

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/15/2026
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 - 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** This citation pertains to intake #: 2996367Based on interview and record review, the facility failed to promptly identify a change in condition and act upon those changes for 1 resident (Resident #2) out of 3 residents reviewed for quality of care resulting in a delay in surgical intervention.Findings:Resident #2 (R2)Review of an admission Record revealed R2 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: severe cervical spinal stenosis (spinal canal narrowing in the neck).Review of R2's hospital After Visit Summary dated 3/4/26 revealed, Please contact (name omitted), neurosurgery, to arrange outpatient follow up of the abnormal cervical spine MRI which does show some pressure on the spinal cord. At the 3rd and 4th cervical vertebrae. You are at risk for severe spinal cord injury with continued falls or cervical spine injuries. You should be extremely careful when moving from a lying down to a sitting to a standing position and always use a walker and assistance. Continue your medications as directed. Return with any concerns. Schedule an appointment with (name omitted) MD as soon as possible for a visit Specialty: Neurological Surgery.Get help right away if: You have severe pain. You have numbness in a hand or foot.Review of R2's Incident Report dated 3/25/26 revealed, Daughter reported mother told sister that she fell a few days ago and her butt hurts. Assessed resident for bruises and found bruise to right upper buttock although resident reports pain to left upper buttock. When asked how this happened resident stated she fell. Resident Description: A few days ago, I was transferring from wheelchair to recliner got stuck on arm of recliner and when I went to pull myself over, I slid down to floor on my butt. I then got to my knees and got part way back into recliner when staff member assisted me to sitting in recliner. Resident does not know time of day or what exact day this occurred other than 3-4 days ago. The incident report did not include the identification of the staff member that assisted R2 from the floor or documentation that the fall had been immediately reported to R2's care team.During an interview on 7/15/2026 at 10:32 AM, Family Member (FM) G reported R2 was to have a neurosurgical consult completed as soon as possible once admitted to the facility. FM G reported that she reported it to the case manager (Unit Manager [UM] M) following R2's admission stating, I truly trusted her to follow-up. FM G reported that due to R2's high risk for spinal cord injury, she would have expected additional diagnostic testing to be completed to ensure R2's cervical spine had not been impacted by the unwitnessed fall.FM G reported R2 had a significant decline in her functional ability following her fall. FM G reported R2 had progressed to the point that on 3/16/26 the therapy team had discussed with them a home evaluation in preparation for discharge. By 3/26/26 the therapy team was discussing discharge from therapy services as she was unable to participate in therapy services and was completely dependent on all aspects of care. FM G reported concerns that R2's symptoms were not immediately acted upon with diagnostic testing and/or a hospital transfer despite the therapy team voicing their concerns with her rapid decline. FM G reported that R2 had to undergo (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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F 0684 Level of Harm - Actual harm Residents Affected - Few	immediate surgery to correct the damage and spent 3 weeks in the hospital before being discharged to a different facility. During an interview on 7/15/2026 at 11:47 AM, Occupational Therapist (OT) K reported that following R2's admission she was making really good progress further reporting that she had progressed to the point that a discharge home assessment was discussed. OT K reported that per her physical therapy notes, by 3/10/26 she had improved to only requiring supervision for walking a short distance, transferring, moderate assistance with stairs and minimal assistance and/or supervision for her ADL (Activities of Daily Living) care. OT K reported the neurosurgical consult should have been completed immediately upon admission based on the severity of her cervical spinal stenosis and reported that during the 3/24/26 Medicare meeting (which included the Interdisciplinary Team [IDT]) the therapy department members discussed her need for the consult. OT K stated I don't know why it never happened. OT K reported that R2 described a fall that she had sustained while at the facility which aligned with the deterioration of her functional abilities and her fine motor coordination as well as complaints of numbness in her arms. OT K reported R2's significant shift in her functional abilities began on 3/26/26 and reported R2's progressive decline in her functional abilities was talked about daily in the IDT meetings, but nobody acted upon the observed decline despite R2's therapy team voicing concern and urging for immediate follow-up. OT K reported she received an email from R2's clinical care coordinator (unit manager) on 3/31/26 asking if tense muscles could have been the cause of R2's numbness, tingling, and inability to use her arms with a request for manual therapy (hands on application of pressure, stretching, and joint movements to improve pain, mobility, and restore function). OT K reported she was deeply concerned and frustrated and explained that that manual therapy wouldn't assist at that point with such a significant change in her condition and she couldn't feed herself. She couldn't use her arm when previously she had no difficulty eating or swallowing. OT K stated, When PT (physical therapy) started coding her as dependent (for functional abilities) on the 29th she reiterated that R2 went from walking on the 25th to needing a maxi lift in a week. OT K reported that R2 required surgical intervention on her neck due to her symptoms and the deterioration of the condition of her cervical spine. Review of R2's therapy Summary of Daily Skilled Services revealed: 3/22/26-increased imbalance. need for therapist intervention to maintain standing with several incidents with knee buckling and pt (patient) stating she was unsure why she is so weak. 3/23/26-PT (physical therapy) and OT (occupational therapy) provided therapy to maximize pt functional tolerance due to increased tremors with functional movements with decreased safety and increased level of assistance required to maintain safety. 