| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235654 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/04/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Orchards at Lapeer | 239 South Main Street<br>Lapeer, MI 48446 |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>This citation pertains to Intake Numbers 2732659 and 2739632.Based on interview and record review, the facility failed to ensure that a wound to the ankle was assessed, monitored and provided treatment for, for one resident (Resident 73) of three reviewed for wounds, resulting in the resident's ankle wound worsening, and developing an infection that resulted in the amputation of the leg.Findings include: Resident #73 (R73):A review of the complaint for Resident 73 (R73) revealed that the Resident admitted into the facility for wound care for a diabetic ulcer on the bottom of R73's foot. The Complainant KK explained that a new wound formed on R73's ankle while residing at the facility. The Resident went to an appointment due to an x-ray that showed dislocation but was sent from the appointment to the hospital for amputation of the leg due to necrotizing fasciitis. A review of R73's medical record revealed an admission into the facility on 1/8/26 with diagnoses that included acute osteomyelitis of left ankle and foot, non-pressure chronic ulcer of left lower leg, diabetes, diabetic neuropathy, and acquired absence of right leg below knee (below the knee amputation). The Resident had a discharge to acute care hospital on 1/28/26. A review of R73's progress notes revealed the following:1/20/26 at 7:28 AM, .Upon assessment residents left ankle was swollen w (with)/ fluid. (Dr. Name) numbed area w/lidocaine, lanced and drained 60 cc (cubic centimeters) serosanguinous fluid from ankle. Resident tolerated procedure will w/no pain or discomfort. While treating ankle and foot wound, (Dr.) heard popping/cracking noises upon movement coming from joint area. Resident states he has no feeling in his left foot and has not had feeling for years. He stated he does ride the bike in therapy every day. He has no pain on movement and was unaware of swelling that occurred. (Dr.'s name) notified. Xray ordered, non-weight bearing until further orders, immobilizer ordered, culture obtained from drainage, and currently on ABT (antibiotic) until 1/30. 1/21/26 at 11:39 AM, Xray resulted with deformity is seen in the tibiotalar joint, with widening of this joint space, with evidence also of deformities of the distal portion of the calcaneus bone and talus and navicular bones, with adjacent corticated bone densities related to old injuries. Diffuse soft tissue edema is seen in the lower portion of the leg and surrounding the ankle, more along the medial aspect, resection of pockets of air collections in the soft tissues adjacent to the distal tibia and the medial malleolus, from soft tissue emphysema. Underlying cellulitis podiatry considered. No obvious evidence of underlying osteomyelitis however is seen. A few vascular calcifications are seen. Orders for resident to follow up with ortho.1/23/26 at 2:14 PM, Nursing Progress Note: Resident was noted to have a swollen left ankle. (Dr. name) laced the area with noted pussy substance coming out, retrieved a culture and it was negative. Xray of the area indicated Sharko Foot. Review of the wound culture with a collection date on 1/21/26 and report date on 1/21/26 revealed a summary of abnormal values No Organism Detected. A review of the Weekly Wound Healing Record for Wound #2, dated 1/27/26 revealed wound to left ankle, acquired during resident's stay on 1/20/26, with epithelial tissue present, granulation tissue present, slough tissue present, and moist. Drainage: bloody, moderate. Wound measurements Length 2.0 cm, Width 3.0 cm, Depth 2.0 cm. Treatment: cleanse with NS (normal saline) apply Medi honey, cover with ABD, wrap with kerlix.A review of R73's Wound Care Assessment, dated 1/20/26, revealed, . Since last visit patient is noted to has a left ankle valgus deformity. Patient has no pain to his limb. The left ankle now displays a medical displacement with significant effusion. Once<br>(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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | anesthetized a #11 scalpel was used to make a cruciate incision. Approximately 60 cc of serous-sanguinous, brownish fluid was expressed. The site was once cleansed and again swabbed with betadine. Treatment Please cleanse the wound with wound cleanser and dry. Please treat wound with xeroform dressing and cover with kerlex or border foam dressing. Change dressing daily/PRN (as needed).A review of R73's Wound Care Assessment, dated 1/27/26, revealed, .Wound #2 Location: Left lateral ankle, Type: effusion with erosion, Description: At the site of aspiration noted on last visit the area is eroded open revealing white, pink-yellow granulation tissue. There is areas of fatty debris and tissue appreciated in the wound base which is partially removed using sharp dissection. The area is nontender. There is no odor. There is scant to moderate serous exudate. Wound edges are unattached with undermining appreciated from 11:00 to 3:00 deepest point being 1.8 cm. There remains mild subcutaneous emphysema in the area. Without signs of infection. There also appears to be some tendon exposure. Dimensions: 2.0 cm x 3.0 cm x 2.0 cm. A review of Resident 73's Treatment Administration Record (TAR) and orders revealed an order dated 1/27/26 to Cleanse left ankle w/wound cleanser, pat dry w/gauze, apply Medi honey to wound bed, cover with ABD pad, wrap w/kerlix every day shift for Diabetic ulcer. The TAR revealed one documented dressing change on 1/28/26. There was no order or documented dressing changes to the left ankle area from 1/20/26 when the swollen ankle was lanced to 1/27/26 with wound care team assessing the wound a week later. The review of assessments and progress notes failed to identify the worsening of the wound. A review of R73's hospital records for date of service at the hospital from the emergency room that started on 1/28/26 revealed the following:-Dated 1/28/26, X-Ray of left ankle Impression: 1. Severe deformity at the ankle with absence of the talus and advanced degenerative changes of the mid and hindfoot. 2. Moderate subcutaneous emphysema surrounding the ankle suggestive of gas-forming infection such as necrotizing fasciitis.-Doctor MM, I saw and examined the patient in the ER. We were asked to see the patient for a left foot wound. He has extensive gas in the soft tissues and was read out by radiology as concerning for necrotizing soft tissue infection. I agree with that assessment he has infection on the lateral aspect of the ankle with complete degeneration of the joint, purulent fluid draining and I am concerned about the possibility of necrotizing fasciitis. I am concerned about his debility and inability to mount an effective immune response. Based on this I would like to bring him emergently to the operating room for surgical intervention with ankle disarticulation and any needed procedures. I am concerned about the possibility of life-threatening worsening of his condition if we do not operate on him now.-Dated 1/29/26, a left amputation below knee was completed. Operative Report revealed date of service 1/29/26 with Postoperative Diagnosis: Necrotizing fasciitis left lower extremity.-On 2/6/26 a left amputation above knee was completed. On 3/3/26 at 2:12 PM, an interview was conducted with the Wound Care Nurse (WCN) - regarding R73's ankle wound. A review of Resident 73's medical record was conducted with the WCN. The Practitioner had lanced the swollen left ankle on 1/20/26 with a scalpel and from that point it was indicated the Resident had an open wound. When asked about their assessment, the WCN indicated she had not done one on the 20th, but the Practitioner had notes on the procedure. A review of the TAR revealed no dressing changes documented as completed on the left ankle until 1/27/26 when the wound care team had seen the Resident. It was reviewed with the WCN of lack of assessment, monitoring and treatment of R73's wound to the left ankle. It was determined that the Resident went to the Orthopedic Doctor's appointment and from there went to the acute care hospital and had not returned. On 3/3/26 at 3:22 PM, an interview was conducted with the Director of Nursing (DON) regarding R73's ankle wound with the lack of assessment, monitoring and dressing changes. The DON reported doing a timeline of the wound and stated, Yes, I have an issue with that also, and indicated, when the skin got worse, the Nurse should have gotten treatment and notified the Doctor and there should have been an order for a dressing change. The DON was asked about skin care policy, and they indicated they would follow the pressure ulcer policies for skin care. A review of the facility policy titled, Pressure Ulcer Preventative Measures, revealed, .2. Residents should be monitored during care and consistently by licensed<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | nurses to identify potential areas for skin breakdown and integrity of overall skin. 5. The nurse inspects any reddened areas and/or breaks in the resident's skin and documents the inspection. A review of the facility policy titled, Pressure Ulcer & Skin Care Management, revealed, .a resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection and reduce the risk of new pressure ulcers developing. 8. The nursing staff reviews the pressure ulcer prevention and treatment procedures with the resident's physician. They select the treatment procedures appropriate for the resident and the type of pressure ulcer or wound. The licensed nurse implements the wound care treatment procedures in accordance with current standards of practice. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area, resulting in the potential to spread food borne illness to all residents who consume food from the kitchen. Findings Include:On 03/02/2026 at 9:17 AM observed an open bag of fresh cut salad with a no open date and a use by date of 2/28/26 in the walk-in cooler. Dietary Manager (DM) E removed the bag to be disposed of.On 03/02/2026 at 9:20 AM observed a container of fruit cocktail without a label or date in the kitchen two door refrigerator. DM E removed the container from the unit.On 03/02/2026 at 9:49 AM observation of the resident fridge located in the dining room found the following items: three lemons cut down the center in a plastic bag and lettuce in a plastic bag without date marking. Open package of bologna inside a plastic bag with a receive date of 1/12/26, without an open or discard date. A container with an orange substance inside, without a label identifying substance and dated 2/7/26. Opened hot dog package with a date of 2/9/26 without discard date. During this observation, DM E indicated, the hotdogs should've been thrown away by now.On 03/03/2026 at 8:31 AM an interview conducted with the DM E found dates should be marked seven days after opening.A record review of the facility provided policy entitled Safe Storage & Handling of Outside Food, states that Any food which is not going to be consumed immediately must be covered and labeled with the resident's name, and date the food was brought into the facility . All food that is stored in the refrigerator & not consumed within 3 days will be discarded by the facility staff daily.A record review of the facility provided policy entitled Safe Storage of Food, states that All foods will be stored wrapped or in covered containers, labeled and dated . According to the 2022 Food Code, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.On 03/02/2026 at 12:09 PM observed two quarter pans sitting above the steam table during lunch service. At this time, the temperature of the pureed turkey was taken with a rapid read thermometer and found to be 179 F. The temperature of the meat patties was taken and found to be 180 F.On 03/02/2026 at 12:35 PM the temperature was taken of the two quarter pans sitting above the steam table, with the following temperatures noted: pureed turkey: 120-122 F, and meat patties: 107-122 F.On 03/02/2026 at 12:43 PM an interview with DM E found they like to see the temperature of food on the steam table at 145 F or higher. Once informed of temperature in quarter pans, DM E removed pans to be reheated. According to the 2022 FDA Food Code section 3-501.16 TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above; or (2) At 5C (41F) or less. |

