried regarding how nurses contact the providers, LPN J reported in this situation, she would contact the provider via the use of Practitioner Communication form. Review of a Practitioner Communications form for Resident #102, with a reference date of 2/2/6, revealed Concern: Would like to see you and speak with you regarding swollen knees. A handwritten response from a provider, dated 2/3/26 read acetaminophen (over the counter pain medication) scheduled, diclofenac gel (anti-inflammatory drug applied topically) added. Review of a Practitioner Communications form for Resident #102, with a reference date of 2/9/26 revealed Concern: pain to all extremities but especially BLE (bilateral lower extremities) and knees. (acetaminophen) is not helping. *Family asking for ibuprofen and acetaminophen to be used intermittently. A handwritten response from a provider dated 2/17/26 read acetaminophen scheduled, PRN (as needed) (opioid analgesic, name omitted) added. In an interview on 3/4/26 at 2:20pm Physician's Assistant (PA) Y reported she was aware Resident #102 had complained of pain in her left knee prior to being hospitalized on [DATE]. PA Y reported she was not aware of any swelling in the resident's legs or of the resident's 9-pound weight gain in 32 days and that a provider should have been notified so the resident's needs would have been assessed. PA Y confirmed Resident #102 was not assessed by a provider between 2/1-2/10/26. When further queried, PA Y reported it was ineffective for staff to communicate with providers via communication sheets because they frequently got overlooked and the staff had been educated to contact the providers via telephone rather than place communication sheets in the provider's mailbox. PA Y reported providers were available via telephone 24 hours a day, 7 days a week.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promptly identify a change in condition for 1 (Resident #102) of 3 residents reviewed for quality of care, resulting in Resident #102 experiencing unmanaged pain and swelling in her legs, decreased functional ability, frustration, and a 3-day hospitalization for treatment of her symptoms. Findings include: Resident #102 Review of an admission Record revealed Resident #102 was a [AGE] year-old female who was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified atrial fibrillation (a common, often rapid irregular heart rhythm where the heart's upper chambers beat chaotically which can cause blood clots, stroke and heart failure). Review of a Minimum Data Set (MDS) assessment for Resident #102 with a reference date of 1/23/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Review of section GG of the MDS revealed Resident #102 was independent for rolling her body while in bed and required only supervision for transferring from a lying to sitting/sitting to lying position, transferring from bed to chair/chair to bed, and transferring to/from the toilet. Review of a MDS assessment for Resident #102 with a reference date of 2/13/26 revealed the resident re-entered the facility on 2/13/26 following a hospitalization on 2/10/26. Section GG of the MDS revealed Resident #102 required supervision/light touching assistance for rolling her body while in bed and maximal assistance (helper does more than half the effort) for transferring from a lying to sitting/sitting to lying position, transferring from bed to chair/chair to bed, and transferring to/from the toilet. Review of a Care Plan for Resident #102 with a reference date of 10/17/25 revealed the following focus/goal/interventions: Focus: (Resident #102) has the potential for pain r/t (related to) AFIB (atrial fibrillation). Goal: (Resident #102) will not have an interruption in normal activities due to pain. Interventions: Administer analgesia (pain medication) as per orders, evaluate the effectiveness of pain interventions. resident satisfaction with results, impact on functional ability. monitor/record/report to Nurse any s/sx (signs and symptoms) of non-verbal pain: vocalizations (grunting, moans, yelling out.). Further review of the care plan revealed no focus/goals/interventions related to monitoring of swelling, daily weights or use of cardiac monitor. During an observation on 3/4/26 at 3:00pm, Resident #102 sat in her wheelchair in her room, it was noted that her left leg appeared larger than her right. In an interview on 3/4/26 at 3:09pm, Resident #102 reported on 2/10/26 she insisted on going to the emergency room because she had experienced unresolved pain, swelling in both lower extremities and a loss of functional ability for more than a week. Resident #102 reported she told several staff members she wanted to be seen by the physician but was not evaluated. Resident #102 reported she became increasingly worried and frustrated when she lost the ability to transfer