STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235038	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Grand Rapids	2000 Leonard NE Grand Rapids, MI 49505

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 0578 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2718302.Based on interview and record review the facility failed to obtain and put into place an advance directive (legal documents that provide instructions for medical care to ensure healthcare preferences are honored) in a timely manner and failed to honor the residents do not resuscitate (DNR) order for 1 (Resident #1) of 8 residents reviewed for advanced directives resulting in a resident who did not want life sustaining services to endure painful lifesaving activities that included cardiopulmonary resuscitation (CPR), receiving automated external defibrillation (AED; delivers electric shock to attempt to restore normal heart rhythm), and insertion of an intraosseous venous access (inserting a specialize needle into the bone marrow cavity to provide immediate vascular (bloodstream) access) of the tibia (shinbone).Findings include:Review of Resident #1's census page indicated Resident #1 was admitted to the facility on [DATE] on hospice services with a diagnosis of Atherosclerotic Heart Disease of Native Coronary Artery (condition of plaque buildup) With Unstable Angina Pectoris (chest pain)).Review of Resident #1's level of care determination assessment, dated [DATE], noted Resident #1's cognitive skills were Independent: The applicant's decisions were consistent and reasonable.the applicant organized daily routine and made decisions in a consistent, reasonable, and organized fashion.Review of Resident #1's facility's DNR (do not resuscitate form) form, dated [DATE], stated, .I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me.Being of sound mind, I voluntarily execute this order, and I understand its full Import. This form was signed and dated by Resident #1 and two witnesses on [DATE]. The physician signature was noted to be on [DATE].Review of Resident #1's physician orders, print date [DATE], included an order of FULL CODE that was started on [DATE] with an end date of [DATE].This order was not updated to Do Not Resuscitate upon receipt of Resident #1's signed and completed DNR form received by the facility on [DATE].During an interview on [DATE] at 1:43 PM, Director of Nursing (DON) B reported Resident #1 was admitted to the facility on [DATE] and the facility discovered they didn't have any consent forms which included advanced directives and the DNR form during an admission audit on [DATE], and confirmed this indicated the DNR form had not been completed on day 1 of admission with Resident #1. DON B reported on [DATE] she got Licensed Practical Nurse (LPN) F to work with Resident #1 to sign consents (which included the DNR form) and Resident #1 was her own person (responsible for herself; no power of attorney or guardian). DON B reported Resident #1's DNR form was completed with herself (DON B), Resident #1, and LPN F on [DATE] and as soon as it was signed she emailed the DNR form to Medical Doctor/Medical Director K to have it signed/finalized by a doctor. DON B confirmed the DNR form signed and emailed back to the facility from the physician on [DATE] at 3:37 PM was not received by anyone at the facility before the code event at approximately 10:30 PM on [DATE]. DON B confirmed the returned signed DNR form for Resident #1 came back to her own individual email inbox, she was (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 0578 Level of Harm - Actual harm Residents Affected - Few	the only one who had access to this inbox, she wasn't working on [DATE], and therefore she didn't check the inbox to be able to receive the signed and completed DNR for Resident #1. DON B confirmed Resident #1's DNR status wasn't updated in the resident record prior to the code event. DON B reported LPN G found Resident #1 unresponsive and checked the code status order in her physician's orders which indicated full code as it hadn't been updated to show the DNR order. DON B reported the DNR form should have been completed with Resident #1 on day 1 ([DATE]) of admission.On [DATE] at 2:15 PM, LPN G was attempted to be contacted, but no response was received before the end of survey.During an interview on [DATE] at 8:24 AM, Resident #1's Family Member I confirmed she was present onsite at the facility with Resident #1 on day 1 of admission; [DATE]. Family Member I confirmed Resident #1 was her own responsible party and completed facility DNR paperwork (to show her wishes to be a DNR) and returned it to the nurse doing the admission paperwork. Family Member I reported on [DATE] she was on the phone talking with Resident #1 when Resident #1 was asking why she was having to refill out DNR paperwork again at the facility. Family Member I confirmed hospice had sent the facility preadmission screening documents on [DATE] that indicated Resident #1 desired to be a do not resuscitate. Family Member I expressed concern that Resident #1's advanced directives and end of life