STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235632	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Samaritan	5555 Conner Avenue, Suite 4000 Detroit, MI 48213

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 - 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. (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

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(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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2687870 and 2692032.Based on observation, interview, and record review, the facility failed to protect the resident's (R701) right to be free from physical abuse by Certified Nursing Assistant (CNA) B resulting in hospitalization for a dislocated shoulder.Findings include: On 12/16/25 at 10:55 a.m. R701 was observed self-propelling in a wheelchair, with a sling applied to the right arm. R701 was asked what happened to the arm. R701 began to laugh and made an unclear statement. R701 was asked if the arm was in pain. R701 looked at the arm, smiled, and rolled away. On 12/15/25 at 11:35 a.m. the Nursing Home Administrator (NHA) provided the facility reported incident regarding an allegation of staff to resident abuse that occurred on 12/1/25 between 9:30 p.m. and 10:00 p.m. (reported on 12/2/25) involving R701. R701 sustained a dislocated right shoulder and was sent to the hospital for treatment. Review of the Incident Summary documented in part: On 12/2/25 at approximate 4:30 AM, a report from CNA (Certified Nursing Assistant) A, stating that CNA B was observed twisting the arm of R701during care. R701 was assessed for injury by RN C. No injuries were noted and per report from RN C, resident was able to move both arms with no indication of pain. R701 was later reassessed and was noted to have slight bruising to wrist and grimacing was noted when right arm was raised. Facility received x-ray results for dislocation. The resident was transferred to the hospital for treatment. Law Enforcement was contacted. Review of the hospital Discharge summary dated [DATE] documented: Call to schedule follow up appointment for shoulder dislocation s/p (status post) reduction (procedure to restore the correct alignment of a dislocated joint). Review of the Skin/Wound Note dated 12/2/25 at 18:53 (6:53 pm) documented: BL (bilateral) upper arms, area of discoloration noted on assessment. Review of the Diagnostic Report (x-ray) dated 12/3/25 14:01 (2:01 pm) documented: MD/NP notified of x-ray results, resident sent to ER. There was no physician order written to send R701 to the hospital. Review of the Interdisciplinary Note dated 12/5/25 documented in part the following: IDT team met to discuss resident r/t right dislocated shoulder. Resident has a sling on right arm at all times. On 12/15/25 at 6:13 p.m. CNA A was contacted via telephone. CNA A was asked to recall the events that occurred on 12/1/25. CNA A reported on 12/1/25 on the night shift (7pm-7am), between 9:30-10:00 p.m., CNA B was observed in the hall attempting to ambulate R701 to the bedroom. R701 was becoming aggressive towards CNA B due to being grabbed on by the arm. CNA B was also observed sitting on R701's lap while in the wheelchair causing R701 to become agitated and aggressive. R701 requires two-person assistance with care. CNA A was asked to assist with putting R701 to bed. Once in the bedroom, CNA A heard CNA B say, I'm putting you to bed. You are getting on my nerves. CNA A then observed CNA B forcefully twisted R701's right arm behind the back and stated, I hope the bitch is broke. R701 was observed squirming and moving trying to get arm free. CNA A verbally stopped CNA B from further causing harm to R701 and assisted with care. CNA A said there were no other staff around and did not know where the unit charge nurse was located. CNA A did not report the incident immediately to the unit charge nurse due to fear of retaliation. CNA A was moved to another unit due to staffing issues and about two hours later (3:30 a.m.) reported the incident to the NHA who was in the facility at the time. On 12/15/25 at 6:53 p.m. CNA B was contacted via telephone and asked to recall the events that occurred on 12/1/25. CNA B reported being the assigned CNA for R701 during the shift 7 pm-7 am. Between 7:30-8:00 pm R701 was in the dining room and had a bowel movement. R701 was taken to the bedroom to get cleaned up. CNA B asked CNA A to assist with care because R701 was a two-person assist. CNA B while rushing, wet and soaped a towel that dripped on the floor, slipped and grabbed R701's right arm to keep from falling. CNA A and CNA B proceeded to clean R701 and put to bed. CNA B said nothing out of the usual happened prior or after the incident, I don't know how (R701) arm got broke. I grabbed her arm to keep from falling. On 12/16/25 at 1:14 p.m. the NHA was interviewed about the events that occurred on 12/1-12/2 (midnight shift). The NHA recalled arriving at the facility on 12/2/25 at 2:15-2:30 am. At 4:30 a.m., CNA A reported, There's abuse in here. There's a situation with a male CNA while providing care. The CNA twisted (R701's) arm. The NHA reported CNA A was visibly upset and became agitated while being interviewed. CNA A stopped engaging which ended the interview. The NHA added they attempted to interview CNA B at 6:30 a.m. A statement was not obtained from CNA B due to immediate suspension and removal from the facility pending investigation. CNA B was asked to return to the facility on [DATE] and gave a statement to law enforcement. The NHA said law enforcement reported CNA B stated R701 had a bowel movement. There was water on

