STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235283	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of East Lansing	1843 N Hagadorn Road East Lansing, MI 48823

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to effectively maintain the physical plant effecting 69 residents resulting in the increased likelihood for cross-contamination and bacterial harborage.Findings include:On 01/07/2026 at 3:44 P.M., The restroom commode drain, located in resident room [ROOM NUMBER], was observed partially obstructed. The commode basin water level was also observed slowly receding and refilling upon flushing. An interview was conducted with Resident #39 regarding the slow flushing restroom commode. Resident #39 stated: The toilet has been clogging since I arrived last August. Resident #39 also stated: Maintenance has been here, but the toilet continues to clog. On 01/07/2026 at 3:52 P.M., The restroom commode seat, located in resident room [ROOM NUMBER], was observed severely loose-to-mount. The commode seat could be moved from side-to-side approximately 12-18 inches. An interview was conducted with Resident #82 regarding the loose commode seat. Resident #82 stated: The seat has pinched my skin more than once. Resident #82 also stated: I hope I don't fall off of the seat before they fix it. On 01/07/2026 at 4:00 P.M., An interview was conducted with Director of Maintenance (DOM) O regarding the facility maintenance work order system. (DOM) O stated: We have the TELS software system. On 01/07/2026 at 4:05 P.M., An interview was conducted with Director of Maintenance (DOM) O regarding Resident #39 's clogged restroom commode drain. (DOM) O stated: I will have to contact our rodding vendor. On 01/08/2026 at 10:25 A.M., An environmental tour of the facility Laundry Service was conducted with Environmental Services (EVS) District Manager P and Environmental Services (EVS) Account Manager Q. The following items were noted: Clean Laundry Room: 2 of 2 overhead clear plastic light lens covers were observed (chipped, broken), adjacent to the entrance door. Ten 12-inch-wide by 12-inch-long vinyl flooring tiles were also observed (etched, scored, chipped, missing), adjacent to commercial washing machine #1. (EVS) District Manager P stated: I'll enter a work order into TELS. Soiled Laundry Room: The 12-inch-wide by 12-inch-long vinyl flooring tiles were observed (etched, scored, stained, chipped). The damaged flooring tile measured approximately 10-feet-wide by 15-feet-long totaling 150 square feet. (EVS) District Manager P stated: I'll enter a work order into TELS. On 01/08/2026 at 10:44 A.M., One 24-inch-wide by 24-inch-long acoustic ceiling tile was observed (stained, particulate) from a previous moisture leak, within the South Unit Biohazard Room. (EVS) District Manager P stated: I'll enter a replacement request into TELS. On 01/08/2026 at 03:15 P.M., Record review of the Policy/Procedure entitled: Maintenance Inspection dated 3/12/2022 revealed under Policy: It is the policy of this facility to utilize a maintenance inspection program in order to assure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. On 01/08/2026 at 03:30 P.M., Record review of the Policy/Procedure entitled: Preventative Maintenance Program dated 3/12/2022 revealed under Policy: A Preventative Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. On 01/08/2026 at 03:45 P.M., Record review of the Direct Supply TELS Work Orders for the last 60 days revealed no specific entries related to the aforementioned maintenance concerns.

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain informed consent for antidepressant medication use for one (R11) of five reviewed.Findings include:Review of the medical record reflected R11 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included chronic respiratory failure with hypoxia (low oxygen level), depression and bipolar disorder. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/3/25, reflected R11 scored 12 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and received antidepressant medication. According to the medical record, R11 had a Guardian in place. R11's Physician's Orders reflected Trazodone (antidepressant medication) was ordered to start on 6/30/25. The medical record did not reflect that R11's Guardian had provided consent for Trazodone use, nor that they had been informed of the medication risks and/or benefits. In an interview on 01/09/2026 at 10:32 AM, Director of Nursing (DON) B reported she did not see a consent for Trazodone in R11's medical record upon review on 1/8/26. DON B reported she contacted the Psychiatric Services Provider, who did not recall contacting R11's Guardian about the medication.

