STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235201	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Munson Healthcare Crawford Continuing Care Center	1100 Michigan Avenue Grayling, MI 49738

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. (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 - Minimal harm or potential for actual harm Residents Affected - Few	This deficient practice pertains to intake 2588223.Based on interview and record review, the facility failed to prevent and readily detect an elopement for one Resident (#1) of three residents reviewed for accident hazards and supervision.Findings include:Resident #1 (R1):Review of R1's electronic medical record (EMR) revealed initial admission to the facility on 8/1/25 with a diagnosis of dementia with behavioral disturbances. Record review of R1's Nursing Clinical admission report, dated 8/1/25, revealed a level of cognitive impairment as, severe impairment (affecting all areas of judgement).Review of R1's Elopement Evaluation, dated 8/1/25, revealed a score of 6.0, indicating the resident was, at risk of elopement.Review of the FRI submitted to the State Agency (SA) on 8/7/25 at 5:15 PM, included an investigation report which read, in part: Resident [R1] was admitted to our department on 8/1/2025 at approximately 11:30 AM. Resident [R1] was noted by staff to be missing at 1600 [4:00 PM]. The resident was found at 1616 [4:16 PM]. Security camera footage was reviewed by security staff and administrator. Resident [R1] exited out of the west door at 1531 [3:31 PM] and moved quickly out of the sight line of the windows.1 CNA [certified nursing assistant] did not [sic] that while she and other staff were assisting the resident through the west door at admission the door was not alarming. She did not see anyone at the nurses' station. The door was open for a prolonged period due to assisting [the] resident into the building with her personal items. The CNA returned directly to work and did not notify any staff that the alarm was not going off. She stated she was very busy and did not realize there was an issue until after the report of the elopement. Resident [R1] was found close to the facility, at the next-door elementary school.On 8/19/25 at 9:10 AM, all documentation related to R1's elopement on 8/1/25 was requested from the Nursing Home Administrator (NHA).On 8/19/25 at 9:55 AM, the NHA presented this surveyor with two witness statements but confirmed the facility did not complete a Risk Watch report in accordance with facility policy following the elopement. The NHA stated, the process will be corrected.On 8/19/25 at 2:12 PM, security footage of the elopement event on 8/1/25 was reviewed with Security Officer (SO) J and the NHA which revealed the following events:At 3:22 PM, R1 was observed exiting the facility via the west hall emergency door and subsequently walked out of view from the outdoor camera.At 3:34 PM, R1 was observed walking in Parking Lot A near the emergency ambulance bay at the attached local acute care hospital.At 4:15 PM, Occupational Therapist (OT) H was observed locating R1 in an elementary school parking lock adjacent to the acute care hospital.At 4:18 PM, R1 is observed walking back toward facility entrance with OT H and an additional staff member. On 8/19/25 at 12:13 PM, an interview was conducted with CNA E who verified she was working the day of R1's elopement event. CNA E stated she assisted R1 off the bus at the west facility door after she arrived at the facility around 11:30 AM. CNA E explained the door was alarmed and will continue to sound if the door was open unless the reset button is continuously held at the nurse's station which will temporarily silence the alarm. CNA E recalled it took an extended amount of time to assist R1 and her belongings off the bus, but noticed the alarm was not sounding despite the open door. CNA E stated she did not observe anybody engaging the silence button as she walked by the nurses' station with R1. When asked if CNA E notified staff about the malfunctioning alarm, she stated she did not because her priority at the time was to ensure R1 was assisted with toileting needs and acclimated to her room and the facility. CNA E stated R1 became restless and somewhat agitated as the day progressed, wandering in and out of resident rooms and walking around the facility. CNA E recalled the nursing assistants started taking their afternoon breaks around 3:15 PM and stated she could not locate R1 upon her return around 3:45 PM - 4:00 PM. On 8/19/25 at 1:50 PM, an interview was conducted with Maintenance Worker (MW) I who confirmed the exit door alarm would continue to sound while open unless the reset button was continuously held. MW I further explained after the door is opened and shuts, the reset button must be pushed once to disengage the alarm.On 8/19/25 at 12:26 PM, a telephone interview was conducted with Registered Nurse (RN) C regarding the elopement event on 8/1/25. RN C recalled soon after R1 arrived at the facility, she appeared restless and began wandering in and out of other resident rooms. RN C stated she placed a WanderGuard (an electronic monitoring system used to prevent at-risk residents from leaving designated safe areas by triggering an automated alarm when the user nears a restricted exit). RN C stated she was notified by CNA E that R1 could not be located and began a facility search around 4:00 PM (38 minutes after R1 was observed exiting the facility via security footage). RN C stated, I am 100% positive I didn't hear a [door] alarm go off.On 8/19/25 at 1:12 PM, an interview was conducted with OT H who confirmed she had located R1 in an elementary school parking lot following the