STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235407	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalkaska Memorial Health Center	419 South Coral Street 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2621196Based on interview and record review, the facility failed to follow fall interventions for one Resident (#4) of five residents reviewed for falls. This deficient practice resulted in a fall with major injury requiring surgery. Findings include: Resident #4 (R4)Review of R4's Electronic Medical Record (EMR) revealed admission to the facility on 6/25/24 with diagnosis including above right knee amputation, dementia, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Review of R4's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 14/15 indicating R4 was cognitively intact. Section GG of the MDS showed R4 required max assistance for toileting and transfers. R4's Fall Risk Evaluation dated 11/21/24 showed a score of 13, indicating a high risk for falls.Review of R4's Progress Note dated 9/9/25 and 9/10/25 read, in part, Approx. (approximately) 9:40 p.m. this nurse called to (R4's room) resident was laying on the floor on her back, resident stated she was on the toilet and stood up by herself to grab a brief and lost her footing and fell. Resident assessed and c/o (complaint of) right hip pain, this nurse phoned E.D (Emergency Department) and gave report.and this nurse sent resident to the E.D. for x-rays and evaluated [sic].fall was unwitnessed. 9/10/25 Approx. 12:20 a.m.,.E.D. called this nurse and resident does have a fractured right hip and is being transferred to [Hospital Name].A witness statement from Certified Nurse Aide (CNA) A dated 9/9/25 read, in part, I had gone into (R4's) room and told her I would be in ASAP (as soon as possible) to get her in the bathroom. It was super busy and I was way behind. I was also trying to get help to turn [Resident room number].I didn't want (R4) to have to wait any longer so I put her in the bathroom and went to [Resident room number] with CNA B. CNA B walked out and went straight to (R4) and found her on the floor.Review of R4's Care Plans read, in part, .The resident is AT risk for falls r/t (related to) deconditioning dx (diagnosis) right AKA (above knee amputation).Do not leave alone in BR (bathroom) date initiated 10/10/24When CNA A was asked by facility staff if they were aware of R4's care plan intervention to not leave alone in the bathroom, CNA A stated she was not.An interview conducted with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on 9/19/25 at approximately 10:45 a.m. confirmed that CNA A did not follow R4's care plans which contributed to R4's fall and fracture.

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