

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235509	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER The Orchards at Warren		STREET ADDRESS, CITY, STATE, ZIP CODE 12250 E 12 Mile Rd Warren, MI 48093	

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 0561</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 and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384</p> <p>Based on observation, interview, and record review, the facility failed to honor a resident's request to be sent out for a higher level of care for one resident (R33) of one reviewed for self-determination. Findings include:</p> <p>On 9/18/24 at 8:47 AM, R33 was observed lying in bed, and asked to speak to the surveyor. R33 explained that their pain management has not been managed well, specifically with them not receiving their prescribed as needed medications timely. R33 further explained that they have a history of kidney stones, and felt as though they had one last week Wednesday, which was causing excruciating pain. R33 explained that as a result, they asked to speak to the Director of Nursing and their physician as they wanted to be transferred to the hospital. R33 further explained that they never spoke to the DON or the physician, but was told that the nurse spoke to the physician who did not order a transfer to the hospital, and that if they chose to transfer on their own they would have to sign themselves out Against Medical Advice (AMA), and be responsible for the transportation bill. R33 further explained that they didn't want a bill, and remained in excruciating pain for the duration of the day and night.</p> <p>A review of R33's medical record revealed that she was admitted into the facility on [DATE] with diagnoses that included Chronic Kidney Disease, Acute Pyelonephritis (Kidney Infection), and Anemia. Further review revealed that the resident was moderately cognitively impaired, and required one-person for assistance for bed mobility, toileting and dressing.</p> <p>Further review of R33's medical record revealed the following progress notes:</p> <p>9/11/2024 15:41 (3:41pm) Nurses Note Text: Resident states at 10:30am [they want] to speak with [physician] and DON regarding pain/kidney stones. Both notified. Pain meds given as ordered. Resident states ineffective.</p> <p>9/12/2024 16:30 (4:30pm) Physician Progress Notes</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Late Entry: Note Text: Called to bedside secondary to medical evaluation and maintenance of care Increased pains in b/l (bilateral) mid-back. Hx (history) of kidney stones and stated similar pains to that. Pain improved today, but quite bad yesterday. Pt (patient) stated [they] requested to go to hospital, but staff stated physician denied. No conversation did occur to indicate [they] needed transfer the night prior when discussing with nursing. Apologized for not completing [their] needs - indicate will work better in future to do so. Pt appears to be ok with today's results. Indicated will start IV (intravenous) to flush any remaining stone that may be present and reminded of muscle relaxers ordered .</p> <p>On 9/19/24 at 10:07 AM, a phone call was made to Licensed Practical Nurse (LPN G), the nurse assigned to R33 during midnight shift on 9/11/24. LPN G explained that they had received report from the previous nurse informing them that R33 was in pain, and that the doctor had been contacted. LPN G explained that they provided R33 their pain medications per the active orders, and attempted to contact the physician again to no avail.</p> <p>On 9/19/24 at 11:35 AM, an interview was completed with LPN C, assigned nurse during the day shift for R33. LPN C was asked about R33's complaints of pain, and request to go to the hospital. LPN C explained that R33 did request to go to the hospital, but when they spoke to the physician regarding the resident's concerns, they did not provide any new orders for the resident. LPN C reports that she continued to provide R33 their pain medications per their current orders. LPN C was asked if they were aware of anyone telling the resident that they would have to sign themselves out AMA, and they stated that they are not sure.</p> <p>On 9/19/24 11:47 AM, an interview was completed with the DON regarding R33 and their request to go to the hospital. The DON explained that the resident has a right to go out to the hospital when they chose, and would follow-up with the resident regarding their concerns.</p> <p>On 9/19/24 at 1:29 PM, the Nursing Home Administrator (NHA), was asked about a resident being told that they couldn't be transferred to the hospital if initiated by the resident themselves, and it being considered an AMA. The NHA explained that it is the resident's right to be transferred and it would not be considered an AMA.</p> <p>A review of the facility's Resident Rights policy revealed the following. .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 6. Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to .b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident .</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330</p> <p>Based on observation, interview, and record review, the facility failed to follow professional standards of practice for medication administration when an extended-release medication was crushed for one Resident (R62) of six residents reviewed for medication administration. Findings include:</p> <p>On 9/18/24 at approximately 9:30 a.m., R62 was observed in their bed with fistled hands, wearing a hospital gown, with Licensed Practical Nurse (LPN) L present. When LPN L was leaving the room, R62 was heard to say they wanted their medications crushed.</p> <p>On 9/18/24 at approximately 9:32 a.m., LPN L started to crush R62's medications. LPN L was asked if R62 should have had their medications crushed, as this was not observed in the physician's orders. LPN L reported R62 sometimes liked their medications crushed and continued to crush R62's medications as follows:</p> <ul style="list-style-type: none"> -Colace Oral Capsule, 100 mg (milligram). Give 1 capsule two times a day for constipation. -Loratadine Oral Tablet. 10 mg. Give 1 tablet by mouth one time a day for allergies. -Duloxetine Hcl Capsule. Delayed-release particles 60 mg. Give 1 capsule by mouth once a day for depression. -Fenofibrate tablet. 145 mg. Give 1 tablet once a day for coronary artery disease. -Hydroxyzine Hcl Oral tablet. 25 mg. Give 25 mg by mouth two times a day for Anxiety. -Hydromorphone Hcl Oral tablet. 4 mg. Give 1 tablet by mouth every four hours as needed for pain. <p>Review of R62's six medications orders, accessed 9/18/24, revealed none of R62's six medications administered had orders to be crushed.</p> <p>Review of R62's Minimum Data Set (MDS) assessment, dated 8/23/24, revealed R62 was admitted to the facility on [DATE] with diagnoses including paraplegia (paralysis of lower body), schizophrenia (chronic mental disorder), and seizure disorder. R62 was dependent for self-care, bed mobility, and transfers. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 11/15, which showed R62 had moderate cognitive impairment.</p> <p>Review of the Electronic Medical Record (EMR) showed R62 had a guardian. The record also revealed R62 was on a regular texture diet, with thin liquid consistency for fluids.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/19/24 at 9:08 a.m., the Director of Nursing (DON) was asked about R62's medications being crushed on 9/18/24. The DON reported LPN L had notified them of this occurrence on 9/18/24 after the medications were passed. The DON stated they had contacted the physician afterwards, who ordered R62's medications to be crushed as needed. The DON was asked if R62 had any adverse outcome and reported they had not been made aware of any. Surveyor reviewed concerns related to the potential for adverse effects when medications not ordered as crushed were dispensed in crushed form. Upon review, the DON called the facility pharmacist, Pharmacist M, with Surveyor present, to inquire if any of the six medications administered were DO NOT CRUSH medications.</p> <p>On 9/19/24 at approximately 9:30 a.m., the DON reviewed R62's six medications which were crushed by LPN L during morning medication pass on 9/18/24 with Pharmacist M on the phone. Pharmacist M reported they reviewed a DO NOT CRUSH medication list and found R62's six medications which were crushed on 9/18/24 were not on the DO NOT CRUSH list and were able to be crushed. Pharmacist M referenced the reference they used as an ISMP (Institute for Safe Medication Practices) - DO NOT CRUSH LIST.</p> <p>Review of the ISMP weblink, Oral Dosage Forms That Should Not Be Crushed 2016 (ismp.org), and a web search including recent literature and resources showed no current ISMP list of DO NOT CRUSH medications since 2016.</p> <p>Review of a response email from ISMP, dated 9/24/24 at 11:12 a.m., revealed, .On November 17, 2022, ISMP removed the table of Do Not Crush Medications from our website. This is because ISMP did not own, update, or review new or existing content on the List of Oral Dosage Forms That Should Not Be Crushed. On May 1, 2023, the updating, printing, and sales of wall charts with the list, by [NAME] Land Publishers, was discontinued .ISMP encourages that organizations maintain, update, and periodically review a list of oral dosage forms that may require alteration through evaluation of package inserts, drug manufacturer inquiries, tertiary drug information resources, and primary literature .</p> <p>Review of the drug manufacturer's literature for R62's six medications administered as crushed revealed one of the six crushed medications, Duloxetine, also known as Celexa, should not have been crushed, as it was a delayed-release medication (designed to release the active ingredient after taking the medication).</p> <p>Review of R62's medication order, dated 8/20/24, revealed, Duloxetine HCl Capsule Delayed-Release Particles. 60 mg. Give 1 capsule by mouth one time a day for depression. There was no directive to crush this medication.