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	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalkaska Memorial Health Center	419 South Coral Street 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. This deficient practice pertains to Intake 3005509.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 three residents reviewed for elopement.Findings include:Resident #1 (R1)Review of the FRI submitted to the State Agency (SA) on 4/30/26 at 9:44 PM, included an investigation report which read, in part: On Thursday 4/30/26 at approximately 8:23 PM LPN (Licensed Practical Nurse) A was alerted by [Hospital Name] reception desk who was notified by the [City Name] Police Department that they had picked up (R1) kneeling alongside the road near the (local restaurant/grocery store).Time the resident was last seen by facility staff members 4/30/26 at 6:40 PM by Certified Nurse Aide (CNA) B.(R1) was observed via camera footage to have exited the facility on 4/30/26 at 7:09 PM. He walked from his chair located near the nurses' station facing the doors on [unit name] that exit into the lobby area. He then proceeded through the next 2 sets of double doors onto the sidewalk of the [unit name] (R1) wearing a (name brand elopement alert device) bracelet on his left wrist. He exited out of the door furthest from the (name brand elopement alert device) sensor with his left arm on the other side of his body from the sensor. The alarm did not sound and was not activated.once outside (R1) proceeded to walk to the left of the exit/building.when resident (R1) approached the stop sign.he cut across the grass area in front.and continued walking down the street passing the stone house and [Hospital Name] entrance of the hospital. He was then lost from camera view. The investigation indicated R1 was located in a compromised position near a roadside that has constant road traffic and the speed limit increases to 55 miles per hour. This road also serves as the main road in and out of the city the facility is located.The Immediate Jeopardy began on 4/30/26 at 7:09 PM when R1 eloped from the facility undetected and was found kneeling alongside a busy street and had been missing for approximately one hour and fourteen minutes. R1 was discovered by an external entity emergency personnel after a phone call was placed by a community member around 7:45 PM. The Nursing Home Administrator (NHA) was notified of the Immediate Jeopardy on 5/13/26 at 3:14 PM. This surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 4/30/26 and the deficient practice was corrected and monitored since 5/1/26, prior to the start of the survey and was determined to be past noncompliance.Review of R1's electronic medical record (EMR) revealed admission to the facility on 9/10/25 with diagnoses including Alzheimer's disease, schizophrenia, and dementia with agitation. Review of R1's Minimum Data Set (MDS) assessment revealed a score of 3/15 for the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Review of R1's Elopement Evaluation, dated 3/16/26, revealed a score of 2, indicating R1 was, at risk of elopement.Review of R1's Physician Orders for April 2026, revealed the following orders: Elopement Evaluation one time a day q (every) 3 months on 15th (active 3/15/26) Resident is at risk for elopement, verify placement of (name brand elopement alert device) q shift. If (name brand elopement alert device) is missing replace if you are unable to replace initiate a 1:1 (one to one) until one is obtained (start date 11/19/25; discontinued 5/2/26). Review of the April Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed ten missed (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

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	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalkaska Memorial Health Center	419 South Coral Street 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	documentations of wander guard placement, including the night of 4/30/26 for R1. On 5/13/26 at approximately 12:45 PM, the location where R1 was sitting at the time of the elopement was observed near the front entrance of the facility. Where R1 was sitting was approximately 10-15 feet away from the set of doors that led to a lobby area. All three doors observed did not have a delayed egress. A witness statement from LPN A was reviewed by this Surveyor as she was unavailable for interview during the survey. LPN A wrote, I came on shift at 18:00 (6:00 PM), received report from 200 hall nurse, then 100 hall nurses. While counting the 200-hall cart I observed (R1) sitting by the nurses' station outside the day room.At approximately 8:23 PM.reception called and this nurse answered the phone.stated that dispatch had just phoned and that the police had (R1) with them.it was verified that the patient was (R1).A witness statement from LPN B was reviewed by this Surveyor as he was unavailable for interview during the survey. LPN B wrote, (R1) was observed sitting in front of nurse's station in chair at shift change from around 6:00 PM. Resident observed again sitting chair while (nurse) doing narcotic count of 200 and 300 cart at 6:20 PM.I did not see (R1) exit the doors and I did not hear the (name brand elopement alert device) alarm.Review of R1's EMR revealed the following progress notes highlighting a history of exit-seeking behavior:1. 2/12/26 at 2:39 AM: At approximately 2100 (9:00 PM), patient was observed packing his clothing into a paper gift bag in his room. When asked why he was doing so, patient replied to CNA that he was going somewhere tomorrow. Pt (patient) left room with his things in a bag and was stopped at nurses' station and asked where he was going. (R1) became frustrated and said that the clothing was his things, and he was ?tired of it'. 2. 4/19/26 at 7:45 PM: (R1) has had increased wandering during shift and has expressed multiple times to staff that he is leaving. During shift resident was opening doors and attempting to follow visitors out of the building. 3. 4/20/26 at 10:33 PM: (R1) agitated and stating he is going to head out the doors.He attempted to go through entry doors and was redirected towards his room. (R1) then set alarm off at end of 300 hall exit doors. (R1) yelled at staff and paced around unit.4. 4/21/26 at 4:14 AM: (R1) came out and sat at the chairs in front of the nurse station. Staff asked him how he was doing and resident became agitated. (R1) stated ?I want the f*** out of this place. (R1) then started following CNA down to a room they were going into.5. 4/22/26 at 6:14 AM: Recent reports of (R1) sundowning at night by staff, it was reported that he was yelling out and threatening to beat staff up, he was also wandering more and going into other rooms.staff report that he is easily angered lately which is not usual for him. Res (resident [R1]) recently had melatonin d/c'd (discontinued) due to him sleeping well. PA [Physician Assistant] will be restarting this med (medication).Will follow up with res and staff in 1 week to see any effect from the melatonin. Review of R1's EMR revealed the following progress note written on 5/1/26 at 2:50 AM:Approx. (approximately) 2023 pm (8:23 PM) [Staff Name] from reception called and told this nurse that dispatch called and the police department brought in (R1). [Staff Name] stated he had an ID bracelet on and thought he might be one of our residents. [Staff Name] stated the police found him on the roadside confused. This nurse informed 300 hall nurses of incident, and this nurse and 300 hall nurses went to the E.D. (Emergency Department) and verified that it was (R1) our resident.DON (Director of Nursing) contacted by 300 hall charge nurses immediately. On 5/13/26 at 11:00 AM, an interview was conducted with Registered Nurse (RN) C, who stated she was R1's morning nurse on 4/30/26 and started working at the facility around 3/10/26. RN C was asked of R1's Physician Order to check the placement of his (name brand elopement alert device). RN C stated she assumed the order was meant for nurses to see if R1 had his (name brand elopement alert device) on his wrist. RN C confirmed she never checked the functioning of R1's (name brand elopement alert device).An interview was conducted with the DON and Nursing Home Administrator (NHA) on 5/13/26 at 11:35 AM. The DON and NHA stated checking the (name brand elopement alert device) for function was a task for CNAs. When asked for documentation of R1's (name brand elopement alert device) was being checked for placement and function, the DON and NHA stated they were unable to pull those records from R1's EMR. The NHA confirmed the maintenance department had also not performed a monthly checking system of the (continued on next page)

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	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalkaska Memorial Health Center	419 South Coral Street 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	(name brand elopement alert device). The DON and NHA also confirmed R1's(name brand elopement alert device) did not properly sound on 4/30/26 when R1 eloped from the facility.Review of the facility's Alarm Use policy dated 5/23/25 read, in part, It is the policy of this facility to utilize resident alarms in limited circumstances, in accordance with the resident's needs, goals, and preferences, so the resident will be able to attain or maintain his or her highest practicable level of physical, mental, and psychosocial well-being.The use of alarms does not eliminate the need for adequate supervision of the resident. Types of alarms include:.Wander/elopement alarms - includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn/attached to the resident that alert the staff when the resident nears or exits an area or building.Each resident shall be assessed for fall and elopement risk upon admission and periodically thereafter as part of the comprehensive assessment process.Resident directed approaches shall be implemented in accordance with the resident's needs, goals, and preferences.Supervision shall be provided to the resident in accordance with the resident's plan of care. When alarms are utilized, additional monitoring shall be provided, including but not limited to: Verifying alarms are used in accordance with the resident's care plan, verifying alarms are working properly.The (name brand elopement alert device) battery will be checked daily and this will be documented. The Immediate Jeopardy that began on 4/30/26 was removed on 4/30/26 when the facility:1) The front door which does not alarm if exit is attempted unless the (name brand elopement alert device) is functioning was immediately placed on 1:1 staff supervision for any resident attempting to exit. 2) Head count was conducted and confirmed by DON upon notification of the incident. 3) R1 was moved to secure units with delayed exit doors which alarm upon return from ED.The deficient practice was corrected on 5/1/26 after the facility: 1) Residents assessed to be an elopement risk and able to exit without staff assistance moved to a secured unit with alarming doors and delayed exit. 2) Resident care plans updated to reflect elopement risk and need for secured unit. 3) Education to all staff on new elopement risk policy and procedure.