

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/29/2026
NAME OF PROVIDER OR SUPPLIER  Munson Healthcare Crawford Continuing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<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>This deficient practice pertains to Intake 2985836. Based on interview and record review, the facility failed to prevent 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. Review of R1's most recent Minimum Data Set (MDS) assessment, dated 2/6/26, revealed a Brief Interview for Mental Status (BIMS) score of 2, indicative of severe cognitive impairment. Review of R1's quarterly Elopement Evaluation, dated 3/21/26, revealed a score of 6.0, indicating the resident was, at risk of elopement. Review of the Facility Reported Incident (FRI) included an investigation report submitted to the State Agency (SA) on 4/10/26 at 2:03 PM, which read, in part: On the evening of 4-09-2026, the Director of Nursing (DON) was exiting the facility for the day at 1624 [4:24 PM] and noted [R1] attempting to cross the front parking lot. [R1] has known wandering activities and has a history of elopement from this facility. [R1's] elopement prevention interventions prior to this incident included wanderguards (a wearable device which triggers an alarm when a resident nears a restricted area) one to each wrist, and fifteen-minute safety tracking. At 1537 [3:37 PM], 4-09-2026, [Facilities Employee/Staff A] responded to the facility as the wanderguard at the facilities front door would not reset. [Staff A] unplugged the power to reset the system. After completing this task, [Staff A] noted that the wanderguard was showing a green light indicating it was functional. [Staff A] left the facility at this time. [R1] was noted to have exited the facility at 4:24:38 PM. [The DON] was noted exiting the facility at 4:24:57 PM and pursued [R1]. [R1's] wanderguards did not trigger the front door wanderguard system to alarm when she exited the facility. At 1630 [4:30 PM], [Staff A] from Facilities returned to the facility to assess the wanderguard. It was noted at this time that the wanderguard was not functioning appropriately. On 4/29/26 at 10:30 AM, an interview was conducted with the DON who confirmed she first saw R1 in the parking lot approximately 75 feet from the entrance after exiting the facility on 4/9/26. The DON stated she immediately called Registered Nurse (RN) D to notify the facility of the elopement and to summon additional help. On 4/29/26 at 10:32 AM, an interview was conducted with RN D who confirmed she received a call from the DON on 4/9/26 at 4:26 PM asking for assistance as R1 was outside the facility in the hospital driveway and beginning to walk toward the road. RN D showed this Surveyor the approximate path she negotiated with R1, nearly a block and half from the facility, before she and a certified nursing assistant (CNA) were able to successfully redirect R1 back into the facility. On 4/29/26 at 10:40 AM, a telephone interview was conducted with Staff A who verified he was asked to fix the wanderguard system around 3:30 PM on 4/9/26. Staff A stated the alarm would not stop sounding, therefore he reset the system to rectify the malfunction. Staff A stated after a system reset, the alarm was silenced, and the green light was illuminated on the system which he assumed indicated the system was properly functioning. Staff A confirmed he left the facility at this point. At approximately 4:30 PM, Staff A stated he was called back to the facility after R1's elopement because the alarm was not sounding as designed when a wanderguard came into proximity of the system. Staff A confirmed this finding when he tested the system with a probe/sensor when he (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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>returned. On 4/29/26 at 10:55 AM, an interview was conducted with Maintenance Director (MD) B regarding the wanderguard system. MD B stated it is protocol to manually test the system with a probe or sensor after performing any type of maintenance on the unit rather than relying on the green system light to indicate proper functioning. On 4/29/26 at 11:17 AM, a phone interview was conducted with CNA C who verified she was working at the time of R1's elopement. CNA C confirmed R1 had been restless in the hours leading up to the elopement, attempting to exit out of the [NAME] facility door just 15 minutes prior to the successful elopement. CNA C confirmed the door alarm did not sound when R1 successfully eloped from the facility at 4:24 PM on 4/9/26. On 4/29/26 at 11:40 AM, an interview was conducted with the Nursing Home Administrator (NHA) who verified R1 eloped from the facility on 4/9/26 and was unattended in the facility parking lot for approximately 19 seconds. The NHA confirmed the root cause of the elopement was failing to manually test the wanderguard system following service for proper functioning resulting in a faulty alarm. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: A staff member was placed at the door to monitor for any residents attempting to exit the facility while the wanderguard system was being serviced following the elopement. The system was determined to be appropriately functioning on 4/9/26 at 8:15 PM. Resident #1 was assessed with no injury following the event and was placed on 1:1 supervision until transferred to a secured dementia unit. Audits of the main entrance door and elevators were conducted for proper functioning. All residents wearing wanderguards were checked for proper functioning following the event and continued to be checked twice per day. The Facilities Department has been educated on manually testing the wanderguard system following any repairs or services. The charge nurse is now responsible for testing the functioning of the exit door and elevator alarms every shift. The NHA or designee will review the main entrance door and elevator door weekly for four weeks then monthly at the discretion of the facility Quality Assurance Performance Improvement Committee to ensure wanderguard units are functioning appropriately for continued compliance. The facility was able to demonstrate monitoring of the corrective action and maintained compliance as of 4/27/26.</p>		