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

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the code status was accurate and reflective of the resident's wishes for one (R7) of two reviewed.Findings include: Review of the medical record reflected R7 admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD), diabetes, legal blindness and presence of an artificial eye. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], reflected R7 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool), had impaired vision without corrective lenses and no natural teeth or tooth fragments (edentulous). According to the medical record, R7 was her own responsible party. On [DATE] at 2:52 PM, R7 was observed seated in a wheelchair, in her room. R7's medical record included a document titled, Advanced Directives Acknowledgements / CPR Consent, which was marked for, No Resuscitation: In the event of a cardiac arrest I am requesting a DNR [do not resuscitate/no CPR] order be issued (must fill out state appropriate form). R7's name was signed on the document, which was dated [DATE]. R7's medical record reflected a Physician's Order for full resuscitation (cardiopulmonary resuscitation/CPR). A Social Services Progress Note, dated [DATE], reflected R7 was self-responsible and a full code. A Physician Progress Note, dated [DATE], reflected, .After our discussion, patient expresses understanding regarding the course of illness and prognosis. Personally confirmed that the patient's code status is DNR . In an interview on [DATE] at 10:16 AM, Social Worker (SW) F reported the Admissions Department completed Advance Directives for those with a full code status upon admission. SW F reported she was responsible for DNRs and tried to see new admit residents on the day of admission or the following day. Upon discussion of R7's code status, SW F reported R7 was a full code. Upon review of R7's medical record documents, during the interview, SW F stated there was a problem. SW F reported R7's document (Advanced Directives Acknowledgements / CPR Consent) was marked for no resuscitation. SW F indicated that was the incorrect form for DNR code status. SW F stated she spoke to R7 after admission, and R7 chose to be a full code. SW F reported she would need to clarify code status with R7. A Social Services Progress Note for [DATE] at 11:11 AM reflected code status was reviewed with R7, and she elected DNR.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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** Based on observation, interview and record review, the facility failed to conduct a care conference after admission for one (R7) of two reviewed.Findings include: Review of the medical record reflected R7 admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD), diabetes, legal blindness and presence of an artificial eye. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/17/26, reflected R7 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool), had impaired vision without corrective lenses and no natural teeth or tooth fragments (edentulous). According to the medical record, R7 was her own responsible party. R7's medical record reflected a prior admission on [DATE] and discharge home on 1/30/26. R7's MDS history included a discharge return not anticipated MDS, with an ARD of 1/30/26. On 04/28/2026 at 2:52 PM, R7 was observed seated in a wheelchair, in her room. R7 reported the facility did not involve her in the plan for her care, and she did not really have a care conference after admission. R7's medical record did not reflect that a care conference had been held since admission to the facility on 2/11/26. On 04/29/2026 at 10:16 AM, Social Worker (SW) F reported 72-hour care conferences were held after admission, then quarterly. SW F reported R7 did not have a care conference after admission on [DATE] because she had not been discharged from the facility for 30 days. SW F reported R7 was not due for a quarterly review until 5/20/26. In an interview on 04/30/2026 at 11:13 AM, Director of Nursing (DON) B reported a care conference should have been held after R7's admission for 2/11/26.

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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** This citation pertains to Intake 2989711.Based on observation, interview, and record review, the facility failed to 1) identify and treat a new wound for one (R70) and 2) treat earwax buildup for one (R58) of 17 reviewed.Findings include: Resident #70 (R70) Review of the medical records reflected that R70 was admitted to the facility on [DATE] and readmitted on [DATE] following hospitalization. Diagnoses of Diabetes Mellitus with Diabetic Polyneuropathy, Peripheral Vascular Disease, left side weakness from previous stroke and a new diagnosis of acute osteomyelitis- right ankle and foot. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/12/2025 revealed R70 had a Brief Interview of Mental Status (BIMS) of 15 (Cognitively Intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R70 was independent to minimal assistance with bed mobility, transfers, toileting. R70 is able to make his needs known. During an interview on 04/28/2026 at 2:39 PM, R70 stated he had his right foot big toe amputated last summer. R70 stated his second toe got a pressure ulcer on the top on it and the third toe developed a pressure ulcer under it and tunneled through. R70 stated the staff never identified it and did not treat it appropriately, and it could have been prevented. During an observation and interview on 04/29/2026 at10:53 AM, Wound Care Nurse H was setting up wound care supplies for wound care on R70's right foot. Wound Care Nurse H gowned and gloved for care, hand hygiene performed. Wound Care Nurse H removed soiled dressing from right foot, disposed of soiled dressing, hand hygiene performed. Wound Care Nurse H stated all of his toes on the right foot were amputated; incision is intact with steri-strips, performed hand hygiene, applied