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| F 0851<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.<br><br>Based on interview and record review, the facility failed to submit payroll-based, direct care staffing information to the CMS/Centers for Medicare and Medicaid Services for the 4th fiscal quarter (July 2025 - September 2025), as required by CMS. Findings Include: A review of the Payroll Based Journal Staffing Data Report for FY/Fiscal Year Quarter 4 2025 (July 1- September 30), indicated the following: This Staffing Data Report identifies areas of concern that will be triggered (e.g., requires follow-up during the survey). Failed to Submit Data for the Quarter: Result- Triggered; Definition- Triggered = No Data Submitted for Quarter.On 3/4/2026 at 1:15 PM the Administrator was interviewed about the PBJ direct care staffing information for the fourth fiscal quarter July 2025-September 2025 that was not submitted to CMS. The direct care staffing data identifies the type, number and hours worked for clinical staff caring for the needs of the residents. The Administrator said the facility's corporate office was supposed to submit the staffing documents to CMS and the information was not sent in. The Administrator said she was aware that it was required for the payroll based direct care staffing data to be sent to CMS every quarter. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake Number 2739632. Based on observation, interview and record review, the facility failed to assist with meal service for one resident (Resident #40) and ensure dignified care for one resident (Resident 29), and a Confidential Group of Residents, of three residents reviewed for dignity. Findings include:<br><br>Resident 29:<br><br>On 3/3/26 at 11:57 AM, an interview was conducted with Resident 29 (R29) who answered questions and engaged in conversation. The Resident was asked about any concerns with care and was asked about comments made by a CNA regarding her recent surgery. The Resident reported that CNA JJ had told her the day before her surgery the doctor was not any good. R29 reported the CNA talked about him being a bad doctor and stated, I only met him a couple of times and didn't really know him, and reported that she didn't know she should trust him after talking with the CNA. When asked how she felt the Resident stated, It really upset me. I felt uncomfortable and nervous. I was going under the knife the next day, I was scared. The Resident reported she had the surgery about 3 weeks ago and it went good without problems.<br><br>On 3/3/26 at 4:30 PM, an interview was conducted with Nurse FF regard comments made by CNA JJ to Resident 29 prior to her surgery. The Nurse indicated she was aware of the situation and reported the CNA had gave her thoughts about the doctor and (R29's name) was upset, she should not have given her opinion. The Nurse reported that administration was aware and that it was not abuse but more of a customer service issue.<br><br>Confidential Group of Residents:<br><br>On 3/2/26 a Confidential Group of Residents were together for a group meeting at approximately 3:00 PM. The Group consisted of seven Residents, all who were able to answer questions and six engaged in conversations and discussions. The group was asked about concerns with care received at the facility that included the following:<br><br>-Hallways blocked with items on both sides of the hall. The Group reported that this has been brought up at Resident Council meetings, it will get better for a couple days than it goes right back to items on both sides of the wall and the medication cart positioned at an angle making it hard to get around. One Resident stated, it's like dodging cars, another reported it was like playing Frogger, and another said you have to zig-zag your way down the hall. One Resident reported that when you have to go down the hallway in your wheelchair, it was very difficult to go around the equipment, they tried to keep the items on one side, but it does not stay that way.<br><br>-Residents having to deal with other Residents with behaviors, staff do not watch the Residents or staff say, oh, she's ok' and 'that's just him/her' when the Resident with behaviors was having issues, wandering in rooms, interacting inappropriately, or touching things that don't belong to them. The Group reported that they were having to deal with or redirect the Residents themselves and watched as Residents play with the food of trays being set up and getting into the ice bucket and ice scooper that were in the hallways. The Group indicated they should not be watching over other Residents or have them touching something they will be consuming. Four of the seven indicated they had concerns<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | with the behaviors of other Residents that affected them.<br><br>-The majority of the Group reported phone use by staff while providing care. All the Residents in the Group reported they had this happen or seen it happen. The Group reported that staff would wear ear buds and be talking to someone, they could not tell if the staff was talking to them or to someone on their phone. One Resident reported you can call the staff's name 3 or 4 times and they don't hear you. Multiple Residents reported that they could see and heard another person on the staffs' phone and reported some staff have Facetime while they were working. The Group reported a concern of staff playing music on their phone and had it in their pocket. One Resident reported that quiet time was to be at 10:00 pm, they are talking while I am trying to sleep, use loud voices when taking care of roommates during the night, staff turn the lights on bright, laugh, talk in loud voices in the middle of the night, and have music playing on their phone. One Resident stated, it is their daytime, but it is our nighttime and we are trying to sleep. Another Resident stated, they lost the ability to care.<br><br>-The Group reported concerns of staff being rude or have an attitude while receiving or asking for help. One Resident reported they complained of a staff member being rude and felt like they were retaliated against and was afraid to voice further concerns. Another Resident reported feeling retaliated against and had to apologize for concerns voiced. The Group as a whole reported concerns about staff rudeness and attitudes. The Group reported it had been brought up in Resident Council but there were ongoing issues. Multiple Residents reported they were afraid to voice concerns of staff being rude. Multiple Residents reported that staff use phrases of not my job if they don't want to do whatever it was that needed to be done and gave example of smelly or overflowing trash can and clogged toilets. When asked about knocking on the door before entering, the Group reported some staff do and some don't knock and announce they were entering.<br><br>-When asked about call light response, the whole group reported concerns with staff response to call lights activated. Concerns included having to wait an hour for someone to show up, nurses don't answer the call lights, the call light turned off, and staff report they will be back, then don't show back up. The Group reported that any time of day it was a concern but worse during shift change. The Group reported concerns of staff leaving the building and not being available when call lights were on. The Group reported that staff will go out to smoke multiple times and hear comments made by CNAs of I need a cigarette after that one and leave to go smoke. The Group reported it had been a concern brought up multiple times in Resident Council and the issue continued.<br><br>A review of 12 months of Resident Council Minutes revealed the following concerns/issues voiced during Resident Council meetings that included:<br><br>March 2025: DON/Nursing: Nurse is on her phone during her whole shift. Talking on speaker phone. Nurse has a foul mouth and bad attitude. Nurse stated doesn't like this place. Nurse takes it out on residents. CNA: Staff are on their phones in resident's rooms.<br><br>May 2025: CNA: Concern with call lights at night. Concern with CNAS on phones or computer.<br><br>August 2025: Housekeeping: Staff member has an attitude towards other residents, talks down, treats them with disrespect. Goes in and out of room without permission.<br><br>September 2025: DON/Nursing: CNA's sitting in nursing station on phones and not being productive. CNA: Wheelchairs and hoyers are not staying on one side of the hall so easily can pass through. Concern form: Aids on North Hall had an attitude feel care has declined since new owners. Quiet time<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | not respected. Phones still in room. Staff wearing earbuds having conversation and ignoring residents. Nursing disturbing resident while blasting music from phone in pocket. Nurse keeping cart angled in hallway instead of respectfully leaving to the side.<br><br>October 2025: DON/Nursing: Negative comments are being discussed in hallways, in front of residents. Staff not knocking before entering. Nurse being rude to the residents in 24. CNA: A certain staff member being rude to residents-it's her way or no way. When addressing residents' needs in a room, noise should be quiet and no bright lights turned on. Especially in the early morning hours. Concern Form: CNAs sitting in nurses station on phones not being productive; Wheelchairs and Hoyers not on one side of hallway so easier to get through.<br><br>November 2025: Administration: Safety concern for residents. Need to address concerns aggressively. Facility feels like it's becoming a psychiatric ward, accepting anybody and everybody. DON/Nursing: Address every one of our concerns and not just announce it a meeting. Make sure staff understands residents' concerns responsibly and effectively. CNA: Respectively knocking on doors before entering. Residents having to call main number to get assistance. Concern Form: A staff member being rude to resident-her way or no way. When addressing or answering lights in room especially during sleep hours, need to be respectful of other residents. No bright lights on or loud noise.<br><br>December 2025: DON/Nursing: Some issues with new night nurse giving attitude. Ensure quiet time is adherd to during times of 10 pm to 6 am.<br><br>February 2026: Administration: Some residents felt that they are not being respected in general by staff and feel they should be seen and not heard. Being talked down to like children. DON/Nursing: Disturbing the residents while blasting music from phone in pocket. Nurse keeps cart angled in hallway instead of respectfully leaving to the side. CNA: Aids on north hall had an attitude said resident would get shower on Saturday but did not receive. Feel the care has declined since new owners took over. Soiled briefs being thrown on the floor. Toilet in 44 was plugged up and dirty and residents were told to still use it. Phones are still being used in room. Quiet time not respected. Staff wearing ear buds and having conversations and ignoring residents.<br><br>On 3/4/26 at 2:22 PM, an interview was conducted with the Director of Nursing (DON) regarding issues brought up through the Confidential Resident Group meeting. The DON reported that the facility had tried to do an afternoon supervisor and weekend manager, but it was hit or miss and that guardian rounds were done to capture concerns and issues, but the guardian rounds were not consistent. The DON reported the facility had programs, but it was hit or miss with them being completed. The DON reported coming in on off hours and on weekends and they were not seeing the issues the Residents were reporting like staff use of the phones. The DON reported it was not allowed to restrict staff personal phones out of care areas and if able to do that, it would help with that concern. The DON reported being aware that the Residents were afraid of retaliation and won't give names, but indicated that when she does not know, then she has to guess on who the staff were that they were having issues with.<br><br>On 3/4/26 at 10:32 AM, an interview was conducted with the Administrator (NHA) regarding concerns voiced by a group of confidential residents. When asked about facility policy on staff using personal phones, the NHA reported they are not supposed to be using their phone while providing care or on the floor. Regarding the complaints of not respecting quiet time, the NHA reported it should be quiet during that time, and they are not to be using headphones, ear buds or playing music on their phones. The NHA reported staff should be using softer voices and going in turning on minimal amount of lights<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | to provide care, staff should be respectful of residents and their rest time.<br><br>A review of the facility policy titled, Resident Rights, revealed, .Resident Rights 1. Resident rights. The Resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 5. Respect and dignity. The resident has a right to be treated with respect and dignity, including: c. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences.<br><br>Review of the facility Employee Handbook revealed the directive for Telephone Usage Policy, revealed, .Under no circumstances should any employee bring a phone containing a camera, an(actual camera or any device which contains a camera), into a resident area. The use of personal cellular telephones and/or pagers are only permitted in the employee designated break room during meal periods and designated break periods and may not be brought into resident care areas.<br><br>Resident #29 (R29):<br><br>R29 admitted to the facility on [DATE] with diagnoses that include hemiplegia affecting the left side and hemiparesis following cerebral infarction.<br><br>On 03/02/2026 at 12:52PM, during an interview with R29, she stated that the staff will tell her to use her brief to go to the bathroom. R29 says that she uses a Hoyer lift for transfers and that the staff won't take her in the bathroom because of that.<br><br>On 03/03/2026 at 1:34PM, an interview was conducted with Family DD of R29. Family DD stated that R29 went out to the hospital for a planned surgery and R29 had requested to be showered and have her brief changed prior to the transfer. Family DD stated the staff did not perform the care that was requested and they told me they couldn't do it because they were short on staff. Family DD stated that when R29 got to the hospital for her surgery she was soaked in urine and that was embarrassing for her. Family DD stated that there was a time the staff put R29 on the sit to stand to take her to the bathroom and pulled her pants down in the room and the curtains were open on the window and she was exposed. Family DD stated I don't want my sister embarrassed, and they need to protect her dignity.<br><br>Resident #40:<br><br>On 3/2/2026, at 12:27 PM, an observation of CNA K was conducted for Resident #40's meal service. There were 3 bowls on the tray with 2 of them empty. 1 bowl housed turkey, mashed potatoes and vegetable blend. CNA K blended all the food items together with a spoon in one bowl and began to feed Resident #40 the mixed food items with the spoon.<br><br>On 3/2/2026, at 1:00 PM, a record review of Resident #40's electronic medical record revealed an admission on [DATE] with diagnoses that included Schizophrenia, Dementia and Multifocal motor neuropathy with borderline intellectual function.<br><br>A review of the COGNITION care plan revealed COGNITION: I display cognitive impairment .<br><br>A review of the ADLs: (activities of daily living) care plan revealed: I have an ADL self care deficit r/t . cognitive deficits/mental impairment . Interventions . EATING: I can be independent with eating sometimes depending on my mood. Assist me with eating when I require assistance Date Initiated:<br>(continued on next page) |