care were not honored, her body was subjected to life saving measures and voiced concern that it could happen to someone else at the facility.Review of Resident #1's #2204 Code Blue (alert signaling someone is experiencing a life-threatening medical emergency) document, dated [DATE], stated, .At around 10:30pm when the nurse (LPN G) was doing her rounds she observed resident lying on the bathroom floor, face down. The nurse called resident's name and resident did not respond. The nurse tried to find a pulse on resident's neck but could not feel a pulse. The nurse yelled to the CNA (Certified Nurse Aide M) to grab the other nurse (Registered Nurse O) and this nurse verified code status and started CPR immediately. Crash cart and AED machine were brought by CNA and other nurse. EMS (emergency medical services) was called around 10:35 PM while CPR continued for resident. When EMS arrived, they started CPR immediately. EMS performed CPR x (for) 30 minutes and were unsuccessful in retrieving a pulse.pronounced resident deceased at 2316 (11:16 PM).Statements.Staff (LPN G).This nurse checked the code status, and it reads FULL CODE and CPR Started.Review of Resident #1's emergency medical services call sheet, dated [DATE], stated, Complaint Type.Cardiac arrest.Duration of Complaint.20 Minutes.Date/Time of Symptom Onset: [DATE] 22:36:00 (10:36 PM).Primary Symptom: Cardiac arrest .The pt (patient) was in a nursing home.She had just been signed up with hospice and they were still working on getting DNR paperwork set up. Staff stated the paperwork was started but not signed.They (facility staff) started CPR and called 911. They also placed the pt (patient) on an AED.The fire department stated they arrived at 2238 (10:38 PM) and took over CPR for nursing home staff.They placed an I-GEL (airway device) and ventilated the pt with high flow oxygen. Once the I-GEL was placed they switched from 30:2 CPR (give two breaths after every 30 chest compressions) to continuous CPR.The paramedic started administering EPI (epinephrine) every 3-5 min, and he started the pt on fluids (intravenous therapy).EMS defibrillated and immediately continued CPR.called TOD (time of death) at 23:16 (11:16 PM).Resuscitation Attempted by EMS: Defibrillation (electrical shock to heart in an attempt to restore normal heartbeat); Ventilation (moving air into and out of the lungs); Chest Compressions (lifesaving manual technique used in CPR to restore blood circulation during cardiac arrest).XXX[DATE] 22:47:00.Procedure.Venous Access - Intraosseous (IO; inserting a specialized needle into the bone marrow cavity to provide vascular access).Vascular Access Location .IO-Tibia (shin bone)-Left.IV(intravenous; within a vein) Flushed Easily.Yes.Review of Resident #1's Quality Assurance Form, dated [DATE], stated, .Communicated by: Family/RP (responsible party) .Name: (Resident #1) .Details: Resident recently (continued on next page)

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F 0578 Level of Harm - Actual harm Residents Affected - Few	admitted 12/22 (2025). Code status not completed prior to resident coding. CPR performed on resident .Findings: DNR (do not resuscitate) paperwork not complete at time of code. Code done, resident was supposed to be DNR.Reporter Satisfied.No.Describe: Family still very upset that loved one had to go through a code .Review of the facility's Do Not Resuscitate Order policy, reviewed/revised date [DATE], stated, .A Do Not Resuscitate (DNR) order form must be completed and signed by the Attending Physician and resident.placed in the front of the resident's medical record and scanned into the electronic medical record.Review of the facility's Residents' Rights Regarding Treatment and Advance Directives policy, reviewed/revised date [DATE], stated, .It is the policy of this facility to support and facilitate a resident's rights to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive.On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive.Review of the facility's Admissions to the Facility policy, reviewed/revised date [DATE], stated, .Prior to or at the time of admission, the resident's Attending Physician must provide the facility with information needed for the immediate care of the resident, including orders covering at least:.Care orders to maintain or improve the resident's function until the physician and care planning team can conduct a comprehensive assessment.Assure that the facility receives appropriate medical records.prior to or upon the resident's admission.Applying the reasonable person concept, one who wished to be do not resuscitate would not want CPR performed to save their life. These lifesaving acts would be in direct contradiction of medical care and life wishes and would have both physical and psychosocial harm as possible outcomes.Review of the Facility Past Non-compliance Checklist, dated [DATE], stated, Was the resident injured? Resident expired (passed away) .Description of deficient practice (why and how did it happen): Resident admitted without proper code status paperwork completed by admission nurse. DON (Director of Nursing) completed appropriate paperwork with resident. Paperwork was sent to Medical Director for signature on [DATE]. DON was out of facility for holiday weekend, signed code status was sent back to DON's email. Resident coded prior to code status being entered into the medical record. Plan of Correction: In-depth analysis of how the deficiency occurred: (RCA (root cause analysis)) Staff did not obtain and complete code status documentation paperwork with resident upon admission.Review of a One-on-one in-service record pertaining to Resident #1, dated [DATE], stated, Employee Name: (Director of Nursing B) . Inservice Topic/Title: DNR/Code Status. If emailing code status info (information) for physician signature, ensure you are frequently checking email for completed documents to avoid any delay in care.Please see F678 for additional information.During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: 1. Identification of residents affected or likely to be affected:-Blanket audit completed for 50/50 facility residents on [DATE] to ensure medical record accurately reflects residents code status and a signed copy of advanced directive has been uploaded into PCC (electronic health record). There were no noted concerns or required corrections at this time.2. Actions to prevent occurrence/Reoccurrence -CPR and Advanced Directive policy reviewed by NHA and DON on [DATE] and remains appropriate. The social service director audited all residents in the facility 50/50 to ensure proper code status were in place. 50/50 residents reviewed on [DATE] to ensure medical record accurately reflects residents code status and a signed copy of advanced directive has been uploaded into PCC and no changes required at that time. Additionally, The DON completed a separate Audit on last 14 days of admissions on [DATE] to ensure proper code status in place for all new admissions during this timeframe, this was completed as an additional audit as the resident noted in the PNC (past non-compliance) was a new admission to the facility in the past (continued on next page)

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F 0578 Level of Harm - Actual harm Residents Affected - Few	14-day timeframe. On the audit looking at the last 14 days of admissions completed by the DON 7/50 residents were reviewed on this audit on [DATE], there were no discrepancies noted and no corrections made.-Additionally, the admission policy was reviewed [DATE] and deemed appropriate.-All Licensed Nurses 22/22 educated on [DATE]. 18/22 educated in person face to face, 4 educated verbally via phone on completing advanced directives paperwork on admission with designated responsible party and notifying physician to obtain orders and place into PCC.-Process: Nurse educated on [DATE] that they will meet with resident/Responsible party immediately upon admission to address code status wishes. Appropriate paperwork will be completed addressing residents' wishes and immediately communicated to the physician to obtain orders to be placed in PCC.-The new facility process for immediate action regarding code status is that the admitting nurse will fax the document to a preprogramed number on the facility fax machine that transmits the document to the provider email and the document can be signed and returned via provider phone to facility fax. Nurses will also contact provider via phone to ensure they are aware of the incoming document. This process was initiated, educated and in place by the DOC for the PNC [DATE]-Audits started on [DATE] and will be completed by DON weekly x 12 weeks to ensure any new admissions code status documentation is obtained and completed by admitting nurse and facility procedure and policy is being followed. Audits will continue until the QAPI committee deems facility has achieved substantial compliance.The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2718302.Based on interview and record review the facility failed to honor a residents choice for do not resuscitate (DNR; no CPR to be performed) and ensure cardiopulmonary resuscitation (CPR) was not performed on a resident who was a DNR in 1 (Resident #1) of 8 residents reviewed for CPR, resulting in Resident #1 being subjected to dehumanization and unavoidable pain when facility staff initiated CPR and contacted Emergency Medical Services (EMS) and then performed unwanted life sustaining efforts (cardiopulmonary resuscitation (CPR), automated external defibrillation (AED; delivers electric shock to attempt to restore normal heart rhythm), and insertion of an intraosseous venous access (inserting a specialized needle into the bone marrow cavity to provide immediate vascular (bloodstream) access) of the tibia (shinbone)) causing the likelihood for serious psychosocial and bodily harm. Findings include:The Immediate Jeopardy began on [DATE] when the facility failed to honor Resident #1's do not resuscitate order and subjected the resident to CPR, automated external defibrillation, and insertion of an intraosseous venous access against her wishes. Nursing Home Administrator A was notified of the Immediate Jeopardy on [DATE] at 12:23 PM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed, and the deficient practice corrected on [DATE], prior to the start of the survey and was therefore past noncompliance.Review of Resident #1's census page indicated Resident #1 was admitted to the facility on [DATE] on hospice services with a diagnosis of Atherosclerotic Heart Disease of Native Coronary Artery (condition of plaque buildup) With Unstable Angina Pectoris(chest pain)).During an interview on [DATE] at 10:13 AM, when discussing Resident #1 having a medical code event (life threatening emergency) on [DATE], Nursing Home Administrator (NHA) A confirmed Resident #1's do not resuscitate (DNR) order had not been signed by a physician and/or received back from the physician before the code ([DATE] at approximately 10:35 PM), the facility was aware of the resident's wishes for DNR but they provided CPR as they hadn't received the DNR order signed by the physician yet, and it had not been updated to DNR to reflect Resident #1's wishes. Review of Resident #1's #2204 Code Blue (alert signaling someone is experiencing a life-threatening medical emergency) document, dated [DATE], stated, .At around 10:30pm when the nurse (Licensed Practical Nurse (LPN) G) was doing her rounds she observed resident lying on the bathroom floor, face down. The nurse called resident's name and resident did not respond. The nurse tried to find a pulse on resident's neck but could not feel a pulse. The nurse yelled to the CNA (certified nurse aide M) to grab the other nurse (Registered Nurse O) and this nurse verified code status and started CPR (cardiopulmonary resuscitation) immediately. Crash cart and AED (automated external defibrillator; can deliver electric shock to restore normal heartbeat) machine were brought by CNA and other nurse. EMS (emergency medical services) was called around 10:35 PM while CPR continued for resident. When EMS arrived, they started CPR immediately. EMS performed CPR x (for) 30 minutes and were unsuccessful in retrieving a pulse.pronounced resident deceased at 2316 (11:16 PM) .Statements.Staff (LPN G) .This nurse checked the code status, and it reads FULL CODE and CPR Started.Review of Resident #1's emergency medical services call sheet, dated [DATE], stated, Complaint Type.Cardiac arrest.Duration of Complaint.20 Minutes.Date/Time of Symptom Onset: [DATE] 22:36:00 (10:36 PM).Primary Symptom: Cardiac arrest .The pt (patient) was in a nursing home.She had just been signed up with hospice and they were still working on getting DNR paperwork set up. Staff stated the paperwork was started but not signed.They (facility staff) started CPR and called 911. They also placed the pt (patient) on an AED (automated external defibrillator) .The fire department stated they arrived at 2238 (10:38 PM) and took over CPR (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(cardiopulmonary resuscitation) for nursing home staff.They placed an I-GEL (airway device), and ventilated the pt with high flow oxygen. Once the I-GEL was placed they switched from 30:2 CPR (give two breaths after every 30 chest compressions) to continuous CPR.The paramedic started administering EPI (epinephrine) every 3-5 min, and he started the pt on fluids (intravenous therapy).EMS defibrillated and immediately continued CPR.called TOD (time of death) at 23:16 (11:16 PM).Resuscitation Attempted by EMS: Defibrillation (electrical shock to heart in an attempt to restore normal heartbeat); Ventilation (moving air into and out of the lungs); Chest Compressions (lifesaving manual technique used in CPR to restore blood circulation during cardiac arrest).XXX[DATE] 22:47:00.Procedure.Venous Access - Intraosseous (IO; inserting a specialized needle into the bone marrow cavity to provide vascular access).Vascular Access Location .IO-Tibia (shin bone)-Left.IV(intravenous; within a vein) Flushed Easily.Yes.Review of Resident #1's Quality Assurance Form, dated [DATE], stated, .Communicated by: Family/RP (responsible party) .Name: (Resident #1) .Details: Resident recently admitted 12/22 (2025). Code status not completed prior to resident coding. CPR performed on resident .Findings: DNR (do not resuscitate) paperwork not complete at time of code. Code done, resident was supposed to be DNR.Reporter Satisfied.No.Describe: Family still very upset that loved one had to go through a code .Review of Resident #1's level of care determination assessment, dated [DATE], noted Resident #1's cognitive skills were Independent: The applicant's decisions were consistent and reasonable.the applicant organized daily routine and made decisions in a consistent, reasonable, and organized fashion.Review of Resident #1's facility's DNR (do not resuscitate form) form, dated [DATE], stated, .I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me.Being of sound mind, I voluntarily execute this order, and I understand its full Import. This form was signed and dated by Resident #1 and two witnesses on [DATE]. The physician signature was noted to be on [DATE]. The DNR order was received by the facility signed and completed approximately 7 