STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235388	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Shores Senior Care and Rehab Center	3254 E Midland Rd Bay City, MI 48706

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area, resulting in the potential to spread food borne illness to all residents who consume food from the kitchen. Findings include: On 03/10/2026 at 8:44 AM, during the initial kitchen tour, observed residue on the blade of a carving fork, stored inside the knife holder. On 03/10/2026 at approximately 9:08 AM, observed built up residue on juice nozzles. During this observation, Dietary Manager F was asked how often the juice nozzles are cleaned, and he stated the nozzles are soaked after each meal.According to the 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have an active plan for reducing the risk of l\Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens being allowed to exist and spread in the facility's plumbing system with an increased risk of respiratory infection among all residents in the facility. Findings include: On 03/10/2026 at 1:07 PM, during the environmental tour with Maintenance Director H, free chlorine residual was tested at a bathroom hand sink, and the result was zero parts per million (ppm) in room [ROOM NUMBER]. During this observation, Maintenance Director H stated that free chlorine is usually at 0.5 ppm. On 03/10/2026 at 1:11 PM free chlorine residual was tested at the spa tub in Superior 1 hallway and the result was zero. On 03/11/2026 at 9:44 AM record review of the facility's Drinking Water Testing logs, shows the facility has designated a normal range of free chlorine at 0-3ppm and each monthly test result from October 2025 to March 2026 resulted at 0ppm.According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems, dated January 3rd, 2025, Ensure disinfectant residual is detectable throughout the potable water system.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review the facility failed to ensure residents were treated in a dignified and respectful manner by respond to call lights timely and complaints of Staff cell phone use in resident care areas for anonymous resident council residents and residents (#1, #12, #13, #90, #46, #117, #138) resulting in a lack of timely response of care needs, extended wait times for assistance, and residents verbalizations of discourteous staff, feelings of being a burden, frustration and sadness. Findings include: Resident #12: An interview was completed with Resident #12 in their room on 3/10/26 at 10:55 AM. When queried if facility staff treat them with dignity and respect, Resident #12 indicated there is a second shift aide (Certified Nursing Assistant [CNA]) who does not. When asked how the CNA does not treat them with dignity and respect, Resident #12 stated, I will ask to go to bed, and (the CNA) says they will have to come back because another (call) light is on. Resident #12 stated, (The CNA) goes and doesn't come back for 25 to 30 minutes. With further inquiry, Resident #12 verbalized it makes them feel unimportant when the staff leave them knowing they are tired and just want to go to bed. When asked the name of the CNA, Resident #12 responded they did not want to provide their name because they did not want to create additional problems. On 3/11/26 at 11:30 AM, a follow up interview was completed with Resident #12. Resident #12 was asked about staffing in the facility and stated, They are short (staffed). When queried how they know the facility is short staffed, Resident #12 revealed the CNA staff tell them. When queried if their care if negatively impacted because of staffing, Resident #12 stated, On 3/7/26, I didn't get my shower because there were only three girls (staff) here. When asked why they did not get their shower if there were three CNAs working, Resident #12 replied, I don't push it because I know they're short. I feel bad and don't want to bother them. When asked, Resident #12 revealed facility staff tell them they are short staffed which makes them feel guilty for taking up the staff member's time. Resident #12 verbalized they had not received their shower a couple weeks prior to that for the same reason. When queried regarding call light response time, Resident #12 replied that it can take a long time when the facility does not have enough staff. When asked for more specific information, Resident #12 replied, This Tuesday, I shit my pants because they didn't get to me in time. When queried how that made them feel, Resident #12 revealed they felt horrible and embarrassed. Review of Resident #12's Electronic Medical Record (EMR) revealed the Resident was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included heart failure, anxiety, ovarian cancer, and chronic respiratory failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required maximum to total assistance for toileting and bathing. Resident #90: On 3/11/26 at 10:20 AM, Resident #90 was observed sitting in a recliner in their room. Leg braces were observed sitting on the floor in the room. When queried regarding the braces, Resident #90 stated, I don't walk. Resident #90 then stated, I lost my core in Vietnam and became tearful. An interview was completed with Resident #90's family member Witness U on 3/11/26 at 1:23 PM. When queried regarding nursing care in the facility, Witness U replied, A couple nurses have an (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attitude problem. When asked to explain what they meant, Witness U revealed there was another resident who resided on the same hall as Resident #90 who had dementia and kept yelling I just need a water one day when they were visiting. When asked who the other resident was, Witness U revealed the resident went to the hospital and did not return to the facility. Witness U continued, I went and told the nurse, and she asked me if (the resident) put their call light on and I said I don't know, I'm just a wife. With further inquiry, Witness U revealed it was not just what the nurse said but also how they said it. When asked who the nurse was, Witness U stated, (Registered Nurse [RN] V). With further inquiry regarding nursing care, Witness U stated, They have problems with their CNA's. Witness U was asked what the problems were and revealed they were told the facility does not have money in the budget for extra CNAs so they take one from one unit and move to another unit. When asked how they knew that CNAs were being moved from unit to unit to cover staffing shortages and not for another reason, Witness U responded that the staff tell them. Witness U then stated, One CNA is crude. I had to request they didn't go into (Resident #90's room). When queried how the CNA was crude, Witness U replied, It's her attitude. When asked, Witness U was unable to recall the CNAs name. With further inquiry regarding nursing care in the facility, Witness U stated, Call lights take up to 45 minutes to answer and indicated they come to the facility daily and ensure their spouse's needs are met. Record review revealed Resident #90 was originally admitted to the facility on [DATE] with diagnoses which included liver cancer, pancreas cancer, Parkinson's disease, and dementia. Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required maximum to total assistance to complete ADLs with the exception of moderate assistance with eating. Resident #138: On 3/11/26 at 11:53 AM, Resident #138's family member Witness S was observed exiting the Resident's room and walking toward the nurses' station. When greeted, Witness S stated, The call light has been on for 18 minutes and (Resident #138) needs to use the restroom. Witness S revealed they were about to take the Resident to the bathroom with the assistance of another family member but decided to look for staff assistance first. An observation of the call light monitoring screen at the nurses' station was completed at this time. The call light monitor revealed Resident #138's call light was put on at 11:34 AM. Unit Manager RN R was sitting at the nurses' station next to the call light station working on a laptop and no other staff were observed in the vicinity. At 12:00 PM, CNA W approached the nurses' station and began speaking to Unit Manager RN R. When queried who Resident #138's assigned CNA was, CNA W replied, (CNA X). When queried where CNA X was, RN R and CNA W both verbalized CNA X was on their lunch break. When queried who covers their assigned area/residents when they are at lunch, CNA W responded the other CNAs working on the unit cover for staff lunches and breaks. When asked who the other CNAs working on the unit were, CNA W replied, (CNA Y) and (CNA Z). At 12:03 PM, Resident #138's call light had still not been answered (total of 29 minutes). When queried why Resident #138's call light had not been on since 11:34 AM and was still not answered, a response was not provided. CNA W went to answer the call light. A review of the current call lights on at this time was completed with Unit Manager RN R. Per the call light monitoring screen, in addition to Resident #138's call light, room [ROOM NUMBER]'s call light had been on and unanswered since 11:35 AM. When asked if that was okay, Unit Manager RN R replied, No. room [ROOM NUMBER]'s call light had been on since 11:47 AM. When asked if that was acceptable, Unit Manager RN R responded, That is longer than we like. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed Resident #138 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy (dysfunction of the brain caused by system illness, organ failure, or chemical imbalances), fall, dementia, and diabetes mellitus. Review of documentation in Resident #138's Electronic Medical Record (EMR) revealed the Resident was alert to self only and required assistance of a mechanical lift and two staff for transfers. An interview was completed with the Director of Nursing on 3/11/26 at 3:16 PM. The DON was informed of Resident #12's statements regarding staff answering their call light then leaving them to assist others, staff informing them they are short staffed, and the Resident's feelings related to incontinence due to lack of timely staff assistance as well as concerns verbalized by Witness U, and observations of call light response times. When asked if that was acceptable, the DON stated, That is not okay. On 3/10/2026, at 11:04 AM, during resident council multiple residents complained of call light responses by staff and care concerns. The following concerns were voiced: If I'm on her assignment for care it will take her an hour to get to me and she says she's got so many people why didn't you tell me that the first time sometimes they raise their voice they say they are always short they say they are short all the time for instance some say stand up so I can wipe you. Sit down. Get in your chair. often times many people come in and shut my door and use their phone they come in and shut the light off they will cancel my light and say it's not time to get up yet it takes them a long time to answer if my aide is in someone else's room, they will make we wait for my aide there can be several sitting at the nursing station and they won't answer the other girls' lights they don't answer the other girls lights and that goes on a lot I'm glad I have a phone. If I was having a heart attack and when they don't answer I'd have to call 911 They think I'm asleep and go in my bathroom to talk on their phone Confidential group of residents voiced concerns regarding CNA L: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She's very loud and she tells you what you need not the other way around she is a bit brusk loud bossy she talks on her phone a lot she tells me what i need: she will do the opposite of what you ask she"ll say calm down calm down Confidential group of residents voiced concerns regarding CNA K: very voicetress she will be on her phone trying to take care of me I had to use a bed pan. She shut my life off and didn't come back I needed to be changed (I was having diarrhea) she told me I will come change you after my break On 3/12/2026, at 1:00 PM, a record review of the facility provided Resident Council Minutes revealed the following: Resident Council Minutes 9/9/2025 revealed resident agree call lights are slowly improving Resident Council Minutes 10/7/2025 revealed Residents agree that call light times continue to improve Resident Council Minutes 11/4/2025 revealed Residents state call light times are starting to be an issue again The corresponding RESIDENT ASSISTANCE FORM revealed . long call light times . is this an ongoing problem . Yes was check marked. FACILITY RESPONSE Continuing to monitor call light times and run reports. Resident Council Minutes 1/9/2026 revealed Res. State call lights have become an issue again Nursing – Residents state they have long waits for call lights at times concern form completed A review of the corresponding RESIDENT ASSISTANCE FORM revealed continue staff education on answering call lights more promptly . will continue to monitor call lights times. Monitor to ensure aids are wearing pagers . Resident Council Minutes 2/3/26 revealed Residents agree that the nourishment rooms/snacks have been stocked more frequently and that call lights are slowly improving (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/12/2026, at 1:40 PM, The Director of Nursing was interviewed regarding concerns voiced during resident council meetings. The DON was asked if she follows up on resident council concerns and the DON offered, I don't go into council to discuss concerns. The DON was asked how the facility follows up on concerns voiced during resident council and the DON stated, concern forms are given to the unit managers and then they give back the Administrator. Resident #1 R1 is [AGE] years old and recently re-admitted to the facility on [DATE] with diagnoses that include periprosthetic fracture around internal prosthetic right knee joint, fall on same level, dementia and wedge compression fractures of the second and third lumbar vertebrae. On 03/11/2026 at 3:08PM, R1 was observed sitting in her wheelchair in the hallway. This surveyor approached R1 and asked about her day. R1 stated she is having a good day but that she would like to go to bed. This surveyor informed Registered Nurse (RN) G of the request made by R1. RN G asked if