

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235653	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Capital Area		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 E Provincial House Dr Lansing, MI 48910	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135</p> <p>Based on interview, observation and record review the facility failed to honor residents rights for one resident #4 (R4) of one resident reviewed for resident rights resulting in increased anxiety, PTSD symptoms, decreased self-worth and psychosocial wellbeing.</p> <p>Findings Include;</p> <p>Resident #4 (R4)</p> <p>Review of the medical record revealed Resident #04 (R04) was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease, acute kidney failure, pressure ulcer of sacral region, malignant neoplasm of connective and soft tissue, major depression, anxiety, post-traumatic stress disorder, acquired absence of left hip joint, absence of left leg, segmental and somatic dysfunction of upper extremity and polyneuropathy.</p> <p>According to Resident #04 (R04)'s Minimum Data Set (MDS) dated [DATE], revealed R04 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS- a cognitive screening tool) and had no behaviors. R04 requires 2 persons for turning and repositioning, 1 person for assistance with personal care due to functional limitation in Range of Motion (ROM) in upper body. Use of a mechanical lift for transfers requires two persons.</p> <p>During an interview on 03/28/24 at 09:20 AM, R4 stated there had been times she had to wait for her call light to be answered and she had care planned female caregivers only. Also stated that they did not always staff two females on her hall so a female caregiver would have to go to another hall to find another female to help her. R4 stated that facility had made changes to her care plan requiring two people to provide all care even when answering the call light. R4 stated the facility was not honoring her wishes for only one caregiver at times when two is not needed. R4 stated the reason they are doing this is because she made an acquisition that an occupational therapist (OT) left bruises on R4's right upper arm turning and repositioning her. R4 stated her right shoulder is painful and had an old tear and the OT left bruises with the way she placed her hand on the right arm. R4 also stated the facility investigated it and found no wrongdoing. R4 stated due to this event, the facility is accusing her of making false allegations and brought it up all the time. R4 also stated the facility stated the two persons entering her room together is to protect her, but R4 stated she did not need protecting. R4 stated she had talked to the ombudsman about having her rights violated and the facility not letting her do self-determination over what she wants and doesn't want.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 235653	If continuation sheet Page 1 of 6

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review revealed the Care plan Focus: Resident is at risk for alterations in psychosocial wellbeing related to diagnosis of depression, anxiety, post-traumatic stress disorder, life changes/housing insecurity, clinical concerns. Initiated 10/04/23.</p> <p>Goal: Resident will be to express and/or show acceptance of current physical limitations through the next review. Initiated 10/04/23.</p> <p>Intervention: Offer resident choices whenever possible to promote a feeling of self-worth and control over her environment and care delivery. Encourage participation from resident to make own decisions.</p> <p>Interventions include give non-judgmental support. Offer resident choices whenever possible to promote a feeling of self-worth and control over the environment and daily care. Encourage participation from resident to make own decisions.</p> <p>Record review revealed on 11/24/2023 16:04 Social Services Progress Note stated .Social Services Director (SSD) E and Nursing Home Administrator (NHA) A met with resident related to cares and incident with OT. Resident adamantly denied any feelings of abuse, states she is safe and I take care of me. Resident upset related to 2 persons assist is for her safety due to accusations of abuse. NHA A and SSD E attempted to explain 2 persons assist is for her safety due to her accusations of abuse and resident requesting to make police report that OT touched her shoulder during repositioning .Resident multiple times told SSD E to stop talking, I don't want to hear it, when attempting to discuss that 2 persons assist is for her safety, with resident stating I'm a private person, I don't need someone else in here when I'm being taken care of .</p> <p>Record review revealed on 11/30/2023 10:38 Alert note . Resident yelling and swearing at Certified Nursing Assistant (CNA) related to the 2 person cares. Resident required 2 persons assist for all cares provided per care plan .</p> <p>Record review revealed on 11/30/2023 15:23 SSD and UM nurse met with resident related to current care planning and 2 persons assist related to inconsistent statements and accusations of abuse. Resident agitated, yelling at SSD and interrupting SSD when explanation for rationale of care planning was attempted to be given. Resident eventually allowed SSD to state that due to accusations of abuse and later statements claiming that she has never been abused and contradictory statements to multiple staff by resident, witnesses are needed to ensure her safety and ensure staff are accountable resident then began yelling further at SSD stating I've never said I've never been abused! I would never make a false accusation; I don't try to get people in trouble! You're a liar! Liar! Liar! Look me in my face when you lie to me! GET OUT YOU'RE A LIAR. SSD attempted to remind resident that SSD and NHA were present together last week when she stated she had never been abused and the conversation was documented. Resident yelled you need to get me out of here, find me somewhere to go! SSD attempted to ask resident where she would like to go, where referrals should be sent, etc, resident interrupted and yelled I'm not going to talk to you about this! Get out! Don't talk to me! Resident was informed that ombudsman will be visiting next week and that shortly after that a care conference will occur the following week. Resident stated I know I talk to the ombudsman every day! GET OUT!. NHA informed of outcome of conversation .