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	02/29/2024

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

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 Based on observation, interview, and record review the facility failed to ensure resident (R102) was assessed for self-administration of a medication. Findings include: On 2/27/24 at 11:31 AM, R102 was observed with an inhaler laying on the bed. R102 stated, I like to handle my inhalers myself. Record review of electronic medical records revealed R102 was admitted into the facility on [DATE] with a pertinent diagnosis of chronic obstructive pulmonary disease (COPD). According to the Minimum Data Set (MDS) dated [DATE], R102 had intact cognition. Further review of EMR revealed no physician orders to self-administer medications or a self-administration assessment was conducted. During an interview on 2/28/24 at 10:52 AM with Licensed Practical Nurse (LPN) G, it was reported that R102 self-administered inhaler medications. During an interview on 2/28/24 at 12:30 PM, the Director of Nursing (DON), reported that R102 did not have a Physician order or an assessment to self-administer medications and keep at bedside. The DON further reported that residents must have a Physician order and an assessment is to be performed and completed before residents can self- administer medications. Record review of policy Medication Administration and Guidelines (no date) documented the following: . 4. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with policy and procedure for self-administration of medications.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 Based on observation, interview, and record review the facility failed to implement a hospice care plan for one resident (R12) out of two residents reviewed for hospice care, resulting in not having goals and interventions to meet R12's hospice care needs. Findings include: On 2/27/24 at 12:30 PM, R12 was observed in room. During an the interview, R12 reported that hospice services did visit often. Record review of R12's electronic medical record (EMR) revealed admission into the facility on [DATE] with a pertinent diagnosis of adult failure to thrive. According to the Minimum Data Set (MDS) dated [DATE], R12 had impaired cognition and required assistance with Activities of Daily Living (ADLS). Further record review revealed resident had a significant change of condition on 1/8/24, and hospice services were started. Review of R12's EMR revealed no hospice care plan was implemented for nursing. During an interview on 2/28/24 at 10:46 AM with the Director of Nursing (DON), it was reported that R12 did not have a hospice care plan related to nursing care. It was also reported that all residents that received hospice care should have an individualized care plan. Record review of policy Comprehensive Plan of Care (no date), documented the following: Each resident will have a comprehensive care plan developed within 7 days after the completion of a comprehensive or quarterly assessment. The comprehensive care plan is prepared by the Interdisciplinary team and to the extent practicable the participation of the resident or the resident's representative. The quarterly care plans are reviewed and updated by the Interdisciplinary team and to the extent practicable the participation of the resident or resident's representative. .14. Care plans should be closed with a Significant Change and new Care plans started to reflect changes.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958 Based on observation, interview, and record review, the facility failed to ensure medication was administered properly and per physician's orders for four residents (R45, R61, R71, and R84) of eight residents reviewed for medication administration, resulting in the potential for less than therapeutic effect of the prescribed medication when medications were not taken or administered properly. Findings include: In an observation on 2/28/24 at 8:09 a.m., Licensed Practical Nurse (LPN) B was observed at a medication cart preparing medication. Two trays sat on the medication cart. One tray had R45's name and a medication cup and the other had R61's name and a medication cup. LPN B then picked up both trays and entered R45 and R61's room. In an observation on 8:11 a.m., LPN B administered R61's medication and then walked to R45's bed and administered medication. Resident #71 In an observation on 2/28/24 at 8:19 a.m., LPN B prepared medication for R71. LPN B placed six medications in a cup. The medications did not include GlycoLax (used for relief of occasional constipation). In an observation and interview on 2/28/24 at 8:23 a.m., LPN B poured liquid protein in a souffle cup (small paper medication cup). LPN B was asked how much liquid protein should R71 receive, LPN B answered 30cc's (cubic centermeters). LPN B reported the liquid protein is poured in the paper med cup and then into the drinking cup. There were no measurements observed on the small paper medication cup or drinking cup. In an observation on 2/28/24 at 8:27 a.m., LPN B entered R71's room and administered medication including the liquid protein, then exited the room, and then documented the medication administration. LPN B did not offer R71's GlycoLax. In an interview on 2/28/24 at 8:34 a.m., LPN B reported she does not normally prepare and give two residents their medications at the same time. LPN B then reported it is not a normal practice. In an observation on 2/28/24 at 8:40 a.m., LPN B documented GlycoLax as given. Review of an Admission Record revealed, R71 admitted to the facility on [DATE] with pertinent diagnoses which included Dementia and Muscle Wasting and Atrophy. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R71 had no cognitive impairment with a Brief interview for Mental Status (BIMS) score of 13, out of a total possible score of 15. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Physician orders revealed R71 had orders which included, Liquid Protein two times a day for wound healing 30 cc each dose PO (by mouth) and GlycoLax Powder give 17 grams by mouth one time a day for constipation (in liquid). Review of the Medication Administration Record (MAR) for February 2024 revealed GlycoLax was documented as given for R71. In an interview on 2/28/24 at 11:29 a.m., LPN B confirmed she did not give R71 GlycoLax. LPN B then reviewed the MAR and confirmed R71's GlycoLax was documented as given. Resident #84 In an observation on 2/28/24 at 9:10 a.m., LPN A prepared medication for R84. LPN A placed five medications in a cup. The medications did not include Folic Acid (supplement). In an observation on 2/28/24 at approximately 9:15 a.m., LPN A entered R84's room and administered medication. LPN A then exited the room and documented the medication administration. Review of an Admission Record revealed, R84 admitted to the facility on [DATE] with pertinent diagnoses which included Anemia. Review of a MDS assessment dated [DATE] revealed R84 had cognitive impairment with a BIMS score of 6, out of a total possible score of 15. Review of Physician orders revealed R84 orders included, Folic Acid give 1 mg (milligram) by mouth one time a day. Review of a Medication Administration Record (MAR) for February 2024 for R84 revealed Folic Acid was documented as given by LPN A. In an interview on 2/28/24 at 11:07 a.m., LPN A reported she thought she gave R84 Folic Acid. LPN A then reported the blister pack for R84's was empty. In an interview on 2/28/24 at 11:09 a.m., Unit Manager C reported nurses should perform a triple check before medication administration to ensure all medications are given. In an interview on 2/29/24 at 12:58 p.m., the Director of Nursing (DON) reported the nurse should prepare medications for one resident at a time. The DON then reported the nurse should triple check medications and check medications against the MAR to ensure they match. The DON reported the nurse should measure liquid medications in a cup with measurement markers to ensure the proper dosage is administered. Review of a Medication Administration and General Guidelines policy dated 4/12/23 documented, Medications are administered as prescribed . 2. Medications are administered in accordance with written orders of the attending physician . 16. Prior to administration, the medication and dosage schedule on the resident's MAR is compared to the medication label . Adheres to the 6 Rights of Medication Administration: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Right Dose 2) Right Route 3) Right Resident 4) Right Medication 5) Right Time 6) Right Documentation . Documents the administration of each medication on the MAR .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958 Based on observation, interview, and record review the facility failed to administer medications accurately for two residents (R71 and R84) out of six residents during medication pass, resulting in a medication error rate of 17.86 %. Findings include: R71 In an observation on 2/28/24 at 8:19 a.m., LPN B prepared medication for R71. LPN B placed six medications in a cup. The medications did not include Senokot (laxative) or GlycoLax (used for relief of occasional constipation). In an observation and interview on 2/28/24 at 8:23 a.m., LPN B poured liquid protein in a souffle cup (small paper medication cup). LPN B was asked how much liquid protein should R71 receive, LPN B answered 30cc's (cubic centimeters). LPN B reported the liquid protein is poured in the paper medication cup and then into the drinking cup. There were no measurements observed on the small paper medication cup or drinking cup. In an observation on 2/28/24 at 8:27 a.m., LPN B entered R71's room and administered mediation including the liquid protein, then exited the room, and documented the medication administration. LPN B did not offer R71 Senokot or GlycoLax. In an observation and interview on 2/28/24 at 8:40 a.m., LPN B documented Senokot as refused and GlycoLax as given. LPN B confirmed that Senokot was not offered, and reported R71 usually refused it every morning. Review of an Admission Record revealed, R71 admitted to the facility on [DATE] with pertinent diagnoses which included Dementia and Muscle Wasting and Atrophy. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R71 had no cognitive impairment with a Brief interview for Mental Status (BIMS) score of 13, out of a total possible score of 15. Review of Physician orders revealed R71 orders included, Liquid Protein two times a day for wound healing 30 cc each dose PO (by mouth), Senokot Extra Strength Tablet (Sennosides) give 1 tablet by mouth two times a day and GlycoLax Powder give 17 grams by mouth one time a day for constipation (in Liquid). Review of a Medication Administration Record (MAR) for February 2024 revealed GlycoLax documented as given and Senokot refused for R71. In an interview on 2/28/24 at 11:29 a.m., LPN B confirmed she did not give R71 GlycoLax. LPN B then reviewed the MAR and confirmed R71's GlycoLax was documented as given. R84 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 2/28/24 at 9:10 a.m., LPN A prepared medication for R84. LPN A placed five medications in a cup. The medications did not include Ferrous Sulfate (iron) or Folic Acid (supplement). In an observation on 2/28/24 at approximately 9:15 a.m., LPN A entered R84's and administered medication. LPN A then exited the room and documented the medication administration. In an interview on 2/28/24 at 9:20 a.m., LPN A reported R84's Ferrous Sulfate was not given because it was not in the cart. Review of an Admission Record revealed, R84 admitted to the facility on [DATE] with pertinent diagnoses which included Anemia. Review of a MDS assessment dated [DATE] revealed R84 had cognitive impairment with a BIMS score of 6, out of a total possible score of 15. Review of Physician orders revealed R84 had orders which included, Ferrous Sulfate Tablet 325 mg (milligram) give 1 tablet by mouth one time a day and Folic Acid give 1 mg by mouth one time a day. Review of a Medication Administration Record (MAR) for February 2024 for R84 revealed Folic Acid was documented as given by LPN A. In an interview on 2/28/24 at 11:07 a.m., LPN A reported she thought she gave R84 Folic Acid. LPN A then reported the blister pack for R84's was empty. In an interview on 2/28/24 at 11:09 a.m., Unit Manager C reported nurses should perform a triple check before medication administration. In an interview on 2/29/24 at 12:58 p.m., the Director of Nursing (DON) reported the nurse should prepare medications for one resident at time. The DON then reported the nurse should triple check medications and check medications against the MAR to ensure they match. The DON reported the nurse should measure liquid medications in a cup with measurement markers to ensure proper dosage is administered. Review of a Medication Administration and General Guidelines policy dated 4/12/23 documented, Medications are administered as prescribed . 2. Medications are administered in accordance with written orders of the attending physician . 16. Prior to administration, the medication and dosage schedule on the resident's MAR is compared to the medication label . Adheres to the 6 Rights of Medication Administration: 1) Right Dose 2) Right Route 3) Right Resident 4) Right Medication (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) Right Time 6) Right Documentation . Documents the administration of each medication on the MAR .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 Based on observation, interview, and record review the facility failed properly store nebulizer (used for breathing treatment) tubing between resident use, for one resident (R258) out of two residents reviewed for respiratory care, resulting in the potential for contamination of respiratory devices and the spread of infection. Findings include: During an observation on 2/27/24 at 9:52 AM, R258's nebulizer tubing and mask was lying on top of nightstand and was not stored in a plastic bag. Record review of R258's electronic medical record (EMR) revealed admission into the facility on [DATE] with a pertinent diagnosis of chronic obstructive pulmonary disease (COPD). According to admission progress notes dated 2/14/24, R258 had intact cognition and required limited to maximum assistance with Activities of Daily Living (ADLS). During an observation on 2/28/24 at 8:53 AM, R258's nebulizer tubing and mask was lying on top of nightstand and was not stored in a plastic bag. During an interview on 2/28/24 at 8:53 AM with R258, it was reported that the tubing and mask just laid on the nightstand. During an interview on 2/28/24 at 8:58 AM with the Director of Nursing (DON) after an observation of the nebulizer tubing on nightstand, it was reported that the equipment should be bagged and dated with resident's name after each use. During a follow-up interview the DON reported the reason to keep equipment bagged was to prevent contamination and the possibility for infection to spread. Record review of policy Nebulizer Therapy (no date), documented the following: .16. Aerosol updraft (nebulizer) equipment will be dated and stored in a set-up bag at the resident's bedside.