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	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Canterbury on the Lake	5601 Hatchery Road 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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint #2649498Based on interview and record review, the facility failed to notify the resident's responsible party of a change of condition after a fall and a subsequent emergent transfer to the hospital for one (R801) of one resident reviewed for notification of changes. Findings include:A review of a complaint submitted to the State Agency revealed an allegation that R801 fell in the early morning of [DATE] and was taken to the local hospital via ambulance. R801's responsible party alleged they were unaware of the fall or hospital transfer until 3:45 PM when the emergency room (ER) physician contacted them to say R801 sustained a Dense fracture of the C-2 Vertebrae.On [DATE], an onsite investigation was conducted.A review of R801's clinical record revealed R801 was admitted into the facility on [DATE], discharged to the hospital on [DATE] and [DATE], and expired in the facility on [DATE]. R801's diagnoses included: chronic obstructive pulmonary disease (COPD), Alzheimer's Disease, and a neck fracture (as of [DATE]). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had moderately impaired cognition. There was documentation that R801's family member was her legal decision maker and R801 was deemed unable to make her own medical decisions on [DATE].A review of R801's progress notes revealed on [DATE], Licensed Practical Nurse (LPN) ‘A' wrote a Nurses Note that documented, Nurse was notified by assigned CNA (Certified Nursing Assistant) that the resident had an audible fall heard from the hallway. Resident reported severe head pain with facial grimacing.MD (medical doctor) notified; order received to transfer resident to (local hospital). EMS (Emergency Medical Services) arrived and resident was transferred via stretcher to (local hospital. There was no documentation that R801's responsible party was notified.A review of a Social Services progress note dated [DATE] revealed documentation that R801's responsible party expressed some frustrations regarding residents d/c (discharge) to the hospital.and requested to speak with someone to provide answers to her questions.A review of a Concern Form dated [DATE] revealed R801's responsible party had the following concern: Nurse did not call to inform her mother was sent out to hospital on [DATE]. The Administrator was interviewed and identified the nurse as LPN ‘A'.A review of a Work Performance/Work Rules Disciplinary Action Record for LPN ‘A' revealed she received a Written warning for [DATE] because she failed to notify residents daughter (POA - Power of Attorney/decision maker) of a fall that occurred on [DATE]. It was documented LPN ‘A' received one to one education by telephone regarding contacting residents' POA, family, and/ or emergency contact for any falls, change of condition, or new orders. The form was signed by a supervisor and the administrator but was not signed by LPN ‘A'.On [DATE] at 1:10 PM, an interview was conducted with LPN ‘A' via the telephone. When queried about whether she contacted R801's responsible party on [DATE] after she fell and was transferred to the hospital, LPN ‘A' reported it was her best practice to call. LPN ‘A' did not give a clear answer on whether she called R801's responsible party on [DATE] or if it was for a second fall on [DATE]. When queried about any education provided regarding contacting residents' POA, family, and/or emergency contact, LPN ‘A' did not recall if she received education regarding that and stated, They call you all the time about stuff and did not recall receiving any disciplinary action (written warning).A review of an undated document that was provided as a facility policy titled, Fall Management Guidelines, revealed, in part, the following, .As soon as practicable, communicate the fall to the attending physician and the resident's responsible party/legal representative and document in the medical record.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2643927Based on observation, interview and record review, the facility failed to ensure medications were available to administer per the Physician's orders for two residents (R901 and R902) of two residents reviewed for medication administration. Findings include:On 10/21/25 a concern submitted to the State Agency was reviewed which alleged R901 did not have their medication available for administration upon being admitted to the facility.R901On 10/21/25 at approximately 11:05 a.m., R901 was observed in their room, up in their wheelchair. R901 was queried regarding their IV ABT (intravenous antibiotics) and they reported they had a PICC line (PICC-peripherally inserted central catheter) in their upper left arm. R901 was queried if they had any concerns regarding their antibiotics that had been administered via the PICC line, and they reported that they did not get them the night they were admitted due the facility because the facility did order them in time. R901 reported they did not receive any ABT until the following day. R901 was queried if the Nursing staff had been donning personal protective equipment (PPE) including gowns when providing care to them, and they reported that nobody was wearing any gowns.On 10/21/25 the medical record for R901 was reviewed and revealed the following: R901 was initially admitted to the facility on [DATE], last readmitted on [DATE] and had diagnoses including Urinary tract infection, Extended Spectrum Beta Lactamase (ESBL) Resistance and Iron deficiency-Anemia. A review of R901's MDS (minimum data set) with an ARD (assessment reference date) of 9/19/25 revealed R901 needed assistance from facility staff with most of their activities of daily living. R901's BIMS score (brief interview of mental status) was 15 indicating intact cognition. A faxed hospital prescription dated 10/13/25 revealed the following: ertapenem 1 g (gram) in sodium chloride 0.9 % 50 mL (milliliters) IVPB (intravenous piggyback) 1 each START-10/13/2025 END-10/20/2025 Route: Infuse 1 g (gram) into a venous catheter 1 (one) time each day at the same time for 7 days. End date 10/20/2025A facility Admissions Notice revealed the following: Return .admit date : [DATE] . Transport Time: 3:00 PM .Immediate Equipment/Intervention Needs .IV/Pump/Supplies .Important Details: Pt (patient) is on IV Ertapenem 1 G for seven days. Start date 10.13. End date 10.20.25. Pt must have IV at 6pm today. A review of R901's hospital discharge instructions with a printed date of 10/14/25 revealed the following: 1 g in sodium chloride 0.9 % 50 mL (milliliters) IVPB (piggyback) 3 START Infuse 1 g into a venous catheter 1 (one) time each day at the same time for 7 days. End date 10/20/2025 .Last time this was given: October 13, 2025 5:27. A review of R901's Physician orders while at the facility revealed the following: Start Date: 10/15/25 Ertapenem Sodium Injection Solution Reconstituted 1 GM (Ertapenem Sodium) Use 1 gram intravenously one time a day for UTI until 10/21/2025 14:00 Administer with 50 mL IVPG of 0.9 sodium chloride.A review of R901's October 2025 Medication Administration Record (MAR) revealed R901 was not administered their Entrapenem on 10/14/25 and did not receive a Dose at the facility until the following day on 10/15/25.R902On 10/21/25 the medical record for R902 was reviewed and revealed the following: R902 was initially admitted to the facility on [DATE] and had diagnoses including Chronic kidney disease and Dementia.A review of R902's Physician orders revealed the following: 1. Potassium Chloride Oral Packet 20 MEQ (milliequivalent) (Potassium Chloride) Give 1 packet by mouth one time a day for hypokalemia and 2. Metoprolol Succinate ER (extended release) Oral Tablet Extended Release 24 Hour 50 MG (milligram)) (Metoprolol Succinate) Give 1 tablet by mouth one time a day for hypertension.A review of R902's October 2025 MAR revealed the following medications that were documented as not being administered: Potassium Chloride Oral Packet 20 MEQ: 10/14, 10/17, 10/18, 10/19 10/21. Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG: 10/17 and 10/21.A review of R902's progress notes revealed the following EMAR notes pertaining to the dates in which R902's medications were not administered: 10/14/25-Potassium Chloride Oral Packet .Give 1 packet by mouth one time a day for hypokalemia-Medication not available awaiting delivery from pharmacy 10/17/25-Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG Give 1 tablet by mouth one time a day for hypertension-medication not available Potassium Chloride Oral Packet 20 MEQ Give 1 packet by mouth one time a day for hypokalemia-medication not available. 10/18/25-Potassium Chloride Oral Packet 20 MEQ Give 1 packet by mouth one time a day for hypokalemia-ON ORDER 10/19/25-Potassium Chloride Oral Packet 20 MEQ Give 1 packet by mouth one time a day for hypokalemia-on order 10/21/25-Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG Give 1 tablet by mouth one time a day for hypertension- medication not available Potassium Chloride Oral Packet 20 MEQ Give 1 packet by mouth one

