STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235407	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalkaska Memorial Health Center	419 S Coral St Kalkaska, MI 49646

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 This deficient practice pertains to Facility Reported Incident (FRI) MI00152479. Based on observation, interview, and record review, the facility failed to prevent, detect, and respond to an elopement resulting in the likelihood of serious harm, injury, impairment, or death for one Resident (#1) of four residents reviewed for elopement. Findings include: The Immediate Jeopardy began on 4/11/25 at 7:17 PM when R1 eloped from the facility undetected and was wandering near a busy street and ambulance garage for approximately 19 minutes. R1 was discovered by external entity emergency personnel wandering near the entrance/exit to the ambulance bays. The Nursing Home Administrator (NHA) was notified of the Immediate Jeopardy on 5/1/25 at 4:16 PM. This surveyor confirmed by observation, interview, and record review that the immediacy was removed on 5/2/25 at 11:14 AM, however, noncompliance remains 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 R1's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, major depressive disorder with psychotic symptoms, and borderline personality disorder (a mental health condition marked by extreme mood fluctuations, instability in interpersonal relationships, and impulsivity). Record review of R1's most recent St. Louis University Mental Status (SLUMS) examination, dated 4/16/25, revealed a score of 19/30, indicative of dementia. Review of R1's MDS Assessment Sections E and G, dated 3/25/25, indicated R1 exhibited wandering behavior occurring 4 to 6 days per week and was independent with mobility. Review of R1's plan of care identified the following focus, initiated 8/10/24: Risk of Wandering/Elopement Identified with an intervention which read, Wanderguard (an electronic wristband used to notify staff of a resident exiting alarmed doors) in place on walker for elopement concerns . Review of R1's Elopement Evaluation, dated 3/11/25, revealed a score of 5, indicating R1 was, at risk of elopement. (continued on next page)

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	Review of the FRI submitted to the SA on 4/21/25 at 7:37 PM, included an investigation report which read, in part: .On 4/11/2025 [Licensed Practical Nurse (LPN) B] called and alerted LTC (long term care) on call manager [Registered Nurse (RN) C] that [R1] had eloped from the facility . Camera footage was obtained, and it was discovered that at 7:17 pm [R1] exited her room and walked to the right and down the hallway. Only a few doors down, [R1] approached the fire exit door which is labeled to hold for exit. [R1] was observed to hold the door until its release, she went through the door and walked to the right - through the second exit door outside of the building. (The door did alarm however it is the far end of the building and staff did not hear the alarm until they were halfway down the hall heading towards [R1's] room) . At 7:23 pm [Certified Nursing Assistant (CNA) D] reported .to [R1's] room .and noted the alarm on the door sounding, she immediately checked the exit (6 minutes after [R1] had exited.) [CNA D] did not see [R1] and she went to inform [RN A] . [RN A] was about to page a missing adult alert when EMS [emergency medical services] called to ask if a resident was missing . [R1] returned to long term care at 7:36 pm . During review of the camera footage we [facility] were able to determine that [R1] did not take her walker which had her Wanderguard attached to it . On 5/1/25 at approximately 9:30 AM, the location of R1's room at the time of the elopement was observed in a back hall, around a corner from the nurses' station where it could not be visualized. Approximately 20 feet from R1's room were a set of doors that led to a vestibule between two units of the facility. Inside the vestibule, a delayed exit door was observed leading to the outside of the facility which read, Keep pushing. This door will open in 15 seconds. Alarm will sound. According to the clinical census, R1's room was in the same location from 11/27/24 - 4/16/25. On 5/1/25 at 3:03 PM, an interview was conducted with LPN L regarding care-planned interventions in the event R1 became exit-seeking. LPN L stated R1 refused to wear a Wanderguard around her wrist so the device was attached to her walker. However, LPN L revealed R1 rarely utilized a walker when walking throughout the facility. LPN L confirmed the set of doors that led to the vestibule where R1 eloped on 4/11/25 were equipped with a Wanderguard sensor, but had not alerted staff of R1's exit because she was not using her walker (which had the Wanderguard attached). Review of R1's EMR revealed the following progress notes highlighting a history of exit-seeking behavior: 1. 10/19/24 at 5:46 PM: Pt [patient (R1)] very agitated all shift Pt [R1] was told she needed to stay in the building. She then tried to exit out the front doors. I encouraged her to call her son which she did. She stood in the front entrance of the building with RN and security while the son was on the phone for over 1.5 hrs [hours] while we tried to coax her back into the building . 