herself to her wheelchair and to the toilet. Resident #102 stated I like to be independent, and it was frustrating to me when I couldn't get in bed on my own. When further queried, Resident #102 stated my legs were so swollen and heavy, I just couldn't pick them up and the pain was more than I could deal with. Resident #102 described her pain as an 8 on the standardized pain scale of 0-10 (0 being no pain and 10 being the worst imaginable pain). In an interview on 3/3/26 at 1:43pm, Family Member (FM) W reported Resident #102 had been struggling with swelling, pain and decreased mobility for more than a week when she went to the hospital on 2/10/26. FM W confirmed they spoke with a floor nurse on 2/2/26 and requested that a provider evaluate the resident. FM W reported she was told the resident would be evaluated by a provider on 2/3/26 but that never happened. FM W reported when she asked the nurse what could be done to address Resident #102's severe pain, the nurse offered to provide the resident with more over the counter pain medication but did not offer to contact a provider. FM W reported she witnessed Resident #102 crying from the pain she experienced. FM W reported at some point during the week of 2/2/26, the staff began offering Resident #102 an over-the-counter cream for her pain, but the application of the cream intensified the pain in her legs, and the resident could not tolerate (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>having it applied. Review of a History of Physical Report for Resident #102, from a local emergency department with a reference date of 2/10/26, revealed Patient is a 91 y.o (year old) female.brought to the emergency department.for left leg pain and swelling.daughter.states it has really been bothering her for the last week. Swelling is in both legs but the left is worse. Patient describes the pain as [NAME] horse.she has history of persistent atrial fibrillation.is tachycardic (has rapid heart rate) on arrival.presumed new congestive heart failure (heart condition in which the heart cannot pump blood efficiently causing fluid to build up in the lungs, legs and other tissues) possibly related to atrial fibrillation with RVR (Rapid Ventricular Response)(critical cardiac condition where the atrial fibrillation cause the heart's lower chambers to beat too fast which often leads to .reduced blood flow).Physical Exam:.Extremities: Bilateral (both sides of the body) pitting edema (type of swelling caused by fluid retention, typically in the legs or feet where pressing on the affected skin leaves a temporary indentation) to mid shin left greater than right.Review of Patient Discharge Instructions for Resident #102 with a reference to date of 2/13/26 revealed Your Diagnosis: Acute CHF (congestive heart failure), Atrial Fibrillation with RVR and bilateral lower extremity edema.discharge instructions: .daily weights, notify facility physician of weight gain of more than 2 pounds in a 1 day or more than 5 pounds in a week.cardiac monitor has been placed at time of discharge.In an interview on 3/3/26 at 2:58pm, Certified Nursing Assistant (CNA) BB reported on 2/3 and 2/4/26 Resident #102 had increased swelling in her leg, the left leg slightly more so than the right, complained of increased pain and needed more help getting her feet into bed and transferring from one surface to another. CNA BB reported she told the nurse and therapy staff that something was off with Resident #102 because she felt Resident #102 needed to be evaluated.In an interview on 3/3/26 at 3:38pm CNA Q reported during the week of 2/1-2/8/26, Resident #102 had swelling in both legs, complained of pain and yelled out with movement. When queried, CNA Q reported Resident #102 needed quite a bit more help with tasks she could normally complete on her own and described the resident as definitely different than her baseline.In an interview on 3/3/26 at 3:42pm, CNA K reported between 2/3-2/9/26 Resident #102 yelled out during cares and asked for pain medication. CNA K confirmed it was unusual for Resident #102 to complain of pain or request medication.In an interview on 3/3/26 at 3:48pm, CNA N reported Resident #102 complained of pain, needed more physical help to move and had a swollen left leg between 2/3-2/9/26. CNA N confirmed she reported her concerns to the nurse overseeing Resident #102's care. In an interview on 3/4/26 at 3:50pm, CNA L reported between 2/3-2/9/26 she observed Resident #102's legs were swollen and painful. CNA L reported Resident #102 tried to be as independent as possible but during that time the resident needed physical assistance to lift her legs and for all transfers. CNA L reported Resident #102 yelled OHHH! and grabbed her legs as she was being assisted with moving them onto the bed. CNA L reported Resident #102's socks left indentations in her calves