STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235509	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Warren	12250 East 12 Mile Road Warren, MI 48093

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2717353.Based on observation, interview, and record review, the facility failed to timely provide incontinence care or repositioning for three residents (R902, R905, and R906) of three residents reviewed for activities of daily living care (ADL). Findings include:R902On 01/21/26 at 7:17 AM and 8:02 AM, R902 was observed to be supine in bed, dressed in a hospital style gown, the head of bed up slightly, a mat was on the floor at the right side of the bed, a low air loss mattress unit was at the foot of the bed, the bed was in a lowered position, R902 had a pillow on the right side under the arm, heel boots on, the call light was clipped to the side of the mattress at the head of the bed, the tray table was at the foot of the bed. Certified Nursing Assistant (CNA) A reported there were two or three aides on the unit.At 8:19 AM, R902 was supine in bed with the head of the bed up around 45-60 degrees. The breakfast tray was on the tray table over the lap of R902 and the mat was folded up on the floor at the right side of the bed. The bed was up slightly higher. R902 was dressed in a hospital style gown, their hair was sticking out stiffly toward the right side.At 10:13 R902 continued in bed as before with their head over toward the right shoulder with their eyes closed. The breakfast tray had been removed, and an empty juice cup and white foam water cup had been left. The bed had been lowered. The variable length of the fingernails was observed, and the nails were observed with soil underneath.At 10:50 AM, CNA A was walking toward the room of R902 and reported they were going to check and change (provide incontinence care) R902. CNA A then went and brought the unit manager who was working the medication cart to assist. R902 was soiled with loose stool in a sufficient amount to cover the private area around the pubic bone. CNA A reported they had been to other residents that were more significantly wet. R902 was not observed to have been check for incontinence prior to 10:50 AM.A review of the record for R902 revealed R902 was admitted into the facility 12/19/25. Diagnoses included High Blood Pressure and Pain. The Minimum Data Set (MDS) assessment dated [DATE] indicated moderately impaired cognition and the need for substantial/maximal assistance from staff for toileting hygiene, personal hygiene, and bathing and also required meal set up. The active care plan documented, .am incontinent of bowel and bladder . check me at least every two hours during the day .R905On 01/21/26 at 10:30 AM, R905 was observed to be supine in bed, with the head of the bed up around 45 -60 degrees. The breakfast tray was on the tray table across the bed of R905. The tray table deck was at the level of R905's mouth and nose. R905 had a utensil in their right hand. R905 did not answer queries about the food or positioning and made nonsensical verbalizations. A urine odor was noted.At 10:38 AM, Licensed Practical Nurse (LPN) C was asked about the position of R905 for their meal and reported R905 could use the call light and may move the bed up and down. LPN C made no attempt to adjust the resident and commented R905 was a slow eater. The bed controller was observed toward the foot of the bed beyond the reach of R905. At 11:07 AM, R905 had been raised up to a height above the tray table, with scant amount of food eaten when CNA A came and took the tray (continued on next page)

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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	away.At 11:12 AM, an observation of care, with CNA A and LPN C revealed the odor of urine and a visibly urine soiled brief. Upon completion of the care with R905, CNA A was asked about the care of R902 and R905 and reported it had been the first time they had provided incontinence care to the residents since the start of their shift (7AM). A review of the record for R905 revealed R905 was admitted into the facility on [DATE]. Diagnoses included Adult Failure to Thrive, Heart Disease and Alzheimer's. The MDS assessment dated [DATE] indicated severely impaired cognition and the need for substantial/maximal staff assistance for toileting hygiene and dependent on staff for bathing, dressing and personal hygiene, and partial assistance to roll in bed and meal set up assistance. The active care plan documented, .am incontinent of bowel and bladder . am at nutritional risk . I can feed myself with set up and supervision .R906On 01/21/26 at 11:44 AM, 12:30 PM, 1:20 PM and 2:18 PM, R906 was observed to be supine in bed, eyes closed, with the head of the bed up around 30-45 degrees. R906 was dressed in a hospital gown, had a blanket covering the feet to the abdomen, their legs elevated on a device with heel boots on and their head on a pillow. R906 did not open their eyes to a knock on the door.At 2:18 PM, R906's head was off the right side of the pillow, the eyes remained closed.At 2:48 the position of R906 had not changed. A review of the record for R906 revealed R906 was admitted into the facility on [DATE]. Diagnoses included Paralysis of the left side, Stroke and Malnutrition. The active care plan documented, .incontinent of bowel and bladder . needs assistance with ADLs . totally dependent on staff for repositioning me in bed at least every two hours and as necessary .On 01/21/26 at 3:00 PM, the Director of Nursing (DON) was asked about the observations and noted the aides may prioritize the timing of the care for the residents based on needs.At 3:55 PM, the DON followed up and indicated the aide had completed rounds initially and between 9AM and 9:30 AM. It was noted that the position of the residents was not observed to have been changed.A review of the facility nursing standard operating procedure titled Toileting revealed, .When a resident indicates verbally or non-verbally a need to use the bathroom staff should promptly assist the resident .

