STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235519	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
King Nursing & Rehabilitation Community	2280 Tower Hill Road Houghton Lake, MI 48629

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 - Minimal harm or potential for actual harm 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 Facility Reported Incident (FRI) 3014540.Based on observation, interview, and record review, the facility failed to prevent, detect, and respond to an elopement for one Resident (#30) of four residents reviewed for elopement.Findings include:Resident #30 (R30)Review of the FRI submitted to the State Agency (SA) on 5/3/26 at 8:05 PM, included an investigation report which read, in part: Staff reported [R30] left facility out west hall door. [R30] was assisted willingly back into the building.[R30] wearing sweatpants, grippy socks, and a shirt. Weather at time sunny 55 degrees.[R30].resides on the west hall. He [R30] is independently ambulatory without the need of assistive devices and routinely ambulates around his room and the facility as he desires. On the afternoon of 5.3.26, [R30] exited the west hall exit door and ambulated outside. [R30] was assisted willingly back inside the building, and when asked, he stated he, just wanted to go outside.A new BIMs [brief interview for mental status] assessment was completed following this incident and showed a significant decline in cognitive status.Witness statement from Licensed Practical Nurse (LPN) C was reviewed by this Surveyor as she was unavailable for interview during the survey. LPN C wrote, At 6:32 PM, [R30] was at [NAME] Hall doors. I was going to the bathroom.At 6:40 PM, Staff notified me that [R30] got out. Staff reported to me that only the alarm panel went off.Witness statement from Certified Nurse Aide (CNA) G was reviewed by this Surveyor as she was unavailable for interview during the survey. CNA G wrote, At 6:20-6:30 PM, I heard someone from nurses' station saying, ?turn off the alarm'. I heard no alarm. Pushed code. Alarm turned off according to coworker. At 6:30-6:35 PM, I looked out the door and did not see anyone. I did not go out and look around outside. I looked out window. We tested the door multiple times, and it did not alarm with the loud exit alarm.Witness statement from CNA E was reviewed by this Surveyor as she was unavailable for interview during the survey. CNA E wrote, At 6:30 PM, I was not in the building when the alarm went off so I did not hear any alarms. I was getting oxygen for another resident.Witness statement from CNA H was reviewed by this Surveyor as she was unavailable for interview during the survey. CNA H wrote, At 6:15 PM, I saw [R30] in Lakeside looking out the window. At 6:20 PM, I returned to East Hall. At 6:35 PM, I was directed by nurse to grab chair and assist [R30] into building. I never heard an alarm.On 5/4/26, the NHA and LPN F went to the [NAME] Hall exit door to perform a door simulation test and the following was discovered: LPN ?F' stated that the door was malfunctioning on 5/3/26 which allowed [R30] to exit without alerting staff by sounding overheard. LPN ?F' and NHA attempted to open door. Alarm did go off. LPN ?F' then showed NHA that the key portion of the door was wobbling and able to be moved out from the door bar. Once LPN ?F' toggled the key spot NHA was able to walk in and out of the [NAME] Hall door with no alarm. Alarm was malfunctioning. Due to door alarm malfunctioning [R30] was able to get out the door without staff being aware.Review of R30's electronic medical record (EMR) revealed the following progress note written on 5/3/26 at 8:28 PM: [R30] was brought back to facility from neighbor who noted [R30] outside on grass down the hill from building around 1840 [6:40 PM] she stated.Review of R30's care plan, dated 2/27/26, unveiled in part Problem: [Resident name] experiences wandering (moves with no rational purpose, seemingly oblivious to needs or safety). Goal: [R30] will not injury/harm (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 - Minimal harm or potential for actual harm Residents Affected - Few	self-secondary to wandering. Approach: Remove [R30] from other resident's rooms and unsafe situations.During an interview on 5/26/26 at 11:50 AM, with the NHA, who was asked what her expectations were of staff if the door alarms went off and replied, I would expect staff to respond appropriately, go outside the exit doors and look around, ensure all residents are accounted for, and not just go and reset the alarm. The NHA was asked if R30 had a wander guard on and replied, We don't use them here.Review of CNA G disciplinary action, dated 5/4/26, read in part .understands she should have checked outside perimeter. It was found that door was not functioning properly.On 5/26/26 at 12:00 PM, an interview was conducted with the Maintenance Director A who was asked how often the exit doors are tested and who is responsible for the testing, and replied, I test the exit doors Monday through Friday and housekeeping is responsible for the testing during the weekends. A request was made for the testing logs and the work orders for the exit doors.Review of the exit door testing logs for the year 2026, revealed an X by each day of each month and did not indicate who performed the testing. On the backside of the exit door testing log for the year 2026 the following was noted:As of 5/3/26 when elopement extra daily checks were done to make sure door was working as it should.5/5/26 Gentleman from Total Fire Protection here to fix latch mechanism.5/18/26 Discovered on my audit check something wrong with it again. Total Fire Protection called again.5/19/26 Total Fire hear at 8:00 AM to check. Determined it is working as it should. Ordering new crash bar to prevent further issues.Review of the work orders for exit doors indicated repairs made on 5/5/26 and 5/12/26.On 5/26/26 at 12:27 PM, an interview was conducted with Housekeeper I who was asked if she tested the exit doors on the weekend of 5/2/26 - 5/3/26 and replied, No. I did not know I was supposed to. Housekeeper I was asked how R30 was behaving on 5/3/26 and replied, He was really agitated and was touching all kinds of things like the fire extinguisher and keypads to doors. Usually, we just walk with him, and the nurse instructed me to keep an eye on him.During an interview on 5/3/26 at 12:34 PM, with Housekeeper J who was asked if she was aware she was responsible for checking exit doors during the weekend and stated, I don't check the door alarms. Never check door alarms. [R30] kinda just like gets into things. He was a little character.On 5/26/26 at 12:50 PM, an interview was conducted with CNA K, who was asked about R30's behaviors and replied, He was very busy. Always wandering around.During an interview on 5/26/26 at 12:55 PM, with CNA H was asked about R30's behaviors, and stated, He would move around and was busy. I had to get him after he got out and I asked him how he was doing and he told me he had a nice walk, but it was hard on his feet. He just had gripper socks on and no shoes. Someone brought him back in a white car. I don't know who it was, some lady.On 5/26/26 at 1:40 PM, the NHA confirmed R30 would wander around the building from hall to hall, in her office, and the Director of Nursing's. The NHA stated, The CNA just adding the code in to shut the alarm off and not actually step outside to see if a resident eloped is one problem and the door not being checked by housekeeping on the weekends is another.At 2:15 PM on 5/26/26, a phone interview was conducted with LPN F who was working at the time R30 eloped from the facility and stated, The other nurse working was assigned to [R30]. I was assigned to the other end of the building. [R30] walked to Lakeside room and then came back near the sink by the nurses' station and just stood there. I got a message from the NHA because she had a few questions for me around 6:15 PM and I left the floor to go back to the conference room so I could call her. I was sitting in the conference room for about 10 to 15 minutes. I was looking out the window and saw this black SUV pull up and a lady came out and I heard the doorbell ring. I could see she had him [R30] in the passenger's seat. We never got her name. She said she had been driving and seen him in the wooded area behind the house down in front of the facility. She stopped to ask him if he was alright and noted he was alright but confused so she put him in her car and took him back to the facility. After we got him back in and secured, I went to check the door. I pressed the door open and the door flung open without an alarm. I messed around with the lock then I pressed on it, and it was not secure it was jiggling and then I hit it back in and then my key worked. I do not know how long it was not working.During the SA investigation on 5/26/26, it was concluded R30 was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	approximately 0.2 miles from the facility and outside for approximately 10-15 minutes before a neighbor intervened.Review of policy titled, Elopement Prevention and Management Program, dated 1/2025, read in part Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in according with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.Policy Explanation and Compliance Guidelines: 1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner.