

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/25/2025
NAME OF PROVIDER OR SUPPLIER Medilodge of Lansing		STREET ADDRESS, CITY, STATE, ZIP CODE 731 Starkweather Drive 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake # 2567245Based on interview and record the facility failed to ensure adequate care, follow up and documentation were in place regarding Advanced Directives, resident alleging fear of certain family members, and failure to assess, monitor and investigate allegations of unwanted visitors giving a resident medication that was not prescribed by facility physician and provided by facility pharmacy. Findings include: Resident #1 (R1) admitted to facility on [DATE] with diagnoses that includes heart disease, diabetes and dementia. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed a Brief Interview Status score of 9 (moderate) cognitive impairment. Review of R1's physician orders reflected R1 was a full code, further review of R1's electronic medical record reflected R1 that Niece P had durable power of attorney and signed a form titled Advanced Directives Acknowledgement/CPR Consent on [DATE] the box do not resuscitate in the event of a cardiac arrest was checked. Further review of medical record revealed on [DATE] family member N (whom has several alias's) came into the facility and signed an Advanced Directive for R1. The form listed facility employee Social Worker (SW)C and Registered Nurse (RN) Q as the witnesses to the signing. The acknowledgement of receipt for the signed advanced directive R1's family member N added as 'DPOA (Durable Power of Attorney) as their relationship to R1.On [DATE] at 10:25 am during an interview with SW C she reported Adult Protective Services (APS) came to the facility on [DATE] regarding concerns for R1. SW C stated she had little information as APS met with admission Director (AD) E . SW C stated she was waiting on correct paperwork from Niece P When queried how she knew who had the correct paperwork for Power of Attorney, SW C said the APS worker brought it in, but facility staff did not ask for a copy. SW C elaborated after being made aware that family members N didn't have legal authority to make decisions the Physician reverted the status and made R1 a full code. SW C stated she believed family member P had legal authority and was waiting for them to provide documentation. SW C elaborated that family member N and family member O have been banned from visiting because R1 reported he was fearful of family member O. There was no documentation in the clinical record from SW C about the Advanced Directives, what concerns APS had or that R1 was fearful of a particular visitor, or that any visitors had been banned from visiting. When queried more about APS, SW C suggested admission Director E be interviewed because SW C wasn't really involved. SW C offered no explanation for the lack of documentation for the above noted concerns. On [DATE] at 11:20am, during an interview with R1's nurse RN D, she reported there was a sign posted at the nurse's station that two of R1's family members with several aliases have been banned from visiting. When queried about the reason form the ban, RN D reported it was due to family member O bringing in and administering medications from the community. RN D did not know the specifics of when or what medications. The sign was only there for a few days then removed RN D was not sure why the sign was removed or if the situation resolved itself. On [DATE] at 12:30pm, during an interview with Director of Nursing (DON) B she reported not having any knowledge of R1 receiving mediations from an outside source. DON B stated that she knew some lady came in about concerns for R1 but assumed she was a case manager from the hospital, did not know she was from Adult Protective Services. DON B stated she was made aware that R1 was fearful of family member O and possibly afraid of family member N too but wasn't sure. When queried why R1 was afraid of family members DON B didn't know and should have followed up with R1. On [DATE] at 12:50pm, during an interview with admission Director E she reported family member N and O came in the facility with DPOA papers, but family member P signed the admission contract. admission Director E stated she asked for both of their ID's and both family member ID reflected the same first name but looked legitimate so they were allowed to sign the documents but then family P called from out of state and APS got involved about 6 weeks ago and family member N and O are now banned. When queried the reason for the ban, admission Director E stated that because R1 stated he was afraid of them and that family member O gave him pills. When queried about the pills admission Director E stated she met with R1 and asked about the pills being brought which R1 didn't know the names of the pills. admission Director E stated the Nursing Home Administrator (NHA) A was on vacation otherwise she would have called him but instead notified DON B. when queried why this was not documented in the medical record, admission Director E stated she did not have access/authorization to document in the medical record.</p>		