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	07/31/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record reviews the facility failed to ensure a dignified dining experience for one (R14) of one resident reviewed for dining, which had the ability to affect multiple residents who dined in the second floor dining room. Findings include: On 7/29/25 at 11:50 AM, an observation of the second floor lunch meal was conducted in the dining room area. Initially, 16 residents were observed in the dining room waiting to be served. At 12:20 PM, the first tray was observed being served. Flies were observed flying around the dining room. The first, second, third, fourth and fifth table were observed to have been provided their lunch meals, with the exception of two residents at the second table and R14 from the third table. The two residents from the second table and R14 were observed with no lunch meals to have been provided. At 12:37 PM, the two residents from the second table was provided their meal. One resident was observed to require the assistance of staff to be fed. At 12:39 PM, R14 was observed looking down, while the rest of the residents at table three were almost completed and/or finished with their lunch. At 12:46 PM, R14 was served a bacon cheeseburger. On 7/30/25 at 2:43 PM, the Administrator and Director of Nursing (DON) were interviewed regarding the observations made of the lunch meal on the second floor on 7/29/25. The Administrator and DON stated they were informed of the observations. Education had been provided to the staff and they were hoping for a better experience moving forward.No further explanation or documentation was provided by the end of the survey.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for two residents (R#'s 49 and 20), of two residents reviewed for accommodation of needs, resulting in the potential for delayed attention to resident care needs. Findings include:On 7/29/25 at 10:11 AM, R49's room was observed with the right side of their bed against the wall. R49 was in their wheelchair on the left side of the bed and it appeared their foot was wedged between the wheelchair pedal and the bottom of the bed rails. R49 asked for assistance to have their foot unstuck from under the bed. They were asked to activate their call light for staff assistance, and said they did not have their call light. At that time, the call light was observed hanging down from the call light box on the right side of the bed against the wall, not within reach of R49. On 7/29/25 at 10:18 AM, R20's room was observed with the left side of the bed against the wall. R20 was in their wheelchair on the right side of the bed at the foot. An oxygen concentrator was placed on the right side of the bed at the head. At that time, R20 requested assistance to use the restroom. R20 was asked to activate the call light and said, I can't reach it. At that time, the call light was observed to be at the head of the bed clipped onto the bed linens behind the concentrator, approximately five foot away from R20's reach. On 7/29/25 at 10:19 AM, Nurse 'C' was made aware R20 requested assistance and their call light was out of their reach. Nurse 'C' said it should have been within reach and went to assist R20. A review of a facility provided policy titled, Call Light Policy was reviewed; however, the policy did not address ensuring call lights were kept within resident reach.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two (R55 and R30) of three residents reviewed for Advance Directives were educated and given the opportunity to formulate an advance directive for their health care wishes. Findings include:R55 On 7/29/25 at 10:45 AM, R55 was observed in bed. R55 had difficulty speaking at times, but appeared to clearly understand the questions being asked. At times, R55 had difficulty verbalizing a word, but explained he understood and knew what to say, but the words did not come out properly (aphasia). On 7/30/25 at 8:25 AM, R55 expressed concerns he had with the care in the facility. R55 said he got out of bed to go to therapy, but otherwise preferred to stay in his room. A review of R55's clinical record revealed R55 was admitted into the facility on 2/11/25 with diagnoses that included: cerebral ischemia (stroke). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R55 had clear speech, with distinct intelligible words, mad himself understood, and had intact cognition. A review of R55's Physician's Orders revealed an order dated 2/11/25, discontinued on 2/23/25 for Full Code (all life-saving measures will be attempted if the heart stops beating or the person stops breathing) by default. An active order with a start date of 2/23/25 documented, Full Code. A review of a Code Status/'Do Not Resuscitate' Directive form revealed R55's signature and a family member's signature dated 211/25 that indicated R55 was a Full Code. A review of a SW (Social Work) Initial Assessment and Discharge Plan progress note dated 2/21/25 revealed documentation that included.able to make needs known .demonstrating moderate cognitive impairment .SW is working in conjunction with IDT (interdisciplinary team) to address cognition with a goal of improvement throughout stay and SW initiated formal Capacity (evaluation). Safety awareness and impulsivity seem to be intact and no concerns at this time .Referral for psych services is indicated at this time for a capacity (evaluation) .Social Work has reviewed Advance Directive and current code status which are appropriate at this time. Resident wishes for code status to remain FULL code . It should be noted that after review of R55's complete clinical record, there was no evidence of a documented Advance Directive. A review of a Physician/Psychologist Determination of Decision Making Capacity form indicated R55 Lacks the capacity to make informed medical decisions independently. The form was signed by a physician on 3/6/25 and a psychologist on 3/5/25. A review of a Social Services note dated 7/22/25, written by Social Services Coordinator (SSC) 'AA' revealed the following documentation, SW notified that resident is in need of establishing a guardian (a person appointed by a judge to make all decisions when the person is deemed incompetent to make their own decisions). SW contacted (guardianship company) to submit referral. (Guardianship company) accepted referral and needed information sent to facility attorney to begin guardianship petition. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/25 at approximately 1:15 PM, an interview was conducted with R55. When queried about whether anyone had a conversation with him about developing an advance directive that would designate someone to make decisions for him in the event he was unable to, R55 reported he was able to make his own decisions at that time, but (R55's son's name) was the person he designated to make decisions for him if he were unable to. R55 reported he had two other sons and referred to them by name, but clearly explained the first son he mentioned was the person who he wanted involved in his treatment decisions. When queried about any conversations the facility staff had with him regarding his code status or what his treatment wishes were in the event that his heart stopped beating, R55 reported nobody in the facility had a meaningful conversation with him about that. R55 said he did not think he would want to be resuscitated but wanted to have a conversation regarding it before making any definitive decision. On 7/30/25 at approximately 2:00 PM, an interview was conducted with SSC 'AA'. When queried about the social services department's responsibility in regard to discussing formulating advance directives with residents, SSC 'AA' reported advance directives were discussed at every care conference and/or quarterly and code status was also discussed with the resident or their legal representative. When queried about who was responsible to explain the residents' rights for decision making and for designating someone to make decisions on their behalf if they became unable to, SSC 'AA' stated, Anyone could talk to them about formulating an advance directive. When queried about who was permitted to make a decision regarding code status for a resident, SSC 'AA' reported a resident signed their own code status form if they were competent to do so, otherwise their Durable Power of Attorney for Heath Care (DPOA - a legal document that designates another person to make decisions on your behalf if you are unable to make your own decisions) or legal guardian would decide and sign the form. SSC 'AA' reported the DPOA became active only when a resident was deemed incapacitated. When queried about whether a resident would be included in any conversations about their treatment wishes even if they had a legal guardian or DPOA, SSC 'AA' reported it depended on whether the legal guardian wished for the resident to be included in the conversation. When queried about the facility's process for determining whether a resident was competent to make their own medical decisions, SSC 'AA' reported the resident was evaluated by a physician and psychologist who determined their competency. SSC 'AA' was asked to explain the process for obtaining a legal guardian for a resident who did not have a DPOA. SSC 'AA' reported it depended on whether the resident had family who were active in their care and if so, the facility would encourage family to file for guardianship. Otherwise, if family was not involved or did not wish to file for guardianship, the facility used their attorney to assist with filing for guardianship through the court. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that time, SSC 'AA' was asked if R55 made his own medical decisions. SSC 'AA' reported he did not and was deemed incapacitated to make medical decisions in March 2025. When queried about who made decisions for R55, SSC 'AA' reported R55 could still assist with decision making and one of R55's son's was active in his care, but Business Office Manager (BOM) 'BB' told SSC 'AA' R55 was in need of a legal guardian and they would utilize the facility's attorney to facilitate that process. When queried about the progress note that documented the facility contacted a guardianship company to facilitate pursuing guardianship for R55 and did not note anything about discussing guardianship with R55's family, SSC 'AA' reported R55's son was supposed to pursue guardianship and never did so they had to move on to the next step. When queried about whether R55 needed a legal guardian as he appeared able to clearly understand others and whether formulating an advance directive (DPOA) was discussed with R55 before going forward with legal guardianship, SSC 'A' reported once R55 was deemed unable to make medical decisions on 3/5/25, he was no longer able to designate a DPOA. SSC 'A' reported R55 did designate his son as his DPOA but the paperwork because null and void because R55 was already deemed incompetent. When queried about any discussion that was had with R55 and his family prior to moving forward with pursuing guardianship as documented on 7/22/25, SSC 'AA' reported the facility only had an umbrella discussion and said she was positive R55 would say he wanted his son (R55's son's name) to make decisions for him. SSC 'A' further reported the facility wanted to get legal guardianship for R55 because R55 needed assistance with completion of the Medicaid application and the son did not provide all the information. On 7/30/25 at 2:50 PM, an interview was conducted with the Administrator. When queried about the facility's protocol on assisting residents with formulating advance directives, the Administrator reported on admission, the social services staff interviewed the residents or if the resident was unable to be interviewed, they would talk to the responsible party or legal guardian. When queried about what was included in the discussion, the Administrator stated, They talk about whether they want to be a full code. The Administrator further explained that the resident was included in a discussion regarding appointing a decision maker if they became unable to make decisions on their own. If the resident was not about to make their own decisions, the facility would verify if they had a financial or medical decision maker in place and if not, legal guardianship would be explored. When queried about how it was determined that a resident was unable to make their own decisions, the Administrator reported it would be discussed by the IDT and then SW would facilitate a competency evaluation by a physician and psychologist. When queried about the facility's process when it was believed a resident needed a legal guardian, the Administrator reported they would first meet with the resident's family to discuss the need for guardianship and to see if the resident had a DPOA already in place. If the resident did not have a DPOA, then the family was strongly encouraged to file for legal guardianship. When queried about whether the resident could designate a DPOA at that time, if they were able to participate in the conversation, the Administrator reported if the facility physician and psychologist already deemed them incompetent to make decisions then they could not choose a DPOA. The Administrator reported all conversations regarding advance directives, guardianship, and steps taken were expected to be documented in the resident's clinical record (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that time, the Administrator was asked about R55 and whether he was able to make his own decisions. The Administrator stated, He is about to make his own decisions. When queried about the progress note that documented the facility contacting a guardianship company and their attorney to file for legal guardianship, the Administrator stated, He owes us a lot of money. The Administrator reported the facility was trying to get R55 a conservator to handle the financial end of things. The Administrator reported R55's son was approached about getting documents in order to apply for Medicaid, but he did not get what they needed. The