STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure: 1. Proper care of a catheter, 2. Accurate and timely documentation was entered for care decisions, and 3. Notification of significant changes were communicated to the physician for one Resident #5 (R5) of three residents reviewed for quality of care. This deficient practice resulted in harm when R5 was hospitalized due to a ruptured bladder, urinary tract infection, and septic shock (a subset of sepsis in which particularly profound circulatory, cellular, and metabolic abnormalities are associated with a greater risk of mortality than with sepsis alone.), with continued decline resulting in death. Findings include: Review of R5's admission Record, retrieved on July 3, 2025, revealed R5 was admitted to the facility on [DATE], with active diagnoses that included the following, in part: benign prostatic hyperplasia with lower urinary tract symptoms, urine retention and type 2 diabetes mellitus with hyperglycemia. R5 scored 15 of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. Review of R5's Progress Notes revealed the following, in part: 5/24/25 22:33 (10:33 p.m.), Writer alerted by CNA that resident had blood in his brief, writer assessed, resident had blood coming from the pin point area at tip of penis . 5/26/25 19:16 (7:16 p.m.) ,Resident has a large area of swelling to his left inner thigh. It feels boggy, no pain to touch and no redness. His lower legs have increased edema . This was not seen on 5/25/25. This needs to be seen by the DR (doctor). 5/27/25 10:17 a.m., Physician Progress Note, included the following, in part: . He has an indwelling Foley catheter. Extremities with 1+ pitting edema to his bilateral legs. According to the nurses he has a small breakdown of skin behind his heel .Assessment/Plan: . 4. BPH (benign prostatic hyperplasia) with lower urinary tract symptoms with indwelling Foley catheter . 9. Lower extremity edema - start furosemide 40 mg daily x 2 weeks, follow weights, leg measurements and urine output. Check labs with a BMP in 2 weeks. There was no documentation related to the 2/24/25 blood in his brief and on the tip of his penis, and no mention of the large area of swelling to his left inner thigh that was boggy. (continued on next page)

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
	235144	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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 0684 Level of Harm - Actual harm Residents Affected - Few	5/29/25 17:44 (5:44 p.m.) LATE ENTRY Nursing Progress Note, entered on 6/24/25 (26 days following the provision of care to R5.) Res (resident) started to c/o (complain of) lower abdominal discomfort around 11:00 (a.m.) and he did not have but 150 mls (milliliters) (of urine) in catheter bag. This writer asked if he felt like he needed to urinate and he said he did. So, this writer flushed foley with 60 mls of sterile water, and then urine immediately started to flow back into the drainage tubing. Then early afternoon res c/o lower abdominal pain again. This writer checked his foley bag and there wasn't much more urine in the bag since flush. Around 200 ml. Urine was yellow in color. So, after discussing what the resident wanted nurse to do, we decided on changing his foley catheter, When removing the old catheter there was blood at the tip (of the deflated balloon) of his foley. This writer then used sterile technique to insert the new foley . urine immediately started filling foley bag. Urine was bloody 5/30/25 04:52 (4:52 a.m.) Nursing Progress Notes Urine continues to be bloody. Had emesis x 3. Hasn't slept much, increasingly confused. Demanding to get out of bed now. 5/30/25 9:56 a.m., At 0940 (9:40 a.m.) CNA (Certified Nurse Aide) came to SN (skilled nurse) and stated resident had a facial droop and was pocketing his food. SN went to assess right hand grasp were not equal. Right side was greatly weaker. Right side of face is dropping (sic), and speech has changed, Vitals 104/69 (blood pressure), 126 (heart rate), 20 (respirations), Temp 98.4 . Resident was sick during the night and vomited 3x (times). Also, vomited this morning but states it was just drool . Tylenol was given for headache this am. Cath was changed yesterday and there is blood in urine. 5/30/25 10:25 a.m., Resident (R5) left facility with EMS (emergency medical services). 5/30/25 11:53 a.m., Report from local hospital (ER). Resident WBC (white blood cell count) is elevated around 18,000 (reflective of infection), and lactic acid at 7 . (indicative of sepsis). 5/30/25 15:12 (3:12 p.m.), Report from [ER]. Resident has a ruptured bladder - looking to send out to [Regional Medical Center]. ER Nurse will call me with up (update) on where resident will be shipped if [Regional Medical Center] can't take him. 5/31/25 10:43 a.m., .Resident was transferred to [Regional Medical Center] for further care. 6/16/25 11:38 a.m., . Resident arrived at facility via stretcher from [Regional Medical Center. On 6/16/25 at 3:00 p.m., R5's Brief Interview for Mental Status (BIMS) was completed with a score of 15 out of 15, reflective of intact cognition . 