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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 09/28/2019 Revision on: 02/23/2026 . The care plan does not state to mix food items together.<br><br>On 3/3/2026, at 12:15 PM, in the main dining room, Resident #40 was assisted by CNA B for their lunch meal. There was fish, potatoes and a vegetable all separate on their plate. Resident #40 was assisted with each item with separate bites. CNA K was asked if the resident likes their food all mixed together and CNA K offered, no, we're not supposed to do that.<br><br>On 3/4/2026, at 2:15 PM, CNA K was asked if they normally mix food items for Resident #40 and CNA K stated, yes that the resident chews and swallows better with the mixed textures.<br><br>On 3/4/2026, at 2:30 PM, the Director of Nursing (DON) was asked if residents are being assisted with meal service if it the facilities procedure to mix all the food together and the DON offered, no, not unless it's care planned that way. The DON was alerted of the observation for Resident #40 on day 1 of the survey. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a clean, sanitary, homelike environment with concerns of privacy curtains with stains, offensive odors in the rooms/hallways and ceiling tiles stained and not in good repair for one resident (Resident #37), of three residents reviewed for environment and for a Confidential Group of Residents. Findings include: Confidential Group of Residents<br><br>On 3/2/26 a Confidential Group of Residents were together for a group meeting at approximately 3:00 PM. The Group consisted of seven Residents, all of whom were able to answer questions and six engaged in conversations and discussions. The group was asked about concerns that they wanted to relay in the group meeting and revealed the following:<br><br>-Odors in the hallway. One Resident expressed concerns about odors in the hallway. Another Resident stated, It smells like piss and (bowel movement) all the time, expressing that they can smell it all down the hallway. The two Residents resided in different areas of the facility. Another Resident stated, I go by a room and can smell it, they leave a dirty diaper in the trash. You can smell it from the hall wheeling by. Another Resident reported CNAs were not emptying the garbage and stated, We get 'it's not my job', when explaining the response by CNAs of trash left with soiled briefs in the garbage. It was a consensus of the group of Residents that there were issues with foul odors in the hallways and some rooms.<br><br>-Toilets getting clogged. It was expressed that toilets were getting clogged and most of the Confidential Group of Residents had experienced it or seen/heard it occurring. A resident reported that a toilet that four residents used, had gotten clogged. The Resident reported they had to find another toilet, and it was inconvenient. Another Resident reported a toilet was not working and the CNA told them to use it anyway, indicating it needed to be plunged but staff reported to them it was not my job to plunge the toilet.<br><br>On 3/4/36 at approximately 4:00 PM, an observation was made of odors in the hallway in the South area and by the front office. One of the toilets in the front office area had a sign on it that stated the restroom was out of order. Maintenance L was asked about why the restroom was out of order and reported he thought it had been leaking. The Maintenance Director opened the door, and a foul odor was in the room. When flushing the toilet, it worked successfully. The Maintenance Director reported the smell might be coming from the drain of the sink since the water in the trap had likely evaporated. He was unsure how long the restroom had been out of order.<br><br>On 3/02/2026, at 8:52 AM, an observation of room [ROOM NUMBER] revealed both residents in their bed. There was a strong smell of urine in the room and in the hallway. The floor appears to be freshly mopped and half dried.<br><br>On 3/02/2026, at 10:02 AM, Resident #37 was resting in their bed. They had 2 privacy curtains encircling their bed. Resident #37 offered, they like it that way. Resident #37 was asked if they knew what the soiled areas were and Resident #37 offered, oh, can you remind them to clean them. Both curtains were soiled with reddish/purple splashes approximately 2 feet by 2 feet areas.<br><br>On 3/02/2026, at 10:38 AM, Near room [ROOM NUMBER] in the North hallway was noted with a<br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | strong smell of urine.<br><br>On 3/02/2026, at 4:06 PM, The soiled privacy curtains remain in Resident #37's room.<br><br>On 3/03/2026, at 8:46 AM, Resident #11 was resting in bed. There was a bag of trash on the floor near the right side of their bed. There was also a trash can that had a liner with trash inside it.<br><br>On 3/03/2026, at 10:00 AM, an observation of room [ROOM NUMBER] revealed an odor urine in the room and in the hall outside of room [ROOM NUMBER]. The floor appeared to be freshly mopped and was still completely wet.<br><br>On 3/03/2026, at 12:02 PM, Resident #11 remained in their room. The bag of trash remained on the floor near their bed.<br><br>On 3/03/2026, at 12:51 PM, there was a strong urine smell noted to the North hallway near the exit door.<br><br>On 3/4/2026, at 11:00 AM, an observation of Resident #37's room revealed new clean hanging privacy curtains.<br><br>On 3/4/2026, at 11:10 AM, Environmental Director (ED) L was interviewed regarding the new privacy curtains. ED offered they had a monthly schedule for cleaning the privacy curtains. ED L was asked to provide the schedule for review. ED L was asked who changed the privacy curtains for Resident #37 and ED L offered they were from another facility.<br><br>On 3/4/2026, at 3:00 PM, a ceiling vent in main hallway appears to be falling out of the ceiling not secured. There were strong odors present in all of the main hallways. There was an out of order sign on the bathroom near the Administrator's office. The facility was asked to open the bathroom door as the odor appeared stronger. There was a strong sewer gas smell coming from the bathroom. The Administrator entered the hallway and was asked if the facility had any sewer problem or work done recently. The Administrator offered that they had called the local gas company to come check the smell and they felt it was coming from outside of the building being pulled inside the hallways via the circulation system. The Administrator was asked for the correspondence and/or any documentation from the company which was not provided.<br><br>On 3/4/2026, at 4:00 PM, an observation along with Human Resources (HR) F of the hallways revealed strong sewer odors. The exit doorway near the beauty shop was unlocked per HR F. Outside of the building was observed to be free of any sewer smell. The outside air smelled fresh and normal. Upon reentry into the hallway from the outside, the odor remained to be a strong sewer smell. The odor remained in all three of the hallways from the entry door to the beauty shop and to the day room. |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>Based on interview and record review, the facility failed to ensure that grievances were addressed timely for a Group of Confidential Residents of seven residents that had concerns voiced during Resident Council meetings and the issues continued to recur.Findings include:On 3/2/26 a Confidential Group of Residents were together for a group meeting at approximately 3:00 PM. The Group consisted of seven Residents, all who were able to answer questions and six engaged in conversations and discussions. The group was asked about concerns with care received at the facility that included the following:-Hallways blocked with items on both sides of the hall. The Group reported that this has been brought up at Resident Council meetings, it will get better for a couple days than it goes right back to items on both sides of the wall and the medication cart positioned at an angle making it hard to get around. One Resident stated, it's like dodging cars, another reported it was like playing Frogger, and another said you have to zig-zag your way down the hall. One Resident reported that when you have to go down the hallway in your wheelchair, it was very difficult to go around the equipment, they tried to keep the items on one side, but it does not stay that way.-The majority of the Group reported phone use by staff while providing care. All the Residents in the Group reported they had this happen or seen it happen. The Group reported that staff would wear ear buds and be talking to someone, they could not tell if the staff was talking to them or to someone on their phone. One Resident reported you can call the staff's name 3 or 4 times and they don't hear you. Multiple Residents reported that they could see and heard another person on the staffs' phone and reported some staff have Facetime while they were working. The Group reported a concern of staff playing music on their phone and had it in their pocket. One Resident reported that quiet time was to be at 10:00 pm, they are talking while I am trying to sleep, use loud voices when taking care of roommates during the night, staff turn the lights on bright, laugh, talk in loud voices in the middle of the night, and have music playing on their phone. One Resident stated, it is their daytime, but it is our nighttime and we are trying to sleep. Another Resident stated, they lost the ability to care.-The Group reported concerns of staff being rude or have an attitude while receiving or asking for help. One Resident reported they complained of a staff member being rude and felt like they were retaliated against and was afraid to voice further concerns. Another Resident reported feeling retaliated against and had to apologize for concerns voiced. The Group as a whole reported concerns about staff rudeness and attitudes. The Group reported it had been brought up in Resident Council but there were ongoing issues. Multiple Residents reported they were afraid to voice concerns of staff being rude. Multiple Residents reported that staff use phrases of not my job if they don't want to do whatever it was that needed to be done and gave example of smelly or overflowing trash can and clogged toilets. When asked about knocking on the door before entering, the Group reported some staff do and some don't knock and announce they were entering.-When asked about call light response, the whole group reported concerns with staff response to call lights activated. Concerns included having to wait an hour for someone to show up, nurses don't answer the call lights, the call lights turned off, and staff report they will be back, then don't show back up. The Group reported that any time of day it was a concern but worse during shift change. The Group reported concerns of staff leaving the building and not being available when call lights were on. The Group reported that staff will go out to smoke multiple times and hear comments made by CNAs of I need a cigarette after that one and leave to go smoke. The Group reported it had been a concern brought up multiple times in Resident Council and the issue continued.-A Resident brought up the concern of not getting fresh water. One resident reported having to go to the dining room to get fresh water and that they don't change it out in their room regularly. Another resident said, They tell me to drink more water because my urine is dark, well get me water and I will drink it. It was brought up that on some weekends it is the same cup from Friday to Monday. The group expressed that when they do them, they date them and sometimes they<br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | do them in the evening and date it for the next day. It was the consensus of the whole group of it being an issue with getting fresh water passed to the rooms. It was brought up that they have complained as a group about this issue at Resident Council Meetings and the issue continues to be a problem.-When asked if the Group felt concerns were addressed and resolved, the group reported They don't follow up on complaints. A Resident voiced, There is a repetition, we complain over and over at every meeting, have to ask for them to take it seriously. Another Resident voiced, They say they discuss it on the town hall (staff meeting), they don't bring it up, even if it is told at the town hall, it doesn't get resolved, they just say it was brought up but the issue is not taken care of, it's like a revolving door. Seven of the Seven Resident indicated there has been no resolution to voiced concerns.A review of Resident Council Minutes revealed the following concerns/issues voiced during Resident Council meetings that included:March 2025: DON/Nursing: Nurse is on her phone during her whole shift. Talking on speaker phone. Nurse has a foul mouth and bad attitude. Nurse stated doesn't like this place. Nurse takes it out on residents. CNA: Staff are on their phones in resident's rooms.May 2025: CNA: Concern with call lights at night. Concern with CNAS on phones or computers.August 2025: Housekeeping: Staff member has an attitude towards other residents, talks down, treats them with disrespect. Goes in and out of room without permission. CNA: Fresh water still not being given to (room number) at times.September 2025: DON/Nursing: CNA's sitting in nursing station on phones and not being productive. CNA: Wheelchairs and hoyers are not staying on one side of the hall so easily can pass through. Concern form: Aids on North Hall had an attitude feel care has declined since new owners. Quiet time not respected. Phones still in room. Staff wearing earbuds having conversation and ignoring residents. Nursing disturbing resident while blasting music from phone in pocket. Nurse keeping cart angled in hallway instead of respectfully leaving to the side.October 2025: DON/Nursing: Negative comments are being discussed in hallways, in front of residents. Staff not knocking before entering. Nurse being rude to the residents in 24. CNA: A certain staff member being rude to residents-it's her way or no way. When addressing residents' needs in a room, noise should be quiet and no bright lights turned on. Especially in the early morning hours. Water passes still a hit or miss.November 2025: Administration: Safety concern for residents. Need to address concerns aggressively. Facility feels like it's becoming a psychiatric ward, accepting anybody and everybody. DON/Nursing: Address every one of our concerns and not just announce it at the meeting. Make sure staff understands residents' concerns responsibly and effectively. CNA: Respectively knocking on doors before entering. Residents having to call main number to get assistance. Waters still an issue-certain staff that never take care of it.December 2025: DON/Nursing: Some issues with new night nurse giving attitude. Ensure quiet time is adhered to during times of 10 pm to 6 am. CNA: Water pass is still an issue with certain aides.January 2026, CNA: Water pass is still an issue, and some have no water in room to take medication or occasionally sip of water if needed for a cough.February 2026: Administration: Some residents felt that they are not being respected in general by staff and feel they should be seen and not heard. Being talked down to like children. DON/Nursing: Disturbing the residents while blasting music from phone in pocket. Nurse keeps cart angled in hallway instead of respectfully leaving to the side. CNA: Aids on north hall had an attitude said resident would get shower on Saturday but did not receive. Feel the care has declined since new owners took over. Soiled briefs being thrown on the floor. Toilet in 44 was plugged up and dirty and residents were told to still use it. Phones are still being used in room. Quiet time not respected. Staff wearing ear buds and having conversations and ignoring residents. A review of facility documents titled Concern Form that were with Resident Council (RC) minutes revealed the following:Concern form with September RC minutes revealed:-Information about your Concern: Please describe the concern: Aids on North Hall had an attitude feel care has declined since new owners. Quiet time not respected. Soiled briefs left on floor. Phones still in room. Assisted feeding time at dinner not being followed. Staff wearing earbuds having conversation and ignoring residents. The rest of the questions were not answered on the concern form such as: When did the problem or incident occur, Who else knows about the problem<br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | or incident?, How can we address you issues?, Is this an ongoing problem?, Have you contacted us in the past about this issue? There was a signature of person completing report that was not legible and dated 2/22/26. The Corrective Action to be Taken: Discuss in town hall and nurse/CNA mtg (meeting) 2/26/26. The Outcome or Satisfaction Level portion of the form was not filled out.- Information about your Concern: Please describe the concern: Nursing disturbing resident while blasting music from phone in pocket. Nurse keeping cart angled in hallway instead of respectfully leaving to the side. Dated 8/11/26. The rest of the questions were not answered on the concern form such as: When did the problem or incident occur, Who else knows about the problem or incident?, How can we address you issues?, Is this an ongoing problem?, Have you contacted us in the past about this issue? There was a signature of person completing report that was not legible and dated 2/22/26. The Corrective Action to be Taken: Discuss in town hall and nurse/CNA mtg (meeting) 2/26/26. The Outcome or Satisfaction Level portion of the form was not filled out. Concern form with October RC minutes revealed:-Concern Form: CNAs sitting in nurses station on phones not being productive; Wheelchairs and Hoyers not on one side of hallway so easier to get through. Dated 9/10/25. The Corrective Action to be Taken: Audit to be completed by the IDT members in October and added to Nurse/CNA meeting, dated 10/11/15. The Outcome or Satisfaction Level portion of the form was not filled out. Concern form with November RC minutes revealed:-Concern Form: A staff member being rude to resident-her way or no way. When addressing or answering lights in room especially during sleep hours, need to be respectful of other residents. No bright lights on or loud noise. Once you punch in for shift, you should not leave right away to get food. Dated 10/13/26. The rest of the questions were not answered on the concern form such as: When did the problem or incident occur, Who else knows about the problem or incident?, How can we address you issues?, Is this an ongoing problem?, Have you contacted us in the past about this issue?. The Facility Response: spoke with different aides and nurses during working hours about concerns listed. Corrective Action to be Taken: will discuss in town hall (the rest was not able to be read as well as the signature and date.) The Outcome or Satisfaction Level portion of the form was not filled out.-Concern Form: Information about your Concern: Nursing staff not showing up. Not enough staff somedays. Negative comments being discussed in front of Residents. Staff not knocking before entering and a Nurse being rude to ladies in room (number). When did the problem or incident occur: Within the last few weeks, dated 10/13/25. The Facility Response: spoke with different aides and nurses during working hours about concerns listed. Corrective Action to be Taken: will discuss in town hall (the rest was not able to be read as well as the signature and date.) The Outcome or Satisfaction Level portion of the form was not filled out. Concern Forms with the December RC minutes revealed:- Concern Form: Information about your Concern: Not just announce it at town Hall, ensure staff is taking residents concerns responsibly and effectively. Still staffing issue, showing up late or not at all. Night nurse not be around enough to assist, dated 11/18/25. Facility Response: There is currently no open nursing positions. Mgmt monitors attendance daily. There have been no issues with staff coming late or not showing up to work. There are 2 nurses on nights and they assist when able. Corrective Action to be Taken: Let nursing staff know about above concerns. Educate nursing staff on resident concerns responsibility and effectively, dated 12/4/25. The Outcome or Satisfaction Level portion of the form was not filled out.Concern Forms with the January RC minutes revealed:- Concern Form: Information about your Concern: Concerns need to be addressed aggressively. Feeling like facility is becoming a psychiatric ward, accepting anyone, dated 11/18/25 and 12/3/25. Facility Response: Central intake assigns admissions-yellow-means Admin/DON review for appropriateness. Denying some personality d/t (due to) behaviors. Corrective Action to be Taken: Spoke with Central intake Spoke with DON and Admissions. Signed by the Administrator, dated 12/3/25. The Outcome or Satisfaction Level portion of the form was not filled out. Concern Forms with the February RC minutes revealed:- Concern Form: Information about your Concern: CNAs to empty trash and urinals before end of shift and have them on hand also. Water pass is still an issue, missing water to take meds with, dated 1/15/26. Facility Response: Meeting with the (continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Aides and Nurses addressing the concerns. Corrective Action to be taken: Rounding, monitoring, correcting any issues, dated 1/16/26. The Outcome or Satisfaction Level portion of the form was not filled out. On 3/4/36 at 10:32 AM, an interview was conducted with the Administrator (NHA) regarding grievances and concerns brought forth by the Confidential Group of Residents and concerns from the Resident Council minutes with concern forms. When asked about the Town Hall meetings, the NHA reported the meetings were where they get together every month, go to the dining room, takes about 30 minutes, discuss concerns the Residents have, change in policies and anything in the past month that needs addressed. When asked if Residents go to the meetings, the NHA reported they have in the past, but they don't need to be there. Regarding repeated concerns, the NHA reported some concerns would be brought up at the Town Hall, and the Activity Staff fills out the concern form. The NHA reported that concerns should be going to social services and respective departments. Regarding rudeness of staff and issues with Resident 29, the NHA reported that she was aware of complaints, it was investigated and the staff was let go and stated, It took a lot of stress out of the building. It was reviewed with the NHA that the Group of Confidential Residents did not feel like their concerns were heard and addressed. The NHA reported she had gone to Resident Council meeting and discussed the issue with getting behavioral residents. It was reviewed with the NHA that the Group of Confidential Residents did not feel like their concerns were heard and addressed. On 3/4/26 at 2:22 PM, an interview was conducted with the Director of Nursing (DON) regarding issues brought up through the Confidential Resident Group meeting. The DON reported that the facility had tried to do an afternoon supervisor and weekend manager, but it was hit or miss and that guardian rounds were done to capture concerns and issues, but the guardian rounds were not consistent. The DON reported the facility had programs, but it was hit or miss with them being completed. The DON reported coming in on off hours and on weekends and they were not seeing the issues the Residents were reporting like staff use of the phones. The DON reported it was not allowed to restrict staff personal phones out of care areas and if able to do that, it would help with that concern. The DON reported being aware that the Residents were afraid of retaliation and won't give names, but indicated that when she does not know, then she has to guess on who the staff were they were having issues with. A review of the facility policy titled, Resident Rights, revealed, .Resident Rights 1. Resident rights. The Resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 5. Respect and dignity. The resident has a right to be treated with respect and dignity, including c The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences.10. Grievances. The resident has the right to: a. Voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished; and the behavior of staff and of other residents; and other concerns regarding their LTC (long term care) facility stay. b. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. A review of the facility policy titled, Concern/Grievance Policy, revealed, Policy: Residents and their family members may voice complaints, concerns and/or grievances to the facility or other entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. The facility will make prompt efforts to resolve grievances. Fundamental Information: The Administrator has been designated as the Grievance Official and is responsible to receive and assure complaints, concerns and/or grievances are addressed timely according to the procedures outline. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations. b. The grievance form will be forwarded to the Grievance Official. c. The Grievance Official will take steps to resolve the grievance, and record information<br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Orchards at Lapeer | 239 South Main Street<br>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.

