

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/25/2024
NAME OF PROVIDER OR SUPPLIER  Medilodge of East Lansing		STREET ADDRESS, CITY, STATE, ZIP CODE  1843 N Hagadorn Rd East Lansing, MI 48823	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49103</p> <p>This citation pertains to Intake MI00145607</p> <p>Based on interviews and record review, the facility failed to protect the resident's right to be free from verbal abuse by staff for one (R3) of 3 residents reviewed for abuse.</p> <p>Findings include:</p> <p>Review of the medical record revealed that R3 had an original admitted [DATE] and a last admitted [DATE]. R3 was last discharged for hospital care on 7/20/24 and was not in the facility during survey. R3 had the following pertinent diagnoses: Cerebral infarction, unspecified (a condition that occurs when blood flow to the brain is blocked or reduced), Major Depressive Disorder, and Anxiety Disorder. Review of the Minimum Data Set (MDS) with an assessment reference date of 2/26/24 documents a Brief Interview for Mental Status (BIMS) score of 6/15 (severe cognitive impairment). The MDS revealed R3 was able to make self understood and was able to understand others with clear comprehension.</p> <p>Review of a Facility Reported Incident (FRI) disclosed documentation on 6/21/24 of a staff Registered Nurse, (RN) C to resident (R3) abuse. The documentation reads in part, resident made a verbal abuse allegation against staff member. RN C was named in the complaint as the abusive staff member. The note further states in part, The resident stated that the staff member yelled at her. The resident said the staff member grabbed her arm. On 6/21/24 a statement by RN C was taken and recorded. RN C did not talk about the period during which the abuse was said to have occurred but rather described a later interaction with resident. Review of the FRI revealed the facility substantiated abuse and RN C's employment was terminated.</p> <p>On 7/24/24 at 9:56 AM an interview with RN C was held by telephone. RN C recalled the date and the fact that the Administrator A presented RN C with paperwork and told RN C to go home. When RN C later inquired by phone about returning, I was not allowed to return. RN C acknowledged having been in the room with R3 and a Certified Nurse Assistant (CNA) D and acknowledged that R3's ostomy bag (an ostomy is a surgically created opening in the abdomen for waste to exit the body) had come off and needed to be changed. When asked if RN C had become upset with R3 and had yelled, RN C responded, I wouldn't say I yelled. I was firm with her. RN C explained there had been a concern that R3 would get a hand into the stool (bowel movement) coming from the open stoma site. RN C said the concern had been for contamination. When asked if RN C had told R3 the bag coming off had been the fault of R3, RN C stated, No and explained the bags . just fall off. They pop off.</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/24/24 at 10:14 AM interview was held with the Certified Nurse Assistant (CNA) D who was in the room with the resident and RN C when the abuse was said to have occurred. CNA D explained that R3 was still in bed and was awaiting RN C to come and reapply R3's ostomy bag. CNA D said RN C entered the room and began yelling at R3 saying, This is your fault! CNA D explained that when R3 began to move her arm in an upward direction RN C grabbed the arm forcefully and continued to yell blaming the resident because the ostomy bag had come off and needed to be reapplied. CNA D said after this R3 was crying and when asked if R3 would like CNA D to report the incident R3 responded by nodding yes. During interview concerning this incident CNA D cried and said it was the worst thing I ever saw.</p> <p>On 7/24/24 at 9:56 AM Social Worker (SW) E was interviewed and said on 6/21/24 after being informed of the incident by CNA D SW E went to the room and asked R3 if there had been an incident between RN C and R3 to which R3 responded with a nod and mouthed the word yes. SW E explained that R3's communication ability was limited but clearly responded yes to the question of Did the nurse yell at you? and no to the question of Do you feel safe with the nurse? SW E reported the incident to the Administrator immediately.</p> <p>On 7/24/24 at 2:02 PM during interview, Administrator A confirmed that on 6/21/24 SW E informed Administrator A of the abuse concern and Administrator A responded by sending RN C home immediately, by doing the investigation, by having SW E follow up with R3, and by notifying the physician. Administrator A further said that during interview following the said abuse, RN C had claimed to have had no recollection of the situation in the room.</p> <p>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included skin and pain assessment for R3, interviews and/or assessments of all residents who had been cared for on 6/21/24 by RN C, abuse training update for all staff, and a QAPI/QAA meeting specifically to address the concern. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.</p>		