Administrator reported they were only trying to get help with the financial side of things and not medical. It should be noted that there was no documentation of the above in R55's clinical record. When queried about her comment that R55 was able to make his own decisions and why R55 was deemed incompetent, the Administrator reported R55 presented differently on admission, but although he had some challenges with verbal communication, he appeared to understand others. The Administrator explained R55's competency should have been reviewed. On 7/31/25 at 8:22 AM, an interview was conducted with R55's son. When queried about any conversations the facility had with him regarding advance directives or obtaining legal guardianship, R55's son said when R55 was admitted the facility talked to him about formulating DPOA paperwork. R55's son said R55 designated him as his DPOA in May 2025, and they had the paperwork developed which designated R55's son as his decision maker in the event he was unable to make decisions for himself. When queried about whether the paperwork was on file at the facility, R55's son said the facility said they no longer needed the DPOA paperwork. R55's son said about two months ago, BOM 'BB' talked to him about applying for Medicaid and requested financial documents which were provided via email. R55's son instructed BOM 'BB' to talk to R55 directly about any life insurance that he had. R55 did not hear anything since then. R55 reported the facility did not inform him of any plans to file for legal guardianship. On 7/31/25 at 9:06 AM, an interview was conducted with BOM 'BB' via the telephone. When queried about contacting SSC 'AA' in regards to R55 needing a legal guardian and what led to that decision, BOM 'BB' said it was determined R55 had to stay for long term care and therefore needed to apply for Medicaid. When queried about any conversation that was had with R55 and his son, BOM 'BB' reported R55's son was helping me to a point but at some point got frustrated with the financial documentation and said to ask (R55) . I asked (R55) and he looked at me bewildered (It should be noted that R55 has aphasia and needs time to process and formulate a response) . BOM 'BB' reported she told R55's son that she needed the paperwork. BOM 'BB' reported the facility needed a conservator in order to get the financial paperwork in order. Further review of R55's medical record revealed no documentation of only needing assistance with financial matters. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an undated policy provided by the facility titled, Advance Directives Policy, revealed, in part, the following, .A resident or a person claiming to responsible for a resident will be asked during the admission process if the resident has an Advance Directive .All Advance Directives .will be reviewed by the Admissions Department when received prior to or on admission. The Social Serivces Department upon admission and at least annually will review the advanced directives .If the advance directive document is found to be insufficient, the resident, responsible party and/or the party claiming to be a healthcare legal decision maker will be notified and the document will be placed on file and the medical record noted that the advance directive was not sufficient .Capacitated/Competent resident who wish to execute a DPOA-HC (Health Care) upon admission will be assisted by the Social Worker or Designee. Competent residents, who wish to execute a DPOA-HC after admission will be assisted by the Social Services Department .A competent resident must have the ability to understand and to communicate both the decision to execute a Durable Power of Attorney for Healthcare and/or a Resident Code Status and understand the effect of any of these documents. An individual's competence may vary from time to time, and even within the same day. Mental illness or a diagnosis of dementia alone, even having a legal guardian, does not necessarily mean that the resident is not 'of sound mind' or not 'competent' for the purposes of executing an Advance Directive . R30 On 7/29/25 at 11:17 AM, R30 was observed lying down on their back in bed. A brief interview was conducted with the resident at that time. A review of the medical record revealed R30 was admitted to the facility on [DATE] with diagnoses that included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia (difficulty speaking) and an anxiety disorder. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 13 (which indicated intact cognition). The resident was noted to be their own responsible party for all clinical and financial decisions. A review of the medical record revealed no documentation of the resident to have been educated and offered to formulate an advance directive. A review of a facility policy titled “Advance Directives Policy” dated “Nov.1991” documented in part, “… Regardless of previously executed Advance Directives, information on resident rights concerning Advance Directives will be provided to each competent adult resident by the Admissions Department at the time of resident admission, or by the Social Worker following admission and documented in the Social Services progress notes…” On 7/30/25 at 2:22 PM, the admission Coordinator (AC) “A” was interviewed and asked their role in educating and offering residents to formulate or decline to formulate an advance directive. AC “A” responded they completed the initial tours of the facility and admission documents with the residents and/or resident representatives and the social workers and nursing was responsible for the advance directives portion. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/25 at 8:34 AM, the Director of Social Work (DSW) “B” was interviewed and asked their role in the education and offering to residents and/or resident representatives to formulate an advance directive. DSW “B” responded they will talk to the residents/resident representatives and discuss code status. DSW “B” stated they ask if they have an advance directive and will note it in their progress notes and ensure the documents are scanned in the medical record. When asked if the residents/resident representatives don’t have an advance directive upon admission if the social workers are educating and offering the residents/resident representatives on advance directives, DSW “B” stated “… We don’t necessarily have this conversation with everyone…” When asked why not, DSW “B” stated most residents are admitted and discharged so fast in the facility. DSW “B” was asked to review the record of R30 and provide any documentation of the resident to have been educated and offered to formulate an advance directive. On 7/31/25 at 8:40 AM, the Director of Nursing (DON) was interviewed and asked the facility’s nursing role in the educating and offering to formulate and/or decline to formulate an advance directive for the residents. The DON stated the nurses would ask on admission if they have an advance directive but they don’t educate the residents/resident representatives. On 7/31/25 at 9:18 AM, DSW “B” followed up and stated they were unable to find documentation of R30 to have been educated or offered to formulate an advance directive. No additional information or documentation was provided by the end of the survey.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to ensure resident equipment was maintained in good repair for one (R8) of three residents reviewed for a homelike environment. Findings include:On 7/29/25 at 10:50 AM, an interview was conducted with R8's Legal Guardian (LG) who was seated in a wheelchair next to the resident who was lying in bed. The wheelchair was observed to have a missing left armrest, and the wheels had no treads and were very worn. When asked about whether that had been provided by the facility or brought in from home, the LG reported that was provided by the facility. When asked how long the wheelchair had been in that condition and if anyone had identified a need to replace or repair the wheelchair, the LG reported the wheelchair had been a wreck for a while and no one from the facility had ever asked about it before.On 7/31/25 at 9:10 AM, an interview and observation of the third floor was conducted with the Maintenance Director (Staff 'R') who has worked at the facility for about four years and in the Director role for about four months.When asked about the facility's process for reporting items that needed to be repaired or replaced, Maintenance Director reported staff usually placed outside their office with a note or verbally told them. When asked if the facility utilized an electronic reporting, they reported they did but most staff told them verbally.On 7/31/25 at 9:15 AM, Staff 'R' confirmed the same observation of R8's wheelchair and reported they were not aware of that before now and would follow-up.Review of the documentation provided of the electronic reporting for items that needed maintenance and had already been addressed did not include R8's wheelchair.According to the facility's undated Standards of Practice titled, Equipment Repair or Replacement: .When a repair or replacement need is identified, the employee should enter the information into the TELs system (an electronic work order reporting system), which will communicate with the Maintenance staff .Log repairs into the TELs system.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, interview and record review the facility failed to protect the resident's right to be free from neglect for one (R141) of five residents reviewed for abuse resulting in R141 being left on a bedpan for four hours. Findings include: On 7/29/25 at 9:56 AM, R141 was observed lying in bed. R141 was asked about care at the facility. R141 explained a couple nights before he had to go to the bathroom during the night. the aide put him on a bedpan. she did not come back, he was on the bedpan for four hours, his bottom was hurting bad, his legs and heels still hurt from being on the bedpan that long. then when the aide finally came back, she took the bedpan to the bathroom, he thought she was going to clean him up, but she walked out of the room. he waited to see if she was going to get supplies, but she did not come back, so he pushed his call light again after about 15-20 minutes. the aide came back and asked what he needed, he asked if she was going to clean him up, she told him she had forgotten and would get the supplies. she never came back. the day shift aide was the one who finally cleaned him up. R141 was asked if he had told anyone at the facility about what happened. R141 explained he told the Social Worker about it the next day.Review of the clinical record revealed R141 was admitted into the facility on 7/26/25 with diagnoses that included: traumatic subdural hemorrhage, repeated falls and Parkinson's Disease. According to a Brief Interview for Mental Status (BIMS) exam dated 7/28/25, R141 scored 15/15 indicating intact cognition.Review of a Concern Form dated 7/28/25 for R141 read in part, .Resident stated call light was answered but task [sic] were not complete. Aide left him on bedside commode (commode was crossed out) bedpan for 2 hours, when taken off bedpan was not properly cleaned. 7/27/25. PM shift.On 7/30/25 at 4:35 PM, R141 was asked if he was placed on the bedpan on the afternoon shift or the midnight shift. R141 explained it was at 1:00 AM, and he was on it for four hours and then had to wait for the day shift to get cleaned up. On 7/31/25 at 8:56 AM, Certified Nursing Assistant (CNA) K was interviewed by phone and asked if she knew anything about R141 being on a bedpan on the night of 7/27/25. CNA K explained she had not worked on 7/27/25, but did have R141 on the midnight shift on 7/28/25 and R141 had told her about being left on the bedpan was very upset about it, and that his bottom and legs were still hurting.On 7/31/25 at 9:15 AM, CNA M, who was R141's assigned midnight shift CNA on 7/28/25, was called and a message left. No return call was received. It should be noted that on 7/31/25 at 10:40 AM, the Administrator emailed she had contacted CNA M to return the call, and on 7/31/25 at 12:57 PM, the Director of Nursing (DON) also contacted CNA M to return the call. On 7/31/25 at 12:01 PM, CNA L, who was R141's assigned day shift CNA on 7/28/25, was interviewed and asked if she knew anything about R141 being on a bedpan during the night. CNA L explained R141 was very upset, the midnight CNA had left him on the bedpan for four hours. she started to clean him up and could still see the ring around his bottom from the bedpan. there was dried feces on his skin she had to wash off. CNA L was asked who had been R141's midnight CNA. CNA L explained she had not received any report when she started her shift, so she did not know who it was.On 7/31/25 at 12:57 PM, the DON was interviewed and asked how long a resident should be left on a bedpan. The DON explained after putting a resident on a bedpan, privacy should be given, but they should be checked on in approximately five minutes. The DON was asked about R141 being left on a bedpan for four hours. The DON explained they had provided education to the CNA. The DON was asked to verify who the CNA was. The DON explained it was CNA L. The DON was asked if a resident should be cleaned up after using a bedpan. The DON explained it was expected that a resident was always cleaned after using a bedpan. On 7/31/25 at 2:00 PM, the Administrator was interviewed and asked if leaving a resident on a bedpan and not cleaning them up after taking them off could be considered neglect, the Administrator acknowledged the concern.Review of a facility policy titled, Abuse & Elder Justice Act Policy dated 1/18/24 read in part, .Neglect: means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. (There is a presumption that neglect has occurred whenever a facility or individual fails to provide a treatment or services to a resident which is necessary for a resident's health or safety, and the failure to provide that treatment or service results in a deterioration of the resident's physical, mental, or emotional condition).

