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	12/15/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to: (1) provide palatable food products, and (2) provide consistent dietary glassware and flatware affecting 131 residents who consume food, resulting in the increased likelihood for resident decreased food acceptance, nutritional decline, and undignified dining.Findings include:During an observation, interview and record review on 12/09/2025 at 12:10 PM several residents were sitting in Main Dining Room and staff were present appearing to be getting ready to serve lunch. Review of the posted menu located behind the silverware at the serving window reflected tomato Florentine soup, Korean BBQ chicken, moist fluffy rice, curried cauliflower, [NAME] gelatin, margarin, and 2% milk was on the menu for lunch. Continued observation with limited silverware noted in holder and several plastic silverware observed in room trays in carts located by the kitchenette. During an interview, Certified Nurse Aid DD reported staff must use plastic silverware when they run out when preparing room trays. Observed some trays with mix of metal and plastic with about half of trays (about 15 to 20 trays) with plastic silverware. CNA DD reported ran out of metal silverware about halfway through room tray prep. CNA DD reported had been issue for about one month and staff have reported to management that they run out of real silverware but continues to be an issue and residents' complaint because difficult to eat with flimsy plastic. CNA DD reported kitchen often runs out of food as well including that morning when several residents had ordered the pancakes, but kitchen ran out and served toast instead and times when they start to run low residents get smaller portions. CNA DD reported residents choose what they want when they arrive at the dining room from meal ticket that has only one choice on it for entrée and reported facility has alternative options, but kitchen staff often say they are not available at least daily. CNA K verified issues with not enough metal silverware and food and reported staff do not have enough blue handled cups with lids to pass water to resident or serve during meals and most don't have lids and have to use poor fitting disposable lids and observed use of thin clear plastic disposable lid used on several cups. CNA K reported if residents require two handled mugs and not available, they do the best they can and provide one handled mugs. Observed clear two handled mugs with lids that do not fit. CNA K reported food service has been a problem for months that frequently run out of food and often do not serve what is on the menu with at least four to five changes in kitchen management since contracted company change. CNA K reported residents complain about having to eat from plastic silverware and ask staff, are we in kindergarten? CNA K reported not homelike and alternative menu items not available except peanut butter and jelly or maybe tuna fish sandwich. CNA K and J reported often run out of 8-ounce glasses and must use two four-ounce glasses for residents that require 8 ounces of milk, with meal or give two four-ounce cups of juice if residents request more juice. CNA J and K reported facility had run out of milk in past as well and reported kitchen staff have had issues with staffing and not enough staff, and facility staff have had to assist in the kitchen over within past two months. CNA J reported one day cinnamon rolls were on the menus and the kitchen had run out and so they served Hawaiian rolls with cinnamon on the top and resident were disappointed. (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	12/15/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R73 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included heart disease, congestive heart failure, diabetic, diverticulosis, irritable bowel, and depression. The MDS reflected R73 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she required assist with meal set up and clean up. During an observation and interview on 12/09/2025 at 2:29 PM, R73 was in room sitting in a wheelchair and appeared calm, pleasant and able to answer questions without difficulty. R73 reported food at facility was bad and stated was served hot dogs 3 times last week. R73 stated, It is bad enough I have to be here, then I get bad food. R73 reported chooses to eat meals in room and two to three times a week has to eat meals with plastic silverware and stated, I pay a lot of money to be here and should not have to eat with plastic silverware. R73 reported was served corn last week and should not have been related to diagnosis and had lost weight recently. R73 stated, food is just not good, after starting to appear upset. R73 reported daughter was working on completing grievance form for food issues. During an observation, interview and record review on 12/10/2025 at 2:00 PM R73 was sitting in room with meal tray at side that had been delivered to room recently. There appeared to be wide egg noodles with ground white meat and pesto, with gravy. asparagus, puree cabbage soup, roll, and Strawberry Bavarian. R73 reported was finished stated, I ate something because I knew I had to eat something. R73 ate roll about 75% asparagus, and 25% entrée. The pureed cabbage soup was untouched as well as dessert. The strawberry dessert appeared to be pureed strawberry over pudding and pureed soup looked like dark mashed potatoes. R73 reported she really liked soup but not like that and did not care for looks of dessert and reported enjoyed sherbet but never offered. R73 meal ticket included entrée of 1 each S. Beef Hot Dog (turkey written in), garlic noodles, 6 ounces puree cabbage soup, roll, and Strawberry Bavarian with texture of regular ground. During an observation, interview and record review on 12/11/25 at 2:45 p.m., observed R73 meal tray at the bedside untouched with R73 in bed with eyes closed. The meal ticket reflected puree chicken noodle soup, stuffed pork chop, Brussel Sprouts, apple crisp. The tray included what appeared to be mashed potatoes, brown substance that looked like consistency of mashed potatoes, scoop of large grain multi color item, green beans and apple crisp with regular ground texture. R73 daughter entered room about 2:50 p.m. and reported R73 had ground meat because it was easier to chew not related to choking concerns and verified unsure why facility would puree pork chop or soup. R73 daughter reported R73 really likes soup. During an interview on 12/11/2025 at 3:10 PM, CNA GG reported alternative meals posted but told by kitchen staff not available at least daily including grilled cheese and mashed potatoes. CNA GG reported residents should have choices for meals and have basic options available. CNA GG reported facility has shortage of blue mugs and lids that fit properly for several weeks. During an interview on 12/11/2025 at 4:00 PM Kitchen Manager (KM) F reported had worked at the facility for about three months. KM F reported food modifications were ordered by Speech Therapy and kitchen staff are expected to follow meal tickets. KM F reported R73 had a hot dog on her meal ticket yesterday at lunch because maybe that is what she wanted and reported main entrée was pesto turkey and should have been R73 main entree on ticket with meat ground per order. KM F was unable to say why R73 had hot dog on ticket as main entrée and unable to say why R73's meal ticket had pureed chicken noodle soup today (12/11/25). KM F reported ground meal should look like ground meat and reported Brussel Sprouts were on the lunch menu today but kitchen staff had to (continued on next page)

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	12/15/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	substitute for green beans for quality reasons at the last minute. KM F reported couscous was served with lunch today (not on menu) but unable to say why it was served to R73 and verified was not on R73 meal ticket. KM F reported had ordered metal silverware three times since September and received more on 12/9/25 and reported was unsure where they go and may be issue with residents' hording silverware. During an interview on 12/15/2025 at 8:54 AM, Dietician H reported was familiar with R73. Dietician H reported R73 had several food eversions on admission and regular diet with ground meat was current texture order for meats only not related to swallowing issues. Dietician H reported if chunks of meat in soup would puree even if ground meat. Dietician H verified R73 had significant weight loss and was not on supplements currently. Dietician H reported alternate menu always available. During an observation on 12/15/2025 at 9:52 AM, R73 was observed in bed with eyes closed and untouched meal tray on bedside table. R73 meal ticket, dated 12/15/25 breakfast, included circled fresh grapes and corn flakes. Observed applesauce and corn flakes with no fresh grapes. Review of R73 Speech Therapy Evaluation, dated 10/23/25, reflected, Regular solids with ground meats, thin liquids. Inadequate mastication of tough meats .Pt's[patients] diet prior to ST[speech therapy] was regular solid, thin liquids. Pt's diet was downgraded to regular solids with ground meats due to pt's preference and inconsistency of cook on eat in the facility . Review of R73 Nutritional Assessment, dated 10/24/25, reflected grapes were on R73 list of liked foods. Continued review of the assessment reflected, Resident denies chewing or swallowing issues with current texture, Recent downgraded to ground meats r/t troubles with chewing some. Review of R73 Dietary Note, dated 11/18/25, reflected, Inadequate oral intakes r/t[related to] poor appetite AEB [as evidenced by] highly variable intakes and 10% weight loss x 6 mos. [times six months] . Review of the Grievance Log, dated 9/1/25 through 11/24/25, reflected over 25 kitchen/food complaints related to plastic silverware, food preferences not honored, no alternative choices available, lack of cups with lids, food temps and modifications. During a second interview on 12/15/25 at about 10:15 a.m. Dietician H reported was unsure why R73 was provided applesauce instead of requested fresh grapes and verified grapes were liked items. During an interview on 12/15/2025 at 11:03 AM, Speech Therapy (ST)HH reported R73 did not have swallowing issues but was started after request of resident on 10/24/25 visits with speech therapy because resident was tiring with chewing and was easier for resident. ST HH reported was unsure why soup was puree and stated that would be kitchen staff. On 12/10/2025 at 2:16 PM, a lunch test tray evaluation was conducted. The meal included cabbage soup, turkey with pesto, noodles, and asparagus. The cabbage soup was overcooked, resulting in the ingredients being excessively soft and mixed together. The noodles lacked flavor, and the turkey was notably dry. On 12/09/2025 at 12:49 P.M., An interview was conducted with Dietary Aide G regarding dietary service flatware inventory. Dietary Aide G stated: We don't have enough flatware (spoons, knives, forks). Dietary Aide G additionally stated: Management stated new flatware (knives, forks, spoons) is (continued on next page)