6/17/25 2:43 a.m., .elevated temp 100.8 degrees . During an interview on 7/3/25 at 11:30 a.m., when asked if there was an incident report for R5's ruptured bladder, the Director of Nursing (DON) stated, No the nurse did not do an incident report for that. When asked about the late progress note, entered on 6/24/25, for replacement of R5's foley catheter on 5/29/25, the DON stated, I have a huge problem with late progress notes, and I have a huge problem with this (absence of investigation documentation, including R5's urine outputs from the investigation file). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/3/25 at 12:43 p.m., Registered Nurse (RN)/Unit Manager M was asked why there was no documentation about the blood in R5's brief, and on his penis on 5/24/25. RN M stated, I don't think he (Physician P) was updated on the blood in the urine. RN/Unit Manager M confirmed RN S had placed a LATE ENTRY progress note in R5's medical record on 6/24/25, when R5's catheter change occurred on 5/29/25. RN M confirmed the facility was aware of R5's ruptured bladder, urinary tract infection, and septic shock diagnoses prior to documentation of the 6/24/25 nursing note by RN S. When asked if it was acceptable practice to document care in the medical record nearly one month late, RN M stated, I would say it is not acceptable . During a telephone interview on 7/3/25 at 1:30 p.m., following review of R5's Physician Progress Note on 5/27/25, Physician P was asked if he was informed by facility staff of any urinary issues, including blood in R5's brief and on his penis on 5/24/25, the large boggy area on R5's upper left thigh, bloody urine and decreased urinary output. Physician P responded, No, paused and stated, I did not know anything until I read the emergency room notes. Review of the local Hospital ED (Emergency Department) Provider Note: 5/30/25 10:42 a.m., Presents from . nursing home with a chief complaint of nausea and vomiting. [Facility] had initially expressed concern for some left-sided neurologic deficits but no evidence of this on arrival. Patient states he vomited last night after supper, a few times overnight and this morning after breakfast. He reports some vague lower abdominal discomfort. Chronically has an indwelling Foley, states it was replaced yesterday, noticed some blood in the tubing yesterday but he has not had any urine output yet today . Physical Exam: Abdomen . Mild tenderness across lower abdomen. ED Course: 100 mL saline flushed through foley easily, but no return of fluid or urine noted. Nursing home did confirm he has had normal urine output, 1200 mL (milliliter) yesterday and 700 drained before he was brought to the ER today . Labs show leukocytosis (elevated white blood cells) with WBC 18.0 . Lactic acid (measures tissue deprived of oxygen in severe illnesses) significantly elevated at 7.5. Patient meeting SIRS (Systemic Inflammatory Response Syndrome [Septic Shock] criteria, no clear source of infection at this time .CT (Cat Scan) with findings concerning for bladder rupture . cystography (bladder imaging) confirms extraperitoneal bladder rupture with contrast extravasation (leakage of x-ray dye) into the anterior extraperitoneal (into the abdomen) space. [Urologist] updated, will consult on patient after transfer (to Regional Medical Center). ABX (antibiotic) coverage broadened to Meropenem 1 g and Vancomycin . We will give loading dose of 2.5 g vancomycin . Assessment: Sepsis, Lactic acidosis, UTI, Bladder rupture . condition at discharge: Fair. CT Abdomen and Pelvis: Marked diffuse bladder wall thickening with diverticulum formation. Extraperitoneal gas and large volume fluid appearing to extend from the anterior superior aspect of the ladder lumen. This is concerning for extraperitoneal rupture. Foley is in the urethra at the level of the prostate apex (entrance of the urethra into the lower part of the prostate) . CT cystogram (Cat scan of the bladder using dye) confirms extraperitoneal bladder rupture from the anterosuperior ladder which contains numerous diverticula (areas of abnormal pouching). Contrast extravasated (leaked) into the extraperitoneal space. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/8/25 at 8:16 a.m., when asked why a progress note detailing R5's condition and catheter change was entered 26 days late, RN S stated, That hall (R5's hall) is hectic. I just forgot that day, and then they called me the next day. I guess I don't know . my boss told me to put a note in . I told him [R5] he was not due to have his catheter changed for two weeks, but we can start with flushing it. I did 60 mls (flush) and I got urine back right away. Then he didn't have much more urine in the bag after that. Then I asked him again what I should do . We laid him down in bed and changed the catheter. The old (catheter) had blood on the tip for about an inch . He had more urine output after the new