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	07/31/2025

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

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to protect a resident from exploitation for one (R124) of five residents reviewed for abuse. Findings include: On 7/29/25 at 11:13 AM, R124 was observed sitting in a wheelchair in his room. R124 was asked if he was able to take himself to the bathroom. R124 explained he needed staff assistance.Review of the clinical record revealed R124 was admitted into the facility on 6/25/25 with diagnoses that included: metabolic encephalopathy, multiple fractures of ribs and diabetes. According to the Minimum Data Set (MDS) assessment dated [DATE], R124 had moderately impaired cognition.On 7/31/25 at 12:01 PM, Certified Nursing Assistant (CNA) L was interviewed about a concern with R124's roommate. During this interview, CNA L was asked if on the morning of 7/28/25 R124 and his bed were left wet. CNA L explained when she started her shift that morning, she had been given no report and both R124 and his roommate needed to be cleaned up. CNA L then explained she had taken a picture. CNA L proceeded to take out her personal phone and explained she had hundreds of pictures. CNA L produced a picture that showed a person sitting on a bed, the face was not visible, but the image was identifiable as R124. The picture showed the blue pad top of the fitted sheet, and the fitted sheet were wet. CNA L was asked why she had pictures of residents on her personal phone. CNA L explained she took the pictures so she could defend herself.On 7/31/25 at 2:30 PM, the Administrator was interviewed and asked if employees were allowed to take pictures of residents on their personal phones. The Administrator explained employees were not allowed to take pictures of residents, it was in their Employee Handbook, as well as in the Abuse Policy.Review of CNA L's employee file revealed documentation of CNA L receiving an Employee Handbook as well as a checklist of items in the Employee Handbook.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a stop-date for a PRN (as needed) order for anti-anxiety medication for one resident (R120), of five residents reviewed for unnecessary medications. Findings include: On 7/31/2025 at 11:02 AM, a review of R120's clinical record revealed they most recently re-admitted to the facility on [DATE] with diagnoses that included: heart disease, protein calorie malnutrition, adjustment disorder, anxiety disorder, falls, delirium, depression, and dementia with behaviors. R120's physician orders were reviewed and revealed a current, active order originating 12/20/24 for Ativan 0.5 mg (milligrams) to be given every four hours as needed. It was noted the medication had been re-ordered on 3/13/25 and 6/9/25 with the same instructions, to be given every four hours as needed with no duration of time for use defined. A review of R120's monthly medication regimen review reports prepared by the facility's pharmacist and reviewed and signed by the attending physician was conducted and revealed the following: A report dated 1/28/25 that indicated R120's PRN Ativan (anti-anxiety medication) order should include a duration of time for use. The report was signed by the physician and a box was checked that read, Continue with the above (Ativan) PRN order for #30 days. Rationale: Hospice patient. A report dated 2/27/25 that indicated R120's PRN Ativan order should include a duration of time for use. The report was signed by the physician and box was checked that read, Continue with the above (Ativan) PRN order for #14 days. Rationale: Hospice and is in need d/t (due to) anxiety. A report dated 3/29/25 that indicated R120's PRN Ativan order should include a duration of time for use. The report was signed by the physician and box was checked that read, Continue with the above (Ativan) PRN order for #14 days. Rationale: Hospice patient, Benefit > Risk. On 7/31/25 at 11:27 AM and 1:00 PM, a request for monthly medication regimen reviews for 4/28/25 and 5/21/25 was made. On 7/31/25 at 3:35 PM, an interview was conducted with the facility's Director of Nursing. They said they could not find the monthly medication regimen reviews for April and May. During the interview it was brought to their attention that in January, February, and March the Pharmacist recommended a duration of use for the Ativan, the Physician put a duration of time for use on the form, but the order had never been changed and still as of the survey remained the original order (dated 12/20/24) for the medication to be given every four hours as needed. They said if the physician signed the form and put a duration of time for use, the physician would be the one responsible for changing the order in the computer system. A review of a facility provided policy titled, Drug Regimen Review was conducted; however, the policy did not address changing the orders based on the Pharmacist's recommendation and the Physician's response to the recommendation.

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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** This citation pertains to intake #1227216 Based on interview and record review the facility failed to report an allegation of neglect and an injury of unknown origin to the State Agency for two residents (R138 and R141) of five residents reviewed for abuse, neglect and mistreatment. Findings include: On 7/29/25 a complaint that was submitted to the State Agency was reviewed that alleged R138 had a head wound from an unknown origin. On 7/29/25 the medical record for R138 was reviewed and revealed the following: R138 was initially admitted to the facility on [DATE] and had diagnoses including Dementia and Brief Psychotic disorder and was discharged to the hospital on 6/16/25. A review of R138’s MDS (minimum data set) with an ARD (assessment reference date) of 6/5/25 revealed R138 needed supervision from facility staff with most of their activities of daily living. A review of R138's progress notes revealed the following: 6/14/2025- Noted new skin issue observed by CNA (Certified Nursing Assistant). Resident observed with discoloration to forehead. Tx (treatment) order noted in place and provided. Noted notification of MD (Medical Doctor), wound care and family. 6/13/2025- Physician Progress Notes- Date: 6/13/2025 .CHIEF COMPLAINT .PRESENT ILLNESS WITH ASSESSMENT AND PLAN: .evaluated at the bedside on June 13, 2025 overall comfortable with no acute distress. Patient later in the day according to the staff and per imaging noted to have infection burn on his forehead. Patient according to the staff did not sustain a fall. Otherwise with no fever or chills .Patient with history of advanced dementia and behavioral disturbances with frequent falls requires frequent redirection and safety measures. According to the staff he did not have a fall at this event we will monitor any changes Patient to continue on current supportive care . Monitor for any bleed with friction rub around his forehead and above his left eyebrow. 6/13/2025- Nurses Note- Writer alerted by CNA that resident had red discoloration to his forehead. Residents skin was assessed. Nurse caring for resident made aware, MD notified, Wife notified. Logged for Wound care. Treatment ordered for TAO (triple antibiotic ointment) daily for one week. A review of the MIFRI (Michigan reporting system) revealed no submitted investigation for R138's wound/burn on their forehead as indicated by the Physican on 6/13/25 was present in the system. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/2025 at approximately 2:08 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding R138's forehead wound/burn documented by the Physican on 6/13/25 and they reported that they were never made aware of it but would have to check their documentation to see if any investigations had been completed. On 7/30/2025 at approximately 2:37 p.m., the facility Administrator and DON were queried regarding R138's wound/burn on their forehead. The Administrator indicated they were never made aware of the injury and no investigation or reporting to the State Agency was done due to them not being aware. The DON was queried if they knew how R138's sustained a wound/burn on their forehead and they reported the injury origin was unknown. The Administrator was queried if they should have been made aware of the injury if its origin was unknown, and they indicated that they should have, and they would have started their process for reporting and investigating an injury of unknown origin. On 7/30/25 a facility document pertaining titled Abuse and Elder Justice Act Policy was reviewed and revealed the following: Component 7: Reporting/Response The facility shall: a. Immediately report (within 24 hours) to the State of Michigan b. Report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required and take all necessary corrective actions depending on the results of the investigation On 7/29/25 at 9:56 AM, R141 was observed lying in bed. R141 was asked about care at the facility. R141 explained a couple nights before he had to go to the bathroom during the night… the aide put him on a bedpan at 1:00 AM… she did not come back, he was on the bedpan for four hours, his bottom was hurting bad, his legs and heels still hurt from being on the bedpan that long… then when the aide finally came back, she took the bedpan to the bathroom, he thought she was going to clean him up, but she walked out of the room… he waited to see if she was going to get supplies, but she did not come back, so he pushed his call light again after about 15-20 minutes… the aide came back and asked what he needed, he asked if she was going to clean him up, she told him she had forgotten and would get the supplies… she never came back… the day shift aide was the one who finally clean him up. R141 was asked if he had told anyone at the facility about what happened. R141 explained he told the Social Worker about it the next day. Review of the clinical record revealed R141 was admitted into the facility on 7/26/25 with diagnoses that included: traumatic subdural hemorrhage, repeated falls and Parkinson’s Disease. According to a Brief Interview for Mental Status (BIMS) exam dated 7/28/25, R141 scored 15/15 indicating intact cognition. Review of a “Concern Form” dated 7/28/25 for R141 read in part, “…Resident stated call light was answered but task [sic] were not complete. Aide left him on bedside commode (commode was crossed out) bedpan for 2 hours, when taken off bedpan was not properly cleaned… 7/27/25… PM shift…” On 7/31/25 at 12:57 PM, the DON was interviewed and asked how long a resident should be left on a bedpan. The DON explained after putting a resident on a bedpan, privacy should be given, but they should be checked on in approximately five minutes. The DON was asked if a resident should be cleaned up after using a bedpan. The DON explained it was expected that a resident was always cleaned after using a bedpan. When asked if leaving a resident on a bedpan for four hours and not cleaning them up could be considered neglect, the DON acknowledged the concern. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/25 at 2:00 PM, the Administrator was interviewed and asked if she had reported to the SA that R141 had been left on a bedpan for four hours and not cleaned up after until the next shift. The Administrator explained she had not, but when put like that, she should have.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #1227216Based on interview and record review the facility failed to complete and document a thorough investigation into an injury of unknown origin for one resident (R138) of five residents reviewed for abuse/neglect/mistreatment. Findings include: On 7/29/25 a complaint that was submitted to the State Agency was reviewed that alleged R138 had a head wound from an unknown origin. On 7/29/25 the medical record for R138 was reviewed and revealed the following: R138 was initially admitted to the facility on [DATE] and had diagnoses including Dementia and Brief Psychotic disorder and was discharged to the hospital on 6/16/25. A review of R138's MDS (minimum data set) with an ARD (assessment reference date) of 6/5/25 revealed R138 needed supervision from facility staff with most of their activities of daily living. A review of R138's progress notes revealed the following: 6/14/2025- Noted new skin issue observed by CNA (Certified Nursing Assistant). Resident observed with discoloration to forehead. Tx (treatment) order noted in place and provided. Noted notification of MD (Medical Doctor), wound care and family.6/13/2025- Physician Progress Notes-Date: 6/13/2025 .CHIEF COMPLAINT .PRESENT ILLNESS WITH ASSESSMENT AND PLAN: .evaluated at the bedside on June 13, 2025 overall comfortable with no acute distress. Patient later in the day according to the staff and per imaging noted to have infection burn on his forehead. Patient according to the staff did not sustain a fall. Otherwise with no fever or chills .Patient with history of advanced dementia and behavioral disturbances with frequent falls requires frequent redirection and safety measures. According to the staff he did not have a fall at this event we will monitor any changes Patient to continue on current supportive care .Monitor for any bleed with friction rub around his forehead and above his left eyebrow.6/13/2025-Nurses Note-Writer alerted by CNA that resident had red discoloration to his forehead. Residents skin was assessed. Nurse caring for resident made aware, MD notified, Wife notified. Logged for Wound care. Treatment ordered for TAO (triple antibiotic ointment) daily for one week.A review of the MIFRI (Michigan reporting system) revealed no submitted investigation for R138's laceration/burn on their forehead as indicated by the Physican on 6/13/25 was present in the system. On 7/30/2025 at approximately 2:08 p.m. , during a conversation with the Director of Nursing (DON), the DON was queried regarding R138's forehead laceration/burn documented by the Physican on 6/13/25 and they reported that they were never made aware of it but would have to check their documentation to see if any investigations had been completed.On 7/30/2025 at approximately 2:37 p.m., the facility Administrator and DON were queried regarding R138's laceration/burn on their forehead. The Administrator indicated they were never made aware of the injury and no investigation or reporting to the State Agency was done due to them not being aware. The DON was queried if they knew how R138's sustained a laceration/burn on their forehead and they reported the injury origin was unknown. The Administrator was queried if they should have been made aware of the injury if its origin was unknown, and they indicated that they should have, and they would have started their process for reporting and investigating an injury of unknown origin. On 7/30/25 a facility document titled Abuse and Elder Justice Act Policy was reviewed and revealed the following: Component 5: Investigation .1. The facility will identify and investigate all situations or incidents in which a resident may have suffered abuse including physical or other harm for reasons which are unknown, unclear or not adequately explained. The facility shall use the investigation guide and algorithm provided by Licensing and Regulatory Affairs (Rev. 02/13-251826). The Facility shall: b. Interview and/or obtain a statement from person reporting the allegation or suspicion of abuse; c. Interview and/or obtain a statement from the resident or victim; d. Interview and/or obtain a statement from the alleged perpetrator; e. Interview and/or obtain a statement(s) from potential witnesses as determined by the scope of the investigation; f. Review the resident's medical record for relevant information (diagnosis, history, similar injuries, etc.); g. Review materials and complete investigation; and h. Conduct a root cause analysis