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	12/15/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	currently on order. On 12/09/2025 at 12:55 P.M., An interview was conducted with Registered Dietician (RD) H regarding dietary service flatware inventory. (RD) H stated: We order $400.00 worth of flatware a month. (RD) H also stated: We mainly order spoons and forks, rarely knives. On 12/09/2025 at 01:30 P.M., An interview was conducted with Dining Service Director F regarding dietary service flatware inventory. Dining Service Director F stated: We have been doing weekly room sweeps for flatware. Dining Service Director F also stated: Some residents are care planned for plastic spoons, knives, and forks. On 12/10/2025 at 11:52 P.M., Lunch meal food products were observed leaving the main food production kitchen, within an insulated stainless steel transport cart. On 12/10/2025 at 11:55 A.M., Lunch meal food products were observed arriving to the South Pantry Kitchenette, within an insulated stainless steel transport cart. On 12/10/2025 at 12:53 P.M., Food product temperatures were monitored utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded for Resident #92's lunch meal: Cabbage Soup - 143.7 Toasted Turkey Sandwich - 88.9 Strawberry Bavarian - 50.1* Beverage (Coffee) - 151.0 The 2022 FDA Model Food Code section 3-501.16 states: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 degrees C (135 degrees F) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 degrees C (41 degrees F) or less. On 12/10/2025 at 01:35 P.M., Food product temperatures were monitored utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded for Resident #72's lunch meal: Cabbage Soup - 137.0 Mashed Potatoes - 137.1 Grilled Cheese - 141.8 Lemon Asparagus - 119.7* (continued on next page)

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	12/15/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Strawberry Bavarian - 50.8* Beverage (Apple Juice) - 51.0* The 2022 FDA Model Food Code section 3-501.16 states: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 degrees C (135 degrees F) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 degrees C (41 degrees F) or less. On 12/10/2025 at 03:01 P.M., An interview was conducted with Dining Service Director F regarding dietary service glass and flatware inventory. Dining Service Director F stated: I thought I only needed juice glasses. Dining Service Director F also stated: I will order new 8-ounce glasses for both dairy and water. On 12/11/2025 at 08:30 A.M, Record review of the Policy/Procedure entitled: Ordering, Assembling, and Presenting a Meal dated (no date) revealed under Assembling the Order: (1) Collect all the serving equipment needed for the course(s) you are picking up. This includes plates, glasses, dollies, and silverware. (2) Get all the food accompaniments and garnishes for this course. For instance, sour cream for baked potato or mint jelly for sliced lamb. (3) Pick up cold food first, taking care to keep it away from hot food on the tray or the steamtable. (4) Pick up hot foods next, covering all hot food with an insulated plate cover (banquet cover) to retain the heat. Use heated underliners for hot foods and chilled underliners for cold foods and salads. (5) Plan the assembling order of the entrees so you can pick up the items as soon as they are ready. (8) Remember that the appearance and temperature of food perfectly prepared when it leaves the kitchen can be spoiled by a server/aide who is thoughtless, slow, or careless. On 12/11/2025 at 08:45 A.M., Record review of the Policy/Procedure entitled: Meal Delivery dated 9/7/22 revealed under Description: Meals will be delivered to all residents/patients in a timely, organized, safe, and sanitary manner. Record review of the Policy/Procedure entitled: Meal Delivery dated 9/7/22 further revealed under Nursing: (1) Serves meals promptly upon delivery. (2) Clears, cleans, and sanitizes overbed tables in preparation for meal. (3) Positions resident/patient to ensure comfort and safety while eating and drinking. Aids with meal set-up as appropriate and assists residents/patients who require assistance. (4) Notifies Dining Services Department of any items missing or if a resident/patient requests a substitute. (5) Picks up the dishes after each meal and returns them to the designated area (Note: Used dishes will not be placed in carts containing unserved foods/beverages).

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	12/15/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility to effectively clean and maintain food service equipment affecting 131 residents who consume food, resulting in the increased likelihood for cross-contamination and bacterial harborage.Findings include:On 12/09/2025 at 10:25 A.M., An initial tour of the food service was conducted with Dining Service Director F. The following items were noted: One 12-inch-wide by 12-inch-long return-air-exhaust ventilation grill was observed heavily soiled with accumulated and encrusted dust/dirt deposits, adjacent to the mechanical dish machine. The 2022 FDA Model Food Code section 6-501.14 states: (A) Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials. (B) If vented to the outside, ventilation systems may not create a public health HAZARD or nuisance or unLAWful discharge. On 12/09/2025 at 11:10 A.M., An initial tour of the South Pantry Kitchenette was conducted with Dining Service Director F. The following items were noted: The [NAME] microwave oven interior was observed (etched, scored, particulate). The interior door frame and ceiling surface were also observed (etched, scored, corroded). Dining Service Director F stated: I will remove the microwave oven immediately. The 2022 FDA Model Food Code section 4-501.13 states: Microwave ovens shall meet the safety standards specified in 21 CFR 1030.10 Microwave ovens. The Manitowac ice machine undersplash and backsplash were observed soiled with accumulated and encrusted mineral (lime and calcium) deposits. The drip tray assembly was also observed soiled with accumulated and encrusted mineral (lime and calcium) deposits, dirt, and food residue. Dining Service Director F stated: I will have staff thoroughly clean and sanitize the ice machine as soon as possible. The 2022 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. The sole hand sink goose neck assembly was observed loose-to-mount. The interior vanity cabinetry was also observed severely (warped, particulate, discolored, and moist). The particle board was further observed separated from continuous moisture exposure. One red sanitization bucket was additionally observed stored directly beneath the polyvinyl chloride (PVC) wastewater plumbing. The red sanitization bucket was further observed completely full of water and overflowing onto the interior cabinetry flooring surface. Dining Service Director F stated: I will place a work order into the maintenance software system (ECHO). On 12/09/2025 at 12:40 P.M., An initial tour of the [NAME] Pantry Kitchenette was conducted with Dining Services Director F. The following items were noted: The Panasonic microwave oven interior was observed soiled with accumulated and encrusted food residue. Dining Service Director F stated: I will have staff thoroughly clean and sanitize the microwave oven as soon as possible. The [NAME] stainless steel commercial toaster interior was observed soiled with accumulated and encrusted food residue. Dining Service Director F stated: I will have staff thoroughly clean and sanitize the toaster as soon as possible. The 2022 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. On 12/09/2025 at 2:59 P.M., A comprehensive tour of the South Pantry Kitchenette was conducted by this surveyor. The following item was noted: Dietary flatware (knives) was observed stored inverted, within a gray plastic caddy, with the food contact surface facing upward. The exposed food contact surface created a potential cross-contamination issue. The 2022 FDA Model (continued on next page)

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	12/15/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Food Code section 4-903.11 states: (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted. On 12/10/2025 at 11:38 A.M., A follow-up tour of the South Pantry Kitchenette was conducted by this surveyor. The following items were noted: The Manitowac ice machine undersplash and backsplash were observed soiled with accumulated and encrusted mineral (lime and calcium) deposits. Water was also observed dripping from the ice dispensing spout into the black drip tray. The drip tray assembly was also observed soiled with accumulated and encrusted mineral (lime and calcium) deposits, dirt, and food residue. The 2022 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. The flooring surface, located directly beneath the Manitowac ice machine was further observed severely soiled with dust, dirt, and debris (paper products, plastic lids, etc.). The 2022 FDA Model Food Code section 6-501.12 states: (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. (B) Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of FOOD is exposed such as after closing. On 12/11/2025 at 09:00 A.M, Record review of the Policy/Procedure entitled: Cleaning Schedule dated 9/7/22 revealed under Description: The health and safety of our associates and guests is of the utmost importance. Keeping clean and properly maintained cafe' and kitchens is critical to our success. On 12/11/2025 at 09:15 A.M., Record review of the Policy/Procedure entitled: Cleaning of Food and Non-Food Surfaces dated 9/7/22 revealed under Description: It is assumed that food contact surfaces within the facility/community are in good condition, made of non-toxic materials and are easily cleanable. It is assumed non-food contact surfaces of utensils and equipment within the facility/community must be made of materials that are safe, corrosion resistant, nonabsorbent, smooth, easily cleanable, and maintained in good condition.

