STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235072	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakview Medical Care Facility	1000 Diana Street Ludington, MI 49431

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 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 2729237. Based on interview and record review, the facility failed to follow policies and procedures to report injuries of unknown origin for one (R2) of 4 residents reviewed for injuries.Findings include:Resident #2 (R2)Review of a Face Sheet revealed R2 admitted to the facility on [DATE] with pertinent diagnoses of Parkinsons disease, Parkinsonism, and dementia. Review of an Incident Report titled Bruise dated 10/16/25 at 2:00 AM for R2 revealed: Incident Description: Nursing Description: purple discoloration noted to upper right arm. Resident Description: Resident does not recall any incident which could have caused bruising. Agencies/People Notified: Physician. No documentation to show the Abuse Coordinator was notified. Review of a Nursing Progress note dated 10/16/25 at 2:17 AM for R2 revealed: Large purple discoloration noted to right upper arm measuring 15cm (centimeters) x 6cm. Resident unable to recall any incident which may have caused the bruising. Message left in [Provider] binder for [Practitioner] review. Family to be notified by day shift in the morning. Review of an Incident Report titled Bruise dated 11/26/25 at 6:25 PM for R2 revealed: Incident Description: Nursing Description: Resident noted to have 4cm x 4cm bruise purple/blue in color with yellow fading around the edges to the lower lumbar region when CNA (Certified Nursing Assistant) was assisting the resident to the bathroom. Unknown how resident obtained the bruise. Resident Description: Resident Unable to give Description. Agencies/People Notified: Physician, Family Member, and MDS Nurse. No indication the Abuse Coordinator was notified. Review of a Nursing Progress note dated 11/26/25 at 6:48 PM for R2 revealed: : Resident noted to have 4cm x 4cm bruise purple/blue in color with yellow fading around the edges to the lower lumbar region when CNA was assisting the resident to the bathroom. Unknown how resident obtained the bruise. Charge nurse notified of new findings, monitoring set up until resolved, a note was place to [Provider]. During an interview on 2/24/26 at 10:20 AM, the Director of Nursing (DON) reported that the incidents on 10/16/25 and 11/26/25 were not reported to the State Agency. The DON reported she did not think she needed to report it because of the way R2 was regarding his restlessness and flailing at times. R2 could not verbalize what had happened. Review of a policy titled Abuse, Neglect & Exploitation last revised 2/9/26 revealed: Policy. This facility is committed to protecting the health, welfare, safety, and rights of all residents. The facility will maintain and enforce policies and procedures that prohibit, prevent, identify, report, and investigate all forms of abuse, neglect, exploitation, and misappropriation of resident property. All staff must comply with these requirements.3) Identification. This policy and corresponding forms guide staff in recognizing potential abuse, neglect and/or exploitation, including staff-to-resident abuse and certain resident-to-resident altercations. Indicators may include but are not limited to the following:-Resident, staff, or family report of abuse -Physical marks such as bruises or patterned appearances such as a handprint, belt, or ring mark on the body -Physical injury of an unknown source . -Reporting Requirements. Reporting guidelines are outlined below and (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	summarized in Abuse Reporting-Suspected Crimes v. Alleged Violations (OMCF Form 1-09). Allegations of resident abuse must only be reported to the designated personnel and agencies identified in this policy to ensure protection of residents and staff. Any inquiries from external parties, including the media, must be directed to the Administrator. (1) Staff Reporting. All allegations or suspected abuse must be reported immediately to the Charge Nurse, who promptly notify the NHA and DON. If Charge Nurse is unavailable, report directly to NHA or DON. (2) Facility Incident Reporting. An NHA or DON who becomes aware of a prohibited act must immediately comply with all applicable regulations and report the incident to the Michigan Department of Health & Human Services (MDHHS) / Department of Licensing & Regulatory Affairs ([NAME]), Bureau of Community & Health Systems (BCHS). Refer External Reporting Procedures at Section 2.E for detailed requirements.