

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 11/20/2025
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)		
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2673919. Based on interview and record review, the facility failed to notify the guardian of a change in condition for one resident (#702) out of one resident reviewed for a change in condition. Findings include: It was reported to the State Agency that the facility failed to notify the guardian that R702 had been sent to the hospital. A review of the clinical record revealed R702 was initially admitted to the facility on [DATE] and readmitted on [DATE]. R702's diagnoses included Chronic Obstructive Pulmonary Disease, Hypertensive Heart Disease and Chronic Respiratory Failure. R702 has a legal guardian who makes their decisions. Further review of the clinical record revealed on 10/29/25, R702 was sent to a vascular doctor's appointment outside the facility. At the doctor's appointment, R702 complained of chest pain and was sent 911 to the hospital. There was no documented communication in the clinical record regarding R702 being sent to the hospital. On 11/20/25 at 3:15 PM an interview with the Nursing Home Administrator (NHA) confirmed the facility did not notify R702's guardian of resident's change of condition and being sent to the hospital from their doctors' appointment. A request was made for a change in condition policy and notification of the guardian but was not received by survey exit.		

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2638560. Based on interview and record review, the facility failed to ensure one resident (R700) did not receive discontinued medications out of two reviewed for unnecessary medications. Findings include: A review of the Electronic Medical Record (EMR) revealed R700 was originally admitted on [DATE]. Diagnoses included Fibromyalgia, and schizoaffective disorder. Further review revealed a Brief Interview for Mental Status score of 13/15 which indicated intact cognition. A review of the physician's orders revealed an order on 9/22/25 to discontinue Ultram (Tramadol-pain medication) once Norco (narcotic pain medication) arrives from pharmacy. The Norco arrived on 9/22/25 however the Tramadol was not discontinued. A review of the September 2025 medication administration record showed the Tramadol was administered on the following dates 9/24/25, 9/29/25, 10/1/25, 10/2/25, and 10/3/25, and the Norco was administered on: 9/23/25, 9/26/25, 10/1/25, 10/2/25, 10/4/25, and 10/5/25. R700 received both medications on 10/1/25 and 10/2/25. On 10/13/25 the order for the Tramadol was discontinued. On 11/20/25 the Nursing Home Administrator (NHA) was queried about the medication orders. The NHA said physician orders should be followed as written. A review of the undated Medication Policy noted the following: Medications are administered in accordance with written orders of the attending physician		