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	235555	A. Building B. Wing	10/24/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2643927Based on observation interview and record review, the facility failed to ensure sufficient staffing was provided to meet resident needs for two residents (R901 and R903) of three residents reviewed for staffing. Findings include:On 10/21/25 a concern submitted to the State Agency was reviewed which alleged the facility did not have enough staff to meet resident needs.R901On 10/21/25 at approximately 11:05 a.m., R901 was observed in their room, up in their wheelchair. R901 was queried regarding the staffing levels in the facility and they reported that the facility is often short of staff and they have had to wait long wait times for their call button (a device used to notify staff of the need for assistance) to be answered resulting in significant delays in getting their needs met. On 10/21/25 the medical record for R901 was reviewed and revealed the following: R901 was initially admitted to the facility on [DATE], last readmitted on [DATE] and had diagnoses including Urinary tract infection, Extended Spectrum Beta Lactamase (ESBL) Resistance and Iron deficiency-Anemia. A review of R901's MDS (minimum data set) with an ARD (assessment reference date) of 9/19/25 revealed R901 needed assistance from facility staff with most of their activities of daily living. R901's BIMS score (brief interview of mental status) was 15 indicating intact cognition.R903On 10/21/25 at approximately 2:51 p.m., visitor F reported that the facility had an issue with staffing in the building and that on 10/19/25 there was only one CNA (Certified Nursing Assistant) caring for resident on the first floor and that R903 was left wet for multiple hours during the day shift and they could not get their brief changed. Visitor F reported R903 was dependent on the Nursing staff to get changed and that the facility does not have enough staff to do it without waiting long periods of time. On 10/21/25 the medical record for R903 was reviewed and revealed the following: R903 was initially admitted to the facility on [DATE] and had diagnoses including Hemiplegia and hemiparesis following cerebral infarction (stroke) and Dementia. On 10/21/25 a review of the staffing sheets for the facility for 10/19/25 revealed two CNA's (Certified Nurse Assistant) were scheduled to work the first floor at 7:00 AM-3:00 PM shift and another CNA was scheduled to come in at 10:00 AM.On 10/21/25 at approximately 3:41 p.m., CNA D was queried regarding working the day shift on the first floor on 10/19/25 and they reported they were the only CNA on the floor for approximately 4-5 hours and were not provided any assistance until after lunch at approximately 1:30 pm. CNA D indicated that visitor F was upset that R903 had not been changed and was left wet so another CNA came to help at that time. CNA D reported that another CNA did not work the set that morning and they were not replaced, and they were doing the best they could to change all the residents on the first floor because the Nurse was busy with giving medications. CNA D was queried how the staffing shortage affected the residents on the floor, and they indicated that call lights were answered late and nobody got any bathing that morning and that some residents were wet longer than they should have been. On 10/21/25 at approximately 3:25 p.m., Staffing Coordinator C (SC C) was queried regarding the staffing shortage during the morning of 10/19/25 on the first floor. SC C indicated that they had a call off on the floor in which one CNA did not work and another that was supposed to come in at 10:00 AM to help. SC C reported that CNA B was supposed to go to the first floor to help CNA D with the resident's care. On 10/21/25 at approximately 3:51 p.m., Nurse E was queried regarding the staffing levels on the first floor on the morning of 10/19/25. Nurse E reported they were only provided one CNA for all the residents on the floor and the residents experienced delays in their care due to the shortage. Nurse E indicated that they did not receive any additional assistance until after lunch when another CNA came down to help them. On 10/21/25 at approximately 3:54 p.m., CNA B was queried regarding the staffing shortage on the first floor on 10/19/25. They indicated that they were unaware of the staffing shortage until they were instructed to go down to the first floor after lunch (around 1pm-1:30pm). CNA B reported when they arrived on the floor, CNA D was the only CNA on the floor and a lot of residents were wet (with urine) and needed to be changed. CNA B was queried why did they not assist CNA D earlier in the morning, and they reported they did not know they were supposed to go to the first floor until someone told them after lunch was finished. On 10/21/25 a facility document titled Staffing and Scheduling was reviewed and revealed the following: Purpose-To assure adequate, competent staff is available to provide care for the residents . Fundamental information-Staffing for acuity involved understanding the needs of residents and staffing accordingly to assure care can be provided to address resident needs. The DON (Director of Nursing) should work closely with the staffing coordinator to identify nursing staffing needs and hire nursing staff accordingly

