STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235014	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Redford	25330 West Six Mile Road Redford, MI 48240

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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to submit mandatory staffing data (direct care staffing information) to Centers for Medicare and Medicaid (CMS) based on the Pay Roll Based Journal (PBJ) data, affecting all 72 residents who resident in the facility. Findings include: Per a review of the PBJ report for the Fiscal year 2026 1st quarter (July1,2025- September 30,2025). The facility also triggered for a one star staffing rating (indicating a lack of reported staffing or inadequate staffing). On 4/9/6 at 12:30 pm in an interview with Staffing Scheduler F and Human Resources (HR) Director L about the PBJ report and submission. HR L stated The facility failed to submit their quarterly staffing numbers to CMS due to a clerical error. No explanation was provided related to the specifics of the clerical error.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP), to include flushing all inactive fixtures to eliminate stagnation, resulting in the potential for increased risk of respiratory infection among all residents in the facility. Findings include: On 4/8/26 at 9:30 AM, Maintenance Supervisor I was queried regarding the facility's Water Management Program. Maintenance Supervisor I stated they test annually, water temps done daily, flushing of unused fixtures is done by environmental services, and that the building has been checked for plumbing dead legs. On 4/8/26 at 10:00 AM, the shower room located on the [NAME] Hall was observed with a sign posted on the door that the room was not in use. The door to the shower room was observed to be locked. Maintenance Supervisor I stated he would have to find the key to unlock the door. Maintenance Supervisor I searched for a key to unlock the door to the unused shower room for approximately 30 minutes and eventually had to use a drill to drill through the lock to access the unused room. Maintenance Supervisor I stated that the water to the unused shower room had been shut off. There was a wall mounted shower arm observed, with no shower head attached. The shower knob was turned to check for the presence of water, and a rush of brown, rusty water shot out of the pipe. On 4/8/26 at 10:35 AM, room [ROOM NUMBER] on the [NAME] Unit was observed to be locked. Maintenance Supervisor I was queried and stated that he was unsure of what room [ROOM NUMBER] was used for. Maintenance Supervisor I unlocked the door, and there was a large, wheelchair washing unit located inside the room. Maintenance Supervisor I was queried at that time and stated that to his knowledge, the wheelchair washer was not used. When asked if the water supply to the wheelchair washer had been turned off, Maintenance Supervisor I stated that he was unsure. The machine was turned on, and water began to fill the unit. On 4/8/26 at 10:40 AM, Nurse Manager E was queried about the wheelchair washer located in locked room [ROOM NUMBER]. Nurse Manager E stated that she has worked at the facility for almost a year, and that they do not use the wheelchair washer located in room [ROOM NUMBER]. Review of the facility's undated Water Management Program-Legionnaires noted: 4. Maintain constant recirculation in hot-water distribution systems serving patient-care areas. 04/08/2026 12:42 PM the Infection Preventionist (IP) was queried if they were part of the facility's Water Management Team, and IP stated No. Review of the facility's undated Water Management Program-Legionnaires noted: Water Management Team: 2. Create the water management team- Members should include the: a. Administrator b. Owner Representative c. Maintenance Director d. Infection Preventionist e. other the facility deems appropriate to fully assess and address risk.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain the mechanical ventilation system, for the [NAME] and North halls, and in the [NAME] soiled utility room. This deficient practice had the potential to affect all residents on the [NAME] and North halls. Findings include:On 04/08/2026 at 9:43 am, the [NAME] soiled utility room was observed with Maintenance Supervisor I. The soiled utility room had a strong, pungent odor. The mechanical ventilation was checked by placing a piece of toilet tissue against the ceiling vent grate. No suction was present, as the piece of toilet tissue did not cling to the ventilation grate cover. Maintenance Supervisor I confirmed that vent was not functional. The mechanical ventilation in the resident bathrooms on the [NAME] and North halls was also checked, and they were found to be non-functional. Maintenance Supervisor I confirmed that the same unit controlled the ventilation for the soiled utility room and the [NAME] and North Hall bathrooms and stated that it might be an issue with the belt.