

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Ingham County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 3860 Dobie Road Okemos, MI 48864	
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** Citation pertains to intake #3039609Based on interview and record review, the facility failed to protect and keep one resident (R70) of one resident safe from accidents that include elopement. Findings Include;Resident #70 (R70)Review of the medical records reflected that R70 was admitted to the facility on [DATE]. Diagnoses of Dementia, Anxiety and Depression. R70 was hospitalized and not on site at the facility during the survey. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/21/2026 revealed R70 had a Brief Interview of Mental Status (BIMS) of 05 (Severe cognitive impact) out of 15. R70 wore a wander guard (security system used to protect residents who are prone to wandering).Record review revealed R70 verbalized an exit plan upon admission to the facility and a wander guard was placed on her right ankle. R70 was wandering in and out of other residents' rooms.Record review revealed the following:On 5/17/26- 9:29 AM- R70 attempting to exit the facility out the rear doors at the end of the hall. R70 asked maintenance staff to let her out so she could go home.On 05/17/26- 9:36 AM- R70 attempting to exit the facility out the rear doors at the end of the hall. R70 went up to nursing staff and said she needed to go home.On 05/17/26- 9:37 AM- R70 walked towards the atrium and was attempting to walk out the front doors to get out and get home, there were people waiting for her.On 05/17/26- 1:28 PM- R70 became agitated while pacing up and down the hallway asking about where her car was, where her son was and how to get out of there because she needed to get home.On 05/18/26- 11:37PM- R70 approached the [NAME] Ridge north exterior exit and attempted to exit out the automated door, in order to get outside, after pressing the blue handicap button. CNA was able to redirect R70 back to the nurse. R70 became agitated and needed to go home and get their car.On 05/18/26- 11:53 AM- R70 was outside briefly during an attempted escape, was observed by staff the entire time attempting to walk towards the exterior gate after getting through the interior door outside. R70 was then brought back inside by staff that could redirect her.On 05/18/26- 12:53 PM- R70 packing her belongings and attempting to leave the facility. R70 was able to be redirected to an activity.On 05/20/26- 10:16 PM- R70 was observed by CNA, walk up to courtyard door, press the handicap button to open the door and walk into the courtyard. Door alarm and wander guard alarm sounded. CNA followed R70 outside and redirected her back inside the building.On 05/20/26- 10:58 PM- R70 had room change due to exit seeking and elopement risk.On 05/20/26-4:03 PM- R70 attempting to go out fire door on unit. R70 trying to find a way out, re-educated on door safety and memory care unit.On 05/21/26- 10:14 AM- CNA reported to nurse, R70 exited the door. R70 re-entered the door to the hallway. Wander guard in place, not reported if it alarmed or not. R70 continued making statements about finding her car.On 05/21/26- 7:07 PM- R70 was restless and anxious and kept approaching exit door, attempted to go home, walk to her car reported by R70, hard to redirect.On 05/22/26- 11:33 AM- R70 noted old yellow bruising to (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 235015	Facility ID: 235015 If continuation sheet Page 1 of 2

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	side of abdomen. Root cause- Resident observed attempting to open exit doors and using her body. R70 walks up to the doors and uses her body to push the doors causing bruises. Immediate intervention; monitor for increase in size/swelling, staff to continue to redirect away from exit doors. On 05/22/26- 6:30 PM- R70 made multiple attempts to approach exit door, making statements about leaving, R70 stated She had to go home with her family, she had to go look for her boyfriend, she had too many things to do at home. R70 was able to be re-directed. On 05/28/26- 2:00 PM- R70 attempting to exit via locked door, adamite that she wanted to leave. Became upset and reported she would find a way out. R70's son was called, spoke to her for a few minutes. Approximately 10 minutes later R70 got up to walk to the exit door. R70 was redirected back from the door. On 05/30/26- 4:38 PM- R70 unable to fall asleep all night, in and out of bed, exit seeking, asking to go home, easy to redirect. On 05/30/26- 7:25 PM- R70 appeared anxious, attempting to approach doors to go home, redirection provided. On 06/09/26- 6:41 PM- R70 exit seeking and packing belongings. On 06/13/26- 8:12 PM- R70 wandering to the end doors stating I'm going home walking so fast she almost tripped over other residents several times. Prn Ativan given. On 06/15/26- 4:26 PM- R70 asking about how to get out and where her car was located. On 06/20/26- 12:01 PM- R70 wandering unit and asking for her car. Aide walked R70 outside in units gaited area for a few minutes. Came back in with staff fine. On 06/22/26- 6:48 PM- R70 did approach exit doors, but no attempts were made to open them. On 06/24/26- 1:52 PM- R70 was attempting to get another resident to go out the back door. R70 stated all you had to do is push on the door and hold it and it will open. R70 reported she needed to go get her car and go home. On 06/24/26-6:58 PM- R70 did approach the door multiple times, attempting to open the exit door. On 06/27/26- 4:54 PM- R70 asked staff can I get out that door pointing to the exit door in the lounge then the unit door. When redirected, stated I need to leave when reminded she stays here, R70 replied forget it, I am just going to leave. During an interview on 07/10/2026 at 9:17 AM, LPN/Unit Manager/Abuse coordinator C stated R70 exited out of the emergency exit door, looking for her car, took a right, couldn't find her car, and came back to the closest door, being front entrance, the receptionist assisted her in and back to her unit. LPN/Unit Manager/Abuse coordinator C also stated she was involved in updating the care plan for R70, updated immediately to prevent anything else from happening. Record review revealed additional elopements dated 05/18/2026 at 11:53 AM, 05/20/2026 at 10:16 AM and 05/21/2026 at 10:14 AM, that were not listed in the report. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included Element 1- The Elopement Assessment, Skin Assessment, Medical Director made a Tele-Health Visit, Nurse Practitioner follow up notes, Medication Administration Record reviewed. Element 2 included Elopement Risk Assessments on all residents, Audit of Wander Guard on Care Plans, Orders and Task. Element 3 included staff re-education, topic and information to be taught, and signatures of all staff attending. Element 4 included audits that were completed weekly to show compliance. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.		