STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235653	A. Building B. Wing	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Capital Area	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 22348 This citation pertains to Intake Numbers MI00148941, MI00148966 and MI00149186 Based on observation, interview and record review the facility failed to protect the resident's (R505) right to be free from sexual abuse by another resident (R501) of 7 sampled residents reviewed for abuse resulting in sexual assault of R505 who was cognitively impaired and also resulted in the likelihood of physical harm, infection, and emotional pain and suffering, based on the reasonable person concept. The Director of Nursing (DON) was interviewed on 12/18/2024 at 10:10 AM. and confirmed viewing the facility surveillance video captured on 12/12/24. The video taken on 12/12/24 at 7:42 PM showed R501 ushered R505 into R501's room. At 9:09 PM, R501 was seen on video looking up the hallway before ushering R505 back to her room. On 12/13/2024, R505 was sent to the emergency room for further examination due to soiled underwear and suspected sexual assault. The DON stated the video was no longer available for review. The facility did not save a copy nor had the facility recorded the incident's surveillance video on 12/12/24. Further interview with the staff revealed R501 barricaded the door of his room to prevent anyone from entering. The Immediate Jeopardy began on 12/12/2024 when the facility failed to prevent the sexual assault of R505 by R501. The Immediate Jeopardy was identified on 12/26/2024 at 3:30 PM. The facility Administrator was notified in writing of the Immediate Jeopardy on 12/26/2024 at 4:45 PM, and a plan for the removal was requested. It was confirmed by interview and record review on 12/30/24, that the Immediate Jeopardy was removed on 12/13/24, but non compliance remained at actual harm due to sustained compliance that had not been verified by the State Agency. Findings include: (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: 235653	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Capital Area		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 E Provincial House Dr Lansing, MI 48910	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON was interviewed on 12/18/24 at 10:10 AM. The DON confirmed viewing the facility's surveillance video captured on 12/12/24. According to the DON, the incident had been reported to the state involving a resident-to-resident encounter for a possible sexual assault. The DON described the incident that occurred on 12/12/24, and the timeline was based on after they viewed the facility's video surveillance that was captured on 12//12/24. The DON indicated they first knew about the incident when the staff called them because they were concerned and suspected sexual abuse may have occurred. On 12/12/24 at approximately 7:42 PM to 9:09 PM, Staff noticed that R505 was not in her room for over an hour. After R505 returned to her room, the staff suspected she may have been in R501's room. It was later verified and confirmed, as seen via surveillance camera, that R505 went into R501's room for 1 hour and 27 minutes. The DON stated she watched the video and she saw R501 entered R505's room, but the conversation could not be heard because there was no audio. R501 approached R505's room, stood by the door, and gestured towards his room right across from R505's room. A few minutes later, R505 followed R501 to his room. The DON stated, after the Administrator and the DON watched the video, they immediately called the police and sent R505 to the hospital for a Rape Kit evaluation and further assessment. On 12/19/24 at approximately 10:00 AM, the surveyor requested to review the video footage pertaining to 12/12/24. The DON stated that the video was no longer available for review. The facility did not save a copy nor had they recorded the incident's surveillance video on 12/12/24. According to the daughter/POA (Power of Attorney), during an in-person interview at the facility on 12/18/24 at 3:45 PM, she revealed that she was at the hospital bedside during the hospital physical examination performed by the Forensic Nurse Examiner (FNE) and had asked for a consent to the examination because she was R505's POA. The POA indicated the FNE revealed to her that there was evidence of vaginal bleeding and apparent vaginal tearing present. The daughter/POA also revealed to the nurse, R505's medical history showed R505 had not had periods since about [AGE] years ago when R505 had a hysterectomy. The daughter mentioned, according to the police, they had assured R505's daughter there was enough evidence to implicate R501 for what he had done to her mother. When asked how her mother was doing, she said they would keep her until after the holiday and wouldn't return until the PPO (Personal Protection Order) was implemented against R501. An interview with the [NAME] Detective (LD) was conducted by phone on 12/19/24 at 10:11 AM. LD stated there was a 99.9% (percent) the sexual encounter occurred. There was enough evidence to incriminate this man (referring to R501). The Detective Investigation Report was reviewed on December 26, 2024, at 3:20 PM. It revealed the incident occurred on 12/12/2024 at approximately 1905 hours. It wrote: I (detective) reviewed the camera footage with the Administrator and CNA B. They advised the camera footage's time is one (1) hour ahead due to the system not accepting daylight saving time changes. With the correct time stamps, the incident occurred as follows: 1. At 1904 hours, both R505 and R501 are seen speaking with each other in the hallway. 2. At 1905 hours, both parties enter their respective rooms (room [ROOM NUMBER] and room [ROOM NUMBER]). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. At 1942 hours, R501 exits his room, goes to R505's door, and gestures to his room. R501 is seen guiding R505 into R501's room. R501 is then seen closing R505's door and placing the stop sign back in place. 4. At 2011 hours, CNA B attempted to enter R501's room to take his vitals and finds it barricaded. 5. At 2020 hours, CNA B entered R505)'s room and advised she was not inside. 6. At 2105 hours, CNA B makes contact with R501 and does not observe R505 inside his room. 7. At 2106 hours, CNA B leaves. 8. At 2109 hours, R501 is seen guiding R505 out of his room and back into her room. 9. At 2111 hours, CNA B enters into R505's room, and R501 attempts to follow. The report by the detective further described: On 12/13/2024 at approximately 0100 hours, I (LD) was dispatched to the facility (name of the facility mentioned and address) in reference to a suspicious situation. Dispatch advised the male in room [ROOM NUMBER] (referring to R501) had barricaded himself and another resident in his room. Dispatch stated the other resident, [R505 (name mentioned)], who has Dementia, is mentally incapacitated, and is unable to make decisions for herself. Dispatch said that the staff was concerned a sexual assault took place. On 12/13/2024, at approximately 1215 PM, I (detective) spoke to the Administrator for the facility (facility name mentioned) via text and obtained her statement. Administrator's statement: I (detective) spoke to the Administrator (actual name mentioned) via TX (text). She explained last night at approximately 1942 hours, [R501 (mentioned resident's name)], the accused, coaxed [R505 (mentioned R505's name)] into coming into his room. The Administrator explained that he (R501) barricaded himself in the room with [R505 (resident's name mentioned)], but the staff did not know she was there with him. At 2105 hours, he left the staff to do his vitals at his bedroom door, but they did not go into the room and were unable to see [R505 (name mentioned)] in the room. At 2109 hours, [R501 (Resident's name mentioned)] was seen taking [R501(resident's name)] back to her room. She (Administrator) explained that [R505(name mentioned)] had a guardian and does want to prosecute charges. On 12/13/2024 at approximately 0100 hours, officers responded to the facility (facility named) in regards to a report of a possible sexual assault. I (detective) spoke with the accused, [R501 (name mentioned)], who denied the accusations. On 12/19/24 at 2:30 PM, a review of the nearby hospital emergency room (ER) records with the arrival date of 12/13/24 at 0157. Chief Complaint: The patient arrives via EMS from the facility, staff requesting a rape kit from the incident. Per staff, the patient was missing for 1 hour and found to be in a male resident's room. The patient has severe Dementia and does not know what happened or why she is at the hospital. Visit Diagnoses: Encounter for screening examination Z13.9 (primary), Assault Y09. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/13/24 at 3:49 AM: Forensic Nurse Examiner to bedside. Medical forensic exam completed w (with)/ pt's (patient's) daughter present as her support person. Pt (patient) is alert and oriented x (times) self only and is not able to provide a history. I reviewed the exam process w/ the pt at cognitively appropriate level. Pt assented to the exam. Pt reports no pain during the exam. Vaginal bleeding was noted during the exam. Pt. has a scant amount of bright red blood present on swabs and with tissue when wiping after using the restroom. No other injuries were noted. See the Medical forensic chart for all findings of the medical forensic exam. Clothing was collected by FNE except for socks and shoes. The patient was given new clothing, including undergarments . Pad applied to underwear due to vaginal bleeding.,.Clothing was collected by FNE except for socks and shoes. Pt was given new clothing, including undergarments and FNE assisted the pt with changing into new clothing. Pad applied to underwear due to vaginal bleeding. SANE (Sexual Assault Nurse Examiner) discharge instructions were reviewed with/ the patient's daughters, including the guardian. Pt to follow up with her Pt. for STI (Sexually Transmitted Infections)/HIV (Human Immunodeficiency Virus) testing and to reassess vaginal bleeding. The patient's family was advised to refer to the Primary MD (Medical Doctor) if the bleeding persists or worsens; they should seek care w/ PCP (Primary Care Physician) or return to the ED (Emergency Department). The family, including the guardian, verbalized understanding. The patient's daughter was given a SANE discharge pack. At 05:45 AM, (Resident 505) was discharged to the hospital emergency room . (Resident 505 guardian) decided to bring her home until after Christmas. ER (emergency room) Physician and the Nurse Practitioner were notified, including STI/HIV prophylaxis and discharge planning were deferred to the Dr (Doctor) and NP (Nurse Practitioner). Resident #501 (R501) R501 was [AGE] years old and admitted to the facility on [DATE] with the diagnosis of Adjustment Disorder with Anxiety, Insomnia, Irritability and Anger, Bipolar Disorder, and Narcissistic Personality Disorder, in addition to other diagnoses. According to the PASARR (Preadmission Screening/Annual Resident Review) Level 1 dated 11/19/2024, R501 was not receiving any treatments and no current medications per his preference. R501 has a BIMS (Brief Interview for Mental Status) Score of 15/15, assessed on November 29, 2024, and was deemed his own responsible person. On 12/18/24, a review of R501's care plan did not reflect interventions in place for precautions or monitoring residents related to the past history of sexual activities and his conviction. R501 was independent with Activities of Daily Living (ADLs). R501 used a motorized wheelchair for mobility and ambulation, especially for long-distance ambulation but was independent during transfers to and from the toilet and bed transfers to the chair. He requires very minimal assistance from staff for ADLs. The Plan of Care does not include any monitoring or activity of intimacy or involvement with consensual sexual relationships/interactions with other residents or visitors/guests. An interview with R501 conducted on 12/18/24 at 9:36 AM. During this particular interview with R501, R501 denied touching R505 nor having sex with R505. R505 was [AGE] years old and admitted to the facility on [DATE] with a diagnosis of diverticulitis of the intestine, contact with and exposure to COVID-19, Alzheimer's disease, and dementia with other behavioral disturbance in addition to other diagnoses. R505's current BIMS Score of 03/15 (severe cognitive impairment) assessment was done on December 2, 2024. She is oriented to self only. Resident has a legal guardian, conservator, and Medical POA (Power of Attorney). She requires minimal assistance with ADLs and is independent with ambulation. R505 Care Plan printed on 12/19/24 was reviewed for impaired cognitive function related to Alzheimer's disease, Dementia and was at risk for falls. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/30/24 at 3:30 PM, the surveyor met with R505 in her room. She was pleasant and welcomed the surveyor to her room. R505 remained pleasant and did not show any emotional distress. R505 stated no when asked if she is afraid or felt harmed. An interview with the Administrator was conducted on 12/18/24 at 12:20 PM. They do have an Abuse Policy that covers detailed information about sexual assault or abuse. The Administrator also justified the provision of privacy and honoring residents' rights, which confused staff. The administrator asserted that because R501 was his own responsible party, R501 had the right to approve guests in his room or restrict entry. According to Certified Nurse Aide CNA B on 12/23/24 at 8:17 AM, He recalled he was doing his vitals at that time and noticed R501's room was barricaded. CNA B explained that he tried to push the door to open gently, but it felt like there was something heavy by the door, and the door would not open. CNA B stated, The door was stuck and shut. CNA B further revealed that he could only visualize an inch of R501's room and did not see R501 or anyone else inside. CNA B could hear R501 respond from inside the room and told him that he would come out and find him in about 15 minutes. CNA B noticed across the hall that R505 was not in her room but did not suspect anything because the stop sign was placed by her door until over an hour later when R505 had returned. CNA B expressed that he felt weird and disgusted and reported the suspicion to the nurse. That was when they called and reported it to the DON and Administrator. CNA B continued to recall that the nurse assessed and examined R505 later in her room. The nurse said that she saw the blood stain or what may appear to be a blood smear in R505's underwear during her physical and skin assessment right after R505 was missing for over one hour. CNA B stated, (R505) was not an elopement risk, so I did not think she was missing. I just thought she may have visited another hall to visit friends. Although I saw (R505) friendly to (R501) that day, I assumed they were friends for a while. When CNA B was asked when he reported R505 missing? He explained that he did not report her missing because she could be visiting her friends in other halls. CNA B also recalled that he had to get other resident's vitals that night. So he was looking for her but also tried to get to complete the vitals task that was due in his set. R501 also told him that she was last seen heading towards 200 Hall. It was not until after R505 returned to her room that he felt something was wrong. He reported to Nurse A immediately. CNA B said he did not pursue getting in R501's closed door because he was his own person and had the right to privacy. They did not have special instructions on what to do or a care plan specific for residents who are sex offenders. Nurse A was interviewed on 12/23/24 at 8:13 AM. She indicated that she was not notified that R505's whereabouts were unknown for 1 hour and 27 minutes. Nobody had reported to her that she was missing. CNA B only told her when R505 had returned to her room at 2109. Nurse A would have actively looked for R505. Nurse A immediately called the DON and Administrator, assessed R505, and sent her to the ER. R501 was a known sex offender but denied the sexual encounter and stated it did not happen. Nurse A admitted she found some stains in R505's underwear upon physical assessment but was not sure and was not further confirmed as R505 started to get agitated and did not want me to proceed with the examination. We decided to have R505 keep the clothes and underwear on her way to the ER to have her SANE/Rape Kit Test. R505 left at around 1:00 AM on 12/13/24. R501, on the other hand, was placed under one-on-one supervision. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview by phone with Nurse C was conducted on 12/18/24 at 2:38 PM. Nurse C indicated she had not seen or heard anything. All she recalled on 12/12/24 was CNA B came to 200 Hall, where she was, and asked if she had seen R505. CNA B did not mention R505 was missing then. CNA B came twice, and then he went away. Nurse C recalled, when in 400 hall to do split jobs with medication pass, she did not notice seeing R501 or R505. Nurse C revealed Nurse A was assigned to the 400 Hall, where both R501 and R505 resided. Nurse C was asked how they monitor residents in the sex offender registry and what to monitor. She said they did not have a policy that she knew of. The Registered OT (Occupational Therapist) staff was interviewed on 12/18/24 at 2:15 PM, she indicated R501 used a motorized wheelchair for mobility to move around long distance in the community. His safety awareness is not a problem when he was evaluated in May 2024. He was evaluated and was independent with ADLs, especially during his transfers, walking going to the toilet, pivoting from bed to chair to toilet. He had no problems doing all these independently. Missing resident policy (undated) reviewed on 12/30/24 at 2:30 PM. Missing Person Policy Code Yellow . Nursing personnel must report and investigate all reports of missing residents. If the resident is discovered to be missing, a search shall begin immediately, per the missing person/s protocol. c The Nurse will assign a staff member to begin a headcount of all current residents. c The Nurse will designate a search leader c Assigning staff to conduct an interior search of the facility to also include closets, storage rooms, offices, and any other accessible interior area . According to Nurse A on 12/23/24 at 8:13 AM, during an interview conducted by phone, the Missing Resident Policy or Code Yellow was not activated because it was not reported to her that R505 was missing for over an hour on 12/12/24. Abuse Policy (date revised on 01/10/2024) was reviewed on 12/19/24 at 3:00 PM. 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, neglect, exploitation, and misappropriation of resident's property . . Sexual Abuse (definition) is non-consensual sexual contact of any type with a resident . Criminal Sexual Abuse (definition) is serious bodily injury/harm shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or any similar offense under the State Law. In other words, serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act . .Prevention of Abuse . The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A. Establishing a safe environment that supports, to the extent possible, a resident consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact . B. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and /or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms Immediate Jeopardy Removal: The Immediate Jeopardy that began on 12/12/24 was removed on 12/13/24 when the facility took the following actions to remove the immediacy: As a result of the finding of Immediate Jeopardy by the survey team on 12/12/24 related to Resident #501 and Resident #505 the facility has reviewed the below to determine causation. Findings include: Element #1 Resident #505 was transferred to hospital on 12/13/24 and was provided a SANE examination. This exam identified no external injuries with vaginal bleeding, scant blood present on tissue when wiping. She was discharged to care of DPOA on 12/13/24. Resident readmitted to the facility on [DATE]. Social Services/designee will complete wellness visits and offer psychosocial support and services. Resident #501 admitted to having resident #505 present in his room to watch a movie on 12/12/24. Beginning on 12/13/2024, he was placed on 1:1 supervision until discharged from the facility on 12/18/24. Element #2 Beginning on 12/12/2024, Female residents with a BIMS 10 or less had skin assessments completed with no concerns identified. Female residents with a BIMS 10 or higher were interviewed regarding any concerns with other residents in the facility and if they feel safe. On 12/13/2024 Social Services Director completed an audit of sex offender registry for residents in facility. Three additional residents were identified. These residents were placed on one to one supervision and assessed regarding risk factors (date of charges, degree of severity, any history of behaviors in facility, cognition and ADLS status or ability move independently throughout the facility). Resident's interventions/supervision updated as deemed appropriate based on risk factors. Care plans updated. These residents had sex offender registration audited to ensure current address was present, any discrepancies were reported to the registry. Element #3 (continued on next page)

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