</p> <p>Review of R62's medication order, dated 9/19/24, accessed 9/19/24 with the DON, showed a new order, dated 9/18/24 at 19:00 [7:00 p.m.], May crush allowable meds, every shift. The DON confirmed this order was entered after R62 received six medications crushed on 9/18/24 during the morning medication pass.</p> <p>Review of the package insert, revised 2023, Cymbalta - duloxetine hydrochloride capsule, delayed- release, [NAME] Lily and Company, revealed, on Page 1, Indications and Usage: CYMBALTA is a serotonin and norepinephrine reuptake inhibitor (SNRI = medication class) indicated for the treatment of the following conditions: Major depressive disorder (MDD) in adults .Dosage and administration: Take CYMBALTA once daily, with or without food. Swallow whole; do not crush, chew, or open capsule .</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the article, Meds that Should Not Be Crushed, https://pharmacist.therapeuticresearch.com/Content/Segments/PRL/2014/Aug/Meds-That-Should-Not-Be-Crushed-7309, accessed 9/26/24, revealed, Crushing pills can improve ease of administration, but some shouldn't be crushed. Crushing extended-release meds can result in administration of a large dose all at once. Crushing delayed-release meds can alter the mechanism designed to protect the drug from gastric [stomach digestion] accidents or prevent gastric mucosal [lining] irritation . The list included Duloxetine as a medication which should not be crushed due to being a modified release medication.</p> <p>Review of the facility policy, PCU018 - Medication Administration and General Guidelines, received 9/19/24, revealed, .2. Medications are administered in accordance with written orders of the attending physician</p> <p>On 9/19/24 at approximately 3:30 p.m., concerns were reviewed with the DON related to R62's medications being crushed without a physician order. The DON reported medications could be crushed when necessary, and it was a resident's right to have their medications crushed per their preference.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207</p> <p>Based on observation, interview, and record review, the facility failed to provide an assistive communication device for one resident (R35) of five reviewed for communication, resulting in limited communication between R35 and staff. Findings include:</p> <p>On 9/17/24 at 10:30 AM, R35 was met in their room for observation and interview. R35 was unable to answer any questions asked. R35 gave a thumbs up, when asked if they were okay.</p> <p>On 9/18/24 at 9:03 AM, R35's Certified Nursing Assistant (CNA) B was interviewed and asked about how they communicated with R35. CNA B stated, [R35] gestures and gives a thumbs up. CNA B was asked if R35 had a communication board to assist with communication with staff. CNA B stated, No, not that I'm aware of. CNA B indicated it would be helpful for R35 to have a communication board.</p> <p>A review of R35's electronic medical record (EMR) revealed that R35 was most recently admitted to the facility on [DATE] with diagnoses that included Cerebral infraction (stroke) and Type 2 diabetes. R35's most recent quarterly minimum data set assessment (MDS) dated [DATE] revealed that R35 had a severely impaired cognition, was dependent upon staff for all activities of daily living (ADL's) other than eating. Per R35's MDS, they were rarely/never understood. A review of R35's care plan revealed that R35's communication goal on their care plan did not include an intervention regarding a communication board.</p> <p>On 9/18/24 at 4:11 PM, Rehabilitation Director (RD), D was interviewed regarding communication involving R35. Based on a review of R35's rehabilitation/therapy record, with RD D it was revealed that R35's most recent Speech Evaluation and Plan of Treatment was dated with an end date of 4/14/21 and addressed R35's swallowing.</p> <p>On 9/18/24 at 4:39 PM, RD D later stated, [R35] has a communication board by their bed. They use it sometimes.</p> <p>On 9/19/24 at 9:24 AM, a follow up visit was conducted with R35 in their room. R35 was observed sleeping and no communication board was observed to be in R35's room.</p> <p>On 9/19/24 at 9:27 AM, Nurse/LPN (Licence Practical Nurse) C was interviewed and asked about R35 having a communication board. Nurse C stated, I've never seen [R35] use one. [R35] gives a thumbs up, and thumbs down, that's about it.</p> <p>On 9/19/24 at 10:00 AM, the Administrator (NHA) was asked about their expectations for providing assistive communication devices, such as a communication board, to non-verbal residents. The NHA stated, If a resident can't communicate, they should get a communication board. The NHA further indicated if a resident was unable to use a communication board, staff should figure out ways to communicate with them.</p> <p>(continued on next page)</p>		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a policy titled, Communication: Sensory and [NAME] Impairments with no date, revealed the following, Policy: It is the policy of this to ensure that qualified persons with disabilities, including those with impaired .speaking .have meaningful access to adequate and effective care .		