| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235094 | A. Building<br>B. Wing | 06/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wexford Senior Care Center | 460 Pearl Street<br>Cadillac, MI 49601 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate supervision by failing to effectively identify and assess elopement risk to assure resident safety needs for one resident (Resident #4) of three residents reviewed for supervision.Findings Include:Resident #4 (R4) was admitted to the facility on [DATE] with diagnoses that included alcohol dependence with alcohol-induced persisting dementia, Wernicke's Encephalopathy (a potentially life-threatening neurological disorder caused by a severe deficiency of thiamine [vitamin B1]), and adjustment disorder with mixed anxiety and depressed mood. The Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderately impaired cognition.On 6/8/26 at approximately 6:55 AM, R4 exited the facility unsupervised and without staff knowledge following activation of a fire alarm on the 100 North Hall. Facility investigation revealed R4 exited through the 100 North Hall exit door and ambulated with a walker down the sidewalk toward the employee parking lot. Staff did not hear the door alarm over the fire alarm until they reached the exit door.On 6/22/26 at 11:30 AM, Licensed Practical Nurse (LPN) D stated R4 exhibited exit-seeking behaviors since admission but was typically easily redirected. LPN D stated that just before 7:00 AM on 6/8/26, while the fire alarm was sounding, a Certified Nursing Assistant (CNA) asked whether R4 was permitted outside unattended. LPN D stated R4 was not allowed outside unsupervised.Record review showed multiple documented behaviors indicating elopement risk, including cognitive impairment, wandering, exit-seeking, and impaired safety awareness, as evidenced by: 3/10/26: Staff documented R4 pacing between the dining room and his room, and he attempted to exit near the dining room before being redirected. 3/12/26: An Elopement and/or Exit Seeking Behavior Analysis documented no changes in risk level. Narrative descriptions were provided for questions 3, 6, 11, 14, and 18, but question 20 indicated Resident is NOT at risk, despite documentation of exitˆseeking statements, dementia, and recent medication changes. 4/11/26: Staff documented pacing, repeated requests to use the phone, and restlessness. 5/19/26: Behavior documentation indicated exit seeking, agitation, and argumentativeness. Staff contacted R4's daughter, and the behavior somewhat improved. 6/4/26: Another Elopement and/or Exit Seeking Behavior Analysis indicated no changes, and question 20 again stated Resident is NOT at risk.During an interview on 6/22/26 at 2:25 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) stated they would not include elopement interventions in a care plan unless a resident made repeated attempts to leave, rather than verbalizing intent. The DON stated elopement assessments were completed upon admission, quarterly, and as needed. When asked how many affirmative responses on the assessment indicated risk, or how risk was determined when narrative comments replaced yes/no answers, the NHA and DON were unable to specify criteria and stated the determination was based on clinical judgment.On 6/22/26 at 2:35 PM, a phone interview was conducted with R4's Guardian who stated she feels that R4 just wants to go home. She stated she cannot take R4 out for a leave of absence because he continuously asks to go home and doesn't understand why he cannot go.Review of the facility's Elopement and/or Exit Seeking Management policy, revised 10/11/19, indicated: 1. Identify resident risk for elopement and<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | implement interventions as needed.The facility failed to complete a comprehensive elopement risk assessment in response to changes in condition and failed to revise the resident's care plan to include individualized interventions to mitigate elopement risk. |