STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235517	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Campus Area	2815 Northwind Dr 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)
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. 46955 This citation pertains to intake MI00143189 Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse by staff for 1 (Resident #3) of 4 reviewed for abuse, resulting in the potential for a decline in physical, mental, and psychosocial well-being Findings include: Review of the medical record revealed that Resident #3 (R3) was initially admitted to facility 10/25/22 with diagnoses including Huntington's Disease, dementia with behavioral disturbance, unspecified psychosis, muscle weakness, and difficulty in walking. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/1/24 reflected that R3 had a Brief Interview for Mental Status (BIMS-a cognitive screening tool) score of 7 (severe cognitive impairment). Review of R3's ADL (Activities of Daily Living) Care Plan reflected that R3 was independent with transfer, ambulation, bed mobility, dressing, personal hygiene, and toileting. Review of a Facility Reported Incident (FRI) dated 2/19/24 revealed, .On 2/8/24, [Certified Nurse Aide (CNA) C's name], CENA [Competency Evaluated Nursing Assistant] through [sic] resident [R3's name] against the wall during an altercation. Reported [Resident #11 (R11)] stated she did not witness the incident. However, the incident was reported to her by another resident [Resident #2's (R2) name] . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 5 Day Investigation Summary dated 2/27/24 revealed, .Allegation: Resident [R11's name] reported she had learned from another resident that [CNA C's name] threw [R3's name] against the wall outside the dining room .Resident statements: [R3's name]: Due to residents [sic] severe cognitive impairment, a statement was not able to be obtained .[R11's name]: [R2's name] told me that [CNA C's name] threw [R3's name] against the wall. I didn't [sic] see anything, but that's [sic] what I was told happened .[R2's name]: I was in the dining room. I didn't see anything because of where I was sitting but I could hear [R3's name] jump on [CNA C's name] back and start beating her .Staff statement: [CNA C's name]: On 2/8/24 .I was struck in the head, from behind, by [R3's name]. [R3's name] continued throwing punches in my direction. I grabbed her arms and lowered her to the floor. While lying on her back, she was still agitated and kicking at me. I continued holding her arms until help arrived .Witness statements: [CNA E's name]: I saw [R3's name] approach [CNA C's name] and hit her in the head from behind. [CNA C's name] turned around and lowered resident to the floor. [CNA C's name] held residents arms down until help arrived .[Registered Nurse (RN) D's name]: I heard a commotion outside the dining room. When I arrived, I saw [CNA C's name] standing over [R3's name], who was on the floor, lying on her back. [R3's name] arms were crossed and [CNA C's name] was holding them down. I thought it was inappropriate the way [CNA C's name] was holding [R3's name] down .Conclusion: While the resident suffered no physical or psychological harm, the facility has determined that [CNA C's name] improperly restrained the resident during the incident. Therefore, the facility substantiates the allegation of abuse . In an observation and interview on 4/30/24 at 11:26 AM, R3 was observed sitting up in bed watching television. R3 was noted to be awake and alert, stated that I'm hanging in there when queried as to how she was feeling and then proceeded to state that she had Huntington's Disease, fell sometimes, but was feeling okay today. R3's speech was noted to be mumbled with frequent topic changes with focus on her love of pop. R3 denied a time that she could remember when staff had ever been rough with her but stated that sometimes they have to hold my arm for blood draws. In an observation and interview on 4/30/24 at 3:33 PM, R2 was observed sitting in room, in wheelchair, at her bedside. R2 stated that a couple months ago when she was in the dining room, around lunch time, she overheard R3 giving CNA C a hard time and thought she heard what sounded like R3 hitting CNA C and jumping on her back and that CNA C could be heard trying to defend herself. R2 stated that as she could not see into the hallway from where she was sitting in the dining room, that she had not told anyone what she had heard as was not exactly sure what had happened. In a telephone interview on 4/30/24 at 3:54 PM, RN D stated that on 2/8/24, she thought around lunch time, she had been coming down East Hall, heard commotion in the vicinity of the dining room, ran down the hall, and observed CNA C straddled over R3 who was lying on her back on the hallway floor right outside of the dining room. RN D stated CNA C was either standing or kneeling with one leg on either side of R3, was hunched forward and using both of her arms and hands to hold down R3's arms that were crossed over her chest. RN D stated that she was mortified as had never seen a staff member straddling or holding down a resident in a restraining manner, such as what she had witnessed, and which she would consider abuse. RN D stated that as she observed Director of Nursing (DON) B approach, calm, and assist R3 off the floor, that she proceeded back to her assigned unit as knew R3 was in good hands. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 4/30/24 at 4:23 PM, CNA E stated that around noon time on 2/8/24 that she and CNA C were standing just outside the dining room when she observed R3 approach CNA C from behind, punch her in the back of the head and grab for her hair. CNA E stated that she was scared, was screaming for help, and that everything happened so fast but from what she could recall, she observed CNA C turn around and grab and hold onto both of R3's wrists or hands so that R3 could not strike her again. CNA E stated that she was unsure how R3 ended up on the floor but that the next thing she knew R3 was lying on her back on the floor and that CNA C was hunched down over her continuing to hold down R3's wrists or hands. Per CNA E, DON B arrived, was able to calm R3 down, assisted her to stand, and that R3 walked away with DON B. In a telephone interview on 5/1/24 at 9:05 AM, CNA C stated that she was working as a restorative aide on 2/8/24 and therefore was assisting to transport residents to the dining room for the lunch meal. CNA C stated that upon exiting the dining room, she heard someone yell watch out and as she turned around, R3 punched her in the face. CNA C stated that her first instinct was to grab onto R3's wrists or hands, she couldn't recall which, to prevent her from punching her again as she was continuing to strike out at her. CNA C stated that although she could not recall the details because everything happened so fast, she was able to get R3 down to the floor, and recalled standing over her she believed with one leg on either side of her and leaning down so that she could hold onto R3 wrists or hands so that she could not continue to strike out. Per CNA C, DON B arrived to help at which time she moved back, and DON B took over and was able to calm R3 down and assist her off the floor. In an interview on 5/1/24 at 8:17 AM, Resident #11 (R11) was observed sitting in wheelchair, in room, eating breakfast. R11 stated that although she could not recall dates, she stated that a few months back she had been in the dining room, heard a commotion in the hallway but did not witness anything and that sometime later, she thought several days, was told by R2 that CNA C grabbed a hold of R3, threw her against the wall and onto the floor. Per R11, she couldn't recall more specific details as several months had since passed but that after her conversation with R2, she informed Nursing Home Administrator A of what she had been told as did not believe it was right for a CNA to put their hands on a resident, grab them, or throw them against the wall and therefore wanted to be sure NHA A knew about it. In an interview on 5/1/24 at 10:14 AM, Director of Nursing (DON) B stated that the facility's abuse policy included both the prevention of abuse and reporting of any potential allegation of abuse, that NHA A was the facility's abuse coordinator and that all allegations of potential abuse should be reported directly to NHA A immediately so that an investigation could be initiated. DON B confirmed familiarity with R3 and stated that from her recollection, on 2/8/24 she had heard commotion in the hallway, jumped up from her office chair, and ran toward the dining room. DON B stated that when she arrived, R3 was observed to have her hand bridged on the floor as was in the process of standing up and that both CNA C and E were standing close by but not in direct contact with R3. DON B stated that upon standing, R3 walked with her to either the Social Work or DON office without difficulty, that R3 kept verbalizing that she was sorry when queried as to what had happened and was upset that she had hit a staff member but that she did not make any statements that anyone had hurt her in any way or that she was in any discomfort. DON B stated that CNA C was paged to the office as R3 verbalized desire to apologize to her and that R3 calmed down after speaking with CNA C, that R3 was then able to be redirected and seemed fine and therefore didn't think anything more of the situation as R3 periodically placed herself on the floor and had intermittent episodes of increased agitation and striking out at staff. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON B stated that both herself and NHA A became aware of the allegation of abuse on 2/19/24, over a week after the initial 2/8/24 incident, when R11 reported to them that she had been told by R2 that CNA C had thrown R3 against the wall and therefore an investigation was immediately initiated. DON B stated that as CNA C was working on 2/19/24, she was interviewed, admitted that she had held R3 down and was suspended on that date. Per DON B, as interviews with both witnesses, RN D and CNA E, confirmed that CNA C was observed to hold R3 down, CNA C was contacted via phone on 2/20/24 and her employment at the facility was terminated for abuse. In an interview on 5/1/24 at 11:41 AM, NHA A stated that the facility's abuse policy outlined abuse prevention, potential signs of abuse, different types of abuse, the steps that should be taken if abuse was observed, and abuse reporting. Per NHA A, the facility's abuse policy was reviewed in orientation and that