STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235033	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Bluffs-Emmet County Medical Care Facility	750 East Main Street Harbor Springs, MI 49740

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete an annual performance review at least every 12 months for five Certified Nurse Aides (CNA's) [B, J, K, L, & M] of five CNA's reviewed for performance reviews. This deficient practice resulted in the potential for inadequate care and unmet resident care needs for all 68 residents residing in the facility.Findings include:Review of facility personnel records demonstrated the following:CNA B was hired on 11/11/19 with no performance review.CNA J was hired on 1/8/24 with no performance review.CNA K was hired on 11/6/22 with no performance review.CNA L was hired on 11/7/21 with no performance review.CNA M was hired on 10/13/08 with no performance review.During an interview on 5/13/26 at 8:42 a.m., when queried about staff performance reviews the Nursing Home Administrator (NHA) stated, We have not completed performance reviews of staff since prior to covid.if the staff have their competencies done and are still with us after going through covid that is good enough.Review of policy titled In-Service Training Program, Nurse Aide last approved 7/14/25, read in part .The facility will complete a performance review of nurse aides at least every 12 months. Inservice training will be based on the outcome of the annual performance reviews, addressing weaknesses identified in the reviews.

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
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include:On 05/12/2026 at 7:57 AM observed the kitchen hand sink was slow to drain after washing hands. The Certified Dietary manager (DM) stated that it has been draining slow for a while now and a new hand sink is being installed as soon as maintenance can get to it. According to the 2022 FDA Food Code section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; and (B) Maintained in good repair. On 05/12/2026 at 8:07 AM observed ice condensation buildup on the ceiling and fan cover of the walk-in freezer. The compressor fan was running, and the fan blades were heard hitting the chunk of ice condensation that was frozen into the fan cover.According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. On 05/12/2026 at 8:12 AM observed the in-line water filter for the ice machine with a discharge line extending directly down into the floor drain, without an air gap present.According to the 2022 FDA Food Code section 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed. P

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed toEnsure the use of Enhanced Barrier Precautions (EBP) and safe handling of an indwelling urinary catheter bag during transfers according to current infection control standards for one Resident (#70) of two residents reviewed for catheter care, and Follow through with their plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP), resulting in the potential for increased risk of respiratory infection among all residents in the facility. Findings include: On 5/11/2026 at 1:29 PM, two water fountains were observed on Lilac Lane with clear plastic bags wrapped around them and out of order signs posted above each fountain. During interview at this time with Maintenance Director (MD), X, he stated that both sets of water fountains have not been in use since Covid began in 2020. He stated that the facility had problems with employees dumping liquids into the sinks. He stated that the water to the fountains had been disconnected. When MD X pushed the button on the two fountains, water came out of the water nozzles. Record review of the facility flushing schedule revealed that the water fountains were not included in the flushing schedule. On 05/11/2026 at 3:18 PM the two water fountains on the Lilac Lane were observed to have been removed and a brown sludge was observed running down the walls from the plumbing openings. On 5/11/2026 at approximately 3:15 PM, two drinking fountain units were observed on a metal utility cart on Lilac Lane. A water pipeline was observed exiting the wall in a vacant space where a drinking fountain had just been uninstalled. A brown sludge-like substance appearing to be rust was observed in the bottom of the water pipeline. Resident #70 (R70) Review of the Minimum Data Set (MDS) assessment, dated 5/12/2026, revealed R70 was admitted to the facility on [DATE] and had diagnoses including urinary tract infection (UTI), neurogenic bladder, Parkinson's Disease, and dementia. Review of the electronic medical record (EMR) revealed R70 was hospitalized on [DATE] for urosepsis and returned to the facility on 4/06/2026 with an indwelling, urinary catheter in place. An observation on 5/13/2026 at 8:55 AM revealed a wheeled cart containing personal protective equipment (PPE), including protective gowns and gloves, positioned in the doorway of R70's room. Atop the cart was a Centers for Disease Control and Prevention (CDC) sign indicating the use of EBP (use of protective gown and gloves to prevent the transmission of multidrug-resistant organisms/MDROs) during care of R70. Review of the sign revealed the following: Providers and Staff must . Wear gloves and a gown for the following high-contact resident care activities: Dressing. Bathing/Showering. Transferring. Changing linens. Providing hygiene. Changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. (continued on next page)

