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	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Capital Area	2100 E Provincial House Drive 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to implement its own written policies and procedures for Abuse and Neglect for four residents (#6, #9, #10) of 10 residents reviewed. Findings Included:Resident #6 (R6):Review of the medical record revealed R6 was admitted to the facility 08/07/2025 with diagnoses that included type 2 diabetes, chronic kidney disease, anemia (low red blood cells, hyperlipidemia (high fat content in blood), gastro-esophageal reflux, dementia and depression. The most recent Minimum Data set (MDS), with an Assessment Reference Date (ARD) of 08/13/2025, revealed R6 had a Brief Interview for Mental Status (BIMS) of 3 (severe cognitive impairment) out of 15. Resident #9 (R9):Review of the medical record revealed R9 was admitted to the facility 07/11/2025 with diagnoses that included dementia, epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures), stage 3 kidney disease, chronic obstructive pulmonary disease (COPD), traumatic brain injury, gastro-esophageal reflux, hypertension, cognitive communication deficient, obstructive sleep apnea, lung cancer, intervertebral disc degeneration, and dysphagia (difficulty swallowing). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/17/2025, revealed R9 had a Brief Interview for Mental Status (BIMS) of 5 (sever cognitive impairment) out of 15. Resident #10 (R10) Review of the medical record revealed R10 was admitted to the facility 12/05/2022 with diagnoses that included cerebral atherosclerosis (condition where fatty deposits build up in the arteries in the brain, narrowing or blocking blood flow), type 2 diabetes, malnutrition, dementia, obesity, hyperlipidemia (high fat content in blood), hypertension, Alzheimer's disease, dysphagia (difficulty swallowing), insomnia, hypokalemia (low levels of potassium), adult failure to thrive, and depression. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/14/2025, revealed R10 had a Brief Interview for Mental Status (BIMS) of 3 (severe cognitive impairment) out of 15. Review of facility incident report dated 08/22/2025 at 03:15 p.m. for R6 revealed: medical record number (medical record number of R9) poke very loudly stating, that's my hat, indicating resident. Resident replied, no it not, peer (medical record number of R9 came up an quickly removed the hat in question. Resident and peer began swinging at each other. It appeared that (medical record number of R9) made contact with resident's back. During an interview on 09/23/2025 at 02:28 p.m. Nursing Home Administrator (NHA) A explained that she was the facility abuse coordinator. NHA A explained that it was her responsibility to investigate and review all allegations of abuse. NHA A was asked to review incident report dated 08/22/25 between R6 and R9. NHA A explained that she had not been notified that R9 had contacted R6. NHA A explained that now that she had reviewed this incident report that it would be an allegation of abuse and should have been investigated. NHA A explained that she did not have an investigation related to this incident and the incident was not report to the appropriate state agency. Review of facility incident report dated 09/10/2025 at 03:45 p.m. for R6 revealed, this writer was given medication when I looked back heard 115A (R10) was getting agitated to this resident (R6) saying give that back to me! Grabbed this resident's arm, so I came in between tried separating both but resident grabbed my left fingers and pushed me and twisted them and tried to twist resident's arm, so this CNA (certified nursing aide) came in between and stopped resident, separated them and this resident scratched CNA's right arm. Assessment done to both resident, the resident's arm 103B (R6) right has pain 5/10, no open area. The residents right middle finger had pain 2/10 painad(sp). Called administrator, DON (Director of Nursing), nurse manager notified. Notified son. Therapeutic communicated done to both. Skin and pain monitored. The same incident report also revealed Resident Description: He hit me and grabbed my arm I was trying to us the ball. During observation and interview on 09/23/2025 at 03:34 p.m. R6 was observed lying in bed. R6 denied that she had any physical altercations with any other residents at the facility.During observation and interview on 09/23/25 at 03:44 p.m. R9 was observed sitting in the dinning room, at the end of the 100 hall. R9 could not recall any physical altercations with any other residents. R9 explained that she had a good relationship with all the residents at the facility. During an interview on 09/23/2025 at 04:15 p.m. Nursing Home Administrator (NHA) A was asked to review R6 incident report dated 09/10/2025 at 03:45 p.m. NHA A was asked if this incident had been reported to the appropriate state agency. NHA A explained that it had not been reported because she had not been notified on what was written on the incident report. NHA A explained that she had not known that R6 had any complaints of pain following this incident. NHA A was asked if she reviewed all incident reports and signed that incidents had been reviewed. NHA explained that she would have to check to see if R6's incident reports had been reviewed and signed by herself. NHA A agreed, after reviewing the