3/24/26-decreased safety and increased ataxic (poor muscle coordination) gait pattern and knees buckling with increased need for assistance to maintain standing .PT and OT provided therapy to maximize pt functional tolerance due to decreased safety with gait and transfers needing increased level of assistance to maintain safety. 3/25/26-PT and OT provided therapy to maximize pt functional tolerance due to decreased safety with transfer and functional mobility needing increased cues and assistance for maximal safety. 3/26/26-(patient experiencing) posterior lean needing frequent assist to maintain upright posture. with decreased UE (upper extremity) function stating she cant hold anything PT and OT provided therapy to maximize pt functional tolerance with pt presenting with increased ataxic movement and increased tremors with difficulty grabbing and placing hands, with decreased safety with transfers and increased need for assistance to maintain safety. 3/27/26-Pt with demonstrating decreased performance with high fearfulness .PT and OT required for safety of pt and staff with pt having decreased control and unsafe impulsive movements. No note on 3/28/26-3/29/26-. ataxic gait pattern, anterior lean with knees buckling and decreased trunk control with use of UE's. 3/30/26-. decreased safety with increased knee buckling and complaints of numbness in hands (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	and unable to support self when knees do buckle.3/31/26-.pt needing increased cueing and encouragement with pt repeatedly stating my hands are numb and her inability to do anything.4/1/26-Pt continues to state, I can't do it! I can't, I can't, I can't!, often before attempt of tasks at hand. She demonstrates impulsive/ataxic motion throughout entirety of session, posing safety risks.Pt throughout session on this date displaying decreased participation stating, my hand is numb I can't do anything and I can't with all instruction and encouragement.Pt instructed on SeraLift and with pt demonstrating decreased safety, no assistance with BLE (bilateral lower extremities) and slumping into lift. PT with discussion with staff and with indicating Maxi Lift to be used due to behaviors and decline in function and safety .pt demonstrating significant decline.Review of a Communication with Physician note dated 3/25/26 revealed, Situation: Review of ED (emergency department) imaging/report for Cervical Spine MRI: per radiology.degenerative changes are apparent w/ (with) severe spinal canal narrowing.Per radiology: r/t (related to) the presence of cord signal changes suggest establish spinal cord injury. Patient likely deserves consult/evaluation by neurosurgery to discuss avoiding progression of disease & possible improvement of neurologic function. Recommendation: (name omitted), neurosurgery, would like for (R2) to be seen in his clinic for follow up, confirming that she is at risk for more significant cord injury with continued falls.Review of R2's Order Summary dated 3/25/26 revealed, okay to see Neurosurgery (name omitted) for a follow up in his clinic, confirming that resident is at risk for more significant cord injury with continued falls. (Confirming the neurosurgical consult had not been completed/ordered upon admission.)Review of R2's Electronic Medical Record revealed no documentation that a neurosurgical consult was initiated upon R2's admission to the facility until 3/25/26 (21 days after admission).Review of R2's Communication with Physician note dated 3/26/26 revealed, Situation: Resident with complaint of left shoulder pain that goes up into her neck. Also reports that both hands feel numb.Review of R2's Skilled Charting note dated 3/27/26 revealed, .Reports no pain at this time. Reports continued bilateral hands numbness.Review of R2's Post Fall Note dated 3/27/26 revealed, .Therapy reported resident to continue 2 assist for transfers.Review of R2's Post Fall Note dated 3/28/26 revealed, .No new injuries observed. Poor strength and balance with 2 assist transfer.Review of R2's Skilled Charting note dated 3/28/26 revealed, .Reports no pain at this time. Reports continued bilateral hands numbness.Review of R2's Skilled Charting note dated 3/29/26 revealed, .Reports no pain at this time. Reports continued bilateral hand numbness.Review of R2's Communication with Physician note dated 3/30/26 revealed, Situation: Resident with increase in tremors last few days to the point that she cannot feed herself breakfast last 3 days (cereal). Indicating a significant change in R2's physical ability x3 days.Review of R2's Skilled Charting note dated 3/30/26 revealed, .Complaint of not being able to feed self this AM. Informed that getting OOB (out of bed) may help. Resident sternly stated that is not the problem .Reports continued bilateral hand numbness.Review of R2's Condition Stability note dated 3/31/26 at 5:11 AM revealed, While toileting around 0430 (4:30 AM) resident said that she could not use her right hand to stand up with staff, staff did observe resident use hand to lift leg and adjust it, staff struggled to lift resident back to w/c (wheelchair). Resident was educated that a maxi lift maybe needed in future if resident is unable to help the 2 CNA's (Certified Nursing Assistants) with transfers.Review