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interview, the facility failed to maintain the air conditioning unit and filter in a clean manner, for Resident #40, resulting in resident complaints with their living conditions. Findings include: On 4/8/26 at 2:30 PM, Resident #40 complained that the filter for the wall mounted air conditioning unit in her room is never cleaned. Resident #40 was visibly upset and stated that she is breathing in all that dust. Resident #40 further stated that she is on oxygen and already has a hard time breathing. The air conditioning unit was observed to be running and blowing air directly at the foot of the resident's bed. The outside front cover of the unit was observed to be coated with dust, and the interior filter was observed to be soiled with a buildup of dust. On 4/8/26 at 2:40 PM, Maintenance Supervisor I was queried about the cleaning of the air conditioner and stated that housekeeping was responsible for cleaning the exterior of the unit, and maintenance was responsible for cleaning the filter. Maintenance Supervisor I confirmed the dusty air conditioning unit but provided no further explanation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure timely showers and incontinence care were provided to dependent residents for one resident (R77) of three reviewed for Activities of Daily Living (ADL) care. Findings include: On 04/07/2026 at 12:00 PM, R77 was observed to be on their back in bed, dressed in a hospital style gown. R77 reported they had not received a shower the day before when they had asked staff. R77 reported they had asked staff for a shower this day and was told they were not signed up for a shower. R77 reported they had not had a shower in the three weeks they had been at the facility and due to their (Multiple Sclerosis) MS they needed assistance to take a shower. R77 also reported they pee a lot and their brief was currently wet. R77 activated their call light and Certified Nursing assistant (CNA) B entered the room and R77 asked about getting a shower. CNA B reported to R77 that as R77 had a wound they could not get a shower. CNA B also reported R77's showers were Monday and Thursday. A shower was not offered to R77. At 12:16 PM, R77 activated their call light. The dome light above the door did not activate nor was there an audible tone in the hallway. At 12:19 PM, a staff member entered and exited the room of R77. R77's brief was not changed. At 12:33 PM, Licensed Practical Nurse (LPN) G had brought medication to R77 and reported R77 had asked to be changed. At 12:53 PM, R77 reported they had not been changed and was wet with urine. The lunch tray had been set up on the tray table. At 2:25 PM, a shower had not been completed. At 3:48 PM, R77 reported they were soiled again and told someone who had not come back. At 4:35 PM, LPN G provided R77 with medication. At 4:41 PM, no staff had been seen to enter the room of R77 and R77 reported they had not been changed. On 04/09/2026 at 8:35 AM, R77 reported they were wet and soiled and had reported to staff they needed to be changed. It had been reported that breakfast was being served and could not be changed. At 9:30 AM, LPN H entered to complete wound care and reported R77 was wet and in need of a brief change. LPN H reported it was important to change R77 timely with the type of wound R77 had on their hip. A review of the progress notes and treatment administration records (TARs) documented a current open wound to the left hip and a recent wound to the buttocks which required daily wound care. A review of the facility records for R77 revealed R77 was admitted into the facility on [DATE]. Diagnoses included Unstageable Pressure Ulcer of the Left Hip, Multiple Sclerosis, and Paralysis. The Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition with a 12/15 Brief Interview for Mental Status (BIMS) score and substantial/maximal staff assistance for toileting hygiene, to roll left and right in bed and lower body dressing. The active care plan revised 04/01/2026 documented, .incontinent of bowel and/or bladder .Assist me to the toilet before meals. Date Initiated: 03/16/2026. Check me at least every two hours during the day and change my brief if needed. Date Initiated: 03/16/2026. Keep me as clean and dry as possible . Date Initiated: 03/16/2026 . I have actual impairment to skin integrity of the Left hip. Date Initiated: 03/16/2026. Keep my skin clean and dry .On 04/09/2026 at 9:51 AM, the Director of Nursing (DON) reported they had visited R77 and typically staff should ensure residents are clean and dry before meals and during meals times resident would not typically be changed due to potential infection control concerns. The DON also noted the concerns related to incontinence care during meals times had been brought up in resident council and residents were encouraged to put their call light on before mealtimes when they needed care. A review of the previous six months of resident council minutes documented timely call light response concerns in March 2026 and February 2026 but not specifically address education related to the use of call lights by the residents. A review of the undated facility Nursing SOP (standard operating procedure) titled, Briefs and Under pads revealed, Purpose: To provide cleanliness, comfort to the resident, and to prevent physiological complications .A review of the undated facility Nursing SOP titled, Toileting revealed, Purpose: To help the resident maintain normal and adequate bowel and bladder habits as indicated by his or her condition .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure sufficient staffing to meet the needs of the residents for three residents (R57, R2 and R39) of three residents reviewed for care needs being met. Findings include:R57 During an observation on 4/7/2026 at approximately 10:00 A.M. Resident (R57), who was alert and oriented, and cognitively intact, complained the facility did not have enough staff and during the night shift when the call light was pushed the Certified Nurse Assistants (CNAs) sometimes took as long as an hour to respond. R57 stated, I am at the end of the hall and when you need to be changed an hour is unacceptable. R2 On 4/7/26 at12:30 P.M. during a lunch meal observation R2 who was alert and oriented and cognitively intact, was interviewed concerning receiving cold food. R2 reported when returning from dialysis a meal tray was left on the bedside table and the food was cold, but no staff was available to reheat (R2) meal tray. R2 reported there is not enough staff on the night shift. The staff will not reheat my food, it's been going on for a while. When I am here my food is served warm but not on days of dialysis. Record reviews revealed R2 received dialysis three times a week on Tuesdays, Thursdays and Saturdays and returned to the facility around 7:00-7:30 P.M. R2 was identified as a nutritional risk and was underweight. The resident was prescribed a Regular diet with Double Protein at all meals. On 4/8/2026 at 5:00 P.M. in a follow up interview and observation, R2 again reported when returning from dialysis the previous night on 4/7/26 (R2) tray was at the bedside. No staff responded when the call light was turned on, and there was no available staff to heat R2's food. R2 stated, I just left the tray; no one should have to eat cold food after dialysis. On 4/8/2026 at approximately 5:15 P.M. Registered Dietitian (RD) O Presence was requested to observe the resident's dinner meal. RD O stated, R2's food should have been reheated by the nursing staff. Dietary staff leaves the unit after serving each meal. R39 On 4/8/2026 at 5:30 P.M. During an interview R39's legal guardian stated, I make daily visits to the facility to make sure he is fed and taken care of and when I cannot come, I send somebody from the family or a friend because the unit is frequently short staff. On 4/9/2026 at 12:50 P.M. Staffing Scheduler F (who is also a CNA) was interviewed regarding staff shortages. Staffing Scheduler F stated they are short of Certified Nurse Aides (CNA's) especially on the afternoon and midnight shifts. Six CNA's' are scheduled for orientation next week, the turnover is high. The new CNA's work and get through orientation but once they work the units they leave, sometimes without notice. This facility has a system that allows staff to get paid at the end of each day, so the CNAs may work two or three days and not return. The average census here runs in the 70's, which they try to schedule two to three CNAs on the (Day shift) on the [NAME] Unit and three (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to four CNAs in the afternoon. Frequently they must pull staff if there is a call-In on the TCU Unit. The facility does not use pool staff. When a CNA calls in sometimes, they stay and there are several other staff members that are also CNAs. On 4/9/26 at 9:23 AM, an interview was conducted with Certified Nurse Assistant (CNA) B, they were asked if they feel they had enough staff to do their job effectively and reported the facility only schedules two or three people for the unit and on two of the hallways where the residents require a lift which requires two person assistance. CNA B continued; saying they pass meal trays, assist people with meals and after mealtime they are expected to pick up trays and clean them off before sending them to the kitchen. The CNA reported the facility also requires them to do laundry for the residents and reports they have difficulty completing assigned tasks in eight-hours along with providing showers. On 4/9/26 at 9:32 AM, an interview was conducted with CNAC and reported they do not feel they have enough staff as the facility adds extra tasks onto us like assisting with dietary, housekeeping and they don't understand how or why they are responsible for resident laundry. On 4/9/26 at 9:58 AM, an interview was conducted with CNAA who reported