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	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay County Medical Care Facility	564 W 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 Based on observation, interview and record review, the facility failed to ensure dignity for 2 residents (Resident's #39 and Resident #51) of 3 residents reviewed for dignity (call light response time) and residents from the confidential Resident Council group meeting (held on 4/16/25), regarding call light response times. Findings Include: Resident #51: Review of the Face Sheet, MDS dated ,d+[DATE], nurse's progress notes dated 2/1/24 through 4/15/25, revealed Resident #39 was [AGE] years old, mild cognitive impairment, admitted to the facility on [DATE], and dependent on staff for Activities of Daily Living/ADL's. The resident's diagnosis included, high blood pressure, heart failure, lymphedema, unsteadiness, lack of coordination, chronic kidney disease, anxiety disorder, cardiac pacemaker with a history of right breast cancer. During an interview done on 4/15/25 at 10:09 a.m., Resident #51 stated If they (staff) are busy, I do wet my pants sometimes. If its real bad, we go in the hall and yell help. Night is fast (call light response times), its more or less before lunch (delayed light response times). They can't get to all of us, so we wait. Resident #51 said she feels embarrassed when she wets her pants. The resident stated One time I thought I was having a heart attack; I couldn't breathe, and I was scared. I think they were short (short staffed), it took them about 45 minutes to get here. I used to be a nursing assistant, I know. Resident #39: Review of the Face Sheet, Minimum Data Set (MDS, resident assessment tool) dated 7/24, and physician orders dated 4/13/25 through 4/17/25, and nurses progress notes dated 4/13/25 through 4/17/25, revealed Resident #39 was [AGE] years old, admitted to the facility on [DATE], alert and able to make own healthcare decisions, had a trach (artificial breathing stoma) and dependent on staff for Activities of Daily Living/ADL's. The resident's diagnosis included, respiratory failure, chronic lung disease, muscle weakness, Dysphagia (deficit swallowing), heart disease, diabetes, Spinal stenosis, anxiety, and oxygen dependence. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview done on 4/15/25 at 10:09 a.m., If there are busy, I do wet my pants sometimes. If it's real bad we go in the hall and yell help. Night is fast, its before lunch. They can't get to all of us, so we wait. Review of the facility Resident Council Notes dated 10/30/24, 12/31/24, 1/28/25, and 2/26/25, revealed complaints regarding call light response times being too long. Review of Council notes dated 10/30/24 and 12/31/24, stated Some of the residents voice concern about the length of time their call lights are on. Review of Council notes dated 1/28/25 and 2/26/25, stated There was a discussion about call lights and residents stated that this has been the same as the previous month (continued delayed response times). Review of the facility resident's Rights policy dated 3/26/25, stated You have a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely (including timely response to call lights). 37771 Resident Group Meeting: On 4/16/25 at 10:30 AM, an interview was conducted with 13 Confidential Residents in a group meeting. The Residents were asked about any concerns they had regarding the care they received at the facility. A couple Residents reported long call light wait times. A Resident stated, The CNAs (Certified Nursing Assistants) are too busy, and the CNAs are busy working with someone else. One Resident complained of having to wait up to 45 minutes at times and another reported 30 minutes. One Resident reported having to use the bathroom and stated, I have been incontinent of stool because of waiting, and another Resident stated, You have to sit and pray that someone will answer the call light and get you to the bathroom in time. Three Residents out of the group reported incontinence while waiting for the call light to be answered. A Resident reported that Nurses don't help with answering call lights, while another Resident voiced that some Nurses do answer, but most will not answer, call lights. When the group was asked who felt the Nurses could help with answering the call lights more, most of the census of the group raised their hands.