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | about the grievance, and those actions, on the grievance form. i. The form includes a section where the resident/representative can provide feedback on satisfaction level of the resolution. The facility should encourage this feedback to determine satisfaction level of the resolution taken. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, interview and record review, the facility failed to ensure that oxygen tanks were available for resident use for one resident (Resident #58) and a confidential group of residents, available on the crash cart for emergency use, and nebulizer equipment was stored appropriately for one resident (Resident #23) of three residents reviewed for oxygen use. Findings include: Confidential Group of Residents:<br><br>On 3/2/26 a Confidential Group of Residents were together for a group meeting at approximately 3:00 PM. The Group consisted of seven Residents, all who were able to answer questions and six engaged in conversations and discussions. During the group meeting, one Resident who was on oxygen by way of an oxygen concentrator, had an alarm go off on his machine. The Resident became upset and expressed he was in trouble if his concentrator was not working. The Resident had an E-tank for oxygen on the back of his wheelchair. When asked if he needed assistance to have someone hook up the oxygen to the tank, the Resident said it was empty. Another Resident reported that there were no tanks of oxygen available throughout the facility. Another Resident reported to the Resident with the oxygen that he had rolled his wheelchair over the oxygen tubing. The Resident was able to adjust the wheelchair and the alarm stopped. The Resident reported being ok and the meeting continued. The Resident reported being unable to freely wander through the facility without an available E-tank that had oxygen due to needing oxygen all the time and reported having to stay in the room until the delivery came in.<br><br>On 3/2/26 at 4:06 PM, an interview was conducted with the Director of Nursing (DON) regarding the Group complaints of lack of oxygen supply in the portable tanks. The DON confirmed a lack of oxygen in the portable tanks. The DON reported that they had come to deliver the tanks on Saturday but due to no key available to the shed where the tanks were stored, the company did not leave any. The DON reported being informed of the situation this afternoon. The DON reported that Resident will be on concentrators in their rooms until the oxygen is delivered, indicating later that evening around 7 PM. The DON reported there were enough concentrators for the Residents on oxygen. The DON reported that the crash cart had a tank she could grab if needed. An observation of the crash cart at a Nurses' Station, across from the DON's office, revealed the tank was on red, which indicated it was empty. The DON reported that it was the only crash cart in the facility.<br><br>Resident #23<br><br>On 03/02/2026 at 9:46AM, during an interview with R23, nebulizer equipment was observed next to the bed. There was condensation noted in the medication cup on the nebulizer, it was stored together, hanging on a towel bar on the nightstand and not covered. R23 was asked when she last had a nebulizer treatment. R23 states the last nebulizer treatment she had was at 8am this morning.<br><br>On 03/03/2026 at 8:11AM, during an interview with R23, the nebulizer equipment was observed next to the bed. The nebulizer equipment was again observed to be together, with condensation in the medication cup and hanging on a towel bar on the nightstand. R23 stated her last nebulizer treatment was at 6:30am this morning.<br><br>On 03/03/2026 at 8:13AM, an interview was conducted with License Practical Nurse (LPN). FF. LPN FF was asked when is the last time R23 had a breathing treatment. LPN FF stated that it appears the last treatment was a PRN (as needed) albuterol treatment this morning. LPN FF was asked what the process is for storing nebulizers after the treatments are done. LPN FF stated we clean it out and<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | then place it back at the bedside. LPN FF was made aware that the nebulizer equipment for R23 was being stored on a towel bar on the nightstand.<br><br>On 03/03/2026 at 1:17PM, record review revealed a physician's order for, Ipratropium-Albuterol Solution 0.5-2.5(3)MG/3ML 3ML, inhale orally every 8 hours related to Chronic Obstructive Pulmonary Disease The March 2026 Medication Administration Reconciliation (MAR) revealed there had not been a nebulizer treatment signed out this month.<br><br>Resident #58<br><br>On 03/02/2026 at 1:51PM, an interview was conducted with R58, who had just returned from an appointment approximately 30 minutes ago. R58 stated he left the facility for an appointment with a full tank of oxygen. R58 stated that he was out too long on his appointment and he ran out of oxygen and still made it back to the facility. R58 stated he requested another tank so he could leave his room again and was told by a staff member that they are out of oxygen tanks. R58 was upset that no one told maintenance that they were out of oxygen tanks in the building. R58 stated the staff placed him on his concentrator and at this time he would have to stay in his room.<br><br>Review of the policy titled, Respiratory Equipment Care & Handling of, revealed:<br><br>11. Reusable equipment must be cleaned with disinfectant, sprayed onto the outside of the body of the equipment following each resident use.<br><br>-Compressors, concentrators, oxygen analysis, regulators,<br><br>-Empty intermittently used nebulizers after use and rinse with tap water, shake dry and place on a clean paper town to air dry. After drying, place in a plastic bag, which is then hung from the flow meter. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Number 2656620. Based on observation, interview, and record review the facility failed to ensure there was 1.) adequate staff to meets the needs of the residents, resulting in resident verbalizations of waiting long periods of time to answer call lights timely; receive assistance with activities of daily living (ADL), including toileting and incontinence care, and showers and 2.) adequate nurses including RN's to care for the needs of the residents, from a census of 68 residents, resulting in resident dissatisfaction, frustration, and unmet care needs. Findings Include:<br><br>Confidential Group of Residents:<br><br>On 3/2/26 a Confidential Group of Residents were together for a group meeting at approximately 3:00 PM. The Group consisted of seven Residents, all who were able to answer questions and six engaged in conversations and discussions. The group was asked about concerns with care received at the facility that included the following:<br><br>-When asked about call light response, the whole group reported concerns with staff response to call lights activated. Concerns included having to wait an hour for someone to show up, nurses don't answer the call lights, the call light turned off, and staff report they will be back, then don't show back up. The Group reported that any time of day it was a concern but worse during shift change. The Group reported concerns of staff leaving the building and not being available when call lights were on. The Group reported that staff will go out to smoke multiple times and hear comments made by CNAs of I need a cigarette after that one and leave to go smoke. The Group reported call light response had been a concern brought up multiple times in Resident Council and the issue continued.<br><br>-One Resident voiced concerns of not enough staff to help during mealtimes, and not enough staff to pass meal trays with voiced concerns of seeing the carts with trays set up and no one bringing them down the hall, they sit on the hall, up to 40 minutes. Another Resident reported their roommate needed help with sitting up and setting up the tray by opening items, it (the meal tray) had sat there for 45 minutes, by that time someone came in, it had been sitting for close to an hour, it must have been so cold. Another Resident reported their roommate needed to be fed and sometimes the staff were not available to assist the resident.<br><br>-Regarding staffing, the group voiced some really good aides, but some are not, new staff come in for a couple days and then they don't show back up, not enough staff at night , not enough help that meets their needs timely, if someone (CNA) doesn't show up (for work) that is a problem, the other CNA has to take on more, and no longer a shower aide to help get showers done. It was the consensus of the Group of issues with not enough staff to meet needs timely.<br><br>Facility<br><br>Resident #27:<br><br>A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #27 was admitted to the facility on [DATE] with diagnoses: Heart failure, respiratory disorder, anemia, deep vein thrombosis, and hypertension. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 14/15 and the<br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | resident needed assistance with activities of daily living (ADL) including dependent for assistance with transfers, toileting, dressing and maximum assistance with bathing.<br><br>On 3/02/2026 at 2:12 PM, Resident #27 was observed in his room. When asked about receiving assistance with care, the resident stated, They don't have enough people, to answer call lights. The resident said he was frustrated that she had to wait long periods of time to receive assistance with care.<br><br>Resident #31:<br><br>A record review of the Face sheet and MDS assessment indicated Resident #31 was admitted to the facility on [DATE] with diagnoses: diabetes, heart failure, hypertension, GERD, recent urinary tract infection/UTI and arthritis. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a BIMS score of 15/15 and the resident needed assistance with all care.<br><br>On 3/02/2026 at 11:11 AM, Resident #31 was interviewed in her room and said she was in her bathroom, and it took 45 minutes for staff to answer her call light while she sat in the bathroom waiting. The resident stated, There are not enough staff. Resident #31 said they thought the food was cold when it was delivered the day before because there were not enough staff.<br><br>Resident #32:<br><br>A record review of the Face sheet and MDS assessment indicated Resident #32 was admitted to the facility on [DATE] with diagnoses: diabetes, heart disease, heart failure, hypertension, Gerd. The MDS assessment dated [DATE] indicated the resident had full cognitive abilities with a BIMS score of 15/15 and needed assistance with all care.<br><br>On 3/02/2026 at1:37 PM, Resident #32 was interviewed in her room when asked if she received assistance with care she said there were multiple instances when there were long wait times to have her call light answered. Resident #32 said at time it took up to 1 hour to have staff respond to her call light.<br><br>Resident #70:<br><br>A record review of the Face sheet for Resident #70 identified an admission date of 2/20/2026 and the resident needed assistance with care. The MDS assessment was not yet completed.<br><br>On 3/02/2026 at 12:18 PM, Resident #70 was observed sitting in a wheelchair in his room. He said his call light was not always answered timely. When asked if this occurred on a specific shift he said it was sometimes both shifts, days and nights.<br><br>A record review of the Daily Staffing Report sheets, that the facility completes and posts daily showing the facilities daily census of residents, and numbers of Registered Nurses/RN's, Licensed Practical Nurses/LPN's and Certified Nursing Assistances/CNA's indicated the documents were not completed and posted daily, as evidenced by the Daily Staffing Report sheet posted near the front of the building by the office on 3/2/2026. It was dated 2/26/2026, 5 days prior than the day observed.<br><br>On 3/4/2026 at 11:45 AM, the Director of Nursing/DON was interviewed about staffing, as the facilities Payroll Based Journal/PBJ staffing report containing clinical staff information, that is<br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | required to be submitted to CMS/Centers for Medicare and Medicaid Services each quarter was not sent to CMS by the facility in the 4th fiscal quarter- July 2025- September 2025. The DON said the corporate office for the facility was responsible for submitting the data. The DON was also asked about the Daily Staffing Sheets and she said the scheduler EE had the forms and she started them and the nurses updated them with changes to the schedule each day. She said the forms were to be posted every day with correct information.<br><br>During the interview, on 3/4/2026 at 11:45 AM, the DON was asked about clinical staffing, as there were several complaints from the residents, as they felt there were not enough staff nurses and CNA's to care for their needs. The residents were saying they had long call wait times, sometimes their food became cold while the resident was waiting for it to be delivered, and there were some residents who were frustrated and discouraged about this. The DON was asked if there were enough staff and she said several nurses had left the facility recently and several more had left in the fall of 2025. She said many of the staff were working over their 12 hour shifts and also working extra days. The DON said because of this, she said she had to work on the floor as there were not enough nurses. The DON was asked how often she worked as a floor nurse and she said it depended, but sometimes several days in a row. The DON was asked how many hours at a time she was working on the floor, and she said sometimes a 12 hour shift and then later that day also. The Daily Staffing Reports for July 2025 to Current 3/4/2026 were requested. The DON was asked if the reports were kept in a binder and she said the scheduler EE had the documents. Clinical staff schedules and assignment sheets were also requested to be reviewed. The DON said the scheduler had all of the documents.<br><br>On 3/4/2025 at 1:10 PM, scheduler EE was observed in her office sorting stacks of documents. The scheduler was asked to review the Daily Staffing Reports and she said she was sorting them. When asked if she kept the documents in a binder or folder, she said no, she kept the Daily Staffing Report, daily schedule and daily assignment sheets stapled together for each day. Reviewed with the scheduler they did not need to be separated as all needed to be reviewed. The scheduler was asked to view them all.<br><br>On 3/4/2025 at 1:15 PM, the Administrator was interviewed about the staffing documents. She said the scheduler was working on them and would send them in batches. Reviewed with the Administrator that the 4th quarter PBJ staffing report submission was not received by CMS. She said she was aware. She said the report was submitted quarterly by the corporate office, but it was not submitted for the 4th fiscal quarter (July 2025- September 2025). The Administrator was asked about clinical staffing, as the Daily Staffing Report was not current on the initial entry into the building on 3/2/2026, as it was dated 2/26/2026. She said it was supposed to be updated every day.<br><br>The daily posted nursing forms Daily Staffing Report as called by the facility, is required to be accurate for each shift with CNA, RN and LPN hours listed for each day, so that any visitor or resident can see what staffing is provided.<br><br>The PBJ staffing report is utilized by CMS to see if the facility is providing enough staff to care for the needs of the residents and to ensure there is adequate RN coverage during every 24 hour day: 8 hours of consecutive RN coverage daily.<br><br>On 3/4/2026 at 1:15 PM, during the interview with the Administrator, she was asked if there were enough nurses, including RN's to care for the residents. She said some of the nurses had left and they were working on replacing them. The Administrator was asked about the DON working on the floor for extended hours and days and she said that was true. The DON's position at the facility was as a<br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | full-time DON, but she was also working many days as a nurse on the floor. Also reviewed with the Administrator that there were complaints from the residents that there were not enough staff, and they were waiting for long periods of time to have their call lights answered, especially on the night shift; she said they were trying to work on this.<br><br>Upon review of the clinical staffing documents, including the Daily Staffing Reports, daily schedules and daily assignment sheets. It was identified that some of the documents were not received, including the days immediately prior to survey entry: 3/1/2026, 2/28/2026, 2/27/2026, 2/25/2026 and 2/24/2026. Each month received from 9/1/2026 through February 2026 had missing days of documents.<br><br>During the review of the staffing documents, it was identified that there were many days that the Daily Staffing Report sheets did not include the name of the facility or identify the nurses as RN's or LPN's it said Nurse and the number of nurses on the day shift (6:00 AM to 6:30 PM) and the number on the night shift (6:00 PM to 6:30 AM): This included 11/16/2025 when 4 nurses were listed on dayshift and 2 on night shift and the Daily Schedule Report indicated on the night shift one nurse would work until 2am instead of 6:30 AM. Leaving one nurse to work by themselves for 4 hours. The report also indicated on 11/16/2025 there were 2 aides on night shift for a census of 68 residents. At times someone would write in ink next to the shift and include RN and LPN.<br><br>Further review of the clinical staffing documents detected days when the Daily Staffing Report identified days when there were a low number of clinical staff.<br><br>On 9/1/2025, 9/2/2025 and 9/3/2025 the Daily Staffing Report did not identify RNs or LPNs (it said Nurse).<br><br>On 9/21/2025 the Daily Staffing Report listed 1 nurse on night shift for a census of 62 residents.<br><br>On 9/23/2025 the Daily Staffing Report was absent.<br><br>On 9/26/2025 the Daily Staffing Report did not identify RNs or LPNs, it said Nurse.<br><br>On 9/27/2025 the Daily Staffing Report did not list RNs or LPNs.<br><br>On 9/28/2025 the Daily Staffing Report listed 3 LPNs and no RNs working.<br><br>On 10/9/2025 the Daily Staffing Report listed 2 nurses on the night shift and 2 nurse aides for a census of 65 residents.<br><br>On 10/11/2025 (Saturday) the Daily Staffing Report listed 1 RN on the day shift and 2 LPNs on the night shift for a census of 67 residents.<br><br>On 11/16/2025 the Daily Staffing Report identified 2 nurses on nights and 2 nurse aides for a census of 68 residents.<br><br>On 11/19/2025 the Daily Staffing Report listed 3 nurses on the night shift and 2 nurse aides for a Census of 67 residents.<br><br>On 12/27/2025 the Daily Staffing Report did not identify an RN working that day.<br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 1/3/2026 and 1/4/2026 the Daily Staffing Report did not list an RN working either day.<br><br>On 2/5/2026 the Daily Staffing Report listed 2 day shift nurses.<br><br>On 2/6/2026 the Daily Staffing Report did not identify any RN's working that day.<br><br>A review of the Daily Schedule Reports identified the following:<br><br>1/2/2026: The DON worked on the floor from 6:00 AM- 10:30 PM. (20 hours) and returned the next morning at 6:00 AM because there was no nurse.<br><br>1/3/2026: 1 nurse was listed on the report (LPN) for the day shift from 12:00 PM- 8:00 PM. There were no additional nurses scheduled for the day shift. The DON worked from 6:00 AM-6:30 PM and was the only nurse from 6:00 AM-12:00 PM.<br><br>1/4/2026: The DON worked on the floor at 6:00 AM – 10:30 PM as the 2 day shift nurses did not start until 10:00 AM that day.<br><br>1/5/2026: There was 1 nurse scheduled to work on the night shift the DON worked from 8:30 AM- 5:00 PM as the DON and then on the floor from 6:00 PM to 10:30 PM.<br><br>A review of the Employee list identified 5 RN's that worked on the floor, and not all were full time.<br><br>A review of the undated Facility Assessment indicated it was a template that was partially completed. It provided examples of 2 staffing models one was incomplete and the other identified the following: Example 1. Evaluation of overall number of facility staff needed to ensure a sufficient number of qualified staff are available to meet each resident's needs. Refer to the guidance in the various tags that have requirements for staffing to be based on/in accordance with the facility assessment, for example, Nursing (F725). Enter number of staff needed or an average or range:<br><br>Licensed nurses providing direct care: Total number Needed or Average or Range- 3 days/2 nights can fluctuate depending on acuity.<br><br>Nurse Aides: 12.<br><br>A review of the facility policy titled, Staffing and Scheduling undated provided, Purpose: To assure adequate, competent staff is available to provide care for residents. The DON should work closely with the staffing coordinator to identify nursing staffing needs and hire nursing staff accordingly. Pulling staff to cover open positions leads to turnover and job dissatisfaction. Hiring of staff is a high priority duty and should be dispersed among nursing management. |

