

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235352	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Cass County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 23770 Hospital St Cassopolis, MI 49031	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #3047103. Based on interview and record review, the facility failed to protect a resident's right to be free from staff to resident sexual abuse in 1 resident (Resident #1) of 8 residents reviewed for abuse, resulting in psychosocial harm for Resident #1 who was fearful and anxious after the incident and did not want the staff member to be around her. Findings include: Resident #1 (R1) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R1 was a [AGE] year-old woman admitted to the facility on [DATE] with pertinent diagnoses including Parkinsonism {a neurological condition (affects the brain, spinal cord and nerves) that cause movement problems such as tremors (involuntary shaking movement), rigidity (stiffness), bradykinesia (slowness of movement), and postural instability} and dementia. Brief Interview for Mental Status (BIMS) reflected a score of 10 out of 15 which indicated R1's cognition was moderately impaired. R1 was transferred to the hospital on 6/17/2026 for the purpose of a Sexual Assault Nurse Examination (SANE) and did not return to the facility. Review of the Facility Reported Incident revealed on 6/17/2026, At 6:20am the charge nurse (Licensed Practical Nurse (LPN) K) called DON (Director of Nursing B) and stated that the resident (R1) stated she was sexually assaulted. (DON B) called me (Nursing Home Administrator (NHA) A) at 6:21am. I (NHA A) arrived to the facility at 6:55am and started interviewing staff and the resident (R1). The resident stated that between 3-4am a black male entered her room and penetrated her vagina and ejaculated. The resident did state the same story to multiple individual's including nurse (LPN K) and (Director of Social Services (DSS) H). The story did change slightly between her conversations with (DSS H) (LPN K) and (NHA A). I (NHA A) reviewed the camera footage and there is a time between 11-11:15pm where the Agency CNA (Certified Nursing Assistant (CNA) R) was in the room with the door closed for an extended period of time. After reviewing this footage, I immediately called dispatch. (Sheriff's Office Deputy (D) T) responded to the call. Staff changed the resident (R1) and bagged up her bedding, night gown, and brief. (Sheriff's Office Deputy (D) T) took the bagged bedding for the investigation. Resident (R1) was transported to (hospital name omitted) for testing. Review of R1's Care Plan with an initiation date of 5/22/2026 revealed that she was dependent for ADLs (Activities of Daily Living) such as toileting and showering. During an interview on 6/17/2026 at 3:21 PM, NHA A reported that she received a call on 6/17/2026 around 6 AM regarding the sexual incident between CNA R and R1. NHA A stated that R1 had dementia but hadn't made accusations like this before and her story basically stayed the same besides a few changes such as fingers penetrated her vagina to penis penetration. NHA A stated that staff took the bed linen off and R1 was drenched in urine around 5:20 AM so she was changed but everything was bagged including the brief and it was given to the police for testing. NHA A said the shift on 6/16/2026 was only CNA R's second shift in the building and stated when she interviewed CNA R he appeared standoffish and never said he didn't do anything. NHA A stated that she called the police and they came out to investigate and also called R1's daughters and they also came to the facility. NHA A reported that there was camera footage of CNA R going into R1's room. NHA A stated that DON B contacted the Agency that CNA R worked for to tell them what happened and so that he (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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