

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235381	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Mymichigan Medical Center-Sault		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Osborn Blvd Sault Sainte Marie, MI 49783	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>40383</p> <p>This Citation Pertains to Intake Number MI00149462.</p> <p>Based on interview and record review the facility failed to ensure a complete and thorough investigation was completed on an incident of potential abuse involving two Residents (#30 and #31) out of three Residents reviewed for abuse. This deficient practice resulted in the potential for undetected abuse. Findings include:</p> <p>Resident #30 (R30)/Resident #31 (R31)</p> <p>A Facility Reported Incident (FRI) was received on 1/1/25 at 7:45 PM, which read in part: Incident Summary Registered Nurse (RN E) reported to NHA (Nursing Home Administrator) . witness and Resident Assistant (RA D) reported . she heard (R31) ask (R30) to touch him on the groin. (R30) subsequently placed her hand on (R31's) groin. Residents were immediately separated .</p> <p>On 1/16/25 at 1:25 PM, the NHA and this surveyor viewed the dining room video of the incident between R30 and R31. The residents involved in the FRI were present in the video but were seated at a far distance from the camera. No sound was recorded. R30 does lean in and is visibly closer to R31 several times but her hand is not visible nor is the lap of R30. She does not wheel away or appear to take offense. At least three other residents were seated in the dining room closer to the camera and several people move in and out of the camera view during the timeframe of the FRI from 2:43 PM until 3:06 PM on 1/1/25. The witness, RA D, was seen in the video entering the dining room and working serving beverages at 2:51 PM. At 3:06 PM, RN E came into the dining room and wheeled R30 out of the room.</p> <p>During an interview on 1/16/25 at 1:35 PM, the NHA was asked about the investigation into the FRI. The investigation folder was reviewed and did not contain any witness statements from RA D or RN E who separated R30 and R31 and did not contain an incident report with details of the event. The other residents and those seated or walking through the dining room during the 23 minutes R30 and R31 were seated together were not interviewed. Other staff working that shift who may have had observations were not interviewed and no statements were obtained. When asked why the hospitality aide had not separated R30 and R31 but instead left the dining room to get a nurse, the NHA did not know. When asked if there had been an incident report completed as part of the electronic medical record the answer was no. When asked if any witness statements had been taken the answer was no.</p> <p>(continued on next page)</p>

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: 235381	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Mymichigan Medical Center-Sault		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Osborn Blvd Sault Sainte Marie, MI 49783	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled LTC (Long Term Care) Abuse, Neglect or Mistreatment, last reviewed 01/2025 read in part: .Resident's care and treatments shall be monitored by all staff, on an ongoing basis, to assure residents are free from abuse, neglect or mistreatment. It is the responsibility of the staff to provide a safe environment for the residents. Allegations of resident abuse, neglect, or misappropriation of property or mistreatment will be reported to the LTC Administrator at which time the LTC Administrator can delegate to the Director of Nursing or designee. The delegated person will thoroughly investigate . 6. An incident report will be completed .9. Results of the investigation shall be reported to officials . The report shall include: i. Witness statements; j. A list of people in the area at the time of the incident:</p>		