

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 06/26/2026
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 - Some	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 intakes: 2969859, 2990774, 2999197, 2999242 Based on observation, interview and record review, the facility failed to protect and prevent abuse in four residents (R12, R34, R95, R101) of four residents reviewed for abuse and six residents (R12, R34, R61, R68, R95, R101) of six residents reported from facility reported incidents. Findings Include: Resident #12 (R12): Per the facility's face sheet R12 was admitted to the facility on [DATE] and re-admitted on [DATE]. Diagnoses included depression and anxiety. Review of a Brief Interview of Mental Status (BIMS) score dated 5/5/2026 revealed R12 scored a 15 out of 15 which indicated full mental cognition. Review of a facility reported incident (FRI), dated 4/11/2026, revealed Licensed Practical Nurse (LPN) II was witnessed by LPN JJ, Certified Nurse Aid (CNA) KK, CNA LL stating to R12 that she was going to mark all her medications as refused after having an argument with her about the medications she was receiving. The FRI revealed that LPN II was suspended from work on 4/11/2026. The facility performed a five-day investigation, dated 4/20/2026, which resulted in an interview with LPN JJ who stated that she heard LPN II state to R12 that she would not give R12 anymore medication. Another interview documented on the five-day with CNA KK revealed CNA KK heard R12 tell LPN II that the pill she was giving her was the wrong pill. Then R12 started to yell at LPN KK, and LPN KK started to argue loudly with R12. Then CNA KK heard LPN II state to R12, as she was walking away, that she was R12's nurse tomorrow and she was going to mark refused on all of R12's medications including her heart medication. The five-day investigation revealed an interview with CNA LL who stated that she heard LPN II state to R12 that she would not be giving R12 her medications for the rest of the day and was speaking loudly to R12. The five-day investigation revealed an interview with LPN II who stated that R12 told her she had given her the wrong medication, and R12 told LPN II she would not take any medication from her, so LPN II told R12 fine I will just mark them refused. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/26/2026 at 9:30 AM, LPN JJ stated that she witnessed R12 by the nurse's cart, and R12 asked her to verify if the pill in her hand was Tylenol. LPN JJ said she got another Tylenol and compared it. LPN JJ said it looked like maybe a Colace, then R12 said to LPN II I told you that was not the right pill. LPN JJ said LPN II then started pointing down at R12, who was sitting in her wheelchair, and raised her voice at her. LPN JJ said she could not recall what LPN II said, but she did recall LPN II saying to R12 that she was not getting any more meds from her today. In an interview on 06/26/2026 at 9:53 AM, CNA KK said LPN II went to give R12 her pills and R12 told LPN II it was the wrong pill. CNA KK said then she witnessed LPN II point her finger at R12 and yelled at her telling her that she did not give her the wrong pill. CNA KK said R12 said yes, you did, and LPN II kept yelling at R12 all the way down the hall and there were other residents present. CNA KK said LPN II told R12 that she was going to be her nurse tomorrow and she was going to put in that R12 refused all her FXXXXXX medications. CNA KK said that the incident went on for about 15-20 minutes. In an interview on 06/26/2026 at 9:15 AM, R12 stated that she recalled the incident. R12 said LPN II would not give her medications to her. R12 said LPN II never did give her medications to her, and after LPN II left her room, she never saw her again. R12 said LPN II was very mean to her. Review of LPN II's employee record revealed LPN II was terminated on 4/14/2026 because of the incident. The facility substantiated that verbal abuse occurred as documented in the facility's five-day investigation. Resident #61 (R61) Review of the medical record revealed R61 was admitted to the facility 04/03/2025 with diagnoses that included Dementia, Degeneration of Nervous System, Mood Disorders, Anxiety and Alcohol Dependence with Alcohol Induced Persisting Dementia. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/31/2026, revealed R61 had a Brief Interview for Mental Status (BIMS) of 00 (severe cognitive impairment) out of 15. Resident #101 (R101) Review of the medical record revealed R101 was admitted to the facility 08/04/2025 with diagnoses that included mild neurocognitive disorder due to known physiological condition with behavior disturbance, adjustment disorder, vascular dementia, PTSD, and major depressive disorder. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/31/2026, revealed R101 had a Brief Interview for Mental Status (BIMS) of 04 (severe cognitive impairment) out of 15. Resident #95 (R95) Review of the medical record revealed R95 was admitted to the facility 07/10/2025 with diagnoses that included post procedural hemorrhage of skin and subcutaneous tissue following other procedure, mild neurocognitive disorder due to known physiological condition without behavioral disturbance, generalized anxiety disorder, major depressive disorder. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/16/2026, revealed R95 had a Brief Interview for Mental Status (BIMS) of 03 (severe cognitive impairment) out of 15. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #61 and Resident #101 Review of MI-FRI (Michigan Facility Reported Incident) #00064236 revealed R61 came out of main dining room after eating on the night of 04/10/2026. R61 walked into the day room and made contact with his right hand to R101's face. When R61 was asked what happened and then stated, what do I do? When R101 was asked what happened, R101 stated get him away from me! Staff immediately separated the residents and R61 was taken back to his room and a 1:1 staff supervision. According to the 24-hour MI-FRI report the incident occurred on 04/10/2026 at 6:15 p.m. Review of the facility 5-day investigation summary revealed the conclusion: The facility acknowledges that physical incident occurred. Review of the facility incident report revealed R101 did not have any physical injury, and pain scale was reported at 0 (no pain). During an interview on 06/23/2026 at 2:53 PM, Writer asked R101 about the incident when another resident (R61) slapped him across the face/jawline, R101 stated R61 isn't watched well enough or he would not do these things. Writer asked him if he had any additional interactions with R61 and he stated no, told them to keep him away from him. During an interview on 06/26/2026 at 1:07 PM, Nursing Home Administrator (NHA) A and Director of Nursing (DON) B Stated LPN BB notified her/ NHA A that R61 went into the TV room and made contact with R101. NHA A stated LPN BB separated the residents, skin assessment for both residents, placed R61 on a 1 to 1, notified the provider, skin assessments for R101 and R61 were completed, reported to the state, before moving R61 to 200 hall, and received no special supervision. During an interview on 06/26/2026 at 1:16 PM, LPN BB stated towards the ends of the evening, she went to get supplies and stopped at the nursing station and saw R61 punched R101 in the face. R101 tried to hit him back but didn't make contact. Certified Nursing Assistants (CNA's) separated the two residents, LPN BB called LHNA A and DON B along with the provider, she filled out a resident-to-resident incident report. R61 was then placed on a 1 to 1 staff supervision. During an observation and interview on 06/26/2026 at 2:23 PM, R101 stated he didn't remember if R61 had caused any issues with him or not. R101 was sitting in the activity room watching bird houses being made. Record review of progress notes revealed R61 was initially admitted to this facility on 04-03-2025 for long-term care due to requiring 24-hour assistance with Activities of Daily Living (ADL's) skilled nursing care, and medication management. Social Work requested evaluation to assess for increased symptoms of his ongoing anxiety, restlessness, and agitation related to dementia. R61 had an increase in physical aggression towards staff and his 1:1staff supervision, which is ongoing for safety. R61 was currently managed by Zolof, Namenda, and Seroquel. Resident was evaluated while lying in his bed in his room with a 1:1 for safety. R61 continued to have restlessness and would wander the halls of the facility frequently. He had exhibited increased physical aggression towards staff with 10 episodes noted in the past 14 days. Cognitive Screening: Brief Interview of Mental Status (BIMS) score remains 0 of 15. R61 was alert and oriented x1 (self only). Baseline confusion with impaired impulse control and memory. Responds with minimal verbal responses, mainly head nods and occasionally answered with yes or no; when asked questions, shakes head and states I don't know.Safety Screening: Patient denies suicidal ideation. Patient denies homicidal ideation. Currently on 1:1 for safety due to episodes of physical aggression (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	towards staff and peers. 