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2729237. Based on interview and record review, the facility failed to follow policies and procedures to thoroughly investigate injuries of unknown for one (R2) of 4 residents reviewed for injuries of unknown origin.Findings include:Resident #2 (R2)Review of a Face Sheet revealed R2 admitted to the facility on [DATE] with pertinent diagnoses of Parkinsons disease, Parkinsonism, and dementia. Review of an Incident Report titled Bruise dated 10/16/25 at 2:00 AM for R2 revealed: Incident Description: Nursing Description: purple discoloration noted to upper right arm. Resident Description: Resident does not recall any incident which could have caused bruising. No statements from staff documented and no thorough investigation of the root cause was completed. Review of a Nursing Progress note dated 10/16/25 at 2:17 AM for R2 revealed: Large purple discoloration noted to right upper arm measuring 15cm (centimeters) x 6cm. Resident unable to recall any incident which may have caused the bruising. Message left in [Provider] binder for [Practitioner] review. Family to be notified by day shift in the morning. Agencies/People Notified: Physician. Review of the Treatment Administration Record (TAR) for R2 revealed there was no documentation of the bruise to R2's right upper arm for monitoring until it resolved. Review of an Incident Report titled Bruise dated 11/26/25 at 6:25 PM for R2 revealed: Incident Description: Nursing Description: Resident noted to have 4cm x 4cm bruise purple/blue in color with yellow fading around the edges to the lower lumbar region when CNA (Certified Nursing Assistant) was assisting the resident to the bathroom. Unknown how resident obtained the bruise. Resident Description: Resident Unable to give Description. Agencies/People Notified: Physician, Family Member, and MDS Nurse. No statements from staff documented and no thorough investigation of the root cause was completed. No documentation to show a thorough nursing assessment/skin assessment was completed. Review of a Nursing Progress note dated 11/26/25 at 6:48 PM for R2 revealed: Resident noted to have 4cm x 4cm bruise purple/blue in color with yellow fading around the edges to the lower lumbar region when CNA was assisting the resident to the bathroom. Unknown how resident obtained the bruise. Charge nurse notified of new findings, monitoring set up until resolved, a note was placed to [Provider]. No documentation to show a thorough nursing assessment/skin assessment was completed. During an interview on 2/24/26 at 10:20 AM, the Director of Nursing (DON) reported that the incidents on 10/16/25 and 11/26/25 were not reported to the State Agency. The DON reported she did not think she needed to report it because of the way R2 was regarding his restlessness and flailing at times. R2 could not verbalize what had happened. The DON reported bruises are to be monitored on the TAR once a day for a week, then weekly until resolved.Review of a policy titled Abuse, Neglect & Exploitation last revised 2/9/26 revealed: Policy. This facility is committed to protecting the health, welfare, safety, and rights of all residents. The facility will maintain and enforce policies and procedures that prohibit, prevent, identify, report, and investigate all forms of abuse, neglect, exploitation, and misappropriation of resident property. All staff must comply with these requirements.3) Identification. This policy and corresponding forms guide staff in recognizing potential abuse, neglect and/or exploitation, including staff-to-resident abuse and certain resident-to-resident altercations. Indicators may include but are not limited to the following:-Resident, staff, or family report of abuse -Physical marks such as bruises or patterned appearances such as a handprint, belt, or ring mark on the body -Physical injury of an unknown source .Investigation. The Abuse Prevention Coordinator or designee is responsible for completing the investigation. (1) Investigation Guidance. The Abuse Response Guide (OMCF Form 1-08) may be used as a reference tool to help ensure a thorough investigation. The Injury of Unknown Source Algorithm/Worksheet (OMCF Forms 1-07) may provide additional guidance. (2) Investigation Worksheet. Use (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Abuse Investigation Worksheet (OMCF Form 1-20) to collect all information required for reporting an incident to the State Agency. Once the investigation is complete, the investigator will submit the completed Form 1-20 including the Investigation Summary to the Abuse Prevention Team for review and final approval.(3) Witness Statements. Interview all relevant witnesses and staff and document each interview. If possible, include a second person during the interview to verify the statements.(4) Other Input. Obtain input from the attending physician and/or legal counsel as appropriate.(5) Evidence Preservation. Carefully handle any evidence that may be relevant to a criminal investigation. Staff must not tamper with or alter evidence, as doing so can compromise both the facility's investigation and that of external authorities. This requirement is especially critical in cases of alleged or suspected sexual abuse. Examples of evidence tampering include, but are not limited to, washing linens or clothing, altering or destroying documentation, or bathing or otherwise cleaning the resident before a medical examination (including a rape kit, when applicable).

