STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235480	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Harper Woods	19840 Harper Avenue 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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2696242, 2694434, and 2696027. Based on observation, interview, and record review, the facility failed to prevent verbal abuse for one resident (R604) and resident to resident physical abuse for two residents (R603 and R605), out of three reviewed for abuse. Findings include:R604 On 12/18/25 at 10:33AM, R604 was asked about the incident that occurred with Nurse A. R604 reported, at around 7:30pm they had pressed their call light to get pain medication and some cough syrup. R604 explained it was an hour later at 9:00 PM, when Nurse A told R604 that she was unable to give them their medications at that time because she had just received the keys. R604 reported they followed Nurse A to the medication cart and they started having an argument with each other. R604 explained they called Nurse A names and that she called R604 names. A review of R604's medical record revealed, R604 was admitted to the facility on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disorder. A review of R604's social service assessment dated [DATE] noted, R604 with an intact cognition. On 12/18/25 at 12:28 PM, Nurse A was called, a voice message was left. Nurse A did not return a call before the end of this survey. A review of Nurse A's facility statement noted, The CENA (Competency Evaluated Nursing Assistant) reported to me (Nurse A) that R604 requested (R604's) pain pill, and I explained to [R604] that I had just received my keys, and [R604] immediately started cursing at me and calling me names. I left [R604's] room and continued to pass meds and then [R601] came out of [their] room and [R601] wheeled up to me and was calling me name and was raising [R601's] hands and acting as if [R601] was going to hit me. At that point I tried to explain to [R601] that I had just received my keys but [R601] was not listening and [R601] continued to argue with me. Eventually [R601] wheeled away. Did you use any curse words? Yes. What was your intent when you used the curse words? I felt threatened and felt that [R601] was going to hit me and I was trying to get [R601] to back off. My intent was not to curse [R601] but rather to protect myself. On 12/18/25 at 12:42 PM, the Director of Nursing (DON) was asked the facility's expectation regarding staff's behavior. The DON explained for staff to maintain professionalism. On 12/28/25 at 1:15 PM, the Nursing Home Administrator (NHA) was asked the facility's expectation, the NHA explained for staff to deescalate and to get help if needed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R603 and R605 A review of Facility Reported Incident (FRI) 2696242 noted the following, Incident Summary: At approximately 10:43pm the administrator received a call from the DON [Director of Nursing] and the DON reported that approximately around 10:30pm CNA [Certified Nursing Assistant] entered resident [R603] room and noticed [R603's] lip was bleeding and some redness under [their] eye. CNA asked [R603] what happened and [R603] was unable to say however [they] pointed towards [their] roommate [R605]. Staff immediately conducted a pain assessment and no pain noted. Staff then conducted a room change and moved resident [R603] to another room. Resident is calm and remains safe in new room. On 12/18/2025 at 10:40 AM, R603 was observed lying in bed, sleeping. No bruises were noted on their face. On 12/18/2025 at 11:16 AM, an interview was conducted with CNA A. CNA A reported they were about to get R603 dressed and up in their wheelchair. CNA A reported they heard about the incident from R603's current roommate but did not notice any changes in R603's behavior. A review of the medical record revealed R603 admitted into the facility on 4/5/2013 with the following medical diagnoses, Major Depressive Disorder and Dysphagia. A review of the most recent Minimum Data Set (MDS) assessment revealed a Brief interview for Mental Status (BIMS) score of 0/15, indicating an impaired cognition. R603 also required staff assistance with bed mobility and transfers. On 12/18/2025 at 10:52 AM, R605 was observed sitting in their bed. R605 was unable to answer any questions related to the incident with R603. A review of the medical record revealed that R605 was admitted into the facility on 1/6/2022 with the following medical diagnoses, Unspecified Dementia without behavioral disturbance and Adult Failure to Thrive. A review of the most recent MDS assessment revealed a BIMS score of 0/15 indicating impaired cognition. R605 also required staff assistance with bed mobility and transfers. On 12/18/2025 at 11:57 AM, a phone interview was conducted with CNA B. CNA B reported they worked the night of the incident between R603 and R605. CNA B reported they heard R605 screaming loudly, and it was not their usual scream, so they went in the room to check on them. CNA B reported they observed R605 trying to pull R603 out of the bed. CNA B stated they observed R603 shaking their head and saying no, with water all over them and a busted lip. CNA B reported they removed R605 out of the room and got the nurse for the room. CNA B reported the nurse then called the DON. On 12/18/2025 at 12:08 PM, an attempted phone call was made to Licensed Practical Nurse (LPN) C with no answer. On 12/18/2025 at 12:29 PM, an interview was conducted with Social Worker (SW) D. SW D reported that R605 is not known to have aggressive behaviors and that R603 and R605 are no longer roommates. SW D reported R605 is currently in a room alone and they are both provided supportive visits. SW D reported that neither R603 or R605 can articulate what happened. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/2025 at 12:43 PM, an interview was conducted with the DON. The DON reported they are unsure what happened because the whole incident was not witnessed. The DON reported R605 is not aggressive and that the only thing they do is refuse care sometimes. The DON reported R603's bedding was wet, but the canister and plunger for the tube feeding was observed to be on the bed. The DON reported they still separated the residents and will be keeping R605 by themselves for a while to make sure they are not missing anything. The DON reported R603 and R605 have never had issues before and that R605 has never had any incidents before this one and none after. A review of a facility policy titled, Abuse and Neglect Prohibition noted the following, Each resident has the right to be free from abuse, mistreatment, neglect, exploitation, involuntary seclusion, misappropriation of property and mental abuse or enabled through the use of technology.