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 37771 Based on observation, interview and record review, the facility failed to inform/educate 13 of 13 residents who attended the confidential group meeting about the location of the survey results and failed to ensure that the recent State Survey and Plan of Correction were readily accessible, affecting all Residents in the facility of a census of 89, resulting in Residents, Resident Representatives, visitors and staff being unable to review the survey results and plan of correction. Findings include: On 4/16/25 at 10:30 AM, an interview was conducted with 13 Confidential Residents in a group meeting. The Residents in the group meeting were asked Without having to ask, are the results of the State inspection available to read? No Resident of the group acknowledged they knew of survey results being available. 13 of 13 Residents reported they did not know what survey results were, that the results were to be available without having to ask for them, or where they would find the results. The majority of the Residents were in wheelchairs. On 4/16/25 at 11:50 AM, an observation was conducted in the hallway near the front entrance and the Administrator's (NHA) office. There was a bulletin board on the wall that had multiple papers attached to the board. On one end of the board were printed survey results with pages clipped together and hung on a push pin. The copy of the results was too high to be accessible from wheelchair height and were in small print impeding reading to acknowledge what the documents were from wheelchair height. The document 2567 of survey results were posted on the bulletin board for 3/7/23 but did not have the plan of correction printed on the documents. There was no survey for 2024 posted on the bulletin board. On 4/16/25 at 12:18 PM, an interview was conducted with the Administrator (NHA) regarding the lack of readily accessible results of the most recent survey of the facility. The NHA reported that there should be the survey up there, that it probably was at one time and that he will copy it off and put it up there. On 4/16/25 at 12:18 PM, an interview was conducted with the NHA regarding the lack of plan of correction with the surveys that was posted on the bulletin board for 2023 and 2021. The NHA reported that the survey that he will post will have the plan of correction with the survey results. A review of the facility policy titled, Resident Rights, reviewed 3/26/25, revealed, . 6. Information and communication . k. You have a right to: i. Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview, and record review, the facility failed to update and/or revise individualized, person-centered care plans to reflect changing needs for 4 residents (#6, #39, #52, #62) of 18 residents reviewed for care plans, resulting in the potential for unmet care needs. Findings include: Record review of facility 'Comprehensive Care Plan' dated 11/27/2024 revealed it is the policy of this facility to develop and implement a comprehensive person-center care plan for each resident, consistent with the rights, that includes measures objectives and time frames to meet a resident's medical and psychosocial needs that are identified in the resident's comprehensive assessment. Resident #62: Observation on 04/16/25 at 08:25 AM with Certified Nurse Assistant's R and S revealed that both CNA's applied enhanced barrier precautions of personal Protective equipment (PPE). CNA R walked into the room and pulled the bed away from wall, air mattress was not placed on hold or stopped. Resident rolled side to side by staff. Bowel soiled brief changed, and dressing covered in stool. The state surveyor observed a Stage 4, opened wound at the rectal/coccyx area, that was red beet bottom with white tissue noted, deep wound bed noted. No barrier cream was noted. Area cleansed and no dressing applied at this time. Record review of Resident #62's 'Daily Care Plan' located in the resident's wardrobe within the resident's room revealed Skin: Encourage to turn side to side while in bed, Head of Bed less than 30 degrees except when eating, Air mattress. There were no documented air mattress settings or when to increase or decrease the firmness of the mattress. Observations and interviews were conducted on 04/16/25 at 08:40 AM with Registered Nurse (RN) J and Certified Nurse Assistant (CNA) R. RN J had opened wound dressing packets at the treatment cart in hallway and squirted solutions into the packets. Both Registered Nurse J and Certified Nurse Assistant (CNA) R applied enhanced barrier personal protection equipment (PPE) and CNA R Bed pulled away from the wall so she could be on side of bed, walked past the air mattress control and did not place on hold or stop the air flow. Settings observed of 5 dots out of 10 dots (soft to firm) during dressing change to coccyx area. RN J applied a pair of gloves and assisted in turning the resident to her left side and removed the soiled brief and performed wound measurements of 2 cm x 1 cm and stated no tunneling, red sanguineous