of R2's Communication with physician note dated 3/31/26 at 7:51 AM revealed, Would resident benefit from checking lab values.r/t (related to) her experiencing numbness in her arms, weakness, & loss of coordination?Review of R2's Communication with Family note dated 4/1/26 revealed, .Family reports that (R2's) RIGHT HAND is almost dead weight. She has poor appetite.last night, she could not eat it. She said it was too difficult to chew and swallow. This is not typical behavior for (R2). Family is concerned that she may have (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	experienced a stroke or TIA (transient ischemic attack [stroke like symptoms]).Review of R2's Communication with Physician note written by UM M and dated 4/1/26 at 9:19 AM revealed, Situation: Notification to PCP (primary care physician) r/t significant change in condition for (R2) & request for urgent neurology &/or neurosurgery evaluation, advanced imaging (MRI or CT of Cervical Spine as previously recommended), & additional workup for acute neurologic change. (confirming a delay in diagnostic studies/treatment)REVIEW/HISTORY/BACKGROUND: (R2) was evaluated in the ER on [DATE], where a cervical spine MRI revealed no acute fracture; however, notable findings included severe spinal canal narrowing at C3-4 with associated cord signal changes consistent with compressive myelopathy, as well as multilevel foraminal narrowing. Neurosurgical consultation was recommended at that time to address risk of progression & potential improvement in neurologic function. A neurology consult remains pending.On 3/25/26, (R2) reported a fall (exact date/time unknown, estimated 3-4 days prior), with subsequent bruising to the right upper buttock & new pain to the left upper buttock.She was seen by FNP (nurse practitioner) on 3/26/26 & diagnosed with cervicalgia (neck pain), with orders for topical Biofreeze. Follow-up evaluation on 3/30/26 for cervicalgia with hand numbness prompted cervical spine X-ray on 3/31/26. Results were limited, with mild degenerative disc disease noted to C5-C6 & recommendation for further imaging (CT or MRI).Current Concerns(New/Progressive):* New onset weakness with marked functional decline* Increased tremors* Right hand described as dead weight with minimal to no functional use* Very limited use of left hand* Regression in therapy; no longer progressing toward goals* Decreased appetite with 3lb weight loss since admission* Elevated blood pressures, including 176/96 & 157/108 on 3/28/26.Recommendation: Given her known cervical spine pathology with cord signal changes, combined with this acute neurologic decline & loss of upper extremity function, there is concern for progression of cervical myelopathy &/or possible new neurologic event.Please advise on next steps. Considerations may include: Urgent neurology &/or neurosurgery evaluation, advanced imaging (MRI or CT of cervical spine as previously recommended), or additional workup of acute neurologic change.Please let us know how you would like to proceed or if new orders are indicated.Review of R2's Communication with Physician note dated 4/1/26 revealed the provider response, 1. Order MRI C-Spine (without contrast) Dx (diagnosis): C-Spine stenosis with worsening pain. 2. Refer to Spine surgeon (time for after MRI results are available).R2 was sent to the hospital on 4/1/26 at approximately 12:30 PM.Review of R2's Wellness Committee Meeting regarding R2's MRI results, diagnosis, and hospital stay revealed, (R2) has been admitted to (hospital name omitted); MRI cervical spine showed multilevel degenerative changes with severe spinal canal stenosis at C3-4, large central disc herniation, facet arthropathy (arthritis), ligamentum flavum thickening (enlargement of spinal ligaments that can narrow the spinal canal and compress nerves), and subtle spinal cord signal abnormality suspicious for myelopathy (collection of symptoms caused by spinal cord compression).Orthopedic spine surgery note: severe central stenosis and apparent spondylolisthesis (slipping of the vertebrae-early intervention can prevent severe long-term complication) at the C3-4 level. Recommending ACDF C3-4 (Anterior cervical discectomy and fusion [remove a damaged disc and stabilize the cervical spine to relieve nerve and/or spinal cord compression]).During an interview on 7/15/2026 at 4:57 PM, The Director of Nursing (DON) reported her first day as the DON at the facility was 3/16/26 so she was not aware of the order for R2's consult upon admission. The DON reported that she was new to the job as the DON but upon her hiring she noted R2 was discussed daily in the IDT meetings which included R2's therapy team and her unit manager (UM M). The DON reported that R2's referral should have been immediately forwarded to Office Staff (OS) N who scheduled all resident appointments upon admission by the admitting nurse or by UM M following her (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	review of R2's admission documentation. The DON confirmed that there was no documentation that R2's neurosurgical consult had been scheduled until the note written by UM M on 3/25/26 following R2's new onset of numbness and decline in functional abilities. The DON reported she had substantial concerns with R2's precarious and fast significant symptoms. Documentation that R2's neurosurgical consult was scheduled at the time of her admission was not received prior to survey exit on 7/15/26 at 5:35 PM. The DON confirmed she was unable to locate documentation that it had been ordered/scheduled. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, (Nurses) are accountable to report any significant changes in your patient's condition in a timely manner to the health care provider and to document these changes in the patient's electronic health record (EHR). Timely and truthful documentation is important to provide communication necessary among health care team members. Documentation must be accurate. In the EHR, ensure that assessments are complete and consistent with those completed previously. Ensure that you conduct your own assessment rather than copying the previous assessment in the patient's medical record to ensure accuracy of information. Notify other team members in a timely manner when changes in condition are triggered within the record. [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #: 3046473Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse by a staff member for one (R1) of four reviewed for abuse.Findings:Resident #1 (R1)Review of an admission Record revealed R1 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: multiple sclerosis.Review of the Facility Reported Incident (FRI) revealed an incident which occurred on 5/30/26. On June 2, 2026 the facility received an allegation that a Certified Nursing Assistant (CNA) used inappropriate language toward a resident. Another CNA reported that the accused CNA directed profanity toward a resident during care. Based on the findings of the investigation, it was substantiated that the CNA used inappropriate and disrespectful language toward the resident. This conduct is considered verbal abuse, as it was willful and had the potential to cause emotional distress to the resident. This conduct violates the residents right to be free from abuse and the right to be treated with dignity and respect, in accordance with facility policy and applicable federal regulations.Review of Certified Nursing Assistant (CNA) D's Witness Statement dated 6/2/26 revealed, On Saturday May 30th around 8PM, I asked (CNA C) if she would help me roll her (R1) for HS (evening cares). We went in, got all of the HS stuff out and lifted the bed. (R1) does have a difficult time with staying still/rolling due to medical related. I had (CNA C) go between the bed and the wall. I had (CNA C) roll (R1) towards her so her bottom half was facing me so I could wash her up. (R1) tried to roll on her back before I was ready for her so I told her to roll back on her side. (CNA C) was holding (R1) up, not forcefully, but she stated, 'you need to stay on your f***ing side (R1). We go through this every f***ing night.' I didn't know what to say so I just reassured (R1) that I was almost done and she could roll back shortly. There have been other circumstances and situations similar to this from every hall on station 1.Review of CNA H's Witness Statement dated 6/3/26 revealed: Q (question): Can you tell me a little about how the weekend went most specifically any time you worked with (CNA C)? Per (CNA H)- 'I can tell you she's not very nice to the residents'.When I delivered (resident name omitted) her dinner she seems upset. When I asked her what was going on she stated that (CNA C) was working and she didn't even want to look at her. I asked her why but she didn't say, I checked to see if she needed anything else and left her to her dinner. This was (CNA C's) section but I just took care of (resident) so she wouldn't have to be upset about (CNA C).Q: Have you heard or seen anything else regarding (CNA C) and her interactions with residents? Per (CNA H) 'Well there was one night when [NAME] as very frustrated in general she came into a room I was working, when we were outside the resident room she was giving report about the resident and put her fists up when talking about that resident. There was another time she yelled at (R1) to stop when (R1) was moving around, (R1) can't control her movements. She told (R1) if you don't stop, I'm going to call (R1's daughter)! You need to stop!Q: Did you report this? Per (CNA H) 'Yes, this has been reported in the past.Review of CNA C's Employee File revealed she was hired in January of 2025. Disciplinary Action dated 9/25/25 revealed 2 written warnings. 1.) Unprofessional conduct towards another employee, supervisor or the public i.e. using obscene or improper language or gestures, immoral conduct or indecency and 2.) Disorderly conduct, horseplay, threatening or interfering with another employee or supervisor.(CNA C) is using unprofessional conduct on the unit. She is impacting her coworkers performance. (CNA C) is using foul language in hallways and nurses stations. It is difficult for staff to locate her. (CNA C) walks past call lights without answering them.(CNA C) will remain professional at all times. She will not use foul (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	language. She will complete her assigned assignments. Disciplinary Action dated 10/10/25 revealed a final written warning. Unprofessional conduct towards another employee, supervisor or the public i.e. using obscene or improper language or gestures, immoral conduct or indecency (CNA C) is using unprofessional conduct on the unit. She is impacting her coworker's performance and resident care. Her conduct is causing problems on the unit with other CNAs and nurses. (CNA C) has a negative attitude and is engaging in negative conversations with coworkers regarding other coworkers. Termination of Employment dated 6/4/26 revealed, On 6/2/2026 it was reported to Nursing supervisors that (CNA C) was cursing at a resident during while performing care on 5/30/2026. This is a group 1:2 violation-Verbal Abuse-includes use of verbal or other communication to curse at, insult or degrade a resident; and Group 1:11-Violation of Resident Rights policy by employee. (CNA C's) actions violated the resident's right to be free from abuse. During an interview on 7/14/2026 at 3:35 PM, the Director of Nursing (DON) confirmed that CNA D had waited for 3 days to report the witnessed verbal abuse of R1. Reported that not only had the facility staff not immediately reported the abuse observed on 5/30/26, but they knew that CNA C had been abusive to other residents previously and failed to report those incidents to the Abuse Prevention Coordinator. The DON reported that upon further investigation and interviews the facility staff reported that she was told that the facility staff quit reporting