hours before Resident #1 experienced a code event but was never updated in the resident's record.Review of Resident #1's physician orders, print date [DATE], included an order of FULL CODE that was started on [DATE] with an end date of [DATE]. This order was never updated to Do Not Resuscitate upon receipt of Resident #1's signed and completed DNR form on [DATE].During an interview on [DATE] at 1:43 PM, Director of Nursing (DON) B reported Resident #1 was admitted to the facility on [DATE] and the facility discovered they didn't have any consent forms which included advanced directives and the DNR form during an admission audit on [DATE], and confirmed this indicated the DNR form had not been completed on day 1 of admission with Resident #1. DON B reported normal routine was to use an audit tool the day after admission to ensure specific things were completed, such as the DNR form. DON B confirmed the facility could not find the consent forms or the DNR form by the end of the day on [DATE]. DON B reported on [DATE] she got Licensed Practical Nurse (LPN) F to work with Resident #1 to sign consents (which included the DNR form) and Resident #1 was her own person (responsible for herself; no power of attorney or guardian). DON B reported Resident #1's DNR form was completed with herself (DON B), Resident #1, and LPN F on [DATE] and as soon as it was signed, she emailed the DNR form to Medical Doctor/Medical Director K to have it signed/finalized by a doctor. DON B confirmed the DNR form signed and emailed back to the facility from the physician on [DATE] at 3:37 PM was not received by anyone at the facility before the code event at approximately 10:30 PM on [DATE]. DON B confirmed the returned signed DNR form for Resident #1 came back to her own individual email inbox, she was the only one who had access to this inbox, she wasn't working on [DATE], and therefore she didn't check the inbox to be able to receive the signed and completed DNR for Resident #1. DON B confirmed Resident #1's DNR status wasn't updated in the resident record prior to the code event. DON B (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reported LPN G found Resident #1 unresponsive and checked the code status order in her physician's orders which indicated full code as it hadn't been updated to show the DNR order. DON B reported it is the facility and the corporate policy that the DNR must be signed by the physician before being changed in the system (physician's orders). DON B reported the DNR form should have been completed with Resident #1 on day 1 ([DATE]) of admission. DON B reported the DNR form should be completed on day 1 or day 2 and confirmed this didn't' happen for Resident #1's admission.On [DATE] at 2:15 PM, LPN G was attempted to be contacted, but no response was received before the end of survey.During an interview on [DATE] at 2:27 PM, Resident #1's Family Member J confirmed Resident #1 completed a DNR form and returned it to the facility on the day she admitted to the facility, [DATE]. Family Member J confirmed a completed DNR form signed by Resident #1 was returned to the facility and given to the nurse on duty. Family Member J reported Resident #1 was on hospice services prior to and upon entering the facility, Resident #1 did not want CPR but rather wanted to be a do not resuscitate, and confirmed Resident #1 would have never wanted her body to be subjected to CPR and/or other life sustaining measures. Family Member J reported he was unhappy that Resident #1's wishes were not honored and didn't want this situation to occur to anyone else at the facility.During an interview and record review on [DATE] at 2:55 PM, Regional Registered Nurse (RRN) N confirmed completing and updating Resident #1's advanced directive (DNR code status) was not completed timely. RRN N confirmed it was an issue of timeliness, and it shouldn't have taken until [DATE] to receive Resident #1's completed (physician signed) DNR form. When asked if Resident #1's hospice team had sent over a DNR order or documentation addressing advanced directive/code status to the facility, RRN N reported there were documents in Resident #1's electronic medical record that were from Resident #1's hospice company that were received and put into the medical record prior to her [DATE] admission. These documents reviewed were titled (Resident #1) REF (1).pdf (file format) Pre-admission Documentation and (Resident #1) REF cont. (continued) (1).pdf Pre-admission Documentation, both with an uploaded date of [DATE]. These hospice documents were reviewed briefly with RRN N and RRN N confirmed the documents included a form that displayed verbiage that stated, DO NOT RESUSCITATE. During an interview on [DATE] at 4:15 PM, DON B reported Admissions staff L or LPN N would have been the staff member responsible to complete the DNR form/advanced directives form with Resident #1 on [DATE]. DON B could not confirm if staff forgot to complete the DNR form with Resident #1 on admission or if the form was completed and then lost. DON B confirmed the facility was unable to find any advanced directive/DNR forms