STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235521	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Wayne	4427 Venoy Rd Wayne, MI 48184

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 - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34851 This citation pertains to intake MI00146507. Based on interview, and record review the facility failed to prevent a resident to resident physical abuse incident, for two sampled residents (R701 and R702) of three residents reviewed for abuse. Findings included: A review of the intake noted, It was reported there was a resident to resident incident that resulted in no injuries. On 10/2/2024 at 12:42 PM, R702 was asked about the incident with R701. R702 explained, R701 was over on 900 hall. R702 stated, I was with my boyfriend and [R701] was coming after him, then after me. R702 continued and explained that R701 hit them in the face and then pulled on their wheelchair. R702 stated, I put my hand up over my face. I guess I wasn't fast enough and [R701] got me in the face. A review of R702's medical record revealed, 8/22/24 20:38 Writer witnessed resident getting hit with close fist on left side of face, neck and shoulder by another resident. Resident denies pain or discomfort, no injuries noted at his time. Assessed Resident head to toe, ROM and VS WNL. Denies being Unsafe or threatened. Law enforcement was called, and Resident interviewed by police. Licensed Practical Nurse (LPN H). On 10/02/2024 at 2:04 PM, LPN H was interviewed via phone and was asked about the incident. LPN H reported that R701 was verbally abusive towards staff and had attacked staff that day but they were able to get [R701] back to their room. LPN H continued and explained, when R701 came back out of their room, R702 went down hallway towards R702 and times and hit R702 three times in the arm, before they were able to separate the residents. Further review of R702 medical record revealed, R702 was admitted to the facility on [DATE], with diagnosis of Chronic obstructive pulmonary disease. A review of R702's quarterly Minimium Data Set (MDS) assessment dated [DATE] noted R702 with an intact cognition. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235521	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Wayne	4427 Venoy Rd Wayne, MI 48184

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 - Minimal harm or potential for actual harm Residents Affected - Few	A review of R701's medical record revealed, R701 was admitted to the facility on [DATE] and discharge on 8/28/24 with diagnosis of Metabolic encephalopathy, Delirium due to known physiological condition, Bipolar disorder, Adjustment disorder with mixed anxiety and depressed mood, Cognitive communication deficit, Impulsiveness. A review of R701's MDS noted R701 with an impaired cognition. Further review of R701's care plan noted, BEHAVIOR: I am at risk of behaviors and can be demanding and at times and may be verbally aggressive to staff. I am accusatory towards staff and other residents. I have a history of impulsiveness and transfer without waiting for assistance. I will state understanding of needing to wait, but if someone is not right there, I will decide to transfer and do so without asking for help. I have a history of sitting on the floor and self transferring, resulting in falls. I can be hyperverbal and eager to express negative feelings towards others. At times, I become focused on events that occurred in the past as if they are current events. I have anxiety Date Initiated: 08/08/2019. Goal: I will have fewer than three behavioral episodes per week throughout the next review date. Date Initiated: 05/21/2021. Intervention: Approach and speak in a calm manner. Divert my attention and remove me from a situation as needed. Date Initiated: 03/30/2016. Focus: I am verbally aggressive. I frequently become verbally aggressive towards staff during my shower I frequently make accusations and complaints non health related. [R701] makes statements that she is allowed to speak to people however she wishes without consequence. I am a hoarder and I keep personal items all around me at my bedside which contributes to my safety concerns Date Initiated: 03/10/2017. Goal: I will verbalize understanding of the need to control my verbally abusive behavior, through the review date. I will be redirected by staff during times of inappropriate verbalization with fewer outbursts through next review. Date Initiated: 03/10/2017. Intervention: When I become agitated: Intervene before my agitation escalates; Guide me away from the source of distress; Engage calmly in conversation; If my response is aggressive, walk calmly. Date