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223</p> <p>Based on observation, interview, and record review the facility failed to ensure broken glasses were addressed for one resident (R109) out of one resident reviewed for vision. Findings include:</p> <p>On 9/18/24 at 10:24 AM, R109 was observed in their room wearing glasses which were observed to be missing a section of the frame and the entire lens on the right side. The lens on the left side was observed to be dirty with many specks of unknown particles covering it and smeared with a greasy appearing substance. R109 was asked how long their glasses had been broken. R109 explained they had been broken for quite a while. R109 was asked if they were able to see. R109 stated, I can see but not very well. R109 was asked if the facility was helping them get new glasses. R109 stated no. they said I had to get them myself.</p> <p>A review of R109's medical record revealed they were admitted to the facility on [DATE] with the following diagnosis: Other sequelae of cerebral Infarction; Ataxia following Cerebral Infarction. A review of R109's Brief Interview for Mental Status revealed a score of 14 indicating mild cognitive impairment.</p> <p>A review of R109's care plan revealed the following: I have impaired visual function r/t (related to) impaired vision. I will use appropriate visual devices to promote participation in ADLS (activities of daily living) and other activities. I wear glasses Please help me with them as needed.</p> <p>A review of R109's progress notes revealed an optometry visit note dated 8/8/24 stating the following: Chief complaint: DM (diabetes mellitus) eye exam .Corrective lenses 1. Yes. Pts (patients) own. A description or mention of R109's broken glasses or an explanation of why they were not fixed or replaced was not included in the note.</p> <p>On 9/19/24 at 9:37 AM, during an interview, Unit Manager (UM E) was asked if they were aware R109's glasses were broken. UM E explained they were not aware and they would let social work know. UM E then stated, social work will place (them) on the list to be seen by the eye doctor.</p> <p>On 9/19/24 at 10:36 AM, R109 was observed sitting on their bed, squinting their eyes, while writing on a piece of paper. R109 was observed to be wearing their broken glasses. R109 confirmed they were seen by an eye doctor in August. R109 was asked if the eye doctor was aware their glasses were broken. R109 stated yes. R109 was asked what the eye doctor said about the broken glasses. R109 stated (they) said I had to get my own.</p> <p>On 9/19/24 at 10:46 AM, Certified Nurse Assistant (CNA F) was asked if how long R109's glasses had been broken. CNA F stated, I think ever since (they've) been here.</p> <p>On 9/19/24 at 10:52 AM, during an interview, Social Worker (SW I) was asked if they were aware that R109s glasses were broken. SW I explained UM E had called them about it and they sent an email to the eye doctor and are awaiting a response. SW I explained when a resident has broken glasses and are seen by optometry they usually repair or replace them right away if possible or they will order new ones and says it should have been addressed during the visit.</p> <p>(continued on next page)</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/19/24 at 11:48 AM, during an interview, the conversation with R109 and a description of R109's glasses was described to the Director of Nursing (DON). The DON was asked to describe what happens when a resident has an issue with their glasses, or their glasses are broken. The DON stated, they are put on a list to be seen. If it's an emergent situation like this one, we would contact optometry right away and have them seen. The DON was asked what the staff should have done when they noticed that R109's glasses were broken. The DON stated, They should have reported it, and optometry should have fixed or replaced them last month when they saw (them).</p> <p>A review of the facility's policy titled Appointments revealed the following: When a resident requires an appointment with a consulting physician or service, the Social Service staff or designee will assist the resident to secure an appointment. If routine service is needed and the service is conducted within the facility (i.e. podiatrist, eye doctor, etc.), the resident will be placed on the schedule for the next scheduled visit. If emergency service is needed, the Social Service staff or designee will contact the physician or service for an appointment .Documentation related to appointments should be placed in the resident record.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46956</p> <p>Based on observation, interview, and record review, the facility failed to maintain a splinting program for one (R68) of five residents reviewed. Findings include:</p> <p>On 09/17/24 at 09:56 AM, R68 was asked about a hand splint that was observed laying on the heat register in their room. R68 reported the splint was for their left hand and stated They never put it on anymore.