bag. Filled the bag with 200-300 mls, and it was bloody at the time it started coming out . At dinner he said he didn't feel good again . When asked if she had informed any physician that R5 had blood in his brief, on his penis, in the urine, or decreased urine output, RN S stated, I did not let the doctor know he was having bloody urine and blood on his removed catheter tip. RN S said she had informed Physician P at the time of R5's Physician Visit on 5/27/25 of the large, boggy area on R5's upper left thigh. RN S stated, I told him about it in the room too, and he didn't even look at his thigh. He had his sheet on, and he (Physician P) didn't pull the sheet down to look at his upper thigh. When asked what concern RN S would have with a Lactic Acid level of 7.0, RN S stated, I think inflammation at 7. When asked if sepsis would be a concern, RN S stated, I guess I don't know that. During an interview on 7/8/25 8:13 a.m., RN L reported she had received report on 5/30/25 that R5 had thrown up three times the previous night, and did say RN S had changed R5's catheter on 5/29/25 due to decreased urine output. RN L stated, It (the urine) was pink in the tubing, and pretty dark in the catheter bag, but there was only a very small amount of urine in there. Between 7:10 and 7:20 a.m. I emptied the 100 ccs of urine . I emptied it myself and then was kind of watching . I sent him out by 9:20 a.m., . I don't need a physician order to send him out on an emergency transfer .When I heard his lactic acid was 7, I immediately thought septic . I knew nothing about the blood in the brief and on his penis. RN L stated, The week prior to all of this (with R5) Certified Nurse Aide (CNA) F stomped down to the nurses' station and was so ticked because the night shift had not emptied the (R5's) catheter bag and it was the size of the football . CNA F was fuming about the football sized catheter bag. I know I walked down to [the Nursing Home Administrators (NHA's)] office and reported that to [the NHA] . The [DON] brought me the outputs, and she had pulled the (urine) outputs, but she didn't let me keep them .There was one 35 ml (urine output documentation), and that was 12 hours with only 35 mls! Why was there no bladder scan? RN L said that facility did have a bladder scanner that was available for use in the facility . During a telephone interview on 7/8/25 at 9:55 a.m., when asked if she had any knowledge of R5's Foley catheter bag being found overly full, CNA T stated, Yes, absolutely. I reported it to my nurse several times. I would come in at 7 a.m., at shift (change) and we would go and check the catheters. One time his catheter bag was so full it was the size of a football, and it was leaking. Another time I found it by myself, and it was the size of a football, like 3000 ccs at the beginning of (my) shift. I had to use the graduated cylinder three times to get it emptied. That catheter had not been dumped all night long .The second time I was back in that hall I noticed that there was blood in his catheter, and there was hardly anything in the catheter other than pure blood. It was also reported to us that he had been throwing up during the night . CNA T said she could not remember which nurse she reported it to, but R5's catheter was the only one that she ever remembered being that full, and noted it was the only hall she worked on. When asked when these observations occurred, CNA T stated, May/June - it was recent. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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 0684 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 7/8/25 at 10:16 a.m., when asked about knowledge of R5's catheter being found overly distended, the NHA stated, I heard that last week, that the catheter had been ballooned, but the NHA was unaware multiple staff had reported the failure of staff in emptying R5's catheter bag. When asked about the very late nursing progress note placed in R5's medical record approximately one month following the provision of care, the NHA stated, That would not be a standard of practice to put in a month later. The NHA said she had not seen the investigation file compiled by the DON. During an interview on 7/8/25 at 11:14 a.m., when asked about R5's medical record documentation and care, RN N stated, I was looking at [R5's] chart and the hospital saying that he had a ruptured bladder. This is a huge concern . (floor staff) were making mention seeing his foley ag being ballooned out like a football . There was no documentation in the Investigation File. When we tried explaining that with the [DON], I felt that she was trying to justify the task for urine output. The numbers were not adding up to accurate numbers. I don't know what kind of follow-through [the DON] did . I feel like there is resistance (to doing the right thing) and hiding of data . One of my bigger frustrations - if something happens here the physician is not being notified . When asked about late progress notes, RN N stated, What about a