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	04/02/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a homelike environment including the availability of warm/hot water, for nine residents (R36, R81, R82, R85, R87, R89, R123, R136, and R160). Findings include:R36 On 3/31/26 at 9:45 AM, R36 was observed lying in bed watching television. R36 pointed to the foot of the bed and stated, Those holes bother me. I don't like that and I wish it was fixed. The footboard at the end of the bed was noted to have two large open areas where the laminate on the footboard was missing and loose. Further observation revealed, in the wall behind the bed was a large hole about 6 inches long and 3 inches wide. A record review revealed R36 was admitted on [DATE] with the following medical diagnoses of Hypertension and Anxiety Disorder. R36's Brief Interview of Mental Status assessment score was 15/15 indicating intact cognition. On 4/01/26 at 10:30 AM, a tour of R36's room was conducted with the Housekeeping Director J and acknowledged the previously noted areas were in need of repair. On 4/02/26 at 10:08 AM, an interview occurred with the Maintenance Director K discussing the areas of concern and confirmed the areas were in need of repair and all rooms should be in good repair and comfortable for all residents. A review of the facility's policy titled Homelike Environment policy documented in part, .the facility provides a personalized, homelike environment that recognizes the individuality and autonomy of our residents to provide an opportunity for self-expression and encourage links with the past, family members and friends. On 3/31/26 at 3:55 PM, a family member of Resident #87 reported that Resident #87 told her the water in the shower room often runs cold. On 04/01/2026 between 10:00 AM-10:30 AM, the following hot water temperatures were measured (the hot water was running for 3 minutes): Rm 2174/2176 (Resident 87,160): 80 degrees Fahrenheit Rm 2170/2172 (Resident #81, 85): 99 degrees Fahrenheit Rm 2130/2132 (Resident #82, 89): 77 degrees Fahrenheit (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Rm 2126/2128 (Resident #123, 136): 86 degrees Fahrenheit. When queried at that time about the hot water temperature in their bathroom, Resident 136 stated It's cold! Resident 136 further stated that the water starts out warm, but that it is cold by the end of the shower. Review of the facility's hot water temperature logs revealed that the hot water temperatures in the above-mentioned rooms had last been measured on 3/8/26. Review of the facility policy Room Environment Safety revised 3/9/26 noted: Each resident has the right to be treated with respect and dignity, which includes a safe, clean, comfortable and homelike environment .8. To assure comfortable and safe temperature levels are maintained .Water temperatures are maintained between 105 and 115.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the invitation and inclusion in care conferences (participation in planning their own care) of one resident (R103) of two reviewed for care planning. Findings include: On 3/31/26 at 10:27 AM, R103 was asked about their satisfaction with the care and services they were receiving at the facility. R103 stated, I want to get out of here. R103 was asked if they had discussed this issue in their care conference meetings. R103 indicated that they had never attended a care conference meeting and didn't know anything about them. R103 expressed a desire to attend their care conferences. A record review of R103's electronic medical record (EMR) revealed documentation of care conferences being conducted regarding R103 on 11/5/25 and 2/11/26. There was no documentation which indicated the residents' invitation to the conference, attendance, refusal, or a reason why the resident was not in attendance at either care conference. Further review of R103's EMR revealed that R103 was admitted to the facility on [DATE] with diagnoses that included, Dementia and Type 2 diabetes. R103's most recent quarterly minimum data set assessment (MDS) dated [DATE] revealed that R103 had a moderately impaired cognition and required setup and cleanup help with oral hygiene and eating. On 4/2/26 at 10:25 AM, Social Worker (SW) H was interviewed about R103's participation in their care conferences on 11/5/25 and 2/11/26. SW H indicated they had not invited and included the resident in their care conferences due to concerns related to behavioral issues by the resident towards their family. SW H was asked if they had documented these concerns and reasons anywhere in the resident's record to which she responded, No. SW H indicated they should have included the resident in the care planning process. On 4/2/26 at 1:30 PM, the Director of Nursing (DON) was interviewed and asked the standard for who should be invited to resident care conferences. The DON indicated the resident and responsible party should be invited, and the care conference is usually conducted by the social worker. A facility policy titled Baseline/Comprehensive Care Plan Reviewed September 19, 2025 stated the following: Comprehensive Care Plans: 1. The comprehensive care plan will be developed .with input from the resident .d. Include resident preference, potential for future discharge and discharge plan as appropriate. 