R1's call light was on and RN G was informed that the call light was not on and that R1 was sitting out in the hallway in her wheelchair. RN G was observed heading towards R1. At 3:20PM R1 was observed sitting in the door of her room in her wheelchair and still requesting to go to bed. The call light was observed to be turned on. RN C approached R1 and asked if she needed anything. R1 again stated that she would like to go to bed. RN C stated she would find another staff member to help her assist R1 back into bed. At 3:23pm, RN C and another staff member placed R1 in bed. Resident #13 R13 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include falls, surgical aftercare of the circulatory system, heart failure and hypertension. On 03/10/2026 at 9:15AM, R13 was asked about the call light response times of the facility. R13 stated the call light takes a long time to get answered. R13 stated he believes the average time to get a call light answered is 30 minutes and that he has had a few times go over an hour. R13 stated, If I were having a real emergency, I would be dead by the time they got here. Resident #46: Record review of Resident #46' Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental status (BIMs) of 15 out of 15, cognitively intact. Section GG functional abilities- noted resident #46 as dependent or substantial/maximal assistance for toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking of footwear, personal hygiene. In an interview on 03/10/2026 at 12:27 PM with Resident #46 revealed the staff/ aides do use their phones when they're in her room, and that it's very annoying, they just keep talking while they care for her. The staff do shut the lights off and don't come back also. The resident stated that it happens when they are short staffed and its income tax time and they get extra money and call-in. Resident #117: Record review of Resident #117's Minimum data Set (MDS) dated [DATE] revealed a Brief Interview of Mental status (BIMs) of 13 out of 15, cognitively intact. Section GG functional abilities- noted (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident #46 as dependent or substantial/maximal assistance for toileting hygiene, shower/bathe, lower body dressing, putting on/taking of footwear, personal hygiene. In an interview on 03/10/2026 at 12:51 PM with Resident #117 stated that the aides do shut off the call light and don't come back, so the resident has to put the call light back on, also stated that the night shift is inconsistent some are good depending on the shift and who is working. The resident stated that the facility staff need more training and have attendance problems. The resident stated that staff use their cell phones while they are in the residents' room and make calls while the resident has to sit and wait. The resident stated that staff talk about residents and other staff while they are working with the resident. The resident stated that the staff are not to use their phones, but they do. They have their cell phones in their pockets and take calls in resident rooms so that the management doesn't see them. Record review of the 'Employee Handbook' dated 11/2018 revealed on page 26, section 4.10 Cell Phones: Personal electronic devices, including but not limited to cell phones, smart phones, camera-equipped phones, MP3 players, and IPad's are not allowed in resident care areas because of resident privacy issues (HIPPA) and quality of care issues. Employees must keep their personal electronic devices in their personal vehicle or a company-provided locker and use it only during break times or other non-working times. In an emergency, there are facility phones available, and family can contact the facility directly to have an employee paged. Record review of 'Health Care Association of Michigan: Rights of Residents in Michigan Nursing Facilities' copyright 2024, Respect and Dignity (C.) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health and safety of the resident or other residents.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate indication of a psychotropic/antidepressant drug dosage for 4 residents (#2, #9, #94, and #138), resulting in the facility's failure to fully inform the resident or responsible party by obtained signed consents with no medication dosage noted, doses per day or the route of the medication. Findings include: Resident #138: On 3/10/26 at 11:05 AM, Family Member Witness S was observed in Resident #138's room but the Resident was not present. When asked, Witness S revealed Resident #138 was out of their room with staff and they were waiting for them to return. Witness S was asked how long Resident #138 had been at the facility and replied, Since Thursday (3/5/26). When queried regarding the Resident's admission to the facility, Witness S revealed multiple family members including themselves and Resident #138's spouse (Witness T) were present when the Resident was admitted to the facility. Witness S was asked about the admission process and stated, They (facility staff) were just like sign this, sign this and continued, I feel like more guidance would have been better. With further discussion regarding the care Resident #138 was receiving at the facility, Witness S verbalized the family did not understand why the Resident was taking psychotropic medications and stated they did not want (Resident #138) to receive them. When asked if Resident #138 had a legal decision maker, Witness S they were as Witness T did not want to make medical decisions and stated, We are just getting the DNR (Do Not Resuscitate) and the DPOA (Durable Power of Attorney) figured out now. Witness S revealed the family had legal documentation of representative for healthcare decisions but the facility was unable to accept the documentation completed by Resident #138's attorney and were working to straighten it out. With further inquiry regarding the psychotropic medications, Witness S responded that Resident #138 did not have a diagnosis of depression and had never taken an antidepressant medication. Witness S verbalized the Resident was started on an antidepressant and another medication in the hospital but that the medications were only supposed to be short term due to confusion related to their infection. When asked, Witness S disclosed they found out Resident #138 had been receiving the medications at the facility and wanted the medications discontinued. On 3/11/26 at 11:00 AM, Resident #138 was observed in their room sitting in a wheelchair. Witness S and Witness T were present in the room. Resident #138's eyes were closed and they did not respond to verbal stimuli. An interview was conducted with Witness S and Witness T. When queried, Witness T revealed the were concerned about the psychotropic medications Resident #138 was taking and verbalized they did think the Resident needed them and did not want them to take them. With further inquiry, Witness S revealed Resident #138 was receiving Seroquel (atypical antipsychotic medication commonly used to treat schizophrenia, bipolar disorder, and major depressive disorder) and Zoloft (antidepressant medication). When asked, both Witness T and Witness S verbalized they