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	235033	A. Building B. Wing	05/13/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/13/2026 at 9:05 AM Certified Nursing Assistant (CNA) N and Registered Nurse (RN) O were observed providing wound care to R70. After completion, RN O removed the gown and gloves worn during wound care, performed hand hygiene, applied clean gloves but no protective gown. From the right side of the R70's bed, RN O assisted CNA N in turning the Resident side to side to position a lift sling for transfer, making direct contact with the Resident and soiled bed linens. Once the lift sling was in place, CNA N utilized the lift to raise R70 from the bed at which time RN O stated, Don't forget the catheter bag. CNA N was then observed to unhook the dependent drainage bag from the bed frame. CNA N held the drainage bag in her left hand as she reached up to grasp the arm of the lift to turn the resident to be seated in the wheelchair. It was noted the position of the dependent drainage bag was held approximately 12 inches above R70, until he was lowered to the wheelchair, at which time the bag was attached to the underside of the wheelchair seat. During the transfer, RN O was observed standing behind the wheelchair to guide R70 while he was lowered into the chair. RN O and CNA N then both worked to remove the lift sling from under R70. RN O did not don a protective gown at any time during the transfer of R70. During an interview immediately following the transfer, RN O was queried regarding the indication for the use of EBP. RN O stated EBP was to be utilized, Any time there is exposure to the wound or when handling the catheter. RN O reported EBP was not indicated during the transfer of R70 from the bed to the wheelchair. When queried regarding the position of R70's urinary catheter drainage bag during the transfer she stated the position of the bag should be always held below the level of the bladder. During an interview on 5/13/2026 at 9:35 AM, CNA N was asked if she was aware of the need to ensure urinary catheter bags were held below the position of the resident during transfers. CNA N reported she was aware of the need and stated, But he [R70] is hard to maneuver due to his pain. Review of R70's April 2026 Medication Administration Record (MAR) revealed the following undated order: Enhanced barrier precautions r/t [related to] foley catheter. Review of R70's comprehensive care plan revealed the following: I have an indwelling medical device. I am at risk for acquiring a MDRO . Use enhanced barrier precautions (EBP) with me during prolong closed [sic] contact during personal cares, such as: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting. Date Initiated: 4/07/2026. Review of the facility policy titled, Appropriate Use of Indwelling Catheter, Last revised 3/21/2025, revealed the following: Additional care practices include . securement of the catheter to facilitate flow of urine, prevent kinks in the tubing and positioning below the level of the bladder . Review of the facility policy titled, Enhanced Barrier Precautions Policy, last revised 3/24/2025, revealed the following: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms . PPE for enhanced barrier precautions is only necessary when performing high-contact care activities . High-contact care activities include: . Transferring .

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure training of no less than 12 hours per year was completed for five Certified Nurse Aide (CNA's) [B, J, K, L & M) of five CNA's reviewed for nurse aide training hours. Findings include:During an interview on 5/13/26 at 7:41 a.m., the Director of Nursing (DON) reported the 12-hours of training in a year is based on the CNA's hire date. The DON acknowledged the facility uses online training.Review of facility documents provided by the Nursing Home Administrator (NHA) revealed the following:CNA B was hired on 11/11/19 with 9.25 hours of training from 11/11/24-11/2/25CNA J was hired on 1/8/24 with 5.75 hours of training from 1/8/24-1/8/25.CNA K was hired on 11/6/22 with 7.25 hours of training from 11/6/24-11/7/25.CNA L was hired on 11/7/21 with 9.25 hours of training from 11/7/24-11/8/25.CNA M was hired on 10/13/08 with 10 hours of training from 10/13/24-10/31/25.During an interview on 5/13/26 at 9:45 a.m., the NHA reported the facility uses online training and presented the printouts of the online training for CNA'S (B, J, K, L, and M) which verified the above total hours of training for each CNA.Review of policy titled In-Service Training Program, Nurse Aide last approved 7/14/25, read in part .All personnel are required to complete in-service training.annual in-services must:.be no less than 12 hours per employment year [based on hire date].address areas of weakness as determined by nurse aide performance reviews.[online training name] can be assigned in a group of courses or individual courses for employees.

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F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid. Based on interview and record review, the facility billed for a personal room telephone which was not present for one Resident (#25) of one resident reviewed for billed services.Findings include:Resident #25 (R25) During a room visit on 5/11/2026 at 4:12 PM, R25 and her Durable Power of Attorney (DPOA) stated they had concerns of improper billing for telephone services. They stated, The facility continues to charge us for a phone (R25) is not using. The DPOA stated R25 came into the facility last November. The DPOA indicated he paid the bills and had spoken to the office. Each month they continued to charge for a phone, and she did not have one. Upon inspection of the room, no telephone was present.During an interview on 5/12/2026 at 10:08 AM, Administrative Staff A stated, Everyone pays $23.00 (for a telephone) if not on skilled care. The admission packet should explain that. When asked if a resident did not have a phone in their room would there be a charge, Staff A said, If no phone is in their room the resident can use the phone at the desk, but there would not be a charge to their bill. Staff A stated R25 had a phone as a recent audit of telephones had taken place. On 5/12/2026 at 10:15 AM, R25's room was observed again. R25 was present and said, I don't have a phone; they took it out of my room when I first got here several months ago. No phone was present.During an interview on 5/12/2026 at 10:19 AM, Certified Nurse Aide (CNA) B said she did not think R25 ever had a phone.During an interview on 5/12/2026 at 10:22 AM, Licensed Practical Nurse (LPN) C stated, She (R25) had a phone when she first got here. She said she could not hear out of it, so they took it out (of her room). I believe they tried another, but she never could use it. LPN C said, Her (R25) hearing is quite bad. So, they took it out and I don't believe she has one now.On 5/12/2026 at 11:26 AM, the billing statement of 5/1/2026 for R25 was presented by Staff A. It was reviewed and did contain a charge of $23.00 for Phone.

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	235033	A. Building B. Wing	05/13/2026

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide information of pending changes in Medicare coverage and the right to appeal this decision for one Resident (R81) of three residents reviewed for reception of a Notice of Medicare Non-coverage (NOMNC) form.Findings include:On 5/12/2026 at 9:30 AM, the Beneficiary Notice - Residents discharged within the Last Six Months worksheet was received from the facility with 14 residents listed as discharged . Three Residents were selected to determine if the facility provided timely NOMNC.During an interview on 5/12/2026 at 10:07 AM, Administrative Staff A stated she did not find a NOMNC for R81.During a follow up interview on 5/12/2026 at, Staff A confirmed, We looked high and low and do not have it.The facility policy titled Advance Beneficiary Notice dated as Last Revised 12/16/2025 read in part, It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2979976.Based on interview and record review, the facility failed to ensure residents were free from misappropriation of resident property when a dose of controlled pain medication was diverted from one Resident (#75) of one resident reviewed for misappropriation. This deficient practice resulted in the potential for ongoing or increased pain and anxiety.Findings include:Resident #75 (R75)Review of the Minimum Data Set (MDS) assessment, dated [DATE], revealed R75 was admitted to the facility on [DATE] for hospice services with a primary diagnosis of end stage lung cancer. Further review revealed the following pain assessment documented under Section J Health Conditions:Have you had pain or hurting at any time in the last 5 days? Yes. How much of the time have you experienced pain or hurting over the last 5 days? Almost constantly. Over the past 5 days, how much of the time has pain made it hard for you to sleep at night? Almost constantly . Please rate the intensity of your worst pain over the last 5 days. Severe.Review of a Facility Reported Incident (FRI), submitted to the State Agency (SA) on [DATE] at 2:54 p.m. revealed the following: On [DATE] [2026] the resident relocated from the Birch Neighborhood to a suite on the Apple Blossom Neighborhood to provide more room for family to be with him overnight. On this date, an order for Morphine Sulfate ER [long-acting opioid pain medication] 30 MG [milligram] was to begin during the morning shift, scheduled for administration twice per day, to address consistent pain management. The first dose was administered as ordered with the day shift nurse accessing the medication from the back-up Cubex [secure back up medication supply] as the routine medication would arrive with the pharmacy delivery later in the evening. That evening the [R75's] son requested [Registered Nurse (RN) U] address his father's pain to which she responded that she could not give any long acting medication due to it being unavailable until after midnight from the pharmacy . On the morning of [DATE], the resident's son shared his concern with the Neighborhood Coordinator [RN D], that the long-acting medication had not been able to be administered. [RN D] immediately began an investigation, evaluating the comfort level of the resident and reviewing medication orders . Neighborhood nurse interviews were conducted with the day shift nurse, [LPN T] and the night shift nurse, [RN U]. [LPN T] . indicated she witnessed the [RN U] retrieve the [evening] dose of the medication . from the Cubex for administration of the evening dose, as would be expected, as the pharmacy would arrive with the routine medication card after the scheduled dose administration time. [LPN T] did not witness the administration of the medication. Upon conducting a phone interview with [RN U], the DON [Director of Nursing] and [Human Resources] Director requested the night nurse [RN U] complete a drug test as her description of the discussion with family and med administration did not match the day-shift nurse report or evidence from the medication administration audit conducted by the DON. The test was set up by the HR Director and she was instructed to complete the test by 5:00 PM on [DATE]. The nurse failed to complete the drug test on [DATE] and was given until noon on [DATE] to complete the test. The nurse failed to complete the required drug test and has not made contact with the facility since the morning of [DATE]. The employment of this nurse has been terminated as of [DATE]. Due to the refusal of the night nurse to cooperate with the investigation and the fact that the medication was not found, destroyed, wasted or reported lost, it is suspected that the medication intended for this resident may have been diverted, resulting in misappropriation of resident property . The Administrator and HR Director reported the suspicion of drug diversion to the [law enforcement] on [DATE] . A complaint filed with the [state licensing body] regarding the employment status of the nurse in question due to the suspicion of diversion as of [DATE].During an interview on [DATE] at 10:37 a.m., Human Resources Director, Staff V reported no current contact information was available for RN U. Staff V reported RN U had severed all contact with the facility during investigation of missing pain medication and after failing to show for two scheduled drug tests ordered as a condition of continued employment.During an (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on [DATE] at 4:15 p.m., RN D confirmed R75's son had reported to her the Resident did not receive his long-acting pain medication on the evening of [DATE]. RN D stated the resident's son was very attentive and knew what R75's medications looked like and he reported when he asked RN U about the missing medication, she reported they would have to wait until the pharmacy arrived with the medication later in the evening. RN D reported the facility had a back-up supply of medication for use when new medications had yet to arrive from the pharmacy. RN D reported the incident to the DON.Review of the facility investigation documents revealed the following interview summary conducted by the DON on [DATE]: 3:30 PM [RN U] . stated that she removed 2 tabs of MS ER [morphine sulfate extended release] 15 mg from the Cubex but could not locate the order on the MAR. She claimed [LPN T] assisted her in searching for the order between 7:30 PM and 8:00 PM. [RN U] asserted that she did administer the medication around 9:30 PM - 10:00 PM while the resident's son was present, but intentionally omitted the documentation .Further review of the facility investigation documentation revealed a written statement signed by LPN T on [DATE]: On the evening of [DATE] at approx. [sic] 1930 [7:30 p.m.], this nurse went to the Cubex with the NOC [night shift] nurse to pull [R75's] MS ER. Together we pulled two 15 mg MS ER tablets for HS [bedtime] administration as medication had not arrived from [pharmacy] . NOC shift nurse was in possession of medication after pulling this from the Cubex .Review of R75's [DATE] Medication Administration Record (MAR) revealed an order for Morphine Sulfate ER Oral Tab 30 MG, Give 1 tab by mouth two times a day for cancer pain. To start 3/9 in a.m. Start Date: [DATE] 0600. Further review revealed the first dose was documented as administered for the AM dose on [DATE] but the PM dose remained incomplete, indicating the order was present on the MAR for administration the morning of [DATE].Review of the Cubex access records revealed two MS ER 15 mg tablets were removed from the facility back up supply (Cubex) by RN U and LPN T on [DATE] at 7:34 p.m.Further review of R75's electronic medication record (EMR) revealed no significant change in the Resident's pain level after missing the scheduled evening dose of MS ER 30 mg on [DATE]. R75 expired under hospice care at the facility on [DATE].During an interview on [DATE] at 12:05 p.m., the DON and NHA reported RN U's refusal to participate with the drug screen during the facility investigation into the missing MS ER 15 mg tablets presented the assumption that the medication was diverted by the RN.Review of the facility policy titled, Abuse, Neglect, & Exploitation Prevention Program Policies & Procedures, effective [DATE], revealed the following: . Residents have the right to be free from . misappropriation of their property . Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of resident's belongings or money without the resident's consent.During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included:An audit of all transactions from the Cubex and narcotic proof of use logs for the past 30 days as compared to the MARs.Blind audits of narcotics in the back-up medication system.Review and revision of policies related to medication administration, controlled substance management, and access to the back-up medication system to include procedures on accessing narcotics, documentation requirements, two-nurse verification requirements, and reconciliation of narcotic counts.Staff education on new procedures for narcotic removal from the back-up supply, medication administration documentation and narcotic reconciliation.Pharmacy consultation, review and approval of procedures.Implementation of weekly reconciliation of the back-up medication supply records with the MARs.The facility was able to demonstrate monitoring of the corrective action and maintained compliance as of [DATE].

