

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of Munising		STREET ADDRESS, CITY, STATE, ZIP CODE 300 West City Park Drive Munising, MI 49862	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed to report an elopement which lasted over 25 minutes in dangerous wintery conditions for one Resident (#10) of four Residents reviewed for unsafe wandering. Findings include: Resident #10 (R10) On 4/7/2026, the State Agency (SA) received a complaint which read in part, The resident (R10), eloped from the facility around 0500 (5:00 AM) in freezing temperatures a couple days ago. She walked a few blocks down the road, without a jacket, on the highway with her walker. Employees noticed after a while she was missing and found her. A nurse picked her up and brought her back. Nursing home employees saw in the camera that the DON checked the front door alarm and shut the alarm system off. On 4/10/2026, the SA received a second complaint which read in part, .on the morning of 4/1/26 around 5:15 am or 5:20 am the DON Shut off the main alarm that alerts staff when residents wearing a (brand name elopement prevention device) leave the facility. Complainant states the DON never called overhead to do a headcount, she instead went back to doing what she was doing disregarding the alarm completely. Complainant states another nurse somehow heard the alarm was shut off, went to inquire about it and through some investigating and speaking with other staff it was determined that an elope (elopement) risk patient was not in the building, staff began searching for resident in the facility, continuing the search outside when realized she must be outside. Complainant states resident, (R10) was found about 15-20 minutes later about a half mile away from the facility, walking with her walker on a main busy road with no coat on. Complainant states, resident was found at 5:40-5:45 am. Complainant states resident was located and taken back to the facility uninjured. Complainant states she is calling because she does not know if it was reported to the State, and the risk management was not filled out. On 4/29/2026 at 11:30 AM, the facility presented an investigation of the elopement event which occurred on 4/1/2026. This report read in part, Description of Deficient Practice (why and how did it happen? (sic) On the early morning of 4/1/2026, (R10) went out of the facility setting off the front door alarm and the (brand name elopement prevention device). (Director of Nursing), DON was in the building and went to the door. She shut off the main alarm and realized the (brand name elopement prevention device) was going off. She looked outside to see if a resident had left the building. Nurse Aides (Certified Nurse Aide CNA A and CNA B) went outside to look in the parking lot and surrounding areas around the building. Nurse Aide, (CNA C) went to the door and talked with (DON). (DON) called for a head count of the people in the building. Nurse (Licensed Practical Nurse LPN D) noted that she could not find (R10). (LPN D) got into her car and drove around to the main street to see if she could find (R10). DON, received a call from (LPN D) stating she found (R10) walking down the sidewalk near the gas station, but (R10) refused to get into the car. Nurse, (Registered Nurse RN E) got into her car and drove to where (LPN D) and (R10) were located. Together they were able to convince her (R10) to get into the car and return to the facility. The facility investigation report of the elopement event included a summary of Concerns: Resident was able to get out of the building. The DON looked outside but did not leave and go out the front door. Other staff had gone out the back door, but no one went immediately out the front door. The resident was triggered earlier and has in the past attempted to get out of the facility. During an interview conducted on 4/29/26 at 6:15 PM, RN E stated At 5:10 (AM) I (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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>was passing meds on 100 hall when I heard an alarm sounding. There was much confusion as the DON said the (brand name elopement prevention device) alarm went off, but there was not an overhead announcement per facility policy and we did not know which door had alarmed or if someone was missing. The service drive was all snowed in and there were no footprints in the snow. LPN D had gone out in her car to search and called RN E and said, I've got her, but she won't get in the car. Then RN E got in her car and went to help R10 and LPN RN E said (R10) was cold. She was freezing. She had no coat on. R10 stated she was not going back, but she was so cold and the nurses convinced her she needed some hot chocolate so R10 got in the car and was brought back to the facility. RN E It took about 20 minutes to find the resident and then more time to pick her up and convince her to get in the car. On 4/29/26 the investigation was reviewed and found to be missing many details, but it was confirmed R10 left the building on 4/1/2026 around 5:15 AM and was gone over 25 minutes walking with her walker. The investigation did not include many facts such as the weather conditions on the day of the elopement. Historical weather was investigated by this Surveyor via the internet site: https://www.accuweather.com/en/us/munising-township/49862/april-weather/2638762 for 4/1/2026 and revealed the temperature on the day of the elopement was 22 - 29 degrees F. R10 eloped from the building in freezing temperatures with potential slippery conditions in the dark morning hours and was gone for over 20 minutes without adequate warm clothing. R10 was found on the sidewalk next to the main highway through the center of town. This situation represents a risk to the resident's health and safety and placed R10 at the risk of cold exposure and danger of being struck by a car. The elopement was not reported to the SA. The facility presented the policy titled Abuse, Neglect and Exploitation last reviewed 1/10/2024. The policy read in part, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property. 