| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235539 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/18/2023 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Orchards at Northwest | 16181 Hubbell St Detroit, MI 48235 |

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 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964<br><br>This citation pertains to intake MI00139366.<br><br>Based on interview, and record review the facility failed to prevent physical restraint use in one resident (R62) out of 10 residents reviewed for abuse resulting in the potential for physical and psychosocial harm.<br><br>Findings include:<br><br>Record review of R62's face sheet revealed admitted to facility on 5/4/2022 diagnoses included diffuse traumatic brain injury, anoxic brain damage, and dementia.<br><br>Review of the Minimum Data Set (MDS) dated [DATE] for R102 revealed severely impaired cognition and R62 required dependent assistance for mobility.<br><br>Record Review of the nursing health status note dated 10/8/2022 revealed During walking rounds at approx. 6:20pm writer observed resident in Geri-Chair with pieces of his brief in his mouth. Writer was able to remove the pieces from resident's mouth, writer then removed the remaining portion of the brief off the resident for safety. Writer informed the CNA (Certified Nursing Assistant) assigned to the resident what happened, and not to place a brief on him so that he would not be able to tear pieces off and place in his mouth. Oncoming nurse arrived @approx 7:05pm at which time she started to do her rounds, she notified me that the resident appeared to be restrained at the hands and feet. I immediately went in to check what the oncoming nurse concerns was. I saw the resident laying in the bed he had on a gown and brief. No covers over him kicking and swarming around. His right arm was tied with a plastic bag, left arm tied with a gown, left leg tied with gown and his right leg was free. I called in the second nurse on the unit who brought in scissors so that I could free his limbs. I called the Abuse Coordinator at approx. 7:22pm and informed her of the situation. The CNA was sent home immediately. A head to-toe assessment was completed there was what appeared to be red rub marks in the fold of the residents left arm. Resident had multiple old scars to his back. Bony area to left hip with darkened area. Old healed over scars to lower left extremity. Resident remains alert and responsive. R62 is able to move extremities per usual. Resident vitals are stable B/P 120/82 HR 106 RR20 SP02 99% R/A Resident is in bed with bed in lowest position, fall mat are in place at this time. When I asked the CNA what her reasoning was for restrain the resident. She stated, I thought that I was protecting him from choking, because he had somehow got a hold to another brief and got it in his mouth. Director of Nursing (DON) notified of situation.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235539 | A. Building<br>B. Wing | 10/18/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Orchards at Northwest | 16181 Hubbell St<br>Detroit, MI 48235 |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 10/17/23 at 10:10 AM with Licensed Practical Nurse (LPN) A stated I received a phone call around 7:30 PM on 10/8/22 from LPN F informing me that Certified Nursing Assistant (CNA) G tied R62 to the bed. I turned around to come back to the facility and went to see the resident. I saw that R62 was tied to the bed with garbage bags, a gown, and a sheet. Both arms and one leg were tied to the bed. I called Registered Nurse (RN) H to help me untie the resident. Along with LPN F we all three untied the resident. I asked CNA G why did she tie up the resident? CNA G said to protect R62 from eating plastic. I told CNA G we don't do that here we don't' use restraints. We are a restraint free building and using restraints is abuse. I reported the incident to the Nursing Home Administrator (NHA).<br><br>Record review of the clinical chart revealed no orders for use of restraints, no consents, no restraint assessments completed and no care plans for restraint use.<br><br>In an interview on 10/17/23 at 1:22 PM the DON stated we are a restraint free building. The DON agreed there were no orders, consents, assessments and/or care plans for the use of restraints for R62. The DON also agreed that the restraints used on R62 (garbage bags, a gown and a sheet) were not an approved type of restraint.<br><br>Record of the facility policy Physical Restraint Management (not dated) revealed in part that physical restraints are not used for purpose of discipline or convenience but only as required to treat the resident's medical system. Any resident using a physical restraint or side rails must have a current signed Physical Restraint Consent in the medical record. The resident, family member or legal representative will be included in the decision process. A care plan will be developed and implemented addressing the restraint, medical symptom, least restrictive alternatives attempted, as well as intervention to promote restraint reduction or elimination.<br><br>Any resident using a restraint will have a current order with the following components:<br><br>Type of restraint.<br><br>Circumstances for using a restraint.<br><br>Medical symptom for using the restraint; and<br><br>A release/exercise statement |

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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** 47964

This citation pertains to intake MI00139366.