</p> <p>Review of the facility record for R68 revealed an admitted [DATE] with diagnoses including Cerebral Infarction with Left Hemiplegia and Muscle Wasting and Atrophy. The record also indicated R68 required total assistance for dressing tasks.</p> <p>On 09/17/24 at 03:27 PM, R68 was observed laying in bed. The hand splint was observed laying on the heat register.</p> <p>Additional review of R68's record revealed the most recent Occupational Therapy (OT) evaluation dated 06/06/24 and discharge summary dated 07/19/24 made no reference to a left hand splint or related interventions. An OT evaluation dated 06/01/21 did reference the left hand splint and stated Short-term goal: Patient will safely wear a resting hand splint on the left hand for up to one hour with minimal signs/symptoms of redness, swelling, discomfort, or pain. The evaluation further indicated the recommendation for resting hand splint for prevention of further contracture and pain in the left hand.</p> <p>On 09/18/24 at 09:28 AM, R68's hand splint was observed laying on the heat register. R68 was asked if the splint was put on the previous evening or during the night and they stated No. R68 was asked if they knew why the hand splint was not being used and they reported they didn't know. When asked if they had any pain in the left hand they stated Sometimes I do. R68 was asked if they wanted the splint to be used and stated It probably should, my hand hurts sometimes and I can't use it anyway.</p> <p>On 09/18/24 1:35 PM, R68 was observed in their room. The hand splint was laying on the heat register.</p> <p>On 09/19/24 at 9:05 AM, R68 was observed laying in bed. The hand splint was laying on the heat register. R68's left arm was laying unsupported and turned inward and the left hand was under the left leg. R68 was asked about the position of their hand and stated I can't always feel where it is unless I grab it with my other hand.</p> <p>On 09/19/24 at 10:13 AM, Certified Nurse Assistant (CNA) B reported they've never used the left hand splint with R68 and have never been made aware of any instruction to do so.</p> <p>On 09/19/24 at 10:14 AM, CNA K reported they had an extended history of caring for R68 and they couldn't recall ever using the left hand splint.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Orchards at Warren		STREET ADDRESS, CITY, STATE, ZIP CODE 12250 E 12 Mile Rd Warren, MI 48093	
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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/19/24 at 10:23 AM, the facility Director of Rehab (DOR) reported R68's current left hand splint was not being used because an orthotics service evaluated the resident for a new splint and they were waiting for the splint to arrive. The DOR indicated the splint was delayed in arriving due to the resident's payor source and authorization process. The DOR was informed no documentation could be located indicating the current splint was contraindicated, ineffective or otherwise deemed inappropriate. They were asked if they were aware of any reason the splint had been discontinued and no reason was specified. The DOR was asked to provide any documentation supporting discontinuation of the current splint at any point. The DOR subsequently provided an orthotics order for a left wrist/hand orthosis dated 07/23/24 with an attached restorative nursing order that included the statement New left resting hand splint waiting to be delivered by orthotist. Effective: 7/26/24 this order was electronically signed by the OT on 09/19/24. No additional documentation addressing any discontinuation of the original hand splint was provided.</p> <p>On 09/19/24 at 01:15 PM, the DOR was asked their expectation regarding documentation when a resident's splint is discontinued and they reported the discontinued splint should be removed from the resident's room and when a replacement is available the direct care staff would be instructed in an updated restorative program. The documentation expectation was not specified.</p> <p>On 09/19/24 at 01:27 PM, the facility Administrator (NHA) was asked their expectation regarding documentation of the discontinuation of a resident's splint. The NHA stated If a new splint was ordered I would assume there was a reason the old one was no longer appropriate whether it be a skin problem or some other reason. The NHA did not specify a documentation expectation.</p> <p>A facility policy addressing splints and orthotics was requested via email and in person and was not provided by the conclusion of the survey.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223</p> <p>Based on observation, interview, and record review the facility failed to obtain a physician order for oxygen for one resident (R76) out of two residents reviewed for oxygen. Findings include:</p> <p>On 9/17/24 at 10:15 AM, 9/17/24 at 11:43 AM, 9/17/24 at 1:34 PM, 9/17/24 at 3:36 PM, 09/17/24 04:04, 9/18/24 at 8:46 AM, 9/18/24 at 11:56 AM, and 9/18/24 at 1:42 PM, R76 was observed lying in bed wearing oxygen at four liters per minute via nasal cannula.