

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235491	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/29/2025
NAME OF PROVIDER OR SUPPLIER The Orchards at Roseville		STREET ADDRESS, CITY, STATE, ZIP CODE 25375 Kelly Road Roseville, MI 48066	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2623867. Based on observations, interview, and record review the facility failed to provide wound care as ordered for one sampled resident (R701) of three reviewed for wound care. Findings include: A review of the complaint summary noted, Today (9/18/24) [R701] was seen by [R701's] wound care providers (that [R701] sees every other week) and [R701's] dressings were dated 09/12/2025. On 9/28/25 at 10:24 AM, R701 was observed in their room lying in bed. R701 feet were observed wrapped and dated 9/28/25 and in heel protector boots. R701 was asked about their wound care and offered no complaints. A review of R701's medical record wound consultation noted, 9/18/2025. Bandage not changed for six days-dated 9/12 !! Not appropriate! A review of R701's treatment record noted. Order: apply betadine and dry dressing to left medial heel. every day shift every 2 day(s) for protection maintain bil (bilateral) heel elevation while in bed. Blank without documentation were September 12th, 14th, 16th, and 18th. On 9/28/25 at 1:01 PM, a review of R701's treatment record was completed with Unit Manager A which confirmed the treatments were not documented as provided on September 12th, 14th, 16th, and 18th. A review of R701's medical record revealed R701 was admitted to the facility on [DATE] with diagnosis of Moderate protein calorie malnutrition and Pressure ulcer right heel unstageable, pressure ulcer of sacral region. On 9/28/25 at 1:35 PM, the Director of Nursing was asked about the missed treatments for R701. The DON explained that they found out about the missed treatments after R701's wound care appointment. The DON explained the Nurses are expected to complete care as ordered daily, as needed, and document daily. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included interventions actions to correct the past noncompliance. The facility was able to demonstrate monitoring of the corrective action and maintained compliance. Past Non-Compliance Issue: Wound Documentation The facility failed to ensure complete and timely documentation, comprehensive skin assessments, treatments and physician orders for residents with wounds. This failure has the potential to delay identifying changes in wound status, hinder appropriate treatment, and follow physician orders which could negatively impact healing outcome. Corrective Action Plan Element 1. All residents identified with wounds during the period 8/13/2025 had an immediate comprehensive skin assessment completed by licensed nursing staff. Skin assessment, wound documentation was updated in the medical record, and treatment orders were reviewed and confirmed by the attending physician. Any changes in wound status were addressed with revised treatment plans. Element 2. A facility-wide skin assessment was conducted for residents to ensure that no additional wounds or skin integrity issues went undocumented. Residents at high risk were identified immediately, physician notified, treatment orders, and appropriate care plans updated. Element 3. Nursing staff were re-educated on the facility policy and procedure for skin assessments, treatment, and wound documentation including frequency, completeness, and accuracy of entries. Element 4. A weekly wound care review process was implemented, led by the wound care nurse/designee, to verify that all wounds are treated as ordered, documented, assessed and care plans updated. Shift supervisors are required to review documentation for completeness at the end of each shift. The Director of Nursing or designee will audit 100% of new wounds and 20% of existing wound documentation weekly for two months, then monthly for three months. Audit results will be reviewed in the facility's Quality Assurance Performances Improvement (QAIP) meetings. Any identified gaps will be addressed with immediate staff education or corrective actions. Compliance will be considered sustained with 6 consecutive months showing 100% adherence to documentation and assessment requirements. Compliance Date 9/26/2025.</p>		