STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235147	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schoolcraft Medical Care Facility	520 Main Street Manistique, MI 49854

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. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficiency pertains to Facility Reported Incident (FRI) 2631248Based on observation, interview, and record review, the facility failed to implement interventions and physician recommendations/orders to prevent one Resident (#1) with a known history of elopement of three residents reviewed for elopement from eloping from the facility. This deficient practice resulted in an immediate jeopardy when Resident #1 eloped from the facility and was found 1.2 miles away and was missing for approximately 2 hours, resulting in the likelihood of series injury, harm or death.Findings include:The Immediate Jeopardy began at 12:16 p.m. on 9/28/25 when R1 eloped from the facility undetected and was reported by a facility staff member to be located at a fast-food restaurant, 1.2 miles away at 2:10 pm. The Nursing Home Administrator (NHA) was notified of the immediate jeopardy on 10/8/25 at 2:10 PM. At that time, an immediacy removal plan was requested from the facility. This surveyor confirmed by observation, interview, and record review that the immediacy was removed on 10/8/25 at 4:06 p.m., however, noncompliance remained at the potential for more than minimal harm due to sustained compliance which has not been verified by the State Agency (SA).Resident #1 (R1)Review of Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on 4/7/25, with active diagnoses that included: Alzheimer's disease and macular degeneration (an eye disease that damages the macula [part of the eye for sharp, central vision], causing blurry or distorted central vision). Further review of MDS Section B1000 Vision revealed R1 vision is severely impaired with no vision or sees only light, colors or shapes; eyes to not appear to follow objects. R1 scored a 4 of 15 on the Brief Interview for Mental Status reflective of severe cognitive impairment.Review of the Facility Reported Incident (FRI) submitted to the SA included an Incident Summary read in part, .R1 was found not to be in the facility.he went out when a family member came into the facility. Investigation Summary/Actions Taken.At approximately 1:13 p.m. on 9/28/25, Administrator was called by charge nurse.who stated that R1 could not be found in the facility.the facility has been checked and R1 was not in the building.at 2:10 p.m. the resident has been found at [fast food restaurant] 1.2 miles away from the facility.the Director of Nursing (DON) and Administrator reviewed the cameras after the event and noticed that the resident was playing with the door code earlier in the day.Views of the camera showed that he waited for a family member to come in the door to sneak out of the facility.he did walk around.before leaving the facility premises.Review of google maps revealed R1 would have crossed multiple streets and likely walked along a busy highway to gain entrance into the fast-food restaurant located next to the highway. The fast-food restaurant is also located near a very large lake with an average surface temperature in late September of approximately 50 degrees Fahrenheit.Review of the Elopement [R1] Incident Timeline dated 9/28/25, read in part .12:16 p.m. a residents family entered the facility in the Northeast entrance. R1 seen them come in and he immediately went to the door and got outside. nobody seen him go out.12:59 p.m. Certified Nurse's Assistant (CNA) went to check on resident and realized he was not there.at 2:10 PM Staff Member D found resident at [fast food restaurant].Review of Incident Report titled Elopement dated 9/28/25, read in part . Nursing Description: Resident waited for a family member enter the building so that he could exit the building.He was seen on [video] camera playing with the door code at 11:35 a.m.No witnesses to that.During an interview on 10/7/25 at 12:28 p.m., the NHA reported I don't know how he made it to the [fast food restaurant], he can't see. I had 40 people looking all over the [city name] looking for him.he wants to get out of here and go to another facility.he does not want to be here, especially since his wife died.she died just before he eloped from here.During a phone interview on 10/7/25 at 1:04 p.m., family member [daughter] A reported He has talked about leaving the facility prior to the elopement.he left that day and he just didn't want to be there since mom died.During an interview on 10/7/25 at 1:15 p.m., CNA B reported He was grieving since his wife passed.he always talked about leaving and going to the city where he used to live [50 miles away].he has gone to the doors before.I worked that day and went to his room to check on him and he was gone.he left the facility and was found a mile or so away.During an observation on 10/7/25 at 1:27 p.m., the Northeast exit door was noted to be across from the dining room.During an observation on 10/7/25 at 1:33 p.m., the NHA replayed the video camera footage which revealed R1 walked out of the dining room and exited the northeast exit door after other visitors entered. R1 walked outside of the fence and then walked across the parking lot towards the street.During an interview on 10/7/25 at 2:40 p.m., R1 stated I wanted to get out of here and I did. I will try again, and they will not find me.I don't want to be here.Review of R1's physician progress notes revealed the following entries:5/21/25, read in part, [R1]