STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235197	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsdale County Medical Care Facility	140 W Mechanic Street Hillsdale, MI 49242

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to assess for the potential of a restraint in one (Resident #3) out of three reviewed. Findings include:Review of the medical record reflected R3 was admitted to the facility on [DATE], with diagnoses that included dementia and anxiety. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/13/25, reflected R3 scored 4 out of 15 (severe impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 9/15/25 at 12:50 pm, R3 was observed consuming lunch on the patio area. Review of a Progress Note dated 6/16/2025 at 1:12 pm reflected Resident (R3) tipped footrest on personal chair tipped out onto the floor hematoma to right forehead .Review of a General Nursing Note dated 6/16/2025 at 12:48 PM stated Post fall and after investigation Elder was sitting in her personal chair with her feet up, sensor pad in place and sounding. Elder is unaware of her limitations and thought she was able to ambulate independently. New orders to not be left unattended in her personal chair with her feet up .In an interview on 9/15/25 at 12:54 PM. Licensed Practical Nurse (LPN) E stated that at the time of the fall, R3 was attempting to get out of her recliner chair and fell out of the front of it. LPN E confirmed that the footrest of the recliner was up, the remote to control the footrest was out of reach, however, LPN E stated that R3 does not have the cognitive ability to effectively operate the remote to the recliner. In an interview on 9/15/25 at 2:00 PM Director of Nursing (DON) B stated that at the time of the fall R3 was in her personal recliner chair with the feet elevated. R3 attempted to climb out of her personal chair and fell forward out of the chair. DON B reported that every resident requires a safety audit of their personal chairs however, R3 had not had a safety audit or a physician restraint audit of her personal chair. As a result of this fall an intervention was added to R3's care plan reminding staff not to leave R3 unattended in her personal chair. Per the State Operations Manual, physical restraint is any manual method, physical or mechanical device/equipment or material that limits a resident's freedom of movement and cannot be removed by the resident such as placing a resident in a chair, such as a beanbag or recliner, that prevents a resident from rising independently.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235197	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsdale County Medical Care Facility	140 W Mechanic Street Hillsdale, MI 49242

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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 - 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** Based on observation, interview and record review the facility failed to prevent a fall during ambulation in one (resident #2) out of three reviewed for falls resulting in a fall during ambulation that caused a clavicle fracture. Findings include: Review of the medical record reflected Resident #2 (R2) was admitted to the facility on [DATE], with diagnoses that included weakness and dementia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/3/25, reflected R2 scored 11 out of 15 (moderately impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 9/15/25 at 10:56 am R2 was dressed and seated in her wheelchair. R2 explained that she was wishing she could go home however, had experienced a fall at the facility that resulted in some setbacks. R2 explained that while walking back to her recliner with the assistance of a staff member, she had lost her balance and sustained a fall that resulted in a right clavicle fracture.Review of R2's Care plan revealed that on 6/2/25, R2 required Assist of 1 person for all transfers with use of gait belt and 2WW (two wheeled walker).Review of a General Progress Note dated 6/22/25 at 2:01 PM reflected Res (Resident #2) was with CNA (Certified Nursing Assistant) walking back from the bathroom, states she let go of the gait belt to pull the pc (personal chair) closer. Res (Resident #2) lost her balance fell in the bathroom doorway landing on her right side and hitting her head on the bathroom door R2 was transferred to the local Emergency Department.Review of R2's Hospital Discharge paperwork revealed R2 was diagnosed with a closed nondisplaced right distal clavicle fracture. In an interview on 9/15/25 11:51 AM, CNA D reported that she was transferring R2 from her bathroom to her personal recliner when the fall occurred. CNA D stated that she was using the gait belt and R2 had her walker and CNA D had a lapse in judgement and took her hand off R2's gait belt. R2 fell sideways, landing on her right shoulder which resulted in a fracture. CNA D stated that she received education from the nurse and stated she should never let go of a gait belt while transferring a resident.In an interview on 9/15/25 at1:43 PM, Director of Nursing B stated that the expectation would be to not remove your hand from the gait belt while transferring a resident.