STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235285	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Lansing	731 Starkweather Drive Lansing, MI 48917

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2656668.Based on observation, interview and record review, the facility failed to report an allegation of abuse to the State Agency for one (R6) of three reviewed.Findings include:Review of the complaint received by the State Agency on 10/24/25 revealed, [R6] reported that staff, [Certified Nursing Assistant (CNA) E and CNA F] punched her in the face .This incident was reported to the supervisor and none of the staff was investigated or suspended.Review of the medical record revealed R6 was admitted to the facility on [DATE] with diagnoses that included moderate intellectual disabilities, dementia, and major depressive disorder. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/5/25 revealed R6 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). On 11/19/25 at 9:45 AM, R6 was observed in bed with the bedroom door open. A sign on the door revealed Do not enter without permission. After knocking and asking permission to enter, R6 shook her head no and threw a cup of water across the room towards the doorway. A staff member entered R6's room to assist. R6 began yelling out but was easily calmed down by the staff member. On 11/19/25 at 9:49 AM, all incident reports and grievances for R6 in the last three months were requested. At 10:02 AM, Director of Nursing (DON) B reported R6 did not have any concern forms or risk managements in the last three months. In a telephone interview on 11/19/25 at 10:00 AM, CNA E reported approximately one to one and a half months ago, R6 reported that CNA E and CNA F hit R6. CNA E reported they were still at work when R6 reported the allegation. CNA E reported DON B took her verbal statement and then DON B called CNA F. CNA E reported since both themself and CNA F had the same verbal story, it was dropped. CNA E reported they were not suspended during an investigation. In a telephone interview on 11/19/25 at 11:01 AM, CNA F reported sometime last month, they received a call from Scheduler D stating there was an incident in R6's room and asked CNA F what happened. CNA F reported she was not aware of an incident. CNA F reported the next day, they came into work and asked CNA E what the phone call was about. CNA F reported CNA E told them that R6 made an allegation that they both hit R6. CNA F reported they were never asked for a statement. In a telephone interview on 11/19/25 at 11:41 AM, Registered Nurse (RN) G reported they recalled R6 reporting she was hit during night shift and it hurt. RN G reported the allegation was reported to them and Scheduler D. RN G reported Scheduler D and someone else went into R6's room to interview about the allegation. In an interview on 11/19/25 at 10:18 AM, Scheduler D reported they were not aware of any incident where R6 alleged being hit by staff. In an interview on 11/19/25 at 11:34 AM, DON B reported there was not an allegation reported to them that R6 was hit by CNA E and CNA F. In an interview on 11/19/25 at 12:15 PM, Nursing Home Administrator (NHA) A reported there was a recent allegation that two staff members hit R6. NHA A reported they were on their way to work when they received a phone call related to the allegation. NHA A reported she asked Scheduler D and Payroll Benefits Coordinator (PBC) I to speak to R6 together. NHA A reported they could not recall exactly what R6 said, but that R6 ended up telling them that she did not like one of the aides being in her room and that nobody hit her. When asked if the allegation was reported to the State Agency, NHA A reported it was not because they ended up feeling like it was not reportable due to R6 eventually reporting nobody hit her.

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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(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** This citation pertains to Intake 2656668.Based on observation, interview, and record review, the facility failed to thoroughly investigate an allegation of abuse for one (R6) of three reviewed.Findings include:Review of the complaint received by the State Agency on 10/24/25 revealed, [R6] reported that staff, [Certified Nursing Assistant (CNA) E and CNA F] punched her in the face .This incident was reported to the supervisor and none of the staff was investigated or suspended.Review of the medical record revealed R6 was admitted to the facility on [DATE] with diagnoses that included moderate intellectual disabilities, dementia, and major depressive disorder. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/5/25 revealed R6 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). On 11/19/25 at 9:45 AM, R6 was observed in bed with the bedroom door open. A sign on the door revealed Do not enter without permission. After knocking and asking permission to enter, R6 shook her head no and threw a cup of water across the room towards the doorway. A staff member entered R6's room to assist. R6 began yelling out but was easily calmed down by the staff member. On 11/19/25 at 9:49 AM, all incident reports and grievances for R6 in the last three months were requested. At 10:02 AM, Director of Nursing (DON) B reported R6 did not have any concern forms or risk managements in the last three months. In a telephone interview on 11/19/25 at 10:00 AM, CNA E reported approximately one to one and a half months ago, R6 reported that CNA E and CNA F hit R6. CNA E reported they were still at work when R6 reported the allegation. CNA E reported DON B took her verbal statement and then DON B called CNA F. CNA E reported since both themself and CNA F had the same verbal story, it was dropped. CNA E reported they were not suspended during an investigation. In a telephone interview on 11/19/25 at 11:01 AM, CNA F reported sometime last month, they received a call from Scheduler D stating there was an incident in R6's room and asked CNA F what happened. CNA F reported she was not aware of an incident. CNA F reported the next day, they came into work and asked CNA E what the phone call was about. CNA F reported CNA E told them that R6 made an allegation that they both hit R6. CNA F reported they were never asked for a statement. In a telephone interview on 11/19/25 at 11:41 AM, Registered Nurse (RN) G reported they recalled R6 reporting she was hit during night shift and it hurt. RN G reported the allegation was reported to them and Scheduler D. RN G reported Scheduler D and someone else went into R6's room to interview about the allegation. In an interview on 11/19/25 at 10:18 AM, Scheduler D reported they were not aware of any incident where R6 alleged being hit by staff. In an interview on 11/19/25 at 11:34 AM, DON B reported there was not an allegation reported to them that R6 was hit by CNA E and CNA F. In an interview on 11/19/25 at 12:15 PM, Nursing Home Administrator (NHA) A reported there was a recent allegation that two staff members hit R6. NHA A reported they were on their way to work when they received a phone call related to the allegation. NHA A reported she asked Scheduler D and Payroll Benefits Coordinator (PBC) I to speak to R6 together. NHA A reported they could not recall exactly what R6 said, but that R6 ended up telling them that she did not like one of the aides being in her room and that nobody hit her. When asked if the allegation was reported to the State Agency, NHA A reported it was not because they ended up feeling like it was not reportable due to R6 eventually reporting nobody hit her. When asked if there was an investigation, NHA A stated yes and provided the file. Review of the facility's investigation revealed five staff statements, but no statements or assessments of other residents who were cared for by CNA E and CNA F. The investigation did not include any documentation on whether R6 had any physical signs of injury or not. The investigation did not include a statement from RN G who was one to receive the initial reported allegation. A written statement by PBC I revealed Went to interview [R6] on 10/21/25 after she said she was hit and after [Scheduler D] and I interviewed her she said she was not hit, she just didn't want a boy in her room.