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	03/03/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 This Citation Pertains to MI00146912 and MI00150426 Based on observation, interview and record review, the facility failed to preserve the dignity of 3 of 4 residents (Resident #2, #318, #32) reviewed for dignity and 4 of 5 residents for residents that attended the confidential group meeting. Findings include: Resident #2 (R2) Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE], revealed Resident # 2 (R2) was admitted to the facility on [DATE] with a readmitted [DATE] with diagnoses that include congestive heart failure, chronic obstructive pulmonary disease. R2 scored 15 out of 15 (cognitively intact) on the Brief Interview Status (BIMS). On 02/25/25 at 09:58 AM during an interview with R2 it was reported that staff complain chronically about their work load and are continuously talking and complaining about Resident 32 (R32) and how frequently R32 pushes the call light for help. R2 elaborated that staff were observed frequently texting or talking on their personal cell phones. R2 elaborated it was uncomfortable to hear staff complain about other residents, their work load and it was frustrating when the call light was on and you can see staff on their phones. When queried if a concern form was filed or if management staff was aware of the concern R2 stated these issues were common knowledge and treated as acceptable behavior. Resident Council On 03/03/25 at 11:00 am during the confidential group meeting 4 of the 5 participants reported the observe staff on a daily basis on their personal cell phones, the participants reported this angered them particularly when their call light was on and they're waiting for help. (continued on next page)

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Five of 5 of the participants reported staff are very noisy at night while they are trying to sleep and again noise level gets unbearable again about 6:00am and wake up due to yelling, screaming and laughing from staff. All 5 participants reported overhearing laughing and conversations about staff personal lives, their upcoming events etc . 5 of 5 participants reported they felt staff have no respect or consideration for residents need for sleep or just peace and quiet. 45038 Resident #32 (R32) Review of the medical record revealed R32 was admitted to the facility 04/18/2019 with diagnoses that included multiple sclerosis, paraplegia (paralysis that occurs in the lower half of the body), neuromuscular dysfunction of bladder, type 2 diabetes, obesity, diabetic neuropathy (nerve damage caused by diabetes), cardiomegaly (enlarge heart), muscle spasm, anemia (low red blood cells), hyperlipidemia (high fat content in blood), chronic obstructive pulmonary disease (COPD), chronic pain, altered mental status, metabolic encephalopathy (impaired brain function), insomnia, edema, anxiety, major depression, migraine, and gastro-esophageal reflux. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) 0f 10/12/2024, revealed R32 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on 02/25/2025 at 11:30 a.m. R32 was observed lying in bed. R32 explained that staff are very loud while providing his personal care and rude in the way that they communicate with me. Review of R32's Quality Assistance Form, dated 1/13/2025 revealed, Nurse was upset that resident used call light 4 times, nurse was talking rudely to resident . (name of nurse) on Sunday night. The Quality Assistance Form, dated 1/13/2025, demonstrated that issue was resolved and description: DON (Director of Nursing) provided nurse education. In an interview on 03/03/2025 at 11:28 a.m. Licensed Nursing Home Administrator (LNHA) B explained that he could not demonstrate that the nurse named in R32 Quality Assistance Form, dated 01/13/2025, had received any education regarding being rude with R32. LNHA B could not explain why the re-education was not completed as stated on R32's Quality Assistance Form, dated 01/13/2025. Resident #318 (R318) Review of the medical record revealed R318 was admitted to the facility 02/13/2025 with diagnoses that included atherosclerotic heart disease (build-up of fats, cholesterol and other substances in the artery walls), bilateral peripheral vertigo (dizziness caused by problem in inner ear), hyperlipidemia (high fat content in blood), hypertension, anemia (low red blood cells), and Barrett's esophagus (damage to the lower part of the esophagus). The most recent Minimum Data Set (MDS), with an Assessment Reference date (ARD) of 02/18/2025, revealed R318 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 02/25/2025 at 10:25 a.m. R318 was observed sitting on the side of his bed. R318 explained that he felt the facility did not honor his dignity because frequently he could hear the nursing staff yelling in the hallway at each other. R318 also explained that he could hear staff talking on their phones and swearing at their children to get to bed. R318 explained that he did not feel that this behavior was respectful to his desire for a peaceful environment. R318 also explained that while voicing concerns about his therapy services, the did not feel that the Director of Therapy was listening to his concerns and treating him with dignity and respect and R318 felt that he only wanted to argue. Review of the facilities Quality Assistance Form completed for R318, with a completion date of 2/16/2025 and 2/17/2025 revealed that R318 had voiced concerns regarding noise level at the facility. The Quality Assistance Form dated 02/16/2025 and 02/16/2025 did not demonstrate that the issue had been resolved to the satisfaction of R318.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 Based on interview and record review the facility failed to ensure that grievances were promptly documented, investigated, tracked and resolved for 5 of 5 residents that participated in the Resident Council (RC) meeting and Resident #2. Findings include: Review of the Resident Council (RC) minutes dated 9/17/24 reflected concerns with staff not wearing name tags, delayed call light response times, noise levels. RC Minutes dated 10/22/24 reflected the Nursing Home Administrator on record (NHA) A attended the meeting and reported inservices were done with staff in relation to concerns brought forth from the 9/17/24 meeting. Residents reported noise level at night continued to be a problem. RC minutes dated 11/26/24 reflected concern related to staff being on their phones in common areas and at the nurses station. RC minutes dated 12/27/24 reflected the concern with staff being on their personal phones continues, call light response time was an issue and staff being loud at night/noise level was a concern. RC minutes dated 1/16/25 reflected call light response time, staff being on their phones, staff being loud/noise levels, staff not wearing name tags and a concerns that RC concerns were not being addressed. Concern forms generated from the RC meetings dated 1/16/25 reflected the NHA A would meet with RC members every two weeks. RC minutes dated 2/20/25 reflected education was provided to staff on the previous months concerns. Resident #2 Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE], revealed Resident # 2 (R2) was admitted to the facility on [DATE] with a readmitted [DATE] with diagnoses that include congestive heart failure, chronic obstructive pulmonary disease. R2 scored 15 out of 15 (cognitively intact) on the Brief Interview Status (BIMS). On 02/25/25 at 09:58 AM during an interview R2 voiced multiple concerns pertaining food, call light response time, noise, staff on their cell phones and lack of help from Social Services Director N. When R2 was queried if concern forms were generated or if the concerns were reported, R2 responded he regularly attends RC meeting and month after month the same issues are brought up and never resolved. Of note R2 did not attend the RC meeting on 03/03/25. On 03/03/25 at 10:59 AM, during the RC meeting , all 5 participants reported the staff were very noisy at night, they scream up and down the hall at each other they gather at the nurses station and laugh and giggle in the middle of the night and often residents will be woken up due to noise level. RC participants stated this had been a long standing problem with no resolution. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Four of 5 RC participants reported they routinely observe staff on their personal phones in the hall and while sitting at the nurses station, this too they reported gets discussed every month with no resolution. 5 of 5 participants further reported Social Services Director N was not responsive to their needs and concerns, ignored them, refused to meet with them and was frequently rude. RC members stated this had been brought up in RC meetings many times but never makes it into the RC minutes. When queried about staffing and call light response time 4 of 5 participants stated this too gets reported monthly and will slightly improve for a few weeks and then slides back into extended wait periods for help. One participant reported call light response time was great while State Agency was in the building. When queried if the Ombudsman or the Director of Nursing (DON) C or the self identified Nursing Home Administrator (NHA) B ever attended the RC meetings , it was reported the DON C never comes, the NHA B was new and the Ombudsman was invited to the March 2025's RC meeting due to the high volume of concerns, lack of accurate documentation of concerns, lack of follow through and lack of resolution of resident concerns. On 03/03/25 at 11:31 AM, Discussed concerns with self reported NHA B whom has been employed at the facility for one week and was unable to offer any explanation for ongoing concerns and lack of resolution.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 49272 Based on interview and record review, the facility failed to ensure that the Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) were provided to two (R323 and R325) of three residents reviewed for beneficiary notification, resulting in the potential for residents and/or representatives to be uninformed of the potential private pay charges of continued services at the facility and inability to file an appeal. Findings include: On 3/3/25 at 12:10 PM, Self-identified Nursing Home Administrator (NHA) B was asked to provide beneficiary notification information including NOMNC and/or SNF-ABN for three residents. A review of the documents provided revealed R323 was missing a SNF-ABN and the NOMNC for R325 was missing the second page, which is where the resident/resident representative would sign, acknowledging receipt and understanding. On 3/3/25 at 3:17 PM, during an interview with social services director (SSD) N, when asked when a resident should receive a SNF-ABN she reported that she gives one for every NOMNC issued. When asked why one was not provided to R323, she reported that she didn't know. When asked where the second page of the NOMC form (that would include a signature) was for R325, she reported that she would attempt to locate it. On 3/3/25 at 3:55 PM, Self-identified Nursing Home Administrator (NHA) B was notified of the missing beneficiary documents. He reported that he was aware. On 3/3/25 at 4:14 PM, SSD N reported that they could not find any of the 2024 beneficiary documents.