CNA C's inappropriate behaviors resident abuse to the Abuse Prevention Coordinator and/or management because they (management) never did anything (disciplinary action, termination, etc) following the submission of allegations. The DON stated CNA C's coworkers quit reporting incidents and it escalated to this (the verbal abuse of R1). The DON reported that she reviewed CNA C's employee file following the substantiated verbal abuse of R1 and reported that CNA C should have been terminated following the Disciplinary Action dated 9/25/25, but unfortunately, she did not assume the role of DON until 3/16/26. During an interview on 7/15/2026 at 7:44 AM, The DON reported that following the identification of the abuse she immediately suspended CNA C pending an investigation and subsequently terminated her on 6/4/26. Additionally, the DON reported CNA C to the Michigan nurse aide registry to ensure appropriate follow up was completed. Review of the facility policy, Abuse, Neglect and Exploitation last reviewed/revised 6/16/26 revealed, Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. III. Prevention of Abuse, Neglect and Exploitation-The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves. B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms. G. Addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur; and H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included the following: On 6/2/26 CNA C was immediately suspended pending an investigation. Her license was reported to the Michigan Nurse Aide Registry. CNA C was subsequently terminated on 6/4/26. On 6/2/26 R1 was assessed and found to have no negative outcomes or long-lasting effects from verbal abuse. R1 had scheduled follow-up meetings/assessments with the facility social worker to ensure she felt safe with no new negative (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	outcomes identified.Beginning on 6/2/26 interviewable residents on the unit CNA C worked were assessed and interviewed related to abuse. No other residents were found to be affected by CNA C.Beginning on 6/2/26 all employees were required to complete education on abuse, neglect, exploitation and misappropriation of resident property. All new hires and Agency staff must demonstrate knowledge of all areas of the abuse policy and the prevention and reporting of abuse prior to working with residents. Existing staff will receive annual education through planned in-services as required and as needed. A modified education was implemented following the QAPI meeting to include dementia care, behavior management/deescalation, and caring for residents with cognitive declines.Beginning 6/2/26 the DON and ADON implemented increased rounding on the units to ensure all staff display professional behavior. Review of camera footage for 3rd shift resulted in areas for improvement on time management and prioritization.Between 6/3/26-6/5/26 the DON initiated a new program called the Best Friends Approach (a type of buddy system where staff members are paired with residents and round with them on the agreed upon date and time.) This was implemented to ensure that all residents residing in the facility were interviewed/and assessed regarding abuse that went unreported and/or uninvestigated as a result of the facility staff's failure to follow the abuse policy and procedure.The Best Friend Approach was implemented to be a permanent audit system to ensure prompt identification and reporting of any allegations of abuse, neglect, or violations of their rights. Unit Manager (UM) M's role was modified to a supervisory status to oversee and manage the Best Friend Approach program. UM M ensures the Best Friend Approach rounds are completed, grievances forms are completed following the identification of a concern, prompt resolution of the grievance, as well as tracking and trending the program outcomes. UM M supervisory status also includes the oversight and supervision of staff in order to assure that the facility policies are implemented and staff provide residents with professional, competent, and dignified care.On 6/8/26, the IDT morning meeting agenda was modified to include a review of any grievances and/or negative outcomes identified from the Best Friends Approach rounds.On 6/17/26 a QAPI meeting was held which included the topics of abuse, abuse reporting, resident rights, and resident safety. The outcome of the Best Friend Approach audits were included in the June QAPI meeting and will continue to be reviewed in future QAPI meetings to track and trend compliance with the Abuse Prevention Program.As of 6/22/26 all staff completed the required abuse prevention and reporting education both in person and with a post-test.The facility was able to demonstrate monitoring of the corrective action and maintained compliance.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Oceana County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 701 East Main Street Hart, MI 49420	
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #: 3046473Based on interview and record review, the facility failed to ensure facility staff immediately reported an allegation of verbal abuse to the abuse coordinator for 1 resident (Resident #1) reviewed for neglect.Findings:Resident #1 (R1)Review of an admission Record revealed R1 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: multiple sclerosis.Review of the Facility Reported Incident (FRI) revealed an incident which occurred on 5/30/26. On June 2, 2026 the facility received an allegation that a Certified Nursing Assistant (CNA) used inappropriate language toward a resident. Another CNA reported that the accused CNA directed profanity toward a resident during care. Based on the findings of the investigation, it was substantiated that the CNA used inappropriate and disrespectful language toward the resident.Review of Certified Nursing Assistant (CNA) D's Witness Statement dated 6/2/26 revealed, On Saturday May 30th around 8PM.