| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235517 | A. Building<br>B. Wing | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Medilodge of Campus Area | 2815 Northwind Drive<br>East Lansing, MI 48823 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2989711.Based on observation, interview, and record review, the facility failed to 1) identify and treat a new wound for one (R70) and 2) treat earwax buildup for one (R58) of 17 reviewed.Findings include: Resident #70 (R70)<br><br>Review of the medical records reflected that R70 was admitted to the facility on [DATE] and readmitted on [DATE] following hospitalization. Diagnoses of Diabetes Mellitus with Diabetic Polyneuropathy, Peripheral Vascular Disease, left side weakness from previous stroke and a new diagnosis of acute osteomyelitis- right ankle and foot.<br><br>The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/12/2025 revealed R70 had a Brief Interview of Mental Status (BIMS) of 15 (Cognitively Intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R70 was independent to minimal assistance with bed mobility, transfers, toileting. R70 is able to make his needs known.<br><br>During an interview on 04/28/2026 at 2:39 PM, R70 stated he had his right foot big toe amputated last summer. R70 stated his second toe got a pressure ulcer on the top on it and the third toe developed a pressure ulcer under it and tunneled through. R70 stated the staff never identified it and did not treat it appropriately, and it could have been prevented.<br><br>During an observation and interview on 04/29/2026 at10:53 AM, Wound Care Nurse H was setting up wound care supplies for wound care on R70's right foot. Wound Care Nurse H gowned and gloved for care, hand hygiene performed. Wound Care Nurse H removed soiled dressing from right foot, disposed of soiled dressing, hand hygiene performed. Wound Care Nurse H stated all of his toes on the right foot were amputated; incision is intact with steri-strips, performed hand hygiene, applied clean gloves, cleaned with wound wash on gauze dressing, hand hygiene completed, applied new gloves, completed dressing change.<br><br>On 04/29/2026 at 2:10 PM, writer asked DON B for documentation on R70's right foot wounds prior to his amputation of all toes. Nursing Progress notes did not reveal any details on the right foot third toe, other than daily dressing changes to the incision where he had his great toe amputated.<br><br>On 04/29/2026 at 4:31 PM, DON B came into the conference room where survey team was working, writer asked again for documentation on R70's right foot third toe concerns. DON B stated they had a different program to document that in so she would print it off for this writer, brought in right foot, great toe surgically removed and following care, but nothing regarding the condition of the 2nd and 3rd toes.<br><br>During an interview on 04/30/2026 at 8:24 AM, Wound Care Nurse H stated R70's 2nd toe was<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | bend/hammer head, and it had a Diabetic Ulcer on it. Writer asked about the 3rd toe, Wound Care Nurse H stated she did skin assessments every Monday and there was nothing there on that specific Monday of 03/09/2026, she was told he went to the hospital that following Saturday 03/15/2026 with a new wound. Writer asked Wound Care Nurse H if she knew when this new wound was identified, she stated she did not, added the 2nd toe concern was documented in the (Electronic Medical Records) EMR, not on the 3rd toe that she was aware of. Writer asked wound Care Nurse H what the process was for any staff would have noticed concerns with skin breakdown. Wound Care Nurse H stated they would come and get her, if it's not on a Monday, she was doing wound care rounds then the staff would address it with the floor nurse.<br><br>Record review of a wound care note and picture of his right foot dated 03/09/2026, completed by wound care nurse H showing black/brown eschar on the tips of the 3rd and 4th toes on the right foot.<br><br>Record review of the spread sheet that is used as a communication tool between the wound care nurse H and NP O revealed R70 had a new wound identified on 02/24/26 on his right foot, 2nd digit, in house acquired, length .75 x width 1.02 x depth of 0. Treatment of Povidone iodine.<br><br>Record review of this same spread sheet dated 03/02/26 revealed R70's right foot, 2nd digit, in house acquired, length .77 x width 1.08 x depth 0.1. Treatment of Povidone iodine.<br><br>Record review of this same spread sheet dated 03/09/26 revealed R70's right foot, 2nd digit, in house acquired, length 1.25 x width 1.54 x depth 0.1. Treatment of soap and water, Povidone iodine.<br><br>Record review of this same spread sheet dated 03/09/26 did not include the new wound on right foot, 3rd toe as it was in the picture of his right foot dated 03/09/26 where it shows eschar on the tips of toes 3 and 4.<br><br>During an interview on 04/30/2026 at 9:30 AM Interview with Nurse Practitioner (NP) O stated she did not make rounds with Wound Care Nurse H here at the facility. NP O stated that Wound Care Nurse H had a spread sheet and would report what was going with the wounds and she wrote orders based on that report. NP O stated they did not have an NP to concentrate on wound care at this time but would within the next week or two.<br><br>NP O pulled up her visit note for 03/05/26- no mention of 3rd toe skin issues new diabetic ulcer to the right dorsum second digit noted on 02/24/2026.<br><br>NP O read the wound care documentation from 3/11/2026 13:05 by a unit manager, wound is stable. Continue with active treatment and pain management plan.