they did not understand why the CNAs were responsible for the residents laundry when the facility has a laundry department. On 4/9/26 at 2:30 PM, an interview with the Director of Nursing (DON) and Administrator was conducted. They were asked about their facility assessment since it was noted that they required 3 nurses on the night shift. The DON was then asked how the nurses are scheduled per unit. The DON reported that there is one nurse on the Transition Care unit and two on the [NAME] unit and one nurse is to go the Greenhouse. The DON was then asked since there is one staff member (CNA) at the Greenhouse, that CNA knows to call the nurse if there is an emergency, saying, we tend to put our less complex medical needs in that unit. There was no additional information provided at the exit of the survey.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interview and record review, the facility failed to provide timely dental services for one resident (R3) of one reviewed for provision of dental care. Findings include: On 04/08/2026 at 2:10 PM, R3 was asked about any recent dental visits and reported they had not been seen by a dentist recently. R3 reported a concern for a mouth infection and some redness to the lower gumline. A review of the most recent dental visit note dated 11/20/25 documented two teeth with fractures and seven missing teeth. A review of the Nurse Practitioner (NP) progress note dated 01/20/2026 at 13:09 (1:09 PM) revealed, (R3) was seen today for follow up on sore gums and left knee pain . (R3) (complaint of) c/o pain to (their) upper gumline, inspected oral cavity. Patient has tooth decay and has a tooth that has partly came off. There is no redness of the gums or swelling, tender to touch . Assessment/Plan: Dental caries/sore . gums: no signs of infection. Will start patient on orajel . Needs Dentist evaluation . A review of the facility records for R3 revealed R3 was admitted into the facility 03/19/24. Diagnoses included Dementia and Diabetes. The active care plan revised 10/13/25 documented, I need assistance with my (activities of daily living) ADLs . Personal Hygiene/Oral care: I require supervision from you for personal hygiene and oral care . On 04/09/2026 at 1:17 PM, Licensed Practical Nurse (LPN) K reported they were not aware of any dental concerns for R3 and asked the Unit manager, LPN E. A Dental Services order dated 02/02/26 entered by LPN E was reviewed with them. LPN E reported the dental service was on site monthly to follow up on dental service referrals. LPN E was asked for documentation that R3 had been followed up by the dental service. No documentation R3 was seen by the dental service in February 2026, or March 2026 was received prior to survey exit. It was also noted to LPN E the ordered Orajel had not been documented as given. Upon review of the January 2026 medication administration records (MARs), Orajel was documented as ordered from the pharmacy but not received. LPN E reported this was due to the Orajel being an over-the-counter medication and the family had brought it in for the resident. On 04/09/2026 at 9:51 AM, the Director of Nursing (DON) reported the Orajel was not a medication the facility kept on hand, and it needed to be ordered. A review of the undated Social Services (standard operating procedure) SOP titled, Dental revealed, Policy: It is the policy of this facility to assist residents in obtaining routine and 24 hour Emergency dental care to meet the needs of each resident .if routine service needed, the resident will be placed on the schedule to see the dentist at the next scheduled visit .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to provide coffee for two (R26, R62) of two residents reviewed for beverage preferences. Findings Include: On 4/7/2026 at 9:00 A.M., R26 was heard asking Unit manager (UM) E for a cup of coffee. R26 exchanged a few pleasantries with UM E and returned from the unit kitchen with a large cup of coffee. R26 proceeded to comment I never get coffee, it makes me feel so good in the morning, I miss my coffee. On 4/8/26 at 9:05 A.M., during a breakfast observation R26 asked Certified Nurse Assistant (CNA) R for a cup of coffee. CNA R acknowledged R26's, request gesturing give me a minute I am helping (name of R39). Hearing R26's request nurse S spoke out stating, I will get your coffee. R26 leaned over the table to R55 and asked Do you want coffee? I don't know why we do not get coffee at least for breakfast. Nurse S began offering coffee and condiments to other residents within the dining area. During the meal service coffee was observed on a side table with other assorted beverages but residents were not offered or given coffee. On 4/8/2026 at 5:00 P.M., review of the master menu provided by the facility revealed residents were to be served juice/beverage of their choice, and milk if desired. The menu was reviewed with Registered Dietitian (RD) O who was present during the meal