drainage noted, bleeding with cleaning. Three 4 x 4 gauzes were noted. RN J used the right hand to change only left-hand glove, applied collagen powder sprayed into the wound and skin prep, and placed exoderm treatment dressing to wound (held to seal wound bed). RN Jthen placed a pillow placed to her upper back area. The state surveyor asked why only changing with one glove? RN J stated that he only changed left hand glove because he was holding Resident #62 with his right hand, and it did not touch anything else. Nurse was observed using the right hand to remove the left glove and re-apply a new left-hand glove (Cross contamination noted). Nurse did not use hand sanitizer or wash hands between cleaning of stool and applying wound dressing, thereby causing a possible cross contamination with the dressing change. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and record review on 04/16/25 at 12:46 PM, Registered Nurse C, who was wound care certified, acknowledged that Resident #62's Stage IV pressure injury developed in house on 03/20/25 as Moisture Associated Skin Damage (MASD) and was treated with Triad cream, but the wound was an open wound, measuring 6 x 4 cm with no depth at that point. RN C stated the wound was covered with slough and that she did write the measurements in the progress notes. RN C stated that she does write a note weekly for wounds. Record review of the 3/26/25 progress note documented wound open with drainage. Then on 4/3/25 the wound developed into a Stage 4 with depth, and a progress note on 4/12/25 noted a Stage 4 pressure wound. The state surveyor asked if the the care plan was updated. RN C stated I thought that I did. I added an air mattress to the care plan. I am used to Point Click Care, the matrix program has been a struggle for me. Record review of Resident #62's care plans, pages 1- 20, revealed on page 7 under Skin management: I have skin interventions in place; pressure relieving mattress on my bed; waffle cushion in my wheelchair; A&D to bilateral feet with AM & HS care . There were no documented settings for the air mattress in use on the resident's bed or when to increase or decrease the mattress air pressure. 22347 Resident #39: Review of the Face Sheet, Minimum Data Set (MDS, resident assessment tool) dated 7/24, and physician's orders dated 4/13/25 through 4/17/25, and nurses' progress notes dated 4/13/25 through 4/17/25, revealed that Resident #39 was [AGE] years old, admitted to the facility on [DATE], alert and able to make own healthcare decisions, had a trach (artificial breathing stoma) and dependent on staff for Activities of Daily Living (ADL). The resident's diagnoses included, respiratory failure, chronic lung disease, muscle weakness, Dysphagia (deficit swallowing), heart disease, diabetes, Spinal stenosis, anxiety, and oxygen dependence. Observation of the residents skin was done accompanied by Nursing Assistant/CNA L on 4/15/25 at 10:37 a. m., revealed 3 small pressure ulcers. Review done on 4/15/25, of the resident's facility Daily Care Plan dated 1/29/25 (in the resident's room) and the Skin Management care plan dated 2/24/25, revealed no documentation of any open areas on the resident at all. The Skin Management care plan stated My skin will remain intact through next review (no open areas were documented). The resident's care plan was not up-dated timely to reflect the actual skin condition (x 3 pressure ulcers). Resident #52: Review of the Face Sheet, physician orders and nursing progress notes, dated 3/1/25 through 5/15/25, and MDS Assessment Summary dated 1/28/25, revealed Resident #52 was [AGE] years old, alert with mild cognitive impairment, admitted to the facility on [DATE], dependent on renal dialysis, and dependent on staff for ADL's. The resident's diagnoses included, end stage renal disease, sepsis, hemiplegia and hemiparesis following a stroke, dialysis dependent, Epilepsy, depression, Acquired absence of kidney, mild cognitive impairment, and mood disorder. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review was done on 4/16/25 at 11: 55 a.m., of Resident #52's facility pain care plan dated 2/3/25. It revealed only one intervention; give meds per physician orders. No documentation was found regarding interventions related to non-pharmacological pain reduction interventions. During an interview done on 4/15/25 at approximately 11:10 a.m., Resident #52 said he was in a lot of pain. The resident denied staff implemented any non-pharmacological measures when given examples. During an interview done on 4/16/25 at 10:00 a.m., MDS Nurse, RN H stated We typically have non-pharmacological approaches in pain care plans. We (MDS) are the ones that up-date the goals/care plans; the nurses notify us of wound care. The care plans should be done the day they find it (the wound). During an interview done on 4/16/25 at 10:15 a.m., Wound Nurse, RN C stated Care plans can only be changed by MDS and wound (wound care nurse). Wound Nurse C said the nurses were not allowed to do or up-date resident care plans. Interview done on 4/16/25 at 10:20 a.m., with the DON, who stated, I feel like more interventions should be in place. Review of the facility Pain Management policy, dated 12/23/24, stated Non-pharmacological pain management interventions include but not limited to: Adjusting room temperature, massage, turning and repositioned to a comfort position, loosen any constrictive bandage or device, applying splinting, physical modalities (cold compress, warm compress), exercises to address stiffness and present contractures as well as restorative nursing programs to maintain joint mobility, cognitive/behavioral interventions (music, diversions). Review of the facility Baseline Care Plan policy, dated 9/25/24, stated (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 met professional standards of quality care. Interventions will be initiated that address the resident's current needs including: Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk. Any special needs such as for IV therapy, dialysis, or wound care. Once established, goals and interventions will be documented in the designated format. In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes shall be incorporated into an updated summary provided to the resident. 37771 Resident #6: A review of Resident #6's medical record revealed an admission into the facility on [DATE] and re-admission on 3/12/25 with diagnoses that included mood disorder, major depressive disorder, mild intellectual disabilities, Alzheimer's disease, dementia with mood disturbance, malnutrition, pressure ulcer of right ankle, right heel and left heel at Stage 4, pressure ulcers of other sites at Stage 2 and unstageable and osteomyelitis. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #6's care plan for risk for skin breakdown pressure/injury, revealed an APPROACH: (Resident's name) has an air mattress on my bed. (Resident name) has a ROHO cushion in her w/c (wheelchair), dated 2/11/2025. Resident #6's care for Mood: (Resident's name) has a diagnosis of ., with a GOAL: I will be free from significant side effects of psychotropic medication through next review, with a listed APPROACH: Nursing administers my medications as ordered by provider. Labs as ordered by provider, and The potential side effects of my medications are monitored as listed in the Nursing Drug Handbook, did not have individualized Resident information on behaviors, medications or the potential side effects to monitor. On 4/16/25 at 2:35 PM, an interview was conducted with the Wound Care Nurse (WCN) C regarding Resident #6's multiple pressure wounds. The WCN was asked what kind of air mattress was on the Resident's bed and what were the settings for the air mattress? The WCN reported that the care plan would have the information, and that the Patriot air mattress was to be set between 5 and 7 dots and set on static. The WCN stated, They put it on the care plan. It's set up to the comfort level at that time (when applied). When asked how staff assess for her comfort level, the WCN reported the Resident was non-verbal and that assessing her comfort level would be difficult. The WCN was asked how would staff know what to set the air mattress machine to. The WCN stated, Usually it is on the care plan. A review of the care plan revealed the approach for an air mattress on my bed, but did not give resident specific settings for the air mattress. On 4/16/25 at 3:07 PM, an observation was made with Wound Care Nurse C of Resident #6 lying in bed. The resident did not respond to verbal stimuli or engage in conversation. The air mattress was on and functioning. The air mattress was set at 6 of 10 dots (the soft to firm setting) and set on static air. The WCN reported that CNA's may firm up the mattress while providing care by changing the settings. A review of the care guide that was in the resident's room revealed no direction for staff on the settings for the air mattress. On 4/17/25 at 12:39 PM, an interview was conducted with the MDS Coordinator, Nurse H regarding Resident #6's lack of individualized care plan. The MDS Nurse reported that the Social Services would complete the interventions for the psych medications. A review of the interventions for the goal for psychotropic medications was reviewed. The Nurse reported a lack of behaviors and stated, Needs to be more resident specific, and asked if the care plans needed to be individualized for the Resident, the Nurse stated, yes.

