STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235555	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Canterbury on the Lake	5601 Hatchery Road Waterford, MI 48329

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2698293Based on interview and record review, the facility failed to ensure proper positioning and to maintain proper bed mobility for one (R701) of two residents reviewed for accidents resulting in R701 falling out of bed during activity of daily living [ADL] care and being transferred to the hospital. Findings include:A complaint was filed with the State Agency [SA] that alleged in part, .Monday morning, 12-15-2025, [R701] called. and stated that he had soiled himself and couldn't any [sic] help. Minutes later he called. and stated that he was on the floor, hurt his right foot and that the aide was just standing there. the aide lowered the bed and told him he could crawl up into bed himself, which he did. he had rolled out of the bed and fell on the floor while the aide was providing care. He stated that he told her that he was falling and she did nothing.Review of the closed record revealed R701 was admitted into the facility on [DATE] with diagnoses that included: nondisplaced trimalleolar [ankle] fracture of right lower leg, fracture of shaft of right fibula [lower leg] and anxiety disorder. According to a Brief Interview for Mental Status [BIMS] exam dated 12/13/25, (R701) scored 10/15 indicating moderately impaired cognition.Review of R701's ADL care plan initiated 12/13/25 revealed an intervention that read, BED MOBILITY: I require 1 person extensive (assistance) by staff to turn and reposition me frequently while in bed.Review of R701's progress notes revealed a Nurses Note dated 12/15/25 at 8:24 AM by Licensed Practical Nurse [LPN] ‘A' that read in part, Resident stated that during ADL care, Cena [Certified Nursing Assistant] asked him to roll over to his left side and in doing he slid to the floor while still on top of his mattress. Resident continued stating that he assisted himself off the floor and back onto the bed. Cena verified. called EMS [Emergency Medical [NAME]] to transfer him to the hospital. Verbal education was reinforced to Cena on proper positioning and safety when providing ADL care.On 1/20/26 at 9:26 AM, LPN ‘A' was interviewed via phone and asked about R701 falling out of bed. LPN ‘A' explained CNA ‘B' came and told him R701 had slid out of bed when she was trying to change him. when he got to R701's room, he was half in and half out of the bed, he tried to help him, but R701 told him he could do it himself. LPN ‘A' was asked if he had asked R701 what had happened. LPN ‘A' explained R701 said CNA ‘B' did not help him when he was sliding out of the bed or on the floor.On 1/20/26 at 9:46 AM, CNA ‘B' was called and a voicemail left. At 12:50 PM, the Administrator was asked to help in contacting CNA ‘B'. At approximately 1:0 PM, the Administrator explained both she and the Director of Nursing [DON] had left voicemails for CNA ‘B'. No return call was made prior to the end of the survey. On 1/20/26 at 11:35 PM, the Administrator and the DON were interviewed and asked about R701's fall. The Administrator explained they had investigated the incident and determined it resulted from improper bed mobility technique and insufficient positioning safeguards at the time of care. The Administrator further explained CNA ‘B' had received 1:1 education.Review of a Work Performance/Work Rules Disciplinary Action Record dated 12/15/25 revealed CNA ‘B' received a Written Warning #1 for Staff received (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	education regarding safe bed mobility. Refused to sign was written on the line for Employee's Signature [CNA 'B'] and was signed by the DON on 12/15/25.Review of a facility policy titled Bed Mobility undated, read in part, .Fundamental Information: Guidelines for instructing the resident: Give clean and concise directions. Use short, direct sentences.; Movements should be performed slowly to allow the resident to optimally assist in the activity.; Slow, small movements help prevent injury to the resident and the staff member's back.; Be consistent. Consistent performance of an activity helps avoid confusion, facilitates the resident's learning, and allows the resident to maximally assist with the activity.During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included staff re-education, equipment review, and enhanced monitoring. Systemic changes were put in place to mitigate risk and prevent recurrence for residents during an Ad Hoc Quality Assurance and Performance Improvement [QAPI] meeting. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.