</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review revealed on 12/2/2023 11:56 Nurses' Notes . Attempted to enter room to get vitals and blood sugar about 1140 with CNA. CNA was going to obtain vitals. Resident raised her voice in a manner that made it known she didn't wanted staff in her room. When trying to explain we were attempting to perform blood sugar and vitals. she said, get out. Nurse and CNA left room without obtaining vitals or blood sugar.</p> <p>Record review revealed on 12/7/2023 14:44 Social Services Progress Note . SSD and UM nurse met with resident today related to scheduled care .Resident requesting to postpone the care conference today in favor of the care conference that's scheduled for 12/13/23 with ombudsman. Resident then showed UM nurse a photo of a small bruise in the healing stages on her RUE (near the back of her upper arm). UM nurse asked if it could be from insulin and resident denies it was an insulin injection but did confirm that she receives her insulin near the affected area. Resident indicated that she will be pursuing the police report r/t previous allegation toward OT staff, incident was documented and reported to appropriate authorities at the time of the incident. UM nurse then assisted resident with getting ready for scheduled therapy while SSD spoke with resident regarding previous incidents/allegations, resident apologized to SSD for her previous behavior/yelling. SSD and resident explored resident's mood, s/sx of her anxiety which include anger as previously noted and care planned, as well as her PTSD dx and potential triggers related to the events that lead to PTSD (being beaten up in high school bathrooms, past abusive relationships). SSD provided active listening and validation. Following conversation resident indicated she wanted to give SSD a hug, SSD provided hug to resident. Care plan reviewed and updated with new known triggers for PTSD.</p> <p>Record review revealed on 12/8/2023 10:38 Behavior Late Entry: IDT/SOC met to review resident related to behavioral status. Resident verbally aggressive at times related to anxiety/PTSD. Resident had history of behaviors of making unsubstantiated statements of abuse or accusatory statements, verbal aggression, will request cares/services at a specific time, then later decline to participate . Interventions attempted: Reassurance, 2 persons assist for all cares related to safety/abuse prevention . Resident at times gets upset/verbally aggressive related to not wanting 2 persons' assist. Intervention revision: Awaiting care conference with ombudsman. Resident prefers to verbalize and direct her care needs. Will at times become verbally aggressive, self-reports it's due to anxiety and PTSD. Current interventions remain in place. Resident at times will voice complaints, staff continue to attempt to meet resident's voiced needs. At times may decline medications. Continues to receive therapy. Will continue current POC .</p> <p>Record review revealed on 2/14/2024 09:35 Nurses' Notes Note Text: Resident was asked if she would like for her wound vac treatment to be changed. Resident refused telling writer No I'm going to the wound clinic .</p> <p>Record review revealed on 2/14/2024 16:00 Nurses note . Resident was aggressive screaming and yelling at CNA, and this LPN, resident was given all her medication and care on time. Resident was sad, she yelled and screamed, and she says sorry. resident request to get blood drawn asap but it was drawn in morning. resident wanted foley changed and UA collected so it was notified to unit manager, and she went to check on resident .</p> <p>Record review revealed on 2/16/2024 10:16 Appointment/Transportation Note: .Resident refuses to go to appointment today at neurology with Dr. [NAME] to go over CT and MRI results. resident said she already went to an appointment this week- which was wound care. she states she can only handle 1 appointment per week .</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review revealed on 2/22/2024 16:36 Nurses' Notes . While providing wound care resident wanted her door completely to shut, nurse informed resident that a second person was waiting by the door and reminded her that she is care planned for two people to be present while providing care. Resident became upset and was verbalizing that this gives her anxiety and that she needs to find a different place to stay. This writer apologized that she is feeling this way. Completed wound care, when finished client was calm and comfortable in bed .</p> <p>Record review revealed on 3/4/2024 19:13 Nurses' Notes . resident skin assessment was done by wound nurse in morning. resident was rude while providing care by the staff. resident keeping on asking for one specific CNA to provide care. Resident need 2 person assist to provide care and resident request for one CNA to provide care .</p> <p>Record review revealed on 3/11/2024 10:20 Nurses' Note: .Resident has been asked multiple times to get a weight obtained on her. Resident keep refusing to have weight obtained .