Initiated: 05/23/2022. Continued review of R701's progress notes revealed, a history of verbal and physical aggressive behavior. R701's Progress notes: 8/21/2024 16:45 Behavior Note Text: Writer observed resident in hallway with feces from head to toe. [CNA] says I have been trying to change [R701] for about 15 minutes now but [R701] keeps calling me a [expletives] and is trying to sling poop on me. Resident says You [expletives] right I called her a [expletives] because she is one and I will let her change me when I'm good and ready too. Writer asked resident to come to shower that writer and [CNA] CNA give resident a shower. Resident says [expletives] you too [expletives] you don't tell me what to do. I'm not taking no shower. Resident began to throw Wash clothes covered in BM on writer and [CNA]. After roughly 30 min resident agreed to take shower. Once in the shower room the resident says I hate you funky stankin [expletives]. Yall ain't [expletives] but a bunch of raggedy [expletives] y'all [expletives] stank. Hurry the [expletives] up and give me a shower. Writer and [CNA] were quiet while resident continued with insults. Resident tested water and agreed to temp. writer and [CNA]began washing residents body. Resident continued saying What the [expletives] are y'all looking at I'm sick of you [expletives]. The began taking water from vaginal area that was filled with BM and throwing it on writer and [CNA]. Both writer and [CNA]moved away from resident. While moving away resident grabbed shower head out of [CNA] hand and began spraying water on [CNA] and writer. At this time resident slid from shower chair onto shower floor. Resident did not hit head and resident was able to move all extremities. Resident reports pain 0/10. Guardian and MD made aware of fall. Unit Manager I. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235521	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Wayne	4427 Venoy Rd Wayne, MI 48184

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 - Minimal harm or potential for actual harm Residents Affected - Few	8/21/2024 19:53 Behavior Note Text: Resident physically assaulted A resident [R702]. Writer observed resident run into the other resident with her wheelchair and strike with close fist 3 times. writer ran and got in the middle to Sheild resident [R702] and removed resident SM back. Police called and on the way. LPN H. 8/21/2024 20:16 Behavior Note Text: Resident still attempting to hit and threaten other residents. Resident punch writer 4 times and other staff multiple times. 8/21/2024 22:33 Nurses Note Text: Resident interviewed by police denied punching another resident on face with a close fist or being verbally and physically aggressive towards staff. Resident was calm noncombative or aggressive when police present. Resident transported to (local hospital) via stretcher EMS . 8/21/2024 23:06 Nurses Note Text: Resident physically assaulted A resident [R702]. Writer observed resident run into the other resident with [R701's] wheelchair and strike with close fist 3 times, left side of face, neck and shoulder. writer ran and got in the middle to sheild resident [R702] and removed resident [R702] back. Police called and on the way. police arrived writer directed law enforcement to residents room. Resident interviewed by police denied punching another resident on face with a close fist or being verbally and physically aggressive towards staff. Resident was calm noncombative or aggressive when police present. Resident transported to (local hospital) . On 10/03/24 at 4:47 PM, the Director of Nursing was asked about the incident with R701. The DON explained that R701 was never abusive towards residents it was always staff. A review of the facility's policy titled Abuse and Neglect Prohibition Policy, revealed, Policy: Each resident has the right to be free from abuse, mistreatment, neglect, exploitation, involuntary seclusion, misappropriation of property and mental abuse facility or enabled through the use of technology. Each resident will be free from chemical or physical restraints imposed for purposes of discipline or convenience that are not required to treat residents symptoms . C. Prevention . 4. Staff is to report any signs of stress from family and other individuals involved with the resident that may lead to abuse, neglect, or misappropriation of resident property, and intervene as appropriate. 5. Residents identified by staff as being self-injurious or exhibiting abusive behavior, which require professional services not provided in the facility, will be reviewed by the physician as soon as possible and treatment plans modified as appropriate .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235521	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Wayne	4427 Venoy Rd Wayne, MI 48184