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide written notifications of transfers and bed holds, and provide requisite resident information to the receiving provider for three Residents (#13, #8, & #70) of four residents reviewed for hospitalizations.Findings include:Resident #13: On 5/11/26 at 12:44 PM, R13 was sitting in a wheelchair in his room with an oxygen concentrator next to his bed. An oxygen mask was atop the concentrator. R13 said he went to the hospital a few weeks ago because he couldn't breathe. Review of the electronic medical record (EMR) revealed R13 was admitted to the facility on [DATE] with diagnoses that included but were not limited to heart failure, atrial fibrillation, chronic kidney disease, and presence of a cardiac pacemaker. A Minimum Data Set (MDS) assessment dated [DATE] documented R13 required staff assistance for Activities of Daily Living (ADL), received anticoagulant medication, was on insulin for diabetes, had two pressure injuries, and had an indwelling urinary catheter. A progress note dated 4/28/26 at 8:52 PM documented R13 experienced shortness of breath, a productive cough, and difficulty with respirations. The progress note described R13 as diaphoretic and utilizing accessory muscles for breathing. R13 was subsequently sent to the hospital emergency department (ED) on 4/28/26. Written notifications of transfer and bed hold were not located in the EMR of R13, nor were these documents referenced in the EMR. An Interact Transfer document titled SNF/NF to Hospital Transfer Form was dated as completed on 4/29/26 but contained an effective date of 4/28/26. The Interact Transfer document did not include R13's usual functional status, primary admission diagnosis, use of an indwelling urinary catheter, presence of pressure injuries, medications including when last received, diet order, use of insulin, risk for bleeding including the use of anticoagulant medication, or relevant lab or diagnostic test information. The EMR did not indicate the Interact Transfer document had been provided to the ED when R13 was transferred. There was no documentation in the EMR detailing what resident-specific information was provided to the ED when R13 was transferred. The Nursing Home Administrator (NHA) was interviewed on 5/12/26 at 11:47 AM. The NHA said she was monitoring for written notifications of transfer and bed hold and acknowledged there were no written notifications provided when R13 was transferred to the ED on 4/28/26. The NHA confirmed there was no documentation indicating information was provided by the facility to the ED on 4/28/29 regarding R13. Resident #8 (R8) An MDS assessment dated of 1/26/26 documented R8 was admitted to the facility on [DATE] with a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235033	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	primary medical condition of debility, and cardiorespiratory conditions. Section C Cognitive Patterns, assessed R8 with severe cognitive impairment and coded R8 as requiring staff assistance with ADLs. The EMR of R8 included physician's orders for blood glucose monitoring and an order for hypoglycemic medication. A progress note in the EMR dated 3/16/26 at 7:01 PM documented R8 was transferred to the ED for hematochezia (the passage of fresh, bright red blood in the stool indicative of bleeding from the lower gastrointestinal tract). The Interact Transfer document titled SNF/NF to Hospital Transfer Form did not include R8's primary diagnosis for admission to the facility, usual functional status of ADLs, usual mental/cognitive status, diet order, or medications including date and time of last medication administrations. Written notifications of transfer and bed hold were not located in the EMR of R8, nor were these documents referenced in the EMR. The EMR did not indicate the Interact Transfer document had been provided to the ED when R8 was transferred. There was no documentation in the EMR detailing what resident-specific information was provided to the ED when R8 was transferred. On 5/13/26 at 7:57 AM, the NHA said she was unable to confirm the resident information was provided to the ED when R8 was transferred to the hospital. The NHA said written notifications of transfer and bed hold were not issued when R8 went to the ED on 3/16/26. The policy Resident Transfer and Discharge - Including AMA dated as last revised 12/23/25 documented, in part: . For a transfer to another provider, for any reason, the following information must be provided to the receiving provider: a. Contact information of the practitioner who was responsible for the care of the resident; b. Resident representative information, including contact information; c. Advance directive information; d. All other information necessary to meet the resident's needs, which includes, but may not be limited to: i. Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs; ii. Diagnoses and allergies; iii. Medications (including when last received); and iv. Most recent relevant labs, other diagnostic tests, and recent immunizations. e. Additional information, if any, outlined in the transfer agreement with the acute care provider . Resident #70 (R70) Review of a Progress Note gleaned from the EMR, dated 3/30/2026, revealed R70 was emergently transferred to an acute care hospital for evaluation on 3/30/2026 related to suspected sepsis. Further review of the EMR revealed R70 was subsequently hospitalized with return to the facility on 4/06/2026. Review of the EMR revealed no evidence that written notification of transfer/discharge or written notification of the facility's bed hold policy were provided to R70 or his representative for the referenced transfer on 3/30/2026. On 5/12/2026 at 4:25 p.m. the Neighborhood Coordinator, Registered Nurse (RN) D, was queried regarding the facility process for provision of the written notification of transfer/discharge and bed hold policy. RN D reported nursing does not provide written notifications. Instead, residents and their representatives were verbally provided with information at the time of transfer regarding the need for (continued on next page)

