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	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Lapeer	239 S Main St Lapeer, MI 48446

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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 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. 37666 Based on interview and record review, the facility failed to ensure that residents were treated in a respectful and dignified manner for a Confidential Group of residents, from a facility census of 54 residents, resulting in staff talking on personal cell phones while in the residents' rooms and while providing resident care. Findings Include: FACILITY Resident Council: On 3/19/2025 at 3:32 PM, during an interview with a Confidential Group of Residents, they said there was an issue with staff talking on their personal phones while providing care for the residents. The residents said some staff wear ear buds and the staff member will be talking to someone with the ear bud and the resident thinks they are talking to them. The residents' said they were embarrassed and upset when they were answering the staff member and were told, the staff member was not talking to them, they were talking to someone else on the ear bud. During the interview with the Confidential Group of Residents on 3/19/2025 at 3:32 PM, the residents said the staff will bring their personal phone in the residents' room and have personal conversations while they perform care for the residents and ignore the residents. The residents also said they will approach a staff member in the hallway because they need something and the staff will not acknowledge them, because they are having a personal call on their phone. The residents said there are some staff who are repeatedly on their phones and are rude about it. They said it happens on all shifts but is worse on the weekends. On 3/19/2025 at 4:40 PM, during an interview with the Director of Nursing/DON, the residents' concerns about staff using personal cell phones and ear buds in the residents' rooms during care or in the hallways when residents need something was discussed. The DON said it had been an ongoing issue and she was working on it. She believed it was happening more on the off shifts and weekends when administration was not around. Reviewed the residents want this to stop. They feel it is an invasion of their privacy and disrespectful. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Telephone and Pager Usage, undated provided, It is the policy of this facility that unless specifically designated otherwise, cellular pones and/or pagers are not permitted in resident care areas. Company telephones will be limited to certain areas and times within the workplace . In this age of technology, cellular telephones increase the risk of HIPPA (Health Information privacy law) and resident privacy violations . At no time may employees use personal cellular phones in resident care areas for any purpose . The use of personal cellular telephones and/or pagers are only permitted in the employee designated break room .

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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** 49944 Based on interview and record review, the facility failed to accurately code a pressure ulcer on the Minimum Data Set (MDS) for one resident (R44) of one resident reviewed for MDS accuracy. Findings include: Resident #44 (R44): R44 is [AGE] years old and admitted to the facility on [DATE] with diagnosis that include congestive heart failure, major depressive disorder, generalized anxiety disorder and metabolic encephalopathy. On 03/18/25 at 01:04 PM, record review of the CMS-802, resident matrix, revealed that R44 currently had an unstageable pressure ulcer that was facility acquired. The pressure ulcer is located on the right heel. On 03/19/25 at 02:52 PM an interview was conducted with the wound care nurse. Wound Care Nurse C was asked when did R44 acquire the right heel pressure wound. Wound Care Nurse C stated the wound started on 11/19/24, the wound started as a hematoma (a closed wound where blood collects) and then turned into what it is now. On 03/19/25 at 04:06 PM, record review of Section M (skin conditions) of the quarterly MDS Assessment, dated 1/7/25 does not mention the presence of an unstageable pressure ulcer. On 03/20/25 at 11:15 AM, an interview was conducted with the Director of Nursing (DON). The DON was asked if the MDS Nurse should have coded the right heel unstageable pressure wound on the most recent MDS assessment. The DON stated that yes it should have been coded on the MDS. I am not sure why she didn't do it. Record review of the policy titled, MDS Accuracy, revealed: Purpose: The accuracy of the MDS is checked to assure that each resident receives an accurate assessment by staff that are qualified to assess the relevant care areas and are knowledgeable of the resident's status, needs, strengths and areas of potential or actual decline. Procedure: 1. The appropriate health professional completes the designated sections/subsections of the MDS. 2. Ensure that interdisciplinary team members review the entire MDS to validate that the assessment accurately reflects the resident's status as of the assessment reference date, or the discharge or reentry date, as applicable. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Following validation of accuracy each interdisciplinary team member who completed a portion of the MDS must sign, date, and indicate the section(s) completed under Section Z, certifying the accuracy of responses and completion of the portion(s) of the assessment, tracking form or face sheet they completed or corrected.