STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235044	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay County Medical Care Facility	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Numbers 2716028, 2716054 and 2723179.Based on observation, interview and record review, the facility failed to ensure that staff followed 2 resident's (Resident #101 and Resident #104) plans of care for safe transfers of 5 residents reviewed, resulting in falls with a fracture, and a head injury, with hospitalization.Findings Include: Resident #101:Review of the Face Sheet, physician orders and care plans dated 9/2018 through current, revealed Resident #101 was 88 years-old, admitted to the facility on [DATE], had cognitive impairment, required assistance with all Activities of daily Living/ADL's and was a two person assist for all transfers. The residents diagnosis included, Vascular Dementia with behaviors, Stroke with Hemiplegia and weakness of the right side, and Heart Disease. Review of the facility Accident/Incident report dated 12/27/25, revealed on on 12/27/25 at 5:15 a.m., Nursing Assistant/CNA I was assisting the resident to bed by her self. CNA I lifted the resident up from the wheelchair, and she started screaming, CNA I immediately sat her on the bed. The nurse assessed the resident and no pertinent signs of injury were noted. At the next shift, she was assessed again due to complaints of right knee pain, with bruising and slight swelling noted; the resident was transferred to the hospital for evaluation. The resident returned to the facility with a non-displaced fracture of the right Fibula. CNA I was interviewed and said she had not followed the residents plan of care, she lifted her herself. CNA I was terminated by the facility and all staff were re-educated on the importance of following resident's plan of care.Review of the facility care plan dated 12/18/25, revealed Resident #101 was a transfer: 2 assist. CNA I revealed in the facility investigation, that she transferred the resident by her self on 12/27/25, when she started screaming and said her right knee hurt. CNA I was not at the facility during the investigation; this survey was unable to contact the CNA for an interview per phone.Review of the x-ray dated 12/27/25, revealed a non-displaced fractured of the right Fibula.Review of the facility Employment Termination Notice dated 12/29/25, revealed CNA I had been sent home on [DATE], pending investigation and terminated on 12/29/25, due to not following the residents care plan-neglect.Observation and interview was done on 1/22/26 at 3:15 p.m., the resident was in bed with Family member E sitting next to her. When asked about pain, the resident denied having any pain. The resident was unable to tell what happened on 12/27/25, she did not recall the incident. During an interview with family member E, he revealed he loved the facility, and did not want the resident to go anywhere else; he said he was not up-set with the facility, things happen.Review of the facility Accident/Incident report dated 12/27/25, revealed the residents leg brace got caught on her wheelchair and she was unable to turn, resulting in a fracture. Nursing Assistant I was terminated, staff were educated on following resident's plan of care and the incident was reviewed by the facility Improvement Committee.Resident #104:Review of the face Sheet, Incident/Accident Report dated 12/25/25, and care plans up-dated 12/25, revealed Resident #104 was 75 years-old, admitted to the facility on [DATE], required total (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assist with all ADL's, was non-ambulatory, bed bound, and required a mechanical lift for all transfers. The residents diagnosis included, Alzheimer's Disease, weakness, contractures of elbows, knees and left hand, Dementia with severe mood disturbance, Anxiety and failure to thrive. The resident received Hospice services prior and post incident (on 12/25/25).Review of the residents care plan dated 12/25, revealed she was a mechanical lift with 2 person assist.Review of the manufactured guidelines for the mechanical lift used with the resident of concern stated There are circumstances, such as combativeness, obesity, contracture (the resident had contractures) of the individual that may dictate the need for a two-person transfer (2 staff used with the transfer using the lift).Review of the facility Incident/Accident report dated 12/25/25, revealed on 12/2525, CNA A put the resident from the wheelchair to her bed using the lift. CNA A transferred the resident with one assist only, put her to bed, left the room to take the lift out and returned to find the resident on the floor, with a laceration above her left eyebrow. CNA A then lifted the resident up and put her to bed; then informed the nurse of her fall.During an interview done on 1/22/26 at 1:34 p.m., Nurse, LPN C stated He (CNA A) stated he needed me in the room ASAP. She was bleeding on her head, she was in her bed. There was blood on the floor. He did not look at the care plan (x2 assist for transfers). I called the other nurse, we called 911, put ice on her head, did a sugar test, she was in the same state as before (prior to fall); she was sent to the hospital.During an interview done on 1/22/26 at 9:00 a.m., the Administrator and Director of Nursing said CNA A did not follow the residents care plan, he was terminated.During an interview done on 1/22/26 at approximately 12:10 p.m., Human Recourses/HR stated yes, he was terminated (CNA A) for neglect. During a phone interview done on 1/22/26 at 3:32 p.m., CNA A stated When I took her (Resident #104) off the lift, she was on the bed, more towards the side, towards you. I took the lift out of the room, came back and she was on the floor. Her head was bleeding; I panicked and I put her on the bed, I couldn't stand to see her on the floor. I got the nurse and she looked at her. I should of had another CNA with me for the transfer, we all transfer like that. She does not move, her body shifts, that's probably how she feel off. I did not look at her care plan that day; yes, I did get terminated.Review of the facility Employee Counseling Form dated 12/26/25, revealed CNA A was terminated due to neglect of a resident and not following procedures procedures (2 person assist with mechanical lift for all transfers).Review of the residents Hospital records dated 12/25/25, stated No intraventricular hemorrhage, subdural hemorrhage. The hospital records revealed there was not a significant brain bleed.Review of the Hospital chest and pelvic X-ray dated 12/25/25, revealed no active findings.During an interview done on 1/22/26 at 3:00 p.m., Medical Director, MD F stated The bleed (brain bleed) was not significant, I don't think the bleed would have caused her (Resident #104) death.Review of Resident #104's Medical Certificate of Death dated 12/29/25, listed the cause of the residents death as Alzheimer's Disease and the manner of death was natural.