annual in-services were completed through web-based training. NHA A further stated that he had educated all staff that the only time a potential allegation of abuse would not be reported to him immediately would be if he was dead. NHA A stated that on the morning of 2/19/24, he was informed by a staff member that R11 had a potential allegation of abuse that she wanted to report. Per NHA A, R11 was interviewed in DON B's office by both him and DON B at which time R11 reported that R2 had told her that CNA C had thrown R3 against the wall. NHA A stated as CNA C was working on 2/19/24, she was interviewed immediately following the reported allegation and then suspended as CNA C stated that she was struck by R3 from behind, that she turned around and held R3 by her wrists as she was continuing to throw punches, lowered her to the floor, and continued to hold her wrists until help arrived. NHA A stated that as CNA C reported to have held R3 down and as both RN D's and CNA E's witness statements confirmed the same action, CNA C's action were in violation of the facility's abuse policy as R3 had been held down when CNA C would have had an opportunity to walk away instead of improperly continuing to restrain R3 and therefore her employment was terminated on 2/20/24 following her 2/19/24 suspension. Review of the facility policy titled Abuse, Neglect and Exploitation with a 10/24/22 reviewed/revised date stated, Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: Element 1 In-depth analysis of how the deficiency occurred: On February 8, 2024, CNA C was struck in the head by R3. CNA C proceeded to hold the resident wrists, lower her to the floor, and hold the resident's arms against chest while resident lied on the floor. Element 2 How the facility identified resident(s) affected and residents with potential to be affected by the same deficient practice: Residents with a BIMS greater than 9 were interviewed on if they felt safe in the facility and if they had any concerns that had not already been addressed. Residents with a BIMS less than 9 had a skin assessment completed. No new concerns were noted during the skin assessments. Element 3 Corrective action to be taken: CNA C was immediately suspended, then terminated. All staff were re-educated the Abuse and Restraint policies by the Administrator and/or designee. An Ad-HOC QAPI meeting was completed with the Medical Director to review the plan. The Administrator and Director of Nursing reviewed the Abuse and Restraint policies and deemed them appropriate. Element 4 How the facility monitors its corrective actions to ensure deficient practice was corrected and will not recur: Abuse quizzes will be completed by the Administrator and/or designee with 5 staff members weekly and reviewed for accuracy. Date of completion of plan of correction: 2/20/2024. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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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 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. 46955 This citation pertains to intake MI00143189 Based on observation, interview, and record review, the facility failed to timely identify, investigate, and report a staff to resident allegation of abuse to the abuse coordinator (the Nursing Home Administrator), and failed to timely report the allegation to the State Agency for 1 (Resident #3) of 4 residents reviewed for abuse, resulting in delayed identification, investigation, and reporting and the potential for further allegations of abuse to go unreported. Findings include: Review of the medical record revealed that Resident #3 (R3) was initially admitted to facility 10/25/22 with diagnoses including Huntington's Disease, dementia with behavioral disturbance, unspecified psychosis, muscle weakness, and difficulty in walking. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/1/24 reflected that R3 had a Brief Interview for Mental Status (BIMS-a cognitive screening tool) score of 7 (severe cognitive impairment). Review of R3's ADL (Activities of Daily Living) Care Plan reflected that R3 was independent with transfer, ambulation, bed mobility, dressing, personal hygiene, and toileting. Review of a Facility Reported Incident (FRI) dated 2/19/24 revealed, .On 2/8/24, [Certified Nurse Aide (CNA) C's name], CENA [Competency Evaluated Nursing Assistant] through [sic] resident [R3's name] against the wall during an altercation. Reported [Resident #11 (R11)] stated she did not witness the incident. However, the incident was reported to her by another resident [Resident #2's (R2) name] . Review of a 5 Day Investigation Summary dated 2/27/24 revealed, .Allegation: Resident [R11's name] reported she had learned from another resident that [CNA C's name] threw [R3's name] against the wall outside the dining room .Resident statements: [R3's name]: Due to residents [sic] severe cognitive impairment, a statement was not able to be obtained .