clean gloves, cleaned with wound wash on gauze dressing, hand hygiene completed, applied new gloves, completed dressing change. On 04/29/2026 at 2:10 PM, writer asked DON B for documentation on R70's right foot wounds prior to his amputation of all toes. Nursing Progress notes did not reveal any details on the right foot third toe, other than daily dressing changes to the incision where he had his great toe amputated. On 04/29/2026 at 4:31 PM, DON B came into the conference room where survey team was working, writer asked again for documentation on R70's right foot third toe concerns. DON B stated they had a different program to document that in so she would print it off for this writer, brought in right foot, great toe surgically removed and following care, but nothing regarding the condition of the 2nd and 3rd toes. During an interview on 04/30/2026 at 8:24 AM, Wound Care Nurse H stated R70's 2nd toe was bend/hammer head, and it had a Diabetic Ulcer on it. Writer asked about the 3rd toe, Wound Care Nurse H stated she did skin assessments every Monday and there was nothing there on that specific Monday of 03/09/2026, she was told he went to the hospital that following Saturday 03/15/2026 with a new wound. Writer asked Wound Care Nurse H if she knew when this new wound was identified, she stated she did not, added the 2nd toe concern was documented in the (Electronic Medical Records) EMR, not on the 3rd toe that she was aware of. Writer asked wound Care Nurse H what the process was for any staff would have noticed concerns with skin breakdown. Wound Care Nurse H stated they would come and get her, if it's not on a Monday, she was doing wound care rounds then the staff (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would address it with the floor nurse. Record review of a wound care note and picture of his right foot dated 03/09/2026, completed by wound care nurse H showing black/brown eschar on the tips of the 3rd and 4th toes on the right foot. Record review of the spread sheet that is used as a communication tool between the wound care nurse H and NP O revealed R70 had a new wound identified on 02/24/26 on his right foot, 2nd digit, in house acquired, length .75 x width 1.02 x depth of 0. Treatment of Povidone iodine. Record review of this same spread sheet dated 03/02/26 revealed R70's right foot, 2nd digit, in house acquired, length .77 x width 1.08 x depth 0.1. Treatment of Povidone iodine. Record review of this same spread sheet dated 03/09/26 revealed R70's right foot, 2nd digit, in house acquired, length 1.25 x width 1.54 x depth 0.1. Treatment of soap and water, Povidone iodine. Record review of this same spread sheet dated 03/09/26 did not include the new wound on right foot, 3rd toe as it was in the picture of his right foot dated 03/09/26 where it shows eschar on the tips of toes 3 and 4. During an interview on 04/30/2026 at 9:30 AM Interview with Nurse Practitioner (NP) O stated she did not make rounds with Wound Care Nurse H here at the facility. NP O stated that Wound Care Nurse H had a spread sheet and would report what was going with the wounds and she wrote orders based on that report. NP O stated they did not have an NP to concentrate on wound care at this time but would within the next week or two. NP O pulled up her visit note for 03/05/26- no mention of 3rd toe skin issues new diabetic ulcer to the right dorsum second digit noted on 02/24/2026. NP O read the wound care documentation from 3/11/2026 13:05 by a unit manager, wound is stable. Continue with active treatment and pain management plan. NP O pulled up her visit note for 3/11/1026, since 3/6/26, R70 had experienced persistent neuropathic pain requiring increased gabapentin (800 mg TID), and ongoing management of a new diabetic ulcer on the right foot second toe, with intermittent refusal of wound care but overall wound stability. NP O read the wound care documentation from 3/12/2026 by floor nurse, location of skin area being documented: 2nd toe of right foot. Continue with plan of care/ Treatment. NP O read the wound care documentation from 3/12/2026 at 9:22 AM by floor nurse, location of skin area being documented: right 2nd toe continues plan of care. NP O read the wound care documentation from 3/13/2026 at 14:19 PM by floor nurse, location of skin area being documented: right 2nd toe, Tx in place. NP O read the wound care documentation from 3/14/2026 at 08:22 AM by floor nurse, location of skin area being documented: right 2nd toe Tx in place. NP O read the wound care documentation from 3/14/2026 at 22:33 PM by floor nurse, location of skin (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	area being documented: right 2nd toe resident on LOA until tomorrow. Was not assessed today. NP O read the wound care documentation from 03/15/2026 at 11:20 AM by Wound Care Nurse H location of skin area being documented: Right foot second toe resident sent out to hospital that today, was not assessed. NP O pulled up her NP visit note for 03/30/2026, over the past three days, the patient has been managed for pain related to a right foot amputation site, with frequent PRN morphine and oxycodone administration. Pain levels have fluctuated, often reaching 8–9/10, but responded effectively to medication, with post-administration scores dropping to 0–3/10. The amputation site remains stable, with wound vac intact and no signs of sepsis; the patient is afebrile and continues on oral antibiotics without adverse reactions. NP O pulled up her NP visit note for 04/01/2026, the surgical site remains intact, with no new signs of infection or sepsis; he is afebrile and has tolerated antibiotics without adverse reactions. The wound vac was removed yesterday. He feels pain management regimen is adequate at this time using oxycodone every 4 hours. During an interview on 04/30/2026 at 12:47 PM, DON B was asked about the 3rd toe wound on his right foot prior to amputation. DON B stated R70 was on Leave of Absence (LOA) on that day, and Wