

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235521	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  The Orchards at Wayne		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964</b></p> <p>Based on observation, interview, and record review, the facility failed to provide an appropriately sized wheelchair for one resident (R79) of one resident reviewed for accommodation of needs, resulting in discomfort.</p> <p>On 7/30/24 at 10:51 AM R79 was observed sitting in standard wheelchair (18-inch-wide seat) with abdominal girth and thighs resting directly on the metal part of the wheel chair arms.</p> <p>On 7/31/24 at 8:24 AM R79 was observed self-propelling in a standard wheelchair down the hallway. R79 was asked about her comfort in the wheelchair and stated My wheelchair is too tight. My legs push against the sides. I'm not comfortable. R79 said she was going to the dining hall for breakfast and spends most of the day in the wheelchair.</p> <p>Record review of R79's Electronic Medical Record (EMR) revealed admitted to facility on 3/8/24 with pertinent diagnosis of Mononeuropathies of bilateral lower limbs, Chronic Congestive heart failure.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] for R79 revealed a Brief interview for Mental Status (BIMS) of 13/15 intact cognition and required a wheelchair for ambulation.</p> <p>Record review of R79's care plan dated 3/8/24 revealed in part, I need tray delivery &amp; setup help @ mealtimes, moderate help with UB(upper body) tasks &amp; substantial help with most LB(lower body) ADL's r/t (activities of daily living related to) obesity &amp; weakness. BMI (body mass index) classified as obese. I have actual impairment to skin integrity of the (Bilateral lower legs and under abdominal folds) r/t skin tears to lower leg.</p> <p>On 7/31/24 at 11:21 AM Therapy Manager A said the therapy department provides wheelchairs for new admits. Therapy Manager A provided documentation that R79 was assessed by physical and occupational therapy on 3/11/24.</p> <p>On 7/31/24 at 2:16 PM Licensed Practical Nurse B agreed R79 required a wider wheelchair due to her abdominal girth and thighs pushing against the arms of the wheelchair.</p> <p>In an interview on 8/1/24 at 8:43 AM the Director of Nursing (DON) said resident wheelchairs should fit correctly so that residents are comfortable.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Unit Rounds undated revealed in part .The purpose of unit rounds is to monitor residents throughout the day to assure their needs are met.</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34901</p> <p>Based on interview and record review, the facility failed to notify the Responsible Representative (RR) of a facility-initiated discharge for one (R76) resident reviewed for transfer.</p> <p>Findings include:</p> <p>A review of the Admission Record for Resident #76 (R76) revealed an initial admitted [DATE], readmitted [DATE], and the designation of RR N as R76's emergency contact and guardian. R76's was diagnosed with schizoaffective disorder. A Minimum Data Set (MDS) assessment dated [DATE] documented severe cognitive impairment.</p> <p>A review of R76's clinical record documented the following:</p> <p>Behavior progress note of 11/20/23, created on 11/21/23: Resident spitting at staff, screaming in hallway, pulling at brief, throwing brief contents at staff and at other residents, did not make contact with others, throws self on floor, attempted to distract with candy, TV, activities, unable to distract, continued to scream, swinging arms at staff, unapproachable most of the time due to aggressiveness towards anyone who approaches her. NP (nurse practitioner) from (company providing psychiatric/psychological services) in to evaluate, unable to have a conversation with resident, she kept screaming and spitting and swinging arms when approached or attempts to engage in conversation.</p> <p>Admission's note dated 11/22/23: At 12pm, resident arrived from (local hospital) via stretcher with 2 EMS personnel. appear stable, verbally aggressive, cursing, yelling and attempting to fight staff during assessment. vital signs WNLs (within normal limits). Lungs clear to auscultate, and no signs of SOB (shortness of breath) noted. Abdomen round and non-distended with active bowel sound in all quadrants. skin intact with old scar on abdomen, right lower leg and left lateral shin. welcome and oriented to her room. bed place in the lowest position with the HOB (head of bed) elevated to improve lung ventilation. safety measures and fall precaution implemented. call light and all personal belonging place within reach. In-House NP verified all prescribe medications and new orders updated in the MAR (medication administration record).