2. The IDT (Interdisciplinary Team) will discuss the plan of care with the resident .at regularly scheduled care plan conferences. 4. If the resident .is unable to participate in the scheduled care plan conference an explanation will be documented in the medical record.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide timely repositioning and transfer assistance for two dependent residents (R85, R160) of three observed for quality of care. Findings include: R85On 03/31/2026 at 12:10 PM, 12:31 PM, 12:40 PM, and 1:17 PM, R85 was observed in the alcove dining area along with eight other residents. R85 was in a 'Broda' style wheelchair (designed for safer positioning and fall prevention). R85 was leaning toward the left side of the chair with the left shoulder lower toward the armrest. At 1:17 PM, R85's head was on the left side bolster, and the torso was leaned over to the left and scrunched down slightly. R85 did not respond to queries. At 1:36 PM, the left elbow was sticking out the back side of the wheelchair between the back support and side of the wheelchair. R85 moved their left leg up and down as it hung over the left arm of the wheelchair. At 2:08 PM, the chair had been leaned back to around 30-45 degrees. At 2:53 PM, R85 was observed in the wheelchair. R85 was observed leaning toward the left side of the chair with their arm hanging out the back side of the chair. The head of the chair was up around 30-45 degrees. On 04/01/2026 at 8:11 AM and 9:02 AM, R85 was in bed lying on their left side, facing the left side of the bed, dressed in a hospital style gown. A foam wedge was on the floor at the left side of the bed. At 9:40 AM, R85 was sitting up with the head of the bed around 30-45 degrees. At 10:00 AM, R85 was in bed as before. At 11:32 AM, R85 was in bed with the head up around 30-45 degrees with the foam wedge at left edge of bed. At 2:00 PM, R85 was in the 'Broda' wheelchair in the alcove dining area. R85's arm was through the opening at the back of the chair and R85 intermittently grabbed the lower frame of the 'Broda' wheelchair. Staff walked over to R85 as the surveyor entered and encouraged R85 to change position but did not change the position of R85.A review of the facility records for R85 revealed R85 was admitted into the facility on [DATE]. Diagnoses included Paralysis of the Right Side, Malnutrition, and Dementia. The care plan high risk for falls revised 03/19/26 documented, Offer assistance if I adjust myself in the wheelchair due to poor trunk control . wedge cushions for pressure relief removed from skin care plan . The active care plan further documented, .need staff to anticipate my care needs . The Minimum Data Set (MDS) assessment dated [DATE] documented severely impaired cognition and the need for substantial/maximal assistance to roll left and right in bed and dependent on staff for dressing, eating, toileting, hygiene, transfer and ambulation.On 04/02/2026 at 11:43 AM, Registered Nurse (RN) E reported the care plan for R85 was appropriate. R160A review of the facility records for R160 revealed R160 was admitted into the facility on [DATE]. Diagnoses included Chronic Ulcer of Left Heel, Malnutrition, and Dementia. The care plan risk for falls revised 03/24/26 documented, .care plan has been developed, reviewed or revised . Report any significant changes . The active care plan further documented, .have a diabetic ulcer to left heel . The self-care performance deficit care plan documented, .out of bed and ready for visits around 11 AM (initiated 01/16/25, revised 03/27/26) . even when I am sitting and visiting with family, interrupt me and make sure I do not have soiled briefs (initiated 05/07/24, revised 03/27/26) . The Minimum Data Set (MDS) assessment dated [DATE] documented severely impaired cognition and dependence on staff to roll left and right in bed, and for dressing, toileting, hygiene, transfer and ambulation. On 04/01/2026 at 8:37 AM, R160 was observed on their back in bed, dressed on the upper body only. At 9:06 AM, R160 remained on their back in bed with the head up around 30-45 degrees. At 10:00 AM, R160 was in bed as before. At 11:32 AM, R160 continued in bed as before, glasses on, eyes closed, the head of the bed up around 30-45 degrees. R160's head was tilted down slightly and over to the right shoulder. At 11:49 AM, a family member came to visit and R160 was in bed as before. At 12:17 PM, R160 was dressed and seated in a wheelchair in the main dining room with the family member (one hour and 17 minutes after care planned time of 11:00 AM).On 04/02/2026 at 8:06 AM, R160 was on their back in bed, with the head of the bed up around 30-45 degrees. At 9:28 AM, R160 was in bed, the head of the bed was up around 45-60 degrees, and a staff member was assisting R160 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to eat. At 12:04 PM, R160 was on their back in bed, with the head up around 30-45 degrees and had a family member in the room and not up in their wheelchair and ready to go to the main dining room for lunch. On 04/02/2026 9:33 AM, Certified Nursing Assistant (CNA) G reported R160 required total care and may help with their arms but was not likely to initiate activity. A review of the facility policy titled, Repositioning Policy last dated 01/06/26, revealed, Purpose: To provide guidelines for safe repositioning of residents, to relieve pressure on bony prominences, increase circulation, and provide comfort. Policy: It is the policy of (the facility) to ensure that residents who are unable to change position without assistance are repositioned appropriately . Residents will be maintained in correct body alignment to the extent possible, knowing the resident may be able to make smaller shifts in position between the time staff have provided repositioning for the resident, and the residents physical condition allows (such as contractures/deformities).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to apply protective heel boots (footwear used to relieve pressure on the heel) for one resident (R147) out of five reviewed for skin conditions. Findings include:A review of the Electronic Medical Record (EMR) for R147 revealed a physician's order last revised 8/28/2024 for R147 to have protective boots while in bed.Further review of the EMR revealed R147 was admitted to the facility 5/24/2022 with diagnoses of peripheral vascular disease, contracture of right and left knees, chronic pain syndrome, and type two diabetes. Review of R147's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out 15, indicating fully intact cognition. Section M (Skin Conditions) revealed that the resident is at risk of developing pressure ulcers/injuries.On 03/31/2026 at 10:30 AM and 1:15 PM, R147 was observed lying in bed with no protective heel boots in place.On 04/01/2026 at 11:29 AM and 2:08 PM, R147 was observed lying in bed with no protective heel boots in place.On 04/02/2026 at 2:06 PM, R147 was observed lying in bed with no protective heel boots in place. R147 was asked if they refused to wear protective heel boots, and their response was not understandable. A pair of protective heel boots were observed sitting on a wheelchair outside of R147's room.On 04/02/2026 at 2:10 PM, an interview was conducted with Licensed Practical Nurse (LPN) D. They stated they float in different areas and only work on that floor about once a month, but they weren't aware of R147 refusing to wear protective heel boots and said R147 would probably agree to put them on if asked. LPN D said that a Certified Nurse Aide (CNA) may have taken off the protective heel boots to provide care but wasn't sure. After LPN D reviewed R147's EMR, they stated that R147 should have protective heel boots on.On 04/02/2026 at 4:09 PM, an interview was conducted with the Director of Nursing (DON), Assistant Director of Nursing) (ADON) F, and Registered Nurse (RN) Unit Manager E. The DON stated when there is an order for protective heel boots, they should be applied. If a resident refuses, that should be documented in their Treatment Administration Record (TAR). ADON F stated when a resident refuses, staff should attempt to reapproach the resident in an hour to encourage them again. If they continue to refuse, staff should attempt to use a pillow or other intervention the resident will be willing to use and inform management about the resident's repeated refusal. RN E said R147 is known to them to sometimes they are willing to wear protective heel boots and sometimes refuse them.A review of the care plan for R147 (last review completed 2/17/2026) revealed I am at risk for impaired skin integrity related to impaired mobility, contractures, medication use, incontinence, weakness, and recurring diabetic ulcers to my feet. I am known to refuse care and refuse to get out of bed. Interventions in the care plan included Heel protector boots on bilateral feet and/or float my heels with a pillow while in bed.A review of R147's March and April 2026 TARs did not reveal documented refusals for protective heel boot applications. A review of a policy titled Pressure Injury Prevention and Management last reviewed 12/19/2025 revealed .Evidenced-based interventions for prevention will be implemented for residents who are assessed at risk or who have a pressure injury present.