STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235285	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Lansing	731 Starkweather Dr Lansing, MI 48917

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45038 This citation pertains to intake: MI00143250, MI00143278 Based on observation, interview, and record review the facility failed to insure that one resident #1 (R1) was free from significant medications errors out of four residents reviewed for significant medication errors resulting in the potential for adverse physical reactions/outcomes to residents. Findings Included: Resident #1 (R1) Review of the medical record revealed R1 was admitted to the facility 03/17/2023 with diagnoses that included nontraumatic intracerebral hemorrhage (stroke), Schizoaffective Disorder Bipolar type, hemiplegia (paralysis) affecting right dominate side, post-traumatic stress disorder (PTSD), dysphagia (swallowing difficulties), depression, hypertension, adjustment disorder with mixed anxiety and depression, muscle weakness, cognitive communication deficit, and hypokalemia (lower than normal potassium in bloodstream). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/07/2024, demonstrated R1 had a Brief Interview for Mental Status (BIMS) of 6 (severe impaired cognition). Resident #9 (R9) Review of the medical record revealed R9 was admitted to the facility 01/12/2024 with diagnoses that included bipolar disorder with psychotic features, intellectual disabilities, intermittent explosive disorder (frequent episodes of impulsive anger), anxiety disorder, seizures, restlessness and agitation, irritability and anger, developmental disorder or speech and language, and muscle weakness. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/28/2024, demonstrated R9 had a Brief Interview for Mental Status (BIMS) of 3 (severe impaired cognition). (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's medical record demonstrated a progress note from 03/08/2024 at 07:21 a.m. which stated, Resident was given wrong medication and posin (sp) was notified with orders to do 1-hour vitals and neuro (neurological) checks for 8 hours then Q (every) 4 hours for 24 hours if any changes to send to hospital. R1's medical record also demonstrated a progress note from 03/08/2024 at 07:25 a.m. which stated, Writer accidentally passed the wrong medication from the wrong cup. The same note explains that the physician assistant and the nurse manager were notified of the incident. The same note also demonstrated orders are to watch for tremors and increased sedation, vitals Q 4 hours X (for) 24 hours. No c/o (complaint) pain or discomfort, Resident A&O (alert and orientated) x 1. R1's medical record demonstrated that he was sent to the hospital on 03/08/2024 at approximately 02:00 p.m. R1's medical record demonstrated that he returned to the facility on [DATE] at 02:25 a.m. and demonstrated a progress note that stated, .spoke with ER physician. The physician reported that (R1's) lab work, vital signs and monitoring was stable and that his cognition/neurological status had returned to base line. No further orders received at this time other than to continuous monitoring of neurological status/vital signs. In an interview on 04/10/2024 at 02:15 p.m. Nurse Manager (NM) C explained that she was aware of the incident involving R1, that occurred on 03/08/2024 and that R1 was given R9's medication. NM C explained that Registered Nurse L had prepared the medication for R1 and had also prepared medication for R9. Licensed Practical Nurse K then took both residents medication and proceeded to administer R9's medication to R1. NM C provided this surveyor with the facility incident report. Review of the facility incident report, 03/08/2024 at 07:15 a.m., demonstrated Writer administered incorrect medications to incorrect patient at AM morning pass. Medication that was incorrectly passed were as follows: Keppra 1500mg (milligrams), Lamotrigine 200mg, Oxcarbazepine 900mg, Seroquel 300mg, Topamax 100mg. The same incident report also demonstrated that R1's at 01:00 p.m. vital signs had become tachycardic (heart rate greater than 120 beats per minute) and he had become lethargic. At 02:00 pm. R1 became more lethargic and had a pulse rate of 40 beats per minute and he was taken to the hospital by Emergency Management Services (EMS). During a telephone interview on 04/11/2024 at 08:39 a.m. Licensed Practical Nurse (LPN) K explained that she was finishing her shift, on the morning of 03/08/2023, and explained that she was assisting the on-coming nurse (Registered Nurse (RN) K) with medication administration. She explained that RN L had prepared the medication that was to be given to R1 and to be given to R9. LPN K explained that she took both medication cups that contained R1's and R9's medication and went into R1's room to administer the medication. She explained that then came R1 the medication of R9 by accident. She explained that she immediately identified the error and proceeded to notify the physician assistant and the nurse manager. LPN K explained that she should not have administered medication that were provided by another nurse or have taken two different residents medications during the same time to administer. In an interview on 04/11/2024 at 12:13 p.m. Registered Nurse (RN) L explained that she had worked 03/08/2024 during the day shift. She explained that she had prepared the medication for R9 and had placed those medications in a medication cup. She explained that Licensed Practical Nurse (LPN) K was going to take those medication and provide them to R9. She further explained that LPN K did not immediately take those medication and walked away from the medication cart. She explained that continued preparing the medication for R1 by placing them in a different mediation cup. LPN K then returned to the medication cart and took both medication cups for R1 and for R9. She explained that shortly after LPN K returned and informed her that she had given R9 medication to R1. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 04/11/2024 at 12: 21 p.m. R1 was observed lying down in his bed. He explained that he was aware of receiving the wrong medication but could not recall the date that it had occurred. He explained that no medication errors had occurred since that time. In an interview on 04/11/2024 at 01:41 p.m. Director of Nursing (DON) B' explained that it was her expectation and a professional standard that medication be prepared and administered by the same nurse. Medication should not be prepared by one nurse and then provided to a resident by a different nurse. She explained that if medication is prepared and dispensed by a different nurse could place the resident at risk for a significant medication error. DON B explained that she was aware of the significant medication error that had occurred with R1 on 03/08/2024. She explained that the root cause was because one nurse prepared the medication, and a different nurse gave the medication. During onsite survey, past none compliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: 1). A root cause analysis of the deficient practice. 2). completed and audit of all residents on the same unit that could have been potentially impacted. 3). Immediate re-education of the two-nursing staff involved in the deficient practice. 4). All licensed nursing staff were re-educated regarding professional standards for medication administration. 5). The Director of Nursing/Designee completed observation of all licensed nursing staff during medication administration. 6). The facility Quality Improvement Committed implemented a quality assurance plan to correct the deficient practice and implemented on going monitoring of medication administration. 7). The Director of Nursing/designee will audit significant medication errors at least one time weekly for four weeks. After which the frequency of those audits will be one time weekly for three months. 8). The Director of Nursing/designee will audit licensed nursing staff for appropriate medication administration, by observation during medication administration, one time weekly for four weeks. After which, the frequency of those audits will be one time weekly for three months. Finding will be presented to the Quality Assurance Performance Improvement (QAPI) team for recommendations and follow-up. The Facility was able to demonstrate the correction action and maintained compliance as of 03/25/2024.