nurse note entered a month late. It is hard to look back on that and how can you remember what happened a month ago. The [NHA said multiple times this investigation should not have been delayed. I have a big problem with it . I am here to do the right things for the residents . Staff Member (de-identified to prevent retaliation) U said that staff were told not to chart things, (and also) . to chart tasks even if you don't do them . I don't believe any of the numbers that are input on the urine output task. They are not checking before the shift. They are not paying attention to it. During an interview on 7/8/25 at 11:49 a.m., when asked about concerns with distended, over-filled urinary drainage bags, the DON stated, That would be backflowing because it was so full. I think our bags only go to 1000 mls. The DON retrieved a Foley catheter bag, which held 2000 mls, and a graduated cylinder for emptying the urine, which held 1000 mls. The DON provided the following information: 1. Resident care should not be documented if staff have not completed the care. 2. Nursing staff should be documenting nurse notes as soon as the task is completed. The DON agreed there would be the potential for inaccuracy when a note is delayed for approximately one month before being placed in the medical record. 3. The DON said a lactic acid level of 7 would mean a sepsis concern for herself. 4. The DON agreed the physician should be notified of changes in condition immediately. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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 0684 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 7/8/25 at 12:03 p.m., CNA F was asked if she had observed R5's catheter overly filled with urine. CNA F stated, When I went into [R5's] room after breakfast his foley was like a water balloon, ready to burst open. It took two or maybe 3 graduated cylinders to empty the foley bag completely. The next day it was the same situation, his foley bag was like a water balloon about to burst open. I reported it to the floor nurse, and I reported that it had happened two days in a row. I said this was dangerous because it could back up into the tubing. Breakfast was done about 9:00 a.m., and he did not urinate 2000 ccs between the start of my shift and the end of breakfast. I spoke with [CNA V] (who had worked both night shifts prior to CNA F's day shift) . There was no reason someone could not have gone in and emptied the foley on night shift. During a return telephone call on 7/9/25 at 7:30 p.m., When asked if she had ever been instructed to document the completion of resident tasks, even if she had not performed the task, CNA W stated, I was told to do that, and I was very uncomfortable with it. I did it one night, and I have talked to other nurses about it, and I know that it is illegal to document that I did something when I didn't. I did it because my nurse told me to do that . CNA W provided the name of the nurse, and stated, To be honest I am afraid of her. When asked if she had ever seen R5's foley bag overly filled with urine, CNA W said there was a CNA who had been repeatedly hired and fired and was fired recently for not emptying R5's foley bag overnight. CNA W also provided a staff who were present at the same time when an RN told them to document uncompleted tasks. During a return telephone call on 7/9/25 at 7:56 p.m., when asked if she had ever observed R5's foley bag over-distended, CNA R stated, The night R5's bladder exploded, terminated CNA V was on that hall. Review of R5's Urine Output Task documentation revealed the following, in part: 5/21/25 Night shift (7 p.m. to 7 a.m.) - Blank, no documentation present. 5/22/25 Day shift (7 a.m. to 7 p.m.) - 3000 ml. 5/26/25 Night shift - Blank no documentation present. 5/27/25 Day shift - 1200 mls. 5/29/25 Day shift - 35 mls. Review of R5's Weights documentation following Physician Ps physician progress note of 5/27/25, documenting Lower extremity edema - start furosemide 40 mg daily x 2 weeks, follow weights, leg measurements and urine output ., revealed no weights were documented between 5/27 and 5/31/25. No leg measurements were found within R5's medical record, and urine output values have the potential for inaccuracy, based on staff interviews obtained. Review of the Investigation Timeline, completed by RN N, revealed the following identified concerns by that investigator: 1. Need statement for [Nurse regarding her note from 5/30/25 stating the Cath was changed yesterday and there is blood in urine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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 0684 Level of Harm - Actual harm Residents Affected - Few	2. Who worked 5/29/25 - need statements. 3. Vital signs ordered to be checked twice daily and report abnormalities to the provider - 6/17/25 - Lack of documentation . 4. Mixed information . notes show he had a low-grade fever, but this is not reflected under the VS (vital sign) tab. 5. May 2025 Treatment Administration Record (TAR) not documented with a catheter change on 5/29/25 or 5/30/25. 6. Need to show we did some type of education with nursing regarding foley care/insertion. Review of Catheter Care policies revealed that no policies were in effect at the time of R5's ruptured bladder, UTI, and septic shock diagnoses following transfer to the local ED. Catheter polices provided by the facility were Implemented by the NHA on 6/23/25. Review of Notification of Changes policy, revised 7/18/24, revealed the following, in part: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification . Circumstances requiring notification include: 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include a. Life-threatening conditions, or b. Clinical complications . 3. Circumstances that require a need to alter treatment. This may include: a. New treatment. B. Discontinuation of current treatment due to: i. Adverse consequences. Ii. Acute condition. Iii. Exacerbation of a chronic condition. 4. A transfer or discharge of the resident from the facility .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficiency pertains to intake #MI00152671. Based on interview and record review the facility failed to ensure adequate assistance and assistive devices were used to prevent a fall with major injury resulting in harm for one resident (R2), out of three residents reviewed for falls. This deficient practice resulted in hospitalization due to a pelvic fracture. Findings include: Review of R2's 4/19/25 Witnessed Fall Incident report, prepared by Registered Nurse (RN) C, revealed the following information, in part: . CNA (Certified Nurse Aide) was in residents room called out for nurse to help, res (resident [R2]) laying on floor in room on right side next to overbed table. Resident Description: Res states she was getting up to use bathroom and fell during transfer. Was this incident witnessed: N (No). Resident Taken to Hospital? N (No) .Notes: wound to right side of head, c/o (complaint of) right leg discomfort no increased disc (discomfort) with ROM (range of motion) . Statements: No Statements Found. Review of R2's Minimum Data Set (MDS) assessment, dated 1/26/25, revealed R2 was admitted to the facility on [DATE]. R2 scored 12 out of 15 on the Brief Interview for Mental Status (BIMS) reflective of moderate cognitive impairment. R2 required partial/moderate assistance with chair/bed-to-chair transfers and toilet transfers, and had active diagnoses that included arthritis, osteoporosis, seizure disorder, non-Alzheimer's dementia, unsteadiness on feet and repeated falls. R2 was noted to be their own decision maker on their Face Sheet. Review of a CNA Incident Report signed and dated by CNA A on 4/19/25, revealed the following Witness Statement Box information: I was helping [R2] into her wheelchair. She started to turn to sit down, her leg stopped, and she fell and hit her head on the bottom of her bed side table. During an interview on 5/7/25 at 11:20 a.m., R2 was asked about any recent falls. R2 said and aide was assisting her during a transfer, and she fell. R2 could not recall if CNA A used a gait belt during the transfer. R2 reported she has a fractured pelvis. Review of R2's 4/19/25 Investigative Summary form revealed the following, in entirety: Resident Name: [R2] . Female . Summary of interview with person(s) reporting the fall .: Helped getting into chair. Slipped out of gripped (sic). Holding her by butt and pants. Doing fine. Launched off of CNA. Between bed and w/c. overbed table. All other areas of the form were blank. R2's ADL care plan, included with the Investigative Summary, had the following Transfer intervention: Transfer limited assist of one to two a gait belt and my FWW (front wheeled walker) for transfers. Date Initiated: 3/6/16. Revision on:1/27/2025. Review of R2's Progress Notes revealed the following, in part: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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 0689 Level of Harm - Actual harm Residents Affected - Few	. 4/19/25 01:18 (1:18 a.m.) . CNA (Certified Nurse Aide) requested nurse assistance in residents room, nurse responded right away res (resident) laying on floor next to bed near overbed table, res on right side, bleeding noted from residents head, blood and hair noted on bottom of overbed table, res assessed and assisted to sitting to assess head, bleeding appeared to slow with change in position, dressing applied to res head, res further assessed and assisted to sitting on bed then w/c (wheelchair), see VS (vital signs) then assisted to bathroom, res sitting out at nurses station with staff, denied HA (headache), c/o (complained of) discomfort to right leg, ROM WNL (range of motion within normal limits). No c/o increased discomfort with movement, alert usual self. Author: RN C. . 4/19/25 02:14 (2:14 a.m.) . bleeding slowed to laceration to head, may need sutures, call placed to on call MD and order obtained to send resident to ED (emergency department). Ambulance called for transfer, res c/o pain to right leg with transfer, res to [ED] for eval at 0210 (2:10 a.m.) res did not want family notified of transfer. Author: RN C. . 