4. Reporting of alleged violations to the Administrator, state agency, and to all other required agencies. within specific timeframes as required by state and federal regulations: . b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>This citation pertains to intakes #2980097 and #2976728Based on interview and record review the facility failed to ensure that a complete and thorough investigation was completed in a timely manner for an incident of elopement for one Resident (#10) of one resident reviewed for accidents and hazards.Findings include:Resident #10 (R10)On 4/7/2026, the State Agency (SA) received a complaint which read in part, The resident (R10), eloped from the facility around 0500 (5:00 AM) in freezing temperatures a couple days ago. She walked a few blocks down the road, without a jacket , on the highway with her walker. Employees noticed after a while she was missing and found her. A nurse picked her up and brought her back. Nursing home employees saw in the camera that the DON checked the front door alarm and shut the alarm system off.On 4/10/2026, the SA received a second complaint which read in part, .on the morning of 4/1/26 around 5:15 am or 5:20 am the DON Shut off the main alarm that alerts staff when residents wearing (brand name elopement prevention device) leave the facility. Complainant states the DON never called overhead to do a headcount, she instead went back to doing what she was doing disregarding the alarm completely. Complainant states another nurse somehow heard the alarm was shut off, went to inquire about it and through some investigating and speaking with other staff it was determined that an elope (elopement) risk patient was not in the building, staff began searching for resident in the facility, continuing the search outside when realized she must be outside. Complainant states resident, (R10) was found about 15-20 minutes later about a half mile away from the facility, walking with her walker on a main busy road with no coat on.Complainant states, resident was found at 5:40-5:45am. Complainant states resident was located and taken back to the facility uninjured. Complainant states she is calling because she does not know if it was reported to the State, and the risk management was not filled out.On 4/29/2026, the facility presented an investigation of the elopement event which occurred on 4/1/2026. This report read in part, Description of Deficient Practice (why and how did it happen? (sic) On the early morning of 4/1/2026, (R10) went out of the facility setting off the front door alarm and the (brand name elopement prevention device) alarm. (Director of Nursing), DON was in the building and went to the door. She shut off the main alarm and realized the (brand name elopement prevention device) was going off. She looked outside to see if a resident had left the building. Nurse Aides (Certified Nurse Aide CNA A and CNA B) went outside to look in the parking lot and surrounding areas around the building. Nurse Aide, (CNA C) went to the door and talked with (DON). (DON) called for a head count of the people in the building. Nurse (Licensed Practical Nurse LPN D) noted that she could not find (R10). (LPN D) got into her car and drove around to the main street to see if she could find (R10). DON, received a call from (LPN D) stating she found (R10) walking down the sidewalk near the gas station, but (R10) refused to get into the car. Nurse, (Registered Nurse RN E) got into her car and drove to where (LPN D) and (R10) were located. Together they were able to convince her (R10) to get into the car and return to the facility. The facility investigation report of the elopement event included a summary of Concerns: Resident was able to get out of the building. The DON looked outside but did not leave and go out the front door. Other staff had gone out the back door, but no one went immediately out the front door. The resident was triggered earlier and has in the past attempted to get out of the facility.During an interview on 4/29/26 at 2:10 PM, the Nursing Home Administrator (NHA) gave the details of the elopement event. She stated the facility did have cameras which were focused on the exit door R10 exited from. When the footage was requested for review, the NHA stated, We did not save footage. We do not know how to. We watched the video. The NHA stated the Maintenance Director (Staff J) knew how to rewind it, but it was not saved for long and has been taped over. The NHA stated, We saw her go out but it was too dark to see where she went.During an interview on 4/29/26 at 2:17 PM, Staff J stated he was able to see the video. He said, (R10) walked out the door in her everyday clothes, jeans and a flowy top, and then out of camera view. We could see her vaguely in the parking lot area. It was very dark. He stated he thought the NHA had documented the elopement (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>times on a post it note. He stated, Time went by (the DON) and another nurse went to the door. Staff J said R10 came back into the