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	12/15/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents were treated with dignity and respect when residents were required to use plastic silverware for meals which diminished the homelike dining experience in two (Resident #33 and #73) and the potential to affect all residents that utilize utensils during meal service. Findings include:Review of the medical record reflected R33 was admitted to the facility on [DATE] and readmitted on [DATE]. The Minimum Data Set (MDS) reflected R33 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 12/09/2025 at 2:36 PM, R33 was observed in bed. R33 was dressed, however, multiple orange stains on R33's shirt were observed. R33 stated that she struggled feeding herself lunch that day. R33 explained that she utilized adaptive equipment and can feed herself when it is provided, except more recently, the facility had been utilizing plastic spoons instead of actual silverware, making it difficult to feed herself without spilling food all over herself. R33 explained that the difference in utensil weight and the spoon handle make a significant difference when self-feeding. R33 confirmed that the spots on her shirt were content of her lunch earlier that day. R33 stated that it made her feel humiliated. During an observation, interview and record review on 12/09/2025 at 12:10 PM several residents were sitting in Main Dining Room and staff were present appearing to be getting ready to serve lunch. Review of the posted menu located behind the silverware at the serving window reflected tomato Florentine soup, Korean BBQ chicken, moist fluffy rice, curried cauliflower, [NAME] gelatin, margarin, and 2% milk was on the menu for lunch. Continued observation with limited silverware noted in holder and several plastic silverware observed in room trays in carts located by the kitchenette. During an interview, Certified Nurse Aid DD reported staff must use plastic silverware when they run out when preparing room trays. Observed some trays with mix of metal and plastic with about half of trays (about 15 to 20 trays) with plastic silverware. CNA DD reported ran out of metal silverware about halfway through room tray prep. CNA DD reported had been issue for about one month and staff have reported to management that they run out of real silverware but continues to be an issue and residents' complaint because difficult to eat with flimsy plastic. CNA DD reported kitchen often runs out of food as well including that morning when several residents had ordered the pancakes, but kitchen ran out and served toast instead and times when they start to run low residents get smaller portions. CNA DD reported residents choose what they want when they arrive at the dining room from meal ticket that has only one choice on it for entrée and reported facility has alternative options, but kitchen staff often say they are not available at least daily. CNA K verified issues with not enough metal silverware and food and reported staff do not have enough blue handled cups with lids to pass water to resident or serve during meals and most don't have lids and have to use poor fitting disposable lids and observed use of thin clear plastic disposable lid used on several cups. CNA K reported if residents require two handled mugs and not available, they do the best they can and provide one handled mugs. Observed clear two handled mugs with lids that do not fit. CNA K reported food service has been a problem for months that frequently run out of food and often do not serve what is on the menu with at least four to five changes in kitchen management since contracted company change. CNA K reported residents complain about having to eat from plastic silverware and ask staff, are we in kindergarten? CNA K reported not homelike and alternative menu items not available except peanut butter and jelly or maybe tuna fish sandwich. CNA K and J reported often run out of 8-ounce glasses and must use two four-ounce glasses for residents that require 8 ounces of (continued on next page)

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	12/15/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	milk, with meal or give two four-ounce cups of juice if residents request more juice. CNA J and K reported facility had run out of milk in past as well and reported kitchen staff have had issues with staffing and not enough staff, and facility staff have had to assist in the kitchen over within past two months. CNA J reported one day cinnamon rolls were on the menus and the kitchen had run out and so they served Hawaiian rolls with cinnamon on the top and resident were disappointed. Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R73 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included heart disease, congestive heart failure, diabetic, diverticulosis, irritable bowel, and depression. The MDS reflected R73 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she required assist with meal set up and clean up. During an observation and interview on 12/09/2025 at 2:29 PM, R73 was in room sitting in a wheelchair and appeared calm, pleasant and able to answer questions without difficulty. R73 reported food at facility was bad and stated was served hot dogs 3 times last week. R73 stated, It is bad enough I have to be here, then I get bad food. R73 reported chooses to eat meals in room and two to three times a week has to eat meals with plastic silverware and stated, I pay a lot of money to be here and should not have to eat with plastic silverware. R73 reported was served corn last week and should not have been related to diagnosis and had lost weight recently. R73 stated, food is just not good, after starting to appear upset. R73 reported daughter was working on completing grievance form for food issues. During an observation, interview and record review on 12/10/2025 at 2:00 PM R73 was sitting in room with meal tray at side that had been delivered to room recently. There appeared to be wide egg noodles with ground white meat and pesto, with gravy. asparagus, puree cabbage soup, roll, and Strawberry Bavarian. R73 reported was finished stated, I ate something because I knew I had to eat something. R73 ate roll about 75% asparagus, and 25% entrée. The pureed cabbage soup was untouched as well as dessert. The strawberry dessert appeared to be pureed strawberry over pudding and pureed soup looked like dark mashed potatoes. R73 reported she really liked soup but not like that and did not care for looks of dessert and reported enjoyed sherbet but never offered. R73 meal ticket included entrée of 1 each S. Beef Hot Dog (turkey written in), garlic noodles, 6 ounces puree cabbage soup, roll, and Strawberry Bavarian with texture of regular ground. During an interview on 12/11/2025 at 11:15 am, Licensed Practical Nurse (LPN) NN reported shortage of cups, lids and silverware for about 2 weeks and residents complain and staff assist with grievance reports. During an interview on 12/11/2025 11:55 PM R73 observed in room drinking from broken blue mug with disposable lid. R73 demonstrated handle was broken and lid was leaking. R73 reported daughter had brought dinner it last evening and verified weight loss since facility admission because she does not always eat food because often does not like served food. During an observation on 12/11/2025 at 12:40 p.m., in main dining room residents observed eating with plastic silverware. During an observation, interview and record review on 12/11/25 at 2:45 p.m., observed R73 meal tray at the bedside untouched with R73 in bed with eyes closed. The meal ticket reflected puree chicken noodle soup, stuffed pork chop, Brussel Sprouts, apple crisp. The tray included what appeared to be mashed potatoes, brown substance that looked like consistency of mashed potatoes, scoop of large (continued on next page)

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	12/15/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	grain multi color item, green beans and apple crisp with regular ground texture. R73 daughter entered room about 2:50 p.m. and reported R73 had ground meat because it was easier to chew not related to choking concerns and verified unsure why facility would puree pork chop or soup. R73 daughter reported R73 really likes soup. During an interview on 12/11/2025 at 3:10 PM, CNA GG reported alternative meals posted but told by kitchen staff not available at least daily including grilled cheese and mashed potatoes. CNA GG reported residents should have choices for meals and have basic options available. CNA GG reported facility has shortage of blue mugs and lids that fit properly for several weeks. During an interview on 12/11/2025 at 4:00 PM Kitchen Manager (KM) F reported had worked at the facility for about three months. KM F reported food modifications were ordered by Speech Therapy and kitchen staff are expected to follow meal tickets. KM F reported R73 had a hot dog on her meal ticket yesterday at lunch because maybe that is what she wanted and reported main entrée was pesto turkey and should have been R73 main entree on ticket with meat ground per order. KM F was unable to say why R73 had hot dog on ticket as main entrée and unable to say why R73's meal ticket had pureed chicken noodle soup today (12/11/25). KM F reported ground meal should look like ground meat and reported Brussel Sprouts were on the lunch menu today but kitchen staff had to substitute for green beans for quality reasons at the last minute. KM F reported couscous was served with lunch today (not on menu) but unable to say why it was served to R73 and verified was not on R73 meal ticket. KM F reported had ordered metal silverware three times since September and received more on 12/9/25 and reported was unsure where they go and may be issue with residents' hording silverware. During an interview on 12/15/2025 at 8:54 AM, Dietician H reported was familiar with R73. Dietician H reported R73 had several food eversions on admission and regular diet with ground meat was current texture order for meats only not related to swallowing issues. Dietician H reported if chunks of meat in soup would puree even if ground meat. Dietician H verified R73 had significant weight loss and was not on supplements currently. Dietician H reported alternate menu always available. During an observation on 12/15/2025 at 9:52 AM, R73 was observed in bed with eyes closed and untouched meal tray on bedside table. R73 meal ticket, dated 12/15/25 breakfast, included circled fresh grapes and corn flakes. Observed applesauce and corn flakes with no fresh grapes. Review of R73 Speech Therapy Evaluation, dated 10/23/25, reflected, Regular solids with ground meats, thin liquids. Inadequate mastication of tough meats .Pt's[patients] diet prior to ST[speech therapy] was regular solid, thin liquids. Pt's diet was downgraded to regular solids with ground meats due to pt's preference and inconsistency of cook on eat in the facility . Review of R73 Nutritional Assessment, dated 10/24/25, reflected grapes were on R73 list of liked foods. Continued review of the assessment reflected, Resident denies chewing or swallowing issues with current texture, Recent downgraded to ground meats r/t troubles with chewing some. Review of R73 Dietary Note, dated 11/18/25, reflected, Inadequate oral intakes r/t[related to] poor appetite AEB [as evidenced by] highly variable intakes and 10% weight loss x 6 mos. [times six months] . Review of the Grievance Log, dated 9/1/25 through 11/24/25, reflected over 25 kitchen/food complaints related to plastic silverware, food preferences not being honored, available alternatives, (continued on next page)

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	12/15/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lack of cups with lids, food temps and modifications. During a second interview on 12/15/25 at about 10:15 a.m. Dietician H reported was unsure why R73 was provided applesauce instead of requested fresh grapes and verified grapes were liked items. During an interview on 12/15/2025 at 11:03 AM, Speech Therapy (ST)HH reported R73 did not have swallowing issues but was started after request of resident on 10/24/25 visits with speech therapy because resident was tiring with chewing and was easier for resident. ST HH reported was unsure why soup was puree and stated that would be kitchen staff.