(CNA C) was holding (R1) up, not forcefully, but she stated, 'you need to stay on your f***ing side (R1). We go through this every f***ing night'.There have been other circumstances and situations similar to this from every hall on station 1.Review of CNA H's Witness Statement dated 6/3/26 revealed, Q (question): Can you tell me a little about how the weekend went most specifically any time you worked with (CNA C)? Per (CNA H) ?I can tell you she's not very nice to the residents'.this has been reported in the past.During an interview on 7/14/2026 at 3:35 PM, the Director of Nursing (DON) confirmed that CNA D had waited for 3 days to report the witnessed verbal abuse of R1. The DON reported that the staff did not implement the facility's policy and procedure following the identification of the verbal abuse observed between CNA C and R1. The DON reported that not only had the facility staff not immediately reported the abuse observed on 5/30/26, but they knew that CNA C had been abusive to other residents previously and failed to report those incidents to the Abuse Prevention Coordinator.The DON reported that upon further investigation and interviews the facility staff reported that she was told that the facility staff quit reporting CNA C's inappropriate behaviors resident abuse to the Abuse Prevention Coordinator and/or management because they (management) never did anything (disciplinary action, termination, etc) following the submission of allegations. The DON stated CNA C's coworkers quit reporting incidents and it escalated to this (the verbal abuse of R1).During an interview on 7/15/2026 at 7:44 AM, the DON reported that the expectation of facility staff was to ensure that any observation, notification, or inclination of abuse was to be immediately reported to her (the Abuse Prevention Coordinator) or to the Nursing Home Administrator.Review of the State Operations Manual revealed, It is the responsibility of the facility to ensure that all staff are aware of reporting requirements and to support an environment in which covered individuals report a reasonable suspicion of a crime, and staff and others report all alleged violations of mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Protection of residents can be compromised or impeded if individuals are fearful of reporting, especially if the alleged abuse has been carried out by a staff member [See S483.12(b)(5)(i)]. During investigations, some staff have stated that he/she was aware, or had knowledge, that the incident had occurred, but did not report because he/she did not think it met the definition of abuse, neglect, mistreatment, exploitation, or misappropriation of resident property or a reasonable suspicion of a crime. Another example is when a nurse aide witnesses an act of abuse but fails to report the alleged violation; the failure to report does not support a conclusion that the abuse did not occur and the facility would not meet the reporting (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requirements. Review of the facility policy, Abuse, Neglect and Exploitation last reviewed/revised 6/16/26 revealed, Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included the following: On 6/2/26 CNA C was immediately suspended pending an investigation. Her license was reported to the Michigan Nurse Aide Registry. CNA C was subsequently terminated on 6/4/26. On 6/2/26 R1 was assessed and found to have no negative outcomes or long-lasting effects from verbal abuse. R1 had scheduled follow-up meetings/assessments with the facility social worker to ensure she felt safe with no new negative outcomes identified. Beginning on 6/2/26 interviewable residents on the unit CNA C worked were assessed and interviewed related to abuse. No other residents were found to be affected by CNA C. Beginning on 6/2/26 all employees were required to complete education on abuse, neglect, exploitation and misappropriation of resident property. All new hires and Agency staff must demonstrate knowledge of all areas of the abuse policy and the prevention and reporting of abuse prior to working with residents. Existing staff will receive annual education through planned in-services as required and as needed. A modified education was implemented following the QAPI meeting to include dementia care, behavior management/deescalation, and caring for residents with cognitive declines. Beginning 6/2/26 the DON and ADON implemented increased rounding on the units to ensure all staff display professional behavior. Review of camera footage for 3rd shift resulted in areas for improvement on time management and prioritization. Between 6/3/26-6/5/26 the DON initiated a new program called the Best Friends Approach (a type of buddy system where staff members are paired with residents and round with them on the agreed upon date and time.) This was implemented to ensure that all residents residing in the facility were interviewed/and assessed regarding abuse that went unreported and/or uninvestigated as a result of the facility staff's failure to follow the abuse policy and procedure. The Best Friend Approach was implemented to be a permanent audit system to ensure prompt identification and reporting of any allegations of abuse, neglect, or violations of their rights. Unit Manager (UM) M's role was modified to a supervisory status to oversee and manage the Best Friend Approach program. UM M ensures the Best Friend Approach rounds are completed, grievances forms are completed following the identification of a concern, prompt resolution of the grievance, as well as tracking and trending the program outcomes. UM M supervisory status also includes the oversight and supervision of staff in order to assure that the facility policies are implemented and staff provide residents with professional, competent, and dignified care. On 6/8/26, the IDT morning meeting agenda was modified to include a review of any grievances and/or negative outcomes identified from the Best Friends Approach rounds. On 6/17/26 a QAPI meeting was held which included the topics of abuse, abuse reporting, resident rights, and resident safety. The outcome of the Best Friend Approach audits were included in the June QAPI meeting and will continue to be reviewed in future QAPI meetings to track and trend compliance with the Abuse Prevention Program. As of 6/22/26 all staff completed the required abuse prevention and reporting education both in person and with a post-test. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.		