</p> <p>On 7/31/24 beginning at 1:05 PM, the Director of Nursing (DON) reviewed R76's clinical record and confirmed that R76 was transferred to the hospital on 11/20/23. The DON said she thought the facility had petitioned the resident out but was unable to provide corroborating documentation. The DON was also unable to provide documentation that R76's RR was notified of the transfer.</p> <p>On 8/1/24 at 11:48 AM, the Nursing Home Administrator (NHA) said R76's guardian should have been notified because she was being sent out to the hospital due to a change in condition.</p> <p>A review of the facility document titled, Transfers and Discharges, undated but provided during the survey, documented in part that for emergency transfers to notify resident and/or resident representative.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/1/24 at 3:30 PM during the exit conference, the NHA and DON did not offer additional documentation or information regarding this citation when asked.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964</b></p> <p>Based on observation and interview the facility failed to provide timely ADL (Activities of daily living) care to include nail care for one resident (R50) of six residents reviewed for ADL care resulting in dissatisfaction with care.</p> <p>Findings include:</p> <p>On 7/30/24 at 10:24 AM R50 was observed in bed sleeping with both hands contracted into fists with long dirty fingernails.</p> <p>On 7/31/24 at 8:14 AM R50 was observed in bed sleeping with both hands contracted into fists with long dirty fingernails.</p> <p>On 7/31/24 at 1:11 PM R50 stated, My nails need to be cut they are too long.</p> <p>Record review of R50's Electronic Medical Record (EMR) revealed admitted to facility on 10/13/22 with pertinent diagnosis of bed confinement status.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] for R50 revealed a Brief interview for Mental Status (BIMS) of 15/15 intact cognition and dependent for personal hygiene.</p> <p>On 7/31/24 at 2:18 PM Licensed Practical Nurse (LPN) B was interviewed and agreed R50's fingernails were long with debris under the nails. LPN B stated, No one told me her nails were long or that she had refused to get them cut. LPN B then asked R50 would you let me cut your nails and R50 agreed.</p> <p>Record review of R50's care plan revealed intervention date initiated 10/25/22 Bathing/Showering: Check my nail length-file and clean them on my bath day as necessary. Report any changes to the nurse.</p> <p>On 8/01/24 at 8:44 AM the Director of Nursing (DON) was interviewed and said dependent residents are expected to have ADLs including nails trimmed timely.</p> <p>Review of the facility policy titled Unit Rounds undated revealed in part . The purpose of unit rounds is to monitor residents throughout the day and assure their needs are met. Resident: Fingernails/Toenails clean and trimmed.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38230</p> <p>Based on interview and record review the facility failed to address Medication Regimen Review (MRR) recommendations timely for one resident (R54) of five residents reviewed for a medication regimen review, resulting in the potential for the continuance of unnecessary medications and lack of communication of recommended medication changes between pharmacist and physician.</p> <p>Findings include:</p> <p>On 8/01/24 at 10:34 am review of the clinical record documented R54 was initially admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type 2 diabetes mellitus with diabetic neuropathy, panic disorder, episodic paroxysmal anxiety, undifferentiated schizophrenia, and bipolar disorder. According to the admission Minimum Data Set assessment, R54 had moderate impaired cognition and dependent for most activities of daily living.</p> <p>Review of R54's physician orders documented the resident's current medications as follows:</p> <ul style="list-style-type: none"> <li>- Cymbalta Oral Capsule Delayed Release Particles 30 MG (Duloxetine HCl) Give 30 mg by mouth one time a day for Mood. Start date 7/20/24.</li> <li>- Abilify Oral Tablet 10 MG (Aripiprazole) Give 10 mg by mouth one time a day for Mood with Psychosis. Start date 7/20/24.</li> <li>- Norco Oral Tablet 7.5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 8 hours for Pain. Start date 7/3/24.</li> <li>-Insulin Glargine Solution 100 unit/ml Inject 35 unit subcutaneous once daily for Diabetes Mellitus. Start date 7/3/24.</li> </ul> <p>Review of monthly pharmacy recommendations in the electronic medical record documented the following:</p> <p>5/29/24- See report for any noted irregularities and/or recommendations. Additional information: 6 types of recommendations.