

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235509	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER The Orchards at Warren		STREET ADDRESS, CITY, STATE, ZIP CODE 12250 East 12 Mile Road Warren, MI 48093	
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	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2729557. Based on interview and record review, the facility failed to provide adequate supervision to prevent an elopement for one resident (R901) from a total of three residents reviewed for supervision. Findings Include: Review of a complaint called into the State Agency revealed, Complainant states a male resident (R901) escaped from the facility two weeks ago and was found at the bus stop. Review of the clinical record revealed R901 was admitted into the facility on 4/4/2025 with the following diagnoses: Vascular Dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. The Minimum Data Set Assessment (MDS) dated [DATE], indicated resident was independent with ambulation and activities of daily living, requiring assistance of one for showering and had a Brief Interview for Mental Status (BIMS) revealed a score of 15/15, indicating intact cognition. A review of the clinical record revealed R901 verbalized on 9/19/25 to staff they were discharging the next day. R901 called (name of a moving company) and their church for assistance repeatedly. R901 also told staff they were going to call the police and was re-directed and re-informed that a discharge was not ordered and could not occur until all the proper people and paperwork was done. Review of a progress note dated 9/26/25, revealed the resident was discussing their discharge set for the next day and was informed that a discharge had not been arranged. R901 then hurriedly moved toward the exit, was redirected and a wander alert device was applied to the resident's ankle. The 9/26/25 care plan reflected the resident was now an elopement risk, but not that a wander alert device was applied to their ankle. An Elopement Risk assessment dated [DATE] indicated R901 was to be at Low Risk for elopement with a score of 8/15, despite multiple conversations of wanting to be discharged. Review of an investigation file provided by the facility revealed on 12/6/25 at 2:00 PM, R901 observed outside of the building walking on the drive around the building, coming from the direction of their room by the Housekeeping Supervisor (HS) E. Unable to coax R901 back into the building the HS E called to the facility for assistance and two employees came to help. R901 returned to the building about 15 minutes after reinforcements arrived. According to the investigation file, R901 removed screws from the inside-window casing that were placed to prevent the window from opening more than 2-3 inches. Once the screws were removed, the resident was able to open the window enough to climb out and was observed unattended. The care plan was updated on 12/18/25 indicating a wander alert device was placed on R901's ankle. On 2/26/26 at 10:15 AM, an interview with Maintenance Director (MD) C revealed they were part of the investigation to determine how R901 was able to exit the building unnoticed. MD C revealed R901 had removed the stop screws that were installed in the inside track of the window to prevent it opening more than 2-3 inches. On 2/26/26 at 10:30 AM, an interview with HS E revealed as they drove on the driveway around the building they noted R901 coming out between the building and asked them where they were going. R901 said they were leaving while HS E attempting to coax them back into the building. During this time R901 was adamant they were</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235509
		If continuation sheet Page 1 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235509	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER The Orchards at Warren		STREET ADDRESS, CITY, STATE, ZIP CODE 12250 East 12 Mile Road Warren, MI 48093	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>not returning, telling HS E over and over, I am leaving, I am not going back in. When they reached the main road, the HS E, contacted the facility and requested help. Two employees then attempted to coax R901 back into the building and after about 15 minutes R901 returned to the building. HS E confirmed, staff did not know the resident was not in the building. On 2/26/26 at 11:00 AM, an interview with the Nursing Home Administrator (NHA) confirmed the events and added R901 preferred to have their door closed at all times and it was difficult to provide privacy along with increased supervision for an elopement risk resident. On 2/26/26 at 12:41 PM, a request for the documentation policy was requested for nurses and Certified Nursing Assistants. The Director of Nursing indicated there was not a policy for documentation.</p>		