

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Oceana County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 701 East Main Street Hart, MI 49420	

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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2685659Based on interview and record review, the facility failed to 1.) ensure medications were administered in accordance with physician orders and 2.) accurately document the administration of medications for 6 out of 7 residents (Resident #1, #3, #4, #5, #7, and #8), reviewed for the provision of nursing services during medication administration. Findings: Resident #1 (R1) Review of an admission Record revealed R1 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: history of kidney transplant. Review of R1's Order Summary revealed: 11/6/25-11/26-25 Tacrolimus ER Oral Tablet Extended Release 24 Hour Give 2 mg by mouth one time a day (anti-rejection medication). 11/27/25-discharge Tacrolimus ER Oral Tablet Extended Release 24 Hour Give 3 mg by mouth one time a day. Review of R1's Medication Error Incident Report dated 11/24/25 revealed, Residents, Tacrolimus ER Oral Tablet Extended Release 24 hour 1 MG, was not given as the nurse did not see the medication in the pill packet nor saw the name on the MAR (Medication Administration Record) on any of the medication bottle(s) within the medication cart. There were three open medications of the same medication in three different spots in the medication cart drawer. Nurse did not feel confident that the medications were the same and held the medication, due to all bottles being opened, and names of meds not matching on the MAR. Review of Licensed Practical Nurse (LPN) D's Disciplinary Action form dated 12/1/25 revealed, (LPN D) did not give a resident their Tacrolimus medication on four separate occasions. This resulted in the resident's Tacrolimus trough levels being below the normal range which could result in increased risk of transplant rejection. Review of the Facility Reported Incident (FRI) dated 11/25/25 revealed, (LPN D) signed on the MAR that he administered the medication 11/19/25 & 11/20/25 however with him holding the medication on 11/24/25 (due to not finding the tablet in the med packs) he was questioned about the accuracy of the documented administration of the Tacrolimus (since he did not know that the Tacrolimus was dispensed in bottles when he couldn't find the medication on 11/24/25). The Tacrolimus level of [1.0] on 11/20/25 would directly correlate that he missed the dose on 11/19/25. The Facility substantiated that the Tacrolimus was not being given consistently with missed doses as described above impacting the Tacrolimus Levels. During an interview on 12/17/25 at 1:50 PM, the Director of Nursing (DON) reported that following the identification of the medication error for R1 a facility wide PIP (Performance Improvement Plan) was implemented to identify areas of weakness for licensed nurses and/or a system breakdown. The DON reported that med pass observations were ongoing and 1:1 education was completed when knowledge deficits or medication errors were identified. Additionally, education through the online education program was ongoing and a mandatory in person education/meeting was scheduled for January. Resident #3 (R3) Review of an admission Record revealed R3 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: quadriplegia. Review of R3's Order Summary dated 6/6/22 revealed, Valium Tablet 2 MG (diazepam) *Controlled Drug* Give 2 mg by mouth four times a day for muscle spasticity related to OTHER MUSCLE SPASM. To be administered in the morning, midday, evening, and bedtime. Review of R3's Controlled Substance Log revealed that on 12/13/25 the bedtime dose of valium was not documented as removed from the medication card (which would indicate the valium was not administered to the resident). Review of R3's December Medication Administration Record revealed that on 12/13/25 the bedtime dose of valium was documented as administered. Review of R3's Electronic Medical Record revealed no documentation and/or order for the withholding of the bedtime dose of valium. Resident #4 (R4) Review of an admission Record revealed R4 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: dementia with behavioral disturbances. Review of R4's Order Summary dated 8/1/25 revealed, LORazepam Concentrate 2 MG/ML *Controlled Drug* Give 0.25 ml by mouth every 12 hours for agitation AND Give 0.25 ml by mouth every 4 hours as needed for agitation for 14 Days. To be administered at 8:00 AM and 8:00 PM. Review of R4's Controlled Substance Log revealed that on 12/7/25 the 8:00 PM dose of ativan was not documented as removed from the medication card. Review of R4's December Medication Administration Record revealed that on 12/7/25 the 8:00 PM dose of ativan was documented as administered. Review of R4's Electronic Medical Record revealed no documentation and/or order for the withholding of the 8:00 PM dose of ativan. Resident #5 (R5) Review of an admission Record revealed R5 was a [AGE] year-old female, admitted to the facility on [DATE] with pertinent diagnoses which included: chronic pain Review of R5's Order Summary</p>		