

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER The Orchards at Lapeer		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 3073775 and 3073809. Based on observation, interview and record review, the facility failed to implement procedures for skin management for two residents (R1, R9) of three residents reviewed for skin management, resulting in missed/inaccurate skin assessments and care plans not being updated. Findings include: Resident #1 (R1): R1 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include severe sepsis, pneumonia, pleural effusion and methicillin resistant staphylococcus aureus (MRSA) infection. R1 has a brief interview for mental status (BIMS) score of 15, indicating R1 is cognitively intact. On 7/14/26 at 11:04am, R1 was observed in bed, dressed in a gown, no odors present, the room is clean and his heels are elevated with a pillow, his right foot turns inward and there is a dressing on the outside of the right ankle dated 07/13/26. R1 was asked what the dressing was for on the outside of his ankle. R1 stated that he had a scab on his ankle and they have it covered up. R1 was asked to provide additional information about the area on his right ankle. R1 was unable to offer any more information on the area, he began to discuss other topics. On 7/14/26 at 3:10pm, an interview was conducted with Wound Care (WC) A. WC A was asked if R1 has any pressure injuries. WC A stated, yes, he has an area on his right ankle on the outside. WC A was asked if R1 admitted with this area on his ankle. WC A stated, yes, it was a small scab on admission, and he has picked at it and now it is open. WC A was asked how big the area is. WC A stated that it is about the size of a quarter. WC A was asked when the scab opened up. WC A stated that 06/14/26 was the day it opened. WC A was asked what interventions they had in place for pressure injury prevention. WC A stated that they have protective boots and floating the heels of R1. WC A was asked if R1 will wear his protective boots. WC A stated that lately has been better at wearing them, but when he first got here, he would take them off. On 7/15/26 at 12:30pm, record review revealed that a head-to-toe skin assessment was completed on 5/31/26. There is no documentation of scabs on the assessment. On 7/15/26 at 12:44pm, an interview was conducted with Registered Nurse (RN) B. RN B was covering for wound care today. RN B was asked if they have seen the right ankle wound. RN B stated that they had not seen it today but stated it started out as a scab. RN B stated that R1 had scabs on his knees, ankles and face on admission. RN B then stated that R1 will pick at his scabs, he is a picker. RN B was asked if this scab was present on admission. RN B stated that on 6/7/26 there is documentation that there is scattered scabbing on his body. RN B was asked if nurses should document these areas of scabbing on admission in the event, they ever become an open area. RN B stated that some of the nurses might not document scabs on admission, but they probably should. RN B reviewed the nurses skin assessment of R1 from admission, and it didn't note the scabbing on admission. On 7/15/26 at 12:55pm, record review revealed a care plan titled, I have actual impairment to skin integrity of the right ankle and knee. Created date 06/24/2026. RN B was asked if that care plan should have been initiated as soon as the facility identified the skin (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235654
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impairment on the right ankle. RN B stated, yes, one should have been put in place earlier. Resident #9 (R9): R9 is [AGE] years old and admitted to the facility most recently on 03/29/2023 with diagnoses that include peripheral vascular disease, dementia, hypertension and anxiety disorder. R9 has been receiving hospice services since 6/20/2024. R9 was observed resting in bed with a dressing on his right pinky toe and heel boots in place. On 7/14/26 at 3:30pm, record review revealed that skin assessments were not being completed timely. A skin assessment was completed on 4/23/26, the next one was completed on 5/14/26 and then one was completed on 6/16/26. On 7/14/26 at 3:35pm, record review revealed a care plan titled, SKIN: I have potential for pressure ulcer development & impaired skin integrity. Created date 08/02/2020, revision date 02/14/2024. On 7/15/26 at 1:00pm, an interview was conducted with RN B. RN B was asked when they noted the wound on the right pinky toe. RN B stated it was noted on 6/23/26. RN B was asked what interventions were in place prior to the wound developing. RN B stated that R9 had the protective boots on to help with prevention, but they didn't protect the top of his feet. RN B was asked how they think the wound developed. RN B stated that the right pinky toe of R9 turns inward and it rubs on the bed and that is what caused the area to develop, it was almost like a rug burn. RN B stated that R9 wears his boots all day long and he is compliant. RN B was asked who updates care plans for skin integrity. RN B stated that the wound nurse does that. RN B stated the care plan for skin is generated automatically on admission, if there is an issue the care plan will state that there is actual impairment. If a wound develops after admission, then we would enter a care plan for actual skin impairment. RN B was asked how often skin assessments are completed on residents. RN B stated that they are done weekly. The SA and RN B reviewed the weekly skin assessments and verified lapses in time of completion. RN B was asked why the assessments weren't done weekly. RN B stated that they just weren't done, I don't know why they wouldn't complete them. RN B was made aware there is a potential for pressure ulcer development care plan and it was last revised on 02/14/2024. RN B was asked if the care plan should have been updated when the pressure area developed. RN B stated, yes, it should be updated to an actual skin impairment care plan. On 7/15/26 at 1:24pm, an interview was conducted with the Director of Nursing (DON). The DON was asked if care plans should be updated when there is actual skin impairment noted. The DON state, yes, there should be one preventative and one actual. The DON was asked who updates the care plans for skin. The DON stated that the wound care nurse is supposed to update them after the wound doctor does the rounds and then I follow up to ensure they are completed. The DON was asked often skin assessments are completed. The DON stated that the nurses do the weekly skin assessments and the wound nurse does pressure and non-pressure skin concerns weekly. The DON was made aware of the care plan concerns and concerns with weekly skin assessments. Review of the policy titled, Pressure Ulcer and Skin Care Management, revealed: Procedure: 1. A licensed nurse checks the resident's body for the presence of pressure ulcers, wounds and other skin conditions: -At admission or readmission to the facility. -Whenever the resident arrives by medical transport-Weekly on residents, and -Prior to discharge. 2. The licensed nurse documents the body check was completed on the resident's weekly head to toe skin assessment. 5. The interdisciplinary team reviews skin risk and initiates or updates care plans accordingly. 7. The interdisciplinary team will develop a care plan addressing risk factors and periodically review and update the care plan as needed to minimize risk and promote healing.		

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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** This citation pertains to intake Number 3046775. Based on interview and record review, the facility failed to implement procedures to prevent elopement for one resident (R4) of three residents reviewed for elopement, resulting in one resident exiting the building unsupervised. Findings include: Resident #4 (R4): R4 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include bronchitis, hyperlipidemia, schizophrenia and hypertension. R4 has a brief interview for mental status (BIMS) score of 13, indicating they are cognitively intact. On 7/14/26 a 9:56am, R4 was observed in bed resting, R4 was well dressed and a wanderguard was observed on the left ankle. R4 was asked how her stay has been going so far. R4 stated that she would like to get out of here and be on her own again, but she would settle for another nursing home. R4 was asked how everyone treats her in the facility. R4 stated the staff treat her nice and they are respectful, but that she is ready to go home again. R4 was asked how long she has been in the facility. R4 stated that she has been here for about three months. R4 was asked why she has the wanderguard on her ankle. R4 stated the facility put it on her because she left the building. R4 was asked about leaving the building and what area did she leave from. R4 stated, I was in the cafeteria and there is a door and I just went out the door that way. It was nighttime and no one else was in the room with me. R4 was asked why she wanted to go outside. R4 stated, I just wanted to go home. R9 stated I really just planned to walk around the building and come back in the front door, but then I got lost and I went up the street a bit. R4 was asked if any staff came to find you. R4 stated, yes. R4 was asked if staff followed her out of the building or did they find you up the street. R4 stated the staff found me up the street and then they brought me back here. R4 was asked if she suffered any injuries. R4 stated that she had a small cut on her foot On 7/14/26 at 10:05am, record review revealed that on 5/18/26 R4 had an elopement risk score of 2, indicating they are low risk for elopement. On 7/14/26 at 10:07am, record review revealed a progress note dated 6/7/26 at 12:17pm. The nurse questioned R4 about leaving the facility. R4 stated that she wanted to go home. R4 stated I should not have left. R4 apologized for the incident. Assessed the cut to bottom of left foot. A circular band-aid intact to the pad of left foot. R4 stated she is tired today. On 7/14/26 at 10:10am, record review of a psychiatric evaluation from 5/14/26 revealed that judgement and insight were intact, impulse control is intact and there are no signs of resistance, impulsiveness, or oppositional behavior. On 7/14/26 at 10:20am, record review of the 5-day investigation from 6/7/26 revealed that R4 has a BIMS of 13 and is cognitively intact. Prior to the incident R4 had a BIMS of 11, indicating mild cognitive impairment. As of 6/3/26 R4 was deemed incompetent to make decisions on her own and a guardian was put in place. On 6/7/26 at 1:15am, facility staff were unable to locate R4 after last seeing her in her room at 12:22am by the assigned nurse, an immediate in facility search was conducted. When R4 was unable to be located, an external search of the building was started. The Director of Nursing (DON) and administrator were notified at 1:18am. The police were contacted at 1:20am. The DON arrived at the facility at 1:30am Staff initiated an external search of the surrounding area. At 1:35am with the assistance of staff and police, R4 was observed just north of the railroad tracks by the facility at a residence. R4 returned to the facility at 1:40am with staff. The root cause of the incident was determined to be a staff member responded to the door alarm but shut it off and did not execute a search immediately. The police were notified at 1:20am and discovered R4 at 1:35am. The alarm was activated at 12:05am and staff responded at 12:25am, at this time the alarm was silenced, and staff did not conduct a search or alert any other (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff. The alarm was functioning after maintenance tested it. The guardian and medical director were notified. R4 indicated she chose to exit the facility because she wanted to go home and this was influenced by emotional distress following a phone call with her daughter earlier in the day. A head-to-toe assessment was completed on R4 and noted a cut on the foot, a wanderguard was applied after completing a new elopement assessment, the care plan was updated, a treatment was put in place for the cut, door and wanderguard alarms were checked and functioning. Root cause was noted to be that staff did not respond timely to the alarm sounding and then shut it off without executing a proper search. The night shift staff was disciplined after this incident. All-staff were re-educated on the elopement policy and the roles of each staff member. The staff member that turned off the alarm and didn't tell any other staff members, no longer works at the facility and could not be reached for interview. The nurse who returned R4 to the facility was attempted to be contacted, her phone would not accept calls, and no message could be left. On 7/15/26 at 12:05pm, an interview was conducted with Certified Nursing Assistant (CNA) C. CNA C stated that R4 was in my set that night and I was her primary CNA. CNA C was asked if they could hear the alarm going off in the cafeteria. CNA C stated that there were a few alarms going off that night, so it is hard to distinguish. CNA C was asked how they discovered that R4 was potentially missing. CNA C stated I was going through some personal stuff at the time and not paying attention and the nurse poked me and was like R4 is missing. CNA C stated that once the code was paged, we went outside and looked for her. The police located her and the nurse brought her back to the facility. On 7/15/26 at 1:40pm, an interview was conducted with the Director of Nursing (DON). The DON was asked what they discovered from their investigation. The DON stated, I found concern with the staff not knowing which alarms were which. The DON stated that the door R4 exited from in the dining room does tend to get caught by the wind and cause the alarm to sound. We know now that wasn't the case and the door to the dining room should have been locked. The DON stated we have added a louder alarm to that door and ensure that the dining room is locked when the kitchen staff leaves for the night. The DON stated, I wrote up all of the nurses and aides that worked on the shift that night. The rest of the third shift staff received education and not a formal write up. Review of the policy titled, Elopement, Potential Resident, Procedure: 8. If a resident cannot be located, the staff member identifying the situation should:a. Notify the charge nurse and determine if the resident is out on authorized leave or pass.b. Notify all staff to initiate search by using facility code.c. Initiate a thorough search of the building, this includes every room, closets, bathrooms, storage closets, walk-ins, stairwell, under/behind furniture and premises. See supervisor to obtain keys to locked rooms.e. The charge nurse shall assign employee(s) to physically check each alarmed exit to determine if all alarms are in working order.		