10 episodes of physical aggression noted in past 14 days. R61 had become a danger to himself and others with multiple episodes of physical aggression. Resident #61 and Resident #95 Review of MI-FRI (Michigan Facility Reported Incident) #00064000 revealed resident to resident incident took place between R61 and R95 on 03/20/26, reported to the state on 03/20/26, 5 day follow up to the state on 03/30/26. According to the 24-hour MI-FRI report the incident occurred on 03/20/2026 at 12:20 p.m. Incident report revealed that staff heard yelling coming from a resident's room. Staff went into the resident's room and saw 95 holding R61 by arms. Staff separated residents. When asked by the nurse if he/R61 was hit by R95 stated, yes. R95 stated I was taking my trash to the cart and the weird guy hit me in the head with his walker. I did not hit him. He is always messing with me, and I do not like him. Staff interviews: LPN CC stated she was at the desk when CNA DD yelled that she needed help. RN EE and LPN CC went down to assess the situation. CNA DD had the residents separated. R95 stated he was going to hurt R61. LPN CC did not see R95 hit R61 LPN CC asked R61 if R95 hit him and he said, Yes. CNA DD was passing the dinner trays and was assisting a resident with dinner. CNA DD heard R95 yelling and cussing and went out and saw R95 holding R61 by the arms. CNA DD attempted to separate them and yelled for help. After separating R95 from R61, R61 lifted his walker straight up with it pointed at R95. R95 grabbed a hold of the walker by the wheels. CNA DD had to keep re-directing R61 away from R95. LPN CC asked R61 if he got hit and he said, Yes. R61 had a lump forming on his forehead and red marks above his eyebrows. R95 said that he was trying to put his tray in the cart when R61 came out and pushed him. RN EE heard CNA DD yell that she needed help. When she got there, CNA DD had the residents separated. R61 tried to flip R95 off. R95 stated he was going to beat R61's butt. According to the 24-hour MI-FRI report the incident occurred on 03/20/2026 at 6:33 p.m. Review of the facility 5-day investigation summary revealed the conclusion: The facility investigation concluded that while there were not independent witnesses, the event between the two residents occurred resulting in injury. Skin Assessment V4- dated 03/25/26, no documentation of lump on his forehead or red above his eyebrows on R61. During an interview on 06/26/2026 at 10:02 AM, LPN CC stated she was here during that particular incident, R61 has had multitude incidents, puts his hands into fist like he was going to punch someone. Stated R95 had walked past his room, R61 started to go after him, by the time she ran down R95 was in R61's doorway, R61 went out and hit/punch R95 in the chest. R61 was on the 100 hall, with him using his walker, if people were in his way, he would push through them and had falls. LPN CC stated other residents were falling because he push his way through. Stated she remember R95 telling R61 that I am fucking going to hit you. R61 can only say good, not good, hell, damn, doesn't remember his ever saying anything more than 1 word. R95 was moved to another room. During an interview on 06/26/2026 at 10:29 AM, DON B and NHA A were together in NHA A office together. NHA A stated she was notified by LPN CC who stated R61 had a lump on his forehead from R95 in a resident-to-resident incident. Placed R95 on a 1 to 1 supervision, neuro checks and R61 on 15min checks. LPN CC called provider and sent R61 out to hospital for evaluation of the lump on his forehead and marks above his right eyebrow. DON B stated she was going to educate nurses to do (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessments, open a new pain or skin assessment, they have to pull it over, does not show available without pulling it over. Stated put R95 on 1 on 1 supervision, R65 on 15 mins checks. Since R95 hit R61 and it was after the fact that R95 had a hold of R61's arm. R95 was on 1 on 1 from 03/20/26 to 04/16/26. R61 went 1 on 1 supervision on 05/10/26. DON B stated R61 was being aggressive with staff, so they started ongoing 1 on 1. DON B stated R61 and another gentleman had an altercation on the TV room. R61, moved to 200 hall, and had issues getting along with people in there, and they thought he could have more space to wander and burn off energy. DON B stated 100 hall to 300 hall R61 walked through the bathroom, and someone was using it and they were upset that R61 walked in on them. Resident #34 (R34) Review of the medical record revealed R34 was admitted to the facility on [DATE] with diagnosis that included Alzheimer's Disease, type 2 diabetes, hypertension, hyperlipidemia, stage 3 kidney disease, benign prostatic hyperplasia, atrial fibrillation, depression, dementia, osteoarthritis of right knee, and bilateral hearing loss. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04-18-2026, revealed R34 had a Brief Interview for Mental Status (BIMS) of 3 (severe cognitive impairment) out of 15. Resident #68 (R68) Review of the medical record revealed R68 was admitted to the facility 09/02/2025 with diagnoses that included stroke, hypertension, antiphospholipid syndrome (an autoimmune disorder that causes your immune system to produce abnormal antibodies), receptive-expressive language disorder (neurological condition that impairs your ability to understand or speak language), explosive disorder (mental health condition characterized by frequent, sudden outburst of impulsive anger or aggression), aphasia (difficulty swallowing), delusional order (mental illness where a person has fixed, false believed that are not rooted in reality), and anxiety. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/08/2026, revealed R68 had a Brief Interview for Mental Status (BIMS) of 11 (moderate cognitive impairment) out of 15. R68 was discharged from the facility 06/26/2026. Review of MI-FRI (Michigan Facility Reported Incident) #00063798 revealed R34 was in the main dining room eating his lunch in the back of the dining room. R68 was observed to approach R34. R68 was observed to close his fist and punch R34 under the right eye. Staff immediately separated the residents and R68 was taken back to his room and a 1:1 staff member was provided to R68. According to the 24 hour MI-FRI report the incident occurred on 03/05/2026 at 12:20 p.m. Review of the facility 5 day investigation summary revealed the conclusion: The facility acknowledges that physical incident occurred. Review of the facility summary revealed that the physical altercation between R34 and R68 had been witness by Certified Nurse Aide (CNA) P. Review of the facility incident report revealed R34 did not have any physical injury and pain scale was reported at 0 (no pain). During an interview on 06/25/2026 at 02:12 p.m. Nursing Home Administrator (NHA) A explained that a physical altercation had been witnessed between R34 and R68. NHA A explained that the R68 had (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been observed to punch R34 under his right eye. NHA A explained that she had concluded that the altercation had occurred but explained she had not substantiated abuse. When asked if punching someone would be defined as physical abuse NHA replied yes. NHA A could not explain why the altercation between R34 and R68 had not been substantiated as physical abuse. During an interview on 06/25/2026 at 02:20 p.m. Certified Nursing Aide (CNA) P explained that she had been passing lunch trays in the dining room on 03/05/2026. CNA P explained that while she was passing trays she had observed R68 pacing back and forth near R34. CNA P explained that she then witnessed R68 make a fist and cold cocked R34 in his face. CNA P was asked what cold cock meant and she explained that R68 punched R34 in the face and R34 had not seen it coming. CNA P explained that she yelled for R68 to stop and ran over and separated the residents. CNA P explained that R34 had made allegations that R68 had been stealing his cloths. CNA P explained that she had reported the allegation to NHA A prior to this altercation. During observation and interview on 06/26/2026 at 08:46 a.m. R34 was observed sitting up on the side of his bed. R34 was asked if he remembered an incident that occurred with another resident? R34 explained that the person who was stealing his clothes had just come up to him and punched him right under his right eye. R34 explained that the punch caused him pain. R34 explained that his pain level was a 10 (scale 1-10 :1 being least and 10 being most) at the time. R34 kept saying that he had told the facility staff that R68 had been stealing his clothes.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for three residents (R34, R68, R107) of six reviewed. Findings include: Resident # 107 (R107) A review of the clinical record revealed R107 was admitted into the facility on 9/26/25 with diagnoses that included: Bipolar disorder, adjustment disorder with mixed disturbance of emotions and conduct and depression. According to the Minimum Data Set (MDS) assessment dated [DATE], R107 scored 6/15 on the Brief Interview for Mental Status exam (which indicated severely impaired cognition). On 6/23/26 at 1:02 PM, R107 was observed sitting on his bed in his room. R107 reported that he kissed a staff member and that staff member kissed him back. He identified the staff member as CNA (certified nursing assistant) P and reported that facility staff are aware. R107 reported being fond of CNA P. A review of R107's Progress notes revealed the following: 6/24/26 1:51 pm Behavior Displayed: Per CNA statement, resident kept stating, you know I kissed you and you kissed me and you know I'm telling the truth. Resident was asked by the CNA to stop saying that, and resident continued to repeat it. CNA reported to writer after finishing the resident's roommate's VS (vital signs). Precipitating factors/events: UNK (unknown), Intervention(s) attempted: Redirection, Intervention results: Initially successful. Redirection will need to be done again, as resident has history of this behavior. Pharmacologic Intervention required: NA, Comments: Administrator and SW (social work) notified. 6/9/26 6:03 pm (R107) is a (age redacted) male with a complex medical and psychiatric history, residing in long-term care for supervision and management of behavioral disturbances. Over the past 72 hours, he has continued to make inappropriate sexual comments towards staff, with redirection proving ineffective. A review of R107's care plan revealed the following: (initiated on 9/29/25 and revised on 6/10/26) Resident at times attempts to show affection towards staff (i.e. trying to kiss on cheek and giving hugs); making sexual or suggestive comments regarding female staff (complimenting physical appearance, stating he wants staff to be his wife, or wants to shower with staff, etc). On 6/25/26 at 2:53 PM, during an interview with CNA P, she reported that R107 had stated that he was in love with her and tried to kiss her. CNA P reported that she told him no and re-directed him when it occurred earlier in her current shift. Additionally, CNA P reported that R107 had accused her of kissing him too. CNA P stated that she reported R107's behaviors to Unit Manager (UM) HH and that to her knowledge the allegations had not been investigated. On 6/26/26 at 9:57 AM, during a follow up interview with CNA P, she reported that about 1.5 weeks ago R107 tried to kiss her on the lips and she had reported it to UM HH at that time. CNA P stated that (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	UM HH told her to re-direct the resident and that other staff members were also aware of R107's allegations. On 6/26/26 at 11:47 AM, during an interview with UM HH, when asked if he was aware of any incidents or allegations about kissing staff involving R107, he reported that R107 likes to go around and try to kiss some of the aides (CNA's). UM HH further reported that CNA P had informed him that R107 had said she kissed him and CNA P denied the allegation. When asked what UM HH did with the information about staff being kissed or kissing R107, he reported that the facility physician had prescribed the resident a medication to help with hypersexuality. When asked if the facility administrator had been made aware, he reported that it was his understanding that she was aware. When asked if it should have been investigated as an allegation of abuse, he reported that he would assume so if the allegation was that a staff member kissed him. UM HH reported that he was made aware a month or two ago but couldn't recall the exact date. On 6/26/26 at 1:01 PM, during an interview with Nursing Home Administrator (NHA) A, she reported that staff had notified her that R107 had been attempting to kiss them, staff had updated his care plan and he had been on every 15 minute checks to ensure he didn't move on to other residents. Both NHA A and Director of Nursing B denied being aware that R107 had also reported that he had been kissed by a staff member. NHA A reported had she been made aware that R107 had alleged he had been kissed by staff an investigation would have been initiated. Interviews with staff and R107's progress notes indicated NHA A had been made aware that R107 alleged he had been kissed by a staff member, however, the allegation had not been reported or investigated. iResident #34 (R34) Review of the medical record revealed R34 was admitted to the facility 10/12/2025 with diagnoses that included Alzheimer's Disease, type 2 diabetes, hypertension, hyperlipidemia (high fat volume in blood), stage 3 kidney disease, benign prostatic hyperplasia (non-cancer enlarged prostate), atrial fibrillation, depression, dementia, osteoarthritis of right knee (joint pain caused by wearing of padding between joints), and bilateral hearing loss. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/18/2026, revealed R34 had a Brief Interview for Mental Status (BIMS) of 3 (severe cognitive impairment) out of 15. Resident #68 (R68) Review of the medical record revealed R68 was admitted to the facility 09/02/2025 with diagnoses that included stroke, hypertension, antiphospholipid syndrome (an autoimmune disorder that causes your immune system to produce abnormal antibodies), receptive-expressive language disorder (neurological condition that impairs your ability to understand or speak language), explosive disorder (mental health condition characterized by frequent, sudden outburst of impulsive anger or aggression), aphasia (difficulty swallowing), delusional order (mental illness where a person has fixed, false believed that are not rooted in reality), and anxiety. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/08/2026, revealed R68 had a Brief Interview for Mental Status (BIMS) of 11 (moderate cognitive impairment) out of 15. R68 was discharged from the facility 06/26/2026. Review of MI-FRI (Michigan Facility Reported Incident) #00063798 revealed R34 was in the main (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dining room eating his lunch in the back of the dining room. R68 was observed to approach R34. R68 was observed to close his fist and punch R34 under the right eye. Staff immediately separated the residents and R68 was taken back to his room and a 1:1 staff member was provided to R68. Review of the facility summary revealed that the physical altercation between R34 and R68 had been witness by Certified Nurse Aide (CNA) P. During an interview on 06/25/2026 at 02:20 p.m. Certified Nursing Aide (CNA) P explained that she had been passing lunch trays in the dining room on 03/05/2026. CNA P explained that while she was passing trays she had observed R68 pacing back and forth near R34. CNA P explained that she then witnessed R68 make a fist and cold cocked R34 in his face. CNA P was asked what cold cock meant and she explained that R68 punched R34 in the face and R34 had not seen it coming. CNA P explained that she yelled for R68 to stop and ran over and separated the residents. CNA P explained that R34 had made allegations that R68 had been stealing his cloths. CNA P explained that she had reported the allegation to NHA A prior to this altercation. During an interview on 06/25/2026 at 02:31 p.m. Nursing Home Administrator (NHA) A was asked if she had been made aware of the allegation that R68 had been stealing R34's clothing. NHA A explained that she had been made aware of the allegation during the investigation regarding the physical altercation between R34 and R68 that had occurred on 3/5/2026. NHA A explained that she had investigated the allegation. NHA A denied that she received the allegation prior to the resident-to-resident altercation that had occurred on 03/05/2026. When asked if the allegation of R68 stealing R34's clothing had been reported, NHA A explained that she had not reported the allegation to the appropriate state agency. NHA A could not explain why the allegation had not been report appropriate state agency. When asked for documentation regarding the investigation of R68 stealing R34's clothing NHA explained that she had not recorded any of the investigation. During observation and interview on 06/26/2026 at 08:46 a.m. R34 was observed sitting up on the side of his bed. R34 was asked if he remembered an incident that occurred with another resident? R34 explained that the person who was stealing his clothes had just come up to him and punched him right under his right eye. R34 explained that the punch caused him pain. R34 explained that his pain level was a 10 (scale 1-10 :1 being least and 10 being most) at the time. R34 kept saying that he had told the facility staff that R68 had been stealing his clothes. During an interview on 06/26/2026 at 09:21 a.m. Licensd Practical Nurse (LPN) S explained that R34 had been calling R68 a thief. LPN S could not recall if this had occurred before or after the altercation on 03/05/2026. LPN S explained that she had reported the allegation of R68 stealing R34's clothing to NHA A.		

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 06/26/2026
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to adequately investigate an allegation of neglect/abuse for two resident (#34, #107) of six residents reviewed for neglect/abuse. Findings Included: R107A review of the clinical record revealed R107 was admitted into the facility on 9/26/25 with diagnoses that included: Bipolar disorder, adjustment disorder with mixed disturbance of emotions and conduct and depression. According to the Minimum Data Set (MDS) assessment dated [DATE], R107 scored 6/15 on the Brief Interview for Mental Status exam (which indicated severely impaired cognition). On 6/23/26 at 1:02 PM, R107 was observed sitting on his bed in his room. R107 reported that he kissed a staff member and that staff member kissed him back. He identified the staff member as CNA (certified nursing assistant) P and reported that facility staff are aware. R107 reported being fond of CNA P. A review of R107's Progress notes revealed the following: 6/24/26 1:51 pm Behavior Displayed: Per CNA statement, resident kept stating, you know I kissed you and you kissed me and you know I'm telling the truth. Resident was asked by the CNA to stop saying that, and resident continued to repeat it. CNA reported to writer after finishing the resident's roommate's VS (vital signs). Precipitating factors/events: UNK (unknown), Intervention(s) attempted: Redirection, Intervention results: Initially successful. Redirection will need to be done again, as resident has history of this behavior. Pharmacologic Intervention required: NA, Comments: Administrator and SW (social work) notified. 6/9/26 6:03 pm (R107) is a (age redacted) male with a complex medical and psychiatric history, residing in long-term care for supervision and management of behavioral disturbances. Over the past 72 hours, he has continued to make inappropriate sexual comments towards staff, with redirection proving ineffective. A review of R107's care plan revealed the following: (initiated on 9/29/25 and revised on 6/10/26) Resident at times attempts to show affection towards staff (i.e. trying to kiss on cheek and giving hugs); making sexual or suggestive comments regarding female staff (complimenting physical appearance, stating he wants staff to be his wife, or wants to shower with staff, etc). On 6/25/26 at 2:53 PM, during an interview with CNA P, she reported that R107 had stated that he was in love with her and tried to kiss her. CNA P reported that she told him no and re-directed him when it occurred earlier in her current shift. Additionally, CNA P reported that R109 had accused her of kissing him too. CNA P stated that she reported R107's behaviors to Unit Manager (UM) HH and that to her knowledge the allegations had not been investigated. On 6/26/26 at 9:57 AM, during a follow up interview with CNA P, she reported that about 1.5 weeks ago R107 tried to kiss her on the lips and she had reported it to UM HH at that time. CNA P stated that UM HH told her to re-direct the resident and that other staff members were also aware of R107's allegations. On 6/26/26 at 11:47 AM, during an interview with UM HH, when asked if he was aware of any incidents or allegations about kissing staff involving R107, he reported that R107 likes to go around and try to kiss some of the aides (CNA's). UM HH further reported that CNA P had informed him that R107 had said she kissed him and CNA P denied the allegation. When asked what UM HH did with the information about staff being kissed or kissing R107, he reported that the facility physician (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had prescribed the resident a medication to help with hypersexuality. When asked if the facility administrator had been made aware, he reported that it was his understanding that she was aware. When asked if it should have been investigated as an allegation of abuse, he reported that he would assume so if the allegation was that a staff member kissed him. UM HH reported that he was made aware a month or two ago but couldn't recall the exact date. On 6/26/26 at 1:01 PM, during an interview with Nursing Home Administrator (NHA) A, she reported that staff had notified her that R107 had been attempting to kiss them, staff had updated his care plan and he had been on every 15 minute checks to ensure he didn't move on to other residents. Both NHA A and Director of Nursing B denied being aware that R107 had also reported that he had been kissed by a staff member. NHA A reported had she been made aware that R107 had alleged he had been kissed by staff an investigation would have been initiated. Interviews with staff and R107's progress notes indicate NHA A was aware that R107 alleged he had been kissed by a staff member, however, the allegation had not been investigated. Resident #34 (R34) Review of the medical record revealed R34 was admitted to the facility 10/12/2025 with diagnoses that included Alzheimer's Disease, type 2 diabetes, hypertension, hyperlipidemia (high fat volume in blood), stage 3 kidney disease, benign prostatic hyperplasia (non-cancer enlarged prostate), atrial fibrillation, depression, dementia, osteoarthritis of right knee (joint pain caused by wearing of padding between joints), and bilateral hearing loss. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/18/2026, revealed R34 had a Brief Interview for Mental Status (BIMS) of 3 (severe cognitive impairment) out of 15. Resident #68 (R68) Review of the medical record revealed R68 was admitted to the facility 09/02/2025 with diagnoses that included stroke, hypertension, antiphospholipid syndrome (an autoimmune disorder that causes your immune system to produce abnormal antibodies), receptive-expressive language disorder (neurological condition that impairs your ability to understand or speak language), explosive disorder (mental health condition characterized by frequent, sudden outburst of impulsive anger or aggression), aphasia (difficulty swallowing), delusional order (mental illness where a person has fixed, false believed that are not rooted in reality), and anxiety. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/08/2026, revealed R68 had a Brief Interview for Mental Status (BIMS) of 11 (moderate cognitive impairment) out of 15. R68 was discharged from the facility 06/26/2026. Review of MI-FRI (Michigan Facility Reported Incident) #00063798 revealed R34 was in the main dining room eating his lunch in the back of the dining room. R68 was observed to approach R34. R68 was observed to close his fist and punch R34 under the right eye. Staff immediately separated the residents and R68 was taken back to his room and a 1:1 staff member was provided to R68. Review of the facility summary revealed that the physical altercation between R34 and R68 had been witness by Certified Nurse Aide (CNA) P. During an interview on 06/25/2026 at 02:20 p.m. Certified Nursing Aide (CNA) P explained that she had been passing lunch trays in the dining room on 03/05/2026. CNA P explained that while she was (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	passing trays she had observed R68 pacing back and forth near R34. CNA P explained that she then witnessed R68 make a fist and cold cocked R34 in his face. CNA P was asked what cold cock meant and she explained that R68 punched R34 in the face and R34 had not seen it coming. CNA P explained that she yelled for R68 to stop and ran over and separated the residents. CNA P explained that R34 had made allegations that R68 had been stealing his cloths. CNA P explained that she had reported the allegation to NHA A prior to this altercation. During an interview on 06/25/2026 at 02:31 p.m. Nursing Home Administrator (NHA) A was asked if she had been made aware of the allegation that R68 had been stealing R34's clothing. NHA A explained that she had been made aware of the allegation during the investigation regarding the physical altercation between R34 and R68 that had occurred on 3/5/2026. NHA A explained that she had investigated the allegation. NHA A denied that she received the allegation prior to the resident-to-resident altercation that had occurred on 03/05/2026. When asked if the allegation of R68 stealing R34's clothing had been reported, NHA A explained that she had not reported the allegation to the appropriate state agency. NHA A could not explain why the allegation had not been report appropriate state agency. When asked for documentation regarding the investigation of R68 stealing R34's clothing NHA explained that she had not recorded any of the investigation. During observation and interview on 06/26/2026 at 08:46 a.m. R34 was observed sitting up on the side of his bed. R34 was asked if he remembered an incident that occurred with another resident? R34 explained that the person who was stealing his clothes had just come up to him and punched him right under his right eye. R34 explained that the punch caused him pain. R34 explained that his pain level was a 10 (scale 1-10 :1 being least and 10 being most) at the time. R34 kept saying that he had told the facility staff that R68 had been stealing his clothes.		