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on interview and record review the facility failed to revise care plans timely for two residents (R30, R44) of 12 residents reviewed for care plan revision, resulting in inaccurate care plans. Findings include: Resident #30 (R30): R30 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include hemiplegia and hemiparesis following a cerebral infarction affecting the left side, hypertension, history of pulmonary embolism and major depressive disorder. R30 has a brief interview for mental status score of 13, indicating they are cognitively intact. On [DATE] at 02:19 PM, record review revealed that R30 had a signed physician's order in place for Advanced Directives-Do Not Resuscitate (DNR), dated [DATE]. Further review of the record revealed a signed document for a DNR Code Status. On [DATE] at 02:25 PM, record review revealed a care plan with a focus that stated, I have chosen full resuscitation dated [DATE]. Interventions in the care plan revealed, If necessary, perform CPR, call 911, call physician and responsible party, prepare discharge papers, dated [DATE]. On [DATE] 10:31 AM, an interview was conducted with Social Service Director B. Social Service Director B was asked who is responsible for updating care plans related to code status. Social Service Director B: stated, that would be me. I update them quarterly or if there is a change in code status. Social Service Director B was asked why the code status care plan for R30 had not been updated since [DATE] despite a change in code status. Social Service Director B stated, We were very busy trying to get everyone updated and it got missed, I am not sure how it got missed but it did. I am currently still auditing charts to ensure the code status matches for the residents. Social Services Director B verified that the care plan had not been updated since [DATE], it was at this time that the Social Service Director updated the care plan to the current code status preference of the resident. Resident #44 (R44): R44 is [AGE] years old and admitted to the facility on [DATE] with diagnosis that include congestive heart failure, major depressive disorder, generalized anxiety disorder and metabolic encephalopathy. R44 has a BIMS score of 6, indicating severe cognitive impairment. On [DATE] at 01:04 PM, record review of the CMS-802, resident matrix, revealed that R44 currently had an unstageable pressure ulcer that was facility acquired. The pressure ulcer is located on the right heel. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 02:52 PM, an interview was conducted with wound care nurse C. Wound care nurse C was asked when did R44 acquire the right heel pressure wound. Wound care nurse C stated that the wound started on [DATE]. Wound care nurse C stated that R44 has boots on, we turn her and keep her up in the chair. Wound care nurse C stated, I believe it (the wound) might have started with her decline overall, it started with a hematoma (a closed wound where blood collects) and then turned into what it is now. On [DATE] at 03:20 PM, record review of an assessment titled, Skin & Wound Evaluation V7.0, revealed that the right heel pressure ulcer was identified on [DATE]. On [DATE] at 03:26 PM, record review revealed a care plan with a focus titled, Wound Management: I have an unstageable pressure injury to right heel, date initiated [DATE]. On [DATE] at 11:15 AM, an interview was conducted with the Director of Nursing (DON). The DON was asked why the care plan for the right heel pressure injury wasn't put in place until [DATE], if the wound was discovered on [DATE]. The DON stated, I am not sure, the wound care nurse is usually very good at updating the care plans. The DON was asked what a reasonable time is to update the care plan related to a pressure ulcer. The DON stated it would be updated as the wound changes or as a wound is identified. The DON stated the wound care nurse usually updates the care plans. Review of the policy titled, Comprehensive Plan of Care, revealed: Fundamental Information -Be periodically reviewed and revised by the interdisciplinary team as changes in the resident's care and treatment occur.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake Number MI00151174. Based on observation, interview and record review, the facility failed to ensure 1) Accurate orders for a feeding tube that was not being used, 2) Maintenance of the feeding tube including water flushes and 3) Care of the feeding tube insertion site to prevent redness and bleeding for 1 Resident (#38) of 2 residents reviewed for feeding tubes. Findings Include: Resident #38: Tube Feeding A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #38 was admitted to the facility on [DATE] with diagnoses: debility, feeding tube, depression, hypothyroidism, arthritis, and heart disease. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and needed some assistance with all care. On 3/18/2025 at 11:47 AM, Resident #38 was observed lying in bed. She said she had a feeding tube and showed her abdomen. There was a dressing dated 3/18/2025 at the insertion site. The resident said it gets red and hurts under the dressing; there was some dried red drainage on the tube button. She said they did not routinely flush the tube with water. There was no graduated cylinder or syringe in the resident's room to flush the peg tube with water On 3/19/2025 at 10:05 AM, observed the residents peg tube site, with Nurse D and Nurse Aide/CNA, the nurse said she had just changed the peg tube gauze dressing dated 3/19/2025. The peg tube insertion site was reddened about 1.5 cm around the peg tube; bloody drainage was observed on the gauze dressing and there was some at the insertion site. The resident asked for a paper towel and the nurse said it was for the drainage. The peg tube was discolored dark brownish red inside the tube. The nurse said it was probably from the drainage. The nurse and resident said the tube was scheduled to be removed. Nurse D said the resident took her medications and food/orally by mouth and the tube wasn't being used. Nurse D said the peg tube was supposed to be flushed on her shift with 50 ml of water. There was no graduated cylinder or syringe for administration of the water in the room. On 3/19/2025 at 10:15 AM, the physician orders for Resident #38 were reviewed with Nurse D. The nurse, said the to flush the resident's peg tube with water/50 ml was with the medication pass, but the resident no longer received medications by the peg tube. A review of the Medication Administration Record/Treatment Administration Record (MAR/TAR) for Resident #38 identified the following: Regular diet, Minced texture, Thin Liquid consistency, date ordered and started 10/2/2024. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Enteral Feed Order: every evening shift Monitor PEG tube for residual before administering enteral feed, before medication administration and PRN (as needed). Hold tube feed and notify MD if >150 (residual), undated. The nurses had initialed they completed this every day from March 1st- March 18th on the night shift, except for 5 days one nurse documented 2 it was refused. Enteral Feed Order: every day and evening shift Flush tube with 50 ml h2O (water) before and after medication administration and feedings. Check residual and hold if >150. Nine times on day shift and Nine times on night shift, a nurse documented the tube was flushed with 50 ml of water. 