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F 0689 Level of Harm - Minimal harm or potential for 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 citation pertains to intake #s: 2996367, 3090866, 3090922, and 3093262Based on interview and record review, the facility failed to 1.) provide adequate supervision and ensure systems were in place to prevent the elopement of 2 residents (Resident #3 and #6) and 2.) operationalize the facility's fall policy for 1 resident (R2), out of 3 residents reviewed for accidents, safety, and supervision.Findings:Resident #3 (R3)Review of an admission Record revealed R3 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: major depressive disorder and anxiety.Review of a Complaint Investigation Report submitted to the State Agency and dated 7/9/26 revealed, Complainant states that on 7/7/26, (R3) exited from the main entrance without staff. Complainant states that the staff ran after (R3) once she started to go to the parking lot. Complainant states that the activities department was taking some residents on a bus ride and (R3) said that she was going to wait to get on the bus, but she should not have been outside unsupervised.Review of R3's Care Plan revealed a new intervention was initiated on 7/7/26 for ROAM ALERT: Right Ankle Exp: 12/2026. (ankle monitor that alarms near an exit).Review of R3's Wandering Risk Scale (elopement risk) dated 7/7/26 revealed that R3 was determined to be a high risk to wander. (R3 was previously assessed on 4/21/26 and deemed a low risk to wander.)Review of R3's Electronic Medical Record revealed no documentation related to R3 exiting the facility unsupervised or documentation related to a rationale for the initiation of a roam alert ankle monitor or a rationale for assessing R3's wandering risk or the significant change in her wandering risk.During an interview on 7/14/2026 at 11:29 AM, Licensed Practical Nurse (LPN) E confirmed there was no documentation related to R3's unsupervised exit from the facility. LPN E reported R3 was able to exit the facility through the front doors during shift change when a vendor entered the facility causing the doors to open (were locked from the inside but not from the outside). R3 made it past the sidewalk to the driveway (less than 25 feet from the entrance). LPN E reported that she did not believe facility staff ever lost sight of her, and she observed the incident at the time R3 had exited the second set of doors and quickly assisted R3 back into the facility. LPN E reported the parking lot where she exited was busy with many visitors driving fast. Additionally, the facility was next to a high traffic roadway which placed the resident at risk as staff were not immediately available to assist her. LPN E reported that staff questioned R3's ankle monitor after the incident as there were no corroborating progress notes to explain the new intervention. LPN E reported the incident was immediately reported to management.During an interview on 7/14/2026 at 3:35 PM, the DON confirmed that R3 had left the facility through the front door without staff assistance/presence reporting that the root cause was due to a vendor that didn't follow facility policy. The DON reported that the vendors were to use the back doors to prevent the locked front doors from opening, allowing residents to exit the facility without supervision from staff. The DON reported they did implement a roam alert monitor due to her being independent with mobility, extremely hard of hearing, visitors and vendors using the front entrance, along with a slow decline in her cognitive ability reporting it was just precautionary.A copy of R3's Incident Report, root cause analysis, or investigation/witness statements related to R3's unsupervised exit from the facility was requested on 7/15/2026 at 1:24 PM via email to the Director of Nursing (DON).During an interview on 7/15/2026 at 4:00 PM, the DON confirmed there was no incident report or progress note completed related to R3 exiting the facility on 7/7/26.Resident #6 (R6)Review of an admission Record revealed R6 was an [AGE] year-old female, admitted to the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on [DATE], with pertinent diagnoses which included: Alzheimer's Disease and dementia with mood disturbances. Review of R6's Care Plan initiated on 10/28/25 revealed, WANDERING/At Risk for ELOPEMENT r/t: Alzheimer's dementia, impaired cognition. Review of R6's Wandering Risk Scales revealed that beginning on 11/21/25 R6 was high risk to wander. Review of R6's Electronic Medical Record revealed the following: 4/22/2026 Behavior Note-Resident had to be redirected more than 2x this shift for advancing to main exit door of facility and setting off alarm. Staff stated she was at threshold of door while lab techs were leaving building. 6/8/2026 Behavior Note-noted wandering halls, attempting to go through doors at the end of the garden to the memory care unit. 6/8/2026 Behavior Note-Increased confusion. Review of the Facility Reported Incident dated 6/25/26 revealed, the resident exited the facility unsupervised through a fire exit door. Another resident reported observing the exit to staff, and staff responded immediately upon notification. The resident was promptly located outdoors in the facility's enclosed courtyard, which is secured by a chain-link fence. Review of Registered Nurse (RN) O's Witness Statement dated 6/25/26 revealed, Was in (a different) residents room assisting (with) a self-transfer. Heard alarm going off to panel noted 7 end of Garden hallway. Found nurse to obtain keys to turn alarm off. Down to door-no residents in site. (Resident #7) came to doorway to let (nurse know) there's a lady out there in a w/c (wheelchair). (RN O) noted door not latched, shut off alarm, no resident in area, (RN O) exited south doors to exit bldg (building). Note resident in w/c slowly strolling along side walk. During an observation and interview on 7/15/2026 at 2:02 PM, the DON and Maintenance Director (MD) B it was observed that the enclosed courtyard had to gates there were latched but were not locked. MD B reported that the fire doors and the door that R3 exited did not have the roam alert alarms, however, the fire door did have a functioning alarm that sounded once opened. The DON reported that at the time of the incident, the fire door was alarming which required a key to disarm. The DON reported that RN O should not have just shut the alarm off when she noticed the fire door was unlatched and alarming and should have ensured that no resident had exited the building prior to just shutting the alarm off per facility policy. Review of the facility policy, Elopements and Wandering Residents/Code Yellow last reviewed/revised 5/30/25 revealed, Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. 1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. h. Adequate supervision will be provided to help prevent accidents or elopements. 8. Procedure Post-Elopement-A nurse will perform a physical assessment, document, and report findings to physician. g. Documentation in the medical record will include: findings from nursing and social service assessments, physician/family notification, care plan discussions, and consultant notes as applicable. Resident #2 (R2) Review of an admission Record revealed R2 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: severe cervical spinal stenosis (spinal canal narrowing in the neck). Review of R2's hospital After Visit Summary dated 3/4/26 revealed, Please contact (name omitted), neurosurgery, to arrange outpatient follow up of the abnormal cervical spine MRI which does show some pressure on the spinal cord. At the 3rd and 4th cervical vertebrae. You are at risk for severe (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	spinal cord injury with continued falls or cervical spine injuries. Review of R2's Communication with Physician dated 03/25/26 at 07:21 AM revealed, (neurosurgical practitioner name omitted) neurosurgery, would like for *R2) to be seen in his clinic for follow up, confirming that she is at risk for more significant cord injury with continued falls. Review of R2's Incident Report dated 3/25/26 at 1:50 PM revealed, Daughter reported mother told sister that she fell a few days ago and her butt hurts. Assessed resident for bruises and found bruise to right upper buttock although resident reports pain to left upper buttock. When asked how this happened resident stated she fell. Resident Description: A few days ago, I was transferring from wheelchair to recliner got stuck on arm of recliner and when I went to pull myself over, I slid down to floor on my butt. I then got to my knees and got part way back into recliner when staff member assisted me to sitting in recliner. Resident does not know time of day or what exact day this occurred other than 3-4 days ago. The incident report did not reflect a witness statement from the staff member that assisted R2 back to her recliner or notification to the management team or R2's emergency contact #1, #2, or #3. During an interview on 7/15/2026 at 10:32 AM, Family Member (FM) G reported that she was R2's Emergency Contact #1/Substitute Decision Maker. FM G reported that due to R2's high risk for spinal cord injury, she would have expected additional diagnostic testing to be completed to ensure R2's cervical spine had not been impacted by the fall. FM G reported that she was never notified of R2's fall and therefore was unable to be involved in and/or request any additional testing to ensure R2 did not suffer any further damage to her cervical spinal cord. Review of R2's Safety Note dated 3/26/26 revealed, Fall Committee reviewed fall dated 3/25/26 Recommendations- Resident reported she slipped down from recliner chair onto floor few days ago. Non slip strips were placed on floor in front of recliner to enhance traction. Non slip grip was placed on recliner seat to reduce fall risk. Additional call light was attached to recliner for ease of use. Review of R2's Electronic Health Record revealed no documentation that a witness statement had been obtained or that a root cause analysis was completed. During an interview on 7/15/2026 at 1:57 PM, the Director of Nursing (DON) reported that the facility had a fall committee as well as a specific staff member that investigated all falls and determined the root cause analysis. The DON reported that Restorative Registered Nurse (RRN) L was the designated staff member and would have expected her to find out who may have assisted R2 off of the floor in order to identify the date the fall occurred and complete a comprehensive root cause analysis. Review of the facility policy, Fall Assessment and Prevention last reviewed/revised 7/11/25 revealed, .10. When any resident experiences a fall, the facility will: Assess the resident for injury. Implement Neurological assessment for unwitnessed falls or witnessed falls when resident has hit their head. Complete a post-fall assessment. Complete an incident report. Notify physician and family. Review the resident's care plan and update as indicated. Complete a Post Fall huddle with staff working on the unit for additional information prior to the resident's fall to determine interventions that may be effective decrease resident's risk for future falls. Document all assessments and actions. Obtain witness statements. Place resident on q (every) shift charting for at least 6 shifts post fall.		