

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Bishop Noa Home for Senior Citizens		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 Third Avenue South Escanaba, MI 49829	

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 - Minimal harm or potential for actual harm</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49735</p> <p>This citation pertains to intake MI00152541</p> <p>Based on interview and record review, the facility failed to provide adequate supervision for one Resident #1 (R1) of one resident reviewed for elopement. This deficient practice resulted in R1 leaving the facility unattended with the potential for fall and injury.</p> <p>Findings include:</p> <p>Resident #1 (R1)</p> <p>Review of Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE] with active diagnoses that included: Alzheimer's disease and dementia. Section C of the MDS revealed R1's cognitive skills for daily decision making were severely impaired. The MDS also indicated R1 rarely or never made decisions and was rarely or never understood.</p> <p>Review of a facility document titled R1-elopement 4/18/25 at 16:20 (4:21 p.m.) read in part, .at 16:20 resident stood up from the table and waved goodbye to everyone who was present, R1 then exited the dining room to the left. Resident proceeded down the hall an exited the facility at 1621 .resident exited the facility at 1621 (4:21 p.m.) and returned at 1634 (4:34 p.m.); elopement verified.</p> <p>During an interview on 4/30/25 at 9:56 a.m., Registered Nurse (RN) A reported R1 went all over the facility during the day, constantly wandered throughout the day, and tries to go out of the exit doors.</p> <p>During a follow-up interview at 10:25 a.m., RN A reported R1 tries to leave the facility and is not picky about which door R1 wants to exit.</p> <p>During a phone interview on 4/30/25 at 10:37 a.m., Licensed Practical Nurse (LPN) C reported R1 tries to exit the facility and wanders all over the facility. We constantly redirect [R1] away from the exit doors. LPN C stated she reported concerns over R1 eloping from the facility to a supervisor, but nothing has changed. LPN C stated I am very concerned about what could happen to [R1].</p> <p>Review of a witness statement on 4/30/25 at approximately 11:15 a.m., revealed the following:</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235651
		If continuation sheet Page 1 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Bishop Noa Home for Senior Citizens		STREET ADDRESS, CITY, STATE, ZIP CODE  2900 Third Avenue South Escanaba, MI 49829	
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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(LPN B) said on 4/18/25 at around 16:20 (4:20 p.m.) the alarm for door 2 was going off. (LPN B) walked down to a room and met (Certified Nursing Assistant [CNA] F). (CNA F) didn't see anyone go out the door .a visitor, who does (R1's) hair said that (R1) was walking on the sidewalk in the parking lot. Then (RN D) and (CNA J) went running outside after (R1).</p> <p>During an interview on 4/30/25 at 11:24 a.m., LPN B reported the alarms went off on 4/18/25 when R1 eloped from the facility. LPN B stated they went to the front of the facility with CNA F and then went back to the nurse's station. LPN B stated they were going back to the nurse's station when a visitor told her R1 was out in the parking lot. LPN B said, I can't imagine how far (R1) could have gone down the street if the visitor had not told us.)</p> <p>Review of a witness statement on 4/30/25 at 1:00 p.m. revealed the following:</p> <p>(CNA F) said that on 4/18/25 door 2 was alarming. (CNA F) went to the door and looked outside, and didn't see anyone . (CNA F) told (LPN B) that she did not see anyone outside.</p> <p>During a phone interview on 4/30/25 at 1:12 p.m., CNA F was asked if she went outside to look for the resident. CNA F reported, I looked at the small parking lot and then went back inside the facility. I didn't look around the side of the facility or down the street. I really didn't know what to do. I was never trained about what to do if a resident elopes outside of the facility.</p> <p>During a phone interview on 4/30/25 at 1:27 p.m., CNA J stated he had worked on the day of the elopement. CNA J indicated he came out of the nurse's lounge and then a visitor came in and told the staff R1 was walking away from the facility. CNA J said, . then we ran outside to catch the resident. The resident was about half a block or so from the facility.</p> <p>During a phone interview on 4/30/25 at 1:36 p.m., RN D reported being in the purchasing office and did not hear the door alarm when it went off. RN D said, I went back to the nursing station area and a visitor told us they saw (R1) outside. I went outside and ran to the edge of the street as I didn't see (R1) in the parking lot. I looked down the street and (R1) was walking away from me. (R1) was easily redirected to return to the facility. It was quite a distance, so it took us several minutes to walk back into the facility.</p> <p>Review of policy titled, [Facility Name] Policy and Procedure Prevention of Wandering and Elopement last updated 4/24, read in part, .It is the policy of [Facility Name] to provide an environment that keeps residents safe and free of injury .Elopement is defined by the State Operations Manual as follows: when a resident leaves the premises or safe area without authorization .and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complication, drowning, or being struck by a motor vehicle.</p>		