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	235033	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Bluffs-Emmet County Medical Care Facility	750 East Main Street Harbor Springs, MI 49740

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer and asked if they would like to hold a bed. During a record review at the time of the interview, RN D referenced the following Progress Note: 3/30/2026, 16:20 [4:20 p.m.]. Resident's sister and DPOA [Durable Power of Attorney, name redacted] notified via [sic] of condition change and physician order to send to ER for suspected sepsis. [DPOA] verbally agrees to send [R70] to hospital for evaluation and treatment and to hold bed . It was noted there was no documentation of notification provided, in writing, of the reason for transfer or of what information was relayed regarding the facility bed hold policy, including how long the bed would be held and reserve bed payment information. During an interview on 5/13/2026 at 4:25 p.m., the DON reported nursing staff were responsibility for verbally notifying resident representatives via telephone of the reason for transfers and information regarding bed hold requirements. The DON confirmed that no written notification or bed hold policy was provided by nursing staff. On 5/13/2026 at 10:00 a.m. the Nursing Home Administrator (NHA) was queried regarding the facility procedure for providing notification of transfer/discharge and the facility bed hold policy. The NHA reported the facility did not provide written notifications to residents or their representatives for emergent transfers or hospitalizations. Review of the facility policy titled, Resident Transfer and Discharge – Including AMA, last revised 12/23/2025, revealed the following: Transfer and Discharge include movement of a resident to a bed outside of the certified facility whether . The facility transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand . Generally, the notice must be provided at least 30 days prior to a transfer or discharge. Exceptions to the 30-day requirement apply when the transfer or discharge is affected because . The immediate transfer or discharge is required by the resident's urgent medical needs . In these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, and LTC ombudsman as soon as practicable before the transfer or discharge.

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	235033	A. Building B. Wing	05/13/2026

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Bay Bluffs-Emmet County Medical Care Facility	750 East Main Street Harbor Springs, MI 49740