Based on interview and record review, the facility failed to report allegations of abuse for one resident (R62) of ten total residents reviewed for abuse, resulting in allegations of abuse that were not reported to the State Agency timely and the potential for further allegations of abuse to go unreported, and not thoroughly investigated.

Findings include:

Record review of R62's face sheet revealed admitted to facility on 5/4/2022 diagnoses included diffuse traumatic brain injury, anoxic brain damage, dementia.

Review of the Minimum Data Set (MDS) dated [DATE] for R102 revealed severely impaired cognition and required dependent assistance for mobility.

Record Review of the nursing health status note dated 10/8/2022 revealed During walking rounds at approx. 6:20pm writer observed resident in Geri-Chair with pieces of his brief in his mouth. Writer was able to remove the pieces from resident's mouth, writer then removed the remaining portion of the brief off the resident for safety. Writer informed the CNA (Certified Nursing Assistant) assigned to the resident what happened, and not to place a brief on him so that he would not be able to tear pieces off and place in his mouth. Oncoming nurse arrived @approx 7:05pm at which time she started to do her rounds, she notified me that the resident appeared to be restrained at the hands and feet. I immediately went in to check what the oncoming nurse concerns was. I saw the resident laying in the bed he had on a gown and brief. No covers over him kicking and swarming around. His right arm was tied with a plastic bag, left arm tied with a gown, left leg tied with gown and his right leg was free. I called in the second nurse on the unit who brought in scissors so that I could free his limbs. I called the Abuse Coordinator at approx. 7:22pm and informed her of the situation. The CNA was sent home immediately. A head to-toe assessment was completed there was what appeared to be red rub marks in the fold of the residents left arm. Resident had multiple old scars to his back. Bony area to left hip with darkened area. Old healed over scars to lower left extremity. Resident remains alert and responsive. R62 is able to move extremities per usual. Resident vitals are stable B/P 120/82 HR 106 RR20 SP02 99% R/A Resident is in bed with bed in lowest position, fall mat are in place at this time. When I asked the CNA what her reasoning was for restrain the resident. She stated, I thought that I was protecting him from choking, because he had somehow got a hold to another brief and got it in his mouth. Director of Nursing (DON) notified of situation.

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 10/17/23 at 10:10 AM with Licensed Practical Nurse (LPN) A stated I received a phone call around 7:30 PM on 10/8/22 from LPN F informing me that Certified Nursing Assistant (CNA) G tied R62 to the bed. I turned around to come back to the facility and went to see the resident. I saw that R62 was tied to the bed with garbage bags, a gown, and a sheet. Both arms and one leg were tied to the bed. I called Registered Nurse (RN) H to help me untie the resident. Along with LPN F we all three untied the resident. I asked CNA G why did she tie up the resident? CNA G said to protect R62 from eating plastic. I told CNA G we don't do that here we don't' use restraints. We are a restraint free building and using restraints is abuse. I reported the incident to the Nursing Home Administrator (NHA).<br><br>Record review of the clinical chart revealed no orders for use of restraints, no consents, no restraint assessments completed and no care plans for restraint use.<br><br>On 10/17/23 at 9:30 AM the NHA stated, I did not report this incident to the State Agency because I didn't think it was abuse. The NHA agreed that R62 was put in restraints.<br><br>In an interview on 10/17/23 at 1:22 PM the DON stated we are a restraint free building. The DON agreed there were no orders, consents, assessments and/or care plans for the use of restraints for R62. The DON also agreed that the restraints used on R62 (garbage bags, a gown and a sheet) were not an approved type of restraint.<br><br>Review of the facility policy titled Abuse and Neglect Prohibition Policy not dated revealed 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. Each resident will be free from chemical or physical restraints imposed for purposes of discipline or convenience that are not required to treat resident symptoms.<br><br>The Administrator or designee is responsible for reporting to the State Agency all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of property:<br><br>. Immediately but no later than 2 hours after the allegation is made if the allegation involves abuse or result in serious bodily injury. a. Or not later than 24 hours if the events that cause the allegation do not involve abuse or serious injury. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>22349<br><br>This citation has two Deficient Practice Statements (DPS).<br><br>DPS #1.<br><br>Based on observation, interview, and record review the facility failed to calibrate (test using a control solution to ensure accuracy) for 3 of 5 glucometers (medical device used to measure blood sugar) in the facility resulting in the potential for inaccurate blood glucose readings.<br><br>Findings include:<br><br>On 10/17/23 at 12:15 PM during observation of blood sugar monitoring with the use of an [EvenCare G2] glucometer Licensed Practical Nurse (LPN) A was asked about calibration of the glucometer. LPN A said that midnight shift performs the calibration and documents it on a 'log'. There was no glucometer calibration log on the 1st floor medication cart, the nurse's station, or the medication room. During inspection of the 1st floor medication cart there were no 'testing solutions' observed.<br><br>On 10/17/23 at approximately 12:30 PM with LPN D observation of the the 2nd floor's East Medication cart revealed a [EvenCare G2] glucometer in the medication cart without any testing solution for calibration. Upon inquiry LPN D said, Midnights calibrates the glucometer and puts the results in the log. There was no glucometer testing log on the 2 East medication cart.<br><br>At approximately 12:40 PM with LPN E observation of the the 2nd floor's [NAME] Medication cart revealed a [EvenCare G2] glucometer in the medication cart without any testing solution for calibration. Upon inquiry LPN E said, Midnights calibrates the glucometer and puts the results in the log. There was no glucometer testing log on the 2 [NAME] medication cart.<br><br>On 10/17/23 at approximately 12:45 PM Nurse Manager LPN A confirmed there were no glucometer calibration logs for any of the 1st floor or 2nd floor glucometers. LPN A said the glucometers are to be calibrated every night shift. I don't know why there are no calibration logs or testing solutions for these glucometers.<br><br>According to the [EvenCare G2] glucometer's manufacturer's insert for care of glucometer:<br><br>The purpose of the control solution testing is to make sure the [EvenCare G2] Gluco Meter and the [EvenCare G2] Test Strips are working properly. You should perform control solution testing when:<br><br>Using the meter for the first time.<br><br>Using a new bottle of [EvenCare G2] Blood Glucose Test Strips.<br><br>. You left the test strip bottle cap open for awhile.<br><br>. You dropped the meter.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | . You suspect your meter and test strips are not working properly.<br><br>The blood glucose test results do not reflect how you feel.<br><br>You want to practice the testing procedure.<br><br>DPS #2.<br><br>Based on observation, interview, and record review the facility failed to administer antibiotics in accordance to physician's orders for one (R68) of five residents reviewed for medication administration resulting in the potential for decreased antibiotic effectiveness and prolonged infection when R68 missed two consecutive doses of antibiotics.