</p> <p>A review of R76's medical record revealed they were admitted to the facility on [DATE] with the following diagnosis: Cerebral Infarction due to Embolism of Right Cerebellar Artery; Chronic Obstructive Pulmonary Disease; Acute Respiratory Failure with Hypoxia.</p> <p>A review of R76's Brief Interview for Mental status revealed a score of 15 indicating intact cognition.</p> <p>A review of R76's care plan revealed the following: I have altered respiratory status/difficulty breathing in my respiratory status r/t (related to) COPD (chronic obstructive pulmonary disease) Acute respiratory failure, cardiac arrest. Oxygen settings: O2 (oxygen) via nasal cannula @ 2-3 L (liters).</p> <p>A review of R76's physician orders revealed no orders for oxygen.</p> <p>On 9/18/24 at 1:46 PM, during an interview, with Licensed Practical Nurse (LPN J) was asked if R76 was on oxygen. LPN J stated, I believe its prn (as needed). LPN J was observed reviewing R76's electronic medical record. LPN J confirmed there was no physician order for oxygen and explained that they would clarify with the doctor. LPN J was asked if there should be a physician order if a resident is wearing oxygen. LPN J stated yes. Unit Manager (UM E) was also present at the time of the interview and explained there should be a physician order if a resident is on oxygen.</p> <p>On 9/19/24 at 11:48 AM, during an interview, the Director of Nursing (DON) was asked to explain their expectation regarding physician orders for oxygen. The DON explained if a resident is on oxygen there should be a physician order stating the type and amount of oxygen that they are on.</p> <p>On 9/19/24 at 10:00AM, during an interview, the Nursing Home Administrator (NHA) was asked to explain their expectation for physician orders for oxygen. The NHA explained if a resident is on oxygen there should be a physician order for it.</p> <p>A review of the facility's policy titled Oxygen Administration revealed the following: A resident will receive oxygen per physician orders and facility protocol. The resident's disease, physical condition, and age will help determine the most appropriate method of administration. This is performed by a licensed nurse or respiratory therapist.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident medications were not left at the bedside for four residents (R22, R44, R63 and R71) of four residents reviewed for medication storage. Findings include:</p> <p>R71</p> <p>On 9/16/24 at 8:40 AM, R71 was observed lying in bed. An inhaler was observed lying on their bedside table.</p> <p>A review of R71's medical record revealed the resident was admitted into the facility on [DATE] with diagnoses included Chronic Obstructive Pulmonary Disease, Alcohol Abuse, and Adjustment Disorder. Further review revealed the resident was moderately cognitively impaired, and required limited assistance with Activities of Daily Living.</p> <p>On 9/17/24 at 12:55 PM, R71 was observed lying in bed awake, inhaler located on their bedside table.</p> <p>On 9/19/24 at 9:19 AM, R71 was observed lying in bed, inhaler lying on their bedside table. R71 was asked about the inhaler, and explained it's their Albuterol rescue inhaler. R71 was asked when was the last time they used it and stated, Today. Just now.</p> <p>A review of R71's physician orders revealed an order for ProAir HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally four times a day for sob (Shortness of Breath).</p> <p>Further review of the medical record did not reveal an assessment for the self-administration of medications.</p> <p>On 9/19/24 at 9:24 AM, Unit Manager H was asked about the inhaler at R71's bedside and whether there was an assessment completed for the resident to self-administer their own medications. Unit Manager H explained they were unable to locate one for the resident.</p> <p>R63</p> <p>9/17/24 at 11:06 AM, R63 was observed in bed, and easily aroused. Observed on the resident's bedside table were a stack of medication cups, and located next to the stack was a medication cup with pills inside. R63 was asked about them, and immediately ingested the medications and explained they were from last night.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of R63's medical record revealed they were admitted into the facility on [DATE] with diagnoses included Heart Failure, Diabetes, and Chronic Kidney Disease. Further review revealed the resident was cognitively intact and required limited to supervision for Activities of Daily Living.</p> <p>On 9/18/24 at 8:46 AM, R63 was observed in bed asleep, a medication cup with two pills were observed sitting on the resident's bedside table. Licensed Practical Nurse (LPN) I was approached outside of R63's room, and asked if they had passed R63's medications yet. LPN I explained they had not, as they were just coming on for their shift. LPN I was asked to view the medications at R63's bedside, and explained they did not provide the resident with those medications. LPN I removed the medication cup from the room, and made observations of the medications statin, It looks like a Gabapentin and a Buspar (Pain medication and an anti-anxiety medication).</p> <p>50223</p> <p>R22</p> <p>On 9/17/24 at 12:51 PM, R22 was observed awake lying in bed with family at bedside. An albuterol inhaler was observed on top of the dresser. R22 was asked if they use the inhaler. R22 stated sometimes.</p> <p>On at 9/18/24 at 8:41 AM, R22 was observed awake in bed. The albuterol inhaler was observed still on the dresser.</p> <p>On 9/18/24 at 8:45 AM, Licensed Practical Nurse (LPN) J was shown the inhaler in the room and was asked if the inhaler should be at R22's bedside. LPN J stated, no I don't think so. LPN J was asked if residents can keep medications at the bedside. LPN J explained sometimes residents keep medications at the bedside but there should be a physician order if they do.</p> <p>A review of R22's medical record revealed they were admitted to the facility on [DATE] with the following diagnosis: Nontraumatic Subdural Hemorrhage, Unspecified. Chronic Obstructive Pulmonary Disease Unspecified.</p> <p>A review of R22's Brief Interview for Mental Status revealed a score of 14 indicating mild cognitive impairment.</p> <p>A review f R22's physician orders revealed the following: Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 base) MCG/ACT (albuterol Sulfate) 1 puff inhale orally every 4 hours as needed for SOB (shortness of breath).</p> <p>R44</p> <p>On 9/17/24 at 9:56 AM, R44 was observed asleep in bed. Fluticasone nasal spray and saline nasal spray were observed on top of the dresser in the room.</p> <p>On 9/18/24 at 8:51 AM, R44 was observed awake in bed. The two nasal sprays were observed to still be on the dresser in the room. R44 was asked if they use the nasal spray. R44 explained that they hadn't used them in a while but could if they needed to.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of R44's medical record revealed they were admitted to the facility on [DATE] with the following diagnosis: Chronic Obstructive Pulmonary Disease Unspecified; Obstructive Sleep Apnea.</p> <p>A review of R44's Brief Interview for Mental Status revealed a score of 15 indicating intact cognition.</p> <p>A review of R44's physician orders revealed the following active order: Saline Nasal Spray Solution (saline) 1 spray in each nostril every 2 hours as needed for congestion Further review revealed the following discontinued order: Fluticasone Propionate Suspension 50 MCG/ACT 1 spray in each nostril one time a day for dryness. Discontinued 7/9/24.</p> <p>On 9/18/24 at 9:09 AM, LPN L was shown the two nasal sprays in R44's room and was asked if they should be in the room. LPN L stated No, they should not. (R44) does not have an order to have them at the bedside. LPN L was asked if there should be a physician order for a resident to have meds at the bedside. LPN L stated Yes. There should be an order in pcc (the electronic medical record) that says they can self-administer and keep medications at bedside.</p> <p>On 9/19/24 at 10:00 AM, during an interview, the Nursing Home Administrator (NHA) was asked to describe their expectation regarding medications at a resident's bed side. The NHA explained that medications should not be left at a resident's bedside unless there is a physician order and the nurse should watch the residents take their medications before leaving the room.</p> <p>On 9/19/24 at 11:48 AM, the Director of Nursing (DON) was informed of the observations of medications at the bedside of R22 and R44 and was asked to explain their expectation regarding medications at a resident's bedside. The DON explained medications should not be left at a resident's bedside unless the resident has had an assessment done and documented that they are able to self-administer medications and have a physician's order to self-administer the medication.</p> <p>A review of the facility's policy titled Self-Administration of medications by residents revealed the following: Each resident who desires to self-administer medication is permitted to do so if the facility's interdisciplinary team/or facility policy allows or has determined that the practice would be safe for the resident and other residents of the facility. Procedure. 1. Each resident is offered the opportunity to self-administer his or her medications during the routine assessment by the facilities interdisciplinary team. 3. the interdisciplinary team determines the resident's ability to self-administer medications by means of skill assessment .4. the results of the interdisciplinary team assessment are recorded on the medication self-administration form, which is placed in the resident's medical record .7. All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and then give unauthorized medications to the charge nurse for return to the family or responsible party.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207</p> <p>Based on observation, interview, and record review, the facility failed to serve food in a palatable manner and at the preferred temperature for one resident (R47) and ten confidential group residents of thirteen reviewed for food palatability, resulting in dissatisfaction during meals. Findings include:</p> <p>On 9/17/24 at 9:25 AM, R47 was met in their room for observation and interview. R47's breakfast was observed to consist of two biscuits, two pancakes, cereal, a small carton of milk, syrup and butter. The only protean observed with R47's breakfast was the carton of milk. R47 was interviewed about the food served to them at the facility and stated, The food is [swear word].</p> <p>On 9/18/24 at 8:38 AM, a followup visit was conducted with R47 and they were asked how their breakfast was. R47 stated, It tasted like garbage, I had two hard boiled eggs, toast, and cereal.</p> <p>A review of R47's electronic medical record (EMR) revealed that R47 was most recently admitted to the facility on [DATE] with diagnoses that included Congestive heart failure and Type 2 diabetes. R47's most recent quarterly minimum data set assessment (MDS) revealed that R47 had a moderately impaired cognition.</p> <p>A review of Food Council Meeting notes dated 8/12/24 revealed the following, The food is horrible, the green beans are nasty and not seasoned at all. The chicken tenders are horrible and the breading is soggy. The food is terrible, I can't eat the food, it has no taste and it's cold. Need more soups, can't mess that up. I wish the food could be better at times. The meat doesn't taste like meat. The pork chop can't even be cut with a knife and the meatloaf is nasty.</p> <p>On 9/18/24 at 10:05 AM, a confidential group meeting was conducted with a group of of ten residents and they were asked about the taste and temperature of the food served to them at the facility. The whole group indicated that the food was cold and didn't taste good. One group member indicated that the dinner portions were small and they frequently were still hungry after finishing their dinner.</p> <p>On 9/18/24 at 12:30 PM, a food cart on one of the units was observed with two food trays on top of the cart, no plate warmers underneath the plates, and the doors to the food cart open while staff was serving meals to the residents. On 9/18/24 at 12:33 PM, Dietary Manager (DM) A temperature tested a random tray and the results were the following, Crusted Parmesan Chicken: 113 degrees Fahrenheit. There was no sauce observed on the chicken. Garlic Buttered Fettuccini: 115.6 degrees Fahrenheit. The noodles appeared to be plain with no butter on them. There was no cooked carrots or apple crumble observed on the plate, these items were indicated to be part of the meal per the menu. DM A was asked about no carrots being served with the meal and stated, Do you want some. DM A was asked about the preferred temperature for the food and stated 100 degrees Fahrenheit or above and per resident preference.</p> <p>22960</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 9/17/24 at 12:45 PM, a test tray was done. The internal temperature of the pork chop was measured to be 107 degrees Fahrenheit. The pork chop was tasted and was lukewarm. The pork chop was extremely fatty, with very little actual meat available to eat.</p> <p>A review of a policy titled, Food Palatability-Hot Food Temperatures Date: 3.13.2018 revealed the following, Policy: The healthcare community prepares and serves food .that [is] palatable, attractive and .[at] appetizing temperature[s].</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>22960</p> <p>This citation pertains to Intake: MI00146189</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program by eliminating harborage conditions in the kitchen. This deficient practice has the potential to affect all residents in the facility. Findings include:</p> <p>09/17/24 at 9:15 AM, there was standing, stagnant, slimy water observed on the floor, in the corner underneath the garbage grinder at the 3 compartment sink. In addition, there were cobwebs and numerous gnats observed in the same area. When queried, Dietary Manager (DM) A stated that the pipe for the garbage grinder was small and sometimes over-flows. DM A did not provide an explanation for why the standing water in the kitchen was not cleaned up, in order to prevent a breeding ground for gnats.</p> <p>On 9/17/24 at 9:20 AM, there was standing water on the floor between the coffee maker and the juice dispenser. There were gnats observed flying about in the same area. When queried, DM A was unsure where the water was coming from.</p> <p>Review of the pest control service reports for 9/12/24 and 9/5/24 noted that the target pests were gnats, and the service report for 8/22/24 noted lots of gnats.</p> <p>According to the 2017 FDA Food Code section 6-501.111 Controlling Pests, The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: .4. (D) Eliminating harborage conditions.</p>