STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235555	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Canterbury on the Lake	5601 Hatchery Rd Waterford, MI 48329

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00151890. Based on interview and record review, the facility failed to report an allegation of misappropriation of property to the Administrator and/or State Survey Agency for one (R802) of three residents reviewed for abuse. Findings include: A review of a complaint submitted to the State Survey Agency revealed allegations that included, Someone at the nursing home has been taking money from (R802) .There was a cell phone bill for $2000 from calls being placed to [NAME]. There was $400 used at (name of grocery store) up the street from the nursing home. Someone was using (R802's) cell phone to make purchases through account .Over the past several months there had been charges for (name of ride share company) rides, (name of grocery store) and (name of drug store). Someone has been purchasing gift cards using the money out of (R802's) account. The gift cards were purchased in (name of city) and (name of city) with her debit card. There have been thousands of dollars taken from (R802's) account. All of (R802's) money is gone from her account. The most recent purchases were on April 3, 2025, at the (name of city) post office for $500 and a little over hundred dollars. (R802) is currently missing $800 out of her account . On 4/10/25, an unannounced, onsite investigation was conducted at the facility. A review of R802's clinical record revealed R802 was admitted into the facility on [DATE], readmitted on [DATE], and discharged on [DATE]. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R802 had intact cognition and no behaviors. A review of a Grievance and Concern Form dated 4/5/25 completed by the Administrator revealed R802's daughter expressed concerns. It was documented on the form that Nurse called Administrator and informed Administrator that the daughter was in (the facility) yelling and screaming at staff and went to resident's room and took items out of the room. The Administrator spoke to the daughter over the phone and the daughter was very angry and would not communicate with the Administrator. The police were notified and when they arrived the daughter had left. Administrator spoke with staff and there were no specific issues identified . Daughter contacted the Administrator and asked if she could come to get her mother's belongings. The Administrator arranged for the daughter to come in to collect her mother's belongings . (continued on next page)

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/25 at approximately 3:10 PM, the Administrator was asked for the name of the nurse who notified her of R802's family member. The Administrator identified the nurse as Licensed Practical Nurse (LPN) 'A'. On 4/10/25 at 3:20 PM, a telephone interview was conducted with LPN 'A'. When queried about the interaction she had with R802's family member on 4/5/25, LPN 'A' reported R802's family member came to the facility and started yelling and screaming and going through R802's belongings. When queried about what she was upset about, LPN 'A' reported she brought up an incident from last year regarding a man R802 had been dating online, but then said someone from the facility is taking her (R802) money. LPN 'A' explained that R802 was her own decision maker and previously there were concerns about her giving money to a man online, but R802 was able to make her own decisions. When queried about what was done when R802's family member alleged someone from the facility took R802's money, LPN 'A' reported she told the Administrator who instructed LPN 'A' to call the police due to the family member's behavior. LPN 'A' confirmed she told the Administrator about the allegation. LPN 'A' further explained R802 did not like anyone involved in her care and at times did not want family notified of things such as hospital transfers. On 4/10/25 at 5:07 PM, an interview was conducted with the Administrator who was the Abuse Coordinator for the facility. When queried about the facility's protocol if a resident or family member made an allegation regarding abuse, neglect, or misappropriation of property, the Administrator reported the staff was required to contact her immediately, explain the actual allegation, and then the Administrator would try to figure out what was going on with the resident, ensure their safety, and report the allegation to the State Agency within 24 hours. When queried about what was reported to her regarding allegations made by R802's family member on 4/5/25, the Administrator reported R802's family member came to the facility yelling and screaming and threatening to remove R802 from the building (R802 was at the hospital at that time). The Administrator reported R802's family member had tried to get access to R802's money in the past and when the Administrator spoke with R802, R802 said she did not want her daughters having access to her money. On 4/5/25, R802 did not want her family notified that she was going to the hospital, but somehow R802's daughter found out and came to the facility. While at the facility R802's daughter was angry and yelling and the nurse called me and told me she felt threatened. When queried about whether LPN 'A' told her that R802's family member alleged someone in the facility had taken R802's money, the Administrator reported she had not. When queried about whether that was something that should have been reportable, the Administrator reported it should have been reported but due to the history with R802's daughter and also with R802's online boyfriend, it was likely not perceived as an allegation due to R802 being her own decision maker. The Administrator explained it should have been reported and investigated. A review of a facility policy titled, Abuse and Neglect Prohibition Policy, revised on 11/9/24, revealed, in part, the following, .The staff will report all allegations of abuse, neglect and misappropriation of property to the Administrator immediately .The Administrator or designee is responsible for reporting to the State Agency ALL alleged violations involving abuse, neglect, exploitation .including .misappropriation of property . immediately but no later than 2 hours after the allegation is made if the allegation involves abuse or results in serious bodily injury .or not later than 24 hours is the events that cause the allegation do not involve abuse or serious injury .

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00151836. Based on observation, interview, and record review, the facility failed to thoroughly investigate multiple falls to determine the root cause and implement effective interventions that included adequate supervision for one (R805) of two residents reviewed for falls, who had repeated falls, resulting in the resident falling 15 times in three months and sustaining a head injury and forehead laceration. Findings include: On 4/10/25 at 4:05 PM, R805 was observed in bed with eyes closed. R805 woke up upon entrance into his room. R805's water cup was observed on an over bed table that was not within reach of the resident. A wound of some sort was observed on R805's forehead. R805 did not participate in a conversation when addressed. A review of R805's clinical record revealed R805 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: dementia, psychotic disorder with delusions, and insomnia. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R805 had severely impaired cognition; behaviors during one to three days during the assessment period that interfere with the resident's care and put others at significant risk of physical injury; required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for bed mobility (rolling left to right, going from lying down to sitting and sitting to lying) and transfers (sit to stand, chair to bed transfer, toilet transfer); was occasionally incontinent of urine; had a history of falls prior to admission into the facility; and had one fall in the facility since admission. A review of R805's progress notes revealed multiple falls between R805's admitted [DATE] and the current date of 4/10/25. A review of R805's incident reports revealed the following falls: 1. 1/10/25 at 6:01 PM, two days after R805 was admitted into the facility, resident stated he was sitting in chair when he wanted to stand up and stretch his legs nurse found resident on his back . It was documented the incident occurred in R805's room. It was documented on 1/13/2025, IDT (interdisciplinary team) reviewed incident on 1/10/25, root cause standing without assistance of staff stretching legs from w/c (wheelchair). Staff to offer (R805) to sit in recliner chair after dinner . 2. 2/8/25 at 6:00 AM, Nurse observed Resident sitting straight up on Buttocks back up against the bed legs straight out Bed was at lowest position bed side table was right before residents feet near room Sink . Resident is Alert and Oriented x2 was not able to give a clear Description of incident resident did state that he could not get comfortable because his butt was hurting so he slid over to the floor . It was documented that improper footwear was a predisposing situation factor. It was documented on 2/10/25, IDT reviewed incident on 2/8/25, root cause attempting to get comfortable in bed. Staff to assist with turning and repositioning in bed for comfort . It should be noted that R805 required assistance for turning and repositioning in bed prior to that incident. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a progress note dated 2/7/25 at 8:07 PM revealed, Resident has been upset yelling majority of the shift attempting to climb out of bed and put himself on the floor. Resident has been redirected and repositioned in bed numerous times throughout the shift. Resident received (pain medication) twice for pain. He continued to yell out and attempt to get out of bed stating he was walking home. Resident was offered to sit up in his wc for a while be <sic> declined. Continued to yell out for hours. There was no documentation of increased supervision. 3. 2/10/25 at 7:15 PM, .writer hear <sic> resident yell out for help, upon entry resident room writer observe resident laying on right side on bedroom floor near bathroom. Resident had non-skid socks and brief was solid <sic>. Call light not on or within reach. Resident was unable to explain to writer what he was trying to do .skin tear to right lateral knee noted .2/11/2025 IDT reviewed for incident 2/10/25. Root cause identified as attempted to self transfer without staff assistance. Staff to offer toileting after dinner . There was no information about what R805 was doing prior to the fall or that the call light not being in reach was addressed. No further investigation was provided. 4. 2/16/25 at 9:20 PM, .Writer was notified that resident was lying on the floor next to the bed. Writer asked resident what happened resident stated that he was trying to sit on the edge of the bed .Writer asked resident did he hit his head. Resident stated 'yes' .Physician ordered to transfer resident to hospital for further evaluation .IDT reviewed for incident 2/16/25. Root cause attempting to sit on edge of bed. Staff to offer (R805) to get up in chair if observed restless . A review of progress notes revealed no documentation that R805 was restless at the time of the fall. No further investigation was provided. 5. 3/7/25 at 11:35 AM, .Observed patient in the wheelchair to left side on the floor. Patient was clamped in between wheel chair. Resident was still in wheelchair and wheelchair closed down on resident while on the floor on his left side. Hard time removing resident from out of wheelchair due to legs rest open and legs where <sic> behind legs rest .Resident stated, 'Trying to pick something from the floor' .root cause reaching for item on floor. Per staff there was nothing on floor. Staff to re-orient (R805) of surroundings and remove footrest when sitting stationary . There was no documentation that addressed the resident being clamped in between the wheelchair and wheelchair closed down on resident while he was still in it. No further investigation was provided. 