<br><br>Findings include:<br><br>During observation of medication administration on 10/17/23 at 9:30 AM with Licensed Practical Nurse (LPN) B a review of R68's Medication Administration Record (MAR) revealed that R68 had missed two consecutive doses of the antibiotic, Bactrim DS 800-160 milligrams (mg) on 10/16/23 at 6:00 PM and again on 10/17/23 at 6:00 AM. The MAR indicated the medication was 'missing'. LPN B said the missing medication had been re-ordered at the pharmacy but it had not been delivered at this time. Upon further interview LPN B said the missing medication (Bactrim DS 800-160) could have been retrieved from the facility's medication 'back-up box' and administered to R68 at the prescribed times. LPN B reviewed R68's Electronic Health Record (EHR) and could not provide documentation to support the physician had been notified that R68 had missed his antibiotics. LPN B said, I will call the doctor and let him know the medications were not given.<br><br>According to R68's EHR the resident had multiple diagnoses that included neuromuscular dysfunction of the bladder that required a urinary catheter to drain urine. R68 was diagnosed with a Urinary Tract Infection on 10/11/23 and had the following physician order; Bactrim DS 800-160 mg twice a day for 8 days. The MAR reflected that two doses of R68's antibiotic were not administered, but there was no progress note to indicate the physician had been notified of the missing medication.<br><br>On 10/16/23 at approximately 10:30 AM LPN A and Nurse Unit Manager retrieved R68's Bactrim DS 800-160 mg from the facility's medication back-up-box. LPN A said, This medication has been available to administer. It should have been given. There was no reason not to give the antibiotics.<br><br>On 10/16/23 at approximately 1:00 PM the Director of Nursing (DON) was asked about missing medications. The DON said that she was aware of R68's missing antibiotics and acknowledged that the medication should have been administered. A request for the facility's medication administration policy/procedure for 'missing medications' was made.<br><br>On 10/18/23 at 9:04 AM, The DON said she was unable to locate a specific policy or procedure for missing medications at this time. The DON said, It's a nursing Standard of Practice to get medications from the back-up box and administer medications as prescribed.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 10/18/23 at 10:14 AM the Corporate Clinical Registered Nurse (RN) C said the facility did not have a specific policy for 'missing medications' but provided the facility's procedure to use the back-up box. The undated procedure for How-to Remove Medication for a Resident included step-by-step instructions on how to obtain medications from the back-up box. RN C said, It is a nursing Standard of Practice to obtain a medication from the back-up box and administer the medication. This education is provided in orientation. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208<br><br>This citation pertains to intake MI00135592.<br><br>Based on interview and record review the facility failed to provide an arm rest on a resident's wheelchair for one resident (R119) out of nine residents reviewed for accidents, resulting in R119 falling from wheelchair and obtaining large hematoma (when an injury causes blood to pool and collect under skin).<br><br>Findings include:<br><br>An interview on 10/16/23 at 9:30 AM with concerned family member (CFM) I, it was reported that R119 was sent to dialysis with only one armrest on wheelchair and resident fell and had to be taken to the hospital.<br><br>Review of R119's face sheet revealed admission into the facility on [DATE] with a diagnoses of end stage renal disease and a history of falling. According to the Minimum Data Set MDS dated [DATE], R119 had impaired cognition and required extensive assist with Activities of Daily Living (ADLS). Further review documented under Balancing During Transitions and Walking, Section E. Surface to surface transfer .- Not steady- only able to stabilize with human assistance .<br><br>Review of care plan I have a history of falls r/t (related to) impaired balance and impaired vision date initiated 4/4/23- interventions- I need a safe environment with floors free from spills and /or clutter; adequate, glare free light, a working and reachable call light, the bed in lowest position and functioning wheelchair and personal items within reach . date initiated 4/5/23.<br><br>Review of hospital providers notes created on 4/6/23 at 9:44 PM, documented the following: . History of Present Illness. This is a [AGE] year-old male who presented via EMS (emergency medical services) from HD (hemodialysis) after he fell outside per report we were told. He has a left head hematoma. He missed his HD and was hyperkalemic (high potassium level). HD needed so he is admitted for neuro checks (an assessment to monitor motor and sensory abilities after injury to head) after head injury and HD.<br><br>Review of Facility investigation dated 4/6/23 at 11:30 AM documented the following: Writer (Nursing Home Administrator-NHA) was informed by DON (Director of Nursing) of a fall that occurred while resident (R119) was on dialysis appointment, it was stated that the center called and stated resident fell while on appointment. The center stated that the wheelchair had one arm rest and resident was in chair and fell over while waiting on his appointment. Resident was sent to ER (emergency room ) from Dialysis .