2. 11/17/24 at 9:53 PM: [R1] was up wandering around the halls . The resident started to walk out the first double doors by the nurse's station. This nurse quickly closed the med cart and followed resident to prevent an elopement. Resident was easily redirected back inside. This nurse suggested making resident a one-on-one, however, the on-call manager initiated every 15 minute checks. Staff were performing this duty when a CNA saw resident beeline it towards the double doors . 3. 11/26/24 at 11:30 AM: This morning [R1] was going to a dental appointment, and this nurse received a call from the transporter that resident was not being safe, she had taken off down the road after she had verbal confrontation with the transporter . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. 12/26/24 at 5:07 PM: [R1] attempted to leave facility . 5. 12/28/24 at 5:34 PM: .One episode of exiting seeking where she [R1] was walking out the front door . 6. 3/8/25 at 6:11 PM: [R1] very agitated today with exit seeking behaviors. Resident up walking without assistance. Resident tried to leave the building, this RN stood at the door holding it shut and attempted to redirect . 7. 3/22/25 at 6:54 PM: [R1] successfully exited the facility today. She was unaccompanied and walked out the front door. A CNA saw her leave and she was brought back inside . 8. 3/23/25 at 8:00 PM: Approx. [approximately] 2000pm [8:00 PM] this nurse heard the door alarm going off in the front lobby area. Upon entering the room resident was between the first set of doors and second set of double doors leading to the outside . 9. 3/27/25 at 6:14 PM: [R1] experienced some exit seeking behaviors and agitation this afternoon . 10. 4/9/25 at 11:28 PM: At approx. [approximately]. 2000 [8:00 PM], [R1] attempted to leave the facility. This nurse was talking with resident, trying to redirect her, while she was walking toward the exit . Review of R1's EMR revealed the following progress note written on 4/11/25 at 9:47 PM: At approx. [approximately] 1925 [7:25 PM] staff found resident was not in her room. Staff checked all rooms and common areas and did not find resident. At 1930 [7:30 PM] this nurse was about to call a missing adult code when EMS called asking if we were missing a resident. Staff went over to EMS and brought resident back into facility .Resident has a one on one with staff tonight, as she continues to threaten to leave . On 5/1/25 at approximately 12:05 PM, security footage from 4/11/25 was reviewed with Security Officer F which revealed the following events: 1. At 7:17 PM, R1 was observed exiting the facility via a delayed egress door. 2. At 7:23 PM, CNA D was observed shutting off the sounding alarm, glancing out the door window, and returning to the unit. 3. At 7:27 PM, a group of 4 staff members were observed looking out the door window. 4. At 7:36 PM, R1 was observed entering the facility via the main doors with a staff escort. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/1/25 at 1:22 PM, a phone interview was conducted with CNA D who verified she first discovered R1 was not in her room on 4/11/25. CNA D stated she was attempting to deliver R1 a snack in an effort to distract her from exit-seeking behaviors when she noticed the room was empty. CNA D recalled hearing the door alarm sounding and subsequently peaked outside through the window, but did not see anybody. When asked why she did not complete a more thorough search before disengaging the alarm, CNA D replied, I just thought there was no way she went outside . I just figured she was in another resident's room. CNA D stated she notified LPN B R1 was not in her room and began searching facility rooms. CNA D stated after searching inside the facility for several minutes, she told LPN B about the alarm sounding. When asked about R1 behaviors prior to the elopement, CNA D confirmed R1 had been verbalizing her desire to leave the facility but does not recall the implementation of any interventions as it was difficult to ascertain if R1 was, serious [about leaving the facility]. CNA D stated she did not recall receiving education or a de-briefing following R1's elopement from facility management. On 5/1/25 at 5:23 PM, a phone interview was conducted with LPN B regarding R1's elopement on 4/11/25. LPN B stated CNA D initially asked if she knew R1's whereabouts. When LPN B was informed R1 was not in her room, facility staff began searching room-to-room. LPN B stated RN A was the charge nurse on duty and began looking for the facility elopement policy because she was unfamilar with elopement protocol. LPN B stated she realized the urgency of the situation and decided to call the on-call manager for further direction instead of looking for the policy. LPN B recalled after several minutes of searching rooms, CNA D had relayed to her, The door alarm was going off, but I didn't see anybody, so I reset it. LPN B stated a group of staff members looked around the exit but did not see anybody. LPN B said, eventually, the facility received a call from EMS with a description of a person who matched R1. LPN B did not recall if R1 was exhibiting exit seeking behaviors earlier that day. LPN B verified she did not receive any education or participate in an in-service following the elopement. On 5/2/24 at 1:37 PM, an interview was conducted with CNA E regarding R1's behaviors on 4/11/25. CNA E recalled telling an on-duty nurse that staff, should keep an eye on R1 as she was repeatedly asking CNA E to let her outside earlier in the shift. CNA E was not aware of any additional interventions put into place following these vocalizations. Review of R1's EMR revealed the following progress note, written 4/11/25 at 6:04 PM (approximately 80 minutes prior to R1's successful elopement): .[R1] having increased agitation and exit seeking. [R1] attempted to leave facility today, door was held closed by this RN which worsened agitation and [R1] became physically aggressive slapping RN in the face and pulling hair. Security was called and [R1] redirected back into the building by 2 CNAs . On 5/1/25 at 11:19 AM, the alarmed door from which R1 eloped, was opened by the NHA to demonstrate the reprogramming of fire alarm exits alerts to staff pagers to this Surveyor. After several minutes of no response to the alarm by staff, the NHA interviewed the floor staff to investigate the lack of response. CNA H stated she received the page but was on lunch break, so she did not respond. CNA I stated she was providing cares to another resident, but verified she received the alert on her pager. CNA G stated she assumed a different staff member was responding to the alert. LPN J was observed standing at a medication cart and did not offer a reason for not investigating the door alarm. All staff verified the notification came to their pager. The NHA stated, They should have responded. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy titled, Elopement precautions, long-term care, revised 2/24/25, read, in part: .Residents with psychiatric disorders .are prone to elopement . Purposeful wandering, including exit-referenced behavior, may predict elopement in residents with dementia . Residents at risk for elopement typically: have significant short-term memory impairment; manifest exit-seeking behaviors, such as verbalizing a desire to go home, staying close to entrance or exit doors, or actually trying to leave . .Preventing elopement: Make sure that the resident is properly assigned to a unit and room based on the elopement risk because a resident at risk for elopement may require a room that's located away from exits, close to the nurses' station, or in a secured unit that requires computer-coded entry and exit to ensure the resident's safety . .Responding to Elopement: Arrange a staff huddle to update staff on the status of the search and gather information that may have been missed during the initial data-gathering process. Use this time to reinforce safety procedures to prevent future elopement . The Immediate Jeopardy which began on 4/11/25 was removed on 5/2/25 at 11:14 AM when the facility took the following actions to remove the immediacy: The facility will immediately change the following: IMMEDIATE ACTION: As of May 1st, 2025, all staff will be educated immediately within 24 hours that they acknowledge and understand that in the event they hear an exit door alarming, they observe the alarm on the facility monitors or a page is obtained stating that an exit door has been opened or is alarming they will respond immediately to investigate. If staff are caring for a resident when this alert is obtained, they will ensure their resident is safe and then respond promptly. Staff that have not signed stating understanding within 24 hours will not be permitted to work until education has been obtained. Any staff who are found not to be compliant will be reeducated immediately. Door alarms were set off and [the NHA] and [Director of Quality and Compliance K] verified that notifications were sent to staff pagers and facility monitors. Resident #1 will be moved to the locked unit in LTC within 24 hours once appropriate notifications have been made due to her noncompliance to wear a wanderguard and her risk of elopement. Until this move occurs she will be placed on 1:1 monitoring when out of her room. All residents who score a 1.0 or higher on the elopement assessment have been reassessed to ensure proper interventions are in place. As of 5/2/2025 the likelihood for serious injury, serious harm, serious impairment or death no longer exists. NEW PROCEDURES / PROCESSES FOR RESPONSE TO EXIT DOORS ALARMING AND RESIDENTS ASSESSED TO BE AN ELOPEMENT RISK. Any resident in the facility that is deemed to be an elopement risk a wanderguard will be placed and care planned for that resident. Any resident that is refusing to wear a wanderguard will be moved to the locked unit in long term care for increased supervision and safety. If a bed is not available in the locked unit, the resident will be placed on 1:1 supervision until an appropriate room is available.