

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/12/2025
NAME OF PROVIDER OR SUPPLIER  The Orchards at Lapeer		STREET ADDRESS, CITY, STATE, ZIP CODE 239 S Main St Lapeer, MI 48446	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37666</p> <p>This Citation Pertains to Intake Number MI00150900.</p> <p>Based on interview and record review, the facility failed to ensure that physician's orders were enacted for one resident (Resident #1) of 3 residents reviewed for a change of condition.</p> <p>Findings Include:</p> <p>Resident #1:</p> <p>A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #1 was admitted to the facility on [DATE] with diagnoses: enlarged heart, anxiety, depression, Barrett's Esophagus, GERD and debility. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of ,d+[DATE] and the resident needed some assistance with all care.</p> <p>A record review of the progress notes revealed Resident #1 was transferred to the hospital on [DATE] at 9:30 AM, with a change of condition related to low blood pressure ,d+[DATE], a rapid pulse rate 118 beats per minute, a rapid respiratory rate of 30 breaths per minute and very low oxygen saturation of 78% with use of oxygen via nasal cannula.</p> <p>Another progress note on [DATE] at 2:12 PM identified the following: Writer called (the hospital) resident admitted to the ICU with metabolic alkalosis, sepsis, hyperkalemia (high potassium).</p> <p>Further review of the progress notes indicated on [DATE] at 2:54 AM, several hours prior to his transfer to the hospital, Resident #1 began to have shortness of breath. The progress note provided, Writer observed resident with (shortness of breath) and consistent spO2 (oxygen saturation) less than 90% ranging from , d+[DATE] on room air. Notified MD. Received order to start O2 at 2 (liters/minute) to maintain spO2 &gt;90%.</p> <p>Upon further review of the medical record, a physician's note dated [DATE] at 4:02 PM revealed the following, . Chief Complaint: Cough and chest congestion with brown sputum. Episodic Visit . Respiratory: Chest expands symmetrical without effort. Breath sounds decreased, clear. Inspiratory/Expiratory wheezing noted . I evaluated the patient's condition today and found it to be stable. The patient will continue present management. Pain management as needed. Obtain a CXR (chest x-ray) and start Robitussin expectorant.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the physician orders for Resident #1 identified the following:</p> <p>[DATE]- Send to hospital for evaluation and treatment.</p> <p>[DATE]- O2 @2L via NC (nasal cannula) to maintain SPO2 &gt;90%.</p> <p>There were no orders for a chest x-ray for Resident #1. There were no new orders from [DATE], the day the physician saw and examined Resident #1 until [DATE].</p> <p>The resident already had an order for Guaifenesin cough syrup as needed.</p> <p>A review of the Results tab for diagnostics including x-rays and the Miscellaneous tab in the electronic medical record/EMR, indicated there were no results for a Chest x-ray for Resident #1.</p> <p>A review of Resident #1's Medication Administration Record for [DATE] indicated the Guaifenesin cough syrup was not provided to the resident.</p> <p>A review of the Care Plans for Resident #1 revealed there was no Care Plan related to the resident's cough and congestion. There was no respiratory Care Plan.</p> <p>On [DATE] the hospital medical records were obtained and reviewed for Resident #1's hospital admission on [DATE]. The medical records revealed the resident was admitted to the hospital with shortness of breath and hypotension (low blood pressure). The resident was transferred from the emergency room /ER to the ICU/Intensive Care Unit. His laboratory results were abnormal showing infection, poor kidney function requiring dialysis and received IV fluids and IV antibiotics. A chest x-ray on [DATE] at the hospital identified the resident had pneumonia. The resident's family chose comfort measures and the resident died on [DATE].</p> <p>During an interview with Nurse A on [DATE] at 11:48 AM, she was asked about Resident #1. The nurse said she was assigned to care for Resident #1 on the day he was transferred to the hospital on [DATE]. Nurse A stated, I got report that morning. I was told he had shortness of breath and they put oxygen on him. Sometimes his sats (oxygen saturation levels) were in the low 90's. He was not eating a whole lot over the last week. Nurse A said the resident was not doing well on [DATE] and she contacted the provider and the resident was transferred to the hospital. Nurse A was asked if she was aware the Physician had wanted an order for a chest x-ray when he saw the resident on [DATE]; she said she was not aware of that. She did not work on [DATE].</p> <p>On [DATE] at 12:35 PM during an interview with the Director of Nursing/DON, she was asked about Resident #1 and the order for a chest x-ray the physician wanted when he examined the resident on [DATE]. The DON said the nurses were supposed to round with the physician when he came in to see the residents; she said the physician was usually at the facility twice a week, including one day on the weekend. The DON said the physician would write down what orders he wanted and review them with the nurses, so they could make sure they were enacted. Also reviewed with the DON that Resident #1 was noted to have a cough, congestion and brown sputum on [DATE], but there was no nursing assessment later that day or on [DATE]; not until early on [DATE] was there additional assessment from the nurses when the resident had shortness of breath and oxygen was applied.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 10:03 AM, during an interview with Nurse E, she said she was working at the facility on [DATE] and was assigned to Resident #1. Nurse E was asked if she rounded with the physician on that day and she said she did not round with the physician. She said she was newer to the facility and had never done that. When asked who rounded with the physician she said she thought it was the receptionist. Nurse E was asked if the physician had talked to her about Resident #1 having a cough, congestion, brown sputum and he wanted to order a chest x-ray and begin cough syrup. She said she was not aware of that.</p> <p>During an interview with Physician G on [DATE] at 10:30 AM, he said he was usually at the facility twice a week to see the residents. Physician G was asked if a nurse went with him during his rounds to see the residents and he said he usually rounded with the receptionist because she would locate where the residents were. He said sometimes the residents were not in their rooms and she would help find them. The physician was asked how he made sure his orders were enacted and he said he would take notes and review them with the nurses when he was done seeing the residents.</p> <p>During the interview with Physician G on [DATE] at 10:30 AM, he was asked about Resident #1. He said he recalled seeing the resident on [DATE]. He said the resident told him he had a cough, and brown sputum. The physician said he examined the resident and listened to his lung sounds and recalled he wanted to order a chest x-ray and cough syrup. He said he did not recall if he reviewed this with a nurse. The physician was asked if he knew his orders for Resident #1 had not been enacted and the resident was transferred to the hospital on [DATE] and was diagnosed with pneumonia. He said he was not aware of that.</p> <p>On [DATE] at 11:00 AM, the DON was interviewed and she said she had spoken with Nurse E and the physician and the nurses were receiving education concerning rounding with the physician when he saw the residents and assessments with a change of condition.</p>		