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	11/21/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a comfortable homelike environment for one resident (R87) out of four residents reviewed for safe, clean, homelike environment resulting in R87's personal items getting wet.Findings include: On 9/22/2025 at 10:57 AM, R87 was observed in bed with an approximate two feet by four feet puddle on the floor at the head of bed. When R87 was asked about the puddle, R87 stated There is a leak in the window. It does that every time it rains. My stuff on the windowsill gets wet. When asked if R87 reported the leak, R87 stated, Yes, they are aware of it. It was actively raining during the interview.On 9/23/2025 at 3:29 PM, R87's roommate R82 was interviewed and said the window or air conditioning unit has been leaking for about a year when it rains.On 9/23/2025 at 3:44 PM, R87 was interviewed and said the staff mopped up the water yesterday.On 9/24/2025 at 9:03 AM, there was an active leak on R87's windowsill. It was raining.On 9/24/2025 at 9:03 AM, R87's window was observed with Maintenance Director (MD) B. MD B acknowledged there was an active leak in the window. MD B said it looked like the bottom window seal was bad and was letting rainwater in the room. When MD B removed R87's personal items from the windowsill a picture frame and stuffed animal were dripping water. Record review of R87's Electronic Health Record (EHR) revealed he was admitted to the facility on [DATE] with a diagnosis of Traumatic Brain Injury.Review of R87's Brief interview for Mental Status assessment performed on 9/2/25 revealed a BIMS of 14/15 intact cognition. Record review of R82's Electronic Health Record (EHR) revealed he was admitted to the facility on [DATE] with a diagnosis of Acquired Right Below Knee Amputation.Review of R82's Brief interview for Mental Status assessment performed on 7/28/2025 revealed a BIMS of 15/15 intact cognition. Review of R82's maintenance room audits for August and September 2025 did not reveal any issues.On 9/24/2025 at 11:30 PM the Nursing Home Administrator (NHA) was interviewed and said the expectation is for resident rooms to be clean and comfortable without window leaks. Review of the facility policy titled Resident Rights undated, revealed in part. 9. Safe Environment The resident has the right to a safe, clean, comfortable and homelike environment.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that an allegation of misappropriation of resident property for one (R35) of four residents reviewed for abuse was immediately reported to the State Agency. This failure resulted in the facility not reporting an allegation of missing funds, placing R35 at risk for further potential misappropriation and lack of external investigation.Finding include:On 9/23/2025 at 11:29 AM, R35 was interviewed and said they had missing personal items and missing money. R35 stated, I had clothing, personal items and $200 that went missing. R35 said they reported the missing items to a staff member whose name they could not recall.On 9/24/2025at 11:29 AM, R35's family member was interviewed by phone and said R35 told them about the missing money and they had reported it to staff. The family member said they had spoken with facility staff regarding the missing money and purchased a lock box to secure R35's belongings. The family member stated, I would have purchased a lock box earlier if I had known they needed one.On 9/25/2025 at 9:05 AM, the Nursing Home Administrator (NHA) was interviewed regarding the allegation of missing money. The NHA stated, We investigated the allegation of missing money but could not verify that R35 ever had $200. If we had been able to verify that, we would have replaced the money. When the NHA was queried why the allegation of missing funds was not reported to the State Agency, the NHA stated, Because we could not verify whether R35 ever had $200. The NHA confirmed that no report had been made to the State Agency regarding the allegation of misappropriation.Record review of a document titled Concern Form, dated 5/26/2025 and signed by R35, revealed R35 documented the following items were missing: Febreze, socks and $200. The facility response, dated 5/27/2025, documented they replaced the Febreze and discussed the missing money with R35's family. There was no documentation that the allegation of missing funds was reported to the State Agency.Review of document titled Pay Source Acknowledgement, dated for 2024, revealed R35 had checked the box indicating they chose to manage their own personal funds.Record review revealed that R35 was admitted on [DATE] with a pertinent diagnosis of Paralytic Syndrome following Cerebral Infarction (left side weakness after stroke), Hydrocephalus (fluid on the brain), Neurocognitive Disorder, Major Depressive Disorder, Slurred Speech, Repeated Falls, Traumatic Brain Injury and Chronic Pain.Record review of R35's Minimum Data Set (MDS) dated for 6/28/2025 noted R35's Brief Interview for Mental Status (BIMS) was a 15 out of 15 indicating R35 was cognitively intact.