

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  03/04/2026
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)		
<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to Intake 2788552. Based on interview and record review, the facility failed to ensure a physician documented that transfer/discharge was necessary for one (R1) of three reviewed. Findings include: Review of the medical record revealed R1 was admitted to the facility on [DATE] with diagnoses that included fracture of left leg, epilepsy, anxiety disorder, depression, schizophrenia, and Post Traumatic Stress Disorder (PTSD). The Minimum Data Set (MDS) with an Assessment Reference Date of 1/30/26 revealed R1 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). In a telephone interview on 3/4/26 at 9:58 AM, R1 reported approximately four police officers, and a social worker came into his room with an order from the judge to send him to the hospital for evaluation. R1 reported that same night, he was ready to discharge from the hospital back to the facility. R1 reported the hospital called the facility, but the facility refused to take him back saying they would rather have a hit on their license than take him back. R1 reported the hospital then told him he had to leave so he discharged to the community with his significant other. Review of the Social Services Progress Note dated 2/26/26 revealed [Social Services Director (SSD)] attempted to issue Involuntary Discharge paperwork to resident with [Nursing Home Administrator]. Resident refused the paperwork but he requested to be given the appeal paperwork. SSD attempted to hand the paperwork to him, he stated he would not touch it, and paperwork was placed gently on his left knee with no physical body contact made between SSD and resident. Review of the Immediate Involuntary Discharge paperwork dated 2/26/26 revealed This letter is to inform You that you will be immediately discharged on February 28, 2026 to [name of a local motel], for the following reason(s): Sec. 21773(2)(a). You have been observed making repeated threats towards staff and other residents and continue to do so despite being counseled on your behavior. Review of the Notice of Involuntary Transfer or Discharge and Facility-Initiated Discharge for Nursing Homes revealed R1 was being transferred/discharged due to the safety of other individuals in the facility is endangered due to clinical or behavioral status of resident and health of other individuals in the facility is endangered. Review of the Nurses' Note dated 2/26/26 revealed Police came to facility [related to] resident calling 911. Before the police left the facility [Director of Nursing (DON)] gave police residents letter of resident's involuntary discharge. Resident stated that he [is] unable to read. Even though he had read things of papers resident had. Resident is aware that he needs to leave tomorrow 2/27/26 as the police told him that. Review of the Nurses' Note dated 2/27/26 revealed resident was unexpectedly discharged via police car to [Emergency Department] [due to] a court appointed petition. In a telephone interview on 3/4/26 at 10:54 AM, Registered Nurse (RN) E reported she worked on 2/27/26 and R1 was sent to the hospital prior to her shift. RN E reported she was told in report that if the hospital called, the facility would not readmit R1. RN E reported the hospital called multiple times wanting to send R1 back to the facility, but the facility refused. In an interview on 3/4/26 at 11:16 AM, Assistant Director of Nursing (ADON) C reported the facility was trying to do an involuntary discharge for R1, but they had not received approval from the State Agency yet. ADON C reported the hospital called the facility to readmit R1, (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
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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>but facility staff were told R1 was to discharge to the local motel. ADON C reported R1 refused to discharge to the motel so the hospital discharged him to the community. In an interview on 3/4/26 at 11:35 AM, Social Services Director (SSD) G reported they had not heard one way or another if R1's involuntary discharge was approved by the State Agency. In an interview on 3/4/26 at 11:46 AM, Nursing Home Administrator (NHA) and Director of Nursing (DON) B reported R1 was given involuntary discharge paperwork on 2/26/26 and that he did not take it well. NHA A reported R1 asked for the appeal, but was not aware of him filing an appeal. NHA A reported on 2/27/26 they still had not heard from the State Agency if R1's involuntary discharge was approved or not. NHA A reported the police showed up on 2/27/26 around 4:00 PM with a court order to take R1 to the hospital. NHA A reported the hospital called the facility shortly after midnight wanting to send R1 back to the facility. NHA A reported the hospital was told that R1 could go to the local motel. NHA A reported R1 was not readmitted to the facility due to concerns with his behaviors and threatening other residents. Review of the medical record revealed a physician did not document that R1's transfer/discharge was necessary due to the safety of individuals in the facility was endangered due to the clinical or behavioral status of the resident and that the health of individuals in the facility would otherwise be endangered.</p>		