STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235381	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mymichigan Medical Center-Sault	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41978 Based on observation, interview and record review, the facility failed to ensure the residents right to be free from abuse for two Residents (R10 and R11) of four residents reviewed for sexual abuse, resulting in the potential for psychosocial harm including feelings of humiliation and fear based on a reasonable person standard. Findings include: Review of a facility five-day investigation summary, submitted to the State Agency (SA) on 2/23/2025 at 6:04 p.m., revealed the following: On 2/23/25, [R10] was sitting in the dining room across the table from [R11] when [CNA C] heard [R10] ask [R11] 'come here and come on, you want to touch it. [CNA C] witnessed [R10] with his penis pulled through the bottom of the left leg of his shorts in his hand. Review of the Minimum Data Set (MDS) assessment, dated 3/6/2025, revealed R10 was admitted to the facility on [DATE] and had diagnoses including anxiety, sleep disorder and dementia. Further review of the MDS assessment revealed R10 was independent for transfers and ambulation and scored 11 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he was cognitively intact. Review of the MDS assessment, dated 2/12/2025, revealed R11 was admitted to the facility on [DATE] and had diagnoses including dementia, anxiety and depression. Further review of the MDS assessment revealed R11 required partial/moderate assistance (helper does less than half the effort) with sit to stand and chair/bed to chair transfers and was independent with wheelchair mobility. R11 scored 00 out of 15 on the BIMS, indicating she had severe cognitive impairment. On 3/12/2025 at 10:15 a.m. R11 was observed lying in her bed, awake and holding a small stuffed animal. When greeted, R11 smiled. An interview at the time of the observation revealed R11 had no recollection of the reported event that occurred on 2/23/2025. On 3/12/2025 at 10:20 a.m., R10 was observed lying in his bed with his eyes closed. R10 was wearing black pants, a t-shirt and black athletic-type shoes. R10 did not respond to this Surveyor's knock on the door or verbal greeting. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 3/12/2025 at 12:19 p.m., R10's legal guardian reported he did not want R10 to be interviewed again related to the alleged incident on 2/23/2025. R10's guardian reported R10 had a long-standing history of depression and he did not want to exacerbate the condition. R10's guardian reported asking the Resident if he exposed himself to R11 and asking her to touch his penis. R10's guarding stated R10 reply was I don't remember. and I won't do it again. During an interview on 3/12/2025 at 2:20 p.m., Certified Nursing Assistant (CNA) C reported witnessing R10 ask R11 to touch his exposed penis on 2/23/2025. CNA C reported R10 was seated across the table from R11 in the dining room. Upon turning around to retrieve a product from the refrigerator, CNA C stated, I heard [R10] say 'Hey come over here, you want to touch it?' CNA C reported upon turning back around to face the dining room, she witnessed R10 talking to R11 with his penis pulled through the leg of his shorts. CNA C reported R10 had his penis in his hand and was shaking it and R11 appeared confused and responded to R10 by stating huh? CNA C reported upon approaching R10, he ceased the activity, placed his penis back inside the leg of his shorts without any redirection like he knew it was wrong. CNA C was queried as to whether R10 had exhibited sexual behaviors toward others in the past. CNA C reported she was aware R10 had a past incident with another resident in the facility which the State Agency had been in to investigate. CNA C was unaware of the prior incident involving R11 on 1/19/2025. CNA C stated, I should have known something was up. When asked what she meant, CNA C reported R10 was out of his usual routine on 2/23/2025 and stated, I noticed [R10] at a table he normally does not sit at. When asked to clarify, CNA C reported on 2/23/2025 R10 entered the dining room at a time out of his normal routine and sat at a table of female residents, which he never did, and was acting sneaky. CNA C stated staff recognized the risk and removed some of the ladies from the dining area. According to CNA C, R10 had a history of watching pornography and masturbating in public areas of the facility. When asked why R10 was not redirected from the dining room if his behavior was suspicious, CNA C reported she thought R10's prior behaviors were only directed toward a specific resident, who had already been removed from the dining area and away from R10. Review of an incident report, provided by the Director of Nursing (DON) and dated 1/19/2025 at 11:55 p.m., revealed the following: This nurse went to check where [R10] was as he had recently been sitting in the dining room . went around the hallway towards the large bathroom. [R10's) one hand was on a female resident's shoulder and what appeared to be pulling down his shorts. This nurse immediately asked what he was doing, and he quickly adjusted his shorts and went to his bedroom . Further review of the incident report revealed R10 to be in