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update the care plan for one (R28) of four residents reviewed for behavior care plans to include R28's one on one sitter to monitor behaviors. Findings include:On 9/22/2025 at 10:44 AM, R28 was observed sleeping in bed with Certified Nursing Assistant (CNA) C sitting near R28's room's door. When CNA C was asked what she was observing CNA C stated, I'm here to watch R28, I don't know why though.On 9/23/25 at 8:40 AM, CNA C was observed sitting in R28's room. When asked what her job assignment was, CNA C was replied, I'm here for a one on one with R28. When asked the reason, CNA C replied, I'm not sure.On 9/23/2025 at 1:55 PM, Licensed Practical Nurse (LPN) H was interviewed and said R28 had a one-on-one for behavior issues, a history of drinking hand sanitizer, and using marijuana products. LPN H further said that she talked to CNA C upon shift change and let them know to look out for odd behaviors such as drinking hand sanitizer and hiding marijuana products. LPN H said the one-on-one should be on the Kardex (CNA reference) and care planned (EHR). Record review of R28's Electronic Health Record (EHR) revealed R28 was admitted to the facility on [DATE] with diagnoses of Bipolar Disorder, Psychoactive Substance Abuse with other Psychoactive Substance-Induced Disorder, Alcohol Abuse with Alcohol-Induced Mood Disorder, and Suicidal Ideations.Review of R28's Brief interview for Mental Status assessment performed on 7/19/2025 revealed a BIMS of 15/15 (intact cognition). Record review of the Progress Note dated 7/21/25 revealed, Resident observed with red and glassy eyes, slurring of speech while complimenting staff members on their looks. Suspicious behavior was notified to the DON (Director of Nursing) and physician. Resident is on 1 on 1 monitoring until further notice. VSS 134/78 P 87 RR 18 02 96%Oncoming nurse given report.On 9/24/2025 at 10:19 AM the Director of Nursing (DON) was interviewed and said R28 had a sitter placed on 7/21/25 due to behaviors -drinking hand sanitizer. R28's care plan was reviewed with the DON and did not reveal a one-on-one sitter to monitor behaviors. The DON said R28 did not have a one-on-one siter care plan/Kardex and should. The DON explained the care plan and Kardex are important . so the sitters know what to look for and what to report to the nurse.Review of the facility policy titled, Comprehensive Plan of Care (undated) revealed in part.The comprehensive plan of care must be periodically reviewed and revised by the interdisciplinary team as changes in the resident's care and treatment occur. Re-evaluate and modify care plans: as necessary to reflect changes in care, service and treatment.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review the facility failed to maintain the physical environment in the dish room in a safe sanitary manner and repair and replace a warming device. This deficient practice had the potential to affect 106 of the 111 residents in the facility. On 9/23/25 at approximately 12:00 P.M. and on 9/24/2025 at 1:28 P.M., during an observation in the dish room the following were observed: The ceiling vents and adjacent ceiling tiles were soiled with ash, lint and residue. Visible strings of lint were attached to the vent covers.The plate warmer used during meal service was broken and not heating plates.The caulking between the dish room table and wall was cracked and detached from the wall. Cracked crevices were noted the entire length of the scrape table.The back splash on the dirty end of the dish machine was not easily cleanable, and the perimeters of the panel had a mold-like substance adhering to the panel edges.Underneath the clean end of the dish machine table, a large hole was present in the wall. There was no excursion or covering to prevent the entry of rodents and vermin.In addition, floor tiles and cove bases around the perimeter of the dish room needed to be replaced or repaired.The threshold entering the kitchen from the hallway was missing, leaving a gap causing spillage of liquid items placed on residents' trays.On 9/24/25 at 1:28 P.M., during an interview with corporate staff members F and C both reported multiple requisitions had been submitted to the Regional Maintenance Director for repairs of the identified concerns, with the most recent request submitted 8/19/25. Regional Manager F indicated the broken plate warmer had recently stopped functioning and the other plate warmer was awaiting service.Review of the 2013 Food Code under 4-501.11 Equipment shall be maintained in good repair. Section 6-101.11 materials for floors/walls, and ceilings, should be smooth, durable and easily cleanable under normal use.On 9/25/25 at 9:00 A.M. Maintenance Director B reported being aware of the identified concerns but provided no explanation why the repairs or replacements of the equipment had not been completed or was delayed.On 9/25/2025 at 12:30 P.M., upon exiting the facility, no other information was provided pertaining to why the repairs had not been addressed in a timely manner.