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45038 This citation pertains to MI00146912, MI00150426 Based on observation, interview, and record review the facility failed to effectively clean and maintain the physical plant for resident rooms 200, 211,214, 301,303, 400 and maintain a homelike environment regarding noise and phone usage for Resident #318 and Resident Council. Findings Included: On 02/25/2026 at 08:50 a.m. in room [ROOM NUMBER] bathroom the laminate that covered the counter of the sink appeared to be coming off the countertop. Gripper strips only the right side of the bed for 200-1 were observed to be torn and coming off the floor. On 02/25/2025 at 09:13 a.m. room [ROOM NUMBER]-2 was observed to have a hole in the closet door. On 02/25/2025 at 10:19 a.m. observed room [ROOM NUMBER] to be unclean. Dust balls were observed on the floor. Review of the bathroom between room [ROOM NUMBER] and 402 sink counter was observed to lose on the wall and able to be moved up and down with ease. [NAME] caulk on sink counter was cracked and not present the entire length of the back wall. On 02/25/2025 at 09:23 a.m. room [ROOM NUMBER]-B was observed to have a wheelchair at bedside that had visibly torn vinyl arm rest, on both sides of the wheelchair. R41 in that room explained that it was his wheelchair, and he used it daily. During a tour on 03/03/2025 at 10:07 a.m. conducted with Maintenance Supervisor (MS) V room [ROOM NUMBER]-bathroom laminate that covered the countertop appeared to still be coming off counter. MS V explained that he had not received a work order to fix the laminate. room [ROOM NUMBER] gripper strips where still observed to be coming off the floor. MS V explained that he had not received a work order to fix the gripper strips on the floor. room [ROOM NUMBER] sink counter was observed to still be loose on the wall. MS V explained that he had not receive a work order to fix the sink counter. room [ROOM NUMBER]-2 closet was observed to still have a hole in the closet door. MS V explained that he had not received a work order to fix the closet door. room [ROOM NUMBER]-B was still observed to have a wheelchair had visibly torn arm rest on both sides of R41's wheelchair. MS V explained that he had not received a work order to fix R41's wheelchair arm rest. Resident #318 (R318) Review of the medical record revealed R318 was admitted to the facility 02/13/2025 with diagnoses that included atherosclerotic heart disease (build-up of fats, cholesterol and other substances in the artery walls), bilateral peripheral vertigo (dizziness caused by problem in inner ear), hyperlipidemia (high fat content in blood), hypertension, anemia (low red blood cells), and Barrett's esophagus (damage to the lower part of the esophagus). The most recent Minimum Data Set (MDS), with an Assessment Reference date (ARD) of 02/18/2025, revealed R318 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 02/25/2025 at 10:25 a.m. R318 was observed sitting on the side of his bed. R318 explained that he felt the facility did not honor his dignity because frequently he could hear the nursing staff yelling in the hallway at each other. R318 also explained that he could hear staff talking on their phones and swearing at their children to get to bed. R318 explained that he did not feel that this behavior was respectful to his desire for a peaceful environment. Review of resident council minutes form 11/26/2024 demonstrated phones: The staff is on their phones at the nurse's stations and in common areas. Review of resident council minutes from 12/27/2024 demonstrated staff is on their phones at the nurse's station and in common areas this remains ongoing. And Noise level: .the noise level is loud. This happens during the 6p-6a. The staff speak loud in the halls and at the nurse's stations when the staff walk down the halls around 4 a.m. Review of resident council minutes from 01/16/2025 demonstrated old Business that stated, .noise level is loud. This happens during 6p to 6a. The staff speak in a loud tone when they walk up and down the halls. also reported when the staff is sitting at the nurse's station they speak loudly. This remains ongoing. A concern form completed. The same minutes also demonstrated a section entitled phones: The staff is on their phones at the nurse's station and in common areas this remains ongoing. A concern form completed. 27306 On 02/25/25 08:36 AM upon entering room [ROOM NUMBER] there was an pungent urine odor permeating the room, the same odor was detected at the same time in room [ROOM NUMBER] that shared the same bathroom. The same overwhelming urine odor was detected again on 2/26/25 at 12:28 pm and again on 02/27/25 at 10:25 am. On 02/27/26 at 10:26 am, during an interview with Certified Nursing Assistant F and K both reported rooms [ROOM NUMBERS] always have a strong urine odor. On 03/03/25 at 10:24 AM, during an interview with Housekeeping Supervisor Q, he agreed both room [ROOM NUMBER] and 303 have a strong urine odor. Housekeeping Supervisor Q reported he personally had tried multiple products to get rid of the odor but cant get rid of it. It never goes away no matter what I do, maybe its just soaked into the floor.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 45038 This citation pertains to Intake: MI00150426 Based on observation, interview, and record review the facility failed to accurately record and make a prompt effort to resolve grievances for one resident (#318) of one resident reviewed for grievances. Findings Included: Resident #318 (R318) Review of the medical record revealed R318 was admitted to the facility 02/13/2025 with diagnoses that included atherosclerotic heart disease (build-up of fats, cholesterol and other substances in the artery walls), bilateral peripheral vertigo (dizziness caused by problem in inner ear), hyperlipidemia (high fat content in blood), hypertension, anemia (low red blood cells), and Barrett's esophagus (damage to the lower part of the esophagus). The most recent Minimum Data Set (MDS), with an Assessment Reference date (ARD) of 02/18/2025, revealed R318 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on 02/25/2025 at 10:09 a.m. R318 was observed sitting on the side of his bed. R318 explained that he had concerns that he had not received his medication as ordered. R318 explained that he had not received his valium until 02/18/2025. R318 explained that he keeps receiving his medication Protonic after his meals instead of prior to meals as it is to be given. R318 explained that he did not receive his Pregabalin until 02/17/2025. R318 also explained that he had a concern regarding that his food was continually cold. R318 also explained that he had concerns about the cleanliness of his room. R318 also explained that he had concerns regarding the noise level at the facility. R318 explained that someone at the facility had filled out a grievance form but he refused to sign the form because they did not record the correct information. R318 denied that any of his concerns had been addressed or that those concerns had been corrected to his satisfaction. Review of the facility Quality Assistance Form for R318, dated 02/17/2025, demonstrated details: Concerns with food temperature, noise level, medication concerns. Plan/Actions: meds addressed- billing issues resolved; noise level addressed with staff. The section Describe demonstrated I have been visiting (resident name) daily and often giving delivering his meal trays. I had suggested he come to the dining room, when he found it to difficult, I would bring him his food hot off the steam table. He has commented that food temps are improving. The Quality Assistance Form dated 02/17/2025 does not have a completion date or a resolved. The document does demonstrate someone wrote on the document Resident refused to sign. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Quality Assistance Form for R318, dated 02/16/25, demonstrated details Noise level, Food temp., Housekeeping. Plan/Actions: noise addressed with staff, housekeeping deep cleaned room. The section Describe demonstrated I have been visiting (resident name) daily and checking in on his food temps. I will deliver his trays as he can't come down to the dining room. He has comment that the temps are improving. The Quality Assistance Form dated 02/16/2025 does not have a completion date or a resolved. The document does demonstrate someone wrote on the document Resident refused to sign. During an interview on 03/03/2025 at 08:44 a.m. Director of Nursing (DON) C was asked to review the Quality Assistance Form, dated 02/16/2025 and 02/17/2025. DON C' was asked to provide detail as to what the issues was regarding R318's medication and R318's concern with noise level. DON C could not provide any detail regarding R318's concerns. During an interview on 03/03/2025 at 10:02 a.m. Licensed Nursing Home Administrator (LNHA) B was asked to explain his expectation of the grievance process. LNHA B explained that he expected that a resident completes a Quality Assurance Form or that a staff member could assist them to complete the form. LNHA B explained that once the Quality Assurance Form is completed that he would review the concern and talk with the resident. LNHA B explained then he would give the Quality Assurance Form to the appropriate department to address the issue. LNHA B explained that he would then expect to see a date that the issue had been completed. The Quality Assurance Form for R318, dated 02/16/2025 and 02/17/2025, were reviewed by LNHA B. LNHA B could not explain why each Quality Assurance Form did not include more detail and did not demonstrate a satisfactory conclusion of the issues.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 45038 Based on observation, interview, and record review the facility failed to accurately complete a Minimum Data Set (MDS) assessment for one resident (#6) of 16 residents reviewed for accurate assessments. Findings Included: Resident #6 (R6) Review of the medical record revealed R6 was admitted to the facility 10/17/2019 with diagnoses that included chronic obstructive pulmonary disease (COPD), atrial fibrillation, peripheral vascular disease (PVD), atherosclerotic heart disease (build-up of fats, cholesterol and other substances in the artery walls), chronic respiratory failure, depression, anxiety, urinary incontinence, lack of coordination, nausea, dysuria (discomfort, pain, or burning when urinating), muscle spasm, metabolic encephalopathy (impaired brain function), thrombocytopenia (low number of platelets), low back pain, generalized edema (excess fluid buildup in the body's tissues), chronic pain, psychotic disorder (mental disorder characterized by a disconnection form reality), developmental disorder of speech and language, obesity, hypertension, absence of left leg above the knee, nicotine dependence, insomnia, epilepsy (seizure disorder), and asthma. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/14/2024, revealed R6 had a Brief Interview of Mental Status (BIMS) of 14 (cognitively intact) out of 15. During observation and interview on 02/25/2025 at 03:45 p.m. R6 was observed sitting up in her wheelchair in the dining room. R6 explained that she usually wears glasses but she recently needed to have them replaced. R6 was not observed to be wearing glasses during the interaction. R6 explained wore glasses for a very long time. Review of R6 medical record demonstrated a progress note, dated 02/13/2025 at 11:20 a.m. which stated, Resident seen by (name of eye Physician and address). Exam completed and glasses ordered. Review of R6's picture in the medical record demonstrate that she was wearing glasses when the picture was obtained. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/14/2024, section B1200. Corrective Lenses- Corrective Lenses (contacts, glasses, or magnifying glass) used was marked as no. During an interview on 02/26/2025 at 04:20 p.m. Minimum Data Set (MDS) Coordinator Z was asked to review R6's picture in the medical record. MDS Coordinator Z explained that she had personally never seen R6 wearing glasses. MDS Coordinator Z explained that she had completed R6's MDS, with an Assessment Reference Date (ARD) of 11/14/2024, section B1200 and had documented that R6 did not have corrective lenses. MDS Coordinator Z explained that MDS Section B1200 was documented a no in error.