on [DATE] for Resident #1, the staff didn't begin working on the DNR form again until [DATE], and it wasn't completed and signed by a physician until [DATE].During an interview on [DATE] at 4:28 PM, LPN N reported she remembered Resident #1 vaguely and doing her admission paperwork. LPN N reported any paperwork including a DNR form from Resident #1 she would have put in the doctor's book to be signed. LPN N reported she wasn't sure if Resident #1 completed a DNR form on [DATE] (day of Resident #1's admission) but thought she initiated the DNR form with Resident #1. LPN N reported she remembered Resident #1 was accompanied by Family Member I on the day of her admission. Any advanced directive/DNR Forms from the doctor's book were requested from Nursing Home Administrator A on [DATE] at 4:34 PM. No documents were provided back by the end of survey that showed LPN N had placed DNR forms for Resident #1 in the physician's book.During an interview on [DATE] at 8:24 AM, Resident #1's Family Member I confirmed she was present onsite at the facility with Resident #1 on day 1 of admission; [DATE]. Family Member I confirmed Resident #1 was her own responsible party and completed facility DNR paperwork (to show her wishes to be a DNR) and returned it to the nurse doing the admission paperwork. Family Member I reported on [DATE] she was on the phone talking with Resident #1 when Resident #1 was asking (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	why she was having to refill out DNR paperwork again at the facility. Family Member I confirmed hospice had sent the facility preadmission screening documents on [DATE] that indicated Resident #1 desired to be a do not resuscitate. Family Member I reported she visited Resident #1 approximately 3 hours after she passed away and Resident #1 had an airway device in her throat (a supraglottic airway device; provide a secure airway), IV (intravenous) catheter drilled into her shin, and showed burn marks from the use of automated external defibrillation (AED; delivers electric shock to attempt to restore normal heart rhythm). Family Member I expressed concern that Resident #1's advanced directives and end of life care were not honored, her body was subjected to life saving measures and voiced concern that it could happen to someone else at the facility.During an interview on [DATE] at 8:49 AM, DON B confirmed consent forms which included advanced directive/code status (DNR) were supposed to be completed on day 1 (Resident #1 was admitted on [DATE]), but not later than day 2 of admission (This would have been [DATE] for Resident #1). When asked why Resident #1's DNR wasn't completed until [DATE] when the facility found it wasn't completed on [DATE] DON B reported they were still looking for the missing DNR form. DON B confirmed the original DNR forms/consents were never found. DON B reported Admissions staff L would have been the staff that reviewed the hospice preadmission documentation that was faxed to the facility on [DATE].During an interview on [DATE] at 10:10 AM, Admissions staff L confirmed Resident #1 was admitted to the facility on [DATE] at 4:29 PM from the community. Admissions staff L reported advanced directive forms should be completed with the resident on day 1 of admission. Admissions staff L reported she gave the admission documents which included advanced directive/DNR forms to nursing staff to complete with Resident #1 on [DATE]. Admissions staff L reported when she returned to Resident #1's room on [DATE] she observed Licensed Practical Nurse F completing a DNR form with Resident #1. Admissions staff L confirmed it was unusual for the DNR form to be completed with a newly admitted resident on the third day after admission as it was usually completed on day 1 of admissionReview of Resident #1's progress note, dated [DATE], stated, .Resident arrived at facility at 1630 (4:30 PM). Daughter-in-law in attendance. Admitting diagnosis is lung cancer. Resident is also patient of [Hospice Company Name] .Review of Resident #1's hospice care plan, initiated date [DATE], stated, Resident has a terminal prognosis with [Hospice Company Name] related to end of life diagnosis Lung Cancer.Goal.Resident's end-of-life wishes will be honored through next review.Review of Resident #1's pre-admission hospice documentation, fax (from hospice company to long term care facility) date of [DATE] and uploaded into electronic medical record date of [DATE], stated, Care Type.HOSPICE.Clinical Info (information).Type.DO NOT RESUSCITATE.Location.CHART.Diagnoses.HEART DISEASE.HRT FAIL (heart failure).PERSONAL HISTORY OF MALIGNANT NEOPLASM OF BRONCHUS (passage in respiratory tract) AND LUNG.Review of the Facility Past Non-compliance Checklist, dated [DATE], stated, Was the resident injured? Resident expired (passed away) .Description of deficient practice (why and how did it happen): Resident admitted without proper code status paperwork completed by admission nurse. DON (Director of Nursing) completed appropriate paperwork with resident. Paperwork was sent to Medical Director for signature on [DATE]. DON was out of facility for holiday weekend, signed code status was sent back to DON's email. Resident coded prior to code status being entered into the medical record. Plan of Correction: In-depth analysis of how the deficiency occurred: (RCA (root cause analysis)) Staff did not obtain and complete code status documentation paperwork with resident upon admission.Review of a One-on-one in-service record pertaining to Resident #1, dated [DATE], stated, Employee Name: (Director of Nursing B).Inservice Topic/Title: DNR/Code Status.If emailing code status info (information) for physician signature ensure you are frequently checking email for completed documents to avoid any delay in care.Review of the facility's Do Not Resuscitate Order (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235038	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Grand Rapids	2000 Leonard NE Grand Rapids, MI 49505

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	policy, reviewed/revised date [DATE], stated, .A Do Not Resuscitate (DNR) order form must be completed and signed by the Attending Physician and resident.placed in the front of the resident's medical record and scanned into the electronic medical record.Review of the facility's Residents' Rights Regarding Treatment and Advance Directives policy, reviewed/revised date [DATE], stated, .It is the policy of this facility to support and facilitate a resident's rights to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive.On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive.Review of the facility's Cardiopulmonary Resuscitation (CPR) & Basic Life Support (BLS) policy, reviewed/revised date [DATE], stated, .Do Not Resuscitate (DNR) Order refers to a medical order issued by a physician.that directs healthcare providers not to administer CPR in the event of cardiac or respiratory arrest.If a resident experiences a cardiac arrest or respiratory arrest and the resident does not show obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition)., facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services.in accordance with the resident's advance directives .In the absence of advance directives or a DNR order.Review of the facility's Admissions to the Facility policy, reviewed/revised date [DATE], stated, .Prior to or at the time of admission, the resident's Attending Physician must provide the facility with information needed for the immediate care of the resident, including orders covering at least:.Care orders to maintain or improve the resident's function until the physician and care planning team can conduct a comprehensive assessment.Assure that the facility receives appropriate medical records.prior to or upon the resident's admission.Applying the reasonable person concept, one who wished to be do not resuscitate would not want CPR performed to save their life. These lifesaving acts would be in direct contradiction of medical care and life wishes and would have both physical and psychosocial harm.The Immediate Jeopardy that began on [DATE] was removed and the deficient practice corrected on [DATE] when the facility took the following actions to remove the Immediacy and correct the noncompliance: 1. Identification of residents affected or likely to be affected: -Blanket audit completed for 50/50 facility residents on [DATE] to ensure medical record accurately reflects residents code status and a signed copy of advanced directive has been uploaded into PCC (electronic health record). There were no noted concerns or required corrections at this time.2. Actions to prevent occurrence/Reoccurrence:-CPR and Advanced Directive policy reviewed by NHA and DON on [DATE] and remains appropriate. The social service director audited all residents in the facility 50/50 to ensure proper code status were in place. 50/50 residents reviewed on [DATE] to ensure medical record accurately reflects residents code status and a signed copy of advanced directive has been uploaded into PCC and no changes required at that time. Additionally, The DON completed a separate Audit on last 14 days of admissions on [DATE] to ensure proper code status in place for all new admissions during this timeframe, this was completed as an additional audit as the resident noted in the PNC (past non-compliance) was a new admission to the facility in the past 14-day timeframe. On the audit looking at the last 14 days of admissions completed by the DON 7/50 residents were reviewed on this audit on [DATE], there were no discrepancies noted and no corrections made.-Additionally, the admission policy was reviewed [DATE] and deemed appropriate.-All Licensed Nurses 22/22 educated on [DATE]. 18/22 educated in person face to face, 4 educated verbally via phone on completing advanced directives paperwork on admission with designated responsible party and notifying physician to obtain orders and place into PCC.-Process: Nurse educated on [DATE] that they will meet with resident/Responsible party immediately upon admission to address code status wishes. Appropriate paperwork will (continued on next page)

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