19 time between the two shifts, a nurse documented they did not flush the tube: 4 times a 0 was documented and 15 times 2/ refused. There was no additional documentation related to why the resident refused or if the provider was contacted. Cleanse Peg tube site with NS (normal saline), pat dry with gauze, apply TAO (triple antibiotic ointment) to PEG tube site. Every shift for belly redness for 14 days. The treatment was documented from 3/5/2025-3/18/2025. It was not initialed as completed twice. There was no documentation that the resident's peg tube site was still red with drainage after the treatment ended on 3/18/2025. Cleanse peg-tube site with NS daily and PRN. Monitor area for signs and symptoms of infection: redness, swelling, purulent drainage and odor, document Y if area remains free from signs and symptoms of infection . Document N if signs and symptoms of Infection are present, notify physician and document in progress notes every shift for PEG tube care. The nurses initialed the entries on day and night shift, but did not identify Y or N or redness etc. 4 times the entries were blank on night shift. A review of the progress notes identified the following: 3/15/2025 at 4:50 PM, Resident has redness on the left side of the lower abdomen adjacent to the peg tube. The area appears to be irritated and sore. There was no additional follow up after the treatment was completed on 3/18/2025. A review of the Care Plans for Resident #38 identified the following: I have an ADL (activities of daily living) self-care performance deficit related to fall with fracture prior to admit. Surgical of repair of right femoral and right humeral neck fracture, and Diverticulosis, dated initiated, 3/62024 and revised 5/23/2024 including Interventions: Eating: NPO (nothing by mouth)/Dependent on Enteral feeding (tube feeding), date initiated 3/6/2025 and revised 2/7/2025. I have a potential fluid deficit related to history of Nausea, vomiting, history of NPO and dependent on tube feedings for hydration due to dysphagia (difficulty swallowing), I am refusing tube feedings, date initiated 5/28/2024 and revised 10/21/2024 with Interventions including: TF (tube feedings) and water flushes as ordered, dated initiated 5/29/2024 and revised 2/7/2025. The resident no longer received tube feedings. I have a nutritional problem related to history of NPO status and dependent on tube feeding to meet nutritional/hydration needs due to failed (swallow study) at hospital Date initiated 3/12/2024 and revised 9/11/2024 with Interventions including: Tube feedings and water flushes, as ordered, date initiated 5/19/2024 and revised 2/7/2025. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's Care Plans did not reflect the resident's current condition and repeatedly referenced that she was still receiving tube feedings. On 3/19/2025 at 11:20 AM, Nurse Manager C was interviewed about Resident #38's peg tube site. She said the site was red, but had been worse. Nurse C said the resident had ongoing complaints of discomfort at the site and her abdomen and was to have the tube removed on 4/1/2025. On 3/19/2025 at 4:30 PM, reviewed with the Director of Nursing, Resident #38 did not have accurate orders or documentation of care of her feeding tube. Also reviewed the Care Plans did not reflect the resident's current status or needs. She said the facility would be working on this.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to follow standards of practice for assessment, monitoring and dressing changes of a PICC (Peripherally Inserted Central Catheter inserted into a vein for the administration of intravenous (IV) medication and fluids) for one resident (Resident #39), of one resident reviewed for intravenous therapy. Findings include: Resident #39: On 3/18/25 at 10:00 AM, an interview was conducted with Resident #39 who answered questions and conversed in conversation. The Resident was lying in bed. The Resident was asked about his PICC line and the resident pulled up his sleeve to expose the PICC line with a clear dressing over top. The dressing was observed to not have a date of when it was last changed. The Resident was asked and reported the dressing had been changed but was unsure of the date. A review of Resident #39's medical record revealed an admission into the facility on [DATE] with diagnoses that included infection and inflammatory reaction due to internal right hip prosthesis, and cellulitis of right lower limb. A review of Resident #39's order for the PICC line care dated 2/24/25, revealed, Change PICC dressing and measure external catheter length and document every 7 days and PRN (as needed). Note any complications. Every day shift every 7 days Change PICC dressing and measure external catheter length and arm document every 7 days and PRN. Note any complications. If any discrepancy in length from any previous measure, stop using line and notify provider immediately. Obtain f/u (follow-up) instructions . A review of the Treatment Administration Record (TAR) for Resident #39 for February 2025 revealed the dressing was documented as changed on 2/28/25 but for the length of the catheter documentation was NA (not applicable). The TAR for March revealed the PICC line dressing was scheduled to be changed on 3/7/25 but was not documented as completed. The PICC line was documented as changed on 3/12/25 but there was no measurement of the PICC line. A review of Resident #39's care plan revealed a focus of I am at risk for complications Central Venous Catheter, date initiated 2/27/25 with an intervention to provide site care and dressing changes per protocol, date initiated 2/27/25. The baseline measurement for the PICC line was not documented in the care plan. There was not a baseline care plan initiated for the PICC line on admission on 2/22/25. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25 at 11:00 AM, an interview was conducted with the Director of Nursing (DON) and Nurse M regarding Resident #39's PICC line care. When asked when the PICC line dressing was to be changed, Nurse M reported they PICC line dressings were to be changed in 24 hours of admission and then every 7 days. The DON reviewed the Resident's medical record and reported it was changed on 2/28 and that it was not at the 24 hours. It was reviewed with the DON that the next documented dressing change was completed on 3/12 and was not changed on 3/7. When asked if there were any measurements of the PICC line, the DON reviewed the medical record and did not find any measurements for the PICC line. The DON reported that they follow the [NAME] standards of care and did not have a policy for PICC line care. A review of the admission assessment revealed no measurements of the PICC line and the initiation of the care plan on admission was not documented. The Resident was admitted with the PICC line, lacked a baseline care plan, lack dressing changes within 24 hours and every 7 days and there was no documentation of the measurement of the PICC line. A review of the [NAME] manual that the DON indicated they use as the standard of practice, revealed, .Use a sterile tape measure to measure the external length of the catheter from hub to skin entry to make sure that the catheter hasn't migrated . There was not guidance of when the dressing change was to be completed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on interview and record review, the facility failed to ensure the acquisition and administration of medications for two residents (Resident #34 and Resident #56) of eight residents reviewed for medication regimen review, resulting in seizures and hospitalization for Resident #34. Findings include: Resident #34: A review of Resident #34's medical record revealed an admission into the facility on [DATE] with diagnoses that included fracture of right clavicle and ribs and epilepsy. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 6/15 that indicated severely impaired cognition. A review of Resident #34's medication orders and Medication Administration Record revealed the following: -For January 2025, the medication Fycompa 10mg, give 1 tablet by mouth at bedtime for seizures, was documented as not given on 1/30 and 1/31. Briviact 100mg, give 1 tablet by mouth every 12 hours for seizures, was documented as not given on 1/30 at 8pm, 1/31 at 8AM and 8PM. -For February 2025, the medication Fycompa 10 mg, give 1 tablet by mouth at bedtime for seizures, was documented as not given for 24 days of the month. Zonisamide 100 mg, give 2 capsule by mouth at bedtime for seizures, was documented as not given on 2/1, 2/2, 2/4 and 2/6. Briviact 100mg, give 1 tablet by mouth every 12 hours for seizures, was documented as not given on 2/1, 2/2, 2/3, 2/4, and 2/5 at 8AM and 8PM. A review of the progress notes revealed the Resident had a fall, was sent out to the hospital on 2/2 at 7:38 PM and returned 2/3/24 at 2:06 am. The progress notes on 2/1/24 indicated that Briviact and Fycompa were on order; on 2/4/25 the progress notes indicated that the Zonisamide, Fycompa and Briviact were on order. -For March 2025, the medication Briviact 100 mg, give one tablet by mouth every 12 hours for seizures was documented as not given on 3/6 at 8PM, 3/7 at 8AM and 3/8 at 8AM. The progress notes on 3/8/25 at 7:51 AM indicated, Briviact .on order, will call pharmacy when they open at 9am. A review of Resident #34's progress note dated 2/24/25 at 10:58 PM revealed, writer was informed resident was having increase in seizure activities. Resident having seizures lasting from 2-6 minutes resident biting tongue two occurrences within several hours. Writer was informed by DON and (Dr. name) was informed and order resident to be sent out to (hospital name) ER via ambulance . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25 at 12:21 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #34 lack of medication Fycompa, Briviact and Zonisamide. The DON reported that the pharmacy was unable to get the medications, the doctor didn't want to discontinue the medication since it was prescribed by the neurologist. The DON stated, it took a long time, and they finally got one in but could not get the other. I had to get him to the neurologist and there was something else ordered. The extended delay in acquiring the medication and/or getting a replacement was reviewed with the DON and that the Resident had seizures and had to be sent to the hospital. A review of the progress notes revealed a lack of documentation that the Resident's Neurologist had been contacted when the medication was not available. Resident #56: A review of Resident #56's medical record revealed an admission into the facility on [DATE] with diagnoses that included fracture of the right tibia, convulsions, end stage renal disease, dependence on renal dialysis, restlessness and agitation, depression, anxiety disorder, and pervasive developmental disorder. A review of the MDS revealed the Resident needed substantial/maximal assistance with toileting hygiene, bathing, and lower body dressing, mobility and transfers. Further review of the medical record revealed the Resident went to dialysis appointments that were scheduled on Monday, Wednesday and Friday. On 3/18/24 at 9:56 AM, an observation was made of Resident #56 lying in bed sleeping. The Resident had Confidential Person Q in the room that there to stay with the Resident. An interview was conducted with the Confidential Person. When asked about any issues with care for Resident #56, the Confidential Person reported issues with the Resident receiving medication and gives example of the binder was to be given right before meals and stated, They just don't get it right. The Confidential Person reported the Resident eats dinner when he returns to the facility. A review of Resident #56's orders and MAR for February revealed the following: -For February 2025, the order for Sevelamer Carbonate oral tablet 800 mg, give 3 tables by mouth before meals for renal failure with a start date on 2/10/25. Documented as not given for 18 doses from 2/10 to 2/28 with documentation of 3 that indicated Absent from Home, 9 that indicated Other/see nurses Notes or Other/See Progress Notes, or 1 that indicated Away from home with meds. The Sevelamer Carbonate was scheduled for 1630 (4:30 PM). The Resident was at dialysis appointments but returned and ate dinner at the facility. A review of Resident #56's orders and MAR for March revealed the following: -Amlodipine Besy-Benazepril 5-10 mg, give one capsule by mouth one time a day for high blood pressure, documented as not given for 7 of 18 days from 3/1 to 3/18. -Donepezil 10 mg, give 1 tablet by mouth at bedtime for physco/neuro agent, documented as not given on 3/9, 3/11 and 3/16. -Gabapentin, give 200 mg by mouth at bedtime for anticonvulsants, dermatologicals, chemicals, documented as not given on 3/1, 3/2, and 3/16. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Sevelamer Carbonate 800mg, give 3 tables by mouth before meals for renal failure, documented as not given for 26 doses from 3/1/25 to 3/19/25, The medications had documentation of 3 that indicated Absent from Home or 9 that indicated Other/See Progress Notes. Review of Resident #56's Progress Notes documentation for the Orders-Administration Note included: -2/14/25 at 6:18 PM revealed, Resident returned from dialysis by ambulance at 17:40 (5:40 PM). In good standing. Resident received dinner when returned. -2/16/25 at 11:49 AM, 5:03 PM, Sevelamer . waiting for arrival from pharmacy. -2/20/25 at 8:05 PM, 2/21/25 at 7:52 PM, Amlodipine Besy-Benazepril . awaiting pharmacy delivery -2/24/25 at 10:32 PM, Amlodipine Besy-Benazepril . med not available. -2/25/25 at 8:02 PM, 2/26/25 at 8:03 PM, Amlodipine Besy-Benazepril . awaiting pharmacy delivery. -2/28/25 at 11:01 AM, 3/1/25 at 12:43 PM, Sevelamer . waiting for arrival from pharmacy. -3/2/25 at 2:16 AM and 3/3/25 at 1:08 AM, Amlodipine Besy-Benazepril . on order -3/3/25 at 1:13 AM, Gabapentin . on order -3/3/25 at 1:13 AM, Donepezil . on order -3/6/25 at 5:13 PM, Sevelamer . Awaiting pharmacy delivery unavailable in back up, called pharmacy informed physician medication not available at this time. -3/6/25 at 6:00 PM, Writer called pharmacy talked to (name) about resident order for Sevelamer Carbonate 800mg, she informed me due to government changes with Medicaid they are no longer allowed to fill medication will have to be filled by resident dialysis center. Writer informed Administrator and NOC (night) shift nurse. -3/11/25 at 8:06 PM, Amlodipine Besy-Benazepril . awaiting pharmacy delivery. -3/11/25 at 8:06 PM, Donepezil . awaiting pharmacy delivery. -3/13/25 at 11:44 AM, Called dialysis center for refill on Sevelamer Carbonate. (Nurse name) at (dialysis center) said he will send them back with Pt (patient). -3/15/25 at 7:01 AM, 11:04 AM and 4:52 PM, 3/16/25 at 7:41 AM, 10:52 AM, 5:46 PM, Sevelamer . Dialysis to order medications waiting for arrival from pharmacy. -3/17/25 at 1:18 AM, Amlodipine Besy-Benazepril . on order -3/3/25 at 1:19 AM, Gabapentin . on order (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/3/25 at 1:18 AM, Donepezil . on order On 3/19/25 at 4:38 PM, an interview was conducted with Unit Manager (UM), Nurse N regarding Resident #56's medications that were not administered. The medication for Sevelamer was reviewed and the lack of acquisition of the medication was reviewed. The UM reported that they were unaware of the medication not being available and reported that if she had been notified of the problem, she could have investigated it, but without getting the information, they were unable to remedy the problem. When asked about the facility process to order in medication to ensure they were available, the UM reported that the Nurse should notify pharmacy ahead of time when the medication cards were getting low to have them arrive at the facility timely before the resident runs out of medication and use the back up medication if available. The UM went to check the back supply of medication in the medication room. The Nurse pulled up the available medications. The UM reported that the back-up medication listed Donepezil 5 mg as a medication that should be available, but the computer did not list any available. The UM reported that when the medication is pulled, the Pharmacy was supposed to monitor it and send refills on the next pharmacy delivery and stated, Pharmacy knows when something is used, and they should send something to replace it. The Gabapentin was looked up in the back-up medication, the UM reported that medication was available, but was unable to tell how many were in there. The UM stated, If a card is low, the nurses should reorder when it gets down to 8 tablets, to reorder so it is available before they run out. Sevelamer Carbonate was not in the back-up medication cart. The UM stated, They (nurses) should contact someone when not available or let management know to look into it, and reported that communication with the pharmacy should be documented. A review of facility policy titled 7.0 Medication Shortages/Unavailable Medications, revision date 1/1/13, revealed, .Procedure: 1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. If the medication shortage is discovered at the time of medication administration, facility staff should immediately take the action specified in Sections 2 or 3 of this Policy 7.0, as applicable. 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery. 3. If a medication shortage is discovered after normal pharmacy hours: 3.1 A licensed facility nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency delivery; or 3.2.2 Use of an emergency (back-up) third party pharmacy . 8. When a missed dose is unavoidable, facility nurse should document the missed dose and the explanation for such missed dose on the MAR or TAR and in the nurse's notes per facility policy. Such documentation should include the following information: 8.1 A description of the circumstances of the medication shortage; 8. 2 A description of pharmacy's response upon notification; and 8.3 Action(s) taken.