STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235521	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Wayne	4427 Venoy Rd Wayne, MI 48184

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3017670.Based on observation, interview and record review the facility failed to administer medications as ordered and failed to notify the physician when missed medications were not administered for one resident (R902) out of three residents reviewed. Findings include:Record review of electronic medical records (EMR) revealed admission into facility on 10/4/25 with a pertinent diagnosis of Multiple Sclerosis (chronic autoimmune disease) and depression. Review of Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 (intact cognition).An observation and interview were conducted on 6/4/26 at 10:03 AM with R902, The resident was observed lying in bed cleaned and groomed appropriately. it was reported that prescribed medications Duloxetine (antidepressant) were not administered as ordered by the physician. It was further reported that nursing staff told R902 it was not available at the facility, and they (staff) were waiting for it to be delivered by the pharmacy.Record review of Physician Orders revealed R902 was prescribed the medication Duloxetine 60 mg capsule-Give one capsule by mouth one time a day for depression.Record review of Medication Administration Record (MAR) for April 2026, it was documented on the 29th and 30th with number nine and Licensed Practical Nurse (LPN) A ?s initials. Review of MAR for May 2026 documented on 6th, 7th, and 11th with a number 9 and LPN B's initials.An interview was conducted on 6/4/26 at 11:15 AM with Director of Nursing (DON) it was reported that documentation of the number nine indicates to review the nursing progress notes.Record review of R902's nursing progress notes indicated on April 29th, no reason was documented. April 30th and May 6, 7, 11 the documented reason was on order. Further review of R902's progress notes found no documentation that the physician was made aware that the medication was not given on those days.An interview was conducted on 6/4/26 at 12:25PM with Director of Nursing (DON), it was reported that the medication Duloxetine was always available in the facility's emergency medication back up system.An observation on 6/4/26 at 12:30 PM of the facility's emergency medication back up system revealed the medication Duloxetine was available in 30mg (milligram) capsules.On 6/4/26 at 12:50 PM a phone interview was conducted with LPN A, it was reported that when the number nine is documented the medication was not available and was not given. LPN A further reported that the physician was not called when the medication was not administered on 4/29, 4/30 and 5/11.On 6/4/26 at 1:03 PM a phone interview was conducted with LPN B, It was reported that when the number nine is documented that the medication was not given and was not able to retrieve the medication from back up. It was further reported that the physician was not notified on 5/6 and 5/7 when the medication was not administered.On 6/4/26 at 1:54 PM an interview was conducted with the DON; it was reported that anytime a medication is not administered the physician should be informed. It was further reported that the medication for R902 was available in the emergency backup system, and nursing staff should have retrieved the medication and administered it to R902.Record review of facility's policy Medication and Administration and General Guidelines' dated 2024 documented the following: .12. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR for that dosage (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration Is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. The physician must be notified when a dose of medication has not been given. If an electronic medical record is being utilized than the caregiver administering the medication will enter the correct documentation that will then be electronically stamped with their initials.