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	12/15/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete accurate Minimum Data Set (MDS) assessments for four resident (#7,#47,#72,#145) of 26 residents reviewed for MDS accuracy, resulting in inaccurate MDS assessments. Findings Include Resident #47 (R#47) Review of the medical record reflected that R47 was admitted to the facility on [DATE] and discharged on 12/10/2025. Diagnoses of displaced fracture of upper end of the left humerus, unspecified sequelae of cerebral infarction (a range of long-term effects and complications), Type 2 Diabetes Mellitus, heart failure and blindness in right eye. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/12/2025 revealed R47 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. Under section GG0115, Functioning Limitations in Range of Motions reveals R47 is independent for all care, used a walker for safe ambulation. Record review of the Minimum Data Set (MDS) skin assessment with an ARD/Target Date of 11/12/2025, did not show accuracy for documentation on pressure ulcers on admission assessment. According to the section within the MDS 3.0 Section M- Skin Conditions under MO100. Determination of Pressure Ulcer/Injury Risk, did resident had a pressure ulcer/injury, a scar over boney prominence, or a non-removeable dressing/device, MDS RN EE marked no, that the resident did not have any pressure ulcers. Then under MO210. Unhealed Pressure Ulcers/Injuries, MDS RN EE marked yes, that R 47 had unhealed pressure ulcers. Then marked R47 as having 1 pressure ulcer stage 1, was not on a turning and repositioning program, had nutrition and hydration interventions to manage skin problems and marked yes for pressure ulcer care. Application of non-surgical dressing (with or without topical medication) other than feet was marked no to any dressing used for the pressure ulcer. 12/15/2025 10:32 AM Interview with Minimum Data Set (MDS) Coordinator RN S and MDS RN EE, writer asked both nurses about MDS admission skin assessment on R47. MDS Coordinator S stated MDS RN EE did the assessment on R47 and MDS RN EE was looking back through the residents' notes in the EMR. Writer asked what tools she used to complete her assessment. MDS RN EE stated she read the nursing /wound care notes upon admission. MDS RN EE stated that R47 had 2 pressure ulcers on the head-to-toe assessment. Wound Care Nurse Practitioner (NP) FF documented R47 had a stage 3 to left buttock, and a stage 2 to the right buttock. MDS RN EE stated she must have marked it wrong because she marked them further down on the MDS skin assessment. Further down revealed MDS RN EE only documented that R47 only had a stage 1 pressure ulcer, and no others, which R47 did not have a stage 1 pressure ulcer. Resident #145 (R145) Review of the medical record reflected that R145 was admitted to the facility on [DATE] and discharged on 12/13/2025. Diagnoses of Pneumonia, respiratory failure, pleural effusion, severe malnutrition, fracture of upper end of left tibia and fusion of the spine. (continued on next page)

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	12/15/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/02/2025 revealed R145 had a Brief Interview of Mental Status (BIMS) of 14 (cognitively intact) out of 15. Under section GG0115, Functional Limitation in Range of Motion, reveals R145 was impaired on one side of her upper extremity, uses a walker for ambulation and requires a set up or clean up assistance and supervision for oral care. R145 is dependent on toileting or showers. Record review of the MDS Skin Assessment documentation, R145 had Deep Tissue Injury (DTI) with open areas in the middle of the injury. MDS RN EE marked 3 DTIs, and the open areas that were measured and documented. R145 did not have 3 DTI's, she had 2 DTI's and a stage 3 pressure ulcer. During an interview on 12/15/2025 at10:45 AM, MDS RN EE stated she did not have Wound Care NP FF assessment note on R145, so she looked at the nursing notes for wound details. MDS RN EE stated wound care NP FF comes into the facility1 day a week, he makes rounds with Licensed Practical Nurse (LPN) L who completes the wound care the other 3 days a week. Stated wound care NP FF did not do his assessment until 12/04/25. Record review of hospital discharge report revealed that R145 came to the facility from the hospital with a stage 3 pressure ulcer of the sacral region. R145 also had a wound on the left ischium, right buttock and sacral region. The sacral region pressure ulcer was noted to have slough in the wound bed and area measured 11.3cm x 8.5cm scant drainage to area, wound base is 70% necrotic tissue, 10% slough and 10% granulating tissue, no malodor noted, wound edges attached. DTI noted on the right buttock, area measuring at 3.1cm x 8cm, wound base was 100% maroon in color. DTI noted on the left ischium measuring 3.6cm x 3.2cm with a bridge of good tissue, no drainage noted, no odor. Record review of a wound care assessment completed by wound care NP FF on 12/04/2025: Wound #1 Wound Assessment: Wound- Sacral unstageable pressure Measurements- 9 x 8.5 x unable to determine true depth Tissue type- slough/subcutaneous Peri Wound- fragile Drainage- moderate serous exudate Pain- moderate to severe Infection- increased drainage, non-viable tissue, recent hx of wound deterioration Overall Wound Condition- stable Wound Plan of Care- Cleanse sacral wound with anasept, pat dry. Apply nickel-thick layer of Santyl to wound bed followed by alginate (NO SILVER), secured with sacral silicone foam dressing daily and (continued on next page)

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	12/15/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prn Wound Additional Orders- Frequent turning and repositioning to offload wounds Wound #2 Wound Assessment: Wound- Left ischium DTI Measurements- 1.5 x 2 x 0cm Tissue type- dark crusting Peri Wound- fragile Drainage- none Pain- none Infection- no observable signs Overall Wound Condition- stable Wound Plan of Care- skin prep daily and leave OTA Wound Additional Orders- Frequent turning and repositioning to offload wounds Wound #3 Wound Assessment: Wound- Right ischium DTI Measurements- 1.5 x 2 x 0cm Tissue type- dark epithelial Peri Wound- fragile Drainage- none Pain- none Infection- no observable signs Overall Wound Condition- stable Wound Plan of Care- skin prep daily and leave OTA (continued on next page)

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	12/15/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wound Additional Orders- Frequent turning and repositioning to offload wounds R145's pressure ulcers were not identified correctly, making the assessment inaccurate and could have affected treatment. Findings Included: Resident #7 (R7) Review of the medical record demonstrate that R7 was admitted to the facility 12/12/2024 with diagnoses that included cerebral infarction (stroke), dementia, chronic obstructive pulmonary disease (COPD), dysphagia (difficulty swallowing), type 2 diabetes, hypothyroidism (low thyroid hormone), anemia (low red blood cells), depression, psychosis (mental state where you lose touch with reality), hyperlipidemia (high fat content in blood), hypertension, anxiety, and insomnia. Review of R7's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/24/2025, revealed R7 had a Brief Interview for Mental Status (BIMS) of 07 (severe cognitive impairment) out of 15. During observation and attempted interview on 12/11/2025 at 09:31 a.m. R7 was observed lying down in her bed. A half length side rail was observed on the right side of the bed and on the left side of the bed. R7 did not respond to verbal questions. Review of the R7's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/24/2025, revealed section P-Restraints and Alarms A. Bed Rail was documented as 0.not used. Review of R7's plan of care did not demonstrate the use of bilateral side rails. Review of R7's physician orders did not include an order for the use of side rails. Review of R7's medical record did not demonstrate a side rail evaluation or that measurements of the bilateral side rails had been conducted. During an interview on 12/11/2025 at 10:32 a.m. Minimum Data Set (MDS) Coordinator S explained that she was responsible for the coordination of the facility MDS's. MDS Coordinator S was asked to review R7's MDS with an Assessment Reference Date (ARD) of 11/24/2025 and the review section P-Restraints and Alarms A. Bed Rail. MDS Coordinator S confirmed that it had been coded that R7 was not using side rails. MDS Coordinator S also confirmed that R7's plan of care did not include the use of bilateral side rails. MDS Coordinator S could not explain why R7's MDS was inaccurate regarding the use of side rails. During observation with MDS Coordinator S on 12/11/2025 at 10:41 a.m. R7 was observed lying in bed. MDS Coordinator S confirmed that R7's bed had two half rails position on the right and left sides of her bed. MDS Coordinator S explained that it was her opinion that R7 could not be using the observed side rails as positioning devices. Resident 72 (R72) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R72 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included cerebral vascular accident affecting left side, heart disease, anxiety and depression. The MDS reflected R72 had a BIM (assessment tool) score of 14 which indicated her ability to make daily decisions was cognitively intact, and she required assist with dressing, hygiene, bathing, and transfers. (continued on next page)

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	12/15/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 12/09/2025 at 10:28 AM R72 appeared calm, pleasant and able to answer questions without difficulty. R72 reported had history of stroke that effected left side with left arm contractures currently. R72 reported had worked with therapy in the past. Review of R72 MDS, dated [DATE], reflected no impairment for upper extremity Range of Motion. Continued review of all MDS, section GG0115, reflected impairment on one side. During an interview on 12/15/2025 at 1:43 PM, Therapy Manager LL reported R72 was currently receiving therapy including for left side impairment and verified had been same since admission and MDS range of motion documented as no impairment was incorrect on 2/24/25.

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	12/15/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure appropriate monitoring of a resident prescribed an antipsychotic medication in one (Resident #93) out of 5 reviewed for medication review. Findings include: Review of the medical record reflected Resident #93 (R93) was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included nondisplaced bimalleolar fracture of right lower leg. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/23/25, reflected R93 scored 7 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 12/10/2025 4:01 PM, R93 was observed in her room watching television. Review of R93's Physician Orders revealed an active order for Seroquel Oral Tablet 50 MG (antipsychotic medication). Review of R93's Antipsychotic medication care plan revealed an intervention dated 1/16/23 which stated, orthostatic blood pressures as ordered. Review of R93's Physician orders revealed no order for orthostatic blood pressures. Review of R93's vital signs revealed no completed orthostatic blood pressures. In an interview on 12/15/2025 at 1:58 PM, Director of Nursing (DON) B stated that residents taking antipsychotic medications had specific monitoring requirements, including orthostatic blood pressure monitoring which is to be completed once a month. DON B reviewed R93's electronic medical record and confirmed the absence of orthostatic blood pressure monitoring.