<br><br>Review of Certified Nursing Assistant (CNA) J statement to NHA dated 4/6/23 at 12:15 PM, documented the following: . I take full responsibility, I got resident up and dressed, I placed him in wheelchair with one arm rest, assisted with his shoes, assisted him to the van. I felt he was okay, didn't think it was unsafe, I didn't think it through take full responsibility for not applying the second arm rest .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 10/18/23 at 1:10 PM with DON, it was reported that CNA J did not apply the arm rest to the wheelchair before leaving the facility. DON was asked if it was the expectation of the facility that when residents are transported that wheelchairs have both arm rests intact to prevent falls, DON said, Yes. When asked if R119's fall could have been prevented if arm rest was provided, DON said, I am not sure if the resident fell because there was no arm rest on wheelchair. DON was asked to provide policy related to transporting residents in wheelchairs. Policies were provided, but no specific policy outlined an intervention to assess resident's had proper equipment and was assembled before transportation. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>15194<br><br>Based on observation, interview and record review, the facility failed to serve standardized portions for menu items and ensure palatable temperatures of food and coffee for six residents (R24 , R49 , R59, R70, R86, and R94) and for eight of eight residents who attended the confidential group meeting, resulting in complaints of small portions, cold food/coffee, and tasteless meals.<br><br>Findings include:<br><br>On 10/16/23 at 12:40 PM review of the planned, posted menu indicated residents were to receive BBQ chicken, Roasted Potatoes, Steamed Broccoli, and Fruit Cobbler.<br><br>Observation of the resident's lunch trays revealed some residents were observed with boneless chicken breast that were less than the three-ounce portion identified on the kitchen production menus. The sliced apple pie that was used as a substitute for the fruit cobbler was sliced very thin (approximately 1/8inch). The roasted potatoes were discolored, dark, and unattractive.<br><br>Residents were randomly queried concerning the food and indicated overall dissatisfaction with the meals and taste of the food served, some of the explanations provided were as follows:<br><br>R24-directed the Nurse Aide before her tray was removed from the cart and stated, I do not want that.<br><br>R49- explained, They serve too much processed foods. The boneless chicken is tough and hard to chew.<br><br>R59- reported, The chicken breast is stringy and dry. You cannot get a wing or a piece of meat with bone. You cannot eat this. The food is also cold. The food tastes like garbage. Dietary has changed so much and that has made the quality of the food go down.<br><br>R86- stated, If you order from the 'Always Available Menu', they, never have all the food's items listed, so you have to eat whatever is sent, when you send meat back and you order a hot dog for a substitute you get one hot dog and maybe a bun or a piece of bread if you are lucky. R86 added that the coffee is cold.<br><br>R70- stated, The meat is hard. I want a different meat.<br><br>R94- explained, Sometimes you get a hot dog and a bag of chips for a meal, that is not enough.<br><br>On 10/17/23 at approximately 10:00 a.m. concerning the portion sizes served on the previous day for lunch, Dietary manager R explained chicken thighs were ordered but there is a food service vendor shortage and delivery . some of the residents were given cut pieces of chicken breast which may have been small. When queried about the slices of apple pie, Manager R acknowledged the slices were not the correct size.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 10/18/23 at 12:35 P.M., the temperature of a regular diet was tested . The Beef Stew registered 125 Degrees Fahrenheit. (semi-Warm). The consistency of the base of the beef stew was of the same consistency of thin soup. Among the meat and vegetable ingredients there were no diced potatoes in the serving tested .<br><br>The beef stew was shown to Corporate Chef S and Dietary Manager R, during the observation the cook was queried concerning the recipe and the addition of the diced potatoes. The cook indicated the recipe was followed but the diced potatoes had been added in the beginning of the preparation of the beef stew and that may have made a difference in the thickening of the base. Corporate Chef S , indicated a little more thickener or starch would have been helpful in thickening the base of the beef stew.<br><br>47964<br><br>On 10/17/23 from 10:30 a.m. - 11:45 a.m., a confidential group interview was held with eight Residents representing various areas within the facility, all of whom were alert and oriented and able to express themselves without difficulty. When asked about whether they felt the facility's food was palatable (pleasant to taste or to one's liking), all eight Residents reported concerns. Responses included:<br><br>The Food is nasty-no seasoning.<br><br>Some of the food looks like dog food.<br><br>The quality of the food is low.<br><br>The food is processed, low quality.<br><br>We have had problems with the food being cold.<br><br>When asked if this had been discussed in previous council meetings, the majority of the residents reported Yes |