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2643927Based on observation, interview and record review, the facility failed to ensure enhanced barrier precautions were provided for one resident (R901) of two residents reviewed for infection control. Findings include: On 10/21/25 a concern submitted to the State Agency was reviewed which alleged R901 was not provided adequate protections to prevent infection. On 10/21/25 at approximately 11:05 a.m., R901 was observed in their room, up in their wheelchair. R901 was queried regarding their IV ABT (intravenous antibiotics) and they indicated that they had a line (PICC-peripherally inserted central catheter) in their upper left arm. R901 was queried if they had any concerns regarding their antibiotics and they reported that they did not get them the night they were admitted , because the facility did not order them in time. R901 was queried if the Nursing staff were donning personal protective equipment (PPE) including gowns when providing care, and they reported that nobody was wearing any gowns. At that time, an observation of R901's room revealed no signage indicating staff were to be donning PPE when providing care. No gowns were observed in the vicinity of R901's room indicating that staff were to don PPE when providing care to R901. An observation of R901's upper left arm was conducted and revealed a dressing covering the PICC line with dried blood underneath it. On 10/21/25 the medical record for R901 was reviewed and revealed the following: R901 was initially admitted to the facility on [DATE], last readmitted on [DATE] and had diagnoses including Urinary tract infection (UTI), Extended Spectrum Beta Lactamase (ESBL) Resistance and Iron deficiency-Anemia. A review of R901's MDS (minimum data set) with an ARD (assessment reference date) of 9/19/25 revealed R901 needed assistance from facility staff with most of their activities of daily living. R901's BIMS score (brief interview of mental status) was 15 indicating intact cognition. A review of R901's careplan revealed the following: Focus-I am on antibiotic therapy r/t (related to) a UTI (Urinary tract infection) Date Initiated: 09/28/2025 .A review of R901's Physician orders revealed the following: Ertapenem Sodium Injection Solution Reconstituted 1 GM (Ertapenem Sodium) Use 1 gram intravenouslyone time a day for UTI until 10/21/2025 23:59 .Further review of R901's Physician orders and careplans did not reveal any orders/instructions for enhanced barrier precautions or any other type of transmission based precautions. On 10/21/25 at approximately 12:32 p.m., during a conversation with facility Infection Control Preventionist H (ICP H), ICP H was queried if R901 should be provided transmission precautions since they had an infection and a PICC line in their arm and were receiving ABT. ICP H indicated that R901 should be on contact precautions due to the EBSL (Extended-Spectrum Beta-Lactamase) infection they had and the PICC line in their arm. ICP H was informed of the observations of R901 not having any precautions provided to them or any Physician orders/careplans in their medical record and they indicated they would implement the precautions immediately and that for some reason R901 was missed when they review who should have been provided precautions upon admission to the facility. On 10/21/25 at approximately 2:27 p.m., during a conversation with the Director of Nursing (DON) the DON was queried regarding the lack of transmission based precautions provided to R901 since they were re-admitted to the facility with a PICC line and they indicated they were aware of the issue and it had been corrected with orders put in place and appropriate signage on R901's door and PPE by the room entrance. On 10/21/25 a secondary review of the medical record was reviewed with an updated Physician order dated 10/21/25 at 12:45 p.m., that documented the following: Contact Precautions for ESBL in urine: Practice hand hygiene and put on gown, mask, and gloves. Wear eye protection (goggles) for splash potential high contactcare. Remove/dispose of used PPE prior to exiting resident's room. Practice hand hygiene. PPE found at nurses' station or Clean Utility room. two times a day forprecautions.On 10/21/25 a facility document titled Transmission Precautions: Contact: was reviewed and revealed the following: Purpose-In addition to Standard Precautions, Precautions are used for residents known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the resident, or indirect contact (touching) with environmental surfaces or resident care items in the resident's environment .3. Gowns-Wear a clean, non-sterile gown upon entering the resident's room if you anticipate substantial contact between your clothing and the resident, environmental surfaces or items in the room .