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	06/16/2026

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 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 intake 3039764. Based on observation, interview and record review, the facility failed to protect R103's right to be free from verbal abuse by staff. Findings include: Record review revealed the following: on 5/22/2026, a verbal altercation occurred between R103 and Nurse A within the facility. During this incident, Nurse A was overheard by Nurse E stating, I am not your wife, I will blow you out. According to R103, Nurse A said she had a pistol and was going to blow him away. The Police Department was called, and Nurse A was sent home. On 6/16/2026 at 1:15 PM, R103 was interviewed and stated, (Nurse A) threatened to shoot me with her pistol. When queried about how this made him feel, he stated, It made me feel challenged. R103 said he was an ex-marine and stated, I felt like I had to prepare to defend myself. R103 also said that he has nurses within his family, so he is familiar with appropriate behaviors expected of nurses. R103 stated, I know how staff should behave and (Nurse A) is in the wrong field. R103 said he heard Nurse A have a verbal altercation with someone else in the hallway minutes before she threatened him. R103 stated, She already had a bad attitude before we engaged. Record review of R103's Minimum Data Set (MDS) dated [DATE] revealed R103 had a Brief Interview of Mental Status (BIMS) score of 14/15 indicating R103 was cognitively intact. On 6/16/2026 at 2:45 PM, the Director of Nursing (DON) was interviewed regarding the allegation of verbal abuse incident against R103 by Nurse A. The DON stated, We suspended (Nurse A) pending an investigation and informed her that she couldn't handle residents like that. She was educated, trained and given a warning. She resigned the next day. When queried about the expectations of professional standards. The DON stated, The staff are expected to treat all residents with respect and should not engage in arguments with them. On 6/16/2026 at 5:41 PM, Licensed Practical Nurse (LPN) E was interviewed regarding the allegation of verbal abuse incident. LPN E stated, I heard a shouting match between (Nurse A) and (R103). I intervened, sent (Nurse A) home and called the police. LPN E was asked about the disposition of Nurse A. LPN E stated, She was already upset with another staff person regarding sharing the care needs of another resident before the incident with (R103). Review of the facility' Policy on Abuse entitled, Abuse and Neglect Prohibition Policy revised 02/17/2020, read in part: Each resident has the right to be free from abuse, mistreatment, neglect, exploitation, involuntary seclusion, misappropriation of property and mental abuse facilitated or enabled through the use of technology. Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. According to the State Operations Manual; verbal aggression includes intimidation.

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