STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235669	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Manor Rehab Center of Novi Inc	31215 Novi Road Novi, MI 48377

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 # 2714575Based on observation, interview, and record review, the facility failed to implement proper safety interventions to prevent falls for one resident (R501) of three residents reviewed for falls, resulting in a fall with injuries requiring a transfer to the hospital for skin tears and sutures to R501's forehead. Findings include:On 1/20/26 at 11:05 AM, a review of R501's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: a fall with femur fracture, diabetes, chronic obstructive pulmonary disease, urinary tract infection, urinary retention, and adjustment disorder. R501's fall risk assessment calculated on 12/9/25 scored them as an 18, with anything greater than 13 equating a high fall risk.A review of R501's progress notes was conducted and revealed a note entered into the record by Nurse 'D' on 1/7/26 at that read, At around 1:15 am, NOD (nurse on duty) heard a loud sound from (R501's room #). NOD found patients [sic] siting [sic] on floor with her back on the wall, walker in between her legs. Forehead was bleeding, rt. (right) arm skin tear, bilateral legs skin tear. Removed the walker, cleanse [sic] the wound on her forehead and pressure applied. called [sic] 911 .911 came at around 1:30 am and left at 1:45 am.A nursing progress note dated 1/7/26 at 11:20 PM entered into the record by Nurse 'J' was reviewed and read, Post fall Day 1. Night shift nurse reports resident had a fall at around 1:15am and was sent out to (Hospital Name).resident returned to the facility around 8:00am.Resident returned with Sutures [sic] in place to forehead.bruising to left temporal area, Xeroform (wound care treatment) wrapped with kerlix (bulky dressing) to Left lower arm skin tear, steri [sic] strips in place to BLE (bilateral lower extremities).Review of a note entered into the record by Dr. 'I' on 1/9/26 at 4:37 PM was conducted and read, .patient reports mechanical fall approximately four days ago with scalp laceration requiring sutures.A review of a RESIDENT ASSISTANCE FORM completed by R501's family member on 1/14/26 was reviewed and read, WHAT is your complaint about? This fall was preventable if proper safety protocol was followed. A handwritten attachment accompanying the form read, On January 7 2026, at approximately 1:00 AM my.mother, who uses a walker and is recovering from a surgical repair of a broken femur.was being assisted to the bathroom by a facility aide.upon exiting the bathroom and walking toward her bed my mother fell.The aide did not physically support my mother. My mother lost her balance and fell striking her head. She sustained a deep laceration to her.forehead requiring 13 stitches, multiple skin tears.this fall was totally preventable if the aide used the proper safety protocols.A review of a facility provided investigation file regarding R501's fall where R501 alleged CNA (Certified Nurse Aide) 'B' pushed them causing the fall was conducted and contained a typed document that read, .The patient is alert and oriented x2 (person/place) with intermittent confusion. During multiple interviews, the patient provided inconsistent statements regarding the incident.When interviewed with (CNA 'B'), the CNA involved, she denied pushing the resident and stated she did not have her hands on the resident at any point.An interview with (CNA 'C').revealed that (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	the patient expressed she wished (CNA ‘C') had been working that night and stated she would not have fallen if he had been present. When (CNA ‘C') further inquired about the incident and he asked about (CNA ‘B's) positioning, both the patient and the patient's daughter responded that the aide was not close enough to prevent the fall. Further review of the file contained staff education and a document titled, Therapy Terms that read, .CGA=Contact Guard Assist. Needs someone standing keeping their hand on them for safety. Likely using a gait belt. The patient is not safe to walk yet.On 1/20/26 at 12:55 PM, a telephone interview was conducted with CNA ‘B' regarding R501's fall. They were asked to describe how they remembered the incident and said they went in to answer R501's call light and assisted them to the bathroom. They said after they were done in the bathroom, R501 ambulated back to their bed with their walker. They said R501 was positioned with their back to the bed and their walker to the side. They explained that when R501 took a step back to get into bed they lost their balance, became tangled in the walker and fell to the floor. CNA ‘B' said they were not close enough to get a hand on the resident to prevent the fall. CNA ‘B' further volunteered they knew R501 had a red tag on their walker, and that meant they were supposed to provide contact guard (hands on assist) and use a gait belt when ambulating with the resident and they did not provide contact guard assist or use a gait belt when R501 sustained the fall.On 1/20/26 at 1:25 PM, an interview was conducted with the facility's Rehabilitation Director. They indicated R501 required contact guard assist. They were asked what that meant and said someone should be, right there in case something happens. They further explained CNA ‘B' should have had a hand on R501 and likely should have used a gait belt.On 1/20/26 at 1:40 PM, R501 was observed in their room in a wheelchair. A scar was observed on their forehead and yellowing of a healing bruise was observed over their left eye. At that time, an interview was conducted with R501 regarding the fall. R501 said, Everything seems so blurry. They further said they sustained a fall and had to go to the hospital for 13 stitches to their forehead. They were asked if the staff member used a gait belt and said they did not, but they should have. After the interview, R501's walker was observed with a red tag attached that read, CGA (contact guard assist)-Amb (ambulate) with walker.On 1/20/26 at 2:36 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding R501's fall. They indicated R501 was a contact guard assist as indicated by a red tag on their walker. They continued to say staff should have had a hand on R501 or at least near enough to attempt to prevent the fall. They further indicated they encourage the use of gait belts especially if preferred by the resident and/or family.A review of a facility provided policy titled, Fall Prevention Program revised 1/2026 was conducted and read, Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.A review of a second facility provided policy titled, Use of Gait Belt revised 1/2026 was also conducted and read, Policy: It is the policy of this facility to use gait belts with resident that cannot independently ambulate or transfer for the purpose of safety.