after they were removed. CNA L confirmed she reported Resident #102's swelling, increased pain and loss of functional abilities to the nurse. CNA L stated I told the nurse I thought the resident was retaining fluid.Review of Weight Summary for Resident #102 revealed the resident gained 9 pounds from 12/30/25-2/1/26, a period of 32 days. Weight increase was documented by Licensed Practical Nurse (LPN) I. A weight gain of 4 pounds was documented by LPN I on 2/6/26.Review of a Nutrition Note for Resident #102 with a reference date of 2/4/26 revealed IDT (interdisciplinary team) met with NAR (nutritional at risk) meeting. Resident weight increase reviewed. Weight gain of 9lbs (pounds) in 2 months (sic) (period was actually 32 days). Resident placed on daily weights x7days (for seven days).Review of a Weight Change Note for Resident #102 with a reference date of 2/5/26 revealed WEIGHT WARNING: .+7.5% (increase 7.5 percent) change.sig (significant) wt (weight) gain noted, resident has daily weights x7 days in place to monitor. No diuretics on board.In an interview on 3/4/26 at 1:54pm Director of Nursing (DON) B reported Resident #102 was supposed to have daily weights for 7 days because of her significant weight gain between 12/30/25-2/1/26. DON B confirmed Resident #102 continued to experience weight gain on 2/4-2/6/26. DON B confirmed the physician was not notified of the weight gain and Resident #102 (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>was not evaluated by a provider between 2/1/26-2/10/26. In an interview on 3/4/26 at 1:49pm LPN I reported she was aware on 2/3/26 that Resident #102 was experiencing increased pain in her legs. LPN I confirmed the resident was not further assessed. Review of an Assessments listing revealed no nursing or physician assessments were completed on Resident #102 between 1/27/26-2/8/26. Review of progress notes 2/1-2/10/26 revealed no documentation of a nurse contacting the provider regarding Resident #102's unexplained weight gain. In an interview on 3/6/26 at 7:15am, LPN J reported Resident #102 suddenly started complaining of leg pain in early February and had never previously had pain issues. LPN J reported she noticed swelling in Resident #102's left leg and was aware the resident was requiring additional physical assistance for mobility. LPN J reported she was not aware Resident #102 had gained 9 pounds in a little more than a month. LPN J confirmed a significant unexplained weight gain like the one Resident #102 experienced, along with her other symptoms were indicative of a need for further medical assessment and the physician should have been notified. When queried regarding how nurses contact the providers, LPN J reported in this situation, she would contact the provider via the use of Practitioner Communication form. Review of a Practitioner Communications form for Resident #102, with a reference date of 2/2/26, revealed Concern: Would like to see you and speak with you regarding swollen knees. A handwritten response from a provider, dated 2/3/26, read: acetaminophen (over the counter pain medication) scheduled, diclofenac gel (anti-inflammatory drug applied topically) added. Review of a Practitioner Communications form for Resident #102, with a reference date of 2/9/26 revealed Concern: pain to all extremities but especially BLE (bilateral lower extremities) and knees. (acetaminophen) is not helping. Family asking for ibuprofen and acetaminophen to be used intermittently. A handwritten response from a provider dated 2/17/26 read acetaminophen scheduled, PRN (as needed) (opioid analgesic, name omitted) added. In an interview on 3/4/26 at 2:20pm Physician's Assistant (PA) Y reported she was aware Resident #102 had complained of pain in her left leg prior to being hospitalized on [DATE]. PA Y reported she was not aware of any swelling in the resident's legs or of the resident's 9-pound weight gain in 32 days and that a provider should have been notified so the resident's needs would have been assessed. PA Y confirmed Resident #102 was not assessed by a provider between 2/1-2/10/26. When further queried, PA Y reported it was ineffective for staff to communicate with providers via communication sheets because they frequently got overlooked and the staff had been educated to contact the providers via telephone rather than place communication sheets in the provider's mailbox. In an interview on 3/4/26 at 12:05pm, Director of Rehabilitation (DOR) C reported due her loss of functional mobility, Resident #102 began therapy upon her return from the hospital. DOR C reported pain initially limited her ability to participate in lower extremity strengthening. DOR C reported as the swelling in her legs decreased, Resident #102 experienced less pain and was now tolerating therapy well and had begun to walk short distances again</p> | | |