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059 Based on observation, interview and record review, the facility failed to provide meals per menu for four residents (Resident #1, Resident #17, Resident #24, Resident #26) of four residents reviewed during dining task, resulting in incomplete meals offered. Findings include: On [DATE], at 1:19 PM, Resident # 24 was in their room eating their lunch meal with the assistance of CNA E. There were two bowls; one with dry mashed potatoes and the other one had pureed tan food. CNA E was asked where the rice and vegetable were and CNA E offered, I think they pureed it all together with the chicken. There was no cake. CNA E was asked where the cake was and CNA E offered, he didn't get any cake. Resident #24 was unable to verbalize. On [DATE], at 9:00 AM, Resident #1 was resting in their bed with their eyes closed. Their breakfast meal was at their bedside. The meal consisted of two pieces of toast, 3 pieces of bacon and a cup of fluids. On [DATE], at 9:01 AM, a record review of the meal ticket on the tray revealed: Menu: Assorted Juice Choice of Hot or Cold Cereal Egg of Choice Breakfast Meat of the Day Hash brown Patty Breakfast Muffin Margarine/Jelly Milk/Beverage There was no hash brown patty, no egg, no cold or hot cereal and no muffin. On [DATE], at 9:05 AM, Dietary Manager (DM) A was asked why Resident #1 did not receive their muffin, egg and hash brown patty and DM A offered, that she don't like eggs. DM A was asked why if items were listed on the meal ticket why Resident #1 was not offered those items and DM A offered, the staff usually will ask they day prior and write what she wants on the meal ticket. DM A was asked to review the meal ticket and was asked why nothing was crossed out or changed and DM A offered, they would have wrote on it and did not know why it wasn't on there. On [DATE], at 1:03 PM, Resident #26 was eating their lunch meal in their room of ham, carrots and potatoes. There was no roll provided nor dessert. Resident #26 had difficulty with speaking. The resident in bed 1 complained out loud I didn't get a roll either. On [DATE], at 1:05 PM, Resident #17 was sitting in their room. CNA F was assisting the resident with their meal. CNA F was asked if Resident #17 received a roll and CNA F no dinner roll. Resident #17 was unable to verbalize. A review of the menu for [DATE] revealed Menu: Baked Ham Baked Potato Candied Carrots Frosted Gelatin Poke Cake Dinner Roll/Margarine Beverage (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], at 1:09 PM, while entering the main dining room, a large plastic container was observed full of bagged up single dinner rolls. DM A exited the kitchen area and was asked why residents didn't receive a dinner roll with their lunch meal. DM A pointed to the container of dinner rolls and asked Dietary Aide J what happened and why do we have so many rolls left and Dietary Aide J giggled and said, it's been a long week. 37666 FACILITY Snacks On [DATE] at 3:32 PM, During an interview with a Confidential Group of Residents, they said they were not always receiving their evening snacks. The residents said the kitchen sent up a bag of snacks on a cart each evening, but they were not always passed to the residents. They said sometimes staff and residents would take some of the residents' snacks. The residents said there was confusion and over the last few days, the snacks were not sent up at all. They said they could ask for snacks at other times, but for some residents, they are not able to ask. On [DATE] at 4:05 PM, the Dietary Manager A was interviewed about the resident's snacks. She said the kitchen delivered snacks on a cart each evening. When asked if the residents were receiving the snacks, she said she wasn't sure. Reviewed some of the residents said they have seen staff and some residents taking the snacks from the cart and then they don't receive them. Some of the residents said they are supposed to have very specific snacks, and when they are gone there aren't any more. The Dietary Manager said she would ask the kitchen staff about the snacks. On [DATE] at 4:40 PM, the Director of Nursing/DON was interviewed about the residents' evening (HS) Snacks. The DON said snacks were to come up from kitchen in the evening and the staff were supposed to pass them out to the residents. Reviewed the residents are not consistently receiving them. The Confidential Group of Residents said some residents take snacks off the cart that are intended for other residents and some staff were observed taking snacks for themselves. She said she was going to speak with the Dietary Manager about the Residents' concerns. A review of the facility policy titled, HS Snacks, undated provided, Purpose: HS snacks are offered to residents prior to bedtime . asked if the resident wishes to have a snack. Place the snack within reach of the resident . Assist the resident as necessary . Repeat until all assigned residents are served . When serving is complete, check back with each resident. Observe the amount of the snack eaten . Document in designated area (electronic of form) HS snack. Dining Observation Resident #8: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #8 was admitted to the facility on [DATE] with diagnoses: Dementia, heart disease, anxiety, depression and peripheral vascular disease. The MDS assessment dated [DATE] indicated the resident had severe cognitive loss with a Brief Interview for Mental Status/BIMS score of ,d+[DATE] and needed assistance with care but was able to feed herself. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:45 PM, Resident #8 was observed in her room lying in bed. The resident's meal tray was on the bedside table, partially eaten. The resident was yelling that it was left there. The resident's meal ticket was on the tray and reviewed. The resident was supposed to receive a roll and a piece of cake on her tray. There was no evidence she received either. Other residents received their cake on a separate dessert plate. There was no additional plate or evidence of cake. The resident said she did not receive the cake and started yelling about it. When asked if she received a roll she said, No I didn't. Nurse D came into the resident's room and asked an aide to take the resident's tray and get her a piece of cake. The aide was asked if the resident received the cake or roll on her tray, and she said she didn't know. On [DATE] at 4:45 PM, the DON was interviewed about Resident #8 not receiving some of the items on her food tray as indicated on her meal ticket. She said usually the resident doesn't say much and she would speak to the dietary department.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review, the facility failed to ensure that residents were receiving fresh fluids at the bedside in a timely manner for one resident (Resident #11) of 18 residents reviewed including a Confidential Group of Residents, resulting in Residents having warm water with no ice. Findings Include: FACILITY A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #11 was admitted to the facility on [DATE] with diagnoses: Traumatic Brain Injury, Dementia, seizure disorder, schizophrenia and peripheral vascular disease. The resident needed some assistance with all care. On 3/19/2025 at 1:55 PM, several residents in the East hallway including Resident #11 did not have fresh water. Resident #11 had a Styrofoam cup on his bedside table dated 3/18/2025. The water was warm and there was no ice. The resident said he didn't know when the facility had provided the water. He said it was not fresh. On 3/19/2025 at 2:00 PM, the residents on the east hall were observed to have either a water cup with no date or a water cup with 3/18/2025 written on it. All of the cups had warm water and no ice. One resident had a water cup dated 3/19/2025 with ice in the cup. On 3/19/2025 at 2:05 PM, Staff member K was observed dating Styrofoam cups at a cart in the hallway. He was asked if he was passing fresh water to the residents and he said he was. Staff member K said the residents received a new cup each day at 2:00 PM and in between the cups were refilled with water and ice from the cart. He said the water was supposed to be refilled in the same cup several times a day. On 3/19/2025 at 3:40 PM, during an interview with a Confidential Group of residents, they said they used to receive water in a washable cup and now they have one Styrofoam cup for a day. The residents said they had observed other residents attempting to get their own water and ice from the water cart that was left in the hallway. They said they did not like this. The residents said they did not always have fresh water, but depending on who their caregivers were, they would get them fresh water if they asked. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/2025 at 4:50 PM, the Director of Nursing/DON was interviewed about residents having fresh water. The DON was asked if the residents use the same Styrofoam cup for 24 hours and she said that was how it was done. She said the facility used a cart in the hall and aides would refill the water cup using the cup dated from the day before. Reviewed several residents on the east hall had water cups dated 3/18/2025 or undated and the water was warm with no ice at 2:00 PM. The DON said the cups were refilled in the early morning 6:00 -7:00 AM, about 10:00 AM and 2:00 PM and again later. Reviewed the residents did not have fresh water when observed at 2:00 PM. She said she would look into that. Also discussed that residents were observed by other residents attempting to get their own ice and water from the cart in the hallway and this could contaminate the water and ice. The used water cups were brought out to the cart and refilled, potentially contaminating the water, ice and scooper. A review of the facility policy titled, Water Pass Policy, dated January 2025 provided, The first water pass will begin at 2:00 PM and will be refilled each shift. The cups will be changed every 24 hours at 2:00 PM Each shift will refill the cups with ice from the coolers and pitchers on the unit . Coolers and scoops will be washed each morning .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on observation, interview and record review, the facility failed to label, date and dispose of expired foods provided by the facility and label, date and dispose of residents' food brought in by outside sources, resulting in the potential for food borne illness. Findings include: On [DATE] at 09:00 AM, observations were made in the walk-in refrigerator and the walk-in freezer revealed: -a bag of frozen zucchini squash had no expiration date on it, no label was present on the bag with a received by or opened by date. -a can of french onion dip that had been opened, no open date or expiration date. -a package of hot dogs opened on [DATE] with no use by date. -a box of blueberries, a label on the box stated to use them by [DATE]. -a box of tomatoes, a label on the box stated to use them by [DATE]. -a box of celery, a label on the box stated to use them by [DATE]. -a bag of onions, a label on the bag stated to use them by [DATE]. These findings were verified with the dietary manager. On [DATE] at 09:45 AM, observations were made of the resident refrigerator/freezer that is in the dining room: - The Freezer had jam, ice cream and popsicles, there were no resident identifiers, received by dates or expiration dates on these items to know when to throw them out. - The refrigerator had a jar of pickles that was dated [DATE] and a jug of oat milk dated [DATE]. There were no resident identifiers on the items. These findings were verified with the dietary manager. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:05 AM an interview was conducted with dietary manager A. Dietary manager A was asked who is responsible for going through the refrigerators and freezers in the kitchen to get rid of expired items. Dietary manager A replied that it is everyone's responsibility, but ultimately the dietary aides are responsible for making sure those items are thrown out. Dietary manager A was asked who monitors the resident refrigerator/freezer in the dining room. Dietary manager A stated that the dietary aides are responsible for that too and making sure it is cleaned out. Dietary manager A was asked how long the resident food should stay in the refrigerator/freezer after receiving it. Dietary manager A stated it should be taken out of there(resident refrigerator/freezer) after three days. Dietary manager A was asked if they have a cleaning schedule that makes certain roles responsible for tasks such as disposing of expired items and making sure resident items are labeled and disposed of. Dietary manager A stated, yes, the schedule outlines who is supposed to perform each task in the kitchen. Review of the cleaning schedule revealed that dietary staff members had been signing off that they are checking the fridge and freezer for expired items. Review of the policy titled, Safe Storage and Handling of Outside Food, revealed: Food Receiving and Safe Food Storage -You must check in at the nurses station when you bring food in for a resident. 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 and placed in the unit refrigerator. Labels and the location of the refrigerator are available at the nurses station as in the pantry area. -All food that is stored in the refrigerator and not consumed within 3 days will be discarded by facility staff daily. Signage regarding this process is displayed on all fridges, any food without the correct labeling will also be discarded.