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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 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 2729237. Based on interview and record review, the facility failed to follow policies and procedures and implement meaningful care plan interventions to prevent falls for one (R2) of 4 residents reviewed for falls.Findings include:Resident #2 (R2)Review of a Face Sheet revealed R2 admitted to the facility on [DATE] with pertinent diagnoses of Parkinsons disease, Parkinsonism, and dementia. Review of a Witnessed Fall Incident Report dated 11/27/25 for R2 revealed: Housekeeping pulled cart up to the door of room [ROOM NUMBER] and found him standing up with his walker. Staff witnessed resident's foot get stuck in the wheel of his walker causing him to lose balance and fall. Resident unable to give description. Injuries Observed at Time of Incident: Skin Tear, Right hand (back). Staff statement from the Housekeeper: . I waited because his CNA (Certified Nursing Assistant) was in there doing care. (R2) was in his chair when (CNA) left the room after caring for him. When I turned to enter (R2's) room, he was up and pivoting to his walker when his foot got stuck on the wheel and the walker moved. (CNA) was right behind me and we then put a pillow under his head and shut the alarm off that was sounding. We noticed there was blood on the pillow we just placed under his head. Nurses showed up and took over. (R2) did not hit his head that I witnessed. Review of a Fall Investigation Review document for the 11/27/25 fall for R2 revealed: Root Cause Analysis- 1. Why did this occur? (R2) experienced periods of anxiety. 2. Why did this occur? Terminal restlessness. 3. Why did this occur? Parkinsons. 4. Why did this occur? Loss of balance. Conclusion/Root Cause: Impaired balance unaware of safety needs. Review of a Nurse-Risk Management Note dated 11/27/25 for R2 revealed: . Recommendations to Prevent Reoccurrence/Immediate Intervention: All safety interventions in place. There were no meaningful post fall interventions documented/implemented. Review of a Fall Packet/Investigation Checklist dated 11/27/25 for R2 revealed: . Q (every) 15-Minute Safety Checks in POC (plan of care). 9. Intervention(s) initiated and added to Care Plan. The Care Plan does not reflect the addition of the 15-minute safety checks. Review of a Fall Investigation Review document for the 11/27/25 fall for R2 revealed: Root Cause Analysis- 1. Why did this occur? (R2) experiences periods of anxiety. 2. Why did this occur? End of life restlessness/Anxiety. 3. Why did this occur? Parkinsons Disease with dyskinesia. Conclusion/Root Cause: (R2) is experiencing anxiety and restlessness and forgets to ask for help/use call light prior to transferring. 7-Day Follow-up: Resident not to be left in room recliner/chair alone. Collaborating with hospice. The Care Plan does not reflect the 7-day follow-up interventions until 12/4/25. Review of an Unwitnessed Fall Incident Report dated 12/4/25 for R2 revealed: Cena (CNA) heard alarm and entered room to resident laying on the floor in front of recliner chair. Resident unable to give description. Statements: Heard chair alarm going off and entered room to find resident lying on the floor in front of recliner chair. I shouted for help and placed a pillow under his head for support while waiting. I suspect he slipped on either his blanket or slippers while trying to self-transfer and fell. Review of a Fall Investigation Review document for the 12/4/25 fall for R2 revealed: Root Cause Analysis: 1. Why did this occur? Terminal restlessness. 2. Why did this occur? Unsafe to be in room in chair without supervision. Conclusion/Root Cause: Not to be in chair in room alone. (Intervention of not leaving resident alone in recliner added already as intervention after 11/27/25 fall). Review of a Nurse-Risk Management Note dated 12/4/25 for R2 revealed: Seen 20 mins prior sitting in recliner chair. CENA answered chair alarm and noted resident on the floor. Blanket on the floor by feet. One slipper half on and one slipper off. Recommendations to Prevent Reoccurrence/Immediate Intervention: Maxi lifted to bed. R2 was to be on 15-minute checks per the Fall Packet/Investigation Checklist. This intervention had been (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented after 11/27/25 fall. Review of a Fall Packet/Investigation Checklist dated 12/4/25 for R2 revealed: . 6. Q (every) 15-Minute Safety Checks in POC (plan of care). already on. 9. Intervention(s) initiated and added to Care Plan: no new interventions. Review of the Fall Care Plan for R2 revealed: Focus: I am at risk for falls r/t Confusion, Deconditioning, Gait/balance problems, Incontinence and Dx of Parkinson's. Date Initiated: 09/30/2025. Interventions included:-Fall team to review information on past falls and implement new safety interventions, initiated 9/30/25. No 15-minute checks post falls are documented.-High Risk Falls program, initiated: 09/30/2025.- Follow facility fall protocol, date initiated: 09/30/2025.-Please do not place him in room recliner, he has fallen out of it twice within 7 days.-Assist him in recliner in front of nurses' station instead please, date initiated: 12/05/2025- Please do not place him in room recliner due to fall risk. Assist him in recliner in front of nurses' station instead please, date initiated: 12/05/2025. In an interview on 2/24/26 at 10:20 AM, the Director of Nursing (DON) was questioned about the care plan interventions post fall for R2. The DON acknowledged the concerns of implementing timely care plan interventions and not following the care plan to prevent a fall. Review of a Fall Prevention Program policy last revised on 12/13/24 revealed: It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents. Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. (1) Identify Risks. Identification of residents at risk for falling is an ongoing process through observation of the resident and communication with staff. (3) Assessments. Assess current interventions for effectiveness as well as initiate new interventions based on the following information related to resident falls . E (5) Mitigation & Interventions. The Falls Committee/IDT will attempt to implement a new intervention as appropriate after each fall to reduce hazards and risks based on the RCA. Development of interim safety measures may be necessary within the first 24 hours if interventions cannot immediately be implemented fully.