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F 0578 Level of Harm - Minimal harm or potential for 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** Based on interview and record review, the facility failed to ensure the accuracy of advance directives for one (R13) of two reviewed.Findings include:Review of the medical record reflected R13 admitted to the facility on [DATE], with diagnoses that included neurocognitive disorder with Lewy Bodies and Alzheimer's. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], reflected R13 was unable to complete the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and had long-term and short-term memory impairments. R13's medical record reflected a Do-Not-Resuscitate (DNR-no cardiopulmonary resuscitation/CPR) form was signed by a Representative (on the Patient Advocate line), the Physician and two witnesses on [DATE]. A Physician's Order, with a revision date of [DATE], reflected Full Resuscitate (CPR to be initiated in the event of cardiac and/or respiratory arrest). On [DATE] at 2:57 PM, Registered Nurse (RN) D reported that a resident's code status could be viewed by selecting the Medication Administration Record (MAR). RN D demonstrated selection of a MAR, which then populated the Electronic Medical Record (EMR) banner, which listed code status. RN D reported there was also a folder at the nurse's station, which included resident code status information. On [DATE] at 3:01 PM, the Resident Face Sheets & Code Status binder, located at the nurse's station, reflected R13's face sheet, with DNR written in black ink, at the top of the page. The signed DNR form for [DATE] and Advance Directives/Medical Treatment Decisions Acknowledgement of Receipt form, also signed [DATE], were noted behind the face sheet. On [DATE] at 3:06 PM, RN E acknowledged being R13's nurse that day. Regarding how they would know the code status of a resident, RN E stated they would go into the chart, under the profile. RN E reported the large bar (banner) had the code status, or it was in the Orders tab of the EMR. In a phone interview on [DATE] at 3:15 PM, Regional Social Service Consultant (SSC) F reported that on admission, nursing staff were to find out the resident's code status. If a resident was to be a DNR, the form had to be signed by the resident, their activated Power of Attorney (POA) or Guardian; the Physician and two witnesses. SSC F reported R13 was a full code, and their DNR was marked as not valid due to their POA being financial, not medical. According to SSC F, the individual that signed the DNR form on behalf of R13 did not have the authority to do so. SSC F reported R13's full resuscitate order was revised on [DATE], which she reported may have been when the facility caught that the DNR form was inaccurate. SSC F reported the binders at the nursing stations were in place in the event the EMR went down. SSC F indicated R13's code status in the binder should have been updated when their code status order was changed. In an interview on [DATE] at 10:32 AM, Director of Nursing (DON) B reported they went back through R13's paperwork and noted there was one sentence that designated R13's POA as having medical decision-making authority. Regarding if R13 had been deemed unable to make their own decisions, DON B stated there was hospital documentation for [DATE], stating R13 had a Durable Power of Attorney in place at that time. An email was sent to Nursing Home Administrator (NHA) A on [DATE] at 11:02 AM, requesting documentation reflecting that R13 had been deemed unable to make medical treatment decisions. The documentation was not received prior to the exit of the survey on [DATE].

