STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235015	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ingham County Medical Care Facility	3860 Dobie Road Okemos, MI 48864

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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235015	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ingham County Medical Care Facility	3860 Dobie Road Okemos, MI 48864

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2575199.Based on observation, interview and record review, the facility failed to protect R1's right to be free from sexual abuse by R2 and R4.Findings Include: R1:Review of the medical record reflected R1 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/19/25, reflected R1 scored three out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and was independent for transfers and walking at least 150 feet.R2:Review of the medical record reflected R2 admitted to the facility on [DATE], with diagnoses that included dementia. The admission MDS, with an ARD of 6/2/25, reflected R2 scored eight out of 15 (moderate cognitive impairment) on the BIMS and was independent for transfers and walking at least 150 feet.R4:Review of the medical record reflected R4 admitted to the facility on [DATE], with diagnoses that included neurocognitive disorder with Lewy Bodies, Parksinson's and dementia. The Significant Change in Status MDS, with an ARD of 6/24/25, reflected R4 scored eight out of 15 (moderate cognitive impairment) on the BIMS. In an interview on 7/30/25 at 11:46 AM, Certified Nurse Aide (CNA) D stated they had previously received report that R2 had his hands in R1's pants, moving them around, and kissed her. CNA D stated R1 had just recently been touched by R4 as well. R1 and R4:On 7/30/25 at 11:14 AM, R1 was observed seated in a chair, attending an activity in the Lounge.In an interview on 7/30/25 at 3:58 PM, CNA E reported that R1 had two incidents with R4, on the same day, earlier in the month of July 2025 (7/9/25). CNA E reported R4 touched R1's buttocks from the outside of her pants. The same day, while in another resident's room, they observed R4 with his hand down R1's pants, inside her brief, touching her buttocks. CNA E reported they intervened and removed R4 from the room. An Incident Report, dated 7/9/25 at 3:15 PM, reflected R1 was in another resident's room, with R4, when R4 walked past R1 and touched her buttocks. A correlating Progress Note was not noted in R1's medical record. R1 and R2:A Progress Note for 7/24/25 at 10:33 PM reflected a CNA reported that while in the activity room, another resident was observed kissing R1's head and had one hand between R1's legs, rubbing her upper, inner thigh. According to the note, R1 was giggling, and the residents were separated. An Employee Statement Form, dated 7/24/25, reflected CNA F was walking by the Lounge area, looked in and observed R1 seated in a chair. R2 was seated on the arm of the same chair, with his left arm around R1 and his left hand on R1's shoulder. R2's right hand was observed between R1's upper thighs, making a rubbing motion, up and down. The form reflected CNA F also observed R2 kissing R1's forehead. An attempt was made to contact CNA F via phone on 7/31/25 at 8:27 AM. A return call was not received prior to the exit of the survey on 7/31/25. R1's Care Plan, initiated on 4/25/25, reflected she had a male friend on her unit and did not have the capacity to consent to a romantic relationship. Interventions dated 4/25/25 reflected to redirect male residents from entering or following R1 to her room and to redirect R1 to sit by other female residents during activities and meals. Interventions dated 7/25/25 reflected, separated the residents and wellness checks. On 7/30/25 at 11:21 AM, R2 was observed walking independently in the hallway, towards his room. On 7/30/25 at 11:25 AM, R2 was observed in his room. When asked about interactions with female residents, R2 reported being in the Lounge (on their unit) and rubbing R1's neck. R2 stated he was not supposed to do that and knew it at the time. R2 stated staff finally walked in on him. R2 denied touching any other part of R1's body. A Progress Note for 7/10/25 at 5:19 PM reflected R2 was seen holding hands with another resident and was successfully redirected. A Progress Note for 7/17/25 at 4:03 AM reflected R2 was attempting to wander into a female resident's room and was redirected. A Progress Note for 7/24/25 at 10:33 PM reflected R2 was observed kissing and rubbing the left upper, inner thigh of a female resident [R1]. According to the note, the residents were immediately separated.A Nurse Practitioner Progress Note for 7/29/25 reflected R2 was seen as follow-up to a recent resident to resident occurrence. According to the note, it was reported that R2 kissed another resident. The note reflected that R2 did not know why it happened and was remorseful. According to the note, R2 knew his behavior was inappropriate. Task documentation for behavior symptoms reflected R2 had sexually inappropriate behavior documented on 7/23/25 at 3:53 AM and on 7/25/25 at 6:29 AM. The documentation did not detail the behavior. In an interview on 7/31/25 at 8:34 AM, Social Worker (SW) H reported there was recently a kiss between R1 and R2. When something of that nature occurred, Care Plans were reviewed for any resident with direct involvement in the incident. SW H reported she had been in two meetings in which Care Plan changes were discussed, but she could not recall what the