STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235491	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Roseville	25375 Kelly Rd Roseville, MI 48066

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** 49102 This citation pertains to Intake MI00148164. Based on interview and record review, the facility failed to implement interventions to reduce the risk for elopment for one resident (R700) of one reviewed for elopement, resulting in a R700 eloping out fire door to the front of the building and walking to the corner. Findings include: On 11/12/24, a facility reported incident submitted to the State Agency was reviewed and indicated R700 had exited the facility on 11/12/24 at 4:15 AM. Door alarms had alerted staff someone had opened door and possibly left the building. R700 was found outside of the building after setting off alarms and leaving through a fire door. On 11/21/24 the medical record for R700 was reviewed and revealed the following: R700 was admitted to the facility on [DATE] with the diagnoses of dementia, hypertension, hyperlipidemia, insomnia, and diabetes mellitus. A review of the minimum data set assessment (MDS) dated [DATE], R700 brief interview of mental status assessment indicated a score of 6 indicating moderate cognitive impairment. R700 was ambulatory without assistance. Further review of the medical record revealed elopment risk assessments with the following dates: - 9/12/2024-ELOPEMENT ASSESSMENT- Low Risk 8.0 - 8/10/2024-ELOPEMENT ASSESSMENT- High Risk to Wander 12.0 - 8/4/2024-ELOPEMENT ASSESSMENT-High Risk to Wander 12.0 (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was held on 11/21/24 at 12:19 PM via telephone with Licensed Practical Nurse (LPN) A, who worked the night of the incident. LPN A stated,Yes, I worked on 12/12/24. The midnight supervisor had just left at 3:30 AM and soon after I heard the door alarm go off. It was (R700) trying to open the door. The nursing assistant took the resident back to bed. LPN A confirmed no additional inverventions were put into place. The nurse went on to say, my nurse hall partner was off the floor on break. After about 10 -15 minutes later, as I was in the bathroom, I heard the alarms and the doors go off again. I hurried and got myself together to respond to the alarms. The nursing assistant told me R700 was not in their room and I initiated a Code [NAME] for missing residents. I alerted my nurse hall partner who was in their car to look out for the resident. The other nurse was able to pull in front of building and saw the resident walking to the corner. The resident was brought back into the building. An attempt was made to contact the other nurse/hall partner and the Certified Nurse Assistants (CNA) who were on staff for R700 during the night of 11/12/2024, however there were no return phone calls by the end of the survey. On 11/21/24 at approximately 2:30 PM, the Nursing Home Administrator (NHA) was interviewed pertaining to R700's elopement on 11/12/24. The NHA stated, the expectation is that all residents would be safe and facilty policies followed to keep the residents safe. A review of the facility policy titled Potential Resident Elopement revealed the following,it is the policy of this facility to provide residents with a safe and secure environment and identify residents who may be at risk for unobserved exit from the facility. If the resident attempts to leave the facility without authorization and there is a witness: a. assist resident and redirect to safe area. B. Obtain assistance from other staff member in the vicinity if necessary .E. Determine what additional interventions are needed to minimize another attempt at an unauthorized leave.