observation. RD O reported coffee was sent to the units daily and could not provide any reason why nursing staff was not giving the residents coffee. On 4/9/2026 at 9:00 A.M. interview with Dietary Supervisor (DS) N and Regional Certified Dietary Manager (CDM) P concerning residents not being served or offered coffee for breakfast. Each reported coffee was sent to both units daily for breakfast and the nursing staff was responsible for providing residents with the beverage of their choice. Any time a resident wants something different nursing staff can always call the main kitchen and that includes coffee. DS N reported coffee should be served with the other beverages like juice and water and not at the end of the resident's meal. Dietary Aides serve food from the steam tables on each unit at each meal, the dietary staff do not pass food to the residents, only the CNAs on the unit. During an interview with an anonymous CNA, they confirmed, We cannot do it all. It is too much. R62 On 04/07/2026 at 11:40 AM, R62 was seated in a wheelchair in their room watching TV. R62 reported the facility had taken away their hotpot appliance that heated water for their coffee. R62 reported they missed having the appliance as they may get a cup of coffee in the morning but were unable to get one at other times during the day. R62 reported staff had told them no coffee was available when they had asked. No coffee cup was observed. On 04/08/2026 at 8:13 AM, R62 was dressed and seated in a wheelchair in their room with the TV on. A cup of coffee was not observed. On 04/08/2026 at 11:04 AM, the Director of Nursing (DON) reported the hotpot had been removed about a year ago, as it was a heat source which may cause a fire. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/08/2026 at 1:19 PM, Activity Aide Q reported coffee is available on most days on R62's unit. Activity Aide Q reported R62 does not come out of their room for the coffee hour and knows R62 does like their morning coffee but was not aware of other times. On 04/08/2026 at 1:49 PM, R62 was in their room, dressed and seated in their wheelchair watching TV. R62 reported they had stopped asking for coffee as the answer had generally been that it was unavailable outside of breakfast time. A review of the facility records for R62 revealed, R62 was admitted into the facility 02/14/23. Diagnoses included Diabetes, Heart Failure and Lung Disease. The active care plan revised 03/02/26 documented, I am dependent on staff for meeting, emotional, intellectual, physical and social needs . I need set up assistance by staff to eat .

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a properly functioning communication system which relays the call directly to a staff member or to a centralized staff work area for one (R76) of one resident reviewed for a properly function call light system. Findings include:On 4/7/26 at 9:22 AM, an interview with R76 was conducted and they reported that since they returned from the hospital two weeks ago the call button does not work. R76 reported that the past two nights were extremely rough for them because they needed to use the restroom but depend on staff to assist them to the toilet and when they pushed the call bell no one came in and when staff finally decided to stroll in they were already a big mess (had a bowel movement on themselves). An observation of the room was made, the call light button was on residents' bed and the box for the button was detached from the wall. R76 did not have a bell or any other means to communicate to the facility if assistance was needed. R76 reported that not being able to get in contact with staff makes them feel uneasy at times. A review of the record revealed that R76 was admitted to the facility on [DATE] with a diagnoses of Chronic Obstructive Pulmonary Disease, Obstructive Sleep Apnea and Essential Hypertension. A Minimal Data Set (MDS)assessment completed on 3/30/26 with an brief interview for mental status score (BIMs) of 15 which indicated no cognitive impairment. On 4/8/26 at 11:20 AM, an interview was conducted with Licensed Practical Nurse (LPN) D and they were asked about the call light system and if it was functioning properly. LPN D reported that the call lights were working and that when a resident presses the call light the call goes to their pager and also displays on a screen located in office. LPN D was then asked to go to R76's room and demonstrate how the call light system works. LPN D pressed the call button and there was no alert to the pager they were assigned to. LPN D went to the office and the room number did display on the screen but there was no sound nor pager alert to let anyone know that assistance was needed. LPN D was then asked, was the call light working for this resident, LPN D reported, no. LPP D was not for sure why it was not functioning. The call light/response time policy was requested on 4/9/26 at 10:52 AM but not received prior to exit.