6. 3/7/25 at 5:00 PM (five and a half hours after the previous fall mentioned above), .Patent <sic> was observed on the fall mat laying on his back .Patient stated, 'I get out of the bed' .Abrasion noted to right knee . Root cause identified as self-transfer trying to get up from bed .encouraged to be up in dining room for dinner . 7. 3/13/25 at 10:20 AM, Resident found on the floor in the dining in front of his wheelchair .Unable to give description .root cause self-transfer without assistance in dining room after breakfast .encouraged to be in high traffic area when in w/c after breakfast . It was not mentioned whether there was any supervision provided in the dining room at the time of the fall. No additional investigation was provided. 8. 3/13/25 at 11:00 AM, (40 minutes after R805's fall in the dining room), Resident had a witnessed fall in the hallway at the 2nd floor nursing station .root cause self-transferring at nursing station without staff assistance. Will have psych to consult related to restlessness and increased agitation . There was no documentation of the level of supervision provided at the nurse's station at the time of the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a progress note dated 3/13/25 at 3:06 PM revealed, UM (unit manager) was notified approx. (approximately) (3:10 PM) that resident had a few more falls today .upon entry of room observed pt (patient), sister and brother-in-law at bedside .observed fidgety and constantly changing position while in bed, going from lying to sitting position, several attempts of wanting to stand. Sister redirected with verbal stimuli . resident unable to follow conversation .resident declined assistance to restroom .confused and scatter thinking . 9. 3/16/25 at 6:00 PM, Writer was walking in (hallway) when she heard 'yelling Help me help me' in (room number). Resident was observed lying on the floor in front of bed on floor in supine position. Writer asked resident what he was trying to do he states going to bathroom .root cause identified as self-transfer. Resident trying to self-transfer to use restroom. Resident to transfer to 3rd floor (dementia unit) when bed becomes available per psych recommendations . It should be noted that R805 was not moved to the 3rd floor until 4/2/25. 10. 3/21/25 at 3:30 PM, .Resident observed sitting on the floor in front of his bed. Resident states he was attempting to transfer himself from the bed to the wheelchair .Root cause identified as transfer without assistance or use of call light .will have labs drawn for medical work up r/t (related to) fall . 11. 3/22/25 at 5:00 PM, .Resident was observed lying on the floor in front of bed on floor in supine position. Writer asked resident what he was trying to do he states going to work .Root cause identified as resident unaware of surroundings; resident states he was trying to go to work. Resident will have a medication review by pharmacy . 12. 3/26/25 at 12:30 AM, .Patient observed sitting on floor next to bed .Patient did not wish to explain reasoning for fall .Root cause identified as resident attempting to get up without assistance. When observed restless offer the resident a snack, to get up, or to use the toilet . It should be noted those interventions were already in place. A review of a progress note dated 4/3/25 at 1:47 AM, one day after R805 moved to a new room on the 3rd floor, revealed, Resident has attempted x 2, so far this shift, to get up from bed unassisted. This nurse observed resident sitting up on the side of the bed, attempting to grab onto the nightstand to assist him in standing . A review of a progress notes dated 4/3/25 at 5:21 PM revealed, .Resident still attempted self-transfers today . 13. 4/5/25 at 8:35 AM (in new room on the 3rd floor), .Upon entering residents room writer observed resident on floor partially lying on left side with w/c leaning on resident rt (right) led <sic> .'I was trying to get into the w/c when I fell ' .Resident is not aware of physical limitations as it related so safety .and is somewhat forgetful .has hallucinations .a couple of small abrasions to rt/lt (right/left) knees .resident c/o (complained of) pain to rt leg .new order for Xray of rt knee/rt ankle .root cause attempting to self transfer without assistance out of bed. Staff to assist (R805) out of bed before breakfast . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a progress note dated 4/5/25 at 8:35 AM revealed, .resident sat across from nurses station for a while .but yelled out for someone to come help him frequently .resident said that he felt like he was falling, writer reassured resident hat he was sitting in his w/c .and to try and sit back and relax .resident would be quiet for a few minutes and then start to yell out again .assisted to bed .explained to resident that he should try to relax .and that if he needed assistance to use the call light and someone will come to assist him . resident continued to yell out periodically calling out to someone .said that he was calling the dog .insisted that he saw a dog .assistance provided q (every) 2 hrs (hours) prn . 