the large bathroom with R11. During an interview on 3/13/2025 at 9:33 a.m., Registered Nurse (RN) D recalled working on 2/23/2025 and being informed by staff of R10's presence in the dining room. RN D reported she was aware R10 had a history of inappropriate sexual behavior but understood the behavior to be directed toward a specific resident, whom staff had removed from the dining room upon R10's entry. When asked if she was aware R10 had a history of sexual behaviors directed toward other residents, RN D reported she was aware of R10's prior behavior of exposing himself in public areas within the facility but was unaware of any incident involving R11 until after the incident on 2/23/2025. Review of a physician encounter note, dated 11/20/2024 at 2:08 p.m., revealed the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	GDR [gradual dose reduction] paxil [anti-depressant medication] from 30 mg [milligrams] to 20 mg for depression/anxiety and associated symptoms with intent to continue monitoring symptoms . Continue non-pharm [pharmacological] interventions might also include: Avoiding over stimulation of TV or radio programs, radios, magazines; involve crafts that occupy his hands to help prevent inappropriate touching or public masturbation, providing stuffed animal such as replica of the pink [NAME] where he is able to fondle the puppet rather than others; provide clothing that lacks zippers . scheduled times for providing privacy in satisfying patient's own sexual drive. During an interview on 3/13/2025 at 10:50 a.m., Social Worker (SW) F reported she had worked with R10 since his admission to the facility. When asked when R10's inappropriate sexual behaviors began, SW F reported R10's behaviors had been present since admission but seemed to worsen at times when R10 was depressed or bored. SW F reported R10 had a dose reduction of his antidepressant medication in December 2024 which she believed contributed to R10's increase in inappropriate sexual behaviors. When asked if R10 was provided with non-pharmacological interventions to deter inappropriate sexual behaviors, SW F reported R10 was provided with pornographic materials to view in the privacy of his own room. SW F stated R10 would not engage in the viewing of the materials in his room but proceeded to view the materials and masturbate in public areas of the facility including the dining room in view of other residents, which was inappropriate. SW F reported R11 did not recall the incident on 2/23/25 and showed no change in her behavior since the incident. Review of R10's Psychiatric Outpatient Evaluation, dated 2/25/2025, revealed the following: The patient's recent concerning behaviors are discussed with him. He reports he has been told by staff that he exposed himself to another female peer on the unit. He does not recall the event. When asked if he felt this was appropriate or inappropriate, he states that it was inappropriate. During an interview on 3/13/2025 at 11:45 a.m., the Nursing Home Administrator (NHA) confirmed R10 was known to have exhibited sexually inappropriate behaviors, including coercion and public sexual acts in the facility prior to the event involving R11 on 2/23/2025. When asked if staff should have anticipated the incident on 2/23/2025 due to the prior incident in which R10 was found in the large bathroom with R11 on 1/19/2025, the NHA did not offer a response and stated, it seems the dining room is a trigger for his behavior. Review of R10's care plan revealed the following: [R10] is at risk and/or has behaviors . making sexually inappropriate statements to staff . engaging in sexual actions in public area of facility [with] other residents . increased social/behavioral disinhibitions because of cognitive loss . [R10] lacks the capacity to make choices regarding sexual activity due to appointment of guardianship. Date initiated, 4/01/2024. Interventions: Provide intervention and redirection when [R10] is attempting or engaging residents where he is displaying inappropriate actions for public areas. Date initiated, 4/01/2024. The care plan had nothing to address preventing the behaviors from occurring in the first place. The focus was on a previous resident R10 had an inappropriate interaction with, and failed to address other potential victims in prevention of further sexual abuse potential. Review of R11's care plan revealed the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[R11] has a behavior problem of invading others personal space, not easily redirected/physical aggression [with] staff . and other residents during incidental contact . Date initiated, 4/01/2024. It was noted in review of R11's care plan, there were no foci, goals or interventions developed and implemented to reduce the likelihood of R11 being exposed to R10's sexually inappropriate behaviors or to alert staff of the incidents that occurred between R10 and R11 on 1/19/2025 and 3/23/2025. Review of the undated facility policy titled, [Facility Name] Abuse Prevention, revealed the following: Purpose: To protect the resident's right to be free from verbal, sexual, physical and psychological abuse . Prevention: The facility will provide supervision of staff and residents to the fullest extent possible . Protect: Responding immediately to protect the alleged victim .