STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235517	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Campus Area	2815 Northwind Dr East Lansing, MI 48823

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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 This citation pertains to intake MI000151964. Based on interview and record review, the facility 1) failed to assess and monitor and 2) follow physician orders for one (Resident #500) of three reviewed for quality of care, resulting in a delay in recognition and response to a significant change in condition which progressed to a cardiac arrest and subsequent poor outcome, including CPR, hospitalization , and ultimately comfort care status. Resident #500 (R500) A review of the medical record reflected that R500 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypotension, chronic obstructive pulmonary disease, and acute respiratory failure with hypoxia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE] indicated that R500 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS), a cognitive screening tool. R500 no longer resided in the facility. On [DATE] at 12:01 AM, Resident #430 (R430) was observed seated on the side of his bed. R430 reported witnessing his roommate, R500, experiencing what he described as a heart attack. He stated that R500 was yelling for help, but no one responded. R430 said he also began yelling for help because he sensed something was seriously wrong. He reported that R500 had been ill for two days and felt staff did not assist him in a timely manner when R500 called out. R430 stated that R500 became unresponsive, and that Emergency Medical Services (EMS) performed cardiopulmonary resuscitation (CPR). A review of an Encounter Note dated [DATE] at 1:00 PM indicated that R500 had been seen by Nurse Practitioner (NP) O. The note stated: (R500) seen today for hypoxia (low levels of oxygen in body tissues, causing symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin) and shortness of breath. He is lying in bed and states it came on suddenly. He is hypoxic and is currently being placed on supplemental oxygen. He also complains of shortness of breath . he is hypotensive. At the end of the note, it was documented: Hypotension, unspecified type - will add PRN (as needed) Midodrine and monitor. An order for Midodrine HCl (a vasopressor used to raise blood pressure), 5 milligrams (mg) tablets, to be given by mouth every 8 hours as needed for hypotension if systolic blood pressure (SBP) was less than 90 mmHg, was initiated on [DATE] at 10:15 AM. The same order was discontinued at 10:28 AM. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235517	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Campus Area	2815 Northwind Dr East Lansing, MI 48823

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 - Actual harm Residents Affected - Few	On [DATE] at 10:24 AM, R500's blood pressure was ,d+[DATE] mmHg, and Midodrine 5 mg was administered at that time. His Mean Arterial Pressure (MAP) was calculated to be 51 mmHg. (A minimum MAP of 60 mmHg is generally required to adequately perfuse vital organs.) R500's blood pressure was rechecked at 10:26 AM and was ,d+[DATE] mmHg, with a MAP of 50 mmHg. At 12:24 PM, it was recorded at ,d+[DATE] mmHg, and at 1:23 PM, it improved to ,d+[DATE] mmHg. Additionally, an order for Albuterol Sulfate nebulization solution (2.5 mg/3 mL at 0.083%) to be administered via nebulizer every 6 hours as needed for shortness of breath was not given, despite R500 stating he was experiencing shortness of breath. According to the physician's order, R500 was eligible to receive another dose of PRN Midodrine if needed at approximently 6:30 PM. However, no additional vital signs were documented after 1:23 PM. In an interview on [DATE] at 10:38 AM, NP O stated that she assessed R500 on the morning of [DATE]. She acknowledged that while R500 was chronically ill, on that day he was acutely hypoxic and short of breath, prompting her to order PRN Midodrine and Albuterol. NP O said that at minimum, R500's blood pressure should have been rechecked at the 8-hour mark to assess if another dose of Midodrine was indicated. She added that vital signs, including oxygen saturation, should have been monitored. NP O stated that if R500's blood pressures remained low, staff should have contacted her and an additional dose of Midodrine could be administered. In an interview on [DATE] at 11:53 AM, RN I confirmed she was assigned to R500 on [DATE]. RN I stated R500 was declining during her shift, so she administered PRN Midodrine, communicated with NP O, and followed through with diagnostic orders. A review of physician orders revealed an order for daily vital signs initiated on [DATE]. However, documentation showed no vital signs were assessed or recorded on: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. A nurse's note dated [DATE] at 9:45 PM stated: Date of incident [DATE] at 8:25 PM. Outgoing nurse reported that resident had a change of condition - hypoxia - and was placed on 2L (liters) oxygen via nasal cannula. This nurse assessed the resident and noted moderate acute distress due to generalized weakness and fatigue. All vital signs were within normal limits except a temperature of 102 F. Nurse requested CNA to clean and assist resident with feeding while notifying the DON. While on the phone, CNA reported the resident had become unresponsive. Nurse immediately contacted EMS. An EMS team already present in the facility responded and initiated CPR until a second team arrived. Resident was transferred to [local] hospital. In an interview on [DATE] at 1:03 PM, CNA E confirmed he was assigned to R500. He described R500 as appearing lethargic and not quite himself. He stated R500 was nonverbal and only able to make gestures. CNA E said R500 continued to decline and was present when R500 became unresponsive and went into cardiac arrest. CNA E stated at baseline, R500 was able to verbalize needs and get around the facility without difficulty. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235517	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Campus Area	2815 Northwind Dr East Lansing, MI 48823

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 - Actual harm Residents Affected - Few	In an interview on [DATE] at 1:59 PM, RN G stated she was on duty when R500 became unresponsive. She noted that at the start of her shift around 6:00 PM, R500 did not look well. The outgoing nurse, RN I, informed her that R500 was declining and advised her to keep an eye on him. RN G did not know R500's baseline, so she contacted DON B, who instructed her to transfer R500 to the hospital. RN G said she called 911, and shortly after, R500 went into cardiac arrest. EMS personnel who were already in the building responded immediately. A review of hospital documentation dated [DATE] showed that R500 was brought to the Emergency Department by EMS after experiencing cardiac arrest shortly before arrival. EMS reported he had been difficult to arouse and underwent 10 minutes of CPR with no shocks advised. He received epinephrine and vasopressin in the field. His last recorded BP was ,d+[DATE] mmHg with a pulse of 111 bpm. R500 had a history of ESBL E. coli bacteremia (Escherichia coli bacteria in the bloodstream) secondary to a complicated UTI (urinary tract infection) and was being treated for MRSA pneumonia and likely bacteremia. He had lactic acidosis secondary to hypoperfusion and circulatory shock due to sepsis. He was placed on comfort care on , d+[DATE]. R500 was nonresponsive-his eyes were open, but he did not track or respond to commands. Pupils were non-reactive, and no corneal, cough, or gag reflexes were present. In an interview on [DATE] at 1:23 PM, DON B stated she had spoken with RN G on [DATE]. RN G reported that R500 did not look well and planned to transfer him to the hospital. DON B confirmed that the expectation was to follow physician orders, including rechecking R500's blood pressure to determine if another dose of Midodrine was needed. According to the Elsevier Emergency Nursing Core Curriculum, 7th edition, shock is a clinical manifestation of the body's inability to adequately perfuse tissues. It is a systemic response to illness, resulting in decreased oxygen delivery to cells and potential end-organ damage. Septic shock causes vasodilation and maldistribution of blood volume, particularly in peripheral vessels, leading to hypotension. It is essential to collect and monitor objective data, including level of consciousness and vital signs.