

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Orchards at Harper Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 19840 Harper Ave Harper Woods, MI 48225	

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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34851</p> <p>This citation pertains to MI00147226.</p> <p>Based on observation, interview, and record review, the facility failed to ensure dignity and respect was maintain for one sampled resident (R704) of two reviewed for respect and dignity. Findings include:</p> <p>A review of the Intake allegations revealed, An allegation was reported the resident (R704) was verbally abused by an employee (Certified Nursing Assistant (CNA) C).</p> <p>On 10/09/24 at 10:20 AM, R704 was asked about the incident with CNA C. R704 explained that during care, CNA C called them out of their name and referred to their buttocks as a [NAME] roast. R704 further explained this was not the first time they had a problem with CNA C, and they were trying to deal with the ongoing things CNA C would say. R704 was asked if they shared the experiences they had with CNA C. R704 stated, they had conversations with the Unit Manager and the Wound Care Nurse (WC Nurse). R704 was asked how the incident affected them. R704 stated, I felt less than human. R704 continued and explained they have requested a transfer to another facility.</p> <p>On 10/09/24 at 12:36 PM, the WC Nurse was asked about R704 and CNA C incident. WC Nurse explained R704 would tell her CNA C would sometimes refuse to provide care to them and say R704 could do it for themselves. WC Nurse was asked when R704 told them about CNA C's behavior. WC Nurse reported, about a couple months ago. WC Nurse was asked if they reported the behavior to the Nursing Home Administrator (NHA). The WC Nurse stated, Yes. I reported it to the team.</p> <p>On 10/09/24 at 1:04 PM, Unit Manager D was called for an interview a voice message was left, a return called from Unit Manager D was not made by the end of the survey.</p> <p>A review of the facility's statement from CNA C revealed, [CNA C] was suspended on Sunday, 9/22/24, after allegations of verbal abuse surfaced. This was done over the phone. [CNA C] was called many times between 9/23/24 and 9/24/24 to get terminated. [CNA C] did answer on 9/24/24 and was terminated over the phone. [CNA C] did say [they] did not do this verbal abuse at any time.</p> <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/09/24 at 1:25 PM, the Director of Nursing (DON) was asked when they became aware of the problems R704 had with CNA D. The DON explained, there was a report CNA C was not helping R704 when they requested or needed care. The DON further explained, they became aware of the incident the day it happened. The DON was asked what happened after they were made aware of CNA C calling R704 buttocks a [NAME] roast. The DON stated, [CNA C] was suspended pending investigation. [R704] did not change their story and [CNA C] was terminated.</p> <p>On 1:39 PM, the NHA was asked when they were made aware of the incident with CNA C and R704. The NHA explained, the day it happened, they came in and made the 24 hour report and talked to the resident.</p> <p>R704 was admitted to the facility on [DATE] with diagnosis of Multiple Fractures of Pelvis. A review of R704's medical record revealed, R704 with an intact cognition and that they required assistance with activities of daily living.</p> <p>A review of R704's progress notes revealed, 9/22/2024 07:37 (AM) Nurses Note Text: Upon arrival, the resident was found comfortably situated in bed with the head of the bed elevated. [R704] was alert and oriented to person, place, time, and situation, clearly able to articulate [R704] needs. The resident expressed concerns about experiencing verbal abuse and neglect from one of [R704] caregivers (CNA). A detailed report was documented, and the resident's statement was promptly forwarded to the abuse coordinator. Both the abuse coordinator and the Director of Nursing (DON) were immediately informed of the situation. The writer took the time to reassure the resident that such treatment is unacceptable and commended [R704] for voicing [their] concerns. To further empower [R704], the writer reviewed the resident's rights (Right to Dignity, Quality of Care, and Quality of Life), emphasizing the importance of reporting any ongoing or future issues. The resident was encouraged to continue advocating for [R704] and assured of the support available to [R704].</p> <p>10/3/2024 17:19 Social Services Text: Social worker met with [R704] today after [R704] requested a transfer be sent to two other nursing facilities. Social worker will gather the referral and contact the other facilities by the beginning of next week.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>44750</p> <p>This citation pertains to Intakes MI00147184 and MI00147299.</p> <p>Based on observation, interview, and record review, the facility failed to provide fresh water in a timely manner for residents (R701, R702, R703, and R705) out of five reviewed for hydration. Findings include:</p> <p>A review of Intake MI00147299 noted the following, Complainant states [they] are not receiving fresh water daily.</p> <p>R701</p> <p>On 10/9/2024 at 10:16 AM, R701's water was observed on the bedside table. The water was noted to be dated 10/9/2024 from 11PM-7AM. The water cup was noted to be warm and empty.