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F 0686 Level of Harm - 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** 22347 Based on observation, interview and record review, the facility failed to 1) Prevent and implement preventive measures to avoid pressure ulcers for 2 residents (Resident #39 and Resident #62) of 3 residents reviewed for pressure ulcers and 2) Follow through with the intervention of an air mattress for 1 resident (Resident #39), resulting in Resident #62 having a facility-acquired, preventable, Stage IV pressure ulcer and, for both residents, an increased likelihood for infection, cross contamination, antibiotic usage with side effects, pain, and discomfort. Findings Include: Resident #39: Review of the Face Sheet, Minimum Data Set (MDS, resident assessment tool) dated 7/24, and physician orders dated 4/13/25 through 4/17/25, and nurses' progress notes dated 4/13/25 through 4/17/25, revealed Resident #39 was [AGE] years old, admitted to the facility on [DATE], alert and able to make own healthcare decisions, had a trach (artificial breathing stoma) and dependent on staff for Activities of Daily Living/ADL. The resident's diagnoses included, respiratory failure, chronic lung disease, muscle weakness, Dysphagia (deficit swallowing), heart disease, diabetes, Spinal stenosis, anxiety, and oxygen dependence. At the time of the survey, the resident had no diagnosis of pressure ulcers. The first observation documented was when this surveyor did an observation on 04/15/25. During an interview on 4/15/25 at 10:29 a.m., the resident stated I got something on my bottom, it hurts; they (staff) saw it yesterday and put something on it. It started hurting yesterday (4/15/25) and I told them, but now it's bad (increased pain). An observation of Resident #39's wound (coccyx pressure ulcers) done on 4/15/25 at 10:37 a.m., revealed on the left and right side there were 3 open areas on the lower buttocks. The resident was verbalizing pain when Nursing Assistant/CNA L turned her over to observe the coccyx area; the resident said it burnt and hurt. There was a layer of white cream that staff had put on her. At this time, the resident did not have a air mattress on her bed, but she had a pressure reduction mattress. Review of the resident's physician's orders and an interview done on 4/16/24 at approximately 10:40 AM, revealed, at this time no assessment or orders were found regarding the pressure ulcers or for any treatment. During an interview done on 4/16/25 at 10:53 AM., Wound Nurse, RN C stated I saw it today (on 4/16/25), it's a Stage 2 (Pressure Ulcer), there are 2 of them (there were 3 open areas documented by Nurse C); they (staff) probably put silicone on it. They should have ordered something. They wait for me to do it. On 4/15/25 at 10:50 AM, a review was done of Resident #39's facility nursing progress notes, dated 4/12/25 at 1:52 PM, through 4/13/25 at 2:17 PM, (at the time of this review, there were no nursing notes at all for 4/14/25, or for 4/15/25) revealed no documentation of any pressure ulcers or any reddened areas on the resident. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/15/25 at 10:55 , review was done of Resident #39's facility weekly skin assessments dated 3/29/25, 4/4/25 and 4/11/25, revealed no documentation of any pressure ulcers, damaged skin integrity nor reddened areas. At the time of the review, no documentation was done on 4/15/25 at all. Review of the resident's facility progress note dated 4/15/25 at 11:40 a.m. (this was after the observation was done of 3 pressure ulcers was made by the surveyor) stated This nurse was asked to assess resident's bottom at this time as she was c/o (the resident was complaining) pain. Upon assessment there was found to be three superficial open areas to left inner buttock. Measurements are as follows; superior wound measuring 1.0 cm x .7 cm, middle wound measuring .8 cm x .3 cm, and inferior wound measures .1 cm x .2 cm. Areas cleansed w/NS (with normal saline), patted dry, Hydrogel was then applied. Area covered w/ 4 x 4 boarded foam patch. Orders placed; Triad cream applied to rest of buttocks as ordered. Res. (resident) stated that feels a little better already. Review of the facility physician order dated 4/15/25, stated Cleanse three superficial openings to left inner lower buttock w/NS, pat dry. Apply Hydrogel, then cover w/ 4 x 4 bordered foam patch for protection. During an interview On 4/17/25 at 9:15 AM, Wound Nurse, RN C stated She (the resident) refused to get up for us to put the air mattress on. Observation and interview with Resident #39 was done on 04/17/25 at 9:40 AM. No air mattress was on her bed. Resident stated, No one asked me if I could get up for the air mattress to be put on, I was up yesterday, no one asked me to get up to put it (air mattress) on; I did not refuse to get up. During an interview on 04/17/25 10:40 AM Maintenance A stated Yes, it was put in TELL's yesterday (on 4/16/25) at 12:36 PM, but it didn't get put on. It was put in as critical; that's an excessive amount of time (for not being put on the resident's bed). During an interview on 4/16/25 at 12: 50 PM, Maintenance B stated They (staff) had just put her back in bed and they said she would not get up again. It did not get put on yet. During an interview on 4/17/25 at 9:23 AM, Wound Nurse, RN C stated I usually initiate an air mattress, I put it in TELL's (facility maintenance communication program) and I put it on critical (meaning to get the requested task done that day). Wound Nurse C said she put the request for an air mattress to be put on the resident's bed on 4/16/25. Wound Nurse C said there was no policy for requests put through the maintenance TELL's. 22927 Resident #62: In an observation and interview on 04/15/25 at 01:59 PM, Resident #62 was noted to be laying in bed getting ready for a nap and laying on her back. Resident #62 denied any concerns. Record review of Resident #62's progress note, dated 3/5/2025 at 9:35 PM, resident weekly skin assessment completed: Resident buttocks is cleared and intact . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #62's progress note dated 3/12/2025 at 9:41 PM, resident weekly skin assessment completed: Resident inner buttocks is pink area cleansed and dried and facility barrier cream applied as ordered. Record review of Resident #62's progress note, dated 3/13/2025 at 2:28 PM, resident did get up in her wheelchair for a few hours and tolerated it well. Buttocks near rectum with macerated area noted measuring approximately 5 cm x 2.5 cm. Resident is incontinent of bowel & bladder and refuses care at times. Area cleansed and triad cream applied. Wound nurse notified. Record review of Resident #62's progress note, dated 3/19/2025 at 05:29 AM, resident has an area on inner buttocks that appears to be open with some slough noted . Triad cream in place at this time. Message sent to wound nurse for possible treatment. Observation on 04/16/25 at 08:25 AM with Certified Nurse Assistant's R and S revealed that both CNA's applied enhanced barrier precautions of personal Protective equipment (PPE) CNA R walked into the room and pulled the bed away from wall, air mattress was not placed on hold or stopped. Resident rolled side to side by staff. Bowel-soiled Brief changed, and dressing covered in stool. The state surveyor observed a Stage 4, open wound at the rectal/coccyx area, that was red beef bottom with white tissue noted, deep wound bed noted, no barrier cream was noted. Area cleansed and no dressing applied at this time. Record review of Resident #62's 'Daily Care Plan' located in the resident's wardrobe within the resident's room revealed Skin: Encourage to turn side to side while in bed, Head of Bed less than 30 degrees except when eating, Air mattress. There were no documented air mattress settings or when to increase or decrease the firmness of the mattress. Observations and interviews were conducted on 04/16/25 at 08:40 AM with Registered Nurse J and Certified Nurse Assistant (CNA) R. RN J had opened wound dressing packets at the treatment cart in hallway and squirted solutions into the packets. Both Registered Nurse J and Certified Nurse Assistant (CNA) R. applied enhanced barrier personal protection equipment (PPE) and CNA R pulled the bed away from the wall so she could be on side of bed, walked past the air mattress control and did not place on hold or stop the air flow. Settings observed on 5 dots out of 10 dots (soft to firm) during dressing change to coccyx area. RN J applied a pair of gloves, assisted in turning the resident to her left side, removed the soiled brief and performed wound measurements of 2 cm x 1 cm and stated there was no tunneling. Red sanguineous drainage noted and bleeding noted with cleaning. Three 4 x 4 gauzes were noted. RN J used the right hand to change only left-hand glove, applied collagen powder, sprayed into the wound, skin prep, and placed exoderm treatment dressing to wound to seal the wound bed. RN J then placed a pillow placed to her upper back area. The state surveyor asked why he was only changing one glove. RN J stated that he only changed left hand glove because he was holding Resident #62 with his right hand, and it did not touch anything else. Nurse was observed using the right hand to remove the left glove and re-apply new left-hand glove (cross contamination noted). Nurse did not use hand sanitizer or wash hands between cleaning of stool and applying wound dressing. Possible Cross contamination with dressing change. (continued on next page)