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a Minimum Data Set (MDS) Assessments was completed accurately for one (R120) of three reviewed for the resident assessment task. Findings include:On 7/29/25 at 10:05 AM, R120 was observed lying in bed and a visitor was conducting a clinical assessment. Upon exit from the room, the visitor reported they were a Hospice Nurse (Nurse 'U') as R120 was on their services.Review of the clinical record revealed R120 was initially admitted into the facility on 6/24/24 and readmitted on [DATE] with diagnoses that included: atherosclerotic heart disease of native coronary artery without angina pectoris, moderate protein-calorie malnutrition, paroxysmal atrial fibrillation, and encounter for palliative care.Review of the physician orders revealed R12 had signed onto hospice services on 11/14/24 and as this review, remained on hospice.Review of the Minimum Data Set (MDS) assessments included a significant change MDS assessment dated [DATE] and quarterly MDS assessment dated [DATE] which identified section O0110 K1. Hospice Care as Yes. However, the quarterly MDS assessment dated [DATE] was documented as No. for this assessment question.On 7/30/25 at 8:35 AM, an interview was conducted with the Director of Nursing (DON). When asked about the MDS roles in the facility, they reported Nurse 'V' was the MDS Coordinator and Nurse 'W' was an MDS Nurse. When informed of the concern with inaccurate MDS assessment for a resident on hospice, the DON reported Nurse 'W' was unavailable during this survey due to a vacation and they would have to address that with the MDS staff.On 7/31/25 at 1:09 PM, the facility was requested to provide a policy addressing MDS accuracy.On 7/31/25 at 1:42 PM, the Administrator reported they don't have an MDS Accuracy policy, the referred to the RAI (Resident Assessment Instrument) Manual.According to the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual. Link to the LTCF RAI User's Manual: https://www.cms. gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf: .an accurate assessment requires collecting information from multiple sources .Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a comprehensive resident centered care plan was developed and implemented for an anxiety disorder for one (R30) of five residents reviewed for unnecessary medications. Findings include: On 7/29/25 at 11:17 AM, R30 was observed lying down on their back in bed. A brief interview was conducted with the resident at that time. A review of the medical record revealed R30 was admitted to the facility on [DATE] with diagnoses that included an anxiety disorderA review of R30's physician orders revealed . Alprazolam oral tablet 0.5 mg (milligram). Give 1 tablet by mouth every 8 hours as needed for anxiety or panic related to anxiety disorder. A review of the care plans revealed no documentation of a care plan implemented for the resident's anxiety disorder or interventions to help the resident manage their anxiety before the use of medication. On 7/30/25 at 2:19 PM, the Director of Nursing (DON) was interviewed and asked who responsibility it was to implement the comprehensive resident centered care plan regarding R30's anxiety disorder. The DON replied it was a team approach and they were unaware that R30 did not have an anxiety care plan implemented. No further explanation or documentation was provided by the end of the survey.

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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 #1227212Based on observation, interview, record review the facility failed to consistently provide bathing assistance/services for one (R63) of seven residents reviewed for Activities of Daily Living (ADL). Findings include: On 7/29/25 at 11:59 AM, R63 was observed sitting in their wheelchair in the dining room. When asked, R63 explained they were supposed to get showers twice a week on Tuesdays and Fridays, however stated the staff had only been giving them a shower once a week. R63 stated last week they did not receive their Tuesday shower and today (Tuesday 7/29/25) they were supposed to receive a shower and had not. R63 stated they were unsure if they would receive their shower later in the day. On 7/30/25 at 1:36 PM, R63 was observed sitting in their wheelchair in their room. When asked if they received their Tuesday 7/29/25 shower, R63 replied . No, I had to gather what I could. and try to do a sponge bath in my bathroom. At this time, a record review was completed and identified an aide to have documented that they completed R63's shower on 7/29/25. R63 was asked about the documented shower on 7/29/25 and replied that it was untrue. The resident went on to state that no staff member had attempted to assist, transfer or helped them with a shower on 7/29/25. A review of the medical record revealed R63 was admitted to the facility on [DATE] with diagnoses that included: cerebral infarction and type 2 diabetes mellitus. R63 was documented to have intact cognition. A review of a care plan titled . has an ADL Self Care Performance Deficit. documented the following interventions . PERSONAL HYGIENE: Supervision. Promote dignity by ensuring privacy. Provide the resident with a sponge bath when a full bath or shower cannot be tolerated, if resident chooses. Will be showered 2x weekly.A review of R63's Shower / Bathe documentation noted a Tuesday and Friday morning shower to be performed. The dates of 7/22/25 and 7/29/25 was documented as the staff to have provided Physical help in part of bathing activity.On 7/30/25 at 3:03 PM, the Director of Nursing (DON) was interviewed and asked how often the residents at the facility are bathed and the DON confirmed twice weekly. The interviews with R63 and the bathing documentation was reviewed and discussed with the DON. The DON stated the Unit Manager had made them aware that R63 had not received their showers as assigned and aware that the aides had been documenting that the showers were completed, although they were not. The DON stated they were following up with the aides to see why the showers were not done. No additional explanation or documentation was provided by the end of the survey.