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| F 0807<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.<br><br>Based on interview and record review, the facility failed to provide fresh water for five residents (R11, R21, R23, R33, R37) of five reviewed for hydration and a confidential group of residents. Findings include:<br><br>Confidential Group of Residents:<br><br>On 3/2/26 a Confidential Group of Residents were together for a group meeting at approximately 3:00 PM. The Group consisted of seven Residents, all who were able to answer questions and six engaged in conversations and discussions. The group was asked about concerns with care received at the facility and the Group brought up concerns with menus not being followed. A Resident brought up the concern of not getting fresh water. One resident reported having to go to the dining room to get fresh water and that they don't change it out in their room regularly. Another resident said, They tell me to drink more water because my urine is dark, well get me water and I will drink it. It was brought up that on some weekends it is the same cup from Friday to Monday. The group expressed that when they do them, they date them and sometimes they do them in the evening and date it for the next day. It was the consensus of the whole group of it being an issue with getting fresh water passed to the rooms. It was brought up that they have complained as a group of this issue at Resident Council Meetings and the issue continues to be a problem.<br><br>A review of Resident Council Minutes revealed the following concerns/issues voiced during Resident Council meetings, of fresh water not passed, that included:<br><br>-August 2025, CNA: Fresh water still not being given to (room number) at times.<br><br>-October 2025, CNA: Water passes still a git or miss.<br><br>-November 2025, CNA: Waters still an issue-certain staff that never take care of it.<br><br>-December 2025, CNA: Water pass is still an issue with certain aides.<br><br>-January 2026, CNA: Water pass is still an issue, and some have no water in room to take medication or occasionally sip of water if needed for a cough.<br><br>Resident #23 (R23):<br><br>On 03/02/2026 at 9:49AM, during an interview with R23, a Styrofoam cup full of water was observed on the bedside table, dated 2/28/26. R23 stated the staff tells her that they run out of cups and just refill the old cups over and over. R23 stated sometimes we get fresh water, but not always.<br><br>On 03/02/2026 at 11:09AM, during an interview with R33, a Styrofoam cup of water dated 2/27/26. R33 stated that the staff tells her that they are out of Styrofoam cups, so they refill ours. R33 was asked if they get fresh water every day. R33 stated we don't always get fresh water.<br><br>On 03/03/2026 at 8:50AM, an interview was conducted with Dietary Manager F. Dietary Manager F<br>(continued on next page) |