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one (Resident #35) out of three residents was up able to regularly attend activities.Findings Included:Per the facility's face sheet Resident #35 (R35) was admitted to the facility on [DATE]. Diagnoses included history of traumatic brain injury and persistent vegetative state. Review of a Brief Interview of Mental Status (BIMS) dated 11/10/2025, revealed R35's BIMS score was zero out of 15 which indicated R35 had no cognitive ability to respond to stimuli or voice his needs.In an observation on 1/07/2026 at 3:34 PM, R35 was observed in bed, but was never observed today to be out of bed and sitting in the Broda chair that was observed in R35's room. The Broda chair was observed to have several wedges and blankets laying on the seat.In an observation on 1/08/2026 at 8:39 AM, R35 remained in bed. The Broda chair remained unchanged from previous day with wedges and blankets laying in the seat. No music, no TV, no entertainment was observed to be on in R35's room. Just silence.In an observation on 1/08/2026 at 11:39 AM, Resident #35 was observed in bed. Broida chair remained untouched with all wedges and blankets as they were from 1/7/2026 observation.In an observation on 1/8/2026 at 2:18 PM, R35 was observed to still be in bed, and Broda chair was observed to still have the blankets and wedges laying on the seat of the chair.Review of a Preferences for Customary Routine and Activities dated 11/11/2025, revealed R35's family informed the facility that R35 would enjoy sports, jazz music, animals, and group activities.Review of R35's care plan with a focus of Resident (R35) at risk for altered activity patterns/pursuits related to.is dependent on staff for activities, cognitive stimulation, and social interactions, dated 4/21/2025.Review of the interventions on R35's care plan revealed R35 enjoyed watching basketball and football, one on one visits from staff and volunteers, staff were to provide periodic friendly visits for increased socialization, R35 enjoys jazz music, outside activities, and religious activities. All the interventions were dated 4/21/2025.In an interview on 1/08/2026 at 9:05 AM, Certified Nurse Aid (CNA) I stated that it was rare that R35 would go to activities. CNA I said R35 did go to church on Wednesdays but said she did not know why R35 did not go to activities. CNA I stated that she had not seen R35 up in his Broda chair daily.In an interview on 1/08/2026 at 11:06 AM, CNA J said R35 would go to church on Wednesdays and said Fridays on one of his shower days he would get up out of bed for a shower. CNA J said sometimes the Activities Director (AD) K would direct the CNAs to clip R35's nails.In an interview on 1/08/2026 at 11:20 AM, Activities Director K stated that the activities department offers music, hand messages, sometimes R35 would make it down to church. AD K said when R35 was not up in his Broda chair it made it harder for her to bring R35 to group activities. AD K said R35 was not up in his chair often. AD K said maybe one time per week R35 would be up in his Broda chair, and that was for Wednesday church. AD K said over the last month R35 had not had much activity with the department, because she only had enough staff for the activities in the dinner room and activity room. AD K said the dining room and activity room always had an activity going on and again stated that she did not have the staff for someone to sit with R35 for 30 minutes. However, AD K said if R35 was up in his Broda chair everyday then she could have him in the dining or activity room daily. AD K stated R35 was never up in his Broda chair for Wednesday church and said R35 was rarely up in his Broda chair at all. AD K said she had spoken to the CNAs about it and it had been mentioned at R35's care conferences but said that had no impact and nothing had changed.Record review of R35's activity log revealed for the last 30 days from 12/14/2025 through 1/1/2026 R35 was provided with only eight activities.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to consistently and timely address Monthly Medication Regimen Review recommendations for one (R37) of five reviewed. On 1/7/26 at 9:04 AM, R37 was observed sitting up in his bed with clear speech. He reported needing a swallow study and being thirsty.A review of the clinical record revealed R37 was admitted into the facility on 8/2/2025 with the most recent re-admission on [DATE], with diagnoses that included: tracheostomy, anxiety, and need for assistance with personal care. According to the Minimum Data Set (MDS) assessment dated [DATE], R37 scored 13/15 on the Brief Interview for Mental Status exam (which indicated intact cognition).A review of R37's physician orders for his diet revealed an NPO order (nothing by mouth) dated 10/21/2025 through current.A review of R37's pharmacy progress notes revealed pharmacy made recommendations for July 2025, August 2025, October 2025, December 2025 and January 2026. A request was made for the facility to provide the above-mentioned recommendations. The facility failed to provide the recommendation for October 2025. A review of the