</p> <p>At 12:04 PM and 12:54 PM, R701 was observed with the same water cup dated 10/9/2024 from 11PM-7AM. R701 stated they never provide them with fresh water and it is an ongoing problem.</p> <p>R702</p> <p>On 10/9/2024 at 10:51 AM, R702's water was observed on the bedside table. The water was noted to be dated 10/9/2024 from 11PM-7AM. The water cup was noted to be warm and half full.</p> <p>On 10/9/2024 at 12:05 PM, R702 was noted to be in their wheelchair. R702 water cup was observed to be the same cup dated 10/9/2024 from 11PM-7AM. R702 stated they wish they had some fresh water. R702 stated they would ask the Certified Nursing Assistant (CNA) when they came into the room again.</p> <p>R703</p> <p>On 10/9/2024 at 12:07 PM and 12:53 PM, R703's water was observed on the bedside table. The water was noted to be dated 10/9/2024 from 11PM-7AM. The water cup was noted to be warm and with a small amount in the cup. R703 said they could go for some fresh water, but they barely get fresh water.</p> <p>R705</p> <p>On 10/9/2024 at 12:57 PM, R705's water was observed on the bedside table. The water was noted to be dated 10/9/2024 from 11PM-7AM. The water cup was noted to be warm and half full. R705 stated they never get fresh water, and they do not know when they will receive water.</p> <p>On 10/9/2024 at 12:56 PM, CNA B was observed going down the hall with the water cart. CNA B the water cart goes down on midnights and they clean it and send it back up. CNA B stated the cart is usually clean and back up to the floor by 8:00 AM. CNA B stated they try and pass water by lunch time or earlier.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/9/2024 at 1:36 PM, an interview was completed with the Director of Nursing (DON). The DON stated water should be passed at a minimum of once a shift and if a resident asks for water. The DON stated they have not heard from the residents that getting fresh water was a problem.</p> <p>A review of a facility policy titled, Hydration noted the following, .D. Assure fresh bedside drinking water is available at all times, unless contradicted. Assist residents to periodically take a drink throughout the day.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>44750</p> <p>This citation pertains to Intakes MI00147299 and MI00147184.</p> <p>Based on observation, interview, and record review, the facility failed to ensure call lights were answered, functioning and within reach for two residents (R702 and R704) out of three reviewed for call lights. Findings include:</p> <p>R702</p> <p>On 10/9/2024 at 10:51 AM, R702 was observed in bed and stated they were ready to get dressed and in the chair. R702 was asked if they had pressed (activated) their call light. R702 stated they did not know where the call light was at. An observation of the call light unit on the wall noted that there was no cord for R702 to push the call light. R702 was asked how long they have been without a call light. R702 stated they did not know.</p> <p>On 10/9/2024 at 10:53 AM, Certified Nursing Assistant (CNA) B was shown the call light unit on the wall and R702 did not have a call light button. CNA B proceeded to switch the call light cord out and stated they were going to notify maintenance. CNA B stated they did not know the call light button for R702 was missing.</p> <p>On 10/9/2024 at 12:05 PM, R702 was observed in their wheelchair. R702 call light button was observed tucked under their pillow. R702 stated they were unable to reach their call light from their current position in the wheelchair.</p> <p>At 10:53 AM, R702's call light was observed in the same position under the pillow. R702 stated they were still unable to reach it from their current position.</p> <p>A review of the medical record revealed that R702 admitted into the facility with the following diagnoses, Hypothyroidism and Diabetes. Further review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 4/15 indicating an impaired cognition. R702 also required assistance from staff with activities of daily living (ADLs).</p> <p>R704</p> <p>On 10/9/2024 at 10:20 AM, R704's call light was observed activated. R704 stated they were waiting for some patient care.</p> <p>At 10:27 AM, 10:35 AM, 10:38 AM, and 10:47 AM, R704's call light was observed to still be activated. At 10:48 AM, an unknown staff member was seen entering R704's room and turning off the call light. They were observed going into another room and informing a CNA that R704 needed patient care.</p> <p>A review of the medical record revealed that R704 admitted into the facility with the following diagnoses, Multiple fractures of Pelvis and Pain in unspecified Hip. Further review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score 15/15 indicating an intact cognition. R704 also required staff assistance with bed mobility and transfers.</p> <p>(continued on next page)</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/9/2024 at 1:26 PM, an interview was conducted with the Director of Nursing (DON). The DON stated call lights should always be within reach and they complete walking rounds daily to ensure that call lights are working and in reach and if the call light is not working then they put in a request with maintenance. The DON stated they are unsure if the rounds were completed that morning. The DON stated they expect call lights to be answered within 15 to 20 minutes depending on the situation.</p> <p>A review of a facility policy titled, Call Light Policy revealed the following, Policy: It is the policy of this facility to answer call lights as promptly as possible.</p>		