STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Lapeer	239 South Main Street 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)
F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Number 2719390. Based on interview and record review the facility to ensure that 1) resident code status was correctly identified, 2) Emergency Medical Services were notified in a timely manner and 3) an AED (automated external defibrillator) was used during an emergent situation when Resident #3 was found not breathing and his heart had stopped. Findings Include: Resident #3: A record review of the Face sheet and Minimum Data Set/MDS assessment for Resident #3 indicated an admission to the facility on [DATE] with diagnoses: Metabolic encephalopathy, history of falls with fractures- left side ribs, COPD, heart disease, peripheral vascular disease/PVD, epilepsy, Dementia, kidney failure, anemia, and aphasia/difficulty speaking. The MDS assessment dated [DATE] revealed the resident had severe cognitive decline with a Brief Interview for Mental Status/BIMS score of 0/15 and the resident needed assistance with all care. On [DATE] at 1:50 PM, during an interview with the Director of Nursing/DON, she said Resident #3 was found in his room not breathing and his heart had stopped on [DATE] and the nurses paged a Code Blue. The DON said it was later in the day about 5:30 PM and she was not at the facility. She said a staff member called her and said there was some confusion on the resident's code status and the staff were not certain if the resident was a Full code requiring CPR to be performed or if he had chosen DNR (Do not resuscitate- no CPR). She said the staff had called 911 for Emergency Medical Services/EMS assistance with CPR and resuscitative efforts and then cancelled EMS; telling them they did not need them because the resident was a DNR. Approximately 30 minutes later the staff were still performing CPR and then called 911 again for assistance telling them the resident was a Full code. EMS arrived a few minutes later and took over the CPR and resuscitative efforts. She said they performed CPR and resuscitation for about 30 minutes more, but the resident died. The DON was asked for copies of the CPR cards for all of the Nurses at this time. A policy for Code Blue was requested as well as a policy for performing CPR. The DON said the facility did not have a policy for CPR and the Nurses all had CPR training and were to follow their training. A record review of the documents section of the electronic medical record/emr for Resident #3, identified a document titled, Code Status/Do Not Resuscitate Directive, (check one) for Resident #3. Resident is a Full Code had an X placed next to it and the instructions indicated If checked, proceed to witness signature. One witness required. Full code by Default dated [DATE] was written on the signature line. An unidentified witness signed the form at the bottom of the page and dated it [DATE]. A review of the Physician Orders for Residents #3 revealed CPR- Full Code Status revision date [DATE] with no start date. A review of the Care Plans for Resident #3 identified the following: I have an advanced directive with the social worker/physician and wish to receive CPR (full code) by default and consent for all other medical or surgical treatments if recommended, date initiated [DATE], with a Goal: My wishes will be followed through the next review date. Interviews On [DATE] at 2:15 PM, during an interview with Nurse D about the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Code Blue for Resident #3 on [DATE] she said she heard a page overhead for a Code Blue to Resident #3's room. She said when she entered the room Nurse C was performing CPR and someone had brought the crash cart that included the AED. Nurse D said she went to the Nurses Desk to start the Transfer paperwork and check the resident's code status. Nurse D stated, I misinterpreted the code status at first because it said, Full code by default and an aide (Nurse Aide) overheard and called off EMS. I brought the paperwork into the room and an aide looked at it also and determined it said, Full code. It took some time with the commotion. The Aide (Nurse Aide E) called EMS again and said he was a Full code then EMS came and took over the code. EMS talked to the doctor at the hospital and he told them to stop. An interview with Nurse M on [DATE] at 10:13 AM about the Code Blue for Resident #3 revealed, I was working that day. I went into the resident's room about 6:00 - 6:15 PM and (Nurse C) was doing CPR, the whole room was full of people. Shortly after, EMS came. On [DATE] at 1:02 PM, Nurse C was interviewed about Resident #3 and stated, (Nurse Aide G) called for a nurse about the time for dinner trays. (Resident #3) was non-responsive; normally he's confused, but alert. I had last given him his medications at 1:00 PM and he was baseline. I checked on him 3:30 - 4:00PM and he was lying in bed. After I came in the room and assessed him I started CPR and said to call a Code Blue. Someone else called the Code Blue overhead. (Nurse Aide G) got the crash cart. I looked at my report sheet, it said Full Code and I started CPR. Someone came