STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235407	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KALKASKA MEMORIAL HEALTH CENTER	419 S CORAL ST 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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Intake: MI 709 Based on interview and record review, the facility failed to ensure an allegation of elopement was reported timely to the administrator and State Agency (SA) for one Resident (#900) out of four residents reviewed for accident/incident reporting. This deficient practice resulted in the potential for further delay in investigations of incidents. Findings include: A review of Resident #900's record revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #900's 12/18/19 Quarterly Minimum Data Set (MDS) assessment revealed an 8/15 on the Brief Interview for Mental Status (BIMS) score, indicating moderate cognitive impairment. A review of the Intake Information submitted to the SA revealed, Date of Alleged Event: [DATE]; Time: 10:30 p.m .Facility incident report received via online submission on: 2/28/20. 3:24 p.m .Incident Summary: Resident (#900) walked out of front door of building. found within 3 minutes . An interview was conducted with Registered Nurse (RN) A on 3/4/20 at approximately 2:15 p.m. in regards to the allegation of elopement for Resident #900. RN A confirmed that she was on-call that evening and Resident #900's elopement was not reported to her until the following day. A review of the facility policy titled, Abuse Prevention Program dated 11/16/16 revealed, .Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation or resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the advents that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other official (include the State Survey Agency and adult protected services where state law provides for jurisdiction in long-term care facilities) in accordance with State law .Adverse Event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or risk thereof.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** MI 709 Based on interview and record review, the facility failed to ensure adequate supervision to prevent an elopement for one Resident (#900) of three residents reviewed for high risk elopement. This deficient practice resulted in Resident #900 exiting from the facility without staff knowledge and the potential for injury for Resident #900 and other high elopement risk residents. Findings include: An abbreviated survey was conducted on 3/4/20 in regard to a facility reported incident dated 2/28/20 which reported Resident #900 had exited the facility unsupervised on [DATE] at 10:30 p.m. and was found by staff near the main front door of the facility. A review of Resident #900's record revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #900's 12/18/19 Quarterly Minimum Data Set (MDS) assessment revealed an 8/15 on the Brief Interview for Mental Status (BIMS) score, indicating moderate cognitive impairment. Resident #900 required limited one person assist for locomotion. A review of the Intake Information submitted to the SA revealed, Date of Alleged Event: [DATE]; Time: 10:30 p.m .Facility incident report received via online submission on: 2/28/20. 3:24 p.m .Incident Summary: Resident (#900) walked out of front door of building. found within 3 minutes . Review of Resident #900's Elopement Risk assessment dated [DATE] and written by Registered Nurse (RN) B revealed the following, .The resident has attempted to leave a residence or other place unescorted that placed him/here in danger. 1.Yes The resident is cognitively impaired with poor decision-making skills (i.e. intermittent confusion, cognitive deficits or disoriented all the time) and independently ambulatory. 1.Yes The resident has a history of elopement. 1.Yes .If the assessment indicates 'YES' to any question, consider initiating a care plan or service plan for elopement risk. Total Elopement Risk Assessment Score 3 . Review of Resident #900's Progress Notes from 3/27/19-3/4/20 revealed a noted dated 3/27/19 written by RN B which read, Family report resident wandered and was at risk for elopement at last home she lived. She does not express any desire to leave facility at this time. Scored 3 on Elopement risk assessment. Does not verbalize intent to leave so will not care plan elopement or wanderguard at this time. An interview was conducted with Social Services Director (SSD) E on 3/4/20 at 1:50 p.m. in regard to Resident #900's elopement from the facility. When asked if the facility had prior knowledge that Resident #900 had eloped from other facilities or her home prior to entering the facility, SSD E stated, Yes. An interview was conducted with Certified Nurse Aide (CNA) C 3/4/20 at 3:08 p.m. in regard to Resident #900's elopement from the facility. CNA C stated, I was working with (Resident #900) the night of [DATE] and around 9:30 p m. that night she was starting to show agitation and didn't want to go to bed. (Resident #900) finally sat down in a chair near the nurses station and front main door. Another CNA (Later identified as CNA D) offered (Resident #900) a snack, which she refused, so we decided to just give her some space. I went to go answer another call light and when I came back out into the hallway, (Resident #900) was gone. As I started to search for her the doorbell rang, and staff started to escort (Resident #900) back into the building. When asked if Resident #900 had a history of [REDACTED]. Review of the facility's video footage was conducted by this Surveyor on 3/4/20 at 4:00 p.m. During the review, this Surveyor observed Resident #900 sitting in a chair across from the nurses station near the main front door. Resident #900 was observed standing up with her front wheeled walker and ambulated towards the main front door. Resident #900 then proceeded to push the front doors open and exit the facility. Approximately two minutes later, unidentified staff members are observed opening the front main doors and escort Resident #900 back inside the facility. Resident #900 was noted to be fully dressed with yellow gripper socks. Upon returning inside the facility, Resident #900 did not appear distressed. Review of Resident #900's Care Plans showed no elopement care plan initiated until after the event on [DATE]. Review of the facility's Code Green for Green House and LTC (long term care) at (name of facility) and (name of facility), 078.999 dated 2/1/2004 read, It is the policy of this facility to enable wandering residents to function at their highest optimal ambulation level while maintaining their safety and ensuring they do not wander away from the facility .the care plan will be updated with diversion, approaches, modifications, and appropriately timed goals that are specific to the resident's individual wandering habits .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.