same door, but he did not know what time that was. It was on the video, but he did not write it down. The investigation did not include the times recorded on the video footage such as when R10 exited the building, who went out the door, or when the resident was found and came back into the building. The investigation did not include the conditions at the time of the elopement. The investigation did not include the route the resident took. It should be noted that the elopement event occurred when there was snow in the area and a walker and a person on foot may have left evidence of the exact path taken, but this was not considered in the investigation. There was no measurement of the distance the resident traveled. The investigation did not include many facts such as the weather conditions on the day of the elopement. Historical weather was investigated by this Surveyor via the internet site: https://www.accuweather.com/en/us/munising-township/49862/april-weather/2638762 for 4/1/2026 and revealed the temperature on the day of the elopement was 22 - 29 degrees F. The risk management report was presented and reviewed. It was written by the DON (who was also the nurse responding to the alarm) and begins This writer heard door alarm going off and responded to alarm at about 0517 ish (5:17 AM). The report is dated and timed as written 4/1/2026 05:14. This means the report was inaccurately stated as written before the DON responded to the elopement alarm. The risk management report also included written witness statements of only two CNAs, one nurse, and the DON involved, even though all staff took part in the head count and may have had information relevant to the investigation. The second nurse who assisted the resident back to the facility was not included as a witness in the investigation. The risk management witness statement of the DON was documented as written on 4/1/2026 but was linked to a progress note in the chart. When the progress note was reviewed, it was found to be a late entry note written by the DON on 4/15/2026, over two weeks after the elopement. During an interview conducted on 4/29/26 at 6:32 PM, LPN D stated the elopement event occurred at the end of her shift and the resident who had eloped (R10) was her resident. She stated she felt she should do the risk management report. LPN D stated, (The DON) asked me if she wanted her (the DON) to do the risk management, even though it was my patient. LPN D said, A while afterwards, quite a while, I checked for a risk management in the chart. She did not see one. LPN D said, I ask (the DON), she said I am still working on it. She said I am doing it. It is not there yet. I had to remind her to do it. I am responsible for my resident. During an interview on 4/30/26 at 10:00 AM, Regional Registered Nurse (RN) H stated she would expect the risk management report and documentation of the event to be completed as part of the investigation as soon as possible and certainly sooner than two weeks later. The facility presented the policy titled, Unsafe Wandering and Elopement Prevention last reviewed 1/1/2022. This policy read in part, Every effort will be made to prevent unsafe wandering and elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement. Nursing personnel must report and investigate all reports of missing residents. 8. Upon return of the resident to the facility the Director of Nursing Services or Charge Nurse should: Complete and file an incident report. 10. Upon return of the resident to the facility the Director of Nursing Services or Charge Nurse should: Complete and file an incident report and Make appropriate entries into the resident's medical record.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes #2980097 and #2976728Based on observation, interview, and record review the facility failed to prevent an elopement for one Resident (#10) and failed to ensure safety measures were in place and care planned to prevent elopement and unsafe wandering for three additional Residents (#11, #12, and #13) in four of four residents reviewed for elopement risk.Findings include:Resident #10 (R10)On 4/7/2026, the State Agency (SA) received a complaint which read in part, The resident, (R10), eloped from the facility around 0500 (5:00 AM) in freezing temperatures a couple days ago. She walked a few blocks down the road, without a jacket , on the highway with her walker. Employees noticed after a while she was missing and found her. A nurse picked her up and brought her back. Nursing home employees saw in the camera that the DON checked the front door alarm and shut the alarm system off.On 4/10/2026, the SA received a second complaint which read in part, .on the morning of 4/1/26 around 5:15am or 5:20am the DON Shut off the main alarm that alerts staff when residents wearing a (brand name elopement prevention device) leave the facility. Complainant states the DON never called overhead to do a headcount, she instead went back to doing what she was doing disregarding the alarm completely. Complainant states another nurse somehow heard the alarm was shut off, went to inquire about it and through some investigating and speaking with other staff it was determined that an elope (elopement) risk patient was not in the building, staff began searching for resident in the facility, continuing the search outside when realized she must be outside. Complainant states resident, (R10) was found about 15-20 minutes later about a half mile away from the facility, walking with her walker on a main busy road with no coat on.Complainant states, resident was found at 5:40-5:45 am. Complainant states resident was located and taken back to the facility uninjured. Complainant states she is calling because she does not know if it was reported to the State, and the risk management was not filled out.The Electronic Medical Record (EMR) revealed R10 was admitted on [DATE] with diagnoses including bipolar disorder, anxiety disorder, depressive disorder, schizoaffective disorder, dementia and unsteadiness on feet. The most current Minimum Data Set (MDS) assessment of 4/2/2026 section C-Cognitive Patterns, indicated R10 had scored 3 of 15 on the Brief Interview for Mental Status (BIMS) indicative of severely impaired cognition. The MDS section E-Mood, indicated R10 asked Has the resident wandered? and was scored, Behavior of this type occurred daily. Physician orders include, Check function and expiration date of [(brand name elopement prevention device) device that alarms exit doors when bracelet nears doors] ordered 12/5/25.On 4/29/2026, the facility presented an investigation of the elopement event which occurred on 4/1/2026. This report read in part, Description of Deficient Practice (why and how did it happen? (sic) On the early morning of 4/1/2026, (R10) went out of the facility setting off the front door alarm and the (brand name elopement prevention device). DON (Director of Nursing) was in the building and went to the door. She shut off the main alarm and realized the wander guard was going off. She looked outside to see if a resident had left the building. Nurse Aides (Certified Nurse Aide CNA A and CNA B) went outside to look in the parking lot and surrounding areas around the building. Nurse Aide, (CNA C) went to the door and talked with (DON). (DON) called for a head count of the people in the building. Nurse (Licensed Practical Nurse LPN D) noted that she could not find (R10). (LPN D) got into her car and drove around to the main street to see if she could find (R10). DON, received a call from (LPN D) stating she found (R10) walking down the sidewalk near the gas station, but (R10) refused to get into the car. Nurse, (Registered Nurse RN E) got into her car and drove to where (LPN D) and (R10) were located. Together they were able to convince her (R10) to get into the car and return to the facility. The facility investigation report of the elopement event included a summary of Concerns: Resident was able to get out of the building. The DON looked outside but did not leave and go out the front door. Other staff had gone out the back door, but no one went (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>immediately out the front door. The resident was triggered earlier and has in the past attempted to get out of the facility. The investigation did not include many facts such as the weather conditions on the day of the elopement. Historical weather was investigated by this surveyor via the internet site: https://www.accuweather.com/en/us/munising-township/49862/april-weather/2638762 for 4/1/2026 and revealed the temperature on the day of the elopement was 22 - 29 degrees F. During a telephone interview conducted on 4/29/26 at 2:04 PM, CNA B stated, she was doing last bed checks with the DON who was working on the 100 hall. CNA B stated, I was helping her on the 100 hall as I was finished on 400. CNA B said it was then the DON mentioned (R10) went out the door and the staff checked all the rooms to see if she was in the building. CNA A went outside with CNA B, and they checked around the entire building. They got a phone call that (R10) was found. During a telephone interview conducted on 4/29/26 at 3:49 PM, CNA A reported a nurse came to her and said an alarm was sounding in the front of the building. CNA A said, I went outside yelling for (R10). Nurses got in the car looking for her. She was on the highway. She made it that far. CNA A stated the wind off the lake can set off the alarm but when I found out the wind had not set off the alarm and it was a code alert, I knew it was (R10) as she had given me a smirk earlier - like she was up to something. CNA A stated she was amazed that (R10) got so far while we were all looking for her in all the rooms of the building. During an interview conducted on 4/29/26 at 6:04 PM, CNA C stated if an alarm is going off, it could be an exit door alarm or (brand name elopement prevention device) alarm. CNA C stated, she met up with the DON at the front of the building. The DON said a (brand name elopement prevention device) was sounding at the front door. CNA C said, The DON said tell your staff over there (the back of the building) to do a head count. I thought it could be (R10) as I saw her in the hallway earlier that night. CNA C said they did a head count and indeed it was (R10). It took about 20 minutes until she was found, and it took a while to convince her to get in the car and back to the building after she was found. CNA C stated, (R10) used to live on 400 and moved to 200 and she does not handle change well. During an interview conducted on 4/29/26 at 6:15 PM, RN E stated, That door is an issue - door fatigue - we don't always tend to run to it. The smokers have free access - The alarms go off a lot because of 8 smokers, and they can go out at will and they do. RN E said the smokers go out to smoke sometimes up to five times a night and stated the facility has alarm fatigue. RN E described the elopement event. She said, At 5:10 (AM) I was passing meds on 100 hall when I heard an alarm sounding. I came out of the room and remember (LPN D) coming up, she heard there was a head count, but it was not