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

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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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number MI001227212. This citation has two deficient practice statements (DPS). DPS #1 Based on observation, interview, and record review, the facility failed to assess a new skin impairment and implement treatments in a timely manner and according to physician's orders for two (R55 and R49) of four reviewed for non-pressure skin impairments, resulting in a wound to R55's arm becoming infected with delayed healing. Findings include: R55 On 7/29/25 at 10:45 AM, R55 was observed in bed. A dressing dated 7/29/25 was observed on R55's right forearm. When queried about what happened to his arm, R55 stated, She burnt it. R55 appeared fully able to understand the questions being asked but had trouble finding words and explained that sometimes the words he wants to say, do not come out correctly or he could not say the word (aphasia). R55 explained the wound on his arm has been present for a long time and was not healing. On 7/30/25 at approximately 1:00 PM, R55 was observed eating lunch. A dressing dated 7/29/25 was observed on R55's right forearm. On 7/31/25 at 9:53 AM, R55 was observed lying in bed. R55's right forearm was observed with a discoloration approximately 3.8 centimeters in diameter with a raised center approximately 1.25 centimeters x 2.4 cm that had two small black scab-like areas with a skin bridge between the scabs. R55 was asked about the wound. R55 explained he was burned in therapy and said the therapist placed a device on his arm, walked away and was on her computer. R55 said it hurt really bad, and he felt pain shooting up his arm. A review of R55's clinical record revealed R55 was admitted into the facility on 2/11/25 with diagnoses that included: cerebral ischemia (stroke). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R55 had intact cognition and was dependent on staff assistance for activities of daily living (ADLs) other than eating and required substantial/maximal assistance for bed mobility and transfers. R55 had one-sided impairment to his lower and upper extremities. The MDS noted R55 had a skin tear. A review of an admission MDS dated [DATE] revealed R55 did not have any skin impairments. A review of R55's Weekly Head-To-Toe Assessment (skin assessments) revealed the following: On 4/4/25, it was documented R55 had a scab discolored area to the right lower arm. The assessment was signed and locked on 5/23/25, 49 days later. On 4/8/25, a skin assessment was started, but was never completed, signed or locked and as of 7/30/25, it was in progress. There were no weekly skin assessments in the clinical record between 4/4/25 and 5/20/25. On 5/20/25, it was documented on a skin assessment that R55 had small size bruising on bilateral arms skin fragile and did not document any open areas. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of a Physical Medicine and Rehabilitation (PM&R) progress note dated 4/7/25 revealed documentation that included, .4/7/25: .Per COTA (Certified Occupational Therapist Assistant), pt (patient) has been tolerating estim (electrical stimulation therapy), but on Friday she noted new skin issues following removal of the estim pads (electrodes) - nursing was notified and estim was removed from his tx (treatment) plan . A review of a (PM&R) progress note dated 4/16/25 revealed documentation that included, .4/7/25: Agree with d/c (discontinue) of estim due to skin intolerance following removal of the pads on 4/4. Discussed with DOR (Director of Rehab) to have the estim unit calibrated ASAP (as soon as possible) . Further review of R55's clinical record revealed no documentation of the new skin issues identified by the COTA after using the estim machine were assessed or evaluated by a nurse of medical provider other than the skin assessment dated [DATE] (locked on 5/23/25) that noted a scab and discoloration. A review of R55's Skin/Wound progress notes revealed the following: A note written on 5/19/25 documented, .Wound Rounds .Seen on wound rounds re (regarding) area on right arm .Seen (regarding) open ulcer to right posterior forearm. Patient states it started as a skin tear. Base with mix of granular tissue (new connective tissue that forms during wound healing) and yellow slough (necrotic tissue) with slightly raised darker discolored rim surrounding. Entire area 2 x 3 cm (centimeters). With erythema (redness), induration (thickening and hardening of the skin) and tenderness to touch. Mild serosanguinous (a mixture of clear, thin, watery drainage and blood). (Treat) with xeroform (a sterile occlusive petroleum-based wound dressing) and cover with bordered gauze. Change daily and PRN (as needed). Will start doxycycline (an antibiotic medication used to treat infection) .10 days for cellulitis (bacterial tissue/skin infection) . There was no documentation present in R55's clinical record that indicated any change to R55's right arm after it was noted in the PM&R notes that the resident had a skin impairment after use of the estim machine on 4/4/25 and the skin assessment dated [DATE] and locked on 5/23/25 that documented a scab and discoloration. A review of R55's Physician's Orders revealed an order dated 5/20/25 with a discontinue date of 6/9/25 to Cleanse forearm wound with NS (normal saline) and pat dry. Apply xeroform and cover with dry dressing. A review of R55's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for May 2025 and June 2025 revealed the above order was not added to the MAR or TAR which would alert the nurse to administer the treatment and sign off when it was completed. Further review of R55's Physician's Orders revealed a new order dated 6/12/25 with a discontinue date of 6/30/25 to Cleanse right forearm wound with NS and pat dry. Apply xeroform and cover with foam dressing every day shift every Mon (Monday), Thu (Thursday) for wound care. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of R55's MAR and TAR for June 2025 revealed the 6/12/25-6/30/25 physician's order was on the TAR. However, treatments were not administered (as evidenced by no nurse's signature) on 6/12/25, 6/16/25, and 6/19/25. The first treatment that was signed off as administered was on 6/23/25. It should be noted that according to the PM&R progress notes, the skin impairment was first identified during therapy on 4/4/25, approximately two and a half months earlier and after the wound was discovered to be infected, there was no wound treatment completed between 5/20/25 and 6/23/25, other than oral antibiotics. A review of R55's care plans revealed a care plan was initiated on 5/27/25 in regard to an actual impairment to skin integrity of the Right arm, r/t (related to) open ulcer, fragile skin, decreased mobility, right side weakness. It should be noted that the skin impairment to R55's right arm was first identified in therapy on 4/4/25.The interventions included encouraging R55 not to pick his skin, to avoid scratching, to turn and reposition, and observe for side effects of the antibiotics. There was no mention of the electrical stimulation machine. Further review of R55's clinical record revealed R55 was evaluated by the wound care provider on 7/14/25. A review of a Skin/Wound Note dated 7/14/25 revealed documentation that the area on R55's right forearm was resolved. The note documented the treatment was to be discontinued and the area left open to air. It should be noted that upon observation of R55 on 7/29/25, there was a dressing applied dated 7/29/25. A review of R55's Physician's Orders revealed the treatment to R55's arm was not discontinued as recommended by the wound provider and the TAR indicated nurses had completed treatment to the area on 7/14/25, 7/17/25, 7/21/25 and 7/28/25. On 7/30/25 at 1:30 PM, an interview was conducted with the Wound Nurse, Licensed Practical Nurse (LPN) 'Y'. When asked if an observation of R55's right arm could be conducted LPN 'Y' reported the treatment was discontinued and there was nothing there anymore. When queried about the dressing dated 7/29/25, LPN 'Y' said it was discontinued a couple weeks ago. At that time, LPN 'Y' instructed LPN 'Z' to remove the dressing on R55's arm and LPN 'Y' discontinued the treatment order without looking at R55's arm. An observation of R55's arm was conducted with LPN 'Z'. LPN 'Z' removed the dressing dated 7/29/25. A scant amount of brown drainage was observed on the dressing. R55's right arm was observed with a discolored area with two small open areas in the center. R55 attempted to explain what happened to his arm and repeated that she burned it. R55 explained there was a computer and he was burned and the wound has taken a long time to heal. On 7/31/25 at approximately 8:30 AM, further review of R55's clinical record revealed no progress note regarding the open areas present during the wound observation with LPN 'Z' on 7/30/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 7/31/25 at 9:17 AM, a follow-up interview was conducted with LPN 'Y'. When queried about what a resolved wound would look like, LPN 'Y' said there would be no drainage and no open area. The observations from 7/30/25 of drainage on the dressing and open areas on R55's arm was discussed. LPN 'Y' reported she was not notified by LPN 'Z' or anyone else about the skin impairment. When queried about what happened to R55's arm, LPN 'Y' said there were allegations that R55 was burned in therapy. LPN 'Y' further explained that R55 received electrical stimulation therapy and when the therapist removed the pads with the electrodes, R55 had a skin impairment that was not there prior to applying the pads. LPN 'Y further reported that R55 was adamant that he was burned during therapy. LPN 'Y' said she was contacted and she assessed the wound within the next day or two, but it was just a scab. When queried about how R55's arm would form a scab during the electrical stimulation treatment, LPN 'Y' reported that she questioned if he was burned. When queried about where LPN 'Y's assessment was documented, LPN 'Y' did not offer a response. (It should be noted that there was no documented assessment from LPN 'Y' in the clinical record on or around 4/4/25). LPN 'Y' reported they started treatments right away, the scab came off, the wound became an open area, and it was not resolved. LPN 'Y' said they were looking into whether it was skin cancer since the wound was not healing, but R55 did not wish to see a dermatologist. At that time, LPN 'Y' was asked to provide information about what interventions and treatment were put in place after the initial skin impairment was identified by the therapist. On 7/31/25 at 12:05 PM, an interview was conducted with COTA 'DD'. When queried about what happened with R55's right arm, COTA 'DD' reported back in April he received electrical stimulation therapy. COTA 'DD' did not see any skin integrity issues prior to applying the pads, but when she took them off he had skin integrity issues. When queried about what R55's skin looked like after the pads were removed, COTA 'DD' reported it looked like a scab, a dark area and R55 said he was fine. COTA 'DD explained she reported the skin integrity issue to the nurse, the Certified Nursing Assistant (CNA), and management and also documented it in her notes. A review of medical provider progress notes for R55 revealed R55 was seen by Nurse Practitioner (NP) 'EE' on 4/9/25 and 4/25/25. However, there was no documentation of any skin changes to R55's right arm. R55 was seen by NP 'EE' on 5/28/25. At that time, the wound to R55's right arm was documented, but he was already on antibiotics and the wound had already worsened. A review of a progress note written by Physician 'FF' on 7/2/25 revealed documentation that included, .Pt has skin lesion on his right upper extremity, open wound/open ulceration .stated