STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235539	A. Building B. Wing	01/08/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 34901 Based on observation, interview, and record review, the facility failed to ensure that a call button was within reach for one resident (R178) reviewed for accommodation of needs, resulting in the resident not having a method to request assistance when needed. Findings include: On 1/6/25 at 3:25 PM, R178 was observed awake and lying in bed. R178's bed was positioned against the wall and R178's right arm appeared wedged between the bed and the wall. R178 indicated he was in pain and was unable to free his arm. R178's call light was clipped to his pillow case. R178's indicated he was unable to reach the call light with his left arm. On 1/6/25 at 3:30 PM, Licensed Practical Nurse (LPN) T joined the Surveyor in R178's room and confirmed R178's arm was wedged between the bed and wall and R178 was unable to reach the call light with his other arm. R178 winced in pain as LPN T moved the bed to free his arm. On 1/8/25 at 12:13 PM, the Director of Nursing (DON) said the call light should have been in place where the resident could reach it . On 1/8/25 at 5:30 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information regarding this concern when asked.

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** 34901 This citation pertains to intake MI00147576. Based on interview and record review, the facility failed to ensure staff reported an injury of unknown source in a timely manner to the abuse coordinator for one resident (R125) out of two residents reviewed for abuse resulting in the untimely investigation of an injury of unknown origin. Findings include: The facility self-reported to the State Agency a resident injury of unknown source. A review of the facility's 5-Day submission dated 10/15/24 documented in part the following: - Investigation Summary: On 10/4/24 R125 complained of bilateral lower extremity pain. An order was entered for a stat x-ray for left knee, tibula, fibula and left foot and ankle. The stat X-ray result revealed no recent fracture or dislocation. The physician was notified of continued pain and swelling to left lower leg and foot. Additional orders given for x-rays for left leg and a venous doppler. The deep vein thrombosis was inconclusive, and R125 was transferred out to the local hospital for further evaluation and treatment. On 10/7/24, personnel from the local hospital reported to the Nursing Home Administrator (NHA) that R125 had a fracture. - Investigation Conclusion: The nature of the origin of the injury could not be identified. Residents and staff were interviewed with no viable results. Staff education was begun on transfers per Kardex specifications as well as continuing to report any abnormal findings such as pain, swelling, skin tears or abnormal looking extremities. A review of nursing staff interviews documented in part the following from Licensed Practical Nurse (LPN) U: The last day I worked (R125) was complaining of pain and we got an x-ray. The x-ray hadn't come when I left on Friday. When they were changing her, she complained of pain. I think it was her left leg. She was guarding the area. It wasn't swollen. She didn't want nobody to change her. It was a small bruise on her lower leg, below the knee. Gave resident Tylenol. A review of R125's clinical record documented an admitted [DATE] R125's diagnoses included vascular dementia, adult failure to thrive, and hypothyroidism. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment. A review of a medication administration note by LPN U was dated 10/4/24 at 12:30 PM but created 10/4/24 at 3:12 PM, revealed R125 was provided two tablets of acetaminophen tablet 325 MG. R125 complained of pain in left lower extremity. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review of the facility reported incident regarding R125 began on 1/8/25 at 10:30 AM with the Nursing Home Administrator (NHA). The NHA indicated they were responsible for the completion of the investigation. The NHA said she was notified of R125 injury by the hospital on 10/7/24 and that was when the investigation was initiated. The NHA confirmed that LPN U worked on 10/4/24 on the 7:00 AM to 7:00 PM shift. The NHA indicated that LPN U should have reported the observation of a bruise on R125's leg, especially if it is a possibility of a fracture. The NHA said it was expected that when there is a change in condition for a resident, that the NHA and/or DON (Director of Nursing) be notified. The NHA stated, They did not notify the DON, because she did not call me. During an interview on 1/8/25 at 12:18 PM, the DON said she was not notified about the presence of a bruise and pain regarding R125 on that Friday (10/4/24). The DON said she should have been notified about the observed bruise because that is not normal. The DON indicated that staff are to notify her of any abnormal findings or change of condition. A review of the facility document titled, Abuse and Neglect Prohibition Policy, dated 2/17/20, revealed in part the following: - The facility will monitor residents for changes in behavior, bruises/injuries of unknown origin or of a suspicious nature, or other types of patterns, occurrences and trends that may constitute potential abuse and investigate such situations. - The staff will report all allegations of abuse, neglect and misappropriation of property to the Administrator immediately. On 1/8/25 at 5:30 PM during the exit conference, the Nursing Home Administrator and Director of Nursing did not offer additional documentation or information when asked.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41423 Based on observation, interview, and record review, the facility failed to maintain and privacy, by not repairing broken window blinds for one resident (R35) of one resident sampled for visual privacy resulting in feelings of disrespect and the potential of exposure during care. Findings Include: On 1/06/25 at 11:56 AM, R35 was observed in bed on their back. R35 was covered with a sheet and was not wearing a gown. An interview was conducted with R35 regarding their stay in the facility. R35 stated that they don't have many complaints but would like window blinds to be fixed because it had been broken for a while and was covered with a soiled sheet. R35 said that although they like being next to the window, they did not like that someone could see them from the outside, especially at night. R35 stated, They (staff) won't tell someone to fix it .It looks bad and I'm tired of looking at that dirty sheet. The sheet was observed hanging on the lower portion of the window blinds and was stained. The blinds had several broken slats that were hanging loose, making them unable to close properly. A review R35's electronic medical record noted the resident was admitted to the facility on [DATE] with the diagnosis of Cerebrovascular Disease, Epilepsy, Hypertension, Osteoporosis, and Chronic Kidney disease. R35 requires substantial to maximal assistance with Activities of Daily Living (ADL). On 1/7/25 at 1:10 PM, the Director of Maintenance was interviewed and asked about the process of maintaining blinds in the residents' room. The Director of Maintenance said that it was the responsibility of the nursing staff to notify maintenance if something is in disrepair. On 1/8/25 at 11:40AM, the Director of Nursing (DON) was interviewed and asked about the responsibility of maintaining window treatments in the residents room. The DON stated, Nursing staff should follow-up with maintenance for anything in need of repair. A review of the facility policy, Resident Room Maintenance noted the following: Check window curtains, and mini blinds for ease of movement in tracks; tracks are securely mounted .blinds are operating properly and are damage free.