<br><br>NP O pulled up her visit note for 3/11/1026, since 3/6/26, R70 had experienced persistent neuropathic pain requiring increased gabapentin (800 mg TID), and ongoing management of a new diabetic ulcer on the right foot second toe, with intermittent refusal of wound care but overall wound stability.<br><br>NP O read the wound care documentation from 3/12/2026 by floor nurse, location of skin area being documented: 2nd toe of right foot. Continue with plan of care/ Treatment.<br><br>NP O read the wound care documentation from 3/12/2026 at 9:22 AM by floor nurse, location of skin area being documented: right 2nd toe continues plan of care.<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | NP O read the wound care documentation from 3/13/2026 at 14:19 PM by floor nurse, location of skin area being documented: right 2nd toe, Tx in place.<br><br>NP O read the wound care documentation from 3/14/2026 at 08:22 AM by floor nurse, location of skin area being documented: right 2nd toe Tx in place.<br><br>NP O read the wound care documentation from 3/14/2026 at 22:33 PM by floor nurse, location of skin area being documented: right 2nd toe resident on LOA until tomorrow. Was not assessed today.<br><br>NP O read the wound care documentation from 03/15/2026 at 11:20 AM by Wound Care Nurse H location of skin area being documented: Right foot second toe<br><br>resident sent out to hospital that today, was not assessed.<br><br>NP O pulled up her NP visit note for 03/30/2026, over the past three days, the patient has been managed for pain related to a right foot amputation site, with frequent PRN morphine and oxycodone administration. Pain levels have fluctuated, often reaching 8–9/10, but responded effectively to medication, with post-administration scores dropping to 0–3/10. The amputation site remains stable, with wound vac intact and no signs of sepsis; the patient is afebrile and continues on oral antibiotics without adverse reactions.<br><br>NP O pulled up her NP visit note for 04/01/2026, the surgical site remains intact, with no new signs of infection or sepsis; he is afebrile and has tolerated antibiotics without<br><br>adverse reactions. The wound vac was removed yesterday. He feels pain management regimen is adequate at this time using oxycodone every 4 hours.<br><br>During an interview on 04/30/2026 at 12:47 PM, DON B was asked about the 3rd toe wound on his right foot prior to amputation. DON B stated R70 was on Leave of Absence (LOA) on that day, and Wound Care Nurse H couldn't assess him. Regional Director of Clinical D was giving answers prior to the DON B answering and writer asked to have DON B look at his medical record to help identify when that 3rd toe wound was identified. Writer asked DON B what her expectations would be if staff found a new skin concern. DON B stated they would put notes in the EMR, report to the floor nurse, they always put it on the communication board, write new orders, and at daily rounding, it would have been brought up at that time. DON B stated R70 was on LOA on 03/14/26. Assistant Director of Nursing (ADON) C stated R70 would refuse to have nurses do his dressing changes.<br><br>During a record review of progress note written by Physician's Assistant (PA-C) O for 03/11/2026 at 14:54PM, Inspection: Eschar present on 2nd and 3rd toes on R foot. Patient is status post first toe removal. Incision there is well healed. He has an eschar on his third distal toe that seems to be irritated. +hammer toe second toe. No surrounding erythema. He does have global swelling to the foot which is very evident compared to contralateral side. He is slightly tender to palpation in the foot as well as the distal left lower leg. No streaking, no induration.<br><br>Record review of nursing progress notes revealed skin assessments/wound care was provided to R70 on 03/01/26, 03/02/26, 03/03/26, 03/04/26 (x4), 03/05/26, 03/06,26, 03/07/26, 03/08/26, 03/09/26, 03/10/26, 03/11/26 at 13:05PM, 03/12/26 (x2), 03/13/26, 03/14/26 done at 8:22 AM before LOA. R70 returned to facility on 03/15/2026 at 15:20 AM from an overnight LOA. Wound care nurse H documented, .there was a new open area to his right foot 3rd toe. Resident wanted to be sent<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | out to the hospital for wound evaluation due to diabetes Type 2. This writer called physician. Awaiting a call back at this time.<br><br>Record review of R70's care plan intervention was to do a skin assessment weekly.<br><br>Record review of nursing progress notes revealed R70 was admitted to the hospital on [DATE] through 03/23/2026. Per DC summary, resident underwent amputation of 2nd and 3rd toes and Achilles tendon lengthening on 3/21 of the right foot and started on a 2-week course of oral antibiotics. Resident was wearing a boot to the right foot and had a wound vac to the right foot. Non-weight bearing (NWB) right foot. Resident was alert and oriented x4, able to make needs known. Provider notified of readmission, reviewed meds, orders entered.<br><br>Record review of hospital coordination from emergency room to admission of R70.<br><br>Right third toe infected ulcer with subcutaneous gas<br><br>LRINEC score 3<br><br>Recurrent diabetic foot ulcer<br><br>History of right first toe amputation in June<br><br>Chronic ulcer on the second toe<br><br>- CT shows soft tissue swelling and distal subcutaneous air without osteomyelitis<br><br>- CRP elevated with no systemic signs of infection<br><br>- Blood cultures show no growth till date follow up on the final blood cultures<br><br>- Started zosyn and Zyvox<br><br>- Podiatry consulted for debridement versus toe amputation<br><br>- Wound care team consulted<br><br>- HbA1c sent<br><br>- strict glycemic control<br><br>Sepsis Documentation:<br><br>Provider assessment: Infection suspected<br><br>Suspected source(s) of infection: Skin and Soft Tissue<br><br>Musculoskeletal Assessment: Negative for back pain and neck pain.