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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. 39059 Based on observation, interview and record review, the facility failed to appropriately clean and store reusable medical equipment, store blood specimens and needles, perform hand hygiene and wear Personal Protective Equipment (PPE) during resident care for four of four residents reviewed for infection control practices, resulting in cross-contamination. Findings include: On 3/18/25, at 1:19 PM, CNA E was observed assisting Resident #24 with their meal. The Resident in bed 1 dropped their pillow which was resting under their head. CNA E set Resident #24's fork down, picked up the pillow and placed back under the head of the resident in bed 1 without replacing the pillow case. CNA E sat back down and continued to feed Resident #24 without performing hand hygiene. On 3/18/25, at 3:25 PM, Upon entry into Resident #25's room, CNA E was observed placing a soiled brief into a clear plastic bag. CNA E was observed performing incontinence care for Resident #25. CNA E was not wearing a protective gown and CNA E's uniform was touching the bed. There was an enhanced barrier precautions sign taped to the front of the door into Resident #25's room. On 3/18/25, at 3:35 PM, Resident #1 was resting in their bed with their oxygen tubing lying on their bed. Nurse I was asked if they had obtained an oxygen saturation recently on Resident #1 and Nurse I offered, no. Nurse I was asked if they could obtain an oxygen saturation as Resident #1 was observed without their oxygen on. Nurse I entered the medication room and grabbed an Choicemed pulse oximetry machine from their personal bag. Nurse I entered Resident #1's room, placed the machine on Resident #1's finger to obtain the result. Upon exiting the room, Nurse I placed the pulse oximetry machine into their pocket without cleaning it. Nurse I was asked why they use their personal machine and Nurse I stated, there was only the one vitals machine because the other one lost a wheel. On 3/19/25, at 8:59 AM, Upon entering Resident #25's room, CNA F and CNA G were observed performing incontinence care with their uniforms leaning on the bed. Both CNA F and CNA G did not have protective gowns on. On 3/19/25, at 10:03 AM, an observation of Resident #25's percutaneous gastrostomy tube insertion site along with Nurse H was conducted. Nurse H was sitting at the nursing station working on the shared computer. Nurse H stood up entered Resident #24's room, grabbed a pair of protective gloves. Nurse H left the gloves in their right hand and did not place the gloves on their hands. Nurse H then walked to the left side of Resident #24's bed, pulled back the blankets, lifted up and pulled back the dressing that was covering the insertion site on Resident #24's abdomen. Nurse H then threw the gloves away, left out of the room and sat back down at the nursing station before answering the shared phone. Nurse H did not perform hand hygiene nor put on a protective gown or gloves. On 3/19/25, at 2:30 PM, a record review of Resident #25's electronic medical record revealed an admission on 12/06/2023 with diagnoses that included Traumatic brain injury and Epilepsy. Resident #25 required extensive assistance with all care and was unresponsive. (continued on next page)

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	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Lapeer	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Physician Orders revealed Enhanced Barrier Precautions r/t (related to) tube feeding Revision Date 3/20/2024. A review of the facility provided Infection Prevention and Control SOP Enhanced Barrier Precautions (EBP) revealed . refer to the use of gown and gloves for certain residents during specific high-contact resident care activities that have been found to increase risk for transmission of multidrug-resistant organisms . A review of the Infection Prevention and Control SOP Hand Hygiene revealed . All personnel shall follow our established hand hygiene procedures to prevent the spread of infection and disease to other personnel, patients, and visitors . Appropriate hand hygiene must be performed under the following conditions: . before and after entering isolation precaution settings . before and after assisting a resident with meals . before and after changing a dressing . 37771 Glucose Monitor: On 3/19/25 at 9:43 AM, an observation was made during medication administration with Nurse L of the Nurse performing glucose monitoring for a Resident. The Nurse and the Resident were in the hallway. The Nurse after donning gloves, performed the finger puncture to get blood for the testing. The Nurse was holding the Resident's hand, completed the puncture, manipulated the Resident's finger to obtained the blood on the test strip that was in the monitor, placed the monitor on top of the medication cart, removed the test strip and wiped the area where the test strip goes in to the monitor with an alcohol swab, and placed the monitor back into the medication drawer without cleaning the monitor or the top of the medication cart. The Nurse was asked about cleaning the monitor between Resident use and the Nurse asked the surveyor if they were supposed to clean the whole monitor. The Nurse when asked about facility policy was unsure what the policy was on cleaning the glucose monitors after Resident use. On 3/19/25 at 11:42, an interview was conducted with the Director of Nursing (DON) regarding cleaning the glucose monitor after resident use. The DON expressed the monitor should be cleaned after resident use, before storage and use the all-purpose wipes that had a one-minute kill time. The DON stated, They should have the purple top container (disinfectant wipes with the 1-minute kill time) on the medication cart. A review of facility policy titled, Cleaning and disinfecting Blood Glucose Meters, revealed, Policy Statement: Each facility will clean and disinfect blood glucose meters between each resident to avoid cross-contamination issues. Equipment: .Materials that the product label instructions recommend for disinfecting the glucose meter or Commercial 1:10 parts bleach wipes or a paper towel dampened with a 1:10 dilution of sodium hypochlorite (1ml of household bleach in 9 ml. water, wrap glucose meter according to guidelines on antiseptic wipe product label instructions. Procedure: .3. Follow label instructions on how to disinfect the product, if indicated. (follow the length of time that the product needs to remain 'wet' when the specified solution is applied.) 4. Care should be taken not to clean the strip port or pour liquid into the strip port or buttons . 6. Follow above procedure when using the same glucose meter between several residents. Blood Draw Equipment (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/20/25 at 8:20 AM, an observation was made of a treatment cart positioned in the hallway with blood draw equipment in a caddy. There was no staff in the area and the caddy was not directly supervised by staff. The caddy had a bag that was open and had capped needles inside the bag. There were blood specimens in tubes on the treatment cart next to the caddy. An observation was made of a needle, tube holder and blood collection tube lying on the top of the treatment cart. The needle did not have any packaging over it and there was not on a barrier, the needle was capped. On 3/20/25 at 8:26 AM, Nurse D was asked about the storage of blood collection equipment, sharps and blood specimens left on the treatment cart. The Nurse reported that it belonged to the laboratory tech who was drawing blood. The Nurse reported that it should not be left on the treatment cart. The Nurse was unsure where the Lab Tech was, and staff went to find her. The equipment was not supervised by the Lab Tech. Lab Tech P was asked about her equipment and indicated she always left it out and did not take it into the rooms with her. The Lab Tech reported she had no way to secure the sharps and specimens. On 3/20/25 at 8:35 AM, medication administration was observed with Nurse D. Upon returning from the Resident's room that was down another hall from where the lab equipment was left unsupervised on top of the treatment cart, an observation was made of the supplies remaining on the cart and not supervised by the Lab Tech. The Nurse indicated the items should not have been left on the treatment cart unattended.