that the wound had been there for a long period of time .he denies scratching it .The chronic nature of the wound make it suspicious for skin cancer .Other possibility wound be venous stasis ulcer . On 7/31/25 at 12:55pm, an interview was conducted with Physician 'FF' via the telephone. Physician 'FF' reported he was not informed that R55 reported being burned by the electrical stimulation machine and was not aware that treatment was not started for over two months, but that he would make the same recommendations that were documented in his progress note on 7/2/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 7/31/25 at 12:13 PM, LPN 'Y' followed up and reported no treatment was implemented on 4/4/25 because it was just a scab. LPN 'Y' said treatment was ordered on 5/20/25 when herself and the wound provider assessed the area and it had worsened. When queried about how a scab formed on intact skin on 4/4/25 within 15-20 minutes while receiving the electrical stimulation treatment, LPN 'Y' said it was more likely from the electrical stimulation machine and not a scab. When queried about whether anyone identified the area worsening prior to it being infected and requiring antibiotics, LPN 'Y' did not offer a response. LPN 'Y' reported she would look into it. A review of an incident report dated 4/4/25 completed by LPN 'C' revealed the following documentation, Writer was notified by CNA that resident had blisters on right arm. Upon assessment writer observed 2 scabbed discolored areas on resident right arm .Resident unable to explain to writer what happened . It was documented that the incident was not witnessed and the wound care nurse and NP were notified on 4/4/25. On 7/31/25 at 1:11 PM, an interview was conducted with LPN 'C'. When queried about the incident report regarding R55's arm on 4/4/25, LPN 'C' reported CNA 'CC' reported that R55 had blisters on his arm. LPN 'C' assessed R55 and explained they were not blisters; they were flat. LPN 'C' said they looked like old scabs and there was an indentation. According to LPN 'C', R55 did not know what happened. When queried about what was done after R55 was identified to have a new skin impairment, LPN 'C' said she notified LPN 'Y' and logged it for the doctor. LPN 'C' reported that she did not complete the incident report until much later (in May) when management asked her to complete one. LPN 'C' said she did not know she had to complete an incident report. When queried about whether she documented her assessment of R55's arm on 4/4/25 and she reported she did not. On 7/31/25 at 1:49pm, an interview was conducted with CNA 'CC'. When queried about the skin impairment she reported to LPN 'C' on 4/4/25, CNA 'CC' stated, It wasn't blistered or anything. It's hard to describe. It wasn't bruised. It just wasn't there before. There was one major area that really stuck out. CNA 'CC' said R55 said it happened at therapy and he was upset about it. CNA 'CC' said she told LPN 'C' but did not remember if she told her what R55 said. When queried about whether LPN 'C' assessed R55, CNA 'CC' said she thought she did, but did not remember. On 7/31/25 at 2:32 PM, LPN 'Y' followed up. At that time, R55's clinical record was reviewed and LPN 'Y' confirmed the treatment that was supposed to start on 5/20/25 was not on the MAR or TAR. LPN 'Y' also confirmed the order that was started on 6/12/25 had several missed treatments. LPN 'Y' reported she was unaware of that and it was not identified when the incident was investigated. On 7/31/25 at 3:40 PM, an interview was conducted with the DON. When queried about R55's going without treatment to the skin impairment to his right arm until 6/23/25, the DON reported she was unaware. When queried about whether the wound care coordinator was responsible to ensure treatments were implemented and administered according to physician's orders, the DON reported they were. R49 On 7/29/25 at 10:11 AM, R49 was observed in their room in their wheelchair. R49's right pant leg was pulled up to their knee and their right shin was observed to have tight, shiny, reddened skin with diffuse areas of blistering and serous drainage. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 7/29/2025 at 1:00 PM, R49 was observed in their wheelchair propelling towards the dining room. R49's right pant leg was again observed pulled up to their knee and their right shin continued to be observed with tight, shiny, reddened skin with diffuse blistering and serous drainage. On 7/29/25 at approximately 2:30 PM, a review of R49's physician orders was conducted and did not reveal any treatment orders for their right leg. On 7/30/2025 at 12:35 PM, R49 was observed in their wheelchair with their right pant leg pulled up to their knee. At that time, their right leg was observed to be wrapped in bulky gauze. On 7/30/2025 at 1:22 PM, a second review of R49's physician's orders was conducted and revealed an order dated 7/30/25 that indicated R49's right leg was to be cleansed with normal saline, covered in a large pad, and wrapped with bulky dressing. On 7/31/2025 at 2:53 PM, an interview was conducted with the facility's Director of Nursing, and they were asked when a treatment should be initiated after the identification of a wound or skin impairment. They indicated it should be implemented, Immediately. Deficient Practice #2 Based on observation, interview, and record review, the facility failed to ensure medications were pulled from the back-up medication supply and administered for one resident (R139), of three residents reviewed for medication administration, resulting in verbalized complaints, frustration, and the potential for complications from not receiving scheduled medications. Findings include: On 7/29/25 at 10:51 AM, R139 was observed in their room. They were asked about their stay in the facility and verbalized some concerns regarding their medications. They said they did not think they received all their cardiac medications prescribed after their discharge from the hospital when they first admitted to the facility and they were concerned about their cardiac condition. On 7/30/2025 at 12:02 PM, a review of R139's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: a heart attack, heart disease, high blood pressure, and presence of a heart bypass graft. R139's physician's orders and Medication Administration Record (MAR) were reviewed and revealed the following: An order for clopidigrel (a medication to prevent blood clots) 75 milligrams (mg) scheduled for 9 AM on 7/25/24 coded as a 9 (indicating the medication was held) with an accompanying progress note that read, New admission medication not available waiting for pharmacy to deliver. An order for Isosorbide Mononitrate (a medication for chest pain) 30 mg scheduled for 9 AM on 7/25/25 coded as a 9 with an accompanying progress note that read, New admission medication not available waiting for pharmacy to deliver. An order for Amiodarone (a medication for irregular heartbeat) 200 mg scheduled for 9 AM on 7/25/25 coded as a 9 with an accompanying progress note that read, New admission medication not available waiting for pharmacy to deliver. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 7/31/25 at 9:08 AM, a review of the facility's back-up medication supply was conducted and revealed the facility stocked Clopidigrel 75 mg, Isosorbide Mononitrate 30 mg, and Amiodarone 200 mg in their back-up medication supply. On 7/31/25 at a 2:53 PM, an interview was conducted with the facility's Director of Nursing, and they indicated the missed medications could have been pulled from the back-up medication supply for administration to R139. A review of a facility provided policy titled, Medication Administration and General Guidelines was reviewed; however, the policy did not address removing medications from the back-up medication supply for administration.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review the facility failed to ensure bed mobility was performed in a safe manner for one (R105) of three residents reviewed for accidents. Findings include: On 7/29/25 at 10:14 AM, R105 was observed lying in her bed. R105 was asked about care at the facility. R105 explained the day before, a Certified Nursing Assistant (CNA) had rolled her over in the bed not realizing the bed was away from the wall, she fell between the bed and the wall and hurt her foot. this was the second time they had taken x-rays of her foot because it was still hurting. R105's bed was observed to have the right side of the bed against the wall. R105 was asked if her bed was always in that position. R105 explained since the call light was located on the wall, staff were always moving her bed away from the wall so they could turn the light off and neither her nor the CNA had realized it was away from the wall when the CNA rolled her over, she just rolled off the bed.Review of the clinical record revealed R105 was admitted into the facility on 5/21/25 with diagnoses that included: heart disease, kidney disease and diabetes. According to the Minimum Data Set (MDS) assessment dated [DATE], R105 had intact cognition. The MDS assessment also indicated R105 required the partial/moderate assistance of staff for bed mobility.Review of R105's progress notes revealed an incident note dated 7/25/25 at 6:30 AM by Licensed Practical Nurse (LPN) P that read in part, Resident was observed between bed and wall. With leg bent under her. Resident stated the cna was doing check and changes when they wwent [sic] to turn her to her right side she rolled between the bed and wall and her leg ended up folded under her stated it never happened before and she nor the cna noticed the bed wasnt [sic] all the way to the wall.On 7/31/25 at 8:54 AM, CNA O was contacted by phone and a voice mail was left. No return call was made prior to the end of the survey.On 7/31/25 at 9:11 AM, R105 was observed sitting in a wheelchair in her room. R105 was asked if she had fallen all the way to the floor, or if she was trapped between the bed and the wall. R105 explained she fell to the floor, her leg was bent underneath her until they moved the bed away and got her up.On 7/31/25 at 11:22 AM, LPN P was interviewed by phone and asked what happened on 7/28/25 with R105. LPN P explained she was working in a different hall when CNA O came and told her R105 had fallen out of bed. was very surprised to hear she had fallen, she was a very safe person. went and talked to R105 who told her while getting changed she rolled towards the wall and fell out of the bed. LPN P was asked if she had seen R105 on the floor. LPN P explained LPN Q had already taken R105's vitals and helped her back into bed before she got there. LPN P was asked if CNA O had told her about what happened. LPN P explained CNA O never told her what really happened, R105 had told her.On 7/31/25 at 12:57 PM, the Director of Nursing (DON) was interviewed and asked about R105's fall. The DON explained CNA O had rolled R105 away from her and R105 fell out of the bed. The DON was asked if a resident should be rolled away or toward a person. The DON explained if there is only one staff member, a resident should never be rolled away from them, they should always roll a resident toward themself.On 7/31/25 at 1:43 PM, LPN Q was interviewed by phone and asked about R105's fall on 7/28/25. LPN Q explained he was in that hall when CNA O came and got him and said R105 fell and was on the floor. he was surprised she had fallen. she was sitting on the floor when he walked in. he took her vitals and did range of motion (ROM) then helped her back into the bed. LPN Q was asked if CNA O had told him what had happened. LPN Q explained she had only told him R105 had fallen, not how she fell.Review of a facility policy titled, Fall Management Guidelines undated read in part, .The presence or absence of a resultant injury is not a factor in the definition of a fall. A fall without injury is still a fall.