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

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| F 0807<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | was asked who orders cups for the residents drinking water. Dietary Manager F stated that she orders cups for the kitchen and central supply orders for the rest of the building. Dietary Manager F was asked if they have heard of the facility running low on cups for the residents. Dietary Manager F stated, not recently, but in the last 6 months the staff has mentioned that they are low on cups at times.<br><br>On 03/03/2026 at 11:59AM, an interview was conducted with Central Supply EE. Centra Supply EE was asked if they order the cups for the residents. Central Supply EE stated, I do now, prior to me ordering, the kitchen wanted specific cups to be ordered. I was going through a lot of cups every week. The kitchen now orders their own lids and cups, and I order my own cups and lids now. Central Supply EE was asked if the facility was short on drinking cups for the residents. Central Supply EE stated we had an issue with not having enough cups and that was a few months ago. Central Supply EE (who also is the nurse staff scheduler) was asked if there an issue with the aides passing fresh water to the residents. Central Supply EE stated there is an issue with aides passing the water timely and there is an issue with labeling and dating water cups. Central Supply EE was asked what the current schedule for passing water to the residents is. Central Supply EE stated in the morning at 6am the residents should be getting the fresh cup and getting rid of last night's cup. Central Supply EE was asked if the aides date the water cups. Central Supply EE' stated yes, and they put the room number and the shift it was given on. Central Supply EE was asked if there is any reason why there were cups dated 2/27/26 still on the resident bedside tables? No, there is no reason, they should have been changed out. There is no reason they couldn't have new cups and fresh water.<br><br>On 3/02/2026, at 9:36 AM, during initial pool, Resident #11 was sitting in their wheelchair in their room. There was a Styrofoam cup with a date 2-22-26 handwritten on it. The resident had the cup in their hand. Nurse A was asked if they could assist with removing the lid. There was a small amount of what appeared to be pop inside. Nurse A offered they must have gotten the old cup out of their nightstand. The nightstand was open and housed 3 cans of Pepsi, a few brown bananas under what appeared to be a towel or washcloths and no Styrofoam cups.<br><br>On 3/02/2026, at 9:58 AM, Resident # 21 was in their bed with a Styrofoam cup in their hand. The cup had a dark line which appeared to be from a tea stain. There was a small amount of tea in the cup. Resident #21 was asked if they were thirsty and Resident #21 stated, I can't take a drink. I can't find a straw. There was no date on the cup. There was no other cup on the resident's overbed table and there were no straws.<br><br>On 3/02/2026, at 10:02 AM, Resident #37 was in their bed. They offered they got water sometimes and sometimes we don't.<br><br>A review of the undated HYDRATION policy provided by the facility revealed It is the policy of this facility to assist residents to maintain adequate hydration whenever possible . Assure fresh bedside drinking water is available at all times, unless contraindicated. Assist residents to periodically take a drink throughout the day . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: 1). follow CDC guidelines for management of residents with Respiratory illness for 3 residents (#22, #38 and #60) of 3 residents reviewed for respiratory illness; 2). ensure prevention of cross contamination of ice scoopers and ice containers; 3). provide a workspace that prevents cross contamination of linen; 4). follow CDC guidelines for Transmission Based Precautions and Personal Protective Equipment/PPE use during wound care for 1 resident (#45), and 5) the facility failed to have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). Findings include: Deficient Practice Statement #1:<br><br>Based on observation, interview and record review, the facility failed to: 1). follow CDC guidelines for management of residents with Respiratory illness for 3 residents (#22, #38 and #60) of 3 residents reviewed for respiratory illness; 2). ensure prevention of cross contamination of ice scoopers and ice containers; 3). provide a workspace that prevents cross contamination of linen; 4). follow CDC guidelines for Transmission Based Precautions and Personal Protective Equipment/PPE use during wound care for 1 resident (#45),<br><br>Findings include:<br><br>Infection Prevention and Control Program.<br><br>On 3/4/26 at 11:18 AM, an interview was conducted with the Infection Control Preventionist (ICP) BB regarding the facility infection control program. A review was conducted with the ICP of line listings. A review of Residents in February with upper respiratory signs and symptoms were reviewed. Resident 22 (R22) and 38 (R38) were two residents that carried over from the month before who had respiratory illness signs and symptoms with R22 having cough and congestion and R38 with a dry cough and congestion per the ICP. The ICP reported the residents did not have a fever, pains or aches and did not present with signs of the flu. The concern, if not testing for influenza with respiratory illness signs and symptoms, then may lack the opportunity for treatment, the resident may have more than one illness, and medications such as acetaminophen or ibuprofen may mask other symptoms. The ICP was unsure what their policy indicated and reported they would go with the doctor's recommendations. The ICP reported the doctor had not ordered for influenza testing. The ICP reported they had tested for Covid but not for influenza. When asked if they had an Influenza policy, the ICP reported they did not and were going to reach out to corporate for assistance. When asked if they follow CDC (Centers of Disease Control) recommendations, the ICP reported they do. The ICP referenced on her computer the CDC guidelines for testing and reported that the CDC recommended testing for influenza with respiratory signs and symptoms. When reviewing residents in December with respiratory signs and symptoms of illness, there were multiple residents listed. When asked if they had been tested for Influenza, the ICP reported they had not tested for the flu but did test for Covid.<br><br>According to the CDC (Centers for Disease Control and Prevention, https://www.cdc.gov/flu/hcp/testing-methods/nursing-homes.html, .2. Test any resident with symptoms of COVID-19 or influenza for both SARS-CoV-2 and influenza viruses as soon as possible. Symptomatic residents should be tested for SARS-CoV-2 and influenza to distinguish between COVID-19 and influenza and other respiratory viral diseases and to guide decisions about treatment and infection prevention and control measures. Because antiviral treatment for either COVID-19 or<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | influenza is indicated early in the course of illness and should be started soon after symptom onset, a symptomatic resident's antiviral treatment options should be assessed immediately. Because a resident can have multiple exposures or co-infection with SARS-CoV-2 and influenza viruses, an incorrect clinical diagnosis could result in missed opportunities for treatment and sub-optimal infection prevention measures.<br><br>Cross contamination of ice scoopers and ice containers.<br><br>On 3/2/26 a Confidential Group of Residents were together for a group meeting at approximately 3:00 PM. The Group consisted of seven Residents, all who were able to answer questions and six engaged in conversations and discussions. The group was asked about concerns with care received at the facility that included the following:<br><br>-Residents having to deal with other Residents with behaviors, staff do not watch the Residents or staff say, oh, she's ok' and 'that's just him/her' when the Resident with behaviors was having issues, wandering in rooms, interacting inappropriately, or touching things that don't belong to them. The Group reported that they were having to deal with or redirect the Residents themselves and watched as Residents play with the food of trays being set up and getting into the ice bucket and ice scooper that were in the hallways. The Group reported watching Residents getting ice from the hallway ice containers. One Resident reported seeing a resident pick their nose and has seen the same resident getting into the ice containers. The Group indicated they should not be watching over other Residents or have them touching something they will be consuming.<br><br>On 3/4/26 at 11:18 AM, an interview was conducted with the Infection Control Preventionist (ICP) BB. When asked about the hydration stations of ice in a thermal bucket with an ice scooper, how did the facility ensure residents not getting into the ice. The ICP reported that staff were supposed to send it back to dietary to be cleaned. When asked what if staff does not see the residents, the ICP stated, That is an issue and reported they used to keep them behind the nurses' station and will address a solution.<br><br>Infection Control<br><br>PPE<br><br>Resident #45:<br><br>A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: history of wound infection with multi-drug-resistant organisms, osteomyelitis (bone infection from a wound), respiratory failure, diabetes, and hypertension. 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 the resident needed some assistance with all care.<br><br>On 3/02/2026 at 10:11 AM, Resident #45 was observed lying in his bed. He said he had a sore on his bottom and the dressings to it were changed daily, usually on day shift. He said he'd had the wound for several months.<br><br>On 3/2/2025 at 4:09 PM, wound care was observed with Nurse II. The resident was in Enhanced Barrier Precautions related to a very large sacral wound (approximately 8 cm long x5 cm wide x 4 cm<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | deep) that had a history of infection with a multi-drug-resistant organism and an indwelling urinary catheter. The nurse wore gloves and an isolation gown and cleansed the wound. She removed her gloves, performed hand hygiene replaced her gloves and then packed the wound with Dakins soaked rolled gauze. She used her hands to pack the roll of gauze into the wound that had deep tunneling. She did not remove her gloves, perform hand hygiene and replace her gloves after using her fingers to pack the gauze into the wound, before applying the top dressing. Nurse II then removed her gloves performed hand hygiene and with her soiled gown on went to the treatment cart outside the room in the hallway to retrieve a marker and returned to the resident's room.<br><br>A review of the facility policy titled, Initiating Isolation, undated revealed, Purpose: Isolation precautions will be initiated when there is reason to believe that a resident has an infectious or communicable disease.<br><br>A review of the CDC/Centers for Disease Control and Prevention: Long-term Care Facilities-Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated April 2, 2024 provided, . 1. Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality. 2. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities .<br><br>Respiratory Infection<br><br>Resident #60:<br><br>A record review of the Face sheet and MDS assessment indicated Resident #60 was admitted to the facility on [DATE] with diagnoses: acute and chronic respiratory failure, COPD, atrial fibrillation, Heart failure, chronic kidney disease, history of a stroke, history of pneumonia, hypothyroidism, hypertension, and anxiety. There was no MDS assessment; the resident needed assistance with care related to weakness.<br><br>On 3/02/2026 at 2:01 PM, Resident #60 was observed sitting in a wheelchair in her room. She had oxygen via nasal cannula set at 4 liters/minute from an oxygen concentrator. The water container for humidification was empty on the concentrator. When asked about the settings for her oxygen, the resident said the facility had been changing her settings.<br><br>A record review of the physician orders identified an order for oxygen therapy for Resident #60 on 3/2/2026 at 8:00 AM, Continuous O2 @ 4L (liters) via nasal cannula. Notify MD if O2 Sat <86%, start date 3/2/2026.<br><br>On 3/2/2026 at 7:00 PM, an order was identified for Resident #60, Change in condition charting q (every) shift for 10 days. Pneumonia, (shortness of breath), lung sounds.<br><br>The resident was started on antibiotics Azithromycin on 3/2/2026 at 5:00 PM and Rocephin on 3/2/2026 at 8:00 PM; a breathing treatment on 3/3/2026 at 11:30 AM and prednisone on 3/3/2026 at 8:00 PM.<br><br>A review of the progress notes indicated Resident #60 had a cough on 3/1/2026, low oxygen saturation rates in the 80's and a chest x-ray showed she had right lung infiltrates.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Further review of the medical record for Resident #60 identified a physician's order to monitor for signs and symptoms of Covid-19 dated 2/16/2026. There was no mention of Influenza monitoring or testing for Influenza when the resident's respiratory condition declined.<br><br>On 3/4/2026 at 1:20 AM a progress note revealed, Writer notified by CNA (Certified Nursing Assistant) that resident mentioned wanting to transfer due to not feeling well. Residents O2 reassessed, stating at 76%. NP (Nurse Practitioner notified, advised giving addition breathing treatment to reach 88%. 86% reached yet not maintained dropping back down to 77%. 911 called.<br><br>A transfer note provided, Transferred out at 1:50 AM.<br><br>DPS #2:<br><br>Based on observation, interview and record review, the facility failed to have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among all residents in the facility.<br><br>Findings Include:<br><br>On 03/02/2026 at 11:00 AM observed the washing machine positioned adjacent to and facing the hopper in the laundry washer room. The door handle was situated on the side opposite the walkway, requiring staff to move past the hopper to access it. Director of Housekeeping Services (DOHS) CC stated the hopper is used frequently.<br><br>On 03/02/2026 at 1:50 PM an interview conducted with DOHS CC found it is difficult for staff to work around and load linen due to the tight space.<br><br>On 03/03/2026 at 10:14 AM an interview with Infection Preventionist (IP) BB found they were unaware of any concerns in laundry regarding hopper location. IP BB stated they did not see any concern until it was pointed out.<br><br>On 03/03/2026 at 11:43 AM an interview with DOHS CC found the washing machine has been there for the past four years.<br><br>A record review of the facility provided policy entitled Description of Steps in the Laundry Process, states It is very important to properly transport and store soiled linens to prevent the spread of infection . The laundry room must have a process in place to effectively sort soiled linen without cross contaminating clean linen .Laundry employees should be conscious of heavily soiled linens, such as blood or fecal matter. Proper handling of these linens will prevent possible exposure to bloodborne pathogens .<br><br>According to the Center for Disease Control and Prevention Guidelines for Environmental Infection Control in Health-Care Facilities dated January 8, 2024 A laundry facility is usually partitioned into (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | two separate areas – a dirty area for receiving and handling the soiled laundry and a clean area for processing the washed items.1259 To minimize the potential for recontaminating cleaned laundry with aerosolized contaminated lint.<br><br>On 03/03/2026 starting at 8:37 AM an environmental tour was conducted with the Administrator and Social Worker. The Maintenance Director was not available to participate.<br><br>On 03/03/2026 at 8:39 AM an interview was conducted with Administrator regarding the spa room and stated there has been no beautician for about three months. When asked if the spa room is used, Administrator said no.<br><br>On 03/03/2026 at 8:40 AM observed an out-of-order sign taped to the bathroom door in the front entry way. An interview at this time with Administrator found there is a leak around the toilet line and the bathroom has been out of order for two weeks. Administrator was unaware if maintenance had been flushing the sink and toilet.<br><br>On 03/03/2026 at 8:42 AM observed no water coming from sink faucet when nozzles were moved in the Main Hall med room. During this observation, Administrator was interviewed on how long it has been nonfunctional, and Administrator stated they were not sure how long it had been. Observed a plastic bin under the sink plumbing line with dried brown substance along the inner edges of container and brown streaks coming from plumbing line.<br><br>On 03/03/2026 at 8:45 AM observed a functional tub in East Hall shower room. During this observation, an interview with Social Worker (SW) AA found the shower is used but not the tub. An interview conducted at this time with the Administrator regarding whether the tub is flushed found they were unaware.<br><br>On 03/03/2026 at 8:47 AM observed a functional tub in the South Hall shower room. During this observation, when asked if the tub was flushed, Administrator stated they were unaware.<br><br>On 03/03/2026 at 8:49 AM observed a functional tub in the North Hall shower room. When the tub fixture was turned on, yellow discolored water was observed coming from the faucet for a few seconds before running clear. During this observation, Administrator asked what that was in reference to the discolored water. SW AA confirmed they saw the discolored water. When interviewed at this time on whether the tub was flushed, Administrator was unsure if the tub was flushed.<br><br>On 03/03/2026 at 8:55 AM observed a small pool of water at the base of a hopper in the North Hall hazardous material storage room. An interview conducted at this time with SW AA found the room is only used for trash and linen. Further observation of the hopper revealed the cold-water handle was turned off and the hot water line releasing a slow stream from the faucet. The flush apparatus was unable to flush, and the spray hose located next to the hopper was shut off. An interview at this time with Administrator found they were not sure if the hopper or hose was flushed and if the hose line was still connected to the plumbing main line creating a possible stagnant line.<br><br>On 03/03/2026 at 9:00 AM an interview was conducted with Administrator regarding the last time the water management team met. Administrator indicated they had not in the time they had been here and stated it may have happened before they got here in September.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/03/2026 at 10:42 AM an interview regarding the water management plan was conducted with Maintenance Director (MD) L. MD L indicated flushing is done monthly when it pops up on Tels to flush and purge all sinks. When asked if there was a flushing log, MD L indicated there is not, and it is completed when it comes on Tels.<br><br>On 03/03/2026 starting at 10:48 AM, an environmental tour was conducted with the Maintenance Director.<br><br>On 03/03/2026 at 10:53 AM observed a functional tub in the South Hall shower room. An interview at this time with MD L found the tub is flushed monthly.<br><br>On 03/03/2026 at 10:55 AM an interview was conducted with MD L regarding whether the spa room is flushed, MD L stated it is on the list for flushing.<br><br>On 03/03/2026 at 10:58 AM observed an out-of-order sign taped to the bathroom door in the front entry way. At this time MD L was asked about how long the restroom had been out of order, MD L stated they had no idea how long it has been out of order. Upon entering the bathroom, a strong odor was present in the room. When sink faucet was turned on, black particulates came out in water for a second before running clear. MD L indicated this room was not a part of flushing.<br><br>On 03/03/2026 at 11:10 AM observed a pool of yellow water at the base of the hopper in the North Hall hazardous material storage room. When MD L tried to flush, the flush apparatus was unable to flush. When the hot water handle was turned on, a slow stream was released from the faucet. During this observation, MD L indicated the cold-water faucet had been turned off due to a corroded pipeline, and indicated the hopper was on the flushing schedule. Observation of the spray hose located next to the hopper was found to be shut off. When asked at this time if the hose is flushed, MD L indicated it is supposed to be flushed. Further observation found the sink faucet discharging yellow discolored water when turned on for a few seconds before running clear.<br><br>On 03/03/2026 at 11:48 AM MD L was asked when the water management team had last gotten together to discuss the water management plan, MD L indicated, they had not in the month they had been working here.<br><br>On 03/03/2026 an interview with the Director of nursing (DON) found maintenance is responsible for bringing up water management concerns at QAPI, however, indicated they have never had a sit-down meeting to discuss water management, and that meetings regarding water management are impromptu.<br><br>A record review of the facility Legionella Water Management Program states The water management team will consist of at least the following personnel: a. The infection preventionist; b. The administrator; c. The medical director (or designee); d. The director of maintenance; and e. The director of environmental services<br><br>A record review of the facility Legionella Water Management Program states QAPI [DATE] Legionella Environmental Assessment Form completed. The Water Management Program will be reviewed at least once a year. The Program includes work orders indicating flushing schedule for various fixtures. Including: purge deadheads and bathtubs. Recommended Schedule. Every 3 months.Instructions. Purge deadheads and bathtubs per location map. Sanitize shower heads and sink aerators. Recommended Schedule. Every 3 months. Instruction. Inspect, clean, and sanitize shower heads and (continued on next page) |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | sink aerators. inspect all purge all sinks. Recommended Schedule. Monthly. Instructions. Inspect and purge all sinks in facility. Verify draining properly and look for leaks. Document findings and repair as needed or generate work order.<br><br>According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits. Eliminate dead legs, which are sections of no- or low-water flow. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235654 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Orchards at Lapeer | 239 South Main Street<br>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) |
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| F 0577<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>Based on observation, interview and record review, the facility failed to ensure that recent State Surveys and Plans of Correction were readily accessible, affecting all residents in the facility of a census of 68, resulting in residents, resident representatives, visitors and staff being unable to review the survey results and plans of correction. Findings include: Confidential Group of Residents:On 3/2/26 a Confidential Group of Residents were together for a group meeting at approximately 3:00 PM. The Group consisted of seven Residents, all who were able to answer questions and six engaged in conversations and discussions. The group was asked that without having to ask, were the results of the State inspection available to read? A couple of the Residents in the Confidential Group of Residents indicated they were unaware of there being a survey book that can be accessible to residents and family. Other Residents in the Group reported that the survey results used to be kept in a binder and kept by the front office. One Resident stated, There used to be one they could look at but it is missing. Other Residents reported they have not seen the binder available for a while now, but indicated there used to be one. On 3/3/26 at 3:22 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked where the survey book could be located. An observation was made of a wire rack on the wall by the front office. The DON indicated it was usually stored in there, but the binder was not in the wire rack and not in the vicinity of the wire rack. The DON took out other papers and reported those should not be in there. It was brought to the attention of the DON that the wire rack was higher than what can be easily accessible to a Resident in a wheelchair. The DON was unaware of where the survey binder was stored and indicated the NHA may know. On 3/4/36 at 10:32 AM, an interview was conducted with the Administrator (NHA) regarding concerns brought up in the Group meeting of Confidential Residents. The NHA was asked about the binder of recent survey results and plan of correction. An observation was made of the wire rack by the front office area without the survey binder. The NHA was informed that the wire rack, where survey results were usually kept, was not easily accessible to a Resident in a wheelchair without standing up to retrieve something out of the wire rack. The NHA reported she would have that fixed today and would try to locate the binder with survey results.A review of the facility policy titled, Resident Rights, revealed, .Resident Rights. 7. Information and communication. The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. k. The Resident has a right to- i. Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235654 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/04/2026 |
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| The Orchards at Lapeer | 239 South Main Street<br>Lapeer, MI 48446 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide Life Enrichment activities and care plan interventions for two residents (Resident #11, Resident 43) of two residents reviewed for activities, resulting in no activities provided. Findings include:Resident #43 On 3/02/2026, at 10:11 AM, Resident #43 was lying in their bed. The room was dark. The television (tv) was off. On 3/03/2026, at 8:55 AM, Resident #43 was sitting on their bed. The room was dark. The tv remained off. There was a tv remote on the over bed table. Resident #43 was asked if they wanted the tv on and Resident #43, shook their head yes. Moments later the resident closed their eyes and appeared to be resting. On 3/03/2026, at 9:10 AM, a record review of Resident #43's electronic medical record revealed an admission on [DATE] with diagnoses that included aphasia, mood disorder and stroke. Resident #43 required extensive assistance with activities of daily living and had severely impaired cognition.A review of the care plans revealed no care plan was provided for life enrichment activities. A review of the most recent LIFE ENRICHMENT ASSESSMENT was dated 10/17/2025.A review of the Activity Notes revealed the following visit dates: 2/25/2026 12/30/2025 12/9/2025 11/30/2025 A review of the Individual Needs Assessment revealed the resident liked the following activities: Observes others in common area/people watch Exercise in facility, walks, self-propels w/c Reads mail, newspapers, books, etc Watches TV Participates in in-room activity Attempt 1:1 depending on sleeping or moodOn 3/03/2026, at 10:11 AM, Nurse A was asked if they could assist Resident #43 with their tv as they had the master remote in their hand. Nurse A entered Resident #43's room. Resident #43 opened their eyes. Nurse A , while holding the master remote for the tv, stated, he has his own remote and he can turn it on himself. Nurse A left out of the room. Resident #43 was asked if they could turn the tv on and Resident #43 nodding, no multiple times.On 3/03/2026, at 10:46 AM, an observation of Resident #43's tv and tv remote with Maintenance worker J was conducted. Maintenance worker J attempted to turn on the tv with the remote with no success. Maintenance worker J offered, that the batteries must be dead, took the remote to replace the batteries. Moments later, Maintenance worker J returned to Resident #43's room and turned the tv on. Resident #43 rolled over and began to watch tv. On 3/04/2026, at 8:54 AM, Resident #43 was lying in bed facing the tv. The tv was on.On 3/04/2026, at 10:39 AM, a record review with Life Enrichment Director (LED) I of Resident #43's electronic medical record was conducted which revealed the last activity note was 2/25/2026 with no visits in January. LED I was asked if Resident #43 liked to watch tv and LED I stated, yes he does. LED I was asked how often they should provide activities for residents and LED I at least twice a week. Resident #11: On 3/02/2026, at 3:53 PM, Resident #11 was resting in bed with their wife at the bedside. Resident #11 was asked if they would like to get up and Resident #11 stated, I'd like to. On 3/3/2026, at 1:30 PM, a record review of Resident #11's electronic medical record revealed an admission on [DATE] with diagnoses that included injury of head, dementia and psychotic disturbance. Resident #11 required extensive assistance with all activities of daily living and had severely impaired cognition. A review of the ACTIVITIES: I will pivot more towards person-centered 1:1 or self-directed activities that honor my needs and autonomy and quiet Date Initiated: 01/26/2026 . Interventions I do enjoy watching sports and my favorite is golf . I do like to watch TV and movies and keep up with news . I wish to visit with pets when present in the building . It is important for my wife to be involved in discussions about my care . My wife visits weekly . On 3/04/2026, at 1:07 PM, LED I was interviewed regarding Resident #11's activity preferences. LED I provide his wife visits weekly.A record review of the activity notes revealed no activities had been provided since admission. And LED I offered, they will do the education for not seeing this resident. A review of Life Enrichment Programming Overview January 2020 revealed the facility shall provide for an ongoing program of activities designed to meet, the interests and physical, mental, and psychological well-being of each resident . Each resident's Life Enrichment plan should be planned<br>(continued on next page) |

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| The Orchards at Lapeer | 239 South Main Street<br>Lapeer, MI 48446 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | around the resident's goals for his/her own life. Residents who prefer to pursue their own activities should be monitored to assure their mental and psychological needs are being met . The resident's comprehensive assessment, care plan, Life Enrichment progress notes, and Life Enrichment attendance records shall identify individual resident history, needs, interests and capabilities, degree of participation, and outcomes/responses to Life Enrichment interventions . |

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

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement interventions to prevent the development of a pressure injury for one resident (R29) of four residents reviewed, resulting in a blister developing and eventually opening. Findings include:Resident #29 (R29): R29 admitted to the facility on [DATE] with diagnoses that include hemiplegia affecting the left side, type 2 diabetes mellitus and hemiparesis following cerebral infarction. R29 has a brief interview for mental status (BIMS) score of 15, indicating she is cognitively intact. On 03/02/2026 at 12:45PM, an interview was conducted with R29. R29 was asked if she had any issues with her skin. R29 stated that she has a blister on her left heel that developed at the facility. R29 says she needs a new pair of heel boots, R29 feels the ones she has aren't in good shape anymore. Observation revealed two heel boots sitting on top of the closet in the room. On 03/03/2026 at 1:52PM, record review revealed a Braden Scale assessment was completed on 12/9/25 with a score of 16, indicating R29 was at mild risk for developing pressure injuries. R29 is noted to be a problem with friction and shear due to needing assistance with bed mobility. A care plan was present in the medical record, titled, I need assistance with my activities of daily living (ADL) related to left sided weakness. I often refuse to assist with my care and completing tasks I am able to complete. Dated 06/25/2025. Interventions include Bed Mobility: I am dependent on staff to turn and reposition me frequently while I am in bed. Date initiated 06/25/2025, last revised on 07/11/2025. Another care plan is present titled, I have limited physical mobility related to left sided weakness. dated 06/25/2025. On 03/04/2026 at 10:27AM, an interview was conducted with Wound Care HH. Wound Care HH was asked about the left heel blister on R29. Wound Care HH stated that R29 currently has an open blister on the left heel. Wond Care HH stated, this blister is not new, we had it closed before and it reopened. Wound Care HH stated the blister was acquired here in the facility on 1/12/26 and we resolved it two weeks later. Wound Care HH was asked how the blister initially developed. Wound Care HH stated, we try to keep the heel boots on her, she had heel boots on her at the time it developed. Wound Care HH was asked if the facility is floating R29's heels. Wound Care HH stated, R29 will float her heels, and we try to keep the boots on her as well. It reopened again recently, staff noted the fluid filled blister on her heel, it popped open in the shower, we started to treat it with betadine and Dr. [NAME] saw her the next time he was here. I do rounds every Tuesday with the doctor, I update care plans as needed, as treatments change and as wounds resolve. Wound Care HH was asked if they though there were enough interventions in place to prevent the blister from forming. Wound Care HH stated, yes, she has a low air loss mattress in place and we try to keep the boots on her, but in the morning, I will notice she has them off, we try to get her out of bed, she works with restorative so we get her out of bed for that. We do all that we can to keep the pressure down. I don't believe it was a pressure injury; it was a fluid filled blister; we had interventions in place. The current treatment in place is padded and helps prevent friction in any way. On 03/04/2026 at 11:18AM, record review revealed a care plan is in place for the left heel blister. The care plan is dated 01/12/26 and indicates that a left soft heel boot was put in place on 1/8/26. The care plan intervention for the left soft heel boot being on at all times, was resolved on 02/11/2206. There were no heel boots in place prior to the development of the left heel blister. On 03/04/2026 at 11:37AM, record review revealed a weekly head to toe skin assessment dated [DATE], that there as a pressure injury on the left heel 4cmx4cmx0cm in size, suspected deep tissue injury (SDTI) and that a left heel boot as applied. On 03/04/2026 at 11:43AM, a weekly head to toe skin assessment, dated 2/18/2026 revealed the left heel blister had opened up again. On 03/04/2026 at 12:09PM, an interview was conducted with the Director of Nursing (DON). The DON was asked about the left heel blister on R29. The DON stated that on 1/8/26, when I saw the left heel, it was a SDTI. When I saw it, it was dark and purple and not fluid filled. By the time the doctor saw it, it could have changed to a fluid filled blister. The DON was asked how they thought the SDTI developed. The DON stated that R29 is<br>(continued on next page) |

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| | 235654 | A. Building<br>B. Wing | 03/04/2026 |

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| The Orchards at Lapeer | 239 South Main Street<br>Lapeer, MI 48446 |

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|---|---|
| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | prone to having that area open on and off because R29 rubs her left foot back and forth on the bed. On 03/04/2026 at 12:14PM, an interview was conducted with R29. R29 was asked for additional information on her left heel pressure area. R29 states the purple spot on her heel developed from resting on the bed and then it turned into a blister. R29 was asked if they were wearing heel boots or if the staff was keeping her heel elevated prior to the blister developing. R29 stated, no, they didn't give me the boots until the blister developed and they didn't elevate my heels either. I have a hard time getting the staff to put the boots on. R29 was asked if they have ever refused to wear the boots. R29 stated, no, I have never refused to wear them even though they can make my feet hot. R29 stated, I have been told I refuse a lot of things that I never have. On 3/04/2026 at 12:20PM, an interview was conducted with Certified Nursing Assistant (CNA) D. CNA D was asked if R29 has ever refused to wear heel boots for you. CNA D stated, no, she has not refused for me. The night shift tells me that she will refuse sometimes, I noticed they were not on this morning when I got here, I am not sure if she refused or the boots just weren't applied. CNA D stated that R29 says the boots make her feet hot, so I leave them open on the top and she never has an issue with that. Review of the Policy Titled, Pressure Ulcer Preventative Measures, revealed:Policy:Residents at risk for the development of pressure ulcers receive interventions to reduce the risk of pressure ulcers.Procedure:11. As needed, use lubricants, protective films (transparent film dressings and skin sealant), protective dressings (hydrocolloid), and/or protective padding to reduce friction injuries. Obtain a physician order as needed.16. For residents in bed, who are completely immobile, use devices that relieve pressure on the heels, most commonly by raising the heels off the bed. Use pillows under the length of the lower leg, suspending the heels. When using a specialty support surface, follow manufacturer's instructions. |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to properly assess and identify the need for podiatry services for one resident (Resident #10) of 1 resident reviewed for foot care, resulting in resident frustration, the development of long, curved toenails, discomfort and delay in needed treatment. Findings include: Resident #10: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #10 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Diabetes, Chronic peripheral venous insufficiency, hypertension, and paranoid schizophrenia. The MDS assessment dated [DATE] indicated the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and the resident needed assistance with lower body care including personal hygiene. On 3/02/2026 at 10:50 AM, Resident #10 was observed lying in bed awake. She said she had some problems with her feet and lifted her sheet to show her feet. Her toenails were very long, some curled over the ends of her toes, chipped and breaking. The resident said she did not know when the last time her toenails were trimmed. When asked if she wanted someone to trim her toenails she responded, Yes, please. In addition, the resident was observed to have several large, scabbed areas on her lower right leg, one was approximately 1 cm x 1cm and the other was approximately 2 cm x 1 cm with several smaller scabs surrounding it. A record review of the Care Plans for Resident #10 identified the following: I need assistance with my ADL's (activities of daily living) r/t (related to) weakness, diabetes, venous insufficiency. dated initiated 7/23/2025 and revised 3/2/2026 with Interventions including: I need (1 person assistance) from you with personal hygiene and oral care, date initiated 7/23/2025 and revised 8/29/2025. I have Diabetes Mellitus, date initiated 7/23/025 and revised 9/19/2025 with Interventions including: Check my whole body for breaks in skin and treat me promptly as ordered by my doctor, initiated 7/23/2025; Refer me to the podiatrist to monitor/document foot care needs and to cut long nails, date initiated and revised 7/23/2025. A review of the Kardex for Resident #10 indicated there was no mention of nail care or toenail care for the resident. A review of a Social Services note dated 7/17/2025 provided, Resident added to podiatry. A review of a Podiatry Group note dated 12/30/2025 indicated the resident was seen by the Podiatrist on this date and her toenails were trimmed. The note included an entry titled, Recall: As medically necessary but no sooner than 60 days. On 3/4/2026 at 9:25 AM, Nurse Aide K was interviewed in Resident #10's room about the resident's toenails. Resident #10 was lying in bed, when asked if her toenails could be observed she said yes and the Nurse Aide lifted the bed sheet. Resident #10 was observed to have several bloody, open areas on her lower right leg and there were 2 large pieces of broken off toenails lying on her bottom bed sheet; each piece was approximately 1.5 cm long x 0.5 cm wide and 1 piece was lying near the toes of the left foot and right foot. When asked about the broken pieces of toenail, the resident said she was not aware of it. Nurse Aide K asked the resident if she could soak her feet and the resident stated, Yes. The Nurse Aide provided a warm clean washcloth to the toes on each foot and the resident stated, Oh, that feels good. On 3/4/2026 at 10:30 AM, the Director of Nursing and Social Services AA were interviewed about Resident #10's toenails. Social Services AA said the resident was on the list to be seen by the Podiatrist on 3/9/2026 and had been seen on 12/30/2025. The Director of Nursing/DON said the resident could be seen sooner and the 60 days was based on billing for the service. She asked the Social Services AA to request the resident to be seen more often. The DON was asked about the resident's last skin assessment, and she said it was completed 3/3/2026. There was no mention of the scabs or bleeding areas on the resident's lower right leg or the resident's toenails that were in need of trimming, as they were broken and growing over some of the resident's toes. The Social Services AA said the staff had not mentioned to him that the resident's toenails needed to be cared for sooner than every 60 days. The DON said someone should have identified the resident's toenails needed to be trimmed and they would take care of it. |

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| NAME OF PROVIDER OR SUPPLIER: The Orchards at Lapeer | | STREET ADDRESS, CITY, STATE, ZIP CODE: 239 South Main Street Lapeer, MI 48446 | |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2679077. Based on observation, interview and record review, the facility failed to provide supervision for one resident (Resident #14) of three residents reviewed for accidents, resulting in a resident-to-resident altercation. Findings include: Resident #14 (R14):<br><br>R14 admitted to the facility on [DATE] with diagnoses that include cognitive communication deficit, dementia, unspecified psychosis and paranoid personality disorder.<br><br>On 03/02/2026 at 1:26PM, an interview was conducted with daughter GG of R14. Daughter GG was interviewed about the resident-to-resident altercation her mother had with another male resident. Daughter GG stated, my mom had only been here about two weeks at the time and another resident hit her. Daughter GG' stated my mom had wandered into his room, he was startled and he hit her. Daughter GG stated she was told that the resident that did it knew better, but it still happened. Daughter GG stated it would be very difficult to prevent these kinds of events unless residents are on one-on-one supervision at all the times. An interview was attempted with R14, however, due to her confusion she had no recollection of the incident.<br><br>On 0302/2026 at 2:00PM, review of a Facility Reported Incident (FRI) revealed that R14 was involved in a resident-to-resident altercation with another resident that resulted in R14 being struck in the face. Through investigation, the facility determined that R14 entered the room of another resident, startled him and resulted in the male resident striking R14 in the face. On 11/15/25 at approximately 4:47am an unwitnessed altercation occurred between R14 and a male resident. Prior to the incident R14 was out in the hallway, looking for her room. According to staff statements about the incident, no staff was present at the time of the incident.<br><br>On 03/03/2026 at 10:12AM, a Wanderguard was noted to the right ankle of R14. R14 is observed self-propelling around the facility independently and not monitored.<br><br>On 03/03/2026 at 10:20AM, review of progress notes for R14 revealed she has a history of going into other resident rooms. A behavior note dated 11/5/2025 at 05:44AM, revealed R14 was showing signs of behavior during the shift. Resident kept wandering in other resident's rooms trying to get inside of the bed with them. Resident was redirected multiple times throughout the night. Resident proceeds to wander and had aides/nurse rotating on watching her one-to- one throughout the night.<br><br>On 03/03/2026 at 12:47PM, an interview was conducted with Social Work (SW) AA. SW AA was asked if R14 receives psych services in the facility. SW AA stated, she was, I believe they see her quarterly now. SW AA' was asked if they provide any psychiatric care for R14. SW AA stated, I try to stop in weekly to see her and see if she has any needs. Most of her behaviors are at night so I miss a lot of those. SW AA' was asked if there has been any consideration of one-to-one care or seeking out alternate placement. SW AA stated I spoke with the daughter yesterday about possibly moving her to another facility in the area that has a secure unit. The daughter said she would consider this; she would just like to speak with the family first and see if everyone else agrees. SW AA was asked if there has been consideration for a one-to-one observation. SW AA stated, I spoke with the administrator and she said no, this is due to staffing and how small we are as a building. SW AA stated I try to keep her (R14) with me all day, but she does go off on her own.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 03/03/2026 at 1:26PM, R14 was observed exiting room [ROOM NUMBER] (not her room) and closing the door, no staff is present. R14 was then observed entering room [ROOM NUMBER] (not her room), staff intervened and redirected her out of the room.<br><br>On 03/04/2026 at 10:01AM, an interview was conducted with the Director of Nursing (DON). The DON was asked about the incident between R14 and a male resident. The DON stated that on 11/15/25, R14 went and opened the room door of R74. R74 got up and walked to the door and hit her in the face. There was an aide nearby, but it was not witnessed. I was notified immediately of this incident and came to the facility. The staff immediately tended to R14 and brought her up to the front of the building. At the time there was no bruising, then bruising developed.<br><br>On 03/04/2026 at 2:15PM, R14 was observed reaching her hand out to another resident passing by her, this resident refused her handshake, at this time R14 turned around and followed the resident into the dining room. Upon entering the dining room R14 approached the resident who did not want a handshake, at this time, the staff present intervened and redirected her out of the dining room on her own.<br><br>On 3/02/2026, at 11:36 AM, during dining observation, there were multiple residents sitting at tables. There were no CNA's nor nurses in the dining room. The double doorway into the kitchen hallway was closed. The single doorway into the kitchen behind the steam tables was open. There was no kitchen staff in the dining room. Resident #14 was observed in their wheelchair wandering around the dining room. Resident #14 entered the area near the steam tables and entered the kitchen. Surveyor followed behind Resident #14 into the kitchen where kitchen staff N' stated, (Resident #14) you can't be in here and assisted the resident backwards out of the kitchen. While Resident #14 was behind the steam tables, multiple residents were calling out Resident #14's name and yelling you can't be there hey, got out of there. Kitchen staff N then placed the rolling silverware cart in a manner that blocked the area behind the steam tables.<br><br>At 11:49 AM, Resident #14 remained wandering throughout the dining room with no staff in the area. Resident #14 propelled up to a female resident and then wandered up to a male resident and stood still without speaking. Then Resident #14 propelled across the dining room up to another male resident and stopped with their knees touching the male resident's knees. Both residents did not speak to each other.<br><br>At 11:51 AM, Resident #14 propelled to the back of the dining room and sat near another male resident. Resident #14 had a scowl on their face. There were alert residents (Resident #19 and Resident #41) sitting at a table. The residents were asked if they have ever observed other residents pick on Resident #14. Both residents offered, sometimes the guys pick on her. Dietary Manager (DM) E entered the area at this time. Resident # 41 offered, the other day she got mad at me, right (DM E) with DM E responded, she can get agitated.<br><br>At 11:53 AM, the Director of Nursing (DON) entered the dining room with another staff member and was approached by Resident #14.<br><br>At 11:54 AM, the DON and staff member exited the dining room.<br>(continued on next page) |