14. 4/7/25 at 1:25 AM, .Writer heard resident call out for help stating he had fallen, writer and CNA (certified nursing assistant) observed resident lying on the floor on his right-side face down with his head towards the bathroom door and his feet by his bed. resident had been observed at (1:15 AM), noting him clean and dry at that time. resident requested something to eat so CNA went to the dining room to get resident a snack .'I'm trying to get out of here, but now I've hurt my head and hip' .Writer assessed for injury noting laceration to right forehead .writer contacted hospice .who stated it would take her 3 hours to visit and since resident is on anticoagulant (blood thinners) medication to send resident to ER (emergency room) for follow up .root cause attempted transfer our of bed unassisted. Staff to offer prn (as needed) anxiety medication if observed restless . A review of a progress note dated 4/7/25 at 4:25 AM revealed, .resident returned from ER visit with no new orders in place. laceration to rt (right) forehead taped . A review of the discharge instructions from the hospital emergency department on 4/7/25 revealed, Final Diagnosis: .Fall from standing .Head injury, acute .Forehead laceration . 15. 4/8/25 at 6:30 PM, .Writer was notified by (CNA) that resident had gotten out of bed .became unsteady on his feet. (CNA) tried to hold onto resident and resident decided to sit on the floor .observed sitting on the floor partially lying on rt side .said he was trying to get to his w/c .root cause self-transfer without assistance. (R805) to be offered activities to help stimulate him when observed restless . A review of R805's care plans revealed the following: A care plan initiated on 1/23/25 and revised on 4/7/25 that read, I experience cognitive impairment related to Dx (diagnosis) dementia . A care plan initiated on 1/9/25 and revised on 4/7/25 that read, I am at risk for falls r/t decreased mobility, decreased cognition. Multiple interventions were initiated between those dates, but other than 3/14/25 when it was initiated to encourage R805 to be in a high traffic area after breakfast, increased supervision was not included as an intervention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/10/25 at 4:56 PM, an interview was conducted with the Director of Nursing (DON). When queried about R805 and whether there were effective interventions in place to prevent him from falling, the DON reported they implemented multiple interventions but none were effective. The DON reported they moved him to the 3rd floor dementia unit (this occurred after R805 fell 12 times) to decrease stimulation, monitored labs, did medication reviews, assessed for pain, and had psychiatric evaluations, but he continued to fall. The DON reported there is a need that is not being met, but they have not been able to identify it. When queried about why R805 had not received 1:1 supervision since he continued to fall without any obvious pattern (time of day, place, situation) and the DON did not offer a response.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00151836. Based on observation, interview, and record review, the facility failed to ensure medications were stored properly and discarded by the expiration date for two of two medication carts reviewed. Findings include: On 4/10/25 at 8:36 AM, an observation of the [NAME] Unit was conducted. A medication cart was observed unlocked and unattended to. When the top drawer was opened, a plastic cup contained one small, round, clear, yellow pill. On 4/10/25 at approximately 8:40 AM, an interview was conducted with Licensed Practical Nurse (LPN) 'C'. LPN 'C' reported the medication cart should have remained locked when not attended to. When queried about the loose pill in the cart, LPN 'C' reported it was left there from midnight shift, but identified the pill as bezonatate (a medication to relieve coughing). LPN 'C' explained all medications should remain in their package and/or bottle until ready for administration. On 4/10/25 at 9:10 AM, an observation of the 3rd floor medication cart was conducted with Registered Nurse (RN) 'D'. Two insulin pens (Lantus/insulin glargine) were observed opened and dated 2/25/25 and 3/1/25. According to RN 'D', insulin pens were good for 28 days after they were opened and then they were to be removed from the cart and discarded. On 4/10/25 at 11:02 AM, an interview was conducted with the Director of Nursing (DON). When queried about proper storage of medication, the DON reported the medication carts were to be locked when not attended to and medication was not pre-prepared and stored loose in the cart. The DON reported medication should be pulled from the package and/or bottle when ready to administer. When queried about insulin pens, the DON reported they were to be dated when opened and discarded after 28 days. A review of an undated facility policy titled, Medication Storage in the Facility revealed, in part, the following: . Medications and biologicals are stored safely, securely .(Pharmacy name) dispenses medications in containers that meet legal requirements .Medications are kept and stored in these containers .Outdated . medications .are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exists .