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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235453	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fraser Villa	33300 Utica Rd Fraser, MI 48026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 This intake pertains to Intake: MI00149945. Based on interview and record review, the facility failed to supervise, prevent an elopement, and operationalize the policies and procedures for a missing resident for one resident, (R901) of three residents reviewed for elopement. Findings include: A review of information reported to the State Agency revealed the following, Resident was observed by the receptionist exiting the facility with appropriate outerwear and a suitcase and a bag at approximately 2:30 PM. Receptionist was not aware that [R901] was a resident residing in the rehab building . A review of R901's medical record revealed they were admitted into the facility on [DATE], with diagnoses that included, Hemiplegia following Cerebral Infarction affecting right dominant side, Aphasia, Dysphagia and Muscle Weakness. Further review revealed upon admission to the facility, the resident was assessed to be significantly cognitively impaired due to their Aphasia (inability to speak), and required the use of a front wheeled walker for gait instability. On 2/4/25 at 11:27 AM, Unit Manager A was interviewed regarding R901 eloping from the building on 1/28/25, and she explained at approximately, 4:15pm she was informed by R901's assigned nurse that they were going to administer medications to the resident, but had not seen them. Unit Manager A explained she began looking for the resident by calling to the therapy department, going to look in the beauty salon, and in the great room where activities are held, but could not locate the resident. Unit Manager A further explained then she contacted the resident's son via phone, and he advised the resident was with him. Unit Manger A acknowledged at that time, she was unaware the resident had left the building on their own. On 2/4/24 at 11:38 AM, Receptionist B was asked about R901's exit from the facility, and she explained she was speaking to a visitor while at the front desk, and saw someone who she thought was a family member walking toward the door wearing their coat, pulling a suitcase, with a purse on their shoulder. Receptionist B explained she unlocked the door allowing R901 to exit not realizing they were a resident of the facility. Receptionist B explained the procedure for allowing residents and guests in and out the facility requires them to sign in and out at the desk, but acknowledged this procedure was not completed on this date. (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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NAME OF PROVIDER OR SUPPLIER: Fraser Villa		STREET ADDRESS, CITY, STATE, ZIP CODE: 33300 Utica Rd Fraser, MI 48026	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/25 at 11:48 AM, an interview was completed with Nurse C, assigned nurse to R901 on the afternoon shift. Nurse C explained she arrived for her shift at 3:00pm, was given shift report, and at that time, had not laid eyes on the resident. At approximately 4:00pm, Nurse C explained she began passing medications and upon arriving to administer medications to R901, noted they were not in their room. Nurse C explained she reported this information to Unit Manager A and from there, attempts to locate the resident in the therapy gym, beauty salon, and common area was completed. Nurse C explained Unit Manager A contacted the resident's son who indicated that he was with the resident. On 2/4/25 at 12:02 PM, Nurse E, assigned nurse for R901 on the day shift was asked about the resident eloping from the facility, and she confirmed she had last laid eyes on the resident between 1:10pm and 1:15pm, as she had provided the resident with pain medication, and wanted to ensure it had been effective. On 2/4/25 at 12:43 PM, Social Worker F was asked about R901, and communication she had with the resident's son regarding discharge. Social Worker F explained the resident and their son were not in agreement regarding discharge plans and upon the final determination after the elopment, the resident would not be returning to the facility. Social Worker F was asked if she was aware how the resident was able to get home from the facility, and explained the resident's son said the resident walked home. A review of R901's medical record revealed the resident lived approximately 1.7 miles away from the facility, which was approximately a 37-minute walk. On 2/4/25 at 1:15 PM, Certified Nursing Assistant (CNA) D was interviewed regarding R901 eloping from the facility, and she explained she started her shift at 3:00pm and at approximately 4:15pm she hadn't seen the resident, and informed the assigned nurse. CNA D explained oftentimes, residents are in therapy or getting their hair done around that time. On 2/4/25 at 1:28 PM, the Nursing Home Administrator (NHA) was asked about the incident involving R901, and explained she received a call from Unit Manager A about the resident, and she in turn contacted the resident's son who explained R901 had returned to their residence, and at that time was not physically with the resident, but indicated when they were, they would contact the NHA back. The NHA explained that a well-being check was completed by the local police department to ensure the resident's safety, and she was not aware of how the resident got home. On 2/4/25 at 1:37 PM, an interview was completed with Physical Therapy staff G who worked with R901, and was asked about the resident's ability to walk without their walker. Physical Therapy staff G explained the resident had demonstrated they could walk 200 feet with the walker, but had never been assessed to walk without the walker. On 2/4/25 at 2:08 PM, Unit Manager A was interviewed again regarding the date of the incident with R901, and explained upon learning R901 wasn't in their room at approximately 4:15pm, it took approximately 15-20 minutes to look for the resident, and the resident's son was eventually contacted at approximately 4:40pm. Unit Manager A confirmed a missing person code/communication had not been completed as it is common family members will take residents out without informing nursing staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Facility Reported Incident folder was reviewed and documented the resident was last seen by facility staff at approxiamtely 2:30pm, and a well-being check to confirm the safety and whereabouts of the resident was completed at approximtely 5:55pm. Further review also revealed a full count of residents was not conducted following the elopement of the resident to ensure all residents had been accounted for. On 2/4/25 at 4:00 PM, the NHA was asked about the facility's outcome regarding R901 leaving the facility, and acknowledged the resident left the facility without signing out or without an appropriate discharge. A review of the facility's Elopement-Missing Resident policy revealed, 3. Should an employee become aware that a resident is missing from the community he/she should a) Determine if the resident in on an authorized leave or pass. If not; b) Shift Supervisor, Director of Nursing or designee assigns direct care staff to look for the resident by dividing teams assigned to look inside and outside the community by area, including, but not limited to, all locked/unlocked rooms, bathrooms, closets, stairwells, elevators, storage spaces, outbuildings, parking lots, and exterior campus. c) Notify the Nurse Manager/Director of Nursing and Administrator d) If the resident is not located in the buildings or on the grounds within 15 minutes, the following process is initiated: 1. The Shift Supervisor, Director of Nsg or designee Notifies: -Police Dept -Legal Guardian -Physician -Medical Director - Communication/code alert is made related to the missing resident with the proper code that staff has been educated on to alert staff on the search . A review of the facility's Signing out of Elders/Residents policy revealed the following .1. Each elder/resident leaving the premises must be signed out .