

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER The Orchards at Samaritan		STREET ADDRESS, CITY, STATE, ZIP CODE 5555 Conner Avenue, Suite 4000 Detroit, MI 48213	

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>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** 39958</p> <p>This citation pertains to intake MI00145863.</p> <p>Based on interview and record review the facility failed to provide adequate supervision for one (R102) of three residents reviewed for elopement, resulting in R102 exiting the facility without staff knowledge.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed, R102 admitted to the facility on [DATE] with pertinent diagnoses which included Dementia and Alcohol Dependence with Alcohol-Induced Persisting Dementia.</p> <p>Review of a Brief interview for Mental Status (BIMS) assessment dated [DATE] revealed R102 had severe cognitive impairment with a score of 4 out of 15.</p> <p>Review of an incident report dated 7/25/24 at 4:10 a.m., revealed, Resident was observed on the blue unit at 7:00pm, he then went to the brown unit where bingo was taking place. Resident was last observed at 8:45pm. Upon doing rounds while passing meds, writer and cena noticed that resident was not in his room. Staff proceeded to search all the units in effort to redirect resident back to his room, ineffective (sic)</p> <p>Review of a nurses note with a date of 7/25/24 at 4:27 a.m., revealed, Resident received at beginning of shift in stable condition. He was observed on the blue unit before going to bingo on the brown unit. At 8:40 resident was last observed on the brown unit. Upon passing meds and doing rounds, writer and cena noticed that resident was not in his room. Staff then performed a thorough search on the whole 4th floor. We then proceeded to search the entire building. Resident is still unable to be located. Administrator, DON, and physician notified of situation. (sic)</p> <p>Review of a nurses note with a date of 7/25/24 at 8:00 a.m., revealed, Resident return to facility around 8AM accompanied by officer via wheelchair. Resident received in good spirits with empty alcohol bottles and 2 unopened beer cans and stated that he was trying to go home, but he was trying to go to work. Resident statements had confusion noted with periods of clarity. Resident was able demonstrate how he exited out of the building .</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER The Orchards at Samaritan		STREET ADDRESS, CITY, STATE, ZIP CODE 5555 Conner Avenue, Suite 4000 Detroit, MI 48213	

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>Review of a Physician progress note with a date of 7/25/24 at 4:35 p.m. revealed, Patient left the facility without informing anyone. The facility contacted the police on finding out that patient is not at the facility. the police brought the patient back earlier this morning .</p> <p>Review of a Visitor Sign In-Out Record with a date of 7/24/24 revealed no visitors signed out after 8:21p.m. R102 was not signed out on the record.</p> <p>In an interview on 7/30/24 at 10:41a.m., R102 asked about leaving the facility. R102 reported did not remember leaving the facility last week.</p> <p>In an interview on 7/31/24 at 9:26 a.m. Receptionist A reported not knowing what time R102 exited the facility on 7/24/24. Receptionist A then reported the nurse notified her at 10:30 p.m. that R102 was missing.</p> <p>In an interview on 7/31/24 at 9:36 a.m. Licensed Practical Nurse (LPN) B reported R102 was in bingo at the beginning of the shift. LPN B reported observing R102 on brown unit at approximately 7:15 p.m. LPN B then reported around 9:40 p.m. the CNA reported R102 was not in the room.</p> <p>In an interview on 7/31/24 at 10:41 a.m., the Nursing Home Administrator (NHA) reported R102 exited the facility through the main elevator near the receptionist desk. The NHA then reported R102 demonstrated the exit from the facility by using the main elevator. The NHA reported R102 was returned to the facility by the police the next morning (7/25/24).</p> <p>Review of a Elopement, Potential Resident policy with no date documented, 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 . Residents with cognitive loss who leave the facility without authorization and without an escort will be considered an elopement and will be assessed to minimize the risk of repeat unauthorized exits .</p>