STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235155	A. Building B. Wing	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martha T Berry McF	43533 Elizabeth Road Mount Clemems, MI 48043

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure appropriate interventions were implemented to prevent a fall with injury for one resident (R901) of three reviewed for falls. Findings include:This citation pertains to Intake 2661503.A review of a progress note by Licensed Practical Nurse (LPN) A dated 10/05/25 at 12:38 PM, documented, Resident was observed lying in the hallway face down in a pile of blood. Writer (LPN A) assisted resident to (their) back then into wheelchair. Writer applied pressure to laceration on (right) R side of forehead and to bridge of nose . Writer asked resident what happened, and (they) began to cry stating that (their) head hurts. Writer applied pressure to bleeding areas until the ambulance arrived. Ambulance arrived and took resident to (hospital). Review of a post fall assessment by LPN A documented, . Post Fall Evaluation Late Entry: Fall Details: Date/Time of Fall: 10/05/2025 11:30 AM. Fall occurred in the hallway. Activity at the time of fall: Ambulating. Reason for the fall was evident. Reason for fall: Ambulating. Did an injury occur as a result of the fall: Yes. Injury details: Hematoma (collection of blood or bruise) in center of forehead, Laceration above R (right) eye . A review of the clinical record for R901 revealed, R901 was admitted into facility on 09/01/2023. Diagnoses included: Dementia with Psychotic Disturbance, Syncope (fainting) and Collapse, and Difficulty Walking. Upon return from the hospital on [DATE] diagnoses included: Zygomatic (cheek bone) fracture, Maxilla (upper jaw) fracture, Le Fort Fracture two and three, (Le Fort indicates a facial fracture and the amount of the face involved. Level one is just the maxilla, two involves in addition the nasal area, and three in addition involves the cheekbones to the level of the eyes.) A Left radius (low arm bone) fracture and contusions to the eyeball and orbital tissues. A review of the hospital discharge notes dated 10/09/25 revealed a physician note dated 10/08/25 which documented, .significant facial swelling . restless . appears uncomfortable . The note also documented admission to the Intensive care unit, opioids for pain and sedatives for the resident's comfort. A review of the Brief Interview for Mental Status (BIMS) scores for R901 dated 08/23/25 documented a score of 3/15 which indicated R901 had a severe cognitive impairment. A review of a care plan dated 9/5/23 for R901 revealed: I am at risk for falls r/t (related to) impaired cognition, impaired mobility, poor safety awareness, incontinence, previous falls, high risk anti-hypertensive & anti-depressant medication use. A care plan intervention added on 9/22/23 documented, Assure elder has assistive device (walker) in reach at bedside and encourage use prior to ambulating. A review of a care plan dated 9/14/24 for R901 revealed: I am at risk for wandering (related to) r/t Cognitive Impairment.A review of the care plan dated 10/3/23 for R901 revealed: I have a potential for decline in ambulation r/t Muscle weakness. Restorative- Ambulate 50 feet with (rolling walker) RW (standby assist) SBA as tolerated.A review of the fall risk evaluations dated 06/07/2025 and 08/30/2025 documented R901 at a 13, with a number greater than ten is considered a high fall risk.On 11/10/25 at 11:29 AM and 12:19 PM, the Director of Nursing (DON) was queried about fall protocol and falls at the facility. The DON reported recent education was provided for activity aide (AA C). AA C had intercepted a resident (R901) walking down the hallway holding onto a bedside table. AA C took the tray table from R901 and instructed R901 to grab the handrail and to stay there. When AA C turned away to return the tray table to the resident's room, R901 walked away from the handrail. The resident then fell. The DON further reported the education to AA C included, you can never tell a demented person to stay and expect them to remember a moment later. On 11/10/25 at 12:41 PM, AA C reported they had known R901 for around two years. AA C recounted the incident with R901 and reported they had been on their way to dietary when they observed R901 coming up the hall to the nurse's station pushing a bedside tray table. AA C met up with R901 in the hallway around twenty feet or so from the resident's room. AA C felt R901 was in danger while using the bedside table and instructed R901 to hold onto the handrail while they went and retrieved the resident's walker. AA C returned the bedside table to the room and before they retrieved the walker they heard a loud noise. AA C exited R901's room to find that R901 had fallen. AA C acknowledged they received education after the incident, to never leave the resident. On 11/10/25 at 3:10 PM, Unit Manager UM D was asked about R901's fall and reported R901 would frequently walk away from their walker and need redirection due to poor safety awareness. UM D recounted the fall and reported staff AA C was seen walking from the nurse station while R901was walking up the hallway from their room. AA C had R901 stand at the railing and holding on. AA C then went to R901's room and as AA C walked away, R901 turned and walked approximately 10-15 steps caught their foot and fell. UM D reported they provided education to AA C which included any resident seen