announced over head. RN E stated, there was much confusion as the DON said the (brand name elopement prevention device) alarm went off, but there was not an overhead announcement per facility policy and we did not know which door had alarmed or if someone was missing. RN E said, I wanted to know which door was alarming. I did not know and (the DON) was in a resident's room. Then RN E said LPN D went into the room to talk to the DON. When LPN D came out she said the alarm sounding was the front door (brand name elopement prevention device) and the DON told her she had shut it off and told someone to do a headcount. RN E never heard the (brand name elopement prevention device) alarm while she was in a resident's room passing the medications. Rooms were being checked and she saw CNA C who looked alarmed and said (R10) is missing. RNE said they went outside and were yelling R10's name and thought they heard her answer way up on the main road. The service drive was all snowed in and there were no footprints in the snow. RN E said LPN D got in her car and she went to get her coat. LPN D called RN E and said, I've got her, but she won't get in the car. Then RN E got in her car and went to help R10 and LPN D who was trying to fit the walker into her car, but it would not fit. RN E said (R10) was cold. She was freezing. She had no coat on. R10 stated she was not going back, but she was so cold and the nurses convinced her she needed some hot chocolate so R10 got in the car and was brought back to the facility. RN E stated the elopement protocol is to keep the (brand name elopement prevention device) alarm on when there is an elopement until the resident was found. It took about 20 minutes to find the resident and then more time to pick her up and convince her to get in the car. During an interview (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>conducted on 4/29/26 at 6:32 PM, LPN D stated the elopement event occurred at the end of the shift and she was working in the back of the building and could not hear the (brand name elopement prevention device) alarm from the 300 hall. LPN D stated, I can only hear the main door alarm it is going off all day and all night. The smokers go out at all hours. CNA C came and said that the DON said we should do a head count and she did not know which door had been alarming. LPN D explained the (brand name elopement prevention device) would set off the alarm at the door in which the resident wearing it had exited, and you would know someone went out. LPN D said, I was trying to think was it a main door alarm set off by a smoker or a wanderer? She said the CNAs were doing a head count and she remembered R10 walking down the hall earlier that night. LPN D said, I thought I should talk to (the DON) but I could not find her. She was in a resident's room and I asked, Was it a (brand name elopement prevention device)? She said yes. I grabbed my coat and keys, and I knew someone was outside probably (R10). LPN D said CNA A was going to sweep around the outside of the building. The head count was done so she got in her car. LPN D described the route she took, and she did not find R10 right away. She returned to the main intersection and saw a pickup down the main road and noticed they did a break check. She turned right and found R10 walking down the snow plowed sidewalk with her walker with a balloon tied to it. She could not fit the walker into her car, so she called RN E to say she had found R10 who did not want to come back to the facility. RN E drove to meet them, and they coaxed R10 into the car with the promise to get her a hot chocolate. LPN D stated the procedure for an elopement was to leave the alarm on and call overhead for a head count and not rely on word of mouth. The care plan for R10 included a focus target behavior of .Elopement risk: stating she hates it here and wants to ?live with at (sic) the tribe' Interventions included: If resident is located by an exit door, staff to intervene and remain present with resident until resident redirected or relocated away from exit door. Date Initiated: 04/09/2026. The care plan also included a separate focus of Resident is at risk for elopement related to exit seeking behavior, history of elopement, verbalizes wanting to leave the facility. Date Initiated: 09/19/2023 Revision on: 07/02/2024 Interventions for this care plan included, Promptly check when alarm system goes off to ensure resident is safe and remains in facility and Resident wears (brand name elopement prevention device) on Right Ankle, monitor placement/function/expiration. Date Initiated: 09/19/2023 Revision on: 12/08/2025 Nurses progress notes on the date of the elopement revealed R10 had recently undergone a room change and was frustrated with the move, 4/1/26 at 00:00 (midnight) Note text: Resident was aggressive towards staff and other residents swearing and charging towards them. Resident was redirected to getting ready for bed and admitted being frustrated not knowing where her room was. These behaviors at midnight on 4/1/26 were like the identified triggers in R10's care plan listed as: RESIDENT TRIGGERS INCLUDE: not getting her own way. desire to leave. being told what to do. when her personal space is invaded or when she feels threatened. Date initiated 09/20/2023 Revision on 03/23/2026. The elopement event was documented as occurring shortly after 5:00 AM the same day as the triggers were documented in R10's chart. During an interview on 4/30/26 at approximately 10:00 AM, RN H stated R10 had previously eloped from the building on 6/2/2025. The care