[R11's name]: [R2's name] told me that [CNA C's name] threw [R3's name] against the wall. I didnt [sic] see anything, but thats [sic] what I was told happened . [R2's name]: I was in the dining room. I didn't see anything because of where I was sitting but I could hear [R3's name] jump on [CNA C's name] back and start beating her .Staff statement: [CNA C's name]: On 2/8/24 .I was struck in the head, from behind, by [R3's name]. [R3's name] continued throwing punches in my direction. I grabbed her arms and lowered her to the floor. While lying on her back, she was still agitated and kicking at me. I continued holding her arms until help arrived .Witness statements: [CNA E's name]: I saw [R3's name] approach [CNA C's name] and hit her in the head from behind. [CNA C's name] turned around and lowered resident to the floor. [CNA C's name] held residents arms down until help arrived .[Registered Nurse (RN) D's name]: I heard a commotion outside the dining room. When I arrived, I saw [CNA C's name] standing over [R3's name], who was on the floor, lying on her back. [R3's name] arms were crossed and [CNA C's name] was holding them down. I thought it was inappropriate the way [CNA C's name] was holding [R3's name] down .Conclusion: While the resident suffered no physical or psychological harm, the facility has determined that [CNA C's name] improperly restrained the resident during the incident. Therefore, the facility substantiates the allegation of abuse . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 4/30/24 at 11:26 AM, R3 was observed sitting up in bed watching television. R3 was noted to be awake and alert, stated that I'm hanging in there when queried as to how she was feeling and then proceeded to state that she had Huntington's Disease, fell sometimes, but was feeling okay today. R3's speech was noted to be mumbled with frequent topic changes with focus on her love of pop. R3 denied a time that she could remember when staff had ever been rough with her but stated that sometimes they have to hold my arm for blood draws. In an observation and interview on 4/30/24 at 3:33 PM, R2 was observed sitting in room, in wheelchair, at her bedside. R2 stated that a couple months ago when she was in the dining room, around lunch time, she overheard R3 giving CNA C a hard time and thought she heard what sounded like R3 hitting CNA C and jumping on her back and that CNA C could be heard trying to defend herself. R2 stated that as she could not see into the hallway from where she was sitting in the dining room, that she had not told anyone what she had heard as was not exactly sure what had happened. In a telephone interview on 4/30/24 at 3:54 PM, RN D stated that on 2/8/24, she thought around lunch time, she had been coming down East Hall, heard commotion in the vicinity of the dining room, ran down the hall, and observed CNA C straddled over R3 who was lying on her back on the hallway floor right outside of the dining room. RN D stated CNA C was either standing or kneeling with one leg on either side of R3, was hunched forward and using both of her arms and hands to hold down R3's arms that were crossed over her chest. RN D stated that she was mortified as had never seen a staff member straddling or holding down a resident in a restraining manner, such as what she had witnessed, and which she would consider abuse. RN D stated that as she observed Director of Nursing (DON) B approach, calm, and assist R3 off the floor, that she proceeded back to her assigned unit as knew R3 was in good hands. RN D denied that she had reported the allegation of abuse to the facility's abuse coordinator, Nursing Home Administrator (NHA) A, as believed that DON B had witnessed CNA C improperly holding down R3 and assumed that DON B would complete an immediate incident report, initiate an investigation, and notify the appropriate authorities as NHA A was on vacation and believed that DON B was acting in his place. RN D stated that she felt at fault as did not realize until a week or more after the incident when she received a telephone call from NHA A and DON B for a witness statement regarding the events that occurred on 2/8/24 that the situation had never been followed-up on. RN D stated that during the same telephone call, NHA A and DON B educated her of the need to immediately report a potential allegation of abuse to the abuse coordinator and that she in return informed them that if she had known that DON B was not going to report and follow-up on the allegation that she believed DON B had also witnessed, that she would have notified NHA A immediately herself. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 4/30/24 at 4:23 PM, CNA E stated that around noon time on 2/8/24 that she and CNA C were standing just outside the dining room when she observed R3 approach CNA C from behind, punch her in the back of the head and grab for her hair. CNA E stated that she was scared, was screaming for help, and that everything happened so fast but from what she could recall, she observed CNA C turn around and grab and hold onto both of R3's wrists or hands so that R3 could not strike her again. CNA E stated that she was unsure how R3 ended up on the floor but that the next thing she knew R3 was lying on her back on the floor and that CNA C was hunched down over her continuing to hold R3's arms down. Per CNA E, DON B arrived, was able to calm R3 down, assisted her to stand, and that R3 walked away with DON B. CNA E confirmed that CNA C continued to hold R3's arms down after she was on the floor and that restraining a resident in that manner could be considered abuse but denied that she had reported the potential allegation of abuse to the