</p> <p>On 8/1/24 at 11:00 a.m. the facility was asked to provide the detailed pharmacy reports and recommendations. They were not located in the electronic medical record (EMR).</p> <p>On 8/1/24 at 2:00 p.m. the Nursing Home Administrator (NHA) was asked again to provide the pharmacy report and recommendation for R54. The NHA said the first request was missed and will be provided.</p> <p>On 8/1/24 at 2:50 p.m. the facility was asked to provide the facility's policy for Medication Regimen Review (MRR).</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/1/24 at 4:00 p.m. the survey team exited the facility and the facility had not provided the pharmacy report and the facility's policy for MRR as requested prior to exiting.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>34901</p> <p>Based on observation, interview, and record review, the facility failed to: 1. Ensure kitchen sinks were in good repair and warm water was available for hand washing; 2. Properly date-label food stored in the walk-in cooler; 3. Ensure proper cooling of cooked, potentially hazardous (time-temperature for safety) food, mixed vegetables; 4. Ensure pans were properly cleaned; 5. Effectively clean surfaces in the kitchen and commercial ice machine; 6. Maintain cleanable walls in the kitchen; and 7. Ensure used meal trays were not placed on a meal cart during meal pass. These deficient practices had the potential to affect all the residents who consumed food from the kitchen and consumed ice from the ice machine, resulting in the potential for food-borne illness.</p> <p>Findings include:</p> <p>On 7/30/24 at 8:40 AM, during an observation of the kitchen with Dietary Manager (DM) G the following was observed:</p> <ol style="list-style-type: none"> <li>1. Caulking around the hand washing sink near the Dietary Manager's office was cracked and separated. DM G said water can get through the cracks.</li> <li>2. The following food items, observed in the walk-in cooler, were dated as indicated but the date marking did not specify if the date was the delivery date, opened date, or use-by date. <ul style="list-style-type: none"> <li>- An opened one-gallon container of mayonnaise dated 7/11.</li> <li>- An opened 32-ounce container of minced garlic dated 6/7.</li> <li>- An opened packaged of shredded Monterey [NAME] cheese dated 7/25.</li> <li>- An opened 80-ounce bag of shredded cheddar cheese dated 7/29.</li> <li>- An opened bag of sliced turkey ham dated 7/27.</li> </ul> </li> </ol> <p>DM G said date labeling needed to include the date received, date opened, and use-by date.</p> <ol style="list-style-type: none"> <li>3. An undated full-size pan of cooked mixed vegetables was stored in the walk-in cooler. The cooling log was reviewed. The last item documented on the cooling log were biscuits cooked and cooled on 5/25/24. DM G acknowledged the mixed vegetables cooked yesterday should have been on the cooling log and they were not.</li> <li>4. The following pans soiled with food debris were observed stored in the clean pot/pan area: one full-size pan, one full-size perforated pan, two one-third size pans, one full-size sheet pan, and one sixth-size pan. DM G said the pots and pans should be air dried with no remaining food particles.</li> <li>5. The back splash of the dish tank area was observed stained with a black substance that was easily removed with a paper towel.</li> </ol> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>6. Cove base tiles, located on the end cap wall between the dish tank area and main kitchen, were missing, exposing a surface that was not easily cleanable. DM G said maintenance was told about the missing tiles but probably forgot about it. DM G acknowledged that the surface was not cleanable.</p> <p>The front faceplate inside of the ice machine, located in resident nourishment room, was observed stained with a black slimy appearing substance that was easily removed with a paper towel. DM G said that maintenance was responsible for cleaning the ice machine.</p> <p>On 7/31/24 at 12:53 PM as Resident #43 (R43) was returning to his room, he asked Certified Nurse Aide (CNA) I if he could be served lunch. CNA I said yes and obtained R43's lunch tray from the enclosed meal cart. After R43's tray was delivered, the contents of the meal cart was examined with CNA I. There were two finished (soiled) meal trays, one from breakfast, that had been placed on the same side of the meal cart as unserved meal trays. CNA I said placing dirty trays with unserved meal trays can cause food contamination. CNA I stated, It's very unsanitary for sure.</p> <p>On 8/1/24 at 9:18 AM, Maintenance Director (MD) C said that maintenance was responsible for cleaning the ice machine. MD C stated, If it was dirty, it should have been cleaned.</p> <p>On 8/1/24 at 11:33 AM, the hot water faucets of the kitchen handwashing sink located near the DM G's office and the automatic handwashing sink were turned on and allowed to run for approximately two minutes. The water temperatures, as measured by DM G, were 74 F (Fahrenheit) and 71 F respectively. DM G felt the water and stated, The water is not warm. It's room temperature. The water should be warm.</p> <p>On 8/1/24 at 11:48 AM, the Nursing Home Administrator (NHA) said she expects the kitchen to be a sanitary department and to uphold their policies and procedures.</p> <p>A review of a document provided during the survey titled, How To Clean a Commercial Ice Machine, documented in part that commercial ice machines harbor dangerous bacterial growth and contamination if not cleaned properly. Frequent cleaning prevents the formation of biofilm. Biofilm protects harmful organisms, and once established, is difficult and expensive to remove.</p> <p>According to the 2013 FDA Food Code:</p> <p>-Section 3-501.14 Cooling. (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 135 F to 70 F; and (2) Within a total of 6 hours from 135 F to 41 F or less.</p> <p>-Section 3-501.17, Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. Refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees F or less for a maximum of 7 days.</p> <p>-Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Section 5-202.12 Handwashing Facility, Installation. Warm water is more effective than cold water in removing the fatty soils encountered in kitchens. An adequate flow of warm water will cause soap to lather and aid in flushing soil quickly from the hands. ASTM (American Society for Testing and Materials) Standards for testing the efficacy of handwashing formulations specify a water temperature of 100 to 108 F.</p> <p>- Section 6-201.11 Floors, Walls, and Ceilings. Except as specified under S 6-201.14 and except for antislip floor coverings or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable</p> <p>On 8/1/24 at 3:30 PM during the exit conference, the NHA and Director of Nursing did not offer additional documentation or information regarding this citation when asked.</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>34901</p> <p>Based on observation, interview, and record review, the facility failed to properly dispose of rubbish and maintain cleanliness of the outside garbage area, resulting in a visually unappealing property and the potential for harborage of pests.</p> <p>Findings include:</p> <p>On 7/30/24 at 8:34 AM, the gates to the outside fenced in dumpster area were opened. Three dumpsters, approximately 4 to 6 yard bins, were located within the fenced in area. The grounds of the fenced in area were littered with overgrown vegetation and trash, such as a mop handle, used cups, used gloves, used lids, disposable food containers, plastic bags, flattened cardboard boxes, a call light pull cord, smashed cans, two 8-foot metal frames, and a 55-gallon trash can which was half full of dark, murky water and also contained a plastic trash bag and green vegetation.</p> <p>On 7/30/24 at 12:10 PM, the outside dumpster area was observed with District Manager of Environmental Services (DMES) F and Dietary Manager (DM) G. The dumpster area remained littered with trash and the middle dumpster lid was opened. DMES F said the dumpster area needs attention because of the trash. DM G said the dumpster lid needed to be closed to prevent animals and water from getting inside.</p> <p>On 8/1/24 at 9:18 AM, Maintenance Director (MD) C said keeping the outside dumpster area clean was a group effort and that moving forward, keeping the dumpster area clean will be part of the maintenance department's preventative maintenance.</p> <p>On 8/1/24 at 11:48 AM, the Nursing Home Administrator (NHA) said that maintenance should have a cleaning schedule to maintain the cleanliness and sanitation of the outside dumpster area.</p> <p>A review of the policy titled, Waste Disposal, undated but provided during the survey, documented in part that the outside dumpsters will be maintained in a clean manner. Trash will not be overflowing and lids will remain closed at all times. The area around the dumpster should be kept clean and swept of debris.</p> <p>On 8/1/24 at 3:30 PM during the exit conference, the NHA and Director of Nursing did not offer additional documentation or information regarding this citation when asked.</p>