<br><br>Skin: Positive for wound (Right third toe). Negative for rash.<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Neurological: Negative for dizziness, syncope and headaches.<br><br>Skin Assessment:<br><br>General: Skin is warm and dry.<br><br>Capillary Refill: Capillary refill takes less than 2 seconds.<br><br>Findings: No rash.<br><br>Comments: Right foot-great toe has been amputated, second toe has a healing wound,<br><br>third toe has a wound with surrounding color changes in the toe. Color changes do not<br><br>extend up the foot, there is no drainage coming from the wound site<br><br>Clinical Impressions as of 03/15/26 21:32 PM, Wound infection.<br><br>During an interview on 04/30/2026 at 1:27 PM, RN/Unit Manager E was asked about the wound care, and dressing changes she had completed on R70 dated 03/11/26 at 13:05 PM. RN/Unit Manager E stated she didn't recall, added her memory isn't that good. Writer asked about identifying a new wound on the 3rd toe and she stated she didn't recall. Writer asked what her expectations would be if a resident develops a new skin concern or wound, RN/Unit Manager E stated she would expect the staff to report that to floor nurse, herself as the unit manager or the Wound Care Nurse H.<br><br>During an interview on 04/30/2026 at 1:47 PM, Registered Nurse (RN) S was asked about the assessment and wound care she provided on R70. RN S stated she remembered doing them but couldn't remember if it was on one toe and two toes.<br><br>During an interview on 04/30/2026 at 1:54 PM, R70's family member T stated R70 showed her his foot. Family member T told him to go to ER, stated R70 told her he had a wound one on top of 2nd toe, one of bottom of 3rd toe, he was having severe pain, and he shouldn't have had pain due to neuropathy. Family member T stated she called the wound care nurse H who told her she didn't see this new wound a week ago, stated they did his dressing 2 x daily and it should have been identified.<br><br>During an interview on 04/30/2026 at 2:09 PM, RN U stated she didn't see any new skin opened, he went on LOA and when he came back the next day, he told her he needed to go to the hospital because he had a new wound and it was painful. Writer asked RN U if she had looked at the entire foot when she did his dressing changes, she stated she usually does but didn't think she did so this time.<br><br>During an interview on 04/30/2026 at 2:44 PM, writer asked wound care nurse H what the dark areas were at the tips of R70's 3rd and 4th toe on the right foot taken during the assessment and wound care pictures on 03/09/26. Wound care nurse H stated it must have been the lighting, writer zoomed in on the picture to show her the dark edges on both toes look like eschar (thick, dry, leathery form of black or brown necrotic tissue (dead tissue) that forms over a wound). Writer commented that it didn't look like poor lighting. Wound care nurse H stated she didn't see any concerns with those toes.<br><br>R58<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the medical record revealed R58 was admitted to the facility on [DATE] with diagnoses that included traumatic subdural hemorrhage and dementia. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/26 revealed R58 scored 4 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool), had minimal difficulty hearing, and did not wear hearing aids.<br><br>In a telephone interview on 04/28/2026 at 10:29 AM, R58's Guardian G reported R58 seemed to have an increased difficulty hearing. Guardian G reported they have asked for R58's hearing to be checked, but nothing was done.<br><br>04/29/2026 10:39 AM Resident #58 was observed in bed. R58 reported she thought she had earwax buildup and that her ears needed to be cleaned out.<br><br>Review of the Progress Note-MD History & Physical dated 3/4/26 revealed She [R58] also says her ears need to be cleaned .[Patient] has bilateral age-related hearing loss, uses headphones to hear the TV better, complains of wax and needing her ears cleaned out. Will ask nursing staff about ear lavage [irrigation] vs cerumenex drops.<br><br>Review of the medical record revealed no indication that R58's earwax had been addressed/treated.<br><br>In an interview on 04/29/2026 at 10:42 AM, Unit Manager (UM) E reported they were not aware of any concerns with R58's ears. When asked about the Physician's progress note dated 3/4/26, UM E reported the facility typically used Debrox (ear wax removal drops), but she did not see where Debrox was ordered for R58 after the Physician's visit on 3/4/26. UM E reported the Physician's visit was shortly after the facility changed provider groups and the new provider group may not have been aware that they needed to enter the order into the system or delegate to a nurse.<br><br>In an interview on 04/30/2026 at 11:12 AM, Director of Nursing (DON) B reported the facility changed provider groups on 3/1/26. DON B reported if a provider noted something in their progress notes, they were responsible for entering the order as the facility staff did not read all the provider notes every day.<br><br>Review of the Physician's Order dated 4/29/26 revealed R58 had an order for Debrox drops for both hears for ear wax and decreased hearing. |