04/19/2025 04:03 (4:03 a.m.) . Res admitted to [acute care hospital] pelvic fx (fracture). . 04/19/2025 09:25 (9:25 a.m.) . At the time of this fall Resident was being assisted by a CNA (CNA A) from her bed to her wheelchair. Per CNA 'I was helping [R2] turn into her wheelchair, she started to turn to sit down, her leg stopped, and she fell and hit her head on the bottom of her bedside table'. Author: RN/Director of Nursing (DON). Review of R2's Care Plans, retrieved 5/7/25 at 2:19 p.m., revealed the following, in part: Focus: I have an ADL self-care performance deficit r/t (related to) impaired mobility, muscle weakness, Dementia, need for staff assistance with ADL/s. I have a pelvic fracture secondary to a fall on 4/19/2025 . Interventions/Tasks: I am non-ambulatory. Date Initiated: 4.22.2025. Non-Weight Bearing to bilateral lower extremities x 12 weeks. Date Initiated: 4/22/2025. Transferring: I am dependent on staff assist of 2 using a full-body mechanical lift (Hoyer lift). Non-weight bearing on lower extremities x 12 weeks. Date Initiated: 4/25/2025. Review of R2's RESOLVED: I had a fall with major injury care plan, Date Initiated 3/6/2016, Revision/Resolved: 4/23/2025 had the following RESOLVED Intervention, in part: Staff need to use a gait belt and extensive assist when transferring me. I have a gait belt in my bag on my wheelchair. Date Initiated: 3/21/24, Revision/Resolved 4/22/25. The NHA acknowledged the facility had not performed monitoring audits of staff use of gait belts following the incident. Attempts were made to contact CNA A via telephone on 5/7/25 at 10:17 a.m., and on 4/7/25 at 2:30 p.m. Voicemail messages were left requesting a return call from CNA A. No return call was received from CNA A during or following the completion of the survey, therefore she was unable to be interviewed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/7/25 at 2:33 p.m., the Five-Day Report to the State Agency regarding R2's fall with major injury was reviewed. The Five-Day Report revealed the following, in part: Investigation determined that at the time of the fall [R2's] plan of care was not followed. The NHA said CNA A had not been on the schedule since the incident and would be receiving education on proper use of a gait belt and also receive a written verbal warning upon her return to work. The NHA said she had spoken to CNA A who confirmed she was holding on to the back of R2's pants and her butt, not using the gait belt as an assistive device during the transfer, therefore not following the residents' plan of care. Review of the facility Use of Gait Belt policy, implemented 7/18/2024, revealed the following, in part: Policy: It is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. Policy Explanation and Compliance Guidelines: 1. Each nursing department employee will use the gait belt assigned to each resident. 2. It will be the responsibility of each employee to ensure the use of gait belts . 4. Failure to use gait belt properly may result in disciplinary action up to termination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficiency pertains to Complaint Intake #MI00150445. Based on interview and record review, the facility failed to prevent a significant medication error for one Resident (R1) of four residents reviewed for medication errors. This deficient practice resulted in the potential for adverse side effects and required transfer to an acute care hospital emergency department for monitoring. Findings include: Review of Complaint Intake #MI00150445 revealed an allegation that R1 was administered the wrong medications on 2/19/25 and was transferred to a hospital emergency department in the morning because they (facility staff and/or emergency room physician) were worried R1s' blood pressure would drop too low. R1 was allegedly alone at the hospital for eight hours worrying that she might have a reaction to the medications, with no notification to the family. Review of R1's Minimum Data Set (MDS) assessment, dated 12/13/24, revealed R1 was admitted to the facility on [DATE] with active diagnoses that included heart failure, hypertension, diabetes mellitus, and depression. R1 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. R1 was usually understood and usually able to understand others. During a telephone interview on 5/7/25 at 10:21 a.m., Registered Nurse (RN) L was asked about R1's 2/19/25 significant medication error. RN L confirmed she had two medication cups prepared for administration to R1 and R4. Both residents had first names that began with the same alphabetical letter. RN L stated, I labeled the cup with initials. I learned I will do first initial and full last name. RN L said she grabbed the wrong cup and administered medications intended for R4 to R1. When asked if R1's family had been notified, RN L stated, I did not notify the family. Review of a facility typed