in the room and said they thought he was a DNR. They called 911 and called it off. Later they determined he was a Full code and called 911 again and EMS came. Nurse C was asked if anyone used the AED prior to EMS arriving and she said she thought it was on the Crash Cart, but it wasn't used. On [DATE] at 1:49 PM Nurse Aide E was interviewed about the Code Blue for Resident #3 on [DATE] and stated, I heard the code called overhead and ran up there. I called 911. They asked if he needed an ambulance and I said I didn't know. I told them I would call them right back. The nurses were under the impression he was a DNR. (Nurse C) was doing CPR. I called 911 twice and said he was a DNR and then somebody else called when they knew he was a Full code. A record review of the nurses CPR cards indicated the nurses obtained CPR training from a variety of sources, including Nurse C, Nurse D and Nurse M who were present during the Code Blue for Resident #3. 14 of 20 Nurses had current American Heart Association/AHA Basic Life Support/BLS for Healthcare Provider training. 6 of 20 nurses did not have Basic Life Support for Healthcare Provider CPR training, as identified in the following: Nurse C had a Student: Standard CPR training dated [DATE]. It was not intended training for Healthcare Providers. Nurse D had taken an online Certificate of Continuing Medical Education BLS recertification training on [DATE]. There was no mention of the training being specific to Healthcare Providers or including AED training. Nurse M had American Red Cross Basic Life Support training dated [DATE]. It was not for Healthcare Providers. All 3 nurses were present during the Code Blue for Resident #3, they did not promptly contact 911 EMS for assistance or attempt to use the AED during the resuscitation as required. Per the American Heart Association: Basic Life Support BLS Training, 2026: Basic Life Support (BLS) -The American Heart Association's BLS course trains participants to promptly recognize several life-threatening emergencies, give high-quality chest compression, deliver appropriate breaths and ventilations, and provide early use of an AED. The course reflects science and education from the 2025 American Heart Association Guidelines for CPR and Emergency Cardiovascular Care (ECC). The American Heart Association's BLS Course is designed for healthcare professionals and other personnel who need to know how to perform CPR and other basic cardiovascular life support skills in a wide variety of in-hospital and out-of-hospital settings; What does this course teach? ‘High Quality CPR for adults, children and infants, BLS concepts from the Chain o Survival, Delivering effective breaths or ventilations, Importance of early is of (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Numbers 2707758 & 2711787.Based on interview and record review, the facility failed to ensure breakfast was offered, prior to leaving for dialysis, for one resident (Resident #6) and Food Acceptance was consistently monitored for one resident (Resident #1) of 3 residents reviewed for food and nutrition. Findings Include: Resident #1 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: history of a stroke, cervical disc degeneration, history of falls, depression, anxiety, hypothyroidism and overactive bladder. The MDS assessment dated [DATE] revealed the resident had severe memory loss with a Brief Interview for Mental Status/BIMS score of 5/15 and the resident needed assistance with all care. A review of the assessments titled, Change in Condition indicated Resident #1 had a change of condition on 12/11/2025 due to an excessive cough. On 12/27/2025 another Change of Condition evaluation was completed related to a Respiratory Infection and the resident continued with a cough; an x-ray and antibiotic were recommended. A review of the progress notes for Resident #1 identified the following: 12/30/2025 at 5:54 PM, Acute Transfer Form identified Resident #1's left leg would not straighten and the Resident was being transferred to the hospital. 12/30/2025 at 6:09 PM, a nursing progress note, revealed the resident was transferring to the Emergency Room/ER at the hospital for right leg weakness and possible stroke. A review of the Hospital ER Discharge Instructions for Resident #1 on 12/30/2025 at 6:47 PM, indicated the resident was diagnosed with low sodium levels, low potassium levels, weakness and was treated for dehydration with IV/intravenous fluids. Resident #1 returned to the facility on [DATE] at approximately 12:52 AM. Further review of the progress notes indicated on 1/5/2025 at 12:40 PM, Resident #1 was removed from the facility by a family member. During an interview with Confidential Person K on 1/21/2025 at 5:21 PM, she said Resident #1 had become ill in the month of December 2025 with a cough and respiratory infection. The Confidential Person said the resident was declining, not eating well, becoming weak and was not herself. She said the resident went to the hospital ER on [DATE] and again on 1/5/2026. The resident was treated for low sodium and potassium levels and dehydration. The resident did not return to the facility after the 1/5/2026 transfer to the hospital. A record