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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. (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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2687870 and 2692032. Based on interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of physical abuse for one (R701) in accordance with section 1150B of the Act, resulting in acts of physical abuse going unreported in a timely manner and further placing residents in harm's way.Findings include: Review of the clinical record documented R701 was initially admitted into the facility on 5/7/20 and readmitted on [DATE] from the hospital for a right dislocated shoulder. R701's other diagnoses include unspecified psychosis, polyneuropathy, adjustment disorder, and dementia. According to the quarterly Minimum Data Set assessment dated [DATE], R701 had severe impaired cognition (BIMS-3) and required total assistance with two-person assistance with activities of daily living. On 12/15/25 at 11:35 a.m. the Nursing Home Administrator (NHA) provided the facility reported incident regarding an allegation of staff to resident abuse that occurred on 12/1/25 between 9:30 p.m. and 10:00 p.m. (reported on 12/2/25) involving R701. R701 sustained a dislocated right shoulder and was sent to the hospital for treatment. Review of the Incident Summary documented in part: On 12/2/25 at approximate 4:30AM, a report from CNA (Certified Nursing Assistant) A, stating that CNA B was observed twisting the arm of R701during care. R701 was assessed for injury by RN C. No injuries were noted and per report from RN C, resident was able to move both arms with no indication of pain. R701 was later reassessed and was noted to have slight bruising to wrist and grimacing was noted when right arm was raised. Facility received x-ray results for dislocation. The resident was transferred to the hospital for treatment. Law Enforcement was contacted. On 12/15/25 at 6:13 p.m. CNA A was contacted via telephone. CNA A was asked to recall the events that occurred on 12/1/25. CNA A reported on 12/1/25 on the night shift (7pm-7am), between 9:30-10:00 p.m., CNA B was observed in the hall attempting to ambulate R701 to the bedroom. R701 was becoming aggressive towards CNA B due to being grabbed on by the arm. CNA B was also observed sitting on R701's lap while in the wheelchair causing R701 to become agitated and aggressive. R701 requires two-person assistance with care. CNA A was asked to assist with putting R701 to bed. Once in the bedroom, CNA A heard CNA B say, I'm putting you to bed. You are getting on my nerves. CNA A then observed CNA B forcefully twisted R701's right arm behind the back and stated, I hope the bitch is broke. R701 was observed squirming and moving trying to get arm free. CNA A verbally stopped CNA B from further causing harm to R701 and assisted with care. CNA A said there were no other staff around and did not know where the unit charge nurse was located. CNA A did not report the incident immediately to the unit charge nurse due to fear of retaliation. CNA A was moved to another unit due to staffing issues and about two hours later (3:30 a.m.) reported the incident to the NHA who was in the facility at the time. CNA A stated, I don't know why I didn't report it immediately to the supervisor before I saw the Administrator. On 12/16/25 at 1:14 p.m. the NHA was interviewed about the events that occurred on 12/1-12/2 (midnight shift). The NHA recalled arriving at the facility on 12/2/25 at 2:15-2:30 am. At 4:30 a.m., CNA A reported, There's abuse in here. There's a situation with a male CNA while providing care. The CNA twisted (R701's) arm. The NHA reported CNA A was visibly upset and became agitated when asked why the incident was not reported immediately to the nurse supervisor. CNA A stopped engaging which ended the interview. The NHA was queried about reporting CNA B license to the state agency. The NHA stated, No. I had not. There was so much going on, I didn't think to report the license. Review of the facility's policy titled Abuse and Neglect Prohibition Policy revision date 2/17/20 documented in part the following: Reporting and Response:1. The staff will report allegations of abuse, neglect and misappropriation of property to the Administrator immediately.2. 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:Immediately but no later than 2 hours after the allegation is made if the allegation involves abuse or result in serious bodily injury. Or not later than 24 hours if the events that cause the allegation do not involve abuse or serious injury.3. If the alleged violation is verified, appropriate corrective action must be taken including proper reporting to the State Agency, the local Police Department, See Facility Suspected Crime Report - Elder Justice Act Policy and Procedure.4. The facility will report any occurrences of abuse by licensed, registered or certified staff to the State Board as required by state law.