STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235005	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maples Benzie County Medical Care	210 Maple Street Frankfort, MI 49635

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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(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 - Actual harm Residents Affected - Few	This citation pertains to Facility Reported Incident (FRI) 2611699.Based on observation, interview, and record review, the facility failed to identify and mitigate environmental hazards, ensure the appropriate use of assistive devices, and implement care planned interventions resulting in falls for three Residents (#24, #25, #26) of three residents reviewed for accident hazards and supervision. This deficient practice resulted in actual harm when Resident #24 sustained multiple lower leg fractures requiring surgical intervention. Findings include:Resident #24 (R24)Review of R24's Electronic Medical Record (EMR) revealed initial admission to the facility on 8/4/23 with diagnoses including vascular dementia, major depressive disorder, and personality disorder. Review of R24's most recent Minimum Data Set (MDS) assessment, dated 8/5/25, revealed a Brief Interview for Mental Status (BIMS) score of 10, indicative of moderate cognitive impairment. Further review of the MDS indicated R24 was independent in walking distances up to 150 feet and transferring from a bed to chair.Review of the facility incident summary submitted to the State Agency (SA) on 9/2/25 at 12:12 PM read, in part: [R24] was observed on the floor in the doorway of the bathroom today at 0835 [8:35 AM]. She was noted to have blood on her left ankle. It appeared that she has an open fracture of the left ankle. She was walking with CNA [certified nursing assistant] from the bathroom after having a shower . She was nude other than a towel around her. She lost her balance on the floor transition. She went backwards hitting her head on the door, she then went down to the floor. [R24] was not moved from the floor due to probable fracture. EMS [Emergency Medical Services] was called at approximately 0845 [8:45 AM] Fractures confirmed at 1127 [11:27 AM] per verbal report, acute comminuted displaced distal tibial diaphyseal fracture, acute comminuted displaced distal fibular fracture, acute proximal fibular fracture [three fractures of the lower two leg bones].Review of the Emergency Department (ED) Consultation Report on 9/2/25 read, in part: .patient seen in emergency department after having a slip and fall in the shower at her facility. she does have an open fracture with exposed tibia on exam. she will require surgical irrigation and debridement with surgical fixation of her tibia and possible fibula.On 9/17/25 at 9:28 AM, R24 was observed sitting at the edge of bed, eating breakfast in her room. Adhesive strips were noted over surgical wounds on both sides of R24's left ankle as well as under and inside R24's left knee. This surveyor entered R24's room and asked how she was feeling to which she replied, So-so. My ankle hurts. R24 was asked the reason for the surgical wounds, she replied, I fell. Three breaks [fractures]. When asked the location of the fall, R24 pointed at the private bathroom located near the foot of her bed and stated, I slipped. When asked if she was showering at the time of the fall, R4 replied, Yes. R24 asked if the floor was wet at the time of the fall to which she responded, Yes then indicated she no longer wished to pursue the conversation.On 9/17/25 a telephone interview was conducted with CNA A who verified she was assisting R24 in the shower at the time of R24's fall on 9/2/25. CNA A stated R24 was finished showering and was wrapped in a towel making her way toward the bedroom to get dressed. CNA A recalled as R24 stepped over the threshold separating the bathroom tile from the bedroom linoleum, her leg slipped out from behind her, and she proceeded to fall backward and hit her head on the doorframe. CNA A stated, At that point, I watched her bone pop out of her leg. When asked about her positioning at the time of the fall, CNA A stated she was walking backward into the bedroom as R24 was walking forward, just because I know the floor is so slippery. CNA A was asked if she attempted to use a shower chair, a gait belt, or non-skid footwear as ways to increase safety on the slippery floor. CNA A stated R24 is usually hard-headed and at times will not allow it. When asked if she attempted to utilize or offer a shower chair, gait belt, or footwear to R24, CNA A replied, No, I just assumed from prior experience that she would decline.Review of an Incident Note written by Registered Nurse (RN) G, dated 9/2/25 at 9:21 AM, read, in part: Called to room found [R24] lying on floor post shower. During shower CNA witnessed [R24] slip and fall, hit back of head on door, no grip socks in place was just getting out of shower feet floor still wet .Review of the Root Cause Review, signed by the Director of Nursing (DON) on 9/5/25 read, in part: Environmental/Equipment Factors: Floor wet from shower.Behavioral Factors (aggression, noncompliance, etc.): none.On 9/17/25 at 10:15 AM, an interview was conducted with RN G who verified she was the floor nurse on duty at the time of the fall on 9/2/25. RN G was called into R24's room and visualized her on the floor coming out of the bathroom with an open fracture to her left lower leg. RN G stated, The floor was wet. I was mad because she [R24] didn't have a gait belt on, and she can be really impulsive. or even use a shower chair. When I was a CNA, I always dried them [residents] off thoroughly on a shower chair or bench and put footwear on them and a towel on the floor. RN G recalled