

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Ingham County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 3029138. Based on observation, interview, and record review, the facility failed to report a resident-to-resident sexual abuse allegation to the State Agency for two (R1 and R2) of three reviewed. Findings include: Review of the medical record revealed R1 was admitted to the facility on [DATE] with diagnoses that included Parkinson's Disease, dementia, anxiety, and depression. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/18/26 revealed R1 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). According to the medical record, R1 had been deemed unable to make his own medical and business decisions. The medical record did not include an assessment that R1 had the ability to consent to sexual activity/relationships or that his Durable Power of Attorney had the authority to make sexual activity/relationship decisions for him. Review of R1's care plan revealed Resident has a female friend on his unit and does not have the capacity to consent to friendly relationship. Spouse is aware of friendly relationship. Hx [history] of holding female friend/resident hand and providing hugs. Resident may comfort other residents and offer a hug if they are upset. The care plan was revised on 5/30/26 to reflect that R1 does have the capacity to consent to friendly relationship. There was no documentation in R1's medical record that he had consented to a sexual relationship with R2. Review of the medical record revealed R2 was admitted to the facility on [DATE]. The MDS with an ARD of 4/16/26 revealed R2 scored 15 out of 15 (cognitively intact) on the BIMS. R2 did not have a care plan regarding a relationship between her and R1. On 6/3/26 at 8:53 AM, R1 was observed sitting in a wheelchair outside his room. R1 then propelled himself back into his room and reported that R2 lives in the next room over and is his best friend. R1 reported he was married and R2 had a boyfriend, so they were only friends and the only physical contact between them has been a hug. On 6/3/26 at 2:04 PM, R2 was observed in his wheelchair in his room. R1 reported he did not recall any incidents where R2 was in his room or where staff had to separate them. When asked how he would feel if R2 touched him in his private area, R1 stated I would be appalled. An observation on 6/3/26 at 9:03 AM revealed R1 and R2's rooms were next door to each other. In a telephone interview on 6/3/26 at 9:22 AM, Certified Nursing Assistant (CNA) F reported they worked from 6:00 PM on 5/29/26 until 7:00 AM on 5/30/26 on R1 and R2's hallway. CNA F reported they heard from CNA E that CNA E witnessed R2 rubbing R1 inappropriately. In a telephone interview on 6/3/26 at 11:58 AM, CNA G reported on 5/29/26, herself and CNA E walked by R1's room and CNA G witnessed R2 rubbing R1 close to his private area. CNA G reported CNA E had a better view of the incident and then reported the incident to the nurse. Attempts were made to contact CNA E via telephone on 6/3/26 at 9:16 AM and 6/3/26 at 12:03 PM. CNA E did not return the calls prior to survey exit. Review of the facility's investigation revealed a statement from CNA E dated 5/29/26. The statement revealed the incident occurred on 5/29/26 at 9:00 PM. The statement was obtained by Unit Manager (UM)/Abuse Investigator (AI) I and revealed [CNA E] stated she was walking past [R1's] room and she observed [R2] sitting in her wheelchair next to [R1] and she had her hand down the front of his pants. She went up to tell the nurse about it. When she came back down the hall she (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	stated [R2] had removed her hand and was now rubbing [R1] on the outside of his pants [on] his groin area. [CNA E] stated to [R2] that she shouldn't do that because [R1] has a roommate. She stated that [R2] got very upset and stated she wasn't leaving. In an interview on 6/3/26 at 10:58 AM, Social Services Supervisor (SSS) H reported R1 and R2 have had a friendly relationship which meant it was a non-physical, emotional friendship. SSS H reported on 5/29/26, it was reported staff observed R2 with her hand in R1's pants. SSS H reported she came into the facility the next morning to assess and see what happened. SSS H reported they were not aware of the facility having any type of assessment to determine if residents had the capacity to consent to sexual activity/relationships. In an interview on 6/3/26 at 11:42 AM, UM/AI I reported when there were allegations of abuse, staff called the abuse hotline which connected to the phone she carried. UM/AI I reported she then called the Nursing Home Administrator (NHA) A to discuss the information, and they decided what will be done. UM/AI I reported if she and NHA A decided to report to the State Agency, she then