

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2025
NAME OF PROVIDER OR SUPPLIER The Laurels of Fulton		STREET ADDRESS, CITY, STATE, ZIP CODE 4735 Ranger Road Perrinton, MI 48871	

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 - Immediate jeopardy to resident health or safety</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>(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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2636578Based on interview and record review, the facility failed to implement measures to prevent the elopement from the facility for one resident known to be at risk for elopement (R101) of four residents reviewed resulting in an Immediate Jeopardy that began on 9/21/25 when R101 left the facility unbeknownst to staff which created a high likelihood for serious harm, injury, and/or death. Findings include: Review of the admission Record reflected R101 originally admitted to the facility 9/19/23 and had pertinent diagnoses that included Alzheimer's Disease, Dementia with Mood Disturbance and Major Depressive Disorder - recurrent and severe with Psychotic Symptoms. Review of the annual Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) dated 8/22/25 reflected R101 was cognitively moderately impaired and could not complete the Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status). Section GG (Functional Abilities) revealed that R101 was independently ambulatory without assistive devices.Review of the Facility Incident Report (FRI) dated 9/22/25 reflected an unauthorized leave of absence by R101 occurred: on 09/21/2025 at approximately 5:00PM. The reported reflected R101 was identified at risk (for elopement) but did not have a [brand name of alarming device] in place. The [brand name of device] is a device worn by a resident that would initiate audible alarms and trigger doors to lock when in proximity doors, Activation of this device would thereby alert staff and prevent an unsafe exit through a door. Review of the Electronic Medical Record (EMR) Progress Notes for R101 reflected an entry on 8/27/25 at 8:04 PM that a Doctor's Order had been received to transfer the Resident from the facility for a psychiatric evaluation and treatment. The Progress Notes reflected R101 readmitted to the facility on [DATE] following in-patient psychiatric treatment.Review of the EMR Reentry Nursing Comprehensive Evaluation dated 9/16/25 at 3:40 AM reflected an Elopement Risk assessment was completed for R101. The documentation revealed R101 had verbalized a desire to leave the facility and had scored 13 on the elopement assessment. The assessment form reflected a score of 11 or higher indicated a resident was at risk for elopement. The documentation reflected (R101) is at risk for wandering with exit seeking as (R101) states is here in error and wants to leave.noted to happen more frequently starting in the afternoon. The documentation revealed that the intervention for a personal alarm was not implemented.On 10/8/25 at 12:20 PM a telephone interview was conducted with Certified Nurse Aide (CNA) G who reported she was scheduled to work on Sunday 9/21/25 at 6:00 PM. CNA G reported on that day she had gone to work early and was traveling east on the rural road that led to the facility. CNA G reported about 5:00 PM she saw someone walking down the road and it was (name of R101). CNA G reported she stopped beside the Resident and rolled down the window. CNA G reported R101 told her she was going to Tennessee. CNA G reported she told R101 that that was quite a distance and asked her to get into the car so that she could call her sister. CNA G reported that R101 got into her car, drove to the facility where she called inside and asked staff to come out and get the Resident. CNA G reported that three or four staff came out and escorted the Resident into the facility. On 10/8/25 at 10:40 AM a telephone interview was conducted with Licensed Practical Nurse (LPN) D. LPN D reported on the afternoon of Sunday 9/21/25 she was getting ready to pass medications and the CNAs were getting residents ready for dinner. LPN D reported she answered a phone call from a night CNA (CNA G) who was coming in early and had picked up (name of R101) down the road from the facility. LPN D indicated she did not know R101 had left the facility. LPN D reported she went out to the parking lot with several other staff members and walked R101 into the facility. LPN D reported that R101 had said that her mom told her to go get some medicine. On 10/8/25 at 10:38 AM a telephone interview was initiated with CNA F who reported she had worked on Sunday 9/21/25. CNA F reported that R101 had been at the Nurse's station a few minutes prior when CNA G called on the telephone and reported that the Resident was outside in her car. CNA F indicated she did not know R101 had left the facility or why R101 did not have a [brand name of alarming device] on. CNA F reported the Resident had recently returned from a psychiatric facility and should have been wearing a [brand name of alarming device]. CNA F reported a [brand name of alarming device] would have locked the front doors when close to them and would have prevented R101 from leaving the building.On 10/8/25 at 10:08 AM an interview was conducted with LPN E who reported she worked on Sunday 9/21/25. LPN E reported she had seen R101 chatting at the front desk and a short while later a CNA coming into work had called and said, I have (name of R101). LPN E reported she went out to the parking lot and helped escort the Resident back into the facility. LPN F reported she</p>		