had informed nursing staff of their concerns and desire to discontinue the medications. At 11:05 AM on 3/11/26, Registered Nurse (RN) E entered Resident #138's room to administer medication. Witness T and Witness S discussed their concerns regarding Resident #138 receiving Seroquel and Zoloft with RN E. At 11:10 AM, while RN E was still in the room, Unit Manager RN R entered Resident #138's room and stated they spoke to (Physician Q) and would discontinue the psychotropic medications. Record review revealed Resident #138 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy (dysfunction of the brain caused by system illness, organ failure, or chemical imbalances), fall, dementia, and diabetes mellitus. Review of documentation in Resident #138's Electronic Medical Record (EMR) revealed the Resident was alert to self only and required (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance of a mechanical lift and two staff for transfers. Review of Resident #138's face sheet revealed diagnoses of Major Depressive Disorder, Recurrent, Unspecified and Mood disorder due to known psychological condition (mood disruptions resulting from brain dysfunction other than primary psychiatric diseases). A corresponding review of Resident #138's hospital referral documentation in the EMR was completed. The documentation in the hospital referral including History and Physical Reports dated 3/2/26 did not include any history of psychiatric disorders. Review of Resident #138's Health Care Provider (HCP) orders and Medication Administration Record (MAR) revealed the Resident was receiving the following psychotropic medications: - Zoloft 50 milligram (mg) once daily for major depressive disorder (Start Date: 3/6/26) - Seroquel 25 mg once daily for insomnia/restlessness (Start Date: 3/5/26) A review of signed and scanned documents as well as progress notes in Resident #138's EMR revealed no documentation of informed consent for Seroquel and/or Zoloft. An interview was completed with Social Worker (SW) I on 3/12/26 at 10:31 AM. When queried regarding consent for Resident #138's psychotropic medications, SW I stated, they were unsure if got consent and that they would check. On 3/12/26 at 11:25 AM, SW I returned and revealed nursing staff utilize an evaluation form when obtaining psychotropic medication consents. Review revealed the following: - 3/5/26 at 8:11 PM: Psychotherapeutic Medication Information Sheet. Seroquel 25 mg- Insomnia and restlessness. C. Potential benefits of psychotherapeutic medications: Reduced symptoms of depression. Reduced symptoms of psychosis. Reduced symptoms of anxiety. Information Provided to: (Resident #138) and (Witness T) . - 3/5/26 at 8:09 PM: Psychotherapeutic Medication Information Sheet. Sertraline (Zoloft) 50mg-Major depressive disorder C. Potential benefits of psychotherapeutic medications: Reduced symptoms of depression. Reduced symptoms of psychosis. Reduced symptoms of anxiety. Information Provided to: (Resident #138) and (Witness T) . Both forms were completed by RN P and neither form was physically signed by Resident #138 and/or their Resident Representative. On 3/12/26 at 11:40 AM, an interview was completed with Resident #138's family members Witness T. When queried if facility staff discussed Resident #138 taking Seroquel and Zoloft with them upon admission to the facility on 3/5/26, Witness T stated, They just told me that (Resident #138) was on that in the hospital and indicated they were continuing all their same medications. An interview was completed with the Director of Nursing (DON) on 3/12/26 at 12:22 PM. When queried regarding facility procedure and what staff are supposed to discuss and address with residents/resident representatives when obtaining informed consent for psychotropic medications, the DON responded that staff should review the medication including its use and potential side effects. The DON was informed of interview completed with Witness T where they verbalized, they (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were only informed that the facility was continuing medications Resident #138 was taking at the hospital and that they did not want the Resident receiving psychotropic medications. The DON responded they were unable to speak for the RN who completed the Psychotherapeutic Medication Information Sheet. When asked, the DON revealed RN P was out of the building and verbalized they would attempt to contact them. An interview was completed with the DON and RN P (via phone) on 3/12/26 at 12:38 PM. When queried who was present when they completed the Psychotherapeutic Medication Information Sheets for Resident #138, RN P stated, Definitely (Resident #138) and (Witness T). When queried what they discussed with Resident #138 and Witness T when consent was obtained for Seroquel and Zoloft, RN P responded by saying what they normally review. RN P was asked what they reviewed with Resident #138 and stated, Did not go over the side effects (of the medications). When asked why they did not review the medication side effects, RN P revealed it was late and Witness T was ready to go home. RN P revealed they planned to follow up with Witness T but did not get back to it. After disconnecting the phone call, the DON verbalized understanding of the concern. Resident #2: Record review of Resident #2's Minimum Data Set (MDS), dated [DATE], revealed medical diagnosis of anemia, coronary artery disease, hypertension, diabetes, cerebrovascular accident, non-Alzheimer's dementia, malnutrition, anxiety, depression, bipolar disease, and chronic obstructive pulmonary disease. Record review of Resident #2's medical records forms revealed a 'mental Illness/Intellectual Disability/related condition exemption criteria certification Level II Screening was dated 1/14/2025. Record review of Resident #2's March 2026 Medication Administration Record (MAR) revealed antidepressant Lexapro 10 mg by mouth in the morning related to major depressive disorder. Medication order started on 7/18/2025. Record review of Resident #2's 'Psychotherapeutic Medication Information Sheet' dated 1/8/2026 revealed 'Lexapro major depressive disorder' information provided to the POA (Power of Attorney) on 1/8/2026. An interview was conducted on 03/12/2026 at 8:19 AM with the Social Service staff I about Resident #2's antipsychotic consents. Social Services staff I agreed with the surveyor that there should have been a dose, frequency of administration, side effects, and black box warnings noted on the consent. Social services staff I stated that the facility has two forms, a PSYCHOTHERAPEUTIC MEDICATION INFORMATION SHEET is used as the consent, where the PSYCHOACTIVE MEDICATION MONITORING triggers the care plan and for staff to monitor for changes. The contracted behavioral services personnel do follow the residents for behaviors/mood. There is a Nurse Practitioner that comes every 2 weeks to see the residents for psych follow-up. Resident #9: Record review of Resident #2's Minimum Data Set (MDS), dated [DATE], revealed medical diagnoses of anemia, coronary artery disease, hypertension, Multidrug-resistant organism diabetes, Parkinson's disease, anxiety, depression, bipolar disease, and schizophrenia. Record review of Resident #9's closed medical record for unnecessary medications revealed the resident was admitted [DATE] and (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discharged on 2/27/2026. Record review of Resident #9's February 2026 Medication Administration Record (MAR) revealed psychotherapeutic medications of: Buspirone 30mg one tablet by mouth two times a day related to unspecified mood disorder. Clonazepam 1 mg by mouth two times a day related to schizoaffective disorder. Oxcarbazepine/Trileptal 600mg by mouth two times a day related to schizoaffective disorder Bipolar type disorder and Effexor 150mg by mouth two times a day related to depression In an interview on 03/11/2026 at 10:45 AM Social services staff I revealed that Resident #9 had a Brief Interview of Mental status (BIMs) score of 14, was his own responsible party, signed all forms. Record review of Resident #9's Psychotherapeutic Medication Information Sheet' s for Buspirone, Clonazepam, Oxcarbazepine/Trileptal and Effexor all listed the medication, but there were no dosage, frequency or black box warnings noted. Resident #94: Record review of Resident #94's Minimum Data Set (MDS), dated 12/192025, revealed medical diagnoses of anemia, coronary artery disease, hypertension, peripheral vascular disease, renal insufficiency, obstructive uropathy, hyponatremia, non-Alzheimer's dementia, and anxiety. Record review of Resident #94's March 2026 Medication Administration Record revealed antipsychotic Rexulti/brexpiprazole 2 mg by mouth one time a day for hallucinations related to dementia with agitation. Medication order started on 2/4/2026. Record review of Resident #94's 'Psychotherapeutic Medication Information Sheet', dated 12/9/2025, Medication change revealed 'Rexulti dementia unspecified severity with agitation' information provided to the POA (Power of Attorney) on 1/8/2026. There were no dosage, frequency, route or black box warnings noted. Record review of the facility 'Use of Psychotherapeutic Medications' policy, dated 2/1/2025, revealed that facilities must ensure that residents are fully informed and have the right to accept or decline psychotropic medications. Full resident participation: Implement protocols to ensure residents (or their legal representatives) are fully informed of the risk, benefits, and alternatives . Psychotherapeutic medications include antianxiety, antidepressant, antipsychotic and hypnotics. The following information in all physician orders psychotherapeutic medications include Name of Medication and strength, route of administration, frequency of administration, supporting diagnosis, and targeting behaviors/symptoms. Record review of the 'Health Care Association of Michigan, Rights of Residents in Michigan Nursing Facilities; copyright 2024, Respect and Dignity the resident has the right to be fully informed in a language that they can understand or your total health status, including but not limited to the residents' medical condition.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that annual Preadmission Screening and Resident Review (PASARR) assessments were completed for 4 residents (#2, #46, #113, #116) of 8 residents reviewed. Findings include: Medicaid.gov. 'Preadmission Screening and Resident Review'Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires Medicaid-certified nursing facilities:Evaluate all applicants for serious mental illness (SMI) and/or intellectual disability (ID)Offered all applicants the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings)Provide all applicants with the services they need in those settingsPASRR is an important tool for states to use in rebalancing services away from institutions and towards supporting people in their homes, and to comply with the Supreme Court decision, [NAME] vs L.C. (1999), under the Americans with Disabilities Act, individuals with disabilities cannot be required to be institutionalized to receive public benefits that could be furnished in community-based settings. PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long-term care.In brief, the PASRR process requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have SMI or ID. This is called a Level I screen. Those individuals who test positive at Level I are then evaluated in depth, called Level II PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care. Resident #2:Record review of Resident #2's Minimum Data Set (MDS) indicated the resident was initially admitted to the facility on [DATE] with diagnoses: non-Alzheimer's dementia, malnutrition, anxiety, depression, bipolar disease, and chronic obstructive pulmonary disease, anemia, coronary artery disease, hypertension, diabetes, and cerebrovascular accident. Record review of Resident #2's medical records forms revealed a 'mental Illness/Intellectual Disability/related condition exemption criteria certification Level II Screening was dated 1/14/2025. In an interview and records review on 03/11/2026 at 1:16 PM with social service staff I did a record review of Resident #2's PASARR and acknowledged that the annual PASARR was due back in January 2026. Resident #46:Record review of Resident #46 Minimum Data Set (MDS) indicated the resident was initially admitted to the facility on [DATE] with diagnoses: depression, coronary artery disease, heart failure, hypertension, peripheral vascular disease, renal insufficiency, diabetes, cerebrovascular accident, and chronic obstructive pulmonary disease. Record review of Resident #46's medical records forms revealed a 'mental Illness/Intellectual Disability/related condition exemption criteria certification Level II Screening was dated 1/14/2025. In an interview and record review on 3/11/2026 at 1:16 PM with the social service staff I acknowledged that Resident #46 needed a PASSAR, that was due in January 2026. Social service Staff I stated that she was auditing charts to get caught back up the previous Social Worker did not get it done. Resident #113: Record review of Resident #113 Minimum Data Set (MDS) indicated the resident was initially admitted to the facility on [DATE] with diagnoses: non-traumatic brain dysfunction, coronary artery disease, heart failure, hypertension, peripheral vascular disease, Alzheimer's disease, and aphasia. Record review of Resident #113's medical records forms revealed a 'mental Illness/Intellectual Disability/related condition exemption criteria certification Level II Screening was dated 1/3/2025. Resident #116: Record review of Resident #116's care plans indicated the resident was initially admitted to the facility on [DATE] with diagnoses: Alzheimer's disease, hypertension, anxiety disorder, major depressive disorder. Record review of Resident #116's medical records forms revealed a 'mental Illness/Intellectual Disability/related condition exemption criteria certification Level II Screening was dated 1/14/2025. In an interview on 03/11/2026 at 1:04 PM with the social services (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff I revealed that the facility did not have a PASARR policy, but that there was a PowerPoint presentation that they used from the Michigan Department of Health and Human Services from last year 2025. Record review of the facility provided PowerPoint 'PASARR for Nursing Homes' 3/13/2025 revealed Preadmission Screen/Annual Resident Reviews Slide 21- Annually, when an individual resides in a nursing home, per the Medicaid Provider Manual, Annually means within every fourth quarter after the previous Level I screening or Level II evaluation, whether it was completed for admission, condition change, or annual review.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to operationalize policies and procedures for safe medication storage for two residents (# 29 and #90) of two residents and one ([NAME] One) of four medication carts reviewed. Findings include:Resident #29: On 3/11/26 at 9:45 AM, an observation of Resident #29's room and interview were completed with the Resident and Family Member B on 3/11/26 at 9:45 AM. A bottle of iVIZIA eye drops (long lasting solution for dry eyes) was observed sitting on the dresser next to the Resident's bed. When asked about the eye drops, Family Member B responded they administered them to the Resident four times a day. When asked why the facility nursing staff did not administer the medication, Family Member B revealed they brought the eye drops to the facility because the Resident needs them, so they do it. When asked if the drops were always sitting on the bedside dresser, Family Member B verbalized they were. Record review revealed Resident #29 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included metabolic encephalopathy (brain dysfunction caused by toxins, organ failure, and/or systemic illness), kidney cancer, stage 4 (severe) chronic kidney disease with surgical kidney removal, heart disease, and osteomyelitis (infection in the bone). Review of the Minimum Data Set (MDS) assessment, dated 2/1/26, revealed the Resident was cognitively intact and required moderate-to-total assistance with the exception of oral hygiene. A review of Resident #29's Electronic Medical Record (EMR) revealed the Resident did not have a Self-Medication Administration Assessment and/or assessment for bedside medication storage. Further review revealed the Resident did not have a Health Care Provider (HCP) order for iVIZIA eye drops. Resident #90: On 3/11/26 at 10:20 AM, Resident #90 was observed sitting in a recliner in their room. A clear plastic cup with a spoon and visible sediment like a dissolvable medication was observed sitting on the overbed table in front of the Resident. When asked what was in the cup, Resident #90 stated, I don't know. Resident #90 was asked if there was a medication in the cup and stated, I already got my meds. On 3/11/26 at 10:30 AM, Registered Nurse (RN) E was asked if they administered Resident #90's morning medications and responded that they did. When queried what was in the clear plastic cup with the spoon in it on the Resident's overbed table, RN E stated, Those are (Resident #90's) cancer pills. With further inquiry, RN E verbalized they medication is dissolved in water, and they left it at the Resident's bedside for them to take. RN E was informed Resident #90 did not know what was in the cup. RN E was then asked to come to Resident #90's room to confirm the cup on the bedside table contained the Resident's cancer medications. RN E went to Resident #90's room and confirmed the clear plastic cup on the overbed table were the Resident's dissolved medications. RN E told Resident #90 the cup contained their medications and then exited the room. Record review revealed Resident #90 was originally admitted to the facility on [DATE] with (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses which included liver cancer, pancreas cancer, Parkinson's disease, and dementia. Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required maximum to total assistance to complete ADLs with the exception of moderate assistance with eating. Review of Resident #90's electronic Medication Administration Record (MAR) revealed the Resident received, Everolimus (targeted therapy medication used to treat certain cancers and tumors) Oral Tablet 10 mg (milligram). 1 tablet by mouth in the morning. Dissolve tab in 25ml of water. upon rising daily. A review of Resident #90's EMR revealed the Resident did not have a Medication Self-Administration Assessment. An interview was completed with the Director of Nursing (DON) on 3/11/26 at 3:16 PM. The DON was informed of observations of both Resident #29 and Resident #90's medications at bedside as well as interview with RN E. When asked, the DON verbalized a self-medication assessment should be completed prior to Resident's and/or their families administering medications. When queried regarding RN E leaving Resident #90's medication on their bedside table, the DON stated, Not okay. Should not have been left. The DON indicated they would address both medications. Review of facility policy/procedure entitled, Medication Storage in the Facility (Dated June 2019) revealed, Bedside Medication Storage . Bedside medication storage is permitted for residents . upon the written order of the prescriber and once self-administration skills have been assessed and deemed appropriate . Medication Cart: On 03/12/2026 at 9:11AM, observation revealed the [NAME] 1 Med Cart unlocked and the screen to the computer is open and displaying resident information. The nurse is observed talking to another staff member at the desk, with her back turned and not watching the medication cart. There are medications on top of the medication cart and accessible to residents. The nurse on duty reapproached the medication cart and began to administer medication again. An interview was conducted with Registered Nurse (RN) D. RN D was asked if they should leave the medication cart unlocked and computer screen open with resident information on it if you are not present at the med cart. RN D stated, no, I should not, the cart should be locked and screen closed. RN D stated, I got distracted with a resident need and I went to help him and when I left the room and went back to my cart, I noticed the Nurse Practitioner (NP) was present I went and talked to her. Review of the policy titled, Medication Storage in the Facility, revealed, B. Administration 16. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. In addition, privacy is maintained always for all resident information (e.g., MAR) by closing the MAR book/covering the MAR sheet or computer screen, when not in use.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a pummel cushion (wheelchair cushion with a raised wedge in the center) was used for the treatment of documented medical symptoms for one resident (Resident #88) of one resident reviewed for restraints, resulting in a lack of a clear indication for use and ongoing assessment/reassessment for use. Findings include:Resident #88: On 3/10/26 at 1:50 PM, Resident #88 was observed sitting in a high back wheelchair in their room with Family Member J. Both footrests were in place on Resident #88's wheelchair with their feet positioned on the footrests. A pummel cushion was in place on the wheelchair. The front of the pummel cushion was slid down with the wedge of the pummel cushion partially off the edge of the wheelchair seat. Upon observation of the back of the wheelchair seat, the pummel cushion was noted to be positioned all the way to the back of the seat. An interview was completed at this time. When queried regarding the reason for the pummel cushion, Family Member J replied, I think it is because (Resident #88) slid down and fell. When queried if Resident #88 had other falls at the facility, Family Member J responded they had but indicated it had been a while. When asked about staff assistance needed for transferring, Family Member J stated, Supposed to be two (staff) but don't always have two. With further inquiry, Family Member J stated, They don't have enough staff. Family Member J revealed they are at the facility from approximately 10:00 AM until 7:00 PM daily and stated, They (staff) do not check on (Resident #88). Family Member J stated hey Have to go get them (staff) when the Resident needs something. Family Member J was asked if they use the call light in the Resident's room when the Resident needs something and responded that they have tried to use the call light, but it takes the staff up to 25 minutes to come and is quicker to just go get them. Throughout the interview, Resident #88 appeared uncomfortable and kept trying to move and reposition themselves in their wheelchair unsuccessfully with the pummel cushion in place. When asked if they were uncomfortable or if they needed something, Resident #88 responded verbally but about an unrelated topic to the question asked. Record review revealed Resident #88 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's disease, dementia, heart failure, cervical disc disorder with myelopathy (spinal cord compression in the neck), difficulty walking and falls. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required moderate to maximum assistance to complete all Activities of Daily Living (ADLs) with the exception of eating. The MDS further specified the Resident did not have any restraints in place. Review of Resident #88's Health Care Provider (HCP) orders in the Electronic Medical Record (EMR) revealed the Resident did not have a current and/or discontinued order for a pummel cushion. Further review of the Resident's EMR no assessment/reassessment for the pummel cushion and no documentation for indication of use. A review of Resident #88's care plans revealed a fall care plan with an intervention for the pummel cushion initiated 8/21/25 but did not include a reason/indication for implementation. A review of Resident #88's EMR Progress Note documentation from 3/12/25 to present revealed no documentation related to pummel cushion implementation/use. Additionally, no documentation of wheelchair positioning concerns, such as medical necessity for hip abduction (away from midline/prevent crossing) and/or sliding forward due to physical conditions affecting wheelchair positioning were present to insinuate the necessity of pummel cushion use as a positioning device. The EMR did include documentation that Resident #88 displayed impulsive behaviors and would ambulate without assistance and/or assistive devices. Further review of Resident #88's EMR revealed the Resident had several falls from March 2025 until July 2025 but none of the falls occurred due to the Resident's wheelchair positioning and no falls occurred in August 2025. The most recent Fall Assessment in Resident #88's EMR was dated 7/30/25. The assessment specified the Resident (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reached down to pick up a Kleenex off the floor and fell over. The facility implemented a Dycem (non-slip pad) to wheelchair cushion at this time. Corresponding incident note documentation was dated 7/31/25 at 2:37 AM and specified Resident #88 was observed at the end of the hall on the floor, leaning against the wall with the handrail broken behind them. A consent for use of the pommel cushion was not present in Resident #88's EMR. On 3/11/26 at 2:00 PM, an interview was completed with the Director of Nursing (DON) and the Infection Control (IC) Registered Nurse (RN) A. When queried regarding the reason Resident #88 had a pommel cushion on their wheelchair, the DON replied, Think for falls because they were sliding down. When asked if there was a consent for use of the Pummel cushion, the DON stated, No. When queried why there was not a HCP order for the pummel cushion, the DON replied, No order, just in care plan. The DON was then asked if an assessment for the pummel cushion had been completed and responded that pummel cushions come from therapy. When asked if a pommel cushion could be considered a restraint, the DON confirmed it could. When queried why a consent and/or assessment for the pummel cushion was not present in Resident #88's EMR, the DON indicated they would need to review the Resident's medical record further. An interview was conducted with Occupational Therapist (OT) Therapy Director N on 3/11/26 at 2:10 PM. When queried regarding the pummel cushion on Resident #88's wheelchair and the reason for the pummel cushion, Director N revealed they were aware of the pummel cushion on the Resident's wheelchair. When queried regarding observation of the Resident appearing uncomfortable and attempting to reposition themselves in their wheelchair unsuccessfully, Director N responded that they were unaware of the Resident having difficulty. Director N revealed Resident #88 has good and bad days due to their Parkinson's disease. When asked if the pummel cushion was recommended by therapy services, Director N revealed they would need to review the Resident's medical record. After reviewing Resident #88's therapy documentation, Director N verbalized they located the following documentation: - 8/21/25: Physical Therapy Treatment Encounter Note. Summary of Daily Skilled Services. Fall Risk. resident is able to stand with pummel cushion in wc safely. Transfers: Sit to stand = Partial/moderate (staff) assistance.- 8/21/25: Occupational Therapy Treatment Encounter Note. Precautions. transfer 2 PA (Person Assist) with FWW (Front Wheeled Walker) . Sit to stand to FWW mod assist (moderate staff assistance) with extra time to complete task. Mod A (Moderate Assist from staff) to sit to stand with and without pummel to FWW.The documentation provided by Director N did not address the ability of the Resident to transfer independently with and without the pummel cushion in place nor did it specify the reason the pummel cushion was implemented.When queried regarding the reason the pummel cushion was applied to the wheelchair, Director N replied, I think the purpose is to stop them from sliding. When asked why the pummel cushion would be placed on the wheelchair to prevent the Resident from sliding when there was no documentation of the Resident sliding and when they did not have a recent fall, Director N was unable to provide an explanation. When asked who monitors the pummel cushion to ensure ongoing appropriateness and placement, Director N revealed the Resident was not currently receiving therapy services and nursing staff would need to notify Therapy if there was a concern. Observations of the position of Resident #88's pummel cushion was explained to Director N at this time. Director N responded, Yeah, that isn't where it is supposed to be. Director N then stated, I need to look and see if there is supposed to be a dysem under it. An observation of Resident #88 in their wheelchair was completed with Director N at this time in the main Activity room. Director N confirmed the pummel cushion was not positioned correctly in the wheelchair. Director N further verified the cushion was positioned all the way to the back of the seat but was hanging off the front of the wheelchair. As Resident #88 was participating in an activity, Director N verbalized they would eval when the Resident returned to their room. On 3/12/26 at 8:42 AM, an interview was completed with the DON. When queried regarding Resident #88 and the interview completed with Director N including lack of documentation of reason for the pummel cushion use, the DON confirmed lack of clear documentation for the reason the pummel cushion was implemented. When queried regarding ongoing evaluation to ensure appropriateness and functionality (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235388	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Shores Senior Care and Rehab Center	3254 E Midland Rd Bay City, MI 48706

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the pummel cushion, including observation of the Resident's unsuccessful self-repositioning attempts and interview with Director N, the DON indicated the Resident was able to reposition themselves in the wheelchair even when they were having a bad day related to their Parkinsons. The DON provided additional documentation for Resident #88 at this time. Review of the provided documentation included the following:- Physical Therapy Treatment Encounter Notes dated 9/21/25 and 1/11/26. Neither note addressed and/or evaluated use of the pummel cushion.- Nurses Note dated 9/25/25 which contained, Resident will frequently attempt to self-transfer or stand by self.- BH - Psychiatry Follow up note dated 3/6/26 which included, Patient's wife reported that patient had appeared more impulsive and frequently getting up and walking without using wheelchair, with staff implementing safety measures. An interview was completed with Licensed Practical Nurse (LPN) O on 3/12/26 at 9:40 AM. When queried, LPN O stated, (Resident #88) does try to self-transfer when they need to use bathroom, but it takes them awhile. LPN O elaborated, (Resident #88) can't quite push themselves up real well. LPN O was then asked the reason for the pummel cushion on Resident #88's wheelchair and indicated it was to prevent falls. LPN O stated, I don't think it helps because (Resident #88) hasn't slid down or fell out the wheelchair. When asked why the pummel cushion was implemented and in place if Resident #88 did not have wheelchair positioning concerns and/or as an intervention related to a fall, LPN O did not provide a response. When queried if the pummel cushion prevented Resident #88 from getting out of their wheelchair by themselves quickly and without staff assistance, LPN O stated, I think so. LPN O was then asked how the pummel cushion was not a restraint if it was being used to subdue the Resident's ability to move independently but did not provide further explanation. Review of facility provided policy/procedure entitled, Restraints (Dated: 7/1/2008) revealed, Restraints to be used for the safety and well-being of residents and only after other alternatives have been unsuccessful. Procedure: 1. Restraints must be used only as a last resort and the medical record must indicate the events which led up to the necessity for restraint usage. 2. Restraints only to be used with a Physician order. 3. Restraints not to be used as a punishment, convenience of staff or as a substitute for supervision. 12. Restraints will be identified on care plan and resident care guide. 13. Resident/ RP to be notified of the necessity for use and notification documented in medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235388	A. Building B. Wing	03/12/2026

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Bay Shores Senior Care and Rehab Center	3254 E Midland Rd Bay City, MI 48706

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, the facility failed to transmit a Minimum Data Set assessment (MDS) for one resident (Resident #108) of one resident reviewed for resident assessments. Findings include. Resident #108: On 3/11/2026, at 10:00 AM, a record review of Resident #108's electronic medical record revealed a 10/20/2025 Discharge Return Anticipated MDS assessment that was completed and not submitted to CMS. A review of the progress notes revealed Resident #108 did not return to the facility. On 3/11/2026, at 11:03 AM, a record review along with MDS Nurse M of Resident #108's MDS assessments revealed the 5-day was submitted, but the discharge assessment was not. MDS Nurse M offered they must have submitted the 5-day assessment instead of submitting the discharge assessment. MDS Nurse M denied having an error report or any way of reconciling assessments that were export ready but not transmitted timely. MDS Nurse M during the interview completed and submitted the discharge assessment for Resident #108.

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	235388	A. Building B. Wing	03/12/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to store nebulizer equipment in a sanitary manner for one resident (R11) of one resident reviewed for respiratory care. Findings include:Resident #11 (R11): R11 is [AGE] years old and admitted to the facility most recently on 02/25/2026 with diagnoses that include acute and chronic respiratory failure, congestive heart failure and chronic obstructive pulmonary disease.On 03/10/2026 at 9:35AM, during an interview with R11, an observation was made of a nebulizer mask fully assembled in a basket on the nightstand, liquid was still present in the medication cup. R11 was asked when the last breathing treatment was administered. R11 stated that she believed it was 2:00am on 03/10/2026, just prior to putting her Continuous Positive Airway Pressure (CPAP) mask on. On 03/10/2026 at 9:51AM, an interview was conducted with Registered Nurse (RN) C. RN C was asked what the process for cleaning nebulizer equipment after the treatment is. RN C stated when the treatments are done, we rinse the medication cup out, wipe them down and then set it on a paper towel to dry in a basin on the nightstand. RN C was asked when R11 last received a breathing treatment. RN C stated that the last administered nebulizer was documented on 3/6/26 at 19:54PM. RN C was made aware of the nebulizer still being in one piece in the room and RN C stated it would be corrected. On 03/10/2026 at 10:00AM, record review revealed a physician's order for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML, 1 vial inhale orally every two hours as needed for shortness of breath (SOB). Review of the policy titled, Nebulizer, revealed: Equipment Cleaning: 10. Following medication administration, disconnect nebulizer cup/mask/mouthpiece from tubing, rinse equipment with hot water and place on paper towel to completely air dry.