STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235264	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ely Manor	1200 Ely St Allegan, MI 49010

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2575758Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent an elopement and ensure safety in 1 of 4 residents (Resident #101) reviewed for safety/supervision, resulting in an Immediate Jeopardy when on 7/20/25 between 7:30 p.m. and 7:45 p.m., Resident #101 exited the facility, unbeknownst to facility staff, and was found by an off duty nurse approximately 0.3 miles away after sustaining a fall. This deficient practice placed all residents, identified as at risk for elopement, at risk for serious harm, injury, and/or death. Findings include:The facility failed to provide adequate supervision to prevent elopement for an exit seeking resident, Resident #101, who was an elopement risk. Resident #101 was found 0.3 miles away from the facility by an off-duty nurse and bystanders. Resident #101 was lying in an embankment holding onto a traffic cone with a bleeding skin tear on his lower right arm. The EMS (emergency medical services) report noted that Resident #101 was observed by bystanders to be walking in the road, weaving in and out of traffic. The road was 35 MPH (miles per hour) with no sidewalks. The Immediate Jeopardy began on 7/20/25 when the facility failed to supervise Resident #101 and he eloped from the facility between 7:30- 7:45 PM. The Nursing Home Administrator (NHA) A was notified of the Immediate Jeopardy on 8/6/25 at 1:30 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 8/6/25, but noncompliance remains at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to sustained compliance has not been verified by the State Agency.Resident #101Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of Resident #101's Nursing admission Evaluation dated 7/18/25 indicated that Resident #101 was ambulatory (able to walk), was noted to wander, had two or more predisposing diseases such as Dementia, OBS (organic brain syndrome- a condition characterized by cognitive and behavioral changes caused by damage to the brain), Alzheimer's, Depression, Mental Illness, or Expressive Language Deficits. Resident #101 was cognitively impaired, took 7 or more medications, was a new admission to the facility, and scored 11 or higher on the elopement risk assessment indicating that Resident #101 was at risk for elopement. Resident #101 had a wander guard placed due to elopement risk.Review of Resident #101's Care Plan revealed, (Resident #101) is at risk for elopement R/T (related to) impaired cognition d/t (due to) advanced dementia, elopement score of 12. Date initiated: 7/18/25. Goal: Will not leave the facility unattended through review date. Date initiated: 7/18/25. Interventions: Apply wander guard per order. Wander guard to the left ankle. Date initiated: 7/18/25. Approach in a slow, calm, manner and redirect away from exit doors as needed. Date initiated: 7/21/25. Distract when wandering into inappropriate areas by offering pleasant diversions, structured activities, food, conversations, etc. Date initiated: 7/21/25. Observe wandering behavior and attempted diversional interventions when wandering into inappropriate locations such as other resident room when not invited, behind nurses' stations, shower rooms, attempts at exiting the (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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B hall nurse replaced wander guard to left ankle.19:30 (7:30 PM) this nurse had visual redirection of exit seeking on C hall side door and visual of his wander guard in place. All staff was made aware to keep visuals on resident d/t exit seeking. Remains on continued visuals .Review of Resident #101's Incident Report dated 7/20/25 revealed, Allegation Statement: At approximately 8:00 PM, RN II contacted the Administrator (NHA) A to report that she was with a male on the roadside with a wander guard to his ankle. The male (Resident #101) was pleasantly confused and unable to tell the off-duty nurse with what his name was. NHA A contacted the facility to complete a head count while RN II remained with the male. Resident: (Resident #101). BIMS (Brief Interview for Mental Status) score of 2/15 indicating severe cognitive impairment. (Resident #101) was admitted to the facility on [DATE], after being hospitalized for a urinary tract infection. While at the hospital. (Resident #101's) wife requested placement for rehab with intention to transfer to long term care related to his progressing dementia. (Resident #101) is able to ambulate independently without the use of an assistive devices and requires supervision and cueing for ADL'S (activities of daily living) related to his cognition . Action Taken: Administrator (NHA) A contacted the facility to complete a full head count, (Resident #101) was taken to (local emergency department) by EMS (emergency medical services) for evaluation, facility nurse conducted an audit to ensure all wander guards were in place and functioning, facility nurse verified doors were locked and in working order, upon return to the facility, the primary nurse verified (Resident #101) wander guard was functioning properly, upon return from the facility, (Resident #101) was placed on a 1:1 for supervision . Intervention: After investigation, it was determined that (Resident #101) did exit the facility, he sustained no significant injuries, he was sent to the ER (emergency room) by ambulance for evaluation, he returned to the facility, and it was determined that his wander guard was functioning properly. He was placed on a 1:1 for supervision upon return. Conclusion: Root cause of the elopement was determined to be due to the staff turning the alarm off without walking outside the door and checking the perimeter . Review of Resident #101's EMS Prehospital Care Report Summary dated 7/20/25 revealed, Patient (PT) is a . male whose chief complaint is elopement. Patient is a resident at (Facility name), a local