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The Orchards at Canterbury on the Lake	5601 Hatchery Road Waterford, MI 48329

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews the facility failed to ensure timely reviewal of the pharmacist recommendations, physician review/documented response of the pharmacist recommendations, maintain documentation of the pharmacist recommendations in the medical record and establish and implement a facility policy for drug regimen reviews for two (R's 30 & 121) of five residents reviewed for unnecessary medications. Findings include: R30On 7/29/25 at 11:17 AM, R30 was observed lying down on their back in bed. A brief interview was conducted with the resident at that time. A review of the medical record revealed R30 was admitted to the facility on [DATE] with diagnoses that included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia (difficulty speaking) and an anxiety disorder. A review of the medication regime review completed by the facility's pharmacist consultant revealed irregularities noted on the 5/3/25, 5/20/25 & 6/29/25 reviews. The recommendation was the same repeated recommendation for 5/3/25, 5/20/25 and 6/29/25. The recommendation documented in part . Medium Priority. Resident continues multiple orders that do not have a medical diagnosis associated with it. Please consider assessing all orders and aligning a proper diagnosis, especially psych meds - olanzapine + Bupropion. The Director of Nursing (DON) noted the medications to be discontinued as of 7/3/25. Review of the medical record revealed no documentation of the physician to have reviewed or to have been informed of the repetitive recommendation prior to 7/3/25. R121A review of the medical record revealed R121 was admitted to the facility on [DATE] with diagnoses that included: dementia, bipolar disorder, anxiety disorder and adjustment disorder. A review of the medication regime review completed by the facility's pharmacist consultant revealed on 11/27/24 and 5/21/25 the pharmacist noted See report for any noted irregularities and/or recommendations.A review of the medical record revealed no documentation and/or reports of the pharmacist recommendations for 11/27/24 and 5/21/25. On 7/30/25 at 3:27 PM, the Director of Nursing (DON) was asked to provide the pharmacist reports for 11/27/24 and 5/21/25. A second request was made to the DON and Administrator on 7/31/25 at 8:59 AM. On 7/31/25 at 9:10 AM, the DON stated they were unable to locate the reports for R121 for the dates of 11/27/24 and 5/21/25. The DON was asked to provide the facility's policy regarding medication regime reviews. The DON stated the facility did not have a policy and they were awaiting for the pharmacy consultant to send over their policy. A review of the policy sent by the pharmacy consultant documented in part . The Consultant Pharmacist reviews the medication regimen of each resident at least monthly, Findings and recommendations are reported to the Administrator, Director of Nursing, the Primary Physician and the Medical Director, where appropriate. Facility responsibility: to establish policies and procedures that address response timeframes for monthly DRR (drug regimen review) and procedures the pharmacist should take if immediate action is required. A written report is provided to the physician within seven working days or according to the facility's policy. The Consultant Pharmacist documents all potential or actual significant nursing documentation problems found relating to medications and communicates them in writing to the Director of Nursing.No further explanation or documentation was provided by the end of the survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview and record review, the facility failed to ensure safe and appropriate storage for three medication (med) carts and one medication (med) storage room of four med carts and two med storage rooms that were reviewed for medication storage and labeling. Findings include:On [DATE] at approximately 12:43 p.m., a medication cart on the second floor (med cart one) was reviewed with Nurse Z and revealed an insulin kwickpen that had an opened date of [DATE] with an expiration date of [DATE]. Nurse Z was interviewed pertaining to the expired insulin pen and they reported they would have to discard it due to it being past the expiration date. On [DATE] at approximately 12:49 p.m., Medication cart 3 (med cart 3) was reviewed with Nurse HH on second floor. An opened vial of multidose insulin was observed to have an expiration date of [DATE]. Nurse HH was interviewed pertaining to the expired insulin vial and reported it would have to be thrown away and a new one had to be opened. On [DATE] at approximately 1:03 p.m., the medication cart located on the third floor was reviewed with Nurse II. The cart was observed to have dust located in the bottom of the drawer along with multiple opened bottles of supplements that contained dried, sticky residues on their tops/sides along with sticky handles. Nurse II was interviewed regarding the sticky residues on the bottles, and the dust particles in the drawer and the reported that the carts should be cleaned out each day. On [DATE] at approximately 2:48 p.m., the medication storage room on the third floor was reviewed which contained an opened bottle of liquid pain relief that had an expiration date of 06/25. On [DATE] at approximately 3:02 p.m., Nurse II was shown the bottle of liquid pain relief with the expiration date of 06/25 and they indicated they would have to throw it away. On [DATE] a facility document titled Medication Storage in the Facility was reviewed and revealed the following: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .13. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exits. 14. Medication storage areas are kept clean, well lit, and free of clutter .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: On 7/29/25 during an initial observation of the kitchen between 8:40 AM-9:30 AM, the following items were observed: There was a wet wiping rag lying on the counter and not stored inside the sanitizer bucket. Food Service Manager JJ confirmed the rag should be stored inside the sanitizer solution. According to the 2022 FDA Food Code section 3-304.14 Wiping Cloths, Use Limitation, .(B) Cloths in-use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under S 4-501.114; The vent grates on the vent hood were observed with a buildup of grease and debris. Food Service Manager JJ stated the vent hood is cleaned quarterly.According to the 2022 FDA Food Code section 4-602.13 Nonfood-Contact Surface, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.The interior of the microwave was soiled with dried on food debris.The ice machine filters were observed to be dusty, and the top exterior of the ice machine was observed with a thick lime scale. In addition, the flooring underneath the ice machine was observed to be wet with a black, slimy film.According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, .(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.The Atmospheric Vacuum Breaker near the hose sprayer in the dish machine room was observed to be missing the top cap.According to the 2022 FDA Food Code section 5-205.15 System Maintained in Good Repair, A plumbing system shall be: (A) Repaired according to law; P and(B) Maintained in good repair.On 7/29/25 at 9:45 AM, the 1st floor resident refrigerator was observed with the following undated items: An Arby's roast beef sandwich, a container of soup, a container of chicken, a bag of chopped salad, a plastic bag with a container of fish and a bowl of soup, 5 containers of various food items labeled with a resident's name but no date, 3 containers of various food items that were undated, 2 food containers dated 7/2/25. When queried, Food Service Manager JJ confirmed all items should be dated. In addition to the undated food items, the interior of the resident refrigerator was observed to be soiled with spills and dried on food debris. In the Hoshizaki cooler located in the 1st floor kitchenette, there was an opened, undated container of thick and easy liquid (the manufacturer's label stated to use by 4 days after opening). On 7/29/25 at 10:00 AM, in the 2nd floor kitchenette Hoshizaki cooler, there was an opened, undated container of ready care thickened dairy drink. According to the undated facility policy Safe Storage & Handling of Outside Food, Any food which is not going to be consumed immediately must be covered and labeled with the resident's name, and date the food was brought into the facility .All food that is stored in the refrigerator and not consumed within 3 days will be discarded by facility staff daily.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records for one (R96) of one residents reviewed for medical records. Findings include: On 7/29/25 at 10:11 AM, R96 was observed lying in her bed. R96's Family Member (FM) GG was also in the room and explained due to R96's aphasia (language disorder that affects communication) she was trying to get a Power of Attorney (POA) because her lawyer had told her not to get Guardianship because R96 was not incompetent.Review of the clinical record revealed R96 was admitted into the facility on 7/9/25 with diagnoses that included: stroke, aphasia and heart disease. According to the Minimum Data Set (MDS) assessment dated [DATE], R96 had severely impaired cognition.Review of R96's progress notes revealed a Social Services note dated 7/19/25 at 8:45 AM by Social Services (SS) N that read in part, An admission assessment was completed with a reference date of 7/14/25. The resident is A&Ox3 (alert and orientated times 3 - person, place and time) and completed a cognitive assessment with a BIMS (Brief Interview for Mental Status) score of 6/15, indicating severely impaired cognition. Resident has been deemed incompetent by a court of law and has a public legal guardian.Further review of R96's clinical record revealed R96 was responsible for herself both medically and financially. There were no guardianship documents found.On 7/30/25 at 3:44 PM, SS N was interviewed and asked if R96 had a guardian. SS N explained R96 did not have a guardian; however, FM GG was in the process of getting POA for R96. SS N was asked about the progress note she wrote on 7/19/25. Upon reading the progress note, SS N explained she did not write that note, R96 did not have a guardian. When asked who did write that specific note, as it was documented in her name, SS N explained she really did not know who had written the note. SS N was asked if she shared her computer with anyone else. SS N explained she did not.On 7/30/25 at 4:15 PM, the Administrator was asked about R96's progress note dated 7/19/25 by SS N that indicated R96 had a guardian. The Administrator explained R96 did not have a guardian. The Administrator was informed SS N insisted she did not write that progress note, even thought it was e-signed with her name. The Administrator explained she did not know who else could have written that note because it was e-signed by SS N.Review of a facility policy titled, Medical Records Management revised 10/2012 read in part, .Medical records must be complete, accurately documented, readily accessible, systematically organized, and maintained in a safe and secure environment.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and record review the facility failed to ensure facility staff had a clear understanding of the Binding Arbitration agreement and residents received a clear explanation of the agreement prior to signing a legal document for two (R84 and R80) of three residents reviewed for the Arbitration Task. Findings include: During the entrance conference the facility explained a Binding Arbitration agreement was offered to all residents admitted into the facility. The facility provided a list of residents that had agreed to the Binding Arbitration agreement that included R84 and R80.Review of the facility's document titled, Agreement To Resolve Legal Disputes Through Arbitration undated read in part, .Any legal controversy, dispute, disagreement or claim of any kind now existing or occurring in the future between the parties arising out of or in any way relating to this Arbitration Agreement or the Resident's stay. shall be settled by binding arbitration. THIS ARBITRATION AGREEMENT WAIVES THEIR RIGHT TO A TRIAL IN COURT AND A TRIAL BY A JURY FOR ANY LEGAL CLAIMS THEY MAY HAVE AGAINST THE FACILITY. Resident, Representative. has the right to cancel this Arbitration Agreement by notifying. in writing. the notice must be post marked within thirty (30) days.On 7/31/2025 at 12:55 PM, the admission Coordinator (AC) A was interviewed and asked if she was the person who offered the Binding Arbitration agreement to residents. AC A explained she was the one responsible for going over the admission contract and the Binding Arbitration agreement was part of the admission contract. AC A was asked how she explained Binding Arbitration to residents. AC A explained she read the agreement to them and let them know if they want to have a trial before a Judge or [NAME] they must submit in writing that they want to rescind from the agreement. When asked if she tells the resident they can only rescind to the agreement in the first 30 days, AC A explained she did not. AC A was asked if she told them by signing the agreement, they can not have a Judge and [NAME] trial, they must go to arbitration. AC A' explained she would not tell them that.R84A review of R84's clinical record revealed the Agreement To Resolve Legal Disputes Through Arbitration document contained no date or who the Resident or Representative was/were. On the line for the signature, Verbal Consent was written.On 7/30/25 at 2:35 PM, R84 was interviewed and asked about signing a Binding Arbitration agreement. R84 explained he did not know what that was. When informed of what a Binding Arbitration agreement entails, R84 explained he did not remember being told that.A further review of the clinical record revealed R84 was admitted into the facility on 7/5/25 with diagnoses that included: heart disease, kidney disease and sepsis. According to the Minimum Data Set (MDS) assessment, R84 was cognitively intactR80A review of R80's clinical record revealed the Agreement To Resolve Legal Disputes Through Arbitration document that was dated 7/8/25 and the Resident was R80. It was signed by R80.On 7/30/25 at 2:40 PM, R80 was interviewed and asked about signing a Binding Arbitration agreement. R80 explained she did not know what that was. When informed of what a Binding Arbitration agreement entails, R80 explained she would not have signed it if she knew she could not go to court if she wanted.A further review of the clinical record revealed R80 was admitted into the facility on 7/8/25 with diagnoses that included: wedge compression fracture of vertebra, heart disease and kidney disease. According to the MDS assessment, R80 was cognitively intact.On 7/31/25 at 12:47 PM, the Administrator was interviewed and informed of the concern with how the Binding Arbitration agreement was being explained to residents. The Administrator acknowledged the concern.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observation, interview and record review the facility Quality Assurance and Quality Improvement (QAPI) program failed to identify and implement plans to address systemic issues regarding Infection Control and Pest Control which had the ability to affect the health, safety and quality of life for all residents who resided in the facility. Findings include: A recertification survey was conducted 7/29/25 through 7/31/25 and systemic concerns were identified in Infection Control and Pest Control.On 7/31/25 at 3:16 PM, a meeting was held with the Administrator to discuss the priority and ongoing issues that the Quality Assurance (QA) committee had identified and were working on to improve the facility. The Administrator explained areas of concern the QA committee were currently working on; however, Infection Control and Pest Control were not identified as areas of concern. The Administrator was asked about the lack of infection surveillance for legionella and failure to follow the county's health department guidance. The Administrator was informed that throughout the survey, observations of flying insects were made on all three floors residents resided on, and that the most recent pest control documentation was from 3/17/25. The Administrator acknowledged the concerns, and explained neither issue had a current QAPI plan. Review of a facility policy titled, Quality Assurance Performance Improvement Procedure Manual undated read in part, .QAPI committee responsibilities include identifying and responding to quality deficiencies throughout the facility, and oversight of the facility'[s QAPI program. The committee must develop and implement corrective action and monitor those actions to ensure performance goals or benchmarks are achieved. It also determines what performance measures will be monitored, the schedule or frequency for monitoring this data, identified opportunities for improvement and prioritizes issues by their size of impact.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record reviews the facility failed to ensure infection control standards, practices and protocols were followed consistently, failed to ensure an effective infection control surveillance program and failed to follow the county's health department guidance regarding the monitoring of legionella that included seven (R's 57, 5, 34, 142, 143, 63 & 144) of seven residents reviewed. Findings include: On 7/30/25 at 8:35 AM, observation of a medication administration for a resident in Contact Precautions revealed Licensed Practical Nurse (LPN) “F” was observed to put on an isolation gown, a simple mask and put on gloves from an isolation cart outside a room. LPN “F” entered the room, took the residents’ vitals, then walked back out of the room to stand at the medication cart in the hallway. LPN “F” then prepared the residents’ medications continuing to wear the same isolation gown and simple mask. After exiting the room, for the second time with the same gown and mask, LPN “F” removed the gown, mask and gloves and washed her hands. LPN “F” was asked about keeping the gown and mask on after exiting the room after she took the vitals. LPN “F” explained she thought since it was right outside of the room, she could keep the gown on. On 7/31/25 at 8:38 AM, IP “T” was interviewed and asked if staff could keep an isolation gown on after being in a Contact Precaution room. IP “T” explained all personal protection equipment (PPE) should be removed before leaving a Contact Precaution room, it should never be taken outside a room. Review of a facility policy titled, “Transmission Precautions: Contact” undated read in part, “…In addition to Standard Precautions, Contact 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…” A review of a letter attached to an email sent to the facility’s Administrator by the county’s Epidemiologist dated 3/14/25, documented in part “… Re: Legionellosis Investigation… One healthcare-associated case who resided at your facility during their incubation period in 2023. Several positive sampling locations in the case’s path, combined with a review of medical records, implicate your facility as the likely exposure location for this case… After initial results identified multiple legionella-positive sampling sites… These results are routinely positive for legionella bacteria at a majority of sampling locations, in both swab and bulk sample types…” On 7/31/25 at 11:52 AM, a telephone interview was conducted with the County’s Epidemiologist (CE) “X”. The above letter was discussed and CE “X” was asked if the facility was provided guidance clinically to follow to ensure the safety of the facility’s residents. CE “X” stated the facility’s Administration team was provided the following guidance, “… We have not been made aware of a case with an exposure at the facility in well over six months, but we recommended the enhanced testing because of environmental sampling results… Clinical symptoms of pneumonia may vary but must include acute onset of lower respiratory illness with fever and/or cough. Additional symptoms could include myalgia, shortness of breath, headache, malaise, chest discomfort, confusion, nausea, diarrhea, or abdominal pain…” (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CE “X” documented in part “… Note that this definition includes a fever or cough. Including only fever would not meet our recommendation. A review of the facility’s Infection Surveillance Program revealed multiple residents that met the requirements for the enhanced legionella testing, which was not identified or conducted by the facility staff. A small sample was identified to establish a pattern of the facility’s deficient practices. A review of the “Infection Control Line Listing” revealed the following: January 2025- documented- shortness of breath and cough for R63. February 2025- documented cough and congestion for R’s 143 and 142. May 2025- documented shortness of breath and cough for R144. June 2025- documented cough, shortness of breath and pain for R5. July 2025- documented cough and positive for pneumonia for R34. A review of R57’s progress note dated 6/30/25 at 3:02 PM, documented in part “levofloxacin Oral Tablet… Give 500mg by mouth one time a day for pneumonia for 7 days…” This was not identified and/or recorded on June 2025 infection surveillance log. Further review of the Infection Surveillance Program and resident medical records revealed enhanced testing for legionella was not performed for residents that met the criteria provided by the County’s health department. This indicated the facility failed to follow the guidance of the County’s health department and failed to ensure an effective Infection Control Surveillance Program. On 7/31/25 at approximately 11:11 AM, the Infection Preventionist (IP) “T” and Director of Nursing (DON) was interviewed and asked about their collaborative plan with the health department in monitoring the residents for legionella. The DON stated they did not have communication with the health department. The DON stated the Administration team at the facility implemented a criteria to test any resident with a fever of 102 degrees or above. On 7/31/25 at 1:49 PM, the IP “T”, DON and Administrator was interviewed together and the guidance provided by the County’s Epidemiologist was discussed. IP “T”, the DON and Administrator was asked why the facility was not following the County’s Epidemiologist guidance clinically for residents that exhibited signs and symptoms noted on the guidance from the health department. An explanation was not provided. No additional information or documentation was provided by the end of the survey.