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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 interview and record review, the facility failed to ensure pressure injury assessments and wound measurements were consistently documented and treatments were completed as ordered by the physician for one Resident (#13) of four residents reviewed for pressure injuries.Findings include: Resident #13 (R13)During an interview on 5/12/26 at 8:02 AM, R13 was observed sitting in a recliner in his room. R13 indicated he had wounds on both buttocks. He said the wounds had previously healed but had re-opened. No pressure reduction cushion was visualized in the recliner beneath R13. When asked if he had a chair cushion on the recliner, R13 said the cushion was in his wheelchair. A pressure reduction cushion was observed in a wheelchair on the other side of R13's bed.Licensed Practical Nurse (LPN) P was interviewed on 5/12/26 at 10:46 AM. LPN P said R13 was admitted to the facility in April 2026 with two stage 2 pressure injuries (Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer). LPN P said R13 went to the hospital and returned with worsening of the wounds, and the documentation of monitoring was in the Skin/Wound notes in the EMR of R13 and in the weekly skin assessment documentation.On 5/12/26 at 2:11 PM, Registered Nurse (RN) Q and Certified Nurse Aide (CNA) R assisted R13 from his recliner into his bed so treatments to his wounds could be completed R13 said he had been in the recliner for 2-3 hours. He said, Sometimes I'm in it a lot longer than that. There was no cushion observed in the recliner R13 had just vacated.RN Q and CNA R positioned R13 on his right side. R13 was observed to have a shallow, linear dark purple area of deep tissue injury on his left buttock from superior to the gluteal cleft down to near his scrotum. The right buttock had a linear, shallow stage 2 pressure injury along the lateral gluteal cleft.The electronic medical record (EMR) revealed R13 was admitted to the facility on [DATE] with wounds to his bilateral buttocks. A Skin/Wound note in the electronic medical record (EMR) dated 4/20/26 at 8:05 PM documented, in part: .Wound bed is minimal depth, scant amount of bleeding. Open area is 8.5 cm [centimeters] x [by] 4.5 cm [length and width, respectively] on left [buttock], 7 cm x 2.5 cm on right side [buttock].R13 was transferred to the hospital emergency department [ED] on 4/28/26 and returned to the facility on 4/30/26. A Skin/Wound note in the EMR dated 4/30/26 documented, in part: . Returned from hospital stay w/ [with] worsened pressure/shearing wound on bilat buttocks and intergluteal cleft. Right side from intergluteal cleft to widest area of wound measuring 5.5 cm With [sic] total length along cleft 15 cm.Left side wound bed measures 6 cm at widest and joins w/ right side at intergluteal cleft measuring 15 cm. This wound has worsening areas of pressure with > [greater than] 20% dark purple, non-blanching [indicates impaired blood flow and tissue damage]. Suspected unstageable deep tissue injury [pressure-induced damage to underlying tissues, such as muscles, bones, and subcutaneous layers that may initially appear as intact skin with discoloration] .The EMR of R13 did not contain wound assessments after 4/30/26.The last skin assessment in the EMR was recorded on 4/30/26. The skin assessment on 4/30/26 documented a stage 2 pressure injury [partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer] on left buttock, unstageable on right buttock. The left buttock was measured at 15.0 cm x 6.0 cm x 0.1 cm (length, width, depth respectively). The right buttock measured 15.0 cm x 5.5 cm x 0.1 cm.After 4/30/26, pressure injury assessments and documentation were absent related to monitoring of the pressure injuries including wound measurements, drainage, appearance, and healing progress.During an interview on 5/12/26 at 2:44 PM, RN S expressed she was the nurse manager. RN S reviewed the EMR of R13 and confirmed no wound assessments, no wound monitoring, and no skin assessments had been completed since 4/30/26 despite documented worsening of the wounds when R13 returned from the hospital on 4/30/26. When asked why pressure injury assessments and skin assessments had not been completed to assess for new pressure injury development or worsening of the existing pressure injuries, RN S said she did not know.Review of the Treatment Administration Record (TAR) of April 2026 revealed R13 did not have treatment orders for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235033	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the wounds on his bilateral buttocks until 4/22/26, 2 days after the initial admission to the facility. Physician orders were obtained on 4/22/26 for daily treatments for the pressure injuries. The April TAR revealed the daily treatments were completed two times (4/22/26 and 4/26/26) from the admission date of 4/20/26 until R13 was transferred to the ED on 4/28/26.The TAR for May 2026 contained no documentation for daily treatments being completed on 5/6/26 and 5/8/26 as ordered by the physician. Further review of the May TAR revealed the treatments were changed to twice daily treatments on 5/8/26. The twice daily treatments were not documented as completed on 5/8/26 and 5/11/26 in accordance with physician orders.There was no documentation in progress notes or the EMR to indicate the missing treatments in April and May were performed, refused, or otherwise unable to be completed.The Director of Nursing (DON) was interviewed on 5/13/26 at 9:40 AM. The DON said wounds were expected to be assessed at least weekly and documented in Skin/Wound notes in the EMR. The DON said nurses were expected to complete skin assessments weekly and document in the EMR. The DON confirmed treatments were expected to be completed as ordered by the physician and documented on the TAR.The policy titled Pressure Injury Prevention and Management dated as last revised 5/19/25 read, in part: .Licensed nurses or trained designee will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and as needed due to change in condition. Findings will be documented in the medical record. Assessments of pressure injuries will be performed by a licensed nurse, and documented in the EMR.Compliance with interventions will be documented in the weekly skin / wound assessment charting. The RN Unit Manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly

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	235033	A. Building B. Wing	05/13/2026

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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. Based on observation and interview, the facility failed to maintain safe water temperatures in the resident's environment. Findings include:On 05/11/2026 at 12:4 2PM, when asked about hot water temperatures at hand sinks, Dietary Manager (DM) stated the hot water at the hand sink should not be above 140 degrees and then corrected herself and said it should not be above 120 degrees. A temperature was taken of the hot water at the hand sink in the Trillium Dining Room and was observed at 147 degrees. The DM said that this sink could be used by the residents. Three residents were observed in the dining room, and a resident was noted in a wheelchair passing directly in front of the hand sink. Record review of the facility's temperature monitoring revealed that this sink temperature is not monitored or documented on a log sheet on a routine basis.