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	12/15/2025

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 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 #2649987 Based on interviews and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act.Findings include: Review of the clinical record, including the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/29/25, revealed Resident 136 (R136) was admitted to the facility on [DATE] and was discharged home on [DATE], with diagnoses that include congestive heart failure and chronic kidney disease. R136 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). On 12/10/2025 09:57 am, during a phone interview with R136 she reported on October second, she was on a diuretic and had to void her bladder frequently, R136 stated used the call light frequently on the midnight shift due to the medication. R136 stated the Certified Nursing Assistant (CNA) was angry that R136 kept asking for help, R136 stated the more she asked for the bedpan, tension and anger from the CNA grew. R136 stated she asked for her name, but the CNA refused to tell R136. Of note, R136 was able to give this writer a physical description. R136 stated as the night progressed the final time, she turned her call light on, the same unknown CNA entered the room and at this time became physically rough with her care and shoved the bedpan hard into R136's hip. R136 reported this was very painful and caused a large bruise resulting her to be sent to the emergency room the next morning. R136 stated she reported to the midnight nurse (name unknown) that the assigned CNA was mad, provided rough care and intentionally shoved the bedpan into her hip causing pain. R136 stated she was dismissed by midnight nurse and told Licensed Practical Nurse (LPN) P when she came on duty that morning. Review of the Unusual Occurrence report dated 10/03/25 at 8:45am, revealed LPN P observed R136 being tearful and complaining of extreme right hip pain, the note reflected LPN P observed a large edematous area on R136's right hip, the physician and the abuse hotline called. On 12/11/25 at 10:30 am, during a phone interview with LPN P she reported that R136 told made an allegation of abuse on the morning on 10/03/25. LPN P reported R136 was tearful and said the midnight was angry she kept turning her call light on and the CNA was rough and shoved the bedpan into her right side/hip. LPN P stated R136 was very vocal and clear this was an intentional act which was why she reported it to the facility's abuse hotline per protocol. LPN P stated she spoke with LPN Q who handles the investigations of abuse allegations and was told that R136's x-ray came back negative and she was already aware and looking into it. R136 was insistent it was a deliberate act on behalf of the CNA, and the abuse hotline was called again to make sure LPN Q was aware of R136's insistence of being a deliberate act but LPN Q stated the root cause of the right hip hematoma was a positioning issue. On 12/11/25 at 10:45am, during an interview with LPN Q she reported she had no recollection of R136 but may have a soft file about the incident. LPN Q then stated was resident was care planned for and well known to change her story. Of note, there was no care plan in place that identified R136 as having behavior problems such as changing her story, embellishing or making false accusations. At 11:39 AM, LPN Q stated there was a soft file and it was determined that R136's right hip hematoma was determined to be a positioning issue. LPN Q elaborated it was not reported to the State Agency because she knew it was related to positioning. Review of the facility policy titled Resident-Abuse Neglect and Exploitation Prevention dated 09/01/21 Under the heading Reporting and Response 1. Alleged violations will be reported to the Administrator and designee per facility reporting process, state agency, adult protective services and all other required agencies (Law enforcement when applicable) within specified time frames.

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	12/15/2025

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 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 #2649987 Based on interview and record review the facility failed to thoroughly investigate an allegation of abuse for one resident (Resident #136) of seven residents reviewed for abuse. Findings include Review of the clinical record, including the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/29/25, revealed Resident 136 (R136) was admitted to the facility on [DATE] and was discharged home on [DATE], with diagnoses that include congestive heart failure and chronic kidney disease. R136 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). On 12/10/2025 09:57 am, during a phone interview with R136 she reported on October second, she was on a diuretic and had to void her bladder frequently, R136 stated used the call light frequently on the midnight shift due to the medication. R136 stated the Certified Nursing Assistant (CNA) was angry that R136 kept asking for help, R136 stated the more she asked for the bedpan, tension and anger from the CNA grew. R136 stated she asked for her name, but the CNA refused to tell R136. Of note, R136 was able to give this writer a physical description. R136 stated as the night progressed the final time, she turned her call light on, the same unknown CNA entered the room and at this time became physically rough with her care and shoved the bedpan hard into R136's hip. R136 reported this was very painful and caused a large bruise resulting her to be sent to the emergency room the next morning. R136 stated she reported to the midnight nurse (name unknown) that the assigned CNA was mad, provided rough care and intentionally shoved the bedpan into her hip causing pain. R136 stated she was dismissed by midnight nurse and told Licensed Practical Nurse (LPN) P when she came on duty that morning. Review of the Unusual Occurrence report dated 10/03/25 at 8:45am, revealed LPN P observed R136 being tearful and complaining of extreme right hip pain, the note reflected LPN P observed a large edematous area on R136's right hip, the physician and the abuse hotline called. On 12/11/25 at 10:30 am, during a phone interview with LPN P she reported that R136 told made an allegation of abuse on the morning on 10/03/25. LPN P reported R136 was tearful and said the midnight was angry she kept turning her call light on and the CNA was rough and shoved the bedpan into her right side/hip. LPN P stated R136 was very vocal and clear this was an intentional act which was why she reported it to the facility's abuse hotline per protocol. LPN P stated she spoke with LPN Q who handles the investigations of abuse allegations and was told that R136's x-ray came back negative and she was already aware and looking into it. R136 was insistent it was a deliberate act on behalf of the CNA, and the abuse hotline was called again to make sure LPN Q was aware of R136's insistence of being a deliberate act but LPN Q stated the root cause of the right hip hematoma was a positioning issue. On 12/11/25 at 10:45am, during an interview with LPN Q she reported she had no recollection of R136 or LPN P reporting an allegation of abuse. When the unusual occurrence report was reviewed with LPN Q which stated the abuse hotline was contacted, LPN Q stated she had no recollection of being notified of the allegation. But will check to see if there was a soft file about the incident. LPN Q then stated was resident was care planned for and well known to change her story. Of note, there was no care plan in place that identified R136 as having behavior problems such as changing her story, embellishing or making false accusations. At 11:39 AM, LPN Q stated there was a soft file and it was determined that R136's right hip hematoma was determined to be more of a positioning issue opposed to an abuse concern. Review of LPN's Q soft file did not include an interview with R136, when queried why R136 was not interviewed, LPN Q stated R136 was at the hospital and not available. Of note, R136 was not admitted to the hospital. Review of the facility policy titled Resident-Abuse Neglect and Exploitation Prevention dated 09/01/21 Under the heading Investigating Alleged Abuse, Neglect and Exploitation1. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.2. Procedure to investigate include:a. Identifying staff responsible for the investigation;b. cautiously handling evidence that could be used in a criminal investigation;c. (continued on next page)

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	12/15/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Investigating different types of alleged violations;d. Identifying and interviewing all persons i. Alleged victim ii. Victim roommates iii. Alleged perpetrators

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	12/15/2025

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 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. Based on observation, interview, and record review the facility failed to develop and implement comprehensive care plan for one resident R7 of 26 reviewed. Findings Included:Resident #7 (R7)Review of the medical record demonstrate that R7 was admitted to the facility 12/12/2024 with diagnoses that included cerebral infarction (stroke), dementia, chronic obstructive pulmonary disease (COPD), dysphagia (difficulty swallowing), type 2 diabetes, hypothyroidism (low thyroid hormone), anemia (low red blood cells), depression, psychosis (mental state where you lose touch with reality), hyperlipidemia (high fat content in blood), hypertension, anxiety, and insomnia. Review of R7's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/24/2025, revealed R7 had a Brief Interview for Mental Status (BIMS) of 07 (severe cognitive impairment) out of 15. During observation and attempted interview on 12/11/2025 at 09:31 a.m. R7 was observed lying down in her bed. A half-length side rail was observed on the right side of the bed and on the left side of the bed. R7 did not respond to verbal questions. Review of the R7's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/24/2025, revealed section P-Restraints and Alarms A. Bed Rail was documented as 0.not used. Review of R7's plan of care did not demonstrate the use of bilateral side rails. Review of R7's physician orders did not include an order for the use of side rails. Review of R7's medical record did not demonstrate a side rail evaluation or that measurements of the bilateral side rails had been conducted. During an interview on 12/11/2025 at 10:22 a.m. Director of Nursing (DON) B explained that residents using side rails would have the following actions completed: - Assist Device/Bed Rail Assessment- Nursing 5 Day Assist Device/bed Rail Monitoring Form- A physician's order for the use of the assist device/bed rail. - The resident care plan would include the use of the assist device/bed railDON B was asked to review R7's medical record. DON B confirmed that R7 did not have any of the above documented actions completed in her medical record. DON B explained that the facility was currently conducting a Quality Improvement Project for the use of Assistive Device/ Bed Rails. DON B explained that currently R7 was not incompliance with the requirements of using assistive devices/bed rails at this time. During an interview on 12/11/2025 at 10:32 a.m. Minimum Data Set (MDS) Coordinator S explained that she was responsible for the coordination of the facility MDS's. MDS Coordinator S was asked to review R7's MDS with an Assessment Reference Date (ARD) of 11/24/2025 and the review section P-Restraints and Alarms A. Bed Rail. MDS Coordinator S confirmed that it had been coded that R7 was not using side rails. MDS Coordinator S also confirmed that R7's plan of care did not include the use of bilateral side rails. MDS Coordinator S could not explain why R7's MDS was inaccurate regarding the use of side rails. During observation with MDS Coordinator S on 12/11/2025 at 10:41 a.m. R7 was observed lying in bed. MDS Coordinator S confirmed that R7's bed had two half rails position on the right and left sides of her bed. MDS Coordinator S explained that it was her opinion that R7 could not be using the observed side rails as positioning devices. During an interview on 12/11/2025 at 11:07 a.m. Director of Nursing (DON) B re-confirmed that R7 did not have a physician's order for the use of side rails, did not have a plan of care for the use of side rails, and did have a Nursing 5 Day Assist Device/bed Rail Monitoring Form. DON B did provide a copy of Assist Device/bed Rail Assessment which had been completed 12/11/2025.

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	12/15/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide bath/showers for one Residents (#13) of three Residents reviewed.Findings Included: Resident #13 (R13): Review of the medical record demonstrated that R13 was admitted to the facility 09/26/2023 with diagnoses that included cerebral infarction, schizoaffective disorder depressive, dementia, chronic obstructive pulmonary disease (COPD), atrial flutter, sleep disorder, hypertension, hyperlipidemia (high fat content in blood), and anxiety. Review of R13's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/02/2025, revealed R13 had a Brief Interview for Mental Status (BIMS) of 09 (severe cognitive impairment) out of 15. During observation and interview on 12/09/2025 at 01:39 p.m. R13 was observed sitting up wheelchair. R13 explained that she had not been receiving showers as frequently she wanted. She explained that she wanted to shower twice per week.Review of R13's MDS, with an ARD of 12/02/2025, section GG- Functional Abilities revealed that she was dependent for showers. Review of R13's Point of Care (computerized documentation of the medical record used by the certified nurse aides), task revealed shower Wednesday and Sunday PM. During an interview on 12/11/2025 at 09:37 a.m. Certified Nurse Aide (CNA) R explained that she is given a paper assignment, which identified which residents are to be bathed/showered during her shift. CNA R explained that showers are recorded on a shower sheet and are given to the nurses. During an interview on 12/11/2025 at 12:04 p.m. Director of Nursing (DON) B explained that residents are given baths/shower according to their plan of care. DON B confirmed that R13 was to receive 2 showers per week to be given on Wednesday and Sunday on the afternoon/night shift. DON explained that paper skin assessment sheets are how the facility demonstrated that a bath/shower was completed. DON B presented skin assessment sheets of R13 for the period of October 2025 to present. DON B explained that the following skin assessments sheets could not be located and therefore R13 had not received a shower on those dates. Review of skin sheets 10/08/25-no shower, 10/12/2025-no shower, 10/15/2025-no shower,10/27/2025-no shower, 11/02/2025- no shower, 11/05/2025- no shower, 11/09/2025- no shower, 11/23/2025-no shower, 12/03/2025- no shower, 12/10/2025-no shower. 11 showers were completed out of a possible 21 days during October until present date. DON B could not explain why showers had not been completed as directed per the plan of care for R13.

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	12/15/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During interviews, observations and record review the facility failed to provide meaningful activities to one of one resident (R86) resulting in boredom, isolation and disengagement. Findings Include Resident #86 (R86)Review of the medical record reflected that R86 was admitted to the facility on [DATE]. Diagnoses of traumatic subdural hemorrhage without loss of consciousness, fracture of left great toe, emphysema, atrial fibrillation, heart failure, dyspnea with repeated falls. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/07/2025 revealed R86 had a Brief Interview of Mental Status (BIMS) of 14 (cognitively intact) out of 15.Under section GG0115, Functional Limitation in Range of Motion reveals R86 had impairment on both sides, used a walker and wheelchair for ambulation and required substantial/maximal assistance for all care. During an observation and interview on 12/09/2025 at 1:44 PM, R86 did not have any activities, magazines, books, or coloring materials for her to do while spending time in her room. R86 stated nobody had talked to her about bringing her activities in her room since it's so painful to go down to the activities off this floor. During an interview on 12/15/2025 at 11:10 AM, activity aide II stated they do check ins on residents and see how they are doing. Then stated not on the room visits or check ins today. Writer asked what a check in was about. Activity aide II stated they just stop in the room to see if they need anything, then stated on the days they make a 1 on 1 visit, they spend about 10-15 minutes with the residents. During an observation and interview on 12/15/2025 at 11:15 AM, R86 and her youngest daughter JJ were sitting in R86's new room. Writer asked both of them if anyone had been by this morning to include R86 in the activities, both stated no, they haven't seen anyone. R86 stated activities do not do anything with her in her room. Writer stated if she had a calendar for the month to let her know when things are going on. R86 stated no. No observation of an activity calendar on the resident's side to show her what activities are offered. Daughter JJ stated someone asked yesterday but R86 wasn't up to it. R86's daughter JJ that was the first time someone has asked her. R86's daughter JJ stated they stick their head in the room, but do not do anything but tell R86 what activity going on but doesn't stay to visit. R86 stated she needs help getting down to the area they are doing activities, that she can't get there herself. During an interview on 12/15/2025 at 12:31 PM, Activity Director KK stated she did not have access to her computer but would try to help. Activity Director KK stated activity staff could provide in room visits, 10-15 minutes per resident, check ins to see how they are doing. Activity Director KK stated she completed that with R86's daughter JJ, and her daughter stated she would not be interested in large groups, after she was admitted on [DATE]. Writer reminded Activity Director that preferences were reviewed with daughter LL and not resident directly. However, R86 is of sound body and mind, and she can make her own decisions regarding how she would like to spend her days. Activity Director KK stated she is unaware of anyone looking into that, also stated they look at that as an unserved activity. Activity Director KK stated the activity calendar would be posted on the magnetic white board at the end of R86's bed. Activity Director KK stated there was a recent room move from short term rehab to long term care, stated that housekeeping most likely threw it, referring to the activities calendar, away. Activity Director KK stated they would look at the calendar when they did a check in so the resident would know which activities they can attend on that day. R86 did not have a calendar posted on her magnetic whiteboard to observe what activates were being offered. R86 was not participating in the activity program.

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	12/15/2025

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 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** Based on observation, interview and record review the facility failed to ensure resident safety during staff assisted mechanical lift transfer for 1 of 3 sampled residents (Resident #3) reviewed for accidents, resulting in Resident #3 right lower leg laceration that required hospital transfer and sutures. Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R3 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included chronic osteomyelitis, heart failure, morbidly obese, diabetes, venous insufficiency, and depression. The MDS reflected R3 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she required staff assist with dressing, hygiene, bathing and transfers.During an observation and interview on 12/09/2025 at 4:05 PM, R3 was sitting in wheelchair in resident room and appeared calm, pleasant and able to answer questions without difficulty. R3 reported an incident on 12/5/25, when staff were transferring her from the bed to the wheelchair and her right lower leg was cut when the lift tipped over during the transfer. R3 reported three staff were present including Certified Nurse Aid (CNA) MM, nurse and another CNA. R3 reported staff were unable to control the bleeding and had to emergency room for stitches. R3 had large dressing in place on right lower leg. R3 requested staff to get her back to bed and R3 granted this surveyor permission to observe. CNA DD reported planned to transfer R3 to bed after another CNA arrived.During an observation on 12/09/2025 at 4:15 PM, this surveyor entered R3's open door room and observe CNA DD hooking up R3 sling, placed under resident in wheelchair, to mechanical life. No other staff was present in the room. CNA DD transferred R3 from the wheelchair to the bed with the use of the mechanical life alone and resident tolerated well. This surveyor continued to observe from doorway area. Review of R3 Progress Notes, dated 12/5/2025, reflected, While transferring resident from bed to chair, staff was trying to reposition resident as she was upset that she was leaning to far to the left and while trying to reposition her the hoyer started to lift up and while we got the hoyer level again as resident was still up in the air nurse notice a large stream of dark red blood streaming from residents leg. Two CNA Staff unlocked wheel and pulled hoyer forward so nurse who was guiding from the back, could asses and apply press to the laceration on residents right calf. Quick assessment nurse assessed that there was an upside down J shaped laceration approximately seven cm from top to bottom. Nurse applied pressure, Cna alerted unit manager and nurse on green who brought ABD pads and colban to wrap leg tight. Once leg was wrapped tight we hoyered resident back onto bed. Resident was unaware that anything had happened to her leg until she realized nurse was concerned as she could not see what had happened. Resident has no feeling bilaterally from the Paramedics arrived and we call [named R3] sister for permission about going to hospital for stitches as resident did not want to go as she did not want to miss bingo. Both sisters were contacted and both stated she should go. Notified [named physician] that resident needed to be sent out for stitches and then called and left a message for PACE hospice on the general mail box. The only area we could think was she had hit with leg on top section of leg rest. So padding was added to her current wheelchair. It was discussed with unit manager and nurse that it might be reasonable to contact her hospice company about getting her a broda chair since she does not ambulated.Review of the Progress Noted, dated 12/5/2025, reflected, Resident returned just before dinner today. [named] hospital called and gave report that residents vitals were stable and that she received four stitches to the laceration on right lower from of shin. Resident returned and was very hungry so staff got her an early dinner. Resident is in bed , call light is within reach and resident can make her needs known. Follow up for an order for stitches removal on 12/12/2025.Review of R3 Care Plan, dated 9/4/24, reflected, TRANSFER: Dependent x 2 with mechanical lift and blue/XL trim sling.During an interview on 12/11/2025 at 11:15 am, Licensed Practical Nurse (LPN) NN reported was present on 12/5/25 and in room when R3s right lower leg was (continued on next page)

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	12/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cut during mechanical lift transfer. LPN NN reported she was behind R3 guiding into wheelchair and CNA MM and OO were on each side of the lift. LPN NN reported the lift tipped when one leg of the lift came off the ground and one of the CNA staff stepped on lift leg quickly. LPN NN reported that is when they noticed R3 right lower leg was bleeding, and she applied pressure after R3 was lowered into wheelchair and lift was moved. LPN NN reported mechanical lift transfers require two staff and reported received re-education after incident to removed foot pedals prior to transfer.During an observation and interview on 12/11/2025 at 11:21 am, R3 was observed in room in bed, denied discomfort and reported there was usually two staff in the room when using mechanical lift for transfers.During an interview on 12/11/2025 at 12:15 PM, CNA OO reported was present on 12/5/25 when R3's leg was cut during transfer. CNA OO reported entered R3 room after R3 was in mechanical lift to assist and LPN NN was behind R3, and CNA MM was on the front left. CNA OO reported R3 was being transferred from the bed to the wheelchair positioned at the foot of the bed. CNA OO reported R3 was almost in the wheelchair when R3 was pushed to back of wheelchair the lift tipped, she grabbed lift and stood on it and it tipped back. CNA OO reported was unsure what caused bleeding, but right lower leg was bleeding and LPN NN was present and tended to that. CNA OO reported mechanical lift was positioned from side of wheelchair with leg of lift between front and back wheel of wheelchair toward the wall. CNA OO reported R3 was a two to three person assist with mechanical lift transfer and never one because requires at least 2 for safety. CNA OO reported received re-education after the incident of proper use of mechanical lift including positioning directly in front of the wheelchair.During an interview on 12/11/2025 at 11:50 AM, CNA MM reported was present when R3 had incident during staff assisted transfer with mechanical lift on 12/5/25. CNA MM reported LPN NN was positioned behind R3, and CNA OO had entered R3 room during the transfer. CNA MM reported the R3 was being transferred from the bed to the wheelchair at the foot of the bed and reported the legs of the mechanical lift were not in widest position because one leg of lift was position between front and back wheel of wheelchair and was not enough room between wall. CNA MM reported received re-education after incident on proper use of mechanical lift including using with legs positioned widest position and straight into wheelchair. CNA MM reported R3 requires two staff with use of mechanical lift transfers. During an observation and interview on 12/11/2025 at 1:55 pm, CNA GG demonstrated mechanical lift in Red Hall and verified exposed orange aluminum sharp areas about 16-18 inches up from floor on piston area of lift. CNA GG demonstrated use of lift and reported lift legs should be wide with transfer including lowering residents into wheelchair. CNA GG demonstrated use with wide legs positioned between front and back wheels of wheelchair indicated it was highly unlikely that lift legs were wide and more likely that legs were narrow on mechanical lift when staff attempted to position R3 to back of wheelchair (pushing R3 sideways in lift) when lift tipped sideways toward wheelchair.During an interview on 12/15/2025 at 2:05 PM, Director of Nursing (DON) B reported Unit Manager and Staff Educator PP completed investigation for R3 incident on 12/5/25. DON B reported would expect staff to use wide legs on lift during transfer and use of two person assist with mechanical lift transfer. During an interview on 12/15/2025 at 2:23 PM, Staff Educator (SE) PP reported was unsure who R3 cut the front of right leg when transfer from bed to wheelchair on 12/5/25 and was responsible for investigation. SE PP reported after speaking was everyone involved thought possibly R3's anterior right leg was cut on wheelchair pedal area but did not make sense. SE PP reported did not notice sharp area on mechanical lift. SE PP reported provided staff re-education related to proper mechanical lift use including proper positioning of lift legs in wide position and wheelchair positioning. SE PP reported would expect staff to always use two staff for all mechanical lift transfers. Review of the facility, MECHANICAL LIFT Policy, dated 12/28/22, reflected, OBJECTIVE: To transfer a Resident/Patient between two surfaces using a mechanical lift .PROCEDURE.Obtain assistance. The minimum number for a safe transfer is two people.Bring lift to the bed.Roll the base, spread wide open under the bed.Make sure there is room to maneuver the lift in the room.Make sure wheelchair is in position for transfer and brakes are locked.

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	12/15/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement and document interventions designed to prevent further weight loss, including consistent monitoring and documentation of dietary intake, nutritional supplements, and snacks in two (Resident #10, Resident #116) out of 4 reviewed for nutrition. Findings include: Resident #10 (R10) Review of the medical record revealed R10 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, anxiety disorder, and insomnia. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/10/25 revealed R10 scored 00 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool), ate a mechanically altered diet, and required setup or clean-up assistance with eating. On 12/15/25 at 9:58 AM. R10 was observed ambulating independently exiting the lounge and walking down the hallway. On 12/15/25 at 10:22 AM, R10 continued wandering the hallway while a group of residents were in the lounge eating applesauce and drinking coffee. A staff member approached R10, took her by the hand and walked briefly with her before redirecting her down another hall. The staff member did not attempt to redirect R10 into the lounge for a snack and coffee. Review of R10's weight history revealed on 11/5/25 R10 weighed 127.2 pounds and on 12/2/25, R10 weighed 119.2 pounds which was a 6.29% significant weight loss. Review of the Nutrition assessment dated [DATE] revealed R10's usual body weight was 130's and adding snacks TID [three times per day] & magic cup BID [twice per day] (290 kcal, 9g protein) r/t [related to] inconsistent intakes. The assessment revealed R10 disliked raisins, bacon, and pork. Review of the Physician's Orders revealed no orders for magic cup twice per day or snacks three times per day. Review of R10's Nutrition Care Plan revealed interventions that included: Provide and serve supplements and snacks as ordered see meal tickets for details (initiated 11/6/25) Provide, serve regular diet/mechanical soft texture/thin liquids as ordered. Monitor intake and record every meal (initiated 11/6/25. Food preferences to be reflected onto meal tickets (initiated 11/6/25) Review of the Nutrition/Dietary Note dated 12/11/25 revealed Resident with -6.3% weight loss x 1 month. Resident frequently walking around unit, increasing her nutritional needs. Currently receiving magic cup BID (290 kcal, 9g pro [grams of protein]). RD [Registered Dietitian] to add fortified smoothie qd [every day] (230 kcal, 6g pro). Will continue to monitor. Review of R10's meal tickets revealed 4-ounce magic cup with lunch and dinner. The lunch tray ticket dated 12/11/25 revealed the entree was 5-ounce ground stuffed pork chop. Pork was listed as one of R10's dislikes on the Nutrition assessment dated [DATE]. (continued on next page)

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	12/15/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Documentation Survey Report revealed the following missing Nutrition-Amount Eaten documentation: 11/7/25-dinner not documented 11/10/25-dinner not documented 11/13/25-lunch and dinner not documented 11/14/25-breakfast, lunch, and dinner all documented as not applicable 11/16/25-dinner not documented 11/18/25-lunch and dinner not documented 11/19/25-breakfast, lunch, and dinner not documented 11/21/25-lunch not documented 11/24/25-lunch and dinner not documented 11/25/25-dinner not documented 11/26/25-dinner not documented 11/27/25-dinner not documented 11/30/25-lunch and dinner not documented 12/1/25-lunch documented as not applicable 12/2/25-breafkast and dinner not documented 12/3/25-lunch and dinner not documented 12/4/25-dinner not documented 12/9/25-dinner not documented 12/10/25-dinner not documented 12/11/25-lunch and dinner not documented 12/14/25-lunch and dinner not documented Review of Documentation Survey Report revealed there were four opportunities to document supplement intake each day that included 12:00 PM day nurse, 12:00 PM day Certified Nursing Assistant (CNA), 5:30 PM day CNA and 5:30 PM evening nurse. The report revealed the following missing documentation for Nutrition: Supplements: (continued on next page)

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	12/15/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/21/25 5:30 PM CNA and nurse documented as not applicable 11/22/35 12:00 PM CNA and nurse documented as not applicable 11/24/25-no documentation 11/25/25 12:00 CNA and nurse documented as not applicable and 5:30 PM CNA and nurse did not document 11/26/25 12:00 PM CNA and nurse documented as not applicable and 5:30 PM CNA and nurse did not document 11/27/25 5:30 PM CNA and nurse did not document 11/28/25-no documentation 11/29/25 12:00 PM CNA and nurse documented as not applicable 11/30/25-no documentation 12/1/25 12:00 PM and 5:30 PM CNA and Nurse documented as not applicable 12/2/25 5:30 PM CNA and nurse did not document 12/3/25-no documentation 12/4/25 12:00 PM CNA and nurse documented as not applicable and 5:30 PM CNA and nurse did not document. There was a PRN (as needed) documentation at 4:28 AM 12/5/25, 12/6/25, 12/7/25, 12/8/25-12:00 PM and 5:30 PM CNA and nurse documented as not applicable 12/9/25 5:30 PM CNA and nurse did not document 12/10/25 12:00PM CNA and nurse documented as not applicable and 5:30 PM nurse and CNA did not document 12/11/25-no documentation 12/12/25 12:00PM and 5:30 PM CNA and nurse all documented as not applicable 12/14/25-no documentation Review of the Nutrition-Snacks documentation revealed there was no documentation related to snacks in the last 30 days. In an interview on 12/15/2025 at 8:56 AM, RD H reported a resident's preferences and dislikes should be reflected on the meal ticket. When asked why R10 was served a pork on 12/11/25 when pork was listed as a dislike, RD H reported R10 may have requested it and that R10's dislike may have been (continued on next page)

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	12/15/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pulled pork, but she would have to verify with R10's daughter. When asked what R10's intake was for that meal, RD H reported it appeared R10 did not eat that meal. When asked how a true intake was being monitored and evaluated when not all meal intakes, snacks, and supplements were documented, RD H agreed there was missing documentation and reported they would have to average the amounts that were documented and speak with staff. When asked what not applicable documentation meant, RD H reported she was unsure and that it could mean too many different things. In an interview on 12/15/25 at 2:02 PM, Director of Nursing (DON) B agreed there was missing documentation related to R10's meal, supplement, and snack intake. Review of the medical record reflected R116 was admitted to the facility on [DATE], with diagnoses that included dementia. R116 was interview able and answered questions appropriately. On 12/9/25 at 10:00 AM, R116 was observed in bed. R116 was conversant and discussing events when a staff member was observed delivering a small cup and spoon for R116. R116 explained that the cup contained a smoothie, and he does not eat the smoothies. On 12/09/2025 at 1:33 PM R116 was observed in his room. A staff member provided R116 with his lunch and assisted R116 with consuming his meal. On 12/11/2025 at 10:24 AM, R116 was observed in bed. A smoothie was observed on his bedside table, untouched. R116 and a family member confirmed that R116 does not touch the smoothies and they are better off in the trash. R116's family member confirmed that the smoothies are provided in an attempt to assist with R116's weight loss. Review of a Nutrition/Dietary Note dated 12/11/25 revealed Resident (116) with -12.4% (precent) weight loss [in] 6 mos. Resident with highly variable meal intakes. Currently receiving fortified smoothie . and pm (night) snack. Intakes encouraged. Review of R116's weight loss care plan revealed interventions including Provide and serve snacks per preference . Provide and serve supplement as ordered, and . Monitor and record meal intakes. Review of the task documentation revealed inconsistent data documentation completion for meal intake and supplement intake documentation, including multiple dates where not applicable was selected as an option for supplement intake and several dates where the amount consumed for meals was not completed. Further review of the task documentation revealed no evidence that R116 was being provided a nightly snack and no documentation for snack acceptance and/or consumption. In an interview on 12/15/2025 at 9:09 AM, Registered Dietician (RD) H states that the dieticians rely on meal consumption, including snacks, all three meals, and supplements, to determine the individual intake needs for the residents. RD H confirmed that R116 was on the significant weight loss list which is what prompted the intervention for smoothies and nightly snacks. RD 'H stated that the staff should be documenting the amounts consumed and should not be selecting not applicable as a response for consumption amounts.

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	12/15/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review the facility failed to ensure that bed rails were assessed and measured to prevent possible entrapment for one Resident (#7) of one resident reviewed for Residents using bed rails. Findings Included:Resident #7 (R7)Review of the medical record demonstrate that R7 was admitted to the facility 12/12/2024 with diagnoses that included cerebral infarction (stroke), dementia, chronic obstructive pulmonary disease (COPD), dysphagia (difficulty swallowing), type 2 diabetes, hypothyroidism (low thyroid hormone), anemia (low red blood cells), depression, psychosis (mental state where you lose touch with reality), hyperlipidemia (high fat content in blood), hypertension, anxiety, and insomnia. Review of R7's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/24/2025, revealed R7 had a Brief Interview for Mental Status (BIMS) of 07 (severe cognitive impairment) out of 15. During observation and attempted interview on 12/11/2025 at 09:31 a.m. R7 was observed lying down in her bed. A half-length side rail was observed on the right side of the bed and on the left side of the bed. R7 did not respond to verbal questions. Review of the R7's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/24/2025, revealed section P-Restraints and Alarms A. Bed Rail was documented as 0.not used. Review of R7's plan of care did not demonstrate the use of bilateral side rails. Review of R7's physician orders did not include an order for the use of side rails. Review of R7's medical record did not demonstrate a side rail evaluation or that measurements of the bilateral side rails had been conducted. During an interview on 12/11/2025 at 10:22 a.m. Director of Nursing (DON) B explained that residents using side rails would have the following actions completed: - Assist Device/Bed Rail Assessment- Nursing 5 Day Assist Device/bed Rail Monitoring Form- A physician's order for the use of the assist device/bed rail. - The resident care plan would include the use of the assist device/bed railDON B was asked to review R7's medical record. DON B confirmed that R7 did not have any of the above documented actions completed in her medical record. DON B explained that the facility was currently conducting a Quality Improvement Project for the use of Assistive Device/ Bed Rails. DON B explained that currently R7 was not incompliance with the requirements of using assistive devices/bed rails at this time. During an interview on 12/11/2025 at 10:32 a.m. Minimum Data Set (MDS) Coordinator S explained that she was responsible for the coordination of the facility MDS's. MDS Coordinator S was asked to review R7's MDS with an Assessment Reference Date (ARD) of 11/24/2025 and the review section P-Restraints and Alarms A. Bed Rail. MDS Coordinator S confirmed that it had been coded that R7 was not using side rails. MDS Coordinator S also confirmed that R7's plan of care did not include the use of bilateral side rails. MDS Coordinator S could not explain why R7's MDS was inaccurate regarding the use of side rails. During observation with MDS Coordinator S on 12/11/2025 at 10:41 a.m. R7 was observed lying in bed. MDS Coordinator S confirmed that R7's bed had two half rails position on the right and left sides of her bed. MDS Coordinator S explained that it was her opinion that R7 could not be using the observed side rails as positioning devices. During an interview on 12/11/2025 at 11:07 a.m. Director of Nursing (DON) B re-confirmed that R7 did not have a physician's order for the use of side rails, did not have a plan of care for the use of side rails, and did have a Nursing 5 Day Assist Device/bed Rail Monitoring Form. DON B did provide a copy of Assist Device/bed Rail Assessment which had been completed 12/11/2025.

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	12/15/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, interview, and record review the facility failed to ensure monitoring and inspection of resident bed frames and mattress for one resident (#7) of one resident reviewed for bed safety. Findings Included: Resident #7 (R7):Review of the medical record demonstrate that R7 was admitted to the facility 12/12/2024 with diagnoses that included cerebral infarction (stroke), dementia, chronic obstructive pulmonary disease (COPD), dysphagia (difficulty swallowing), type 2 diabetes, hypothyroidism (low thyroid hormone), anemia (low red blood cells), depression, psychosis (mental state where you lose touch with reality), hyperlipidemia (high fat content in blood), hypertension, anxiety, and insomnia. Review of R7's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/24/2025, revealed R7 had a Brief Interview for Mental Status (BIMS) of 07 (severe cognitive impairment) out of 15. During observation and attempted interview on 12/11/2025 at 09:31 a.m. R7 was observed lying down in her bed. A half-length side rail was observed on the right side of the bed and on the left side of the bed. R7 did not respond to verbal questions. Review of the R7's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/24/2025, revealed section P-Restraints and Alarms A. Bed Rail was documented as 0.not used. Review of R7's plan of care did not demonstrate the use of bilateral side rails. Review of R7's physician orders did not include an order for the use of side rails. Review of R7's medical record did not demonstrate a side rail evaluation or that measurements of the bilateral side rails had been conducted. During an interview on 12/11/2025 at 10:22 a.m. Director of Nursing (DON) B explained that residents using side rails would have the following actions completed: - Assist Device/Bed Rail Assessment- Nursing 5 Day Assist Device/bed Rail Monitoring Form- A physician's order for the use of the assist device/bed rail. - The resident care plan would include the use of the assist device/bed railDON B was asked to review R7's medical record. DON B confirmed that R7 did not have any of the above documented actions completed in her medical record. DON B explained that the facility was currently conducting a Quality Improvement Project for the use of Assistive Device/ Bed Rails. DON B explained that currently R7 was not incompliance with the requirements of using assistive devices/bed rails at this time. During an interview on 12/11/2025 at 10:32 a.m. Minimum Data Set (MDS) Coordinator S explained that she was responsible for the coordination of the facility MDS's. MDS Coordinator S was asked to review R7's MDS with an Assessment Reference Date (ARD) of 11/24/2025 and the review section P-Restraints and Alarms A. Bed Rail. MDS Coordinator S confirmed that it had been coded that R7 was not using side rails. MDS Coordinator S also confirmed that R7's plan of care did not include the use of bilateral side rails. MDS Coordinator S could not explain why R7's MDS was inaccurate regarding the use of side rails. During observation with MDS Coordinator S on 12/11/2025 at 10:41 a.m. R7 was observed lying in bed. MDS Coordinator S confirmed that R7's bed had two half rails position on the right and left sides of her bed. MDS Coordinator S explained that it was her opinion that R7 could not be using the observed side rails as positioning devices. During an interview on 12/11/2025 at 11:07 a.m. Director of Nursing (DON) B re-confirmed that R7 did not have a physician's order for the use of side rails, did not have a plan of care for the use of side rails, and did have a Nursing 5 Day Assist Device/bed Rail Monitoring Form. DON B did provide a copy of Assist Device/bed Rail Assessment which had been completed 12/11/2025.