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

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At 12:10 PM, Resident #14 remained wandering about in the dining room in their wheelchair. There were no nursing staff in the dining room. Resident #14 propelled to the back of the dining room and Resident #14's Family Member H entered the dining room looking for Resident #14. Family member H introduced themselves as they looked on and observed Resident #14.<br><br>At 12:12 PM, Resident #14 propelled to a table in-between Resident # 19 and Resident #41, picked up a purse of Resident #19's. Both Resident #19 and Resident #41 grabbed onto the purse as Resident #14 struggled to pull it away. At this time, Family Member H walked quickly to Resident #14 and stated, you can't take her purse. The purse was pulled in a strong manner out of Resident #14's hands.<br><br>AT 12:13 PM, There were still no nursing staff in the dining room.<br><br>On 3/02/2026, at 1:00 PM, The DON was made aware of the above.<br><br>On 3/04/2026, 9:30 AM, Resident #14 was observed in the hallway near room [ROOM NUMBER]. Resident #14 entered a male residents' room where two male residents were in their beds. There was a family member visiting. Resident #14 propelled up to the visitor, sat for a moment, then turned and left out of the room. Family member G offered, she comes in all the time and just stares. They offered they say hi and then she just leaves out. Resident #14 quickly propelled down the hall into room [ROOM NUMBER] where a staff member quickly pulled the resident backwards out of the room and stated, oh you don't want to go into that room. The staff member left the area.<br><br>On 3/04/2026, at 9:37 AM, Resident #14 entered room [ROOM NUMBER] for a moment, backed out and went down towards East Hall where they sat near the Medication cart where a nurse was standing.<br><br>At 9:41 AM, Resident #14 propelled toward the exit door and entered room [ROOM NUMBER]. The nurse remained standing at the medication cart which was facing the wall.<br><br>At 9:42 AM, CNA M entered room [ROOM NUMBER] with bed linen. Resident #14 was sitting quietly. CNA M assisted Resident #14 out of the room and asked Resident #14 if they could help with anything. Resident #14 offered, they needed a bathroom. CNA M assisted the resident to the bathroom. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide necessary care of an indwelling urinary catheter for 1 resident (Resident #45) of 2 residents reviewed for urinary catheters, resulting in a lack of documentation of catheter care and an observation of the resident's catheter lying flat on the floor. Findings Include: Urinary CatheterResident #45:A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: history of wound infection with multi-drug-resistant organisms, osteomyelitis (bone infection from a wound), sacral wound, respiratory failure, diabetes, and hypertension. 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 the resident needed some assistance with all care.On 3/02/2026 at 10:26 AM, Resident #45 was observed lying in bed in his room. An indwelling urinary (foley) catheter was observed hanging on the side of the bed with sediment in the tubing. The resident said he had had the catheter and a colostomy for approximately 2 months after he was hospitalized .On 3/2/2026 at 4:09 PM, during a wound care observation for Resident #45 with Nurse II the resident's foley catheter was observed lying flat on the floor; it was not hanging from the side of the bed to ensure urine could flow freely into the bag, or to prevent contamination from the floor.A review of the physician orders for Resident #45 identified the following: Foley catheter care q (every) shift and prn (as needed) per protocol, every day and evening shift, start date 12/20/2025. Foley Catheter type: 16 FR Balloon size: 10cc Change catheter every 30 days as needed, Check q shift, every day and evening shift, start date 12/20/2025. Foley output q shift, every day and evening shift, start date 12/20/2025.A review of the Medication Administration Record and Treatment Administration Records identified the following:Treatment Administration Record February 2026: Foley catheter care q shift and prn per protocol every day and evening shift for foley, there were 8 days missing documentation that the foley catheter care had been completed, this included 7 times on nights and 2 times on day shift.Treatment Administration Record February 2026: Foley catheter type: 16 FR Balloon size: 10cc change catheter every 30 days as needed, Check q shift, every day and evening shift for wound, there were 10 missing entries for documentation that the foley catheter had been checked, 7 on night shift and 3 on day shift.Treatment Administration Record February 2026: Foley output q shift, every day and evening shift for foley, there were 12 days missing documentation that the foley catheter output was identified, 10 entries on night shift and 4 on day shift.The urinary catheter care and urinary output for Resident #45 was not consistently documented as completed.On 3/4/2026 at 10:55 AM, during an interview with the Director of Nursing/DON about Resident #45's foley catheter, the missing documentation of catheter care and urinary output was reviewed. The DON said the catheter care should have been completed and documented, and the urinary output should have been recorded every shift.A review of the facility policy titled, Indwelling Catheter Care, undated provided, Purpose: Routine catheter care helps prevent infections and other complications, and is usually performed daily. Inspect the catheter and tubing periodically to detect compression or kinking that could obstruct urine flow. Empty the collection bag at least every 8 hours. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that residents received pain medication in a timely manner and as ordered for 1 resident (Resident #2) of 1 resident reviewed for pain management. Findings Include: Pain Management Resident #2:A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #2 was admitted to the facility on [DATE] with diagnoses: History of a stroke, Diabetes, hypothyroidism, hydronephrosis, urinary stents, history of digestive surgeries, GERD, chronic sinusitis, right foot drop, sacral pressure ulcer, history of urinary tract infections, bronchitis, and hypertension. 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 assistance with some activities of daily living.On 3/02/2026 at 11:50 AM, Resident #2 was observed lying in bed. She said she was newer to the facility and stated, When I first got here, they didn't have my pain medication, and I had to wait over 24 hours to get it. The resident was asked if the pharmacy had delivered her medication and she stated, They said it is out of state. The resident was asked if she received any type of pain medication after she was admitted and she said the facility said they had Tylenol, but that didn't work well for her. Resident #2 said she kept asking for pain medication and she could not sleep because of the pain. Resident #2 said she had been taking a different pain medication at another facility prior to arriving at the facility. She said she was now receiving the pain medication.A record review of progress notes for Resident #2 indicated she was admitted to the facility at approximately 5:30 PM on 2/13/2026.A record review of the Physician orders for Resident #2 identified the following:An order for Acetaminophen/Tylenol dated 2/13/2026 at 6:35 PM.An order for Tramadol dated 2/14/2026 at 4:41 PM.An order for Norco tablet 5-325 mg, dated 2/18/2026 at 1:03 PMA review of the Medication Administration Records/MAR's for Resident #2 identified the following:She received one dose of Acetaminophen/Tylenol 650 mgs on 2/15/2026 at 3:45 PM. She didn't receive any Tylenol prior to or after this date.Tramadol HCl Tablet 50 mg every 4 hours as needed for moderate and severe pain: The resident received the first dose of Tramadol on 2/14/2026 at 9:42 PM for a pain level of 6/10. She received a total of 6 doses over a 5-day period (2/14/2026 to 2/18/2026). This was the first dose of pain medication the resident had received since she was admitted on [DATE] at 5:30 PM: approximately 28 hours after admission.Norco tablet 5-325 mg, give 1 tablet by mouth every 8 hours as needed for moderate pain. This was ordered on 2/18/2026 and the Tramadol was discontinued on 2/18/2026. The resident received the first dose of Norco on 2/22/2026.During a review of the transferring facility documents including the medication list for Resident #2, it was identified that the resident had been receiving Tramadol 50 mg every 4 hours as needed prior to being admitted to this facility.A review of the Nursing admission Assessment with Care Plan for Resident #2, indicated the assessment was started by the nurse on 2/14/2026 at 2:14 AM: approximately 9 hours after the resident was admitted . A review of the Pain section of the assessment, revealed it was initiated at 2:32 AM on 2/14/2026, approximately 9 hours after the resident was admitted . The question Does the resident have the presence of Pain? was documented Yes.On 3/03/2026 at 12:05 PM Nurse HH was interviewed about resident's who were newly admitted . Nurse HH was asked how long it took to receive the resident's medications, and she said if the pharmacy was notified of new orders that day, they could deliver them that evening or early the next morning. The Nurse was asked if some medications were available in the facility's back up medication dispensing system and she stated, Yes, some were available.On 3/3/2026 at 12:15 PM the Director of Nursing/DON was interviewed about pain medication availability in the medication dispensing system. She said both Tramadol and Norco should be in there. Upon a tour of the medication room containing the Medication Dispensing machine, the DON said Tramadol 50 mg and Norco 5/32/5 mg were both in the backup. The DON was asked how long after admission a resident should have to wait to receive pain medication, she said it would take about 3 hours to process the orders, send them to the<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | physician for signature and then send the order to the pharmacy. The DON was asked if it should take over 24 hours and she said it should never take that long.On 3/03/2026 at 12:23 PM, Resident #2 was interviewed in her room; she said she had previously taken Tramadol, and it was working for her, then the doctor changed it to Norco. She said she was still upset she had to go through being in pain for so long.A review of the Care Plan for Resident #2 identified a Pain care plan dated 3/14/2026: I have the potential for pain/discomfort r/t (related to) generalized weakness and wounds, date initiated 2/14/2026 and revised 2/16/2026 with one Intervention: Observe/report my complaints of pain or requests for pain treatment, dated 2/14/2026. There was no mention of providing pain medication or any type of pain management for the resident.A review of the facility policy titled, Pain Management undated provided, The facility will assess and identify residents experiencing pain, determine the type and severity of the pain and develop a care plan for pain management. The care plan is implemented and continually evaluated for its effectiveness. The staff monitors and documents the resident's response to pain management interventions. A Pain Evaluation must be completed: a. Upon admission. |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Post nurse staffing information every day.<br><br>Based on observation, the facility failed to provide an updated daily staffing report, resulting in a four-day old staff list and the inaccessibility for residents, visitors and staff to what staff was working. Findings include. On 3/02/2026, at 9:05 AM, a record review of the DAILY STAFFING REPORT hanging on the wall in the main entry was conducted. The report was dated 2/26/2026 |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>Based on observation, interview and record review, the facility failed to provide listed menu items to dining room residents, resulting in no bread offered for the lunch meal, and frustration voiced by a confidential resident group. Findings include.Confidential Group of Residents:<br><br>On 3/2/26 a Confidential Group of Residents were together for a group meeting at approximately 3:00 PM. The Group consisted of seven Residents, all who were able to answer questions and six engaged in conversations and discussions. The group was asked about concerns with care received at the facility and the Group brought up concerns with menus not being followed. A Resident brought up the concern that menu items were substituted without letting the Residents know. Two Resident voiced they don't get a menu and that there used to be someone dedicated to do the menu with you but now they are gone. One Resident stated, The menu will say one thing and you don't get it. They replace it with something else, and gave an example that they were going to have scalloped potatoes, and we got mashed potatoes instead, they didn't let us know, it just showed up as mashed potatoes and expressed disappointment. Four residents out of the group had concerns and it bothered them that the menu items were not followed.<br><br>On 3/03/2026, at 12:02 PM, during lunch meal observation in the main dining room, all residents that were sitting at dining tables were served their lunch meals. There was no bread offered to any resident. And not all the residents had the dessert of peach cobbler. An alert resident offered that the menu for the day hangs on the wall outside the dining room.<br><br>On 3/03/2026, at 12:10 PM, a record review of the menu for the lunch meal revealed Lunch Seasoned Baked Fish Parmesan Pasta Normandy Blend Vegetables Bread/Margarine Fruit Cobbler Beverage.<br><br>On 3/03/2026, at 12:10 PM, a confidential staff member offered that the residents get the bread and butter sometimes but not always when it's on the menu. An alert confidential resident was asked if they wanted bread and they stated, yes. The resident was asked if the facility offered the bread which was on the menu and the resident stated, sometimes.<br><br>On 3/03/2026, at 12:28 PM, Dietary Manager (DM) E was standing behind the steam tables and was asked if the facility had bread. DM E stated, yes. DM E was asked why the bread was not offered to the residents in the dining room and DM E responded, was it on the menu. [NAME] O who was serving the food quickly offered, they forgot. [NAME] O was asked if it was their responsibility to provide the bread and [NAME] O stated, yes. |

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| F 0847<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.<br><br>Based on interview, the facility failed to explain arbitration agreements in a manner that could be understood for four residents (R2, R27, R42, R70) of four residents reviewed for arbitration agreements, resulting in confusion about the agreements that were signed and feelings of regret for signing the agreement. Findings include:On 03/04/2026 at 2:36PM, an interview was conducted with Social Worker (SW) AA. SW AA stated that he is responsible for getting admission paperwork completed at the facility, this includes completing arbitration agreements with the residents. SW AA was asked how long they have been responsible for getting admission contracts and arbitration agreements completed. SW AA stated they have been doing admission contracts and arbitration agreements since February 20, 2025. SW AA was asked how he explains arbitration agreements to the residents. SW AA' stated that they first ask the resident if they understand what arbitration is. SW AA then stated that whether they say yes or no, I still explain to the agreement to them. SW AA' stated, I explain that it is our way of trying to resolve an issue with a mediator before it goes any further. I also tell the residents that it is not necessary to sign the agreement to be admitted to the facility. On 03/04202 at 3:00PM, SW AA provided four signed arbitration agreements from recent admissions to the facility. On 03/04/2026 at 3:02PM, an interview was conducted with R2. R2 was asked about the arbitration agreement she signed on admission and if it was explained in a way that she could understand it. R2 stated she used to be a legal secretary. and that she has a previous knowledge of arbitration agreements but didn't feel the facility representative explained it very well to her. R2 then stated, I probably shouldn't have signed it, but oh well. R2 then stated they still have a few days to cancel the agreement. On 03/04/2026 at 3:11PM, an interview was conducted with R70. R70 was asked about the arbitration agreement he signed on admission and if it was explained well to him. R70 stated he had no recollection of signing an arbitration agreement and did not know what it was for. On 03/04/2026 at 3:15PM, an interview was conducted with R42. R42 was asked about the arbitration agreement she signed upon admission. R42 stated they don't remember signing the agreement. R42 stated she wasn't sure what the agreement was and wanted this surveyor to explain it to her. This surveyor suggested that R42 have the facility explain it to her again. On 03/04/2026 at 3:56PM, an interview was conducted with R27. R27 was asked about the arbitration agreement she signed and if it was explained to her. R27 stated that she was not aware of what the arbitration agreement was. R27 stated that usually her daughter would help her with things like that. On 03/04/2026 at 3:59PM, an interview was conducted with SW AA. SW AA' was made aware of the resident interviews and their confusion about arbitration agreements. SW AA stated that I typically have residents sign paperwork on admission. But maybe I should give them more time to adjust to the facility and have them sign the agreement the next day when things settle down a bit. |