entered the information on the State Agency's reporting website and then an investigation was completed. UM/AI I reported she received a call the evening of 5/29/26 with a report that a CNA observed R2 with her hand down R1's pants. UM/AI I reported the information was discussed with NHA A and it was determined that since R1 and R2 had an ongoing relationship, could make their needs known, and could make their own decisions, the incident was not reportable to the State Agency. UM/AI I reported staff were instructed if something was going on between R1 and R2, to make sure it was private, so others were not uncomfortable with the situation. UM/AI I reported it wasn't until the next day (5/30/26), statements were obtained from R1 and R2. When asked to define friendly relationship according to R1's care plan, UM/AI I reported R1 and R2's relationship was a friendly, emotional, non-physical relationship. UM/AI I reported they do hold hands and hug. In an interview on 6/3/26 at 1:24 PM, NHA A reported on 5/29/26, staff called UM/AI I at the abuse hotline. UM/AI I then called NHA A and reported staff observed R1 and R2 together in R1's room and the CNA observed R2's hand down R1's pants. NHA A reported it was determined this was not an allegation of sexual abuse because R1 and R2 spend a lot of time together, were in a relationship, and could make their needs known. NHA A reported the physician saw R1 on 5/29/26 for other reasons so the facility reached out to the physician on 5/30/26 at which time the physician reported they felt R1 was cable of making their own medical and business decisions. When asked if there was any documentation prior to the alleged incident showing R1 and R2 had the ability to consent to sexual activity/relationship or that they have consented to a sexual relationship, NHA A reported she would have to check. No documentation was provided prior to the survey exit. In an interview on 6/3/202 at 6 9:14 AM, Licensed Practical Nurse (LPN) C stated Certified Nurse Aid (CNA) E had reported she had witnessed R2 touching R1 private area inappropriately to LPN C on 5/29/2026. LPN C said CNA E tried to separate R1 and R2 but they were unable to. LPN C said R1 and R2 were not care planned to have a relationship of the type. LPN C said R1's wife was ok with R1 and R2 being only friends. LPN C said she called the abuse hotline and LPN I answered the call. LPN C said LPN I told her not to document the incident but said she did anyway. LPN C said LPN E told her it was okay that the two residents do that (sexual acts), but they needed to do it in private. LPN E said she then contacted the Assistant Director of Nursing (ADON) J who told her that an investigation would be done regarding the incident. LPN C said her and CNA E both wrote a statement about the incident;		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number 3029138. Based on interview and record review the facility failed to ensure a comprehensive care plan was in place for one out of three residents (Resident #2). Findings Included: Per the facility face sheet Resident #2 (R2) was admitted to the facility on [DATE]. Review of a Brief Assessment for Mental Status (BIMS) dated 4/16/2026 revealed R2 had a BIMS score of 15 out of 15 which indicated full cognitive abilities. Review of a progress note dated 4/28/2026 revealed R2 became upset the night before when she was asked to leave another resident's (R1) room. Review of a social service progress note dated 5/19/2026 revealed R2 was met with in order to discuss R2 interfering with R1's care, to not wake R1 while sleeping, and to leave and return later if R1 was in the bathroom or receiving care. Another progress note dated 5/29/2026 revealed R2 was witnessed in R1's room inappropriately touching R1. R2 was asked to leave R1's room, however, would not comply. In an interview on 6/3/2026 at 9:14 AM Licensed Practical Nurse (LPN) C stated that on 5/9/2026, Certified Nurse Aid (CNA) E had reported to her R2 was in R1's room inappropriately touching R1. LPN C said CNA E reported to her that she was unable to separate the two residents. LPN C stated that R1's wife was ok with R1 and R2 being friends, and she had seen the two hug and hold hands. In an interview on 6/3/2026 at 10:59 AM Social Services (SS) H stated that R2 entering into R1's room was an issue. SS H said R2 would interfere with R's care. SS H stated there was no Interdisciplinary Team (IDT) meeting held to discuss R2's relationship with R1 and stated more should have been documented about their relationship. SS H said yes there should have been a care plan in place regarding R2 interfering with R1's care, and also regarding the relationship/friendship R2 had with R1. Review of R2's care plans revealed there was no care plan in place regarding R2's behaviors towards R1 nor a relationship with R1.		