

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Huron County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 1116 South Van Dyke Road Bad Axe, MI 48413	

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (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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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a baseline care plan that provided person-centered care to meet the Resident's needs for one resident (Resident #81) of one resident reviewed for baseline care planning. Findings include: Findings include: Resident #81: A review of Resident #81's medical record revealed an admission into the facility on 6/30/25 with diagnoses that included acute respiratory failure with hypoxia, heart failure, and chronic obstructive pulmonary disease. On 7/15/25 at 2:35 PM, an observation was conducted of Resident #81 lying in bed with the head of the bed elevated. The Resident was interviewed, answered questions and engaged in conversation. The Resident was observed with oxygen on wall oxygen per nasal cannula. The Resident reported his oxygen should be at 2 Liters. An observation was made of the oxygen set at just above 2 liters and just under 2.5 liters. The Resident was asked if they had an intravenous (IV) catheter in their arm. The Resident reported having an IV that could not be used, and he had to go out of the facility and get another one put in. The Resident reported he received antibiotics through the IV line. An observation was made of a [NAME] transmitter at the Resident's bedside. On 7/16/25 at 3:48 PM, an interview was conducted with Unit Manager, Nurse E regarding Resident #81's care of the IV catheter. The Nurse reported that the Resident had come into the facility with a Midline catheter for antibiotics for an infection. The Unit Manager reported issues with the catheter and the Resident went out for an IV catheter replacement. The Unit Manager was queried regarding a baseline care plan for the infection and IV catheter. The Unit Manager reviewed the Resident's care plan and determined there was not a care plan for the IV catheter. On 7/16/2 at 4:10 PM, an interview was conducted with MDS Nurse F regarding Resident #81's baseline care planning. The MDS Nurse was asked about Resident #81's baseline care plan for the IV catheter. The MDS Nurse reported that she had been off and had just returned, during her absence, the facility had a remote group helping out with the MDS (Minimum Data Set) assessments and the development of the care plans. The MDS Nurse indicated that the Resident came in with the IV and infection and that both were to be captured on the care plan on admission within a couple days. A review of the care plan revealed a lack of care planning for the IV and infection. A review of facility policy titled, Baseline Plan of Care Summary, reviewed/revised 3/2025, revealed, Policy: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. Procedure: 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. Initial goals based on admission orders. ii. Physician orders. 2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. b. Interventions shall be initiated addressing the resident's current needs including: i. Any health and safety concerns to prevent decline or injury. iii. Any special needs such as for IV therapy, dialysis, or wound care. 3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility to ensure that a urinary catheter bag and tubing were secured off of the floor for one resident (Resident #6) of one resident reviewed for urinary catheters, resulting in contamination, an improperly secured catheter bag and tubing with the likelihood of infection. Finding include:Resident #6:On 7/15/2025, at 1:18 PM, Resident #6 was in the dining room in the wheelchair. They had a urinary catheter bag hooked under their wheelchair. The tubing was secured through their left pant leg near their ankle. There was approximately eight inches of catheter tubing resting on the floor. The catheter bag cover appeared to be touching the floor. On 7/16/2025, at 9:30 AM, a record review of Resident #6's electronic medical record revealed an admission on [DATE] with diagnoses of cancer, Anemia and obstructive uropathy. Resident #6 had severely impaired cognition and required extensive assistance with all Activities of Daily Living. On 7/16/2025, at 4:10 PM, Resident #6 was up in their wheelchair in their room. CNA A assisted the resident via their wheelchair into the main dining room. There was a loop of the catheter tubing exposed and resting on the floor. The tubing was dragged on the floor through the hallway. CNA A assisted the resident to a stationary position in their wheelchair in the dining room and left out of the room. Unit Manager B was alerted of Resident #6's catheter tubing on the floor and Unit Manager B stated, they would get it cleaned and up off the floor. On 7/16/2025, at 4:20 PM, The Director of Nursing was alerted of Resident #6's urinary catheter being on the floor on two separate days. According to CDC.GOV, . Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor . According to Wikipedia, Catheter maintenance . Never placed on the floor, due to the risk of bacterial infection .</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure accurate physician's orders for oxygen administration for two residents (R38, R81) of two residents sampled for respiratory care, resulting in physician's orders without an oxygen flow rate. Resident #38</p> <p>R38 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include pulmonary fibrosis, chronic obstructive pulmonary disease, acute respiratory failure and interstitial pulmonary disease.</p> <p>On 07/17/2025 at 11:39 AM, observation revealed an oxygen concentrator in the hall outside of the room of R38 it was administering oxygen at 6 liters per minute.</p> <p>On 07/17/2025 at 12:05 PM, record review of the physician's orders revealed an order for oxygen administration dated 07/03/2025 that read, Treatment Respiratory: Apply oxygen (per nasal cannula) to maintain O2 sat > or equal to 90%, AM, PM, NOC. The oxygen order did not specify an oxygen flow rate for R38.</p> <p>On 07/17/2025 at 12:25 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked if the physician's orders for oxygen administration should contain a flow rate. The DON replied, I believe our physician's orders are supposed to specify flow rate. The DON reviewed the oxygen administration orders for R38 and other residents receiving oxygen and none of them have flow rates in the orders. The DON stated, I guess none of them have flow rate in the physician's orders. The DON was asked how the staff would know what the flow rate is for a resident on oxygen. The DON replied, If I was a nurse on the floor, I wouldn't know the current rate without checking the last charting. Other than that, I wouldn't know the rate. The DON was asked again if the physician's orders for oxygen administration should contain a flow rate. The DON stated, yes the order should have a flow rate.</p> <p>Review of policy titled, Oxygen Administration, revealed:</p> <p>Procedure:</p> <p>1. Licensed Nurse to obtain physician order for oxygen use with parameters including flow rate, route, and duration. HCMCF has a standing order for the administration of oxygen to maintain oxygen saturation >90%. Physician is to be notified following initiation of oxygen therapy for verification of oxygen order.</p> <p>Resident #81</p> <p>A review of Resident #81's medical record revealed an admission into the facility on 6/30/25 with diagnoses that included acute respiratory failure with hypoxia, heart failure, and chronic obstructive pulmonary disease.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/15/25 at 2:35 PM, an observation was conducted of Resident #81 lying in bed with the head of the bed elevated. The Resident was observed with oxygen on wall oxygen per nasal cannula. The Resident reported his oxygen should be at 2 Liters. An observation was made of the oxygen set at just above 2 liters and just under 2.5 liters.</p> <p>On 7/17/25 at 11:30 AM, an observation was conducted of Resident #81 on the first floor with a visitor. The Resident had oxygen on, and the tank was observed to have oxygen.</p> <p>A review of Resident #81's order for oxygen was dated 7/1/25, "Apply oxygen (per nasal cannula) to maintain O2 sat >or equal to 90% AM PM&hellip;"</p> <p>A review of Resident #81's treatment record for oxygen revealed documentation that the Resident was on 4 L/min (liters per minute) on 7/4, 7/5, 7/6 with oxygen saturation (O2 sat) of 95% to 98%. On 7/7 the oxygen was set at 4 L/min in AM with O2 sat of 98%; 3.5 L/min in PM with O2 sat at 96%; and 4 L/min with O2 sat at 95% at night; the liters/min fluctuated between 3 and 4 l/min with O2 sats ranging from 98% to 94% on 7/8 to 7/10. On 7/11 the oxygen was set at 3 L/min, O2 sat at 98% in AM; 2 L/min O2 sat at 98% in PM; and 4 L/min O2 sat at 4 L/min with O2 sat 98%. From 7/12 to 7/17 the O2 was set at 2L/min with O2 ranging from 93% to 99%. There was not a corresponding oxygen order for the liters/min in the Resident's orders.</p> <p>On 7/17/25 at 12:30 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #81's oxygen order. The DON indicated the oxygen order was to have the liters ordered for oxygen for the Resident.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observation, interview and record review, the facility failed to maintain a sanitary kitchen, ensure that food items were dated with an opened date, that expired food was removed and/or disposed of, and that food temperatures were monitored prior to serving. This deficient practice had the potential to affect all residents who consume food prepared and served from the facility kitchen and kitchenettes of a census of 72 residents. On 7/15/25 at 10:00 AM, a tour of the kitchen was conducted with Dietary Manager C of the facility kitchen. The following items were observed:-The juice dispenser had juice in boxes that were connected to be dispensed. The boxes had a delivery date but did not have an open date. The DM was asked about facility policy and reported they should be dated. The DM reported there was a three-month shelf life after opened.-Cups and lids stacked and on a cart that was covered with a cloth, many of the cups and lids were stacked wet.-Plates were stacked and when observed with the DM, a couple of the plates were stacked wet and the tops for the plates were stacked with some of the tops wet. The DM reported the plates were stacked and ready to go to the floors. The DM reported that the dishes had been washed 20 minutes to a half hour, they were to stay on the rack to dry and stated, Didn't set long enough. -Plastic water containers were observed with a couple containers had debris inside the container. Multiple containers had whitish water sediment on the inside of the container.-Stored water cups stacked together with multiple cups wet.-Two non-stick fry pans with coating missing on the cooking surface.-Dated bread on 7/17. When asked about the date on the bread being today was 7/15, the DM reported that it was bread that was just put out and it should be dated when it was set out. -Container of molasses had a use by date on 1/25. The container of molasses was mostly gone and had molasses on the outside of the container and on the tray where other spices/cooking items were stored and in contact with the molasses debris on the tray.-Drain pipe that led to a sink area where the DM reported where staff spray off the dishes was flush with the floor drain and not elevated above the drain. The DM reported he would have Maintenance department look at it.-Multiple metal pans stacked together with a couple of the pans that were wet.-Freezer had a build up of frost inside the door towards the bottom and there was an area of wetness along the floor at the threshold of the door. The DM was asked if it was a poor seal causing the frost and water on the floor. The DM reported that he would have Maintenance look at the door. The food items inside the door with the frost built up on them appeared to be frozen.-In the walk-in refrigerator section, cucumbers with a receive date of 6/27 were observed in a box that was partially full. Multiple cucumbers were expired with mold growth on the outside of the cucumbers. After the review of the main kitchen area, the kitchenette on the 3rd floor was reviewed with the Dietary Manager. There was bread that was in the cupboard with a use by date of 7/12/25. The DM took the bread out to discard. A couple of ready to use bowls were stacked together with moisture in the bowls. A review of the 2nd floor kitchenette with the Dietary Manager revealed coffee pots with the lids loosely on top and the coffee pots were wet inside; one coffee pot was not clean inside. Bread was discarded by the DM that had a use by date of 7/12/25. A bag of buns with mold on the bottom buns was removed by the DM. The use by date on the packaging was 6/24/25. A review of the food temperature logs in the main kitchen area was reviewed. The logs were in a binder dated 7/7 to 7/14. The documents had an area on one side for temperatures under the title Kitchen the other side of the document read Dining Room. A review of the binder documents revealed the following concerns:-Dated 7/10 no dinner food temperatures were documented. -Dated 7/11, two items for lunch had temperatures documented and there was no dinner temps recorded. -Dated 7/12, No dinner food temperatures were documented.-Dated 7/13, no dinner temps were documented. The DM was asked about the facility policy on monitoring food temperatures prior to serving. The DM indicated that the temps were to be completed at the kitchen before they go to the kitchenettes and then temp again before serving the food up on the floors. A review of other food temperature logs that the DM had from the kitchenettes were reviewed and there was documentation in both areas under kitchen and dining room. [NAME] D reviewed the logs with the Surveyor and it was reported from the cook that when she does the temps, the kitchen side of the document was for the main kitchen and the other side for the floors kitchenette. When she does the temps on the floors, the temps are to go on the right side under dining room. There was one log that was not dated, and the logs did not identify if the temperature logs were from the 2nd floor or the 3rd floor kitchenettes. Copies of the July logs were requested. On 7/16/25 at 1:07 PM, a review of the temperature logs received for the month of July (July 1 to 15) had documents that did not indicate which floor the documents were from. A document with no date had three items with temperatures documented, no</p>		