STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235224	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lenawee Medical Care Facility	200 Sand Creek Highway Adrian, MI 49221

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** Based on interviews and record reviews, the facility failed to thoroughly investigate the alleged sexual abuse on one resident (R2) of one resident investigated for abuse.Linked to intake 2645136Findings IncludeResident #2 (R2)Review of the medical record reflected that R2 was admitted to the facility on [DATE]. Diagnoses of Congestive Heart Failure, Stroke, Traumatic Brain Injury, Dysphagia (difficulty swallowing), Major Depression, High Blood Pressure, Bi-Polar, weakness and unsteady on her feet.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/11/2025 revealed R2 had a Brief Interview of Mental Status (BIMS) of 07 (Moderate to severe cognition impairment) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R2 needed assistance of 1 person with personal care.Resident #3 (R3)Review of the medical record reflected that R3 was admitted to the facility on [DATE]. Diagnoses of Congestive Heart Failure, Adjustment disorder with mixed disturbance of emotions and conduct, Vascular Dementia without behavioral disturbance, unsteady on his feet and abnormalities of gait and mobility.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/22/2025 revealed R3 had a Brief Interview of Mental Status (BIMS) of 03 (severe cognition impairment) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R3 needed assistance of 1 person with personal care. Record review revealed an incident of sexual abuse that took place on 09/25/2025 between R3 and R2 at this facility. The incident report also reported this abuse was witnessed by Certified Nursing Assistants (CNA) H. It was alleged the abuse was verified, by the facility, not only by staff witness but also by reviewing the hallway camera footage. Incident report included the timeline of events.Camera footage was reviewed to verify the timeline of events from 09/25/2025.2125 pm. R3 approached R2 in the hall near the nurse's station. They were both in their wheelchairs.2126pm. R3 gets even closer to R2 and touches her wheelchair arm. R2 appears to be consoling R2 as she was crying. R3 reaches and touches R2's face. They were talking and then R3 rubs R2's back.2127pm. R3 attempted to hug R2.2127:07pm. R3 reached over and touched R2's right breast.2127:09pm. R3 removed his hand from touching R2's right breast.2127:15pm. R3 places his hand back on R2's right breast.2127:17pm. R3 moved his hand to R2's left breast.2127:18pm. R3 moved his hand back to the wheelchair.2127:19pm. RSA H approached R3 and R2.2127:21pm. RSA H reached R3 and R2 and separated them.2127:24pm. R3 self-propels backwards.2128pm. RSA H took R2 into her room.2155pm. RSA H reported this event to LPN D. Record review revealed the facility completed two witness statements, from CNA H and CNA I on 09/25/25 at 9:45pm. CNA I stated she did not witness that incident on her hall.Record review revealed LPN D followed up with R2 regarding the incident who was sitting on her bed crying.Record review revealed Social Service Coordinator (SSC) C followed up with R2 regarding the incident, R2 could not recall the incident.During an interview on 02/04/26 at 1:07 PM, SSC C stated she followed up with R2 after the incident and R2 had some confusion and difficulty finding words during conversation, however appeared pleasant. SSC C also stated R2 had a fall on 09/29/25. Stated R3 had a room change from the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	first-floor household to the second-floor household related to this incident.During an observation on 02/04/26 at 3:00 PM, R3 was sleeping in his bed with his head covered with a white sheet, TV on in the background.During an interview on 02/05/26 at 9:35 AM, CNA G stated she had cared for R3, he sleeps all day like a second shifter, he was a little hands on with staff, sometimes he would make comments like hey baby, why don't you crawl in to bed with me. CNA G stated she never felt unsafe with him.The alleged perpetrator continues to have access to the alleged victim and/or othervulnerable residents.State Operations ManualDuring an interview on 02/05/26 at 9:45 AM, CNA F stated R3 was flirty with the female residents and staff. CNA F stated R3 never bothered men, just the females.A resident who continually fondles other residents is moved to another unit, where he/shecontinues to exhibit the same behaviors to other residents. State Operations Manual.Assurance that ongoing safety and protection is provided for the alleged victim and, as appropriate, other residents. State Operations ManualDuring an observation and interview on 02/05/26 9:55 AM, R2 was resting in her bed with her eyes closed, stated she didn't want to talk to anyone, she was sleeping.During an observation on 02/05/26 at 9:22 AM, R3 was sleeping in his bed with his head covered.During an interview on 02/05/26 at 11:07 AM, LPN D, stated CNA H told him of the incident the night of 09/25/25, he was coming down the hall, separated the residents and called Nursing Home Administrator (NHA) A. LPN D stated they came to the conclusion to keep them separated for the night, and they would change rooms the next day. LPN D stated he talked to R3 that night and he could not remember the incident, nor could R2 remember the incident.During an interview on 02/05/26 at 10:55 AM, Registered Nurse (RN) E stated R3 was moved to her hallway, due to having less residents on the floor. RN E stated R3 made comments that were charted and not very nice, but only to staff that she recalled. RN E stated she usually told the RSAs to tell R3 that it is inappropriate, and he cannot talk like this. RN E stated R3 liked to sleep and would get up late afternoon or early evening. RN E stated if R3 repeats the behavior, the RSAs go to her, and she would go to NHA A for directions.During an interview on 02/05/26 at 11:30 AM, NHA A and Quality Assurance Manager (QAM) H stated they reported the incident to QAPI and had minutes under the board meeting minutes. Writer asked NHA A if other residents on that household were interviewed. NHA A stated whatever is in the folder is what they did. Writer asked NHA A if any other staff had been interviewed the night of the incident regarding R3's behaviors. NHA A asked QAM H if SWC C had interviewed any other residents, QAM H stated she could not remember, as NHA A was looking through the folder. NHA A stated there wasn't anything in the folder.Writer asked to view the camera recording of the incident, QAM H was looking through her cell phone for it then stated she didn't have it anymore. Writer asked NHA A if they called the police for this abuse allegation. NHA A stated they were not called because both residents were cognitively impaired. No other explanation. Writer asked NHA A what education was provided and to whom was it provided to regarding the sexual abuse? NHA A stated she wasn't sure what education would be provided, residents were impaired, the staff knew what to do as this worked. Writer asked NHA A how they were tracking R3's repeated behaviors since this was not a new behavior. QAM H stated he wasn't abusive to any other residents, just the staff.They have a stop and watch program and a monitoring program in place. QAM H stated staff tell R3 that it was inappropriate and if he is safe, they can leave him in his room.Record review of the conclusion revealed the facility observed and reviewed the camera footage of the incident and verified R3 did touch both of R2s breast. Shortly after the incident, neither R3 nor R2 could recall the occurrence. Both residents' care plans were updated to reflect new interventions. R3 had a room change from one alert hallway to another alert hallway. Stated R3 was adjusting well to his new private room and household. SSC C followed up with R3 for 4 weeks to ensure he was adjusting to his new household (continued on next page)

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