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 - Immediate jeopardy to resident health or safety 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** 38207 This citation pertains to intake number MI00147248. Based on interview and record review, the facility failed to initiate a Code [NAME] (Notification for a missing resident) in a timely manner for one resident (R703) that was missing from the facility, after identifying that the resident had left the faciity on [DATE], unbeknownst to staff, of five residents reviewed for elopement, resulting in the potential for serious injury or death from the resident being outside and unsupervised for an extended period of time. Findings include: The Immediate Jeopardy (IJ) started on 9/25/24 and was identified on 10/3/24. The Administrator was notified of the IJ on 10/3/24 at 3:18 PM, and was asked for a plan to remove the immediacy. The IJ was removed on 9/26/24, based on the facility's implementation of the removal plan as verified onsite on 10/3/24. Although the immediacy was removed, the facility's deficient practice was not corrected and remained isolated with the potential for actual harm that is not immediate jeopardy. On 10/2/24 at 11:15 AM, Activity Aide (AA) H was interviewed regarding the elopement of R703 on 9/25/24. AA H indicated that they were coming to work at the facility at approximately 11:00 AM, and observed R703 on the sidewalk in their wheelchair approximately a mile and a half from the facility. AA H further indicated that upon observing R703, they contacted the facility and themselves and two other staff were able to bring R703 back to the facility. On 10/2/24 at 11:22 AM, R703 was met in their room and attempted to be interviewed. A one to one staff was observed in R703's room and R703 was observed to be sleeping. On 10/2/24 at 11:25 AM, the Director of Nursing (DON) was asked to provide the names and phone numbers of the staff assigned to R703 on 9/25/24 on day shift. The DON provided the requested information for Certified Nursing Assistant (CNA) B and Nurse/LPN (Licensed Practical Nurse) C, and stated, Both staff were terminated following the elopement incident for not following the facility's elopement policy. On 10/2/24 at 12:52 PM, R703 was met with again in their room and interviewed regarding the elopement incident which they were involved in. R703 indicated that they exited the front door of the facility on 9/25/24, After 11:00 AM, and stated, I was wheeling around all night. R703 indicated that they returned to the facility on [DATE], with no time provided by R703. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235521	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Wayne	4427 Venoy Rd Wayne, MI 48184

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/2/24 at 12:55 PM, Certified Nursing Assistant (CNA) B was attempted to be contacted by phone for an interview regarding the elopement of R703 on 9/25/24. CNA B did not answer their phone and a voicemail message was left for them A review of a written statement completed by CNA B regarding the elopement of R703 indicated that CNA B stated that they had last seen R703 in the facility at 9:30 AM, on 9/25/24. Further review of CNA B's written statement revealed that CNA B approached Nurse C twice between the morning hours and After lunch and asked Nurse C if R703 was in the building. On 10/2/24 at 1:00 PM, Nurse C was attempted to be contacted by phone for an interview regarding the elopement of R703 on 9/25/24. CNA C did not answer their phone and a voicemail message was left for them. A review of a written statement completed by Nurse C regarding the elopement of R703 indicated that Nurse C stated that they had last seen R703 in the facility between 8:00 AM-9:00 AM, on 9/25/24. Nurse C's written statement also indicated that CNA B approached them in the the morning and after lunch to ask if R703 was present in the building. On 10/3/24 at 9:15 AM, Nurse/LPN F was interviewed regarding the elopement involving R703. Nurse F indicated that they last saw R703 on/around 7:00 AM when they administered medication to [R703]. On 10/3/24 at 1:31 PM, Nurse C was contacted by phone and interviewed regarding the elopement involving R703 on 9/25/24. Nurse C was asked when they suspected that R703 had eloped from the building. Nurse C stated, I knew they were gone around 11:45 AM-12:00 PM. I thought I saw [R703] when I did my rounds, I had his medications pulled to go, but got sidetracked with something else and didn't get to [R703]. Nurse