skilled nursing facility. POSITION PT FOUND/INITIAL SCENE FINDINGS: Dispatched priority 1 for a male that was walking in the road, weaving in and out of traffic. Arrived on scene of the side of the road to find patient lying supine (face up on back) in the grass. Bystanders state that patient was walking on the road carrying a traffic cone approximately 4 feet tall, then sat on the ground. Patient knows his name but is unable to answer any other questions appropriately .Patient has a small skin rear on his lower right arm, bleeding controlled. The bystander that found patient observed a monitor on patient's right ankle. Bystander reports that she is a nurse at (facility name) and believes that patient may be a patient at (facility name). Nurse called the facility and confirmed that patient is a resident there and staff was unaware that patient had eloped from the facility. Staff reports that they want patient taken to the hospital to be evaluated .In an interview and observation on 8/5/25 at 1:15 PM, NHA A walked outside of the facility with surveyor to show the location which Resident #101 was found by bystanders. This writer walked to the location where Resident #101 was found and noted the location to be 0.3 miles away from the facility. It was noted that there were no sidewalks, and the speed limit of the road was 35 MPH. Resident #101 had crossed the street of the facility. NHA A reported that she was unable to (continued on next page)

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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	that (local service company) came to the facility on 7/21/25. 16. Receptionist is scheduled from 7am-7pm to monitor front doors, doors lock at 7pm and unlock at 7am. Staff member is assigned to monitor doors when receptionist is on break/lunch. 17. DON/designee-initiated education 7/21/25 on elopement policy/response to elopement (100% completed by 7/22/25). 18. (Local service company) to provide quote for new wander guard keypad that will increase the enunciator volume. 19, (Local service company) has provided a quote to replace service hall door (7/21/25). 20. The maintenance director/designee will check wander guard doors for functioning 7 days per week. 21. Education initiated 7/21/25, any staff not educated by 7/21/25 will be educated prior to working next shift, 71/94 employees educated 7/21/25. (100% completed by 7/22/25). Staff were educated on elopement policy, responding to alarms, ensuring resident safety and doing exterior observation when responding to the door alarms, key pad code has been changed and maintenance disabled exit release at nurse's station and front desk so that staff have to let visitors out/in after 7 pm ensuring safety of residents and ensuring residents are not exiting with visitors/staff and staff to provide/initiate one-on-one with actively exit seeking residents. Staff will contact DON and/or NHA if there is a need for one on one to assist with adequate staffing.22. DON/designee reeducated licensed nurses on following physician orders, audit tool shift to shift between nurses to ensure MAR/TAR (medication administration record/treatment administration record) is complete and to retrieve the wander guard checker to complete task prior to leaving shift on 8/6/25. An additional Accutech machine is being ordered on 8/6/25 to allow each side of the facility access to an Accutech machine. An Accutech machine has been available and in working condition. The facility provided education to nursing staff on documentation of wander guards, and the expectation to place the resident on 15-minute checks if unable to test wander guard. 23. NHA/DON reviewed the Elopement Policy and deemed appropriate 7/21/25. Resident #104 Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnoses which included personal history of traumatic brain injury.In review of the Incident Report dated 7/11/25 for Resident #104 which revealed, (Resident #104) went through the service doors and was retrieved by staff. He was assisted into the building at the front lobby. Resident stated he was going to the store . Wander guard in place and functioning properly .In a follow up interview on 8/6/25 at 12:19 PM, NHA A confirmed that Resident #104 had a wander guard on and was able to make it through the service doors without staff knowing. NHA A reported that she had completed an investigation into the incident and determined that staff did not close the door all the way and ensure that a resident did not follow them. NHA A was not able to provide evidence of her investigation. Review of the facility's Elopement Policy last revised 4/26/222 revealed, Policy: It is the policy of this facility to prevent to the extent reasonably possible, that elopement of guests/residents from the facility . Procedure: The facility will evaluate guest's/resident's risk for elopement upon admission, weekly x 4, quarterly, and with a significant change. Periodic reviews will be completed as deemed necessary by the interdisciplinary team.2. After the Risk for Elopement is completed, and a guest/resident is deemed at risk for elopement, the licensed nurse will: a. Assure the guest/resident has an identification band with guest/resident's name, and facility phone number. b. If the facility has a wandering system, the wandering device will be checked for functionality prior to placement on the guest/resident according to manufacturer's specifications. c. Verification of the placement of the wandering device will be done on each shift and documented on the MAR (Medication Administration Record) by the licensed nurse. d. The Social Worker/designee will create and maintain a current log for all guests/residents that are at risk for elopement. Minimally, this log will be kept at the nursing station, reception desk and/or additional locations as deemed appropriate by the facility's interdisciplinary team. e. Verification of unit functionality will be tested by the midnight shift licensed nurse using wandering testing device and documented on the [TRUNCATED]