review of the Tasks: Nutrition- Amount Eaten record in the electronic medical record for Resident #1 from 12/29/2025 to 1/5/2026 revealed there were two documents to chart Amount Eaten. Neither document consistently documented meal times. Document #1- 12/29/2025: There were 3 meals documented with 2 at 11:01 AM and 1 at 5:30 PM. Both 11:01 AM documentations listed the resident ate 51-75% of the meals and the 5:30 PM showed 26-50%. Nutrition- Amount Eaten document #2- 12/29/2025: There were 3 entries- 5:51 AM (this was prior to the breakfast meal- 75-100% eaten; 11:01 AM 0-25% eaten (this contradicts the Document #1 11:01 AM meal intake); 2:26 PM 0-25% (this was prior to the supper meal). Document #1- 12/30/2025: There was 1 meal documented at 10:00 AM for 76-100% eaten. The resident was transferred to the hospital at approximately 6:09 PM. There was no lunch or supper documented. Nutrition- Amount Eaten document #2- There were 2 meals documented: 2:28 AM 76-100% and 10:00 AM 76-100%. Document #1- 12/31/2025: No documentation of a meal. The resident returned from the hospital at approximately 12:45 AM and was present for all meals. Nutrition- Amount Eaten document #2: There was 1 meal documented at 5:43 AM, prior to the breakfast meal and stated, Resident refused. Document #1- 1/1/2026: 3 meals were documented- 2 at 12:33 PM for 51-75% eaten and 1 at 4:37 PM with 76-100% eaten (this is prior to the evening meal being served). Nutrition- Amount Eaten document #2: 3 meals were documented 2:45 AM, and 2 meals at 12:33 PM - all were documented for 51-75% eaten. Document #1- 1/2/2026: 3 meals documented- 2 at 1:42 PM for 0-25% eaten and one for 26-50% eaten and 1 at 5:21 PM for (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	76-100% eaten. Nutrition- Amount Eaten document #2: 3 meals documented- 1 at 12:00 AM for 51-75% eaten; 2 meals at 1:42 PM, 26-50% and 0-25% eaten. Document #1- 1/3/2026: No documentation. Nutrition- Amount Eaten document #2: 1 meal at 3:51 AM with 26-50% eaten. It was unclear if the resident received 3 meals that day or when. Document #1- 1/4/2026: 2 meals both documented at 3:21 PM with 76-100% eaten for both. Nutrition- Amount Eaten document #2: 3 meals documented 1 at 3:39 AM 26-50%, and 2 at 3:21 PM for 76-100% eaten. Document #1- 1/5/2026: 3 meals documented 9:11 AM with 0-25% eaten; 12:49 PM and 4:16 PM Resident not available. The resident left the faciity on 1/5/2026 at approximately 12:40 PM and did not return. Nutrition- Amount Eaten document #2: 4 meals were documented- 1 at 1:04 AM for 51-75% eaten, 9:11 AM 0-25% eaten, 12:50 PM and 7:56 PM (Resident not available- as the resident was discharged). The documentation of the nutritional meal intake for Resident #1 was erratic. Meal times could not consistently be determined, charting was often in batches for several meals at a time and prior to the meals. The resident's meal intake could not accurately be accounted for. A review of the Care Plans for Resident #1 provided the following: I have a potential for alteration in nutrition and hydration and (weight) changes r/t (related to) diagnosis of depression, hyperlipidemia and cerebral infarction, and hypothyroidism. date initiated 2/3/2024 with Interventions: . Staff will monitor and record how much I eat. date initiated 2/3/2024.An interview with the Kitchen Manager I on 1/28/2026 at 1:45 PM related to Resident #1, revealed the resident usually ate in her room and fed herself, but she had been ill with a respiratory infection in December 2025. The Kitchen Manager I said the Registered Dietitian monitored the residents nutritional intake. On 1/28/2026 at 11:25 AM, Registered Dietitian/RD J was interviewed about Resident #1. She said she saw Resident #1 in the beginning of December 2025, prior to her respiratory illness. The last weight for the resident was 12/9/2025 prior to her illness. When asked about monitoring of the resident's meal and food intake, RD J said if the Food Acceptance Record/FAR showed the resident was eating less than 50% for 2 or more meals for 3 or more days, the Nurse Managers would review. The RD said she was at the facility once a week and sometimes a diet Tech came to the building, less than weekly. The RD was asked if she had seen the meal documentation for Resident #1 at the end of December 2025 through January 5, 2026 when the resident was discharged . She said she had not seen it. Reviewed with the RD J that the documentation was inconsistent and did not always capture the meals for the resident. She said she was not aware of that. Also reviewed, the resident had been transferred to the ER on [DATE] and returned 12/31/2025 after treatment for low sodium, low potassium and dehydration. She said she was not aware of this. Resident #6 A record review of the Face sheet and MDS assessment for Resident #6 revealed an admission to the facility on 6/24/2024 with diagnoses: Diabetes, end stage renal disease, hemodialysis, heart disease, anemia, depression, anxiety and a left humerus/arm fracture 9/29/2025. The MDS assessment dated [DATE] indicated the resident had a BIMS score of 13/15 with full cognitive abilities and the resident needed assistance with care. On 1/27/2026 