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	07/31/2025

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

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews the facility failed to ensure an effective system to monitor antibiotic use in the facility for four (R's 145, 14, 8 & 126) of four residents reviewed. Findings include:A review of the facility's Infection Control Logs and the monitoring of antibiotics revealed multiple residents identified to have potentially been prescribed an unnecessary antibiotic. A small sample was identified for review: April 2025-4/20/25- R8 confusion, urgency, freq (frequency). Incont (incontinence). + dipstick UA (urinalysis). Macrobid. A review of a Nursing note dated 4/2025 at 5:59 PM, documented in part . writer observed resident with confusion. vitals are within normal limits. collected UA by straight cath. positive for leukocytes. Called on call and was given an order to start resident on Macrobid 100mg two times a day for 5 days. Sample was collected at 5:40 PM and placed in the 1st floor refrigerator.The medical record did not identify urgency, frequency or incontinence of urine. Further review of the medical record revealed no documentation of results from a urinalysis or sensitivity and urine culture. May 2025-5/23/25- R126 urgency, freq, incont. + UA. Review of R126's medical record revealed no identification or documentation of the resident to have urgency, frequent and incontinence of urine. Further review of the medical record revealed no results of a culture and sensitivity test to have been conducted. June 2025-Upon admission [DATE]) R145 was documented to have been prescribed metronidazole. There was no documentation of the antibiotic to have been reviewed for appropriateness. July 2025-7/29/25- R14 was prescribed Macrobid 100mg twice a day for 5 days for an asymptomatic urinary tract infection (uti). A review of the medical record revealed no identification or documentation of signs or symptoms of a uti.Review of the Infection control logs and resident medical records revealed no documentation of the review of appropriateness of the antibiotics prescribed to the above residents. On 7/31/25 at approximately 11:11 AM, the Director of Nursing (DON) and Infection Preventionist (IP) T was interviewed and asked about the oversight of antibiotic use in the facility and the reviewal of appropriateness of the antibiotics prescribed. The IP T explained they were newly hired into the role of the IP. IP T stated they would input the data for the resident into the computerized McGeer checklist to see if it met criteria. IP T stated they would review referrals, labs, and results. When asked if they consulted with the Physician regarding the appropriateness (risks/benefits) of the antibiotic usage, IP T stated they were not. The DON and IP T was asked about the review of the appropriateness of antibiotics prescribed to R's 8, 126, 145 and 14. The DON and IP T stated they would look into it and follow back up. At approximately 1:52 PM, the DON and IP T returned and stated they were discussing the appropriateness of the antibiotic for R14. No further explanation or documentation was provided by the end of the survey.

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

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	07/31/2025

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The Orchards at Canterbury on the Lake	5601 Hatchery Road Waterford, MI 48329

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review, the facility failed to ensure an effective pest control program by eliminating harborage conditions and provision of routine and/or as needed pest control which had the potential to affect all residents (including R8) in the facility. Findings include:Observations during the recertification survey from 7/29/25 - 7/31/25 revealed flying insects were observed in multiple locations including the conference room (utilized by residents, visitors, and staff), throughout the hallways and resident rooms on first, second, and third floors, and in the resident dining areas on the second and third floor.The facility's main elevator was observed from 7/29/25 - 7/31/25 to have multiple dead insects inside the elevator's ceiling light cover.Additionally, just prior to the start of this survey, a resident was identified with maggots in a wound.On 7/29/25 at 10:10 AM, observation of the third floor dining room revealed five tables that had meal trays with uncovered food items. Additionally there was a small pushcart that contained several meal trays with uncovered food items. Flying insects were observed throughout the dining room and kitchenette area.On 7/29/25 at 10:50 AM, an interview was conducted with R8's Legal Guardian (LG) who was seated in a wheelchair next to the resident who was lying in bed. Throughout this interview there were several flying insects observed throughout the resident's room. When asked about the flying insects, the LG confirmed the same observation and reported when they complained about it a while ago, one of the nurses gave them this (pointed to a small red apple container on the resident's bedside dresser which was a vinegar gnat bait). When asked if anyone had been back to check the trap, the LG reported no one had followed up and they further reported they thought the problem was the staff let the food sit out too long in the rooms and dining room before they clear it.On 7/29/25 at 11:38 AM, the facility was requested to provide pest control logs since January 2025.Review of pest control documentation provided by the Administrator revealed the most recent visit was on 3/17/25 which did not include any specific details of findings. The documentation labelled April 2025 was actually from April 2024 and 2023. There was no documentation that routine pest control had been provided since March 2025.On 7/31/25 at 8:32 AM, the facility was requested to provide any additional documentation since March 2025 and informed the April documentation was from 2024 and to confirm if that was accurate.On 7/31/25 at 8:39 AM, the Administrator reported they would follow-up.On 7/31/25 at 9:10 AM, an interview and observation of the third floor was conducted with the Maintenance Director (Staff ‘R') who reported they worked at the facility for about four years and in the Director role for about four months.When asked about the facility's pest control, they reported they weren't responsible for that, but if staff saw anything, they might call them or put it in a work order. They were not aware of any staff concerns regarding flies and gnats.On 7/31/25 at 9:15 AM, while walking throughout the facility from the first floor to the third floor, multiple flying insects were observed throughout the hallways.When asked about R8's room, Staff ‘R' reported they were not aware the vinegar bait had been given to them. When asked if they were made aware of any concerns with flying insects, they reported they were not. When asked who was responsible for monitoring the facility's pest control, Staff ‘R' reported they weren't sure, but it was not them. On 7/31/25 at 1:30 PM, the Administrator reported the pest control contact had not returned their call as of now. When asked if they had any documentation of staff reporting concerns with flying insects, they reported they didn't have any formal documentation. There was no further documentation of pest control provided by the end of the survey.According to the facility's Standards of Practice (SOP) titled, Pest Control dated March 2019: .It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents .Effective pest control program is defined as measures to eradicate and contain common household pests (e.g., bed bugs, lice, roaches, ants, mosquitos, flies, mice and rats) . Facility will maintain a report system of issues that may arise in between scheduled visits with the outside pest service and treat as indicated .According to the 2022 FDA Food Code section 6-501.111 Controlling Pests, The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: 4. (D) Eliminating harborage conditions.