</p> <p>Record review revealed on 3/13/2024 16:07 Nurses' Notes: Resident refused Sacral wound dressing change. Wound Vac is currently off due to order for alternative dressing placed and changed daily until 03/16. Alternative dressing was placed on Tuesday 03/12. Resident mentioned not wanting to put any pressure on her shoulders. Dressing change would require her to lay on her side. Resident educated on possible infection if wound is not cleansed, and dressing changed as ordered. Resident verbalized understanding and mentioned that her shoulders are more important. Resident educated that the order after her cortisone injection states to not lift more than 5# and does not mention rolling or pressure, resident verbalized that she was told to not put any pressure on her shoulders. Nurse manager notified of refusal .</p> <p>Record review revealed on 3/22/2024 15:01 Nurses' Notes: Resident was offered her restorative program (ROM) by restorative aid, at agreed time of 3pm. Resident refused ROM stating that her shoulders hurt too much, the wound nurse took too long, she had her wound vac applied, and that she had just finished her lunch. Offered resident to do ROM at a later time today and she has declined, stating that maybe tomorrow she would do it.</p> <p>During an interview on 03/27/24 at 4:30 PM, Ombudsman G stated she had met with R4 a few times related to R4 not having her voice heard on exercising her residents rights. Ombudsman stated that R4 had voiced the right to facilitate her own care as well as refuse care. R4 is of sound mind, her own person and should be able to direct her care in the fashion she wishes to. R4 is aware of her rights for self-determination as well, even though they are not being honored. Ombudsman stated R4 becomes very upset when the facility does not allow her to make her own choices, even if they are not the best choices, that was her right. Writer asked Ombudsman if she thought R4's rights were being violated, and she responded yes.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 03/28/24 at 11:30 AM, R4 stated the facility is making her have 2 persons for all care, even to answer the call light. R4 also stated they did not care about her rights and do not listen to what she wants. R4 stated the compromise was to have the second person stand outside her door, left open so they can hear all the conversations in the room. R4 stated she has no privacy in her own room. R4 stated she is very private and every time they come in her room in numbers it makes her anxious and her PTSD flares up. R4 stated they will do her case conference in her room and there are several people standing there staring at her, and she becomes anxious and gets agitated. R4 added that the staff keep calling her agitation and her getting upset as behaviors. R4 stated I would not have to get to that point if they would let her make her own choices. R4 then stated she had the right to refuse care, decline 2 people in her room at all times, but staff try telling her it was for her own safety. R4 stated she could take care of herself and doesn't need someone else look out for her safety, she can do it.</p> <p>During an Observation and interview on 03/28/24 at 2:00 PM, R4 was to receive wound care by wound care nurse D. Unit manager F came in to R4's room holding a container of santi-wipes and stood at the right end of R4's bed with wound care nurse D at the side of the bed to provide care. R4 became upset that 2 people came in there and they were violating her privacy. Unit manager F just stood there staring at R4, who became upset and tearful about the violation of her privacy. R4 also stated this was wrong and they know how it affected her mental health. R4 was visibly emotionally distressed. R4 stated this was supposed to be her home and she wasn't allowed to do so. Stated if this was her home, people wouldn't just walk in her house like they do here. R4 asked wound care nurse D to close her door. R4 became very tearful, and upset, repeated how she is violated, nobody cares about her mental health. R4 stated she feels like a child in her room but leave her door open so everyone can hear what's going on in here. Wound care nurse D provided emotional support to the R4. R4 stated she did not like the interventions the social worker put on her care plan for 2 people to be present for all care. R4 stated they put anything they want on the care plan even though she did not want in on her care plan. R4 stated the social worker kept repeating the need for 2 persons care and when she would tell them she does not need 2 persons at all times, they disagree with her and then she got upset again and they told her she is having behaviors. R4 stated they know what her triggers were for her PTSD and anxiety, and they continued to ignore the triggers and got her worked up.</p> <p>During an interview on 03/28/24 at 0300 PM, DON B stated those intervention were put in place by the previous administrator. DON B stated R4 had a couple of reportable allegations of abuse. Wanted to provide a way to protect the resident. DON B stated this had been an ongoing conversation including the ombudsman. DON B stated R4 wasn't a fan of the 2 persons in her room. DON B stated R4 compromised with a person standing behind the curtain, or outside of the door with the door cracked open.</p> <p>During an interview on 03/28/24 at 3:15 PM, Social Services Director (SSD) E stated due to R4's alleged allegations they had implemented 2 persons at all times for care. SSD E stated R4 had made allegations, then retracted them, said she did not get care needs addressed when she did. SSD E stated all staff go in her room together from care, IDT, call lights, everything. SSD Stated that R4 was not thrilled with this plan but had come around to be more accepting. Writer asked if R4 was allowed to exercise her rights about the need for 2 persons in her room at all time. SSD E stated it was to keep her safe. SSD E also stated that R4 refuses care at times even when given explanation for care. SSD E also stated they were monitoring her behaviors and will re-evaluate at next IDT.</p> <p>(continued on next page)</p>		

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