at 8:54 AM, Confidential Person L was interviewed and said Resident #6 discharged home on 1/22/2026. The resident had been receiving dialysis services at an outpatient setting 3 times a week and she said he would continue to go to dialysis. Confidential Person L said the resident left before breakfast about 4:45 AM and returned between 10:30 AM and 11:00 AM. The Confidential Person said the resident did not receive a meal or food prior to leaving for dialysis and did not take a sack lunch or food with him. She said the resident sometimes did not receive an evening snack the night before and would have no food from the time of the evening meal ~6:00 PM to almost lunch time the next day after he returned from dialysis. Confidential Person L said sometimes the resident had to ask for the evening snack and did not always receive it. She said at times the dialysis center would provide him with a snack, but the resident (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was diabetic and she said sometimes he would not feel well without eating. A review of the Dialysis Communication Forms for December 28, 2025, through January 21, 2026, for Resident #6 identified a documentation section titled, Facility Pre-Dialysis Information, a section titled, Dialysis Center Information and Facility Post-Dialysis Information. In the Facility Pre-Dialysis and Dialysis Center sections was a category Meal/Snack Sent. In the section Facility Pre-Dialysis Information on 12/28/2025, 1/5/2026, 1/16/2026, 1/18/2026 and 1/21/2026, the Meal/Snack Sent entry said wither None, Noor was blank. For the same days, the Dialysis Center Information section for Meal/Snack Intake was 0 except for 1/21/2026 when a dialysis supplement was given. A review of the Tasks: Nutrition- HS Snacks- Did resident take snack (evening snack) documentation for Resident #6 revealed there was not consistent daily documentation if the resident received a snack. 12/30/2025, 12/31/2025, 1/1/2026, 1/2/2026 and 1/11/2026 were missing any documentation. On 1/7/2026, 1/18/2026 and 1/19/2026 the documentation said, Not applicable. A review of the Care Plans for Resident #6 provided the following: I have Diabetes Mellitus, date initiated 4/18/2025. The interventions did not mention providing the resident snacks, an HS snack or a meal/snacks to take to dialysis 3 times a week. I have potential for alteration in nutrition/hydration r/t Renal diet with 1500 ml (fluid restriction) due to ESRD (end stage renal disease) with HD (hemodialysis). date initiated 6/26/2024 with Interventions including: Provide, serve diet as ordered. Monitor intake and record q (every) meal, date initiated 6/26/2024. There was no mention of providing snacks for the resident or ensuring he received a pre or post- dialysis meal. I receive Hemodialysis 3x a week r/t renal failure, date initiated 6/25/2024. There were no interventions related to ensuring the resident had a morning meal or snacks. On 1/27/2026 at 2:00 PM, Kitchen Manager I was interviewed about Resident #6. She was asked if the resident was offered a sack lunch or snacks to take to the Hemodialysis center with him. She said the resident left very early in the morning usually at 4:45 AM and that was before the kitchen opened. When asked if something was prepared for him the night before, so that he could take it the next morning, she said he didn't want anything. When asked if he didn't want anything each day he went to dialysis, the Kitchen Manager said she didn't know. The Kitchen Manager I as asked about evening snacks and said the kitchen provided snacks for the clinical staff to pass to the residents. On 1/28/2026 during an interview with RD J about Resident #6, she was asked if diabetic residents who went to early morning dialysis were offered a breakfast, sack lunch or snacks and she said sack lunches are available, but she didn't think the resident wanted one. The RD was asked if something was offered to him, in case he changed his mind and she stated, That would be up to the facility. The Care Plans for Resident #6 were reviewed with the RD, and she said they often updated the residents' care plans. When asked why Resident #6 had no mention of nutrition offered from supper the evening before dialysis (about 6:00 PM) to after anytime before or after breakfast, she said she didn't know. Reviewed with the RD there was no mention of an HS snack for Resident #6 and upon review of the Task documentation for snacks, it was unclear if he was consistently being offered a snack or received one. The RD J said the facility would monitor that. A review of the facility policy titled, Dialysis Nutrition Review, dated 7/18/2018 provided, It is the policy of this facility to assure dialysis residents maintain their nutritional needs which includes identifying and assessing each resident's nutritional status and risk factors, evaluating/analyzing the assessment information, developing and consistently implementing pertinent approaches, and monitoring the effectiveness of interventions and revising them as necessary and coordinating care with dialysis. Review of dialysis communication sheets. Update care plans with most recent concerns, goals and interventions.