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	04/08/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review, the facility failed to provide a process for visitors, staff, and residents to submit concerns and grievances anonymously potentially affecting 73 total residents. An observation on 4/7/26 at 2:00PM throughout the facility revealed there was not a concern or grievance form available outside of asking for one at the nurse's station and no box or location could be found to drop a grievance anonymously. In an interview on 4/7/26 at 2:50 PM Director of Social Services (DSS) C reported that grievances are not completed for residents unless a resident asks for one. DSS C reported that the facility did not have grievance forms outside of the nurse's station and if a person wanted one, they had to ask for it. In an interview on 4/7/26 at 3:17 PM the Director of Nursing Services (DONS) reported that grievances can be filled out by anyone, and the facility policy reflects that a grievance should be accessible to be submitted anonymously and at that time there was not a specific location for residents to file grievances anonymously. Review of facility policy Resident & Family Grievances revised 9/2/25 revealed grievances or complaints may be submitted verbally in person, by telephone, in writing, or anonymously.

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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(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 - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess a skin concern identified upon admission for 1 resident (R4) of 6 residents reviewed for skin and pressure ulcer concerns.Findings include:Review of an admission Record revealed R4 admitted to the facility on [DATE] with pertinent diagnoses which included dementia, diabetes, and dependence on renal dialysis.Review of R4's Baseline Care Plan, dated 12/16/2025, revealed .spot on bottom, long time, (no change), hurts, barrier cream, wife places bandaid. Further review revealed no assessment of this chronic wound and no interventions specific to this wound.Review of a current Care Plan focus and interventions for R4, initiated 3/23/2026, revealed a stage 2 pressure ulcer on his right gluteus. Further review revealed R4 was noted to be at risk for pressure injuries but there were no mention or interventions pertaining to the chronic wound on his gluteus prior to identification of the stage 2 pressure ulcer.Review of R4's admission Assessment, dated 12/15/2025 at 4:43 PM, revealed no assessment of R4's chronic buttock wound mentioned on his Baseline Care Plan. Further review of the Electronic Medical Record (EMR) revealed no documentation of R4's buttock wound until it was identified by staff on 3/22/2026. In an interview on 4/8/2026 at 11:13 AM, Registered Nurse (RN) D reported she was not aware of R4's history of chronic buttock pressure ulcer until it was recently identified. RN D reported nurses check a box on the Treatment Administration Record (TAR) when they perform weekly skin checks but do not document further unless they note a new skin concern. In an interview on 4/8/2026 at 11:20 AM, Wound Nurse E reviewed R4's admission Assessment and Baseline Care Plan and reported his chronic buttock wound should have been assessed at the time of his admission to the facility and appropriate interventions ordered. Wound Nurse E reported she could not prove whether R4's buttock wound was open or healed at the time of his admission to the facility on [DATE].