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	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay County Medical Care Facility	564 W Hampton Road Essexville, MI 48732

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview and record review on 04/16/25 at 12:46 PM, Registered Nurse C, who is wound care certified, acknowledged that Resident #62's Stage 4 pressure injury developed in-house on 3/20/25, as Moisture Associated Skin Damage (MASD) and was treated with Triad cream, but the wound was an open wound, measuring 6 x 4 cm with no depth at that point. RN C stated the wound was covered with slough and that she did write the measurements in the progress notes. RN C stated that she does write a note weekly for wounds. Record review of the 3/26/25 progress note documented an open wound with drainage. On 04/03/25 the wound had developed into a Stage 4 wound with depth. A progress note on 4/12/25 noted a Stage 4 pressure wound. The state surveyor asked about updating the care plan. RN C stated I thought that I did. I added an air mattress to the care plan. I am used to Point Click Care, the matrix program has been a struggle for me. In an interview and record review on 04/16/25 01:59 PM, Registered Nurse C, who is wound care certified, revealed that Resident #62's pressure ulcer did develop at the facility and the wound started on 3/19/2025 as slough. Resident #62 went out to hospital on 3/24/2025 and came back. Resident #62's pressure ulcer area on 4/3/2025 was open and measured 4 cm x 2.3 cm and a depth of 1 cm with drainage. Observation was made on 04/17/25 at 08:12 AM of Resident #62 laying on her right hip area with pillows behind her upper back area. Resident #62 was awake, but she was chilled and has on extra blankets. Observation of air mattress setting was made- still on static with a half firm setting. Resident #62 stated its just stays hard on her butt all the time. In an interview on 04/17/25 at 09:23 AM, Registered Nurse C was asked about the facility air mattress usage and if the actual pressure ulcer is a criteria for an air mattress. RN C replied, It just depends on how bad the wound is. I will initiate an air mattress with open wound. I put it in the tells maintenance (computer program) to let them know about the need for the mattress. Usually, it takes just a couple of hours or a day. An interview and observation on 04/17/25 at 09:43 AM with Registered Nurse C, revealed there is no policy or procedure for the use air mattress on resident beds. The owner's manual maintenance is look for it. Setting of air mattress, some have cycled air. The Patriot brand of air mattress has a setting of 10 dots from soft to firm and facility sets it on between 3 to 5 and go down from there. Static setting- I don't know what that is. Alternating setting is used. I'd have to look at the bed. Registered Nurse C and the state surveyor went to room [ROOM NUMBER] to observe the resident's Patriot bed air mattress, which was set on static with 6 dots. Registered Nurse C, stated I don't understand the air mattress settings. I don't know the difference between the static and alternate settings. That would be a Licensed Practical Nurse (LPN) M restorative nurse question. I just don't know. I came from the hospital setting and not long-term care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an observation observation and interview on 04/17/25 at 10:28 AM, Licensed Practical Nurse (LPN) M (restorative nurse) came into the resident's room, room [ROOM NUMBER], and stated that the Patriot air mattress is the older model and the comfort level with a pressure wound should be between 5 and 7 dots on the control setting. During resident care, the staff are to firm up the mattress to 10 dots and then back down to the settings on the care plans. We use the static setting, and we do not use the alternate setting. The wound care nurse sets the settings and does the care plans. Record review of the resident's in-room 'Care Guide', located in the room wardrobe, revealed no settings were stated on the care guide for air mattress use. In an observation and record review on 04/17/25 at 10:00 AM, Licensed Practical Nurse (LPN) M and the State surveyor Went to the second-floor [NAME] unit to room [ROOM NUMBER]. Resident #62 has a Patriot air mattress in place with settings at 5 dots, a static setting. Record review of the in-room care guide, dated 4/9/2025 and located inside the wardrobe closet door, revealed under the heading of ski: Air mattress (no settings were documented). Record review of Resident #62's nurse notes, dated 3/19/2025 at 8:48 AM, noted that the Head of Bed (HOB) is not to be over 30 degrees. Resident was observed with 4 pillows placed behind her upper back areas raising the resident further up on her coccyx.