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	235033	A. Building B. Wing	05/13/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the clinical record documented a medical condition justifying the continued use of an indwelling urinary catheter for one Resident (#8) of four residents reviewed for urinary catheters.Findings include:Resident #8 (R8)On 5/11/26 at 12:04 PM, R8 was observed with catheter tubing extending from under a blanket. The catheter tubing was draining light yellow urine with sediment. When asked the reason for the urinary catheter, R8 said he did not know the reason for the catheter. R8 moved freely in the bed without signs or symptoms of pain or discomfort.Review of the clinical record revealed R8 was transferred to the hospital on 3/16/26 without a urinary catheter and returned to the facility with a urinary catheter on 3/23/26.A Minimum Data Set (MDS) assessment dated [DATE], prior to the hospitalization of R8, did not document the use of an indwelling urinary catheter. The MDS coded R8 as always continent of bowel and bladder.Review of the most recent MDS with an assessment reference date of 3/31/26 indicated R8 utilized an indwelling urinary catheter; however, the assessment did not identify a qualifying medical condition supporting catheter use.Review of physician orders identified an order for urinary catheter changes, but the order did not include a diagnosis, clinical condition, or reason indicating the need for the catheter.A diagnosis of urinary retention was added to R8's list of diagnoses on 3/23/26 when R8 returned from the hospital, but review of Electronic Medical Record (EMR) including R8's comprehensive assessment, care plan, progress notes, physician documentation, and hospital records failed to identify a medical diagnosis or clinical condition indicative of the need for continued use of an indwelling urinary catheter.A progress note dated 5/12/26 at 2:36 PM indicated R8 was irritated by the urinary catheter and referred to the catheter as a piece of wood in his private area. The note read, in part: .He was talking to RN about the piece of wood in his private area. Realized that he was referring to the Foley catheter and let him know that it is a silicone catheter in place to drain the urine from his bladder.On 5/13/26 at 8:18 AM, Licensed Practical Nurse (LPN) T said R8 came back from the hospital with the catheter and did not have a catheter prior to hospitalization. LPN T said R8 was voiding sufficiently prior to going to the hospital and had no history of urinary retention. LPN T said the decision was made to keep the catheter because R8 was having a large amount of urinary output.During an interview on 5/13/26 at 9:39 AM, the Director of Nursing (DON) said she did not know R8 well enough to speak on the catheter and requested questions be directed to the nurse manager. The DON said the facility should have documentation identifying the medical reason for an indwelling urinary catheter.The nurse manager, Registered Nurse (RN) D, was interviewed on 5/13/26 at 9:43 AM. RN D said she did not know if R8 had an indwelling urinary catheter in place prior to hospitalization because R8 was on a different unit prior to being sent to the hospital. RN D confirmed there had been no trial discontinuance of the urinary catheter since R8 was readmitted from the hospital. When asked the reason R8 had a urinary catheter, RN D said R8 had a catheter because he was on hospice and was not getting out of bed as often as he was before he was hospitalized .RN S was interviewed on 5/13/26 at 10:03 AM. RN S verified she was the nurse manager on the unit where R8 resided prior to hospitalization. RN S confirmed R8 never had a urinary catheter prior to the hospitalization. RN S said she would review paperwork from the hospital to ascertain the reason for the catheter and determine if R8 experienced urinary retention while in the hospital.On 5/13/26 at approximately 11:13 AM, RN S reported she was unable to determine the reason R8 returned from the hospital with the urinary catheter and the reason R8 was given a new diagnosis of urinary retention. RN S reported there was no documentation indicating R8 had urinary retention. RN S acknowledged the medical record for Resident R8 did not contain documentation supporting the continued use of the catheter.The surveyor reviewed 118 pages of hospital documentation. No documentation was found to indicate the medical necessity or clinical indication to justify the use of the urinary catheter.The (continued on next page)

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	235033	A. Building B. Wing	05/13/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility policy regarding urinary catheter use, Appropriate Use of Indwelling Catheters dated as approved on 4/1/26, directed staff to ensure indwelling urinary catheters were used only when medically necessary and that the medical record documented clinical indication for catheter use. The policy read, in part: .An indwelling urinary catheter will be utilized only when a resident's clinical condition demonstrates that catheterization was necessary. Residents. who are admitted with an indwelling urinary catheter, or residents who subsequently receive and indwelling catheter, will be assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary. The use of an indwelling urinary catheter will be in accordance with physician orders, which will include the diagnosis or clinical condition making the use of the catheter necessary.

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	235033	A. Building B. Wing	05/13/2026

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain general repair of one exterior door, resulting in the potential for pest entry. Findings Include: On 05/12/2026 at 10:00 AM observed the door sweep missing from the base of the maintenance door and approximately a half inch of daylight visible underneath. The exterior door sweep on the vendor entrance door was damaged and partially detached from the base. The Maintenance Director MD said that they do have occasional mice but felt those were getting in from the attic areas, and that pest traps were kept up there to prevent the pests from getting down into the facility.