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 Based on interview and record review the facility failed to notify the local state mental health authority of Pre-Admission Screening (PAS)/Annual Resident Review (ARR) (PASARR) changes for one (Resident #33) of two reviewed for PASARR. Findings include: Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE], reflected Resident 33 (R33) was admitted to the facility with diagnoses that included end stage renal disease, developmental disorder of scholastic skills, and bipolar disorder. Review of R33's clinical record reflected R33 scored 12 out of 14 (cognitively intact) on the Brief Interview Mental Status (BIMS). Review of R33's level one screening/3877 dated 12/28/23 reflected R33 had a mental illness and was learning disabled, the level II screen dated 12/29/23 reflected that R 33 was on a 30 day exemption and expected to be discharged from the facility within 30 days. The next 3877 was dated 9/12/24 and reflected R33 had a diagnosis of bipolar disorder, developmental disorder of scholastic skills and was prescribed an anti-depressant medication. On 02/26/25 02:54 PM, during an Interview with Social Service Director (SSD) N reported she did not complete 3877's that the corporate Social Worker did that and that person was out of the country and not available for an interview. SSD N then stated delay obtaining a level II assessment was due to Omnibus Budget Reconciliation Act (OBRA) refused do a level II assessment until a significant change in status was established related to R33's level of capacity and potential need for a guardian. When queried why there was no documentation in R33's medical record that OBRA opted not to complete a level II due to R33's capacity being in question, SSD N stated she could not document everything all the time, and although it was not documented she did communicate with (Licensed Master Social Worker (LMSW) R from Community Mental Health Authority who instructed SSD N hold off on submitting a 3877 until R33's capacity and guardianship was established. During a phone interview with LMSW R from Community Mental Health Authority on 02/27/25 08:46 AM, she reported a level II screening was in fact on hold until the determination of capacity /decision making ability was completed for R33. Review of R33's clinical record reflected the court appointed a legal guardian for R33 on 6/06/24 and R33's significant change 3877 was not completed until 9/12/24. LMSW R reported over 3 months from the time guardianship was granted and the 3877 was submitted to Community Mental Health was not timely. During a follow up interview on 02/27/25 01:53 PM with SSD N she offered no explanation as to why it took over 3 months to complete the significant change PASARR.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45038 Based on observation, interview, and record review the facility failed to develop and implement comprehensive care plans for one resident (#32) of 16 reviewed. Findings Included: Resident #32 (R32) Review of the medical record revealed R32 was admitted to the facility 04/18/2019 with diagnoses that included multiple sclerosis, paraplegia (paralysis that occurs in the lower half of the body), neuromuscular dysfunction of bladder, type 2 diabetes, obesity, diabetic neuropathy (nerve damage caused by diabetes), cardiomegaly (enlarge heart), muscle spasm, anemia (low red blood cells), hyperlipidemia (high fat content in blood), chronic obstructive pulmonary disease (COPD), chronic pain, altered mental status, metabolic encephalopathy (impaired brain function), insomnia, edema, anxiety, major depression, migraine, and gastro-esophageal reflux. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) 0f 10/12/2024, revealed R32 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on 02/25/2025 at 01:30 p.m. R32 was observed lying in bed. R32 explained that he wore upper dentures but that he currently could not find them and was waiting for the facility to replace them. R32 could not recall if he had told any staff that he could not find his upper denture. R32 further explained that he had just received new upper dentures in the fall of 2024. Review of R32's plan of care did not have any information that he wore upper dentures. R32's Kardex (document explaining necessary resident care to be used by Certified Nursing Aides) did not demonstrate that R32 wore upper dentures. Review of R32's medical record demonstrated a document entitled Dental Group with a date of 11/20/24 which stated, Inserted upper flexible partial denture. Adjusted buccal flanges on right side to make insertion easier. Partial was stable and occlusion was good. Patient thought it felt comfortable . Review proper care of partial with the patient. Dispensed denture case and denture brush obtained from the staff. Advised patient that will do any needed adjustment at my next visit. During an interview on 03/03/2025 at 01:29 p.m. Social Service Director N explained that she was not aware that R32 was missing his dentures. She explained that she had just assisted him with obtaining his upper dentures several months ago. Social Services Director N explained that she would go to R32's room and attempt to locate his dentures. During an interview on 03/03/2025 at 01:42 p.m. Minimum Data Set (MDS) Coordinator Z explained that she was the person that was responsible to update the plan of care if a resident had dentures. MDS Coordinator Z was asked if R32 had partial dentures and she responded that he did. MDS Coordinator Z confirmed that R39's partial upper dentures where not included on his plan of care or Kardex. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/03/2025 at 01:50 pm. Social Services Director N explained that R39's dentures were located in this closet and provided back to R39.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 Based on observation, interview and record review the facility failed to include one resident (R#29) in care plan development of 16 residents reviewed for participation in care planning. Findings include: Resident #29 (R29) Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] reflected Resident 29 (R29) was admitted to the facility on [DATE] with diagnoses that included mild cognitive impairment, schizophrenia and seizure disorder. R29 scored 10 out of 15 (mild cognitive impairment) on the Brief Interview for Mental Status (BIMS). On 02/25/25 at 09:04 AM, R29 was observed sitting in her room and was observed to have sad facial expressions. When queried about her mood R 29 reported she did not like living at the facility and wanted to be discharged back to the community. R29 elaborated that she was admitted to the facility last spring or summer and was discharged to an adult foster care in August 2024 with in home services from the community. R29 reported during her initial stay she had a care conference and was included and involved in her plan of care, R29 stated since her readmission last September, she has not had a care conference and was not included in her plan of care. When queried if she had met with Social Service Director (SSD) N to discuss her concerns R29 stated she tried on more than one occasion but SSD N was always very short and always has an attitude. R29 further stated she was well aware her brother was her guardian but did not think having a guardian made her lose her voice related to wants, needs, and desires be completely bypassed. R29 stated she just wanted to have a care conference and discuss her discharge plans. On 02/27/25 at 01:45 PM, SSD N verified that R29 was discharged in August of 2024 to an Adult [NAME] Care (AFC) and was not expected to return to return to the facility. Review of R29's clinical record including the MDS the admission to the facility on [DATE] was new. When queried why there was no patient care conference held in September 2024 upon R29's admission, SSD N stated there was a care conference held in December 2024. When reiterated why there wasn't a care conference in September 2024 while treated as a new admission with a new MDS , SSD N stated R29 Wasn't gone that long. When queried why the interdisciplinary team wouldn't meet with R29 to discuss what occurred at AFC , reason for returning to the facility and what current goals were SSD N stated she knew R29 was going to stay long term and didn't need to have a care conference. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R29's medical record with SSD N present, reflected a form titled Care Plan Conference Summary dated 12/31/24 the form indicated neither R29 or R29's legal guardian attended. There was no documentation that R29 or the R29's guardian was invited to the care conference held on 12/31/24. Page 1. question 1. of the care plan conference summary form asks what attempts were made to involve the resident or resident representative if they did not attended , several options were available to check off i.e.; different day, different time, via phone or written correspondence. None of which were checked. When SSD N was queried about the 12/31/24 care conference she reported R29's guardian attended, when queried why that was not documented on the attendance form or else where in R29s medical record SSD N stated she didn't know. When queried if R29 was invited to the 12/31/24 care conference SSD N stated she couldn't recall, but remembered the guardian attended. SSD N elaborated that R29 seeks her out several times a week and these conversations were discussed. When queried where this was documented or care planned SSD N stated she could have documented better.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45038 This citation pertains to intake: MI00150426 Based on observation, interview, and record review the facility failed to follow physician orders for three residents (R11-brace application, R41-prosthetic fitting appointment, and R318-medication administration time) of sixteen residents reviewed for quality of care. Findings Included: Resident #41 (R41) Review of the medical record revealed R41 was admitted to the facility 10/27/2021 with diagnoses included chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD), alcoholic liver disease, emphysema (chronic lung disease that permanently damages the lungs making his difficulty to breath), anemia (low red blood cells), alcoholic fatty liver, polyneuropathy (a peripheral nerve disorder that causes multiple nerves throughout the body to malfunction simultaneously), hypertension, hypotension, hyperlipidemia (high fat content), acquired absence of right leg above the knee, acquired absence of left leg above the knee, muscle spasm, chronic pain, anxiety, nicotine dependence, alcohol abuse, and dementia. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/03/2025, revealed R41 had a Brief Interview of Mental Status (BIMS) of 12 (moderate cognitive impairment) out of 15. During observation and interview on 02/26/2025 at 08:54 a.m. R41 was observed lying in his bed. R41 explained that he did not have lower limbs bilaterally and was waiting to receive prosthetics. R41 explained that his stump incision had healed, and he was looking forward to being able to walk again. Review of R41's medical record demonstrated Appointment/Transportation Note, 12/23/2024 at 08:33 a.m. Note Text: Wound RN (RN) contact [NAME] Heart and Vascular office regarding staples to L(left) AKA (Above the knee) incision. Incision is healed and appears that staples are beginning to push outward and causing resident discomfort. No s/s (signs and symptoms) of infection observed by writer verbal order received for OK to remove staples to incision ok to schedule resident to return in 1 week to clinic to office if resident is wishing to pursue a prosthesis. Wound RN disgusted with resident during staple removal. Resident wishes to move forward with prosthesis . Review of R41's medical record demonstrated an order entered 01/29/2025, Order Summary: Referral for prosthetic fitting. Review of R41's medical record demonstrated a Social Services Progress Note, 02/03/2025 at 02:49 p.m. Note Text: . Utilizes a wheelchair for all motivation, recent orders placed for prosthetic fitting. Resident is eager to ambulate again. To follow up with both Endocrinology and Cardiology per facility NP/Physician . No other documentation in R41's medical record demonstrated that an appointment for prosthetic fitting had occurred. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/2025 at 09:30 a.m. Assistant Director of Nursing (ADON) T explained that when an order is received for an appointment that the facility scheduler would call the service provider and schedule an appointment. ADON T verified the R41 had a referral for prosthetic fitting. ADON T explained that she would have to verify if the appoint had been made yet. During an interview on 02/27/2025 at 09:58 a.m. Assistant Director of Nursing (ADON) T returned and explained that R41's appointment for the referral for prosthetic fitting had not bee completed yet. ADON T explained that the Manager of Therapy was calling today to schedule that appointment. ADON T could not explain why the appointment had not been requested before this date. Resident #318 (R318) Review of the medical record revealed R318 was admitted to the facility 02/13/2025 with diagnoses that included atherosclerotic heart disease (build-up of fats, cholesterol and other substances in the artery walls), bilateral peripheral vertigo (dizziness caused by problem in inner ear), hyperlipidemia (high fat content in blood), hypertension, anemia (low red blood cells), and Barrett's esophagus (damage to the lower part of the esophagus). The most recent Minimum Data Set (MDS), with an Assessment Reference date (ARD) of 02/18/2025, revealed R318 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on 02/25/2025 at 10:41 a.m. R318 was observed sitting at the side of his bed. R318 explained that he was supposed to receive his medication Protonix prior to his meals. R318 explained that he had expressed his concerns to the facility but it still keeps occurring that he does not receive his Protonix until after his meals. R318 explained that he still had not received his Protonix today and it is currently 10:15 a.m. - clearly after breakfast. Review of R318's medical record demonstrated an order, written 02/17/2025, Pantoprazole Sodium (Protonix) Oral Tablet Delayed Release 40 mg (milligrams) (Pantoprazole Sodium) Give 1 tablet by mouth two times a day for GERD (Gastro-esophageal reflux disease). During an interview on 02/27/2025 at 04:29 p.m. Director of Nursing (DON) C was asked when the medication Protonix was supposed to be given to residents. DON C explained that Protonix usually is given before meals. Requested DON C to provide report that demonstrated what time Protonix had been given to R318. Review of R318's Medication Administration Record (MAR) for the month of February 2025 revealed that Pantoprazole Sodium oral tablet delayed release 40 mg (milligrams) was ordered 02/14/2025 to be given as a liberal med pass (once on day shift and once on night shift). The MAR revealed that the Pantoprazole order was discontinued 02/17/2025 and rewritten on 02/17/2025 to be given at 06:00 a.m. and 04:00 p.m. Review of the facility of mealtimes demonstrated that R318s meals were delivered before his breakfast and dinner mealtimes. Review of R318's EMAR (electronic medication administration record)- Resident Details report revealed Pantoprazole was given on the following date and times (after meals): 02/14/2025 at 07:45 p.m., 02/15/2025 at 09:46 a.m. and 08:03 p.m., 02/16/25 at 09:25 a.m. and 07:53 p.m., 02/21/2025 at 09:21 a.m., and 02/25/25 at 07:39 p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/03/2025 at 08:44 a.m. Director of Nursing (DON) C review R318's EMAR (electronic medication administration record)- Resident Details report for Pantoprazole. DON C could not provide an explanation why the medication had not been provided before meals. 46954 Resident #11 (R11) Review of the medical record reflected R11 was admitted to the facility on [DATE], with diagnoses that included generalized anxiety disorder, dependence on renal dialysis, depression, legal blindness, and major depressive disorder. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/18/24, reflected R11 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 2/25/25 at 1:15 PM, R11 was observed in bed watching television. R11 had lidocaine patches applied to her neck. R11 reported that the lidocaine patches were for pain control and that she was supposed to be wearing a neck brace at all times, however the neck brace was not observed on R11. The cervical spine collar (neck brace) was observed on the bedside table, out of reach from R11. Review of an active Physician Order dated 11/29/24 reflected CT [cervical spine] collar at all times, remove every shift for skin checks and bathing. On 2/28/25 at 1:54 PM, R11 was observed in her room watching television. R11 did not have the cervical spine collar on. The cervical spine collar remained in the same spot as the previous observation. In an interview on 2/28/25 at 2:00 PM, Certified Nursing Assistant (CNA) X stated that she did not know the purpose of the cervical spine collar, but R11 is supposed to be wearing it. CNA X stated that R11 was not able to apply or remove the cervical spine collar herself. Review of the medical record revealed no documented refusals for the cervical spine collar.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49272 Based on observation, interview and record review, the facility failed to provide diabetic foot care to one (R47) of one reviewed for foot care, resulting in long toenails and discomfort. Findings include: Review of the clinical record revealed R47 was admitted into the facility on [DATE] with diagnoses that included: Type 2 Diabetes Mellitus and need for assistance with personal care, reduced mobility. Review of R47's physician orders revealed the following order entered on 12/12/24, May be seen by Ophthalmology, Podiatry, Audiologist, Psychiatrist, Psychologist, Optometrist, dentist, and wound care as needed or warranted. Review of R47's progress notes revealed no notes regarding podiatry services. According to the Minimum Data Set (MDS) assessment dated [DATE], R47 had scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition), required partial/moderate assistance with personal hygiene. On 2/25/2025 at 3:52 PM, R47 was observed lying in his bed with his family member (family member U) at his bedside. R47 and family member U both reported that they have been waiting a long time for someone to trim resident's toenails. Family member U reported that since they had not been trimmed by facility staff, they had trimmed all of them except the nails on his big toes. Bilateral big toenails were observed to be long, extending past the resident's toes. Family member U reported that the long toenails scrape the resident's legs and cause discomfort. Family member U stated that she has asked the facility social worker to assist the resident to be seen by podiatry for the past 2 months. On 2/26/25 at 3:35 PM, R47 was observed asleep on his back, with his legs/feet uncovered. Bilateral big toenails observed to still be very long, extending past his toes. A small, round, scab was noted on R47's right lower leg. On 3/03/25 at 11:53 AM, R47's bilateral big toenails were observed to still be long, extending past his toes. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 10:10 AM, during an interview with Social Services Director (SSD) N, they reported that they were responsible for ancillary services (including podiatry) and had taken it over about three weeks ago. When asked how the facility ensures residents are seen by ancillary services in a timely manner, SSD N reported that they had went through the whole building a couple weeks ago and sent consents and face sheets to their ancillary services provider. When asked what the status was for R47 being seen by podiatry, SSD N stated the resident was rather new (it should be noted that the resident was admitted to the facility approximately 2.5 months ago) and that she had not been given any new orders or alerted to any need for services. When asked who determines when residents need services, SSD N reported that the resident can tell the nurse or physician for emergent needs and for non-urgent needs their ancillary services provider gets a monthly census so that residents can be added to the appropriate specialties rotation. SSD N was notified that R47 has a diagnosis of diabetes and was observed to have very long toenails. When asked if there is a special consideration for diabetic residents to be seen by podiatry, SSD N reported they should be seen by podiatry on their next visit following the order/consult and that to her knowledge an order/consult was not sent to podiatry for R47. SSD N further reported that podiatry is typically at the facility about every 45 days. On 2/27/25 at 5:09 PM, during an interview with Director of Nursing (DON) C, DON C reported that they were already aware of the concern related to R47's long toenails. DON C reported that they had not seen the resident's toenails yet but the resident is on her list to be seen. No additional information was received at that time. Review of the facilities policy titled Nail Care updated 8/24, documented in part Assessments of residents nails will be conducted on admission and readmission to determine the resident's nail condition, needs, and preferences for nail care .Obtain history and preferences regarding podiatrist .Identify conditions that increase risk for foot or nail problems, such as diabetes .Routine cleaning and inspection of nails will be provided during ADL (activities of daily living) care on an ongoing basis .Routine nail care, to include trimming and filing, will be provided on a regular basis and as need arises .Nails should be kept smooth to avoid skin injury .Only podiatrists, physician/practitioners, or licensed nurse shall trim toenails for residents with diabetes or circulation problems .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 38383 This citation pertains to intakes MI00150119, MI00146912 and MI00150426. Based on interview and record review, the facility failed to maintain sufficient staffing levels to ensure adequate and timely resident care for four (Resident #6, #32, #50 and #318) from a total census of 65. Findings include: During an interview on 02/27/25 at 3:54 PM, Scheduler J reported staffing levels were primarily based on facility census. 27306 On 02/25/25 09:11 AM, during an interview with Certified Nursing Assistant (CNA) W reported that today she was assigned 13 residents, will at times have 16 residents which was very difficult but impossible to complete all the assigned tasks in caring for that many residents. During an interview with CNA X on 02/25/25 at 09:37 AM, it was reported 13 residents were assigned today. CNA X elaborated on many occasions closer to 20 residents have been assigned, and it was not possible to provide the care needed for 20 residents. On 02/27/25 at 10:26 AM, CNA's E and K reported they normally have 12 or 13 residents assigned to care for but the facility experiences a lot of staff that call in sick and when this happens they will have 20 residents assigned to them and this was not doable. When queried if the Nurses help them answer call lights, toilet residents etc both CNA E and CNA K stated it depended on what nurse was working. On 03/03/25 at 10:59 AM, during the Resident Council (RC) meeting 4 of 5 participants reported the facility was routinely short staffed and call light response time could take an hour or more. RC members agreed staffing concerns get reported monthly and will slightly improve for a few weeks and then slides back into extended wait periods for help. One participant reported call light response time was great while State Agency was in the building. 45038 Resident #6 (R6) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed R6 was admitted to the facility 10/17/2019 with diagnoses that included chronic obstructive pulmonary disease (COPD), atrial fibrillation, peripheral vascular disease (PVD), atherosclerotic heart disease (build-up of fats, cholesterol and other substances in the artery walls), chronic respiratory failure, depression, anxiety, urinary incontinence, lack of coordination, nausea, dysuria (discomfort, pain, or burning when urinating), muscle spasm, metabolic encephalopathy (impaired brain function), thrombocytopenia (low number of platelets), low back pain, generalized edema (excess fluid buildup in the body's tissues), chronic pain, psychotic disorder (mental disorder characterized by a disconnection form reality), developmental disorder of speech and language, obesity, hypertension, absence of left leg above the knee, nicotine dependence, insomnia, epilepsy (seizure disorder), and asthma. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/14/2024, revealed R6 had a Brief Interview of Mental Status (BIMS) of 14 (cognitively intact) out of 15. During observation and interview on 02/25/2025 at 03:50 p.m. R6 was observed sitting in the dining room in her wheelchair. R6 explained that the facility never has enough staff because she always sees them sitting at the nurse's station. R6 explained that it took 3 hours to answer her call light the other night. Resident #32 (R32) Review of the medical record revealed R32 was admitted to the facility 04/18/2019 with diagnoses that included multiple sclerosis, paraplegia (paralysis that occurs in the lower half of the body), neuromuscular dysfunction of bladder, type 2 diabetes, obesity, diabetic neuropathy (nerve damage caused by diabetes), cardiomegaly (enlarge heart), muscle spasm, anemia (low red blood cells), hyperlipidemia (high fat content in blood), chronic obstructive pulmonary disease (COPD), chronic pain, altered mental status, metabolic encephalopathy (impaired brain function), insomnia, edema, anxiety, major depression, migraine, and gastro-esophageal reflux. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) 0f 10/12/2024, revealed R32 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on 02/25/2025 R32 was observed lying in bed. R32 explained that his call light is frequently on for an hour to an hour and a half. R32 explained that he is bedridden and when he placed his call light on it is mostly to assist with getting a drink of water or having items handed to him that he can not reach. Resident #50 (R50) Review of the medical record revealed R 50 was admitted to the facility 06/14/2024 with diagnoses that included acute respiratory failure, cerebral infarction (stroke), type 2 diabetes, anemia (low red blood cells), encephalopathy (impaired brain function), acute kidney failure, hyperkalemia (low potassium), atrial fibrillation, bipolar disorder, acquired absence of Right leg below the knee, depression, hypothyroidism (low thyroid hormone), muscle weakness, and unsteady gait. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/22/2025, demonstrated a Brief Interview of Mental Status (BIMS)of 15 (cognitively intact) out of 15. (continued on next page)

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	235517	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 02/25/2025 at 03:11 p.m. R50 was observed sitting up in her wheelchair at her bedside. R50 explained that it sometimes takes over an hour for staff to answer her call light. R50 explained that it usually occurs on the night shift. R50 explained when she placed her call light on she usually is in need to use the bathroom. Resident #318 (R318) Review of the medical record revealed R318 was admitted to the facility 02/13/2025 with diagnoses that included atherosclerotic heart disease (build-up of fats, cholesterol and other substances in the artery walls), bilateral peripheral vertigo (dizziness caused by problem in inner ear), hyperlipidemia (high fat content in blood), hypertension, anemia (low red blood cells), and Barrett's esophagus (damage to the lower part of the esophagus). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/18/2025, revealed R318 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on 02/25/2025 at 10:27 a.m. R318 was observed sitting on the side of his bed. R318 explained that he has had times where it will take over 45 minutes for staff to answer his call light. He explained that recently he had diarrhea and had been incontinent of his bowels. R318 explained that he walked himself to the bathroom and cleaned himself up and that staff did not come to answer his call light until he was head back to bed. R318 explained that that event had occurred longer than an hour for someone to answer his call light. In an interview on 02/25/25 at 09:24 a.m. Unit Manger (UM) P explained that she frequently works as a nurse manager and a nurse caring for residents. UM P explained that the facility is very short staffed. UM P explained that many times during the day shift there is on four certified nursing assistants for entire building. UM P explained that yesterday she had worked the floor, taking care of residents, for nine hours and four minutes and then was relieved by the MDS coordinator. During an interview on 02/27/2025 at 08:22 a.m. Certified Nursing Aide (CNA) X explained that she had worked at the facility a little over two months. CNA X explained that she usually worked the first shift (6 a.m. to 6 p.m.) and that she works 36 hours per week. She explained that staff call-in frequently and no one comes in to replace them. CNA X explained that they are supposed to have six CNA's working in the building, but they frequently only have three to four CNA's. CNA X explained that when they are short staff, she could have to provide care for twenty residents and all of the resident care can not be completed. CNA X explained that working short staff occurs approximately two times per week. When asked if managerial staff assisted when the units are short staffed, CNA X explained that management does not help. CNA X explained that she observed Maintenance Supervisor V passing trays and that is only been observed when State Surveyors are in the building. 46954 In an interview on 2/27/25 at 2:05 PM, Certified Nursing Assistant (CNA) K stated that staffing at the facility sucks and most management doesn't assist on the floor when needed. CNA K stated that she does not get time for her breaks that she is entitled to and has witnessed other CNA's ignoring call lights. CNA K stated that she often comes in to her shift and discovers residents being saturated in their briefs. CNA K stated she had to do a complete bed change that morning because her resident was discovered saturated in urine, and the linens on the bed were soaking wet with urine. CNA K stated that it is heartbreaking to observe staff ignoring the screams for help from the residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/28/25 at 8:27 AM, Licensed Practical Nurse (LPN) E stated that the nursing workload is extremely heavy during the day due to the amount of medications to administer, the treatments that need completed, and assisting with meals. LPN E stated staffing becomes a bigger issue with call ins. In an interview on 2/28/25 at 10:01 AM, Registered Nurse (RN) P stated staffing is not good and has personally witnessed time and time again care not being completed such as showers, oral care, nail care, brief changes, and turning and repositioning. RN P stated she has observed call lights being activated for over an hour, and has discovered residents saturated and soiled in urine and feces. In an interview on 2/28/25 at 11:49 AM, CNA F stated staffing at the facility is bad enough that they had recently decided to leave the facility. CNA F stated that there had been times when they were the only CNA in the facility for 66 residents, and on another occasion recently, they were one of two CNA's in the building, leaving them responsible for over 30 residents. CNA F stated that the management does not assist when staffing is short. CNA F stated, this place is horrible, the staffing is horrible, and we are never fully staffed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45038 This citation pertains to intake: MI00150426 Based on observation, interview, and record review the facility failed to provide medication in a timely manner for one resident (R318) out of four residents reviewed for pharmacy services. Findings Included: Resident #318 (R318) Review of the medical record revealed R318 was admitted to the facility 02/13/2025 with diagnoses that included atherosclerotic heart disease (build-up of fats, cholesterol and other substances in the artery walls), bilateral peripheral vertigo (dizziness caused by problem in inner ear), hyperlipidemia (high fat content in blood), hypertension, anemia (low red blood cells), and Barrett's esophagus (damage to the lower part of the esophagus). The most recent Minimum Data Set (MDS), with an Assessment Reference date (ARD) of 02/18/2025, revealed R318 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on 02/25/2025 at 10:14 a.m. R318 was observed sitting on the side of his bed. R318 explained that he had not received his valium until several days after being admitted . R318 also explained that he had not received his Lyrica for several days after being admitted . R318 explained that he did not thing it was unreasonable that his medications would be available upon his arrival to the facility. Review of R318's medical records demonstrated a physician order, dated 02/14/2025, that stated: Pregabalin Oral Capsule 25mg (milligrams), give 2 capsules by mouth two times per day. Review of R318's Medication Administration Record (MAR) demonstrated that Pregabalin Oral Capsule 25mg was documented as 9 (other/see progress notes) twice for the dates of 02/14/2025, once for the date of 02/15/2025, and once for the date 02/17/2025. Review of R318's progress notes demonstrated 02/14/2025 at 08:07 Pregabalin Oral Capsule 25mg awaiting drug delivery, 02/14/2025 at 04:51 p.m. Pregabalin Oral Capsule 25 mg . awaiting drug delivery, 02/15/2025 at 09:46 a.m. Pregabalin Oral Capsule 25 mg . awaiting drug delivery, 02/17/2025 at 10:00 a.m. Pregabalin Oral Capsule 25mg Medication not available. R318 medical record also demonstrated a progress note entered 02/17/2025 at 11:55 a.m. that stated, Pregabalin now appears to be in the process of being filled . Review of R318's medical record demonstrated a physician order, dated 02/14/2025, that stated: Diazepam (valium) Tablet 5mg (milligrams) give 0.5 tablet by mouth every 8 hours as needed for dizziness for 14 days. Review of R318's Medication Administration Record (MAR) demonstrated that documentation for Diazepam Tablet 5mg was blank until 02/18/2025, demonstrating that the medication was not given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/27/2025 at 04:29 p.m. Director of Nursing (DON) C explained that it was her expectation that medication that is ordered is delivered from pharmacy within 24 hours that a resident has been admitted . DON C reviewed R318's medical record and confirmed that there was a delay in obtaining R318's Pregabalin and his valium. DON C could not explain why there was a delay. In an interview on 03/03/2025 at 08:44 a.m. Director of Nursing C explained that because a controlled prescription had not been received for the medication of valium and pregabalin, R318's medication had a delay in the dispensing of those medications. DON C explained that it was not acceptable that the controlled prescriptions for valium and pregabalin were not provided to the pharmacy for several days.