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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 - Some	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** Based on observation, interview, and record review the facility failed to report allegations of abuse to the State Agency for four residents (#1,#6,#9,#10) of ten residents reviewed for abuse. This citation pertains to intake #2615129 Review of the medical record reflected R1 was admitted to the facility on [DATE], with diagnoses that included alcohol dependance and anxiety disorder. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/29/25, reflected R1 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). In an interview on 9/23/25 at 9:30 AM, Family Member (FM) D reported concerns that R1's debit card was removed from the facility by staff and used to purchase items. Additionally, the staff member had withdrew cash from the bank and kept some for themselves. The staff member was identified as CNA E. In an interview on 9/23/25 at 1:56 PM, Certified Nursing Assistant (CNA) H confirmed that R1 will regularly ask staff to take her debit card and purchase her items. CNA H stated that it was nothing that they would do and has educated R1 on several occasions about how staff is not permitted to do that. In an interview on 9/23/25 at 2:15 PM, CNA E voiced familiarity of R1. CNA E stated that R1 has requested CNA E to take her bank card on several occasions and purchase her items, including alcohol. CNA E denied doing so and reported the frequent requests to management. CNA E recalled an incident where R1's FM had accused CNA E of using R1's debit card, leading to a suspension and investigation regarding the accusation. Review of an undated Witness Statement completed by R1 revealed [CNA E] did take my card I gave it to him to purchase me alcohol and a joint. with my [family member] present. In the same witness statement, the handwritten paragraph below stated, after the daughter left the facility [R1] came to Administrator and DON (Director of Nursing] and stated that she felt pressured by [family member] to say [CNA E] did it and that [CNA E] has never purchased anything for her using her card. In an interview on 9/23/25 at 2:16 PM, DON B stated R1's family member came into the office and shared the concern that staff was taking R1's bank card. DON B stated that she went to R1's room and R1 reported the allegation to Nursing Home Administrator (NHA) A and DON B. After R1's family member left, R1 retracted her statement and denied the allegation that CNA E removed her bank card from her possession and used it. DON B confirmed that thought retracted after some time, R1's initial statement was still an allegation of misappropriation and should have been reported. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 9/23/25 at 2:27 PM, NHA A confirmed that R1's family member had reported that CNA E was using R1's bank card. NHA A spoke to R1 who confirmed the allegation. NHA A stated that she suspended CNA E. NHA A stated that after R1's family member left, R1 retracted the allegation. NHA A stated that she suspended CNA E pending the allegation of misappropriation and therefore, should have reported the allegation to the State of Michigan. Findings Included: Resident #6 (R6) Review of the medical record revealed R6 was admitted to the facility 08/07/2025 with diagnoses that included type 2 diabetes, chronic kidney disease, anemia (low red blood cells, hyperlipidemia (high fat content in blood), gastro-esophageal reflux, dementia and depression. The most recent Minimum Data set (MDS), with an Assessment Reference Date (ARD) of 08/13/2025, revealed R6 had a Brief Interview for Mental Status (BIMS) of 3 (severe cognitive impairment) out of 15. Resident #9 (R9) Review of the medical record revealed R9 was admitted to the facility 07/11/2025 with diagnoses that included dementia, epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures), stage 3 kidney disease, chronic obstructive pulmonary disease (COPD), traumatic brain injury, gastro-esophageal reflux, hypertension, cognitive communication deficient, obstructive sleep apnea, lung cancer, intervertebral disc degeneration, and dysphagia (difficulty swallowing). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/17/2025, revealed R9 had a Brief Interview for Mental Status (BIMS) of 5 (sever cognitive impairment) out of 15. Resident #10 (R10) Review of the medical record revealed R10 was admitted to the facility 12/05/2022 with diagnoses that included cerebral atherosclerosis (condition where fatty deposits build up in the arteries in the brain, narrowing or blocking blood flow), type 2 diabetes, malnutrition, dementia, obesity, hyperlipidemia (high fat content in blood), hypertension, Alzheimer's disease, dysphagia (difficulty swallowing), insomnia, hypokalemia (low levels of potassium), adult failure to thrive, and depression. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/14/2025, revealed R10 had a Brief Interview for Mental Status (BIMS) of 3 (severe cognitive impairment) out of 15. Review of facility incident report dated 08/22/2025 at 03:15 p.m. for R6 revealed: medical record number (medical record number of R9) poke very loudly stating, that's my hat, indicating resident. Resident replied, no it not, peer (medical record number of R9 came up an quickly removed the hat in question. Resident and peer began swinging at each other. It appeared that (medical record number of R9) made contact with resident's back. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/23/2025 at 02:28 p.m. Nursing Home Administrator (NHA) A explained that she was the facility abuse coordinator. NHA A explained that it was her responsibility to investigate and review all allegations of abuse. NHA A was asked to review incident report dated 08/22/25 between R6 and R9. NHA A explained that she had not been notified that R9 had contacted R6. NHA A explained that now that she had reviewed this incident report that it would be an allegation of abuse and should have been investigated. NHA A explained that she did not have an investigation related to this incident and the incident was not report to the appropriate state agency. Review of facility incident report dated 09/10/2025 at 03:45 p.m. for R6 revealed, this writer was given medication when I looked back heard 115A (R10) was getting agitated to this resident (R6) saying give that back to me! Grabbed this resident's arm, so I came in between tried separating both but resident grabbed my left fingers and pushed me and twisted them and tried to twist resident's arm, so this CNA (certified nursing aide) came in between and stopped resident, separated them and this resident scratched CNA's right arm. Assessment done to both resident, the resident's arm 103B (R6) right has pain 5/10, no open area. The residents right middle finger had pain 2/10 painad(sp). Called administrator, DON (Director of Nursing), nurse manager notified. Notified son. Therapeutic communicated done to both. Skin and pain monitored. The same incident report also revealed Resident Description: He hit me and grabbed my arm I was trying to us the ball. During observation and interview on 09/23/2025 at 03:34 p.m. R6 was observed lying in bed. R6 denied that she had any physical altercations with any other residents at the facility. During observation and interview on 09/23/25 at 03:44 p.m. R9 was observed sitting in the dinning room, at the end of the 100 hall. R9 could not recall any physical altercations with any other residents. R9 explained that she had a good relationship with all the residents at the facility. During an interview on 09/23/2025 at 04:15 p.m. Nursing Home Administrator (NHA) A was asked to review R6 incident report dated 09/10/2025 at 03:45 p.m. NHA A was asked if this incident had been reported to the appropriate state agency. NHA A explained that it had not been reported because she had not been notified on what was written on the incident report. NHA A explained that she had not known that R6 had any complaints of pain following this incident. NHA A was asked if she reviewed all incident reports and signed that incidents had been reviewed. NHA explained that she would have to check to see if R6's incident reports had been reviewed and signed by herself. NHA A agreed, after reviewing the incident report, that an investigation should have been initiated and the incident should have been reported to the appropriate state agency. During an interview on 09/23/2025 at 04:30 p.m. Nursing Home Administrator (NHA) explained that she had signed R6's incident reports. Review of the provided facility report that demonstrated when Nursing Home Administrator A had signed R6's incident reports revealed: the incident report for the date of 08/22/2025 was signed by NHA on 09/04/2025, and the incident report for the date of 09/10/2025 was signed by the NHA on 09/17/2025. During an attempted interview on 09/24/25 at 09:59 a.m. R10 was observed sitting in the 100 hall activity room sleeping. R10 appeared well groomed and was not disturbed to interview during this time. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of policy titled Abuse, Neglect and Exploitation, implementation date 07/28/2020 and last revised date of 01/10/2024, revealed Abuse means the willful infliction of injury.which can include staff to resident abuse and certain resident to resident altercations. The same policy also revealed Physical abuse – includes, but is not limited to hitting, slapping, punching, biting, and kicking. The same policy revealed section entitled Investigation of Alleged Abuse. A. an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur. The same policy also revealed Reporting 1. Reporting of alleged violation to the Administrator, state agency, adult protective services, and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes as required by state and federal regulations.