plan had been updated on 6/4/2025 as well. During an interview on 4/29/26 at 5:41 PM, Social Services designee (Staff F) stated she tracked all residents who were at risk for elopement and wore a (brand name elopement prevention device). She presented a current handwritten list of residents with an elopement risk but did not have previous months lists. Staff F said, Everyone with a (brand name elopement prevention device) is on the list. Staff F stated the elopement risk list is updated monthly or added to if a new at-risk for elopement resident was admitted .Resident #11 (R11) On 4/29/26 at 11:41 AM, R11 was observed in bed with her shoes on. Her left ankle contained a (brand name elopement prevention device) bracelet. R11 was pleasantly confused and was trying to lift her feet from the bed exposing her ankle. On 4/30/26 at 8:25 AM, R11 was observed standing at the door to service hallway trying to go through the door toward the outside exit. Activity Director (Staff I) and this Surveyor were coming out of the service hall and encountered R11 trying to come through. When (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of Munising		STREET ADDRESS, CITY, STATE, ZIP CODE 300 West City Park Drive Munising, MI 49862	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>the door was opened, R11's (brand name elopement prevention device) triggered the alarm. R11 had to be redirected away from the door as she tried to enter the service hallway toward the outside exit. A review of the EMR for R11 revealed and admission date of 11/15/2024. The most current MDS assessment of 2/20/2026 section C-Cognitive Patterns, indicated R11 had scored 5 of 15 on the BIMS assessment indicative of severely impaired cognition. The MDS section E-Mood, indicated R11 asked Has the resident wandered? and was scored, Behavior of this type occurred 4 to 6 days, but less than daily. Although a wander guard bracelet was on R11's ankle there was not a physician order for this device or an order to check the function of this device. The care plan for R11 included a focus: TARGET BEHAVIOR 1: Resident often wanders around building throughout the day. Often gets confused and forgets location of room. Initiated 11/19/2024. Revision on 05/06/2025. The interventions for the behavior care plan which included wandering did not include the wearing of a (brand name elopement prevention device).The elopement risk list which had been presented by Staff F as containing all residents who were wearing a (brand name elopement prevention device) was reviewed. R11 was not on the elopement risk list. Resident #12 (R12) On 4/29/26 at 5:08 PM, CNA G was in the dining room and checked R12's ankle and confirmed R12 was observed wearing a (brand name elopement prevention device). A review of the EMR for R12 revealed and admission date of 4/10/2024. The most current MDS assessment of 4/28/2026 section C-Cognitive Patterns, indicated R12 had scored 0 of 15 on the BIMS assessment indicative of severely impaired cognition. The MDS section E-Mood, indicated R12 asked Has the resident wandered? and was scored, Behavior of this type occurred daily. There was a physician order for Check function and expiration at bedtime Check function and expiration date of (brand name elopement prevention device)/electronic bracelet ordered 12/5/25. The care plan for R12 included a focus: TARGET BEHAVIOR 1: Elopement risk: increases at night - asking when her family will pick her up, putting on her coat - may attempt to go out service doors or front door. Initiated 8/3/2023. Revision on 07/01/2025. The interventions for the behavior care plan which included wandering did not include the wearing of a (brand name elopement prevention device) although R12 was included on the elopement risk list. Resident #13 (R13) On 4/29/26 at 5:10 PM, R13 was observed wandering in the dining room in her wheelchair. She was moving in and around the dining room tables and was unable to communicate where she would like to go. CNA G checked R13's ankle and confirmed R13 was wearing a wander guard (brand name elopement prevention device). A review of the EMR for R13 revealed and admission date of 8/26/2025. The most current MDS assessment of 4/27/2026 section C-Cognitive Patterns, indicated R13 had scored 0 of 15 on the BIMS assessment indicative of severely impaired cognition. The MDS section E-Mood, indicated R13 asked Has the resident wandered? and was scored, Behavior of this type occurred daily. There was a physician order for Check function and expiration every night shift. Check function and expiration date of (brand name elopement prevention device)/electronic bracelet ordered 9/7/25. The care plan for R13 included a focus: TARGET BEHAVIOR 4: Intrusive Wandering: Resident has a hx (history) of intrusive wandering, in and out of other resident rooms, around the building. Initiated 8/28/2025. Revision on 04/07/2026. The interventions for the behavior care plan which included wandering did not include the wearing of a (brand name elopement prevention device). The elopement risk list which had been presented by Staff F as containing all residents who were wearing a (brand name elopement prevention device) was reviewed. R13 was not on the elopement risk list. The facility presented the policy titled, Unsafe Wandering and Elopement Prevention last reviewed 1/1/2022. This policy read in part, Every effort will be made to prevent unsafe wandering and elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement. Nursing personnel must report and investigate all reports of missing residents.</p>		