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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** 46954 Based on interview and record review, the facility failed to ensure the attending physician documented in the medical record the rationale for no changes to the medication review for one (Resident #4) of five reviewed. Findings include: Resident #4 (R4) Review of the medical record revealed R4 was admitted to the facility on [DATE] with diagnoses that included vascular dementia. Review of R4's Physician's Orders revealed a current orders for Atorvastatin Calcium 20 milligrams (mg). Review of the Medication Regimen Review dated 5/7/2024 revealed this resident is on hospice. please consider the long term benefit of the atorvastatin 20 mg therapy and discontinue at this time. The Physician/Prescriber response was marked as disagree and signed on 5/21/24. There was no documented rationale in R4s medical record as to why the recommendation was not implemented. only a hand written note at the bottom of the document which stated keep on statin. In an interview on 3/03/25 at 2:14 PM, Director of Nursing (DON) B stated that when the facility receives a pharmacy recommendation, the recommendation is printed out and given to the provider to go over. If the provider disagrees, the provider will complete a rationale as to why they disagree with the recommendation. The request for the justification was not fulfilled by survey exit.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45038 Based on observation, interview, and record review the facility failed to ensure that two residents (#6), #50) of five reviewed were free from unnecessary medications. Findings Included: Resident #6 (R6) Review of the medical record revealed R6 was admitted to the facility 10/17/2019 with diagnoses that included chronic obstructive pulmonary disease (COPD), atrial fibrillation, peripheral vascular disease (PVD), atherosclerotic heart disease (build-up of fats, cholesterol and other substances in the artery walls), chronic respiratory failure, depression, anxiety, urinary incontinence, lack of coordination, nausea, dysuria (discomfort, pain, or burning when urinating), muscle spasm, metabolic encephalopathy (impaired brain function), thrombocytopenia (low number of platelets), low back pain, generalized edema (excess fluid buildup in the body's tissues), chronic pain, psychotic disorder (mental disorder characterized by a disconnection form reality), developmental disorder of speech and language, obesity, hypertension, absence of left leg above the knee, nicotine dependence, insomnia, epilepsy (seizure disorder), and asthma. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/14/2024, revealed R6 had a Brief Interview of Mental Status (BIMS) of 14 (cognitively intact) out of 15. During observation and interview on 02/25/2025 at 04:09 p.m. R6 was observed sitting in the dining room with a smoking apron covering her chest and legs. R6 explained that it was time to go outside and smoke a cigarette. Review of R6 medical record demonstrated a physician order which stated Nicotine patch 24 hour 14 MG(milligram)/24 HR(Hour) apply 1 patch transdermally one time a day for smoking cessation until 02/20/2026 and remove per schedule. The previous order was written 02/20/2025. Review of R6 February medication record demonstrated the transdermal nicotine patch was applied 02/21/2025 and refused daily until 02/26/2025. In an interview on 02/26/2025 at 01:48 p.m. Licensed Practical Nurse (LPN) D explained that R6 had an order for a nicotine patch to be applied daily but that R6 had been refusing application of the nicotine patch and went outside to smoke. LPN D explained that this order was written during a recent illness but that it was never used by R6. LPN D explained that the order for the nicotine patch should have been discontinued as the resident has continued to smoke. According to Drugs.com use of a transdermal nicotine patch states Do not use -if you continue to smoke, chew tobacco, use snuff, or us nicotine gum or other nicotine containing products. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/26/2025 at 02:22 p.m. Director of Nursing (DON) C explained that R6 had an order for a transdermal nicotine patch that was to be used while she had been on isolation if she had requested. Documentation of R6's Medication Record demonstrated that it had been refused and never used. DON C explained that R6 should not be allowed to smoke if she had used a nicotine transdermal patch, and the order should have been discontinued on 02/26/2025 not discontinued on 02/26/2026 as written in R6's medical record. 46954 Resident #50 (R50) Review of the medical record revealed R50 admitted to the facility on [DATE] with diagnoses that included acute kidney failure. Review of the Physician's Order dated 2/11/25 revealed an as needed order for Tylenol Oral Tablet 325 MG (Acetaminophen). Give 2 tablet by mouth every 8 hours as needed for Elevated Temperature;Pain. Review of the Physician's Order dated 2/11/25 revealed an as needed order for Norco Oral Tablet 7.5-325 MG (Hydrocodone-Acetaminophen). Give 1 tablet by mouth every 4 hours as needed for pain. Review of these orders revealed no parameters for the maximum dose permitted for acetaminophen, and if given as ordered, would exceed the maximum dose of acetaminophen allowed. In an interview on 03/03/25 at 2:16 PM, Director of Nursing (DON) C agreed the ordered doses exceeded the prescribed parameter of 3000 mg.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49272 Based on observation, interview, and record review, the facility failed to ensure their medication error rate was below 5% when two medication errors were observed from a total of 27 opportunities for one resident (R61) of three reviewed, resulting in a medication error rate of 7.41%. Findings include: On 2/27/25 at 7:55 AM, registered nurse (RN) S was observed preparing and administering Spiriva inhaler (medication used to treat lung disease) 2.5 mcg and Advair discus (steroid inhaler used for lung disease) 250/50 mcg. Resident was handed and self-administered the Advair and immediately after was handed and self-administered the Spiriva. Upon exiting the room, RN S was asked if they would normally give any instructions related to the inhalers, they reported that they would normally have instructed the resident to wait 2 minutes in between each inhaler and that she had forgotten. On 2/27/25 at 4:48 PM, director of nursing (DON) C was asked what their expectation would be for specific instructions related to administration of both Spiriva and Advair inhalers. DON C reported that nursing should be instructing residents to swish and spit with steroid inhalers and should instruct them to wait 2 minutes in between each inhaled dose. According to the website mayoclinic.org when using Advair Rinsing your mouth with water after each dose may help prevent hoarseness, throat irritation, and infection in the mouth.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45038 Based on observation, interview, and record review the facility failed to ensure proper storage of medication for two residents (R41, R55) of 16 sampled residents and one medication cart of two medication carts reviewed for medication storage. Findings Included: Resident #41 (R41) Review of the medical record revealed R41 was admitted to the facility 10/27/2021 with diagnoses included chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD), alcoholic liver disease, emphysema (chronic lung disease that permanently damages the lungs making his difficulty to breath), anemia (low red blood cells), alcoholic fatty liver, polyneuropathy (a peripheral nerve disorder that causes multiple nerves throughout the body to malfunction simultaneously), hypertension, hypotension, hyperlipidemia (high fat content), acquired absence of right leg above the knee, acquired absence of left leg above the knee, muscle spasm, chronic pain, anxiety, nicotine dependence, alcohol abuse, and dementia. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/03/2025, revealed R41 had a Brief Interview of Mental Status (BIMS) of 12 (moderate cognitive impairment) out of 15. During observation and interview on 02/26/2025 at 08:36 a.m. R41 was observed lying in bed. As conversation was occurring R41 presented a cup of medication. When asked what was in the medication cup, R41 responded that the nurse had brought his medication in this morning. 9 pills were observed in the medication cup. R41 explained that he wanted to wait until after he ate breakfast to take his medication. R41 explained most of the time the nurses wait and watch him take his medication but occasionally, like today, they just leave them with him. R41 was then observed to place all 9 medications in his mouth and consume. Review of R41 medical record did not demonstrate an order or any assessments that he was capable of self-medication administration. In an interview on 03/03/2025 at 08:53 a.m. Director of Nursing (DON) C explained that it is facility policy to have an assessment for self-administration conducted then a decision will be reached by the inter-disciplinary team allowing the resident to self-administer medication. That determination is then placed in the resident medical record. DON C explained that currently there are not any residents that are approved for self-administration of medication. DON C confirmed that R41 was not allowed to self-administer medication. DON C could not explain why R41 was allowed to self-administer medication 27306 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 55 (R55) review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] reflected R55 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS) . On 02/25/25 at 08:36 AM, while entering R55's room alongside Social Service Director (SSD) N, R55 was observed in bed, there was a medication cup observed on R55's nightstand. The medication cup was observed to have 5 pills in the cup. R55 reported we woke her up at which time SSD N left the room. R#55 reported she was not woken up for breakfast or to take her medications. When queried if her medication were usually left at the bedside R55 reported yes sometimes. On 02/27/25 at 12:06 PM, during an interview with Assistant Director of Nursing (ADON) T reported there were no current residents in facility that were approved for self administration of medication. The observation that occurred on 2/25/25 at 8:36 am was shared ADON T who reported the expectation was that Nurses were to administer medications and ensure oral medications were consumed in the presence of the licensed nurse and not left at the bedside. 46954 On 2/28/25 at 7:58 AM, Licensed Practical Nurse (LPN) G was observed at the medication cart, preparing medications for the residents. When LPN G opened the top drawer on the medication cart, 4 medication cups stacked on top of eachother with two white pills in each cup was observed. LPN G explained that the medication cups each contained 2 Tylenol's and they were pre-pulled as a time saving measure. Another medication cup was observed in the top drawer containing roughly 7 pills in the cup. LPN G stated that those medications were for a resident however, when she went to administer the medications, the resident was sleeping so LPN G returned them to the cart and stored them in the top drawer. In an interview on 03/03/25 at 2:18 PM, Director of Nursing C stated that it was not okay to store medications in medication cups in the medication cart.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 Based on observation, interview and record review, the facility failed to address dental need for one resident (resident #2) of 3 reviewed for dental services. Findings include: Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE], revealed Resident # 2 (R2) was admitted to the facility on [DATE] with a readmitted [DATE] with diagnoses that include congestive heart failure, chronic obstructive pulmonary disease and morbid obesity. R2 scored 15 out of 15 (cognitively intact) on the Brief Interview Status (BIMS). On 02/25/25 at 10:11 AM during an interview, R2 was observed to have multiple teeth missing and the teeth that were present were observed to be discolored. R2 stated he had mouth pain and saw a dentist at the facility and extractions and dentures were discussed. R2 stated he wanted to have a 2nd opinion from his dentist in a neighboring town. R2 reported he discussed this with Social Services Director (SSD) N and was instructed R2 or his niece to make the appointment and transportation arrangements that she was not going to assist in getting a second opinion. R2 stated he was not sure how to do this because wheelchair vans were not equipped to someone of his size. Review of R2's Dental consult completed at the facility dated 1/10/25 reflected He is having trouble chewing properly and a complete upper denture and lower partial denture are indicated following the extractions of several teeth. This will benefit his nutrition and general health. The consult further revealed the extractions should be done by an oral surgeon. On 02/26/25 at 02:45 PM, during an interview with SSD N she reported that R2 saw the facility dentist and their recommendation was for R2 to see an oral surgeon for extractions. SSD N acknowledged that she was aware R2 wanted to see his personal dentist in a neighboring town and had not assisted with arrangements because he didn't need a second opinion, he needed an oral surgeon. When queried if assistance was provided in making an appointment with an oral surgeon SSD N stated no R2 refused to see the oral surgeon. When queried if it was SSD N's decision to make if a resident requests to a second opinion, there was no response. SSD N was requested to provide documentation where R2 made the refusal for to address his oral health needs. No documentation was provided by the end of the survey.

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	235517	A. Building B. Wing	03/03/2025

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49272 This citation includes intake MI000150426 Based on observation, interview and record review, the facility failed to provide requested dietary items for three residents (R29, R60 and R319) of ten residents reviewed for food. Findings include: Resident #60 (R60) Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] reflected Resident 60 (R60) was admitted to the facility on [DATE] with diagnoses that included: anxiety and depression. R60 scored 14 out of 15 (indicating intact cognition) on the Brief Interview for Mental Status (BIMS). On 2/25/2025 at 9:50 AM, during an interview with R60, he reported he often has requested double portions of certain foods and he rarely has been provided double portions or what is indicated on his meal ticket. On 3/03/25 at 11:48 AM, R60 was observed sitting up eating lunch, he reported his lunch was correct however his breakfast that morning was incorrect. He reported that he asked for two packets of brown sugar for his oatmeal and only received one (he further stated that happens often), and his preference is whole milk and he was given 2% milk. R60 reported that his preference of whole milk is listed at the top of his ticket each day but is not always followed. Resident #319 (R319) Review of the clinical record revealed R319 was admitted into the facility on [DATE] with diagnoses that included: fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, obstructive sleep apnea, muscle weakness, history of falling. On 2/25/25 at 10:50 AM during an interview with R319 he reported that the food is not good, and that he does not routinely get asked what he wants for each meal. On 2/26/25 at 12:15 PM, R319 again reported that he is not being offered menu choices and that he received a banana which he hates. On 2/27/25 at 12:33 PM, R319 reported that he had gotten a visit from DM Y the day before and he was told that he would get more say in what food he received. A review of his lunch tray revealed he should have received coffee or hot tea and he did not, instead he received apple juice, orange juice and grape juice. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/3/25 at 2:49 PM, during an interview with Dietary Manager (DM) Y, she reported that dietary staff meet with the resident upon admission and determine their preferences which is printed on the top of the meal tickets. DM Y further stated that meal tickets are filled out by the residents themselves whenever possible and her staff is trained to put whatever is on the ticket, on the tray. When asked how the facility ensures residents receive what they ask for each meal she again stated, her team was trained to put whatever is on the ticket, on the tray. When asked if there are any audits done to ensure accuracy, DM Y reported that she spot checks meal service every four weeks. When asked about the discrepancies for R60 and R319 she reported that the facility had ran out of whole milk and she was not sure what happened with the missing tea. 27306 Resident #29 (R29) Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] reflected Resident 29 (R29) was admitted to the facility on [DATE] with diagnoses that included mild cognitive impairment, visual impairment, schizophrenia and seizure disorder. R29 scored 10 out of 15 (mild cognitive impairment) on the Brief Interview for Mental Status (BIMS). During a bedside interview with R29 on 02/25/25 at 09:06 AM, R29 reported the food was awful and often has to pay out of pocket and order out. R29 reported big problem was that food preferences were not honored and what was ordered isn't given. On 02/26/25 at 11:56 AM, R29 was observed sitting up in bed, the meal tray was five feet away and nothing had been set up. R29 stated the tray was just delivered and she had not eaten anything yet. A bowl peas, a bowl soup, one small glass cranberry juice one banana was observed on the tray. The outside of each bowl was cool to the touch. R29's meal ticket was observed sitting on the tray and reflected R29 was to receive soup of the day, 1/2 cup peas, a dinner roll with margarine , and 2 fruit cups. When R29 was queried about the 2 requested fruit cups and the dinner roll with margarine that were not provided, R29 stated she wanted those items stating this confirmed what she complained about the day before, R29 elaborated it was very common not to get basic food items. On 03/03/25 at 02:57 PM during an interview with Dietary Manager Y she reported that fruit cups were always available. When the observation of R29's meal tray on 2/26 and what the meal ticket read for what was supposed to be provided, Dietary Manager Y reported the dietary staff were trained to follow the meal tickets and offered no explanation for why or how R29s preferences were not met.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 45038 This citation pertains to Intake: MI00149724, MI00150426 Based on observation, interview, and record review the facility failed to maintain preferred food temperature and acceptable palatability for three residents (R11, R41, and R318) out of ten residents reviewed for food palatability and food preferred temperatures. Findings Included: Resident #41 (R41) Review of the medical record revealed R41 was admitted to the facility 10/27/2021 with diagnoses included chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD), alcoholic liver disease, emphysema (chronic lung disease that permanently damages the lungs making his difficulty to breath), anemia (low red blood cells), alcoholic fatty liver, polyneuropathy (a peripheral nerve disorder that causes multiple nerves throughout the body to malfunction simultaneously), hypertension, hypotension, hyperlipidemia (high fat content), acquired absence of right leg above the knee, acquired absence of left leg above the knee, muscle spasm, chronic pain, anxiety, nicotine dependence, alcohol abuse, and dementia. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/03/2025, revealed R41 had a Brief Interview of Mental Status (BIMS) of 12 (moderate cognitive impairment) out of 15. During observation and interview on 02/26/2025 at 08:33 a.m. R41 was observed lying down in bed. R41 explained that the food is always cold. In an interview on 02/27/2025 at 07:54 a.m. Dietary Manager (DM) Y explained that try carts are insulated and it is necessary for the staff the keep the doors on the carts shut. She explained that dietary staff bring the food carts to the units then nursing staff would deliver the dietary trays to the Residents rooms. On 02/27/2025 at 08:03 a.m. the food cart was observed to arrive on the hall that R41 resides. At 08:10 a.m. R41's food tray arrived in his room. Dietary Manager (DM) Y was asked to test food temperatures of R41's food. Food cover was removed from the tray. Oatmeal had temperature of 137.4 F (Fahrenheit), scramble eggs 105.2F, Coffee 150.4F. When asked what temperature of eggs should be, DM Y responded that it was to the palatability of the Resident. DM Y left the room and R41 was asked to taste his scrambled eggs. R41 sampled scrambled eggs and stated they taste cold to me. Resident #318 (R318) (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed R318 was admitted to the facility 02/13/2025 with diagnoses that included atherosclerotic heart disease (build-up of fats, cholesterol and other substances in the artery walls), bilateral peripheral vertigo (dizziness caused by problem in inner ear), hyperlipidemia (high fat content in blood), hypertension, anemia (low red blood cells), and Barrett's esophagus (damage to the lower part of the esophagus). The most recent Minimum Data Set (MDS), with an Assessment Reference date (ARD) of 02/18/2025, revealed R318 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on 02/25/2025 at 10:09 am. R318 was observed sitting up on the side of the bed. R318 explained that his food is always cold. R318 explained that he had told the facility about his concern and their response was that he needed to come to the dining room if he wanted warm food. On 02/27/2025 at 11:45 a.m. is was observed the delivery of food cart that contained part of the east hall and part of the west hall. Staff were observed passing trays to the east and west halls. At 11:52 a.m. is was observed that the food cart was delivered for the remainder of the west hall and staff where observed passing trays. At 12:05 p.m. it was observed that all trays had been passed to the west hall. R318 still did not have his lunch tray. Dietary Manager (DM) Y was asked where R318's lunch tray was and she could not answer. At 12:09 p.m. R318's tray was located on the first food cart that contained part of the east hall and part of the west hall. DM Y was asked to test temperatures of the tray before the tray was provided to R318. DM Y determined temp of coffee 134.2F (Fahrenheit), temp of Pizza was 112F, temp of salad was 68.8F (told by DM Y salad need to be below 40F), and temp of peaches were 54.2F (told by DM Y peaches needed to be below 40F). R318's lunch tray as discarded and another lunch tray was provided to R318. 46954 Resident #11 (R11) On 2/25/25 at 1:15 PM, R11 was observed in her room, watching television. R11 reported that she dislikes the food, stating that the food is not appetizing and is often cold. On 2/28/25 at 12:03 PM, a lunch tray was requested. The tray contained lemon baked tilapia, roasted potatoes, and steamed broccoli. The steamed broccoli was tasteless and was so overcooked and mushy, that it could not be picked up with a fork. The lemon baked tilapia was not flavorful and did not contain any lemon flavor.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 45038 Based on observation, interview, and record review the facility failed to maintain an effective, comprehensive, data-driven Quality Assurance and Performance Improvement (QAPI) program. Findings Include: Review of the facility policy entitled QAPI Plan with a date of implementation of 10/24/22 demonstrated in the purpose statement, It is the policy of this facility to systemically collect date as part of the QAPI program to ensure the care and services it delivers meet acceptable standard of quality in accordance with recognized standard of practice. Key components, listed in the policy, include: 1. Tracking and measuring performance 2. Establishing goals and thresholds for performance improvements 3. Identifying and prioritizing quality deficiencies 4. Systematically analyzing underlying causes of system quality deficiencies. 5. Developing and implementing corrective action or performance improvement activities. 6. Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as need. In an interview on 03/03/2025 at 03:55 p.m. Licensed Nursing Home Administrator (LNHA) C explained that the facility has a Quality Assurance and Performance Improvement committee that followed the Policy entitled QAPI Plan. LNHA C was asked what QAPI projects have been implement since last survey. LNHA C explained that projects included staff retention, food tray pass, water pass, tray removal and noise level. When asked to explain the specifics for each project he explained that he would have to ask his team. This surveyor asked if the Quality Assurance Committee had identified concerns about med storage, cell phone usage, foot temp and palpability, issues with grievances, issues with smoking, issue with Activities of Daily Living, issues with influenza or pneumococcal vaccination. LNHA C responded that he did not know about any of these issues until during the State Survey Process. LNHA C was asked to provide any projects or monitoring that he had for any projects. In an interview on 03/03/2025 at 04:31 LNHA C returned with temperature logs obtained by the dietary department. When requested to see actual Performance Improvement plan for food temperatures including identified concerns and plan of corrections, LNHA C explained he had no other information other than the temp logs form dietary services. No other performance improvement projects presented by time of exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 This citation includes intake MI000150119 Based on observation, interview and record review, the facility failed to 1) ensure tracking and trending of employee illness; 2) implement timely Transmission-Based Precautions (TBP) for one COVID-19 positive resident (Resident #30) of one reviewed; and 3) ensure appropriate cleaning and storage of a CPAP (continuous positive airway pressure) mask for one (Resident #319). Findings include: During review of the facility's Infection Prevention and Control Program on 02/27/25 at 2:01 PM, Assistant Director of Nursing (ADON) T reported there was a sheet for the charge nurse to write down the reason for employee call-ins, and the Scheduler kept the employee call-in forms. If they were seeing trends in call-ins, the data was entered into the infection watch system, with tracking that included which hall staff worked on and who they had cared for. If staff tested positive for COVID-19 or when noticing multiple staff calling in for the same thing, the data was entered into the facility's infection watch system. When asked how they would be alerted to multiple staff calling in for the same illness/symptoms, ADON T reported call-ins were discussed in morning meetings, and they also spoke with the Scheduler and reviewed call-in sheets. ADON T reported there was not a formatted documented for tracking and trending of employee illness. Resident #30 (R30) Review of the medical record reflected R30 admitted to the facility on [DATE], with diagnoses that included displaced fracture of second cervical vertebra, end stage renal disease and dependence on renal dialysis. The Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/12/25, reflected R30 scored five out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). A Progress Note for a date of service of 2/24/25 at 10:02 PM reflected R30 was to be transferred to the hospital for evaluation of chest pain. A Progress Note for 2/25/25 reflected R30 returned from the hospital at 12:55 PM. A Provider Progress Note for 2/26/25 reflected R30 was seen for follow-up. According to the note, R30 was found to be COVID-19 positive in the emergency room . A Progress Note for 2/27/25 at 8:12 AM reflected R30 was positive for COVID-19 during their hospital visit. According to the Progress Note, TBP were not implemented until 2/27/25 (two days after R30 returned from the hospital with a positive COVID-19 test result). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/27/25 at 2:01 PM, ADON T reported COVID-19 positive residents were to be placed on TBP for ten days, which included the use of a gown, gloves, N95 mask and eye protection. ADON T reported R30 was transferred to the hospital on 2/24/25, tested positive for COVID-19 and returned to the facility on [DATE]. According to ADON T, TBP were implemented for R30 on 2/27/25, when the facility became aware of R30's COVID-19 positive status by a Cardiology office. ADON T reported the nurse would have been provided with R30's hospital After Visit Summary (AVS) upon return from the hospital. R30's hospital AVS, dated 2/25/25, reflected a COVID-19 positive test result for 2/25/25. 46954 This citation pertains to intake #MI00150119 Review of the medical record reflected Resident #267 (R267) was admitted to the facility on [DATE], with diagnoses that included end stage renal disease. On 2/28/25 at 8:21 AM, Licensed Practical Nurse (LPN) H was observed outside of the room of R267 donning personal protective equipment (PPE), including an N95 mask. A sign was observed on the door of R267's room that indicated R267 had enhanced barrier precautions, which does not require an N95 mask. When asked what the purpose of the PPE was, LPN H reported that R267 tested positive for COVID that morning and she was entering the room to COVID test the roommate. LPN H stated that R267 was in the room, however, they were preparing to remove him and place him in a private room. On 2/28/25 at 8:23 AM, LPN I was observed exiting R267's room wearing only a surgical mask. When asked what PPE LPN I wore in R267's room, LPN I reported that he only wore the surgical mask in the room. When asked if it was the surgical mask that he currently had on his face, LPN I responded that it was. LPN H proceeded to explain to LPN I that R267 tested positive for COVID that morning. LPN I was unaware of R267's positive COVID status and reported that a sign on the door of R267's room would have been helpful to notify LPN I of the correct required PPE requirements. 49272 R319 Review of the clinical record revealed R319 was admitted into the facility on [DATE] with diagnoses that included: fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, obstructive sleep apnea, muscle weakness, history of falling. According to the Minimum Data Set (MDS) assessment dated [DATE], R319 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition). On 2/25/2025 at 10:50 AM, during an interview with R319, they reported that their C-pap mask (respiratory equipment used for sleep apnea) had just been placed in a plastic bag that day (despite him being admitted several days prior) and further reported that he felt it didn't matter if it was placed in a bag since it had fallen on the floor multiple times without staff cleaning it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at approximately 5 PM, R319's C-pap mask was observed to be lying on the floor. LPN M entered residents' room and picked up residents C-pap mask. LPN M informed the resident that she would have to clean his mask. When asked what she would use to clean the C-pap mask, LPN M reported that she would use a purple wipe (Super Sani-Cloth Germicidal Wipe). On 2/26/25 at 12:20 PM, R319 reported that his c-pap mask is no longer being stored in a bag like it was the day before. Mask was observed on resident's nightstand, not housed in a plastic bag. No bag was visible at the bedside or in resident's room. On 3/3/25 at 9:30 AM, R319 reported that his c-pap mask had been dropped several times and not washed and had never been placed back in a plastic bag. Mask was observed to not be housed in a plastic bag. On 2/27/25 at 4:48 PM during an interview with director of nursing (DON) C, they reported that c-pap masks should be cleaned with soap and water if they fall on the floor and/or are visibly soiled. Review of the facilities policy titled CPAP/BiPAP Cleaning updated 12/23, documented in part Respiratory therapy equipment can become colonized with infectious organisms and serve as a source of respiratory infections .Clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry well, ensuring no visible moisture or water droplets remain on the equipment prior to storing. Cover with plastic bag or completely enclosed in machine storage when not in use . Review of the Safety Data Sheet for Super Sani-Cloth Germicidal Wipes documented in part Use as a disinfectant on hard, non-porous surfaces .Hazard statements: Causes serious eye irritation, May cause drowsiness or dizziness, Flammable liquid and vapor .Precautionary Statements-Prevention: Wash face, hands and any exposed skin thoroughly after handling, Avoid breathing dust/fume/gas/mist/vapors/spray, Use only outdoors or in a well-ventilated areas .Precautionary Statements-Response: IF ON SKIN (or hair): Take off immediately all contaminated clothing. Rinse skin with water/shower .IF INHALED: Remove victim to fresh air and keep at rest in a position comfortable for breathing, Call a POISON CENTER or doctor if you fell unwell .Other information: May be harmful if inhaled .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on interview and record review, the facility failed to obtain consent and/or declination for influenza and pneumococcal immunizations for one (Resident #18) of five reviewed for immunizations. Findings include: Review of the medical record reflected Resident #18 (R18) admitted to the facility on [DATE], with diagnoses that included heart failure, chronic obstructive pulmonary disease (COPD) and end stage renal disease with dependence on renal dialysis. According to the medical record, R18 had a medical Power of Attorney in place. Review of the medical record reflected R18 had not received any immunizations in the facility. There were no immunization consents or declinations in the medical record. In an interview on 02/27/25 at 2:01 PM, Assistant Director of Nursing (ADON) T reported influenza immunizations were offered yearly, and the facility began attempts to obtain consents and/or declinations around August. The facility provided a Progress Note dated 12/11/24, which reflected multiple messages had been left for R18's Guardian related to needing consents. The note reflected the Guardian had not returned any calls. The facility provided a Progress Note for 2/28/25, which reflected a call was placed to R18's Responsible Party regarding immunization consents, with a request to return the facility's call.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on interview and record review, the facility failed to offer COVID-19 booster immunizations to three (Resident #6, #18 and #32) of five reviewed for immunizations. Findings include: Resident #6 (R6) Review of the medical record reflected R6 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included congestive heart failure and chronic obstructive pulmonary disease. According to the medical record, R6 had a Guardian in place. According to the medical record, R6 had last received a COVID-19 immunization on 12/2/23. The medical record did not reflect documentation that any further booster immunizations had been offered. Resident #18 (R18) Review of the medical record reflected R18 admitted to the facility on [DATE], with diagnoses that included heart failure, chronic obstructive pulmonary disease (COPD) and end stage renal disease with dependence on renal dialysis. According to the medical record, R18 had a medical Power of Attorney in place. Review of the medical record reflected R18 last received a COVID-19 immunization on 11/9/21. There were no immunization consents or declinations in the medical record. The facility provided a Progress Note dated 12/11/24, which reflected multiple messages had been left for R18's Guardian related to needing consents. The note reflected the Guardian had not returned any calls. The facility provided a Progress Note for 2/28/25, which reflected a call was placed to R18's Responsible Party regarding immunization consents, with a request to return the facility's call. Resident #32 (R32) Review of the medical record reflected R32 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included multiple sclerosis and chronic obstructive pulmonary disease. According to the medical record, R32 was their own responsible party. The medical record reflected R32 had last received a COVID-19 immunization on 11/30/23. The medical record did not reflect documentation that any further booster immunizations had been offered. (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	03/03/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/25 at 2:01 PM, Assistant Director of Nursing (ADON) T reported COVID-19 immunization boosters were offered to residents when they became available. ADON T reported there was a COVID-19 booster that became available in 2024.