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2718756.Based on observation, interview, and record review, the facility failed to ensure essential equipment was readily for use, for one sampled resident (R904) of three reviewed for patient care equipment. Findings include:A review of an Intake revealed, AED (Automated external defibrillator) pads not on crash cart. The Complainant reported on 1/15/26 on [NAME] unit R904 had a code blue and when the staff went to use the unit's AED, staff had to go and get another AED from another unit due to the closest AED not having pads. A review of R904's medical record noted R904 was admitted to the facility on [DATE] and readmitted on [DATE]. R904's medical record documented on 1/15/26 after a code and 911 were called, the resident was transferred to the local hospital. A review of R904's Minimum Data Set (MDS) assessment noted R904 with intact cognition and required assistance from staff to complete activities of daily living. A review of R904's advanced directive was noted as full code. During the survey a phone call was made to the nurse K involved in the code and a voice message was left but the call was not returned.On 01/21/26 at 7:42 AM, a red cased AED on top of the crash cart outside reception was observed to be cracked open and a status light could not be seen in the status window.At 9:15 AM, on the [NAME] unit, the crash cart and log were observed with all items checked for the day. Just above the crash cart and attached to the wall, a white box labeled AED was observed to be empty (without the AED inside the box). At 9:19 AM and 2:33 PM, the crash cart in the large dining room was observed with soiled towels on the top of the cart. The cart was without a form to indicate/monitor the inventory inside the cart. The towels remained on top of the cart during the length of the survey.On 1/21/26 at 9:25 AM, the crash cart on the [NAME] unit was observed with a completed inventory sheet. The AED machine was observed on the top of the cart inside a red case labeled AED, once opened the machine was observed with the battery on the outside of the machine.On 1/21/26 at 12:40 PM, Central supply Staff J was asked about replacement pads for the AED machines. Staff J was then observed with three replacement pads one for the AED machines. Staff J was asked the process of notification when the pads need to be replaced and reported the nurses, or the Unit Manager would let them know.On 1/21/26 at 12:57 PM, Rose/Lavender Unit Manager (Nurse I) was asked about the AED machine for the Lavender unit. Nurse I was observed to locate the crash cart for the unit and opened the AED wall container. Inside the container was a Red case which contained the AED, the battery was observed on the outside of the machine. Nurse I was asked why the battery was not left inside of the machine and explained the machine would continuously beep and may drain the battery.On 1/21/26 at 1:50 PM, the Director of Nursing (DON) was asked about R904's code blue and if the AED machine closest to R904 was used. The DON explained that the Nurse called and gave report but did not report which AED machine was used. The DON was asked about the two AED machines that had the battery observed on the outside of the machine and confirmed they are kept that way in order to maintain the battery. A review of the manufacture's manual was reviewed with the DON and made aware of the manual's documentation, Note: Always store the (name of AED machine) with a set of SMART Pads and a battery installed, so it will be ready to use and can perform daily self-tests. Further review of the manual noted the AED Machine completed automatic self-tests. On 1/21/26 at approximately 2:40 PM, the [NAME] unit manager Nurse B was asked to demonstrate the self-test on the red case AED. Nurse B was observed to open the red case, place the battery inside the machine, and turned it on. The machines automated voice said to connect the pads, which Nurse B reported it would be a waste of pads to continue. Nurse B was shown the manual that noted the self-test instructions. Nurse B report they were unable to complete it without connecting the pads.A review of the owner's manual for the (Name of) Defibrillator Edition 13, revealed, . 4. After Using the (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(name of defibrillator) . 6. The (name of defibrillator) will automatically run a self-test when the battery is inserted. Press the Shock button and On/Off button when instructed. Be sure to let the self-test run all the way to completion. When the self-test is over, the (name of defibrillator) will report the result, and tell you to push the green On/Off button in case of an emergency. Then the (name of defibrillator) will turn off and go to standby mode. The green Ready light will be blinking to show the (name of defibrillator) is ready for use. (Note: Always store the (name of defibrillator) with a set of SMART Pads and a battery installed, so it will be ready to use and can perform daily self-tests.). 7. Return the (name of defibrillator) to its storage location so it will be ready for use when needed. Place the updated inspection log/maintenance booklet on the defibrillator wall mount or cabinet. A facility's policy was requested to address the AED machines and crash cart. The Nursing Home Administrator reported the facility did not have polices for those items requested.