document entitled AM Medications administered on 2/19/2025, received from the facility on 5/7/25 at 11:52 a.m. revealed the following list of medications administered to R1, including eight medications that were not prescribed for R1: Amiodarone HCL oral tablet 200 mg (medication used to treat abnormal heart rhythms). Amlodipine besylate oral tablet 5 mg (medication treats high blood pressure and angina). Empagliflozin oral tablet 10 mg (for diabetic management). Ezetimibe oral tablet 10 mg (cholesterol medication) Lisinopril oral tablet 30 mg (high blood pressure medication) Metoprolol succinate oral capsule ER 24-hour sprinkle 25 mg (high blood pressure medication) **Sertraline HCL oral tablet 100 mg (antidepressant) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Acetaminophen ER tablet 650 mg (pain management medication) Haloperidol tablet 1 mg (antipsychotic medication) **Vancomycin HCL oral capsule 125 mg (antibiotic) **Medications also on [R1's] list** Review of R1's Incident Report, dated 2/19/25, included the following, in part: SN (skilled nurse) went to give resident medications but resident was being washed up by CNAs (Certified Nurse Aides) and with having C-diff (Clostridium Difficile bacterial infection of the colon) SN made decision to label med cup and put in top drawer (of the medication cart). SN moved on to hall 300 to give med and pulled another residents meds. CNA then came and told (SN) [R1] was ready for her meds. SN grabbed the wrong (medication cup). SN knew as she was pouring meds into resident (R1's) mouth she had made a mistake . IMMEDIATE ACTION TAKEN: Resident Taken to Hospital N (for no) . Agencies/People Notified: Resident Representative, Registered Nurse (RN) M . Review of R1's ED (Emergency Department) Provider Note, dated 2/19/25 at 9:35 a.m., revealed the following, in part: Chief Complaint: incorrect morning meds (medications). History of Present Illness: [R1] . reportedly received amlodipine 5 mg, amiodarone 200 mg, Jardiance 10 mg, ezetimibe 10 mg, Haldol 1 mg, lisinopril 30 mg, metoprolol 25 mg, and Zoloft 100 mg . Patient (R1) takes losartan 50 mg for her hypertension. She is not on any diabetic medications . On arrival [R1] reports some mild dizziness . does feel that she has a dry mouth this morning . ED COURSE: Patient does have hypertension but likely to be overtreated with what she was given this morning . Haldol certainly likely to make patient a bit sleepy today. Risks include hypotension, hypoglycemia, arrhythmia, stomach. Plan to monitor patient on telemetry and frequent blood pressure monitoring as well as check blood sugar every hour . Discharge home . PLAN: Continued monitoring at [facility] . During an interview on 5/7/25 at 11:30 a.m., R1 confirmed she was responsible for her own decisions prior to transfer to the ED for monitoring following consumption of another resident's medications. She said they took her to the hospital and monitored her and she was there all day. When asked if she was asked if she wanted her family to know when she was transferred to the ED, R1 stated, My daughter wants to know when they are sending me to the hospital . During an interview with the Director of Nursing (DON) and NHA on 5/7/25 at 1:14 p.m., when asked if nursing staff are permitted to save medications dispensed into open 30 ml (milliliter) plastic cups, the NHA stated, No they are not allowed to save medication cups in the medication cart. When asked if the facility had performed monitoring of staff or audits of medication administrations following the significant medication error, the DON acknowledged they had not done medication monitoring or audits to ensure compliance following identification of this deficient practice. Both the NHA and DON confirmed the nurse involved with the medication error was the only staff person educated. During an interview on 5/7/25 at 4:30 p.m., when asked about the Incident Report showing RN B was the family member notified of R1's medication error and transfer to the ED, the NHA confirmed RN B should not have been listed as a family member notification. When asked if facility staff had asked R1 regarding notification to emergency contacts, the NHA reviewed the R1's EMR (Electronic Medical Record) and acknowledged there was no documentation showing R1 had been asked about family notification, or evidence that family emergency contacts had been notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration policy, implemented 8/3/2023, revealed the following, in part: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination . Identify resident by photo in the MAR (medication administration record) . Review MAR to identify medication to be administered . Review of the Institute for Healthcare Improvement Five Rights of Medication Administration, 3/1/2007, revealed the following, in part: One of the recommendations to reduce medication errors and harm is to use the 'five rights'; the right patient, the right drug, the right dose, the right route and the right time.