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review the facility failed to investigate allegations of abuse for three residents (#6,#9,#10) out of ten residents reviewed for abuse. Findings Included: Resident #6 (R6)Review of the medical record revealed R6 was admitted to the facility 08/07/2025 with diagnoses that included type 2 diabetes, chronic kidney disease, anemia (low red blood cells, hyperlipidemia (high fat content in blood), gastro-esophageal reflux, dementia and depression. The most recent Minimum Data set (MDS), with an Assessment Reference Date (ARD) of 08/13/2025, revealed R6 had a Brief Interview for Mental Status (BIMS) of 3 (severe cognitive impairment) out of 15. Resident #9 (R9)Review of the medical record revealed R9 was admitted to the facility 07/11/2025 with diagnoses that included dementia, epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures), stage 3 kidney disease, chronic obstructive pulmonary disease (COPD), traumatic brain injury, gastro-esophageal reflux, hypertension, cognitive communication deficient, obstructive sleep apnea, lung cancer, intervertebral disc degeneration, and dysphagia (difficulty swallowing). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/17/2025, revealed R9 had a Brief Interview for Mental Status (BIMS) of 5 (sever cognitive impairment) out of 15. Resident #10 (R10)Review of the medical record revealed R10 was admitted to the facility 12/05/2022 with diagnoses that included cerebral atherosclerosis (condition where fatty deposits build up in the arteries in the brain, narrowing or blocking blood flow), type 2 diabetes, malnutrition, dementia, obesity, hyperlipidemia (high fat content in blood), hypertension, Alzheimer's disease, dysphagia (difficulty swallowing), insomnia, hypokalemia (low levels of potassium), adult failure to thrive, and depression. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/14/2025, revealed R10 had a Brief Interview for Mental Status (BIMS) of 3 (severe cognitive impairment) out of 15. Review of facility incident report dated 08/22/2025 at 03:15 p.m. for R6 revealed: medical record number (medical record number of R9) poke very loudly stating, that's my hat, indicating resident. Resident replied, no it not, peer (medical record number of R9 came up an quickly removed the hat in question. Resident and peer began swinging at each other. It appeared that (medical record number of R9) made contact with resident's back. During an interview on 09/23/2025 at 02:28 p.m. Nursing Home Administrator (NHA) A explained that she was the facility abuse coordinator. NHA A explained that it was her responsibility to investigate and review all allegations of abuse. NHA A was asked to review incident report dated 08/22/25 between R6 and R9. NHA A explained that she had not been notified that R9 had contacted R6. NHA A explained that now that she had reviewed this incident report that it would be an allegation of abuse and should have been investigated. NHA A explained that she did not have an investigation related to this incident and the incident was not report to the appropriate state agency. Review of facility incident report dated 09/10/2025 at 03:45 p.m. for R6 revealed, this writer was given medication when I looked back heard 115A (R10) was getting agitated to this resident (R6) saying give that back to me! Grabbed this resident's arm, so I came in between tried separating both but resident grabbed my left fingers and pushed me and twisted them and tried to twist resident's arm, so this CNA (certified nursing aide) came in between and stopped resident, separated them and this resident scratched CNA's right arm. Assessment done to both resident, the resident's arm 103B (R6) right has pain 5/10, no open area. The residents right middle finger had pain 2/10 painad(sp). Called administrator, DON (Director of Nursing), nurse manager notified. Notified son. Therapeutic communicated done to both. Skin and pain monitored. The same incident report also revealed Resident Description: He hit me and grabbed my arm I was trying to us the ball.During observation and interview on 09/23/2025 at 03:34 p.m. R6 was observed lying in bed. R6 denied that she had any physical altercations with any other residents at the facility.During observation and interview on 09/23/25 at 03:44 p.m. R9 was observed sitting in the dinning room, at the end of the 100 hall. R9 could not recall any physical altercations with any other residents. R9 explained that she had a good relationship with all the residents at the facility. During an interview on 09/23/2025 at 04:15 p.m. Nursing Home Administrator (NHA) A was asked to review R6 incident report dated 09/10/2025 at 03:45 p.m. NHA A was asked if this incident had been reported to the appropriate state agency. NHA A explained that it had not been reported because she had not been notified on what was written on the incident report. NHA A explained that she had not known that R6 had any complaints of pain following this incident. NHA A was asked if she reviewed all incident reports and signed that incidents had been reviewed. NHA explained that she would have to check to see if R6's incident reports had been reviewed and signed by herself. NHA A agreed, after reviewing the