pharmacy recommendation for 8/21/2025 revealed NURSING: Please correct the route of administration for the following medications; Milk of Mag, (magnesium), Furosemide, GuaiFENesin Liquid 100mg/5ML. Resident is NPO with a PEG (feeding tube placed directly through the skin into the stomach). Under the Follow-Through section of the form there was a hand-written triangle/Delta symbol indicating an agreement to the change. A review of R37's physician orders revealed the recommended changes from August were not made until 12/11/2025 for both the Milk of Magnesium and Furosemide and 10/21/2025 for the GuaiFENesin. In an interview on 1/9/26 at 10:32 AM, Director of Nursing (DON) acknowledged that the August recommendations were not changed timely, no rationale was provided. No rationale was provided for the omission of the October recommendation as well.Review of the facilities policy, titled Addressing Medication Regimen Review Irregularities, documented in part The facility will utilize a systematic approach for reviewing each resident's medication regimen which includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team. The medication regimen of each resident must be reviewed by a licensed pharmacist at least once a month.The report should be submitt4ed to the DON within 10 working days of the review.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (R9) of three reviewed was able to understand and consent to the binding arbitration agreement.Findings include: Review of the medical record reflected R9 admitted to the facility on [DATE], with diagnoses that included cerebral infarction (stroke) due to thrombosis (blood clot) of other precerebral artery (8/26/26), persistent vegetative state (8/26/25) and tracheostomy status (surgical hole through the neck and into the windpipe). The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/2/25, reflected R9 was coded as being in a persistent vegetative state/no discernible consciousness. The Quarterly MDS, with an ARD of 12/3/25, reflected R9 was coded as being in a persistent vegetative state/no discernible consciousness. An Alternative Dispute Resolution Agreement reflected R9's first and last initials were written with notation that R9 verbally consented to the Agreement on 11/19/25. The Agreement reflected, .YOU ACKNOWLEDGE AND AGREE; (I) THAT YOU HAVE FULLY READ, UNDERSTAND AND ARE VOLUNTARILY ENTERING INTO THIS AGREEMENT; AND (II) THAT, YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS BEFORE SIGNING THIS AGREEMENT . Additionally, the Agreement reflected, .YOU ACKNOWLEDGE AND AGREE; (I) That you have been offered to, or have been able to view the audio/visual recorded video that details this agreement and what it includes . In an interview on 01/09/2026 at 9:47 AM, Admissions Coordinator (AC) N reported they had been responsible for Arbitration Agreements (Alternative Dispute Resolution Agreement) since October 2025. Their process was to review the agreement with the resident or their Responsible Party, including informing them if there were issues with care, finances or anything pertaining to the facility, they agreed to speak to an arbitrator/mediator. When asked how they ensured the resident or Responsible Party understood the Arbitration Agreement, AC N stated because they (resident or Responsible Party) agreed to check yes or no on the document and were notified that they could have a copy of the document. When asked how they ensured they were reviewing the document in terms that were understood, AC N stated they made sure to explain the concepts of arbitration and mediator. In an interview on 01/09/2026 at 11:05 AM, AC N reported being unaware of any audio and/or visual recording the facility had which detailed the Arbitration Agreement. AC N was unaware the facility's Arbitration Agreement included language pertaining to offering an audio/visual recording. R9's medical record included a Physician Progress Note for 8/27/25, which reflected, .Today, he remains unresponsive on the vent [ventilator/machine that helps with breathing or breathes for a person] . A Physician Progress Note for 10/1/25 reflected R9 was unresponsive on exam. A Physician Progress Note for 11/12/25 reflected R9 did not follow commands. R9's Social Service Progress Review, dated 12/3/25, reflected R9 was marked as rarely/never understood for their ability to express ideas and wants, considering both verbal and non-verbal expression. R9 was marked as rarely/never understands for understanding verbal content and their ability to understand others. The same Progress Review reflected R9 was unable respond nor showed signs of understanding. In an interview on 01/09/2026 at 12:10 PM, AC N recalled being in R9's room at the time the Arbitration Agreement was reviewed with them (11/19/25). AC N reported R9 was trying to sign the document but could not, so they asked R9 if they were verbally consenting. AC N reported R9's eyes were open and they were alert at the time. When asked if they believed R9 was able to understand what they were going over, AC N reported they would not have had R9 sign the agreement if they did not know what she was saying.