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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. 39059 Based on observation, interview and record review, the facility failed to ensure clean, reusable medical equipment for one resident (Resident #12) and hand hygiene for one resident (Resident #62), resulting in cross-contamination and the likelihood of further cross-contamination. Findings include. On 4/16/25, at 1:48 PM, an observation of Nurse P at Resident #12's doorway was conducted. Nurse P asked Nurse Q if they had scissors. Nurse Q entered their left pocket, pulled out a pair of scissors and handed them to Nurse P. Nurse P entered Resident #12's room and closed the door. Upon opening Resident #12's door, an observation was made of Nurse P cleaning the scissors with an alcohol pad with their gloved hands. Nurse P was asked if they were using an alcohol pad and Nurse P offered, Yes, its an alcohol pad. On 4/16/25, at 1:55 PM, Nurse Q was asked if the scissors were shared scissors and Nurse Q offered, the scissors were shared. Nurse Q was asked what their normal disinfection process was for reusable scissors between resident use and Nurse Q offered, we use alcohol. On 4/16/25, 3:30 PM, a record review of Resident #12's electronic medical record revealed an admission on 1/2/2024 with diagnoses that included Stroke, Diabetes and seizure disorder. Resident #12 had intact cognition and required extensive assistance with all activities of daily living. Resident #12 required enhanced barrier precautions due to their urinary catheter and had an order for a dressing change to their coccyx. Resident #12 had a recent history of a wound infection. On 4/17/25, at 11:38 AM, an interview along with Infection Control Nurse (IC) Nurse N was conducted. IC Nurse N was asked to clarify the Standard Precautions policy to ensure proper disinfection of reusable medical equipment. IC Nurse N stated, we would use the EPA disinfectant. 22927 Resident #62: An observation on 04/16/25 at 08:25 AM with Certified Nurse Assistant's R and S revealed that both CNA's applied enhanced barrier precautions of Personal Protective equipment (PPE). CNA R walked into the room and pulled the bed away from wall. The air mattress was not placed on hold or stopped. The resident rolled side to side by staff. Bowel-soiled brief was changed, and the dressing was covered in stool. The state surveyor observed a Stage 4, open wound at the rectal/coccyx area, that had a red beef bottom with white tissue noted. A deep wound bed was also noted. No barrier cream was noted. The area cleansed and no dressing was applied at this time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of Resident #62's 'Daily Care Plan', located in the resident's wardrobe within the resident's room, revealed Skin: Encourage to turn side to side while in bed, Head of Bed less than 30 degrees except when eating, Air mattress. There were no documented air mattress settings or when to increase or decrease the firmness of the mattress. Record review of a 'Enhanced Precautions' form located on the same clip board with the 'Daily Care Plan', undated, noted Resident #62 with rectal wound, staff to wear gloves and gown when providing care to resident and change gloves if contact with infective material. Hand hygiene after resident contact, contact with resident surroundings, or when removing gloves. An observation and interview was conducted on 04/16/25 at 08:40 AM with Registered Nurse J and Certified Nurse Assistant (CNA) R. RN J had opened wound dressing packets at the treatment cart in hallway and squirted solutions into the packets. Both Registered Nurse J and Certified Nurse Assistant (CNA) R applied enhanced barrier personal protection equipment (PPE). CNA R pulled the bed away from the wall so she (CNA R) could be on side of bed. CNA R walked past the air mattress control and did not put on hold or stop the air flow. Settings observed at 5 dots out of 10 dots (soft to firm) during dressing change to the coccyx area. RN J applied a pair of gloves, assisted in turning the resident to her left side, removed the soiled brief, and performed wound measurements of 2 cm x 1 cm and stated that there was no tunneling. A red sanguineous drainage and bleeding were noted with cleaning. Three 4 x 4 gauzes were also noted, RN J used the right hand to change only the left-hand glove, applied collagen powder by spray it into the wound, skin prep, and placed the exoderm treatment dressing to the wound and held it to seal wound bed. RN J then placed a pillow placed to her upper back area. The state surveyor asked why RN J only changed one glove. RN J stated that he only changed the left-hand glove because he was holding Resident #62 with his right hand, and it did not touch anything else. The nurse was observed using the right hand to remove the left glove and re-apply a new left-hand glove (Cross contamination noted) RN J did not use hand sanitizer or wash hands between cleaning of the stool and applying the wound dressing. There is a possible cross contamination with the dressing change. In an interview on 04/17/25 at 01:45 PM with Registered Nurse/Infection Preventionist N, the state surveyor inquired about hand washing with dressing changes. RN N stated that the nurse needs to wash before and during the dressing change. After a dirty dressing change, remove gloves and wash hands. Both gloves should be changed and hands washed before proceeding with the dressing change. The state surveyor asked about cross contamination. RN N stated that that is the cause for cross contamination and should be done- pre-wash. use gloves, remove soiled dressing, remove dirty gloves, wash hands, reapply clean gloves, set-up a barrier, perform the treatment and place the dressing. Then remove the gloves and wash hands again.