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 02/25/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of Capital Area		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2747733.Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse by a vendor for one (R3) of three reviewed.Findings Include:Review of the medical record revealed R3 admitted to the facility on [DATE] with diagnoses that included major depressive disorder and history of traumatic brain injury. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/26/26 revealed R3 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R3 discharged from the facility on 2/19/26.Review of the incident investigation that the facility reported to the State Agency revealed Background: [R3] was admitted on [DATE]. On 2/8/26, the physician ordered an x-ray for [R3]. [Xray Technician (XT) E] .came into the facility. XT E entered [R3's] room. [XT E] stood over top of [R3] and began swearing at him while shaking a closed fist. Investigation: [R3], Administrator [Nursing Home Administrator (NHA) A] spoke with resident who stated that [XT E] came in room using profanity. [XT E] stood over me and got in my face while threatening me with a closed fist and using profanity towards me. [R3] stated that him and [XT E] exchanged words and staff stepped in and removed [XT E] from room and the facility .Conclusion: [R3] was ordered an x-ray. [Name of x-ray vendor] sent x-ray tech, [XT E], to come and provide service to [R3]. [XT E] came into [R3's] room; and used profanity towards [R3]. [XT E] and [R3] had a verbal altercation. The nursing staff intervened [sic] and removed [XT E] from the facility. The facility substantiated that the incident occurred but cannot substantiate that verbal abuse occurred.An attempt to contact R3 via telephone was made on 2/24/26 at 10:12 AM, but R3's phone number was out of service. Review of the Nurse's Note dated 2/8/26 revealed The resident was having an X-ray performed when this nurse heard yelling for help. Staff went into room and noted a verbal altercation with the resident and the x-ray technician.Review of the Social Services Progress Note dated 2/9/26 revealed [Social Services Director (SSD)] checked in with resident [related to] interaction with x-ray technician from 2/8/26. Resident reports he and x-ray tech exchanged pleasantries and called each other derogatory names.In a telephone interview on 2/24/26 at 10:53 AM, Licensed Practical Nurse (LPN) G reported while XT E was in R3's room, she heard R3 yell Help! Help!. LPN G reported herself and another nurse went into R3's room and witnessed XT E cursing at R3. LPN G reported XT E told R3 that he didn't give a f*ck who he told and that he was going to finish his job. LPN G reported XT E and R3 went back and forth, XT E 'was going off on R3. LPN G reported R3 said if his leg wasn't messed up, he would get out of bed at which point XT E said I would like to see you f*cking try and continued to antagonize R3 to get out of bed. LPN G reported staff had to get in between them and pull the privacy curtain shut, LPN G reported XT E grabbed the x-ray plate roughly, left the room, and yelled while going down the hallway. LPN G reported R3 was very scared after this incident. In a telephone interview on 2/24/26 at 11:24 AM, Registered Nurse (RN) F reported on 2/8/26 she heard yelling coming from R3's room. RN F (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
	235653	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Capital Area	2100 E Provincial House Drive Lansing, MI 48910

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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	reported herself, LPN G and Certified Nursing Assistant (CNA) H entered R3's room. RN F stated XT E was going back and forth, yelling at the resident. RN F reported it was all verbal exchanges which included statements such as XT E saying he was going to do his f*cking job and part of his f*cking job was to make sure he got the x-ray. RN F reported R3 alleged XT E got in R3's face and pulled his fist back like he was going to hit R3 but did not hit him. In an interview on 2/24/26 at 1:27 PM, CNA H reported while answering a call light in another room, she heard someone yelling Help! Help! CNA H reported she entered R3's room with two nurses and witnessed XT E talking aggressively to R3. CNA H reported R3 asked staff to remove XT E from his room because he was being threatening and disrespectful. CNA H reported XT E continued to yell at R3 and said things such as this is why you're in here and I wish you could get up and hit me. CNA H reported it was inappropriate and she got in between R3 and XT E and closed the privacy curtain. In a telephone interview on 2/25/26 at 3:44 PM, XT E reported when he arrived at the facility, R3 was not in his room so he had to wait for R3 to come back to his room and get into bed without staff assistance. XT E reported he took a couple images and about halfway through, things started to go left. XT E reported R3's ankle needed to be turned for the next image and R3 kicked the plate on the floor. XT E reported he picked up the plate and that's when the cursing started to go back and forth .It was all verbal. XT E reported R3 told him he needed to give better f*cking instructions to which XT E responded that R3 better watch his mouth or I was going to leave because I do not take disrespect from anyone. XT E stated the conversation was elevated the entire time. It definitely wasn't at the volume we are speaking right now. Everything about the conversation was extremely heated. XT E reported R3 called for staff and that he didn't stop working even when the verbal part started. XT E reported he was there to do a job and continued to do the x-rays. XT E reported staff responded and pulled the privacy curtain between him and R3 so he then left the room, completed his paperwork, and left the facility. In an interview on 2/25/26 at 12:03 PM, NHA A and Director of Nursing (DON) B reported the facility substantiated that there was yelling and words exchanged between R3 and XT E. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included interviews, skin, and pain assessments on all residents, all staff abuse education, weekly abuse audits. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.