facility's abuse coordinator, NHA A, as believed that since DON B had been present, that she would be writing up a report. CNA E stated that from what she could recall, NHA A and DON B contacted her by telephone approximately one week later, asked for her statement regarding the events of 2/8/24 and provided education regarding the immediate reporting of something that may be considered abuse to the abuse coordinator. CNA E stated that in hindsight she realized that she should have immediately reported the potential allegation of abuse to NHA A but that as her direct supervisor, DON B, was present she had assumed that DON B would have handled the situation from there as she was the boss and thought that she had also seen CNA C holding R3 down. In a telephone interview on 5/1/24 at 9:05 AM, CNA C stated that she was working as a restorative aide on 2/8/24 and therefore was assisting to transport residents to the dining room for the lunch meal. CNA C stated that upon exiting the dining room, she heard someone yell watch out and as she turned around, R3 punched her in the face. CNA C stated that her first instinct was to grab onto R3's wrists or hands, she couldn't recall which, to prevent her from punching her again as she was continuing to strike out at her. CNA C stated that although she could not recall the details because everything happened so fast, she was able to get R3 down to the floor, and recalled standing over her she believed with one leg on either side of her and leaning down so that she could hold onto R3 wrists or hands so that she could not continue to strike out. Per CNA C, DON B arrived to help at which time she moved back, and DON B took over and was able to calm R3 down and assist her off the floor. CNA C stated that DON B paged her to the Social Work office a short time later and R3 apologized to her, but that DON B did not ask any additional questions regarding her interaction with R3, and she proceed to return to her restorative position tasks for the remainder of the shift. CNA C stated that 1 to 2 weeks later, during one of her scheduled shifts at the facility, she was called into NHA A's office and that DON B was present as well, was asked to give her statement regarding the events of 2/8/24, was informed that she was being investigated for abuse, was immediately suspended and then was contacted by telephone the next day, again by both NHA A and DON B and was told that her employment at the facility was being terminated for staff to resident abuse. In an interview on 5/1/24 at 8:17 AM, Resident #11 (R11) was observed sitting in wheelchair, in room, eating breakfast. R11 stated that although she could not recall dates, she stated that a few months back she had been in the dining room, heard a commotion in the hallway but did not witness anything and that sometime later, she thought several days, was told by R2 that CNA C grabbed a hold of R3, threw her against the wall and onto the floor. Per R11, she couldn't recall more specific details as several months had since passed but that after her conversation with R2, she informed Nursing Home Administrator A of what she had been told as did not believe it was right for a CNA to put their hands on a resident, grab them, or throw them against the wall and therefore wanted to be sure NHA A knew about it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/1/24 at 10:14 AM, Director of Nursing (DON) B stated that the facility's abuse policy included both the prevention of abuse and reporting of any potential allegation of abuse, that NHA A was the facility's abuse coordinator and that all allegations of potential abuse should be reported directly to NHA A immediately so that an investigation could be initiated. DON B confirmed familiarity with R3 and stated that from her recollection, on 2/8/24 she had heard commotion in the hallway, jumped up from her office chair, and ran toward the dining room. DON B stated that when she arrived, R3 was observed to have her hand bridged on the floor as was in the process of standing up and that both CNA C and E were standing close by but not in direct contact with R3. DON B stated that upon standing, R3 walked with her to either the Social Work or DON office without difficulty, that R3 kept verbalizing that she was sorry when queried as to what had happened and was upset that she had hit a staff member but that she did not make any statements that anyone had hurt her in any way or that she was in any discomfort. DON B stated that CNA C was paged to the office as R3 verbalized desire to apologize to her and that R3 calmed down after speaking with CNA C, that R3 was then able to be redirected and seemed fine and therefore didn't think anything more of the situation as R3 periodically placed herself on the floor and had intermittent episodes of increased agitation and striking out at staff. DON B stated that as R3 was in the process of getting up by the time she arrived, that R3 relayed no concerns with her interactions with CNA C, and as the staff present at the time of the interaction did not report anything to her, she had no reason to believe that anything more had happened then R3 hitting CNA C. DON B stated that both herself and NHA A became aware of the allegation of abuse on 2/19/24, over a week after the initial 2/8/24 incident, when R11 