C was asked how they knew R703 was gone from the facility on 9/25/24. Nurse C stated, The CNA came to me and said, 'I don't think [R703] is here.' That's when we did the search. Nurse C was asked how long the search for R703 lasted and stated, It was going on at the time I left on 9/25/24 at around 8:00 PM-8:30 PM, and continued the next day. Nurse C was asked if they had ever witnessed R703 try to leave previously. Nurse C stated, No, but [R703] would make statements that they were going to go. [R703] was always looking out. Nurse C was asked if they knew how R703 got out of the building and which door they exited out of. Nurse C stated, No, I don't know what door. On 10/3/24 at 2:10 PM, the Administrator was interviewed about the elopement involving R703 on 9/25/24, and asked about the timeline of initiating a Code [NAME] for R703. The NHA indicated that Code [NAME] was initiated at 1:55 PM on 9/25/24. The NHA indicated that the code should have been initiated immediately when Nurse C realized that R703 was missing. A progress note located in R703's electronic medical record (EMR) which was dated, 9/25/2024 14:53 (2:53 PM) was reviewed and revealed the following, Alert Note Note Text: Writer was alerted by staff that resident could not be located. Code [NAME] was called, and the facility and grounds were searched by staff. Police were called and a simultaneously search of the community was initiated. Resident has a BIMS (Brief interview for mental status) of 6 and is mobile independently in [their] wheelchair. Staff were interviewed and the charge nurse stated [they] administered [R703] A.M. medication just prior to breakfast and [R703] propelled [themselves] towards the Oaks side of the building. C.N.A.(Certified Nursing Assistant) [indicated] [they] observed resident watching TV (television0 in the Oaks TV area after punching in this morning 9/25/2024. State agency notified, MD (Medical Doctor) notified, family notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235521	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Wayne	4427 Venoy Rd Wayne, MI 48184

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of R703's progress notes revealed the following, 9/26/2024 11:03 [AM] Alert Note Note Text: Activity staff called the facility to report resident being seen in [their] wheelchair on [Main roads within a mile and a half from the facility]. Staff drove and picked resident up. Resident was in good spirits laughing and joking with staff. Resident asked where he went, and [R703] responded that [they] had to go to work, and [were] on [their] way back home. Writer asked resident where he was. Resident stated he was with [their] brother. Resident spoke with [their] sister and mother on the phone and assured them [that they were] doing well. Resident was given breakfast and provided a shower he remains in good spirits and remains up in his wheelchair. Resident placed on 15-minute checks. Review of R703's EMR revealed that R703 was admitted into the facility on [DATE] with diagnoses that included Traumatic brain injury and Alcohol abuse. R703's most recent quarterly minimum data set assessment (MDS) dated [DATE] revealed that R703 had severely impaired cognition and required extensive assistance for all activities of daily living (ADLs). Review of a quarterly elopement assessment completed on R703 on 9/6/24 revealed that R703 Had no history of wandering; No diagnosis of .cognitive impairment, and had no reported episodes of exit seeking behavior in the past six months. R703 was evaluated to be at Low Risk for elopement. A facility policy titled, Missing Resident Hazard Code [NAME] with no date, was reviewed and revealed the following, Policy: It is the policy of this facility to reasonably protect the residents from harm through the prevention of elopemements. A missing resident is one that cannot be located within the facility and has not been signed out. Procedure: If it is determined that the resident was not signed out, the charge nurse will immediately announce over the paging system Code Green. This will be repeated three times. IJ Removal Plan-F689 1. Facility educated staff on policy of Code Green. Policy reviewed, updated, and education conducted on 9/25/24 and 9/26/24. 2. The Code [NAME] will be enacted immediately upon staff noticing that resident missing and not on appointment or LOA. Staff will page overhead Code [NAME] (Resident Room Number) three times. Staff will initiate head count of residents, search of rooms, grounds, other offices, and surrounding areas. Staff will page periodically Code [NAME] until the resident is located. The facility alleged compliance is September 26, 2024.