

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Bay County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 564 West Hampton Road Essexville, MI 48732	

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake 2660956. Based on interview and record review, the facility failed to protect the one (#701) resident's right to be free from sexual abuse by another resident of three residents reviewed resulting in a non-verbal, severely cognitively impaired resident (#701) having their genital area touched by Resident #702, and staff not immediately separating the residents. Findings include: Review of Facility Reported Incident (FRI) documentation revealed on 10/12/25 at approximately 11:37 AM, the Administrator was informed of allegation of sexual abuse involving Resident #701 and Resident #702. Per the FRI, Resident #702 is Resident #701's father and was witnessed by staff with their placed on (Resident #701's) groin region. An interview was conducted with the Director of Nursing (DON) on 12/18/25 at 10:00 AM. During the interview the DON verbalized the facility switched Electronic Medical Record (EMR) system from Matrix to Point Click Care (PCC) on 10/1/25. Review of facility provided investigation documentation related to the FRI included the following: - Five Day Investigative Summary of Incident which included a recapitulation of resident information, staff statements, resident interviews, and actions taken by the facility including implementation of a 1:1 staff member for Resident #702, Resident #701 moving rooms to a different unit of the facility and follow up review/monitoring by the facilities Quality Assurance and Performance Improvement (QAPI) Committee. - Memo to Nursing Staff re: All Staff dated 10/13/25. The Memo was entitled, Immediate Action Required for Inappropriate Resident Contact and specified, If any staff member observes a resident attempting to inappropriately touch another resident, it is critical that the following steps are taken immediately: 1. Intervene and separate the residents without delay. 2. Ensure the safety and dignity of both individuals. 3. Stay with the resident(s) involved until a supervisor or appropriate clinical team member can assess the situation and determine next steps. 4. Document the incident thoroughly and report it according to facility protocol. - Copy of email documentation from the DON to facility staff dated 10/13/25 at 2:02 PM which detailed, (Resident #702) IS NOW a 1:1 INDEFINATELY. I want the 1:1 to stay far pay and just make sure he is not going into other rooms or touching any other residents inappropriately. (Resident #701) did move rooms. WE DO NOT want (Resident #702) brought up to see (Resident #701). If (Resident #702) wants to see (Resident #702) then she will have to come to. dining room and not his room and the 1:1 stays the whole time. - Documentation of staff education/training with signed Staff In-Service/Meeting sign-in sheets and Sign-In Sheets pertaining to the memo, email communication, and facility protocol for abuse were included. - Interview forms with other residents on the unit with the questions, Do you feel safe here? and Have you ever had an interaction with another resident that made you feel unsafe? - Written, signed statement from Certified Nursing Assistant (CNA) A dated 10/12/25. The statement detailed, I (CNA A) saw (Resident #702) rubbing his daughter (Resident #701's) private area. Once I was seen coming, he removed his hand. I reported to the nurse who then went to approach him and was seen with his hands on (Resident #701's) private area and quickly moved his hand. - Written, signed statement from Registered Nurse (RN) C dated 10/12/25. The statement specified, At approximately 11:30, I was made known by (CNA A) that (Resident #702) was inappropriately touching his daughter (Resident #701) in the groin area. As (Resident #702) saw me coming closer, he pulled his left hand back. I then confronted him asking if he was just touching (Resident #701) to which he responded, 'That's my daughter.' (Resident #702) then self-propelled to the back of the dining room to look out the window. (Resident #701) was then transported to her room for a skin assessment. On 12/18/25 at 12:00 PM, Resident #701 was observed in the dining/central room area of the unit. The Resident was reclined in a Broda chair (specialized, highly adjustable wheeled chair with solid leg rests and increased upper body support for positioning). Resident #701 did not respond verbally when spoke to and did not make eye contact. An interview was completed with Licensed Practical Nurse (LPN) B on 12/18/25 at 12:02 PM. When queried regarding communication with Resident #701, LPN B stated, Never heard (Resident #701) talk. When asked if the Resident responds non-verbally to communication, LPN B responded the Resident has made eye contact when I feed them. LPN B was then asked if Resident #702 comes to the unit to see Resident #701 and revealed they had not seen Resident #702 come to see Resident #701. LPN B continued, It was requested that we would take (Resident #701) down there (unit where Resident #702 resides) to visit for the first week or so. When queried, LPN B revealed they were aware of the incident that occurred involving Resident #'s 701 and 702 but did not observe anything themselves. Record review revealed Resident #701 was originally admitted to the facility</p>		