reported to them that she had been told by R2 that CNA C had thrown R3 against the wall and therefore an investigation was immediately initiated. DON B stated that as CNA C was working on 2/19/24, she was interviewed, admitted that she had held R3 down and was suspended on that date. Per DON B, as interviews with both witnesses, RN D and CNA E, confirmed that CNA C was observed to hold R3 down, CNA C was contacted via phone on 2/20/24 and her employment at the facility was terminated for abuse. DON B stated that she would have expected that the individuals, RN D and CNA E, who witnessed CNA C holding R3 down on 2/8/24 to have reported the allegation of abuse immediately to NHA A so that an investigation could have been initiated on that same date. In an interview on 5/1/24 at 11:41 AM, NHA A stated that the facility's abuse policy outlined abuse prevention, potential signs of abuse, different types of abuse, the steps that should be taken if abuse was observed, and abuse reporting. Per NHA A, the facility's abuse policy was reviewed in orientation and that annual in-services were completed through web-based training. NHA A further stated that he had educated all staff that the only time a potential allegation of abuse would not be reported to him immediately would be if he was dead. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235517	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Campus Area	2815 Northwind Dr East Lansing, MI 48823

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NHA A stated that on the morning of 2/19/24, he was informed by a staff member that R11 had a potential allegation of abuse that she wanted to report. Per NHA A, R11 was interviewed in DON B's office by both him and DON B at which time R11 reported that R2 had told her that CNA C had thrown R3 against the wall. NHA A stated that an abuse investigation was immediately initiated, CNA C was interviewed and suspended, the event was reported to the State Agency, and that CNA C's employment was terminated on 2/20/24 as witness statements confirmed that CNA C's actions were in violation of the facility's abuse policy. NHA A confirmed that his expectation was that any potential allegation of abuse be reported immediately to him, that he would have expected both RN D and CNA E to have reported the allegation of abuse to him at the time of occurrence on 2/8/24 instead of making an assumption that other staff would be following up so that he could have completed a report to the State Agency and started an immediate investigation on that same date. Review of the facility policy titled Abuse, Neglect and Exploitation with a 10/24/22 reviewed/revised date stated, Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse . Reporting/Response .1. Reporting of all alleged violations to the Administrator, state agency .within specified timeframes .a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse . During onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: Element 1 In-depth analysis of how the deficiency occurred: On February 8, 2024, CNA E and RN D observed a staff member holding a resident's arms against her chest while the resident was lying on the floor. Staff members CNA E and RN D received disciplinary action for failure to report abuse. The staff members had previously been educated on abuse reporting and are aware of the abuse policy. Element 2 How the facility identified resident(s) affected and residents with potential to be affected by the same deficient practice: Residents with a BIMS greater than 9 were interviewed on if they felt safe in the facility and if they had any concerns that had not already been addressed. Residents with a BIMS less than 9 had a skin assessment completed. No new concerns were noted during the skin assessments. Element 3 Corrective action to be taken: All staff were re-educated on abuse reporting by the Administrator and/or designee. An Ad-HOC QAPI meeting was completed with the Medical Director to review the plan. The Administrator and Director of Nursing reviewed the Abuse Reporting policy and deemed it appropriate. Element 4 How the facility monitors its corrective actions to ensure deficient practice was corrected and will not recur: Abuse reporting quizzes will be completed by the Administrator and/or designee with 5 staff members weekly and reviewed for accuracy. Date of completion of plan of correction: 2/20/2024. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46955 This citation pertains to intake MI00143099 Based on observation, interview, and record review, the facility failed to provide assistance with activities of daily living (ADLs) for 1 (Resident #2) of 3 residents reviewed for ADLs, resulting in unmet care needs and the potential for a decline in emotional and physical health. Findings include: Review of the medical record revealed that Resident #2 (R2) readmitted to facility 4/25/23 with diagnoses including acquired absence of right leg above knee and left leg above knee, congestive heart failure, lack of coordination, muscle spasms, conversion disorder with seizures, mild cognitive impairment, and schizoaffective disorder. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). Section E of the same MDS revealed that R2 did not exhibit rejection of care. In an observation and interview on 4/30/24 at 10:19 AM, R2 was observed sitting in her wheelchair in her room. R2 stated that her main concern surrounded the fact that she was still not routinely receiving her showers or bed baths, that they were scheduled on Wednesday and Sunday evening per her preference, that staff had not even been approaching her to discuss, and that she had stopped reminding them as they knew when her shower days were and was tired of having to [NAME] them. R2 stated that she was able to do quite a bit herself including moving in bed, transferring, and dressing but that needed help with both showers and bed baths to get her hair and body thoroughly washed. R2 stated that she chose between a shower and a bed bath depending on how she was feeling that date, had refused showers on occasion opting for a bed bath instead but that staff had not recently been giving her an opportunity to receive either. Review of R2's ADL Care Plan Focus indicated, Resident has an ADL self-care performance deficit . Resident often chooses to decline shower and then state it wasn't offered with an associated intervention that reflected, Bathing: 1 person assist. Resident prefers Sunday and Wednesday night both with an 8/31/23 date of initiation. Review of documentation included within R2's Shower/bathe .Sunday and Wednesday night shift task over the last 30 days reflected that R2 had not been offered/provided a shower/bath on 5 of the 9 scheduled days as entries on 4/4/24, 4/11/24, 4/18/24, and 4/22/24 reflected that a shower/bath was Not Applicable, and no entry was noted for R2's scheduled Wednesday shower on 4/24/24. Review of documentation included within R2's Target Behavior .Refusal of personal care task reflected that R2 had no episodes of care refusal on any of the scheduled shower dates. Review of R2's Progress Notes from 3/31/24 through 4/30/24 was not noted to include any documentation pertaining to shower/bath refusal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/30/24 at 11:13 AM, Certified Nurse Aide (CNA) H stated that each resident was scheduled a bath or shower twice a week on either day or night shift, that completion of the shower would be documented within POC (Point of Care-electronic documentation used by staff to record care provided at or near the point of care) and that any care refusal would be indicated within that same POC task. CNA H further stated that upon a resident refusal of a shower, that resident would be approached 2 additional times and that after the third refusal, the nurse would be notified. CNA H stated that a shower sheet was completed with each resident shower to reflect any abnormal skin conditions and that when a resident declined a shower, she would indicate the refusal on that same sheet and provide to the nurse for a signature. In an interview on 4/30/24 at 1:23 PM, Director of Nursing B stated that most residents were scheduled for twice weekly showers based on the days and times of their preference, that the CNA's documented shower completion within the specific POC task, and that a shower refusal was indicated within the same task. Additionally, DON B stated that a shower sheet was completed by the assigned CNA with every scheduled shower, that a shower refusal would be indicated on the sheet as well, and that the sheet was turned into the assigned nurse for review. DON B stated that the assigned nurse was expected to provide education and encouragement whenever a resident declined a shower and document any episodes of shower refusal in a progress note. During the interview, DON B confirmed familiarity with R2, stated that she was alert/oriented and able to make all needs known, and that she did have a history of shower refusals with false statements that the shower was never offered as her ADL Care Plan reflected. DON B stated that her expectation was that R2 was offered and encouraged to complete all scheduled showers, that the assigned CNA would document any refusal within the POC task, and that the assigned nurse would complete a progress note to reflect the care refusal as well. Upon review of R2's Shower/bathe task, DON B confirmed that R2 was scheduled for showers on Sunday and Wednesday night, that documentation for R2's 4/4/24, 4/11/24, 4/18/24, and 4/22/24 scheduled shower reflected Not Applicable and that the task included no entry or documentation for R2's 4/24/24 scheduled shower date. DON B could offer no explanation as to way documentation would reflect Not Applicable or why scheduled shower date entries were missing as stated that if R2 had refused the scheduled shower on any of the indicated dates, documentation should have been completed to reflect Resident Refused. Upon review of R2's progress notes, DON B confirmed that she did not see any documentation to reflect that R2 had refused scheduled showers on any of the indicated dates. DON B further stated that R2's shower refusal may have been indicated on the shower sheets that were supposed to be completed with each scheduled shower and that she would try to find and provide them. No shower sheets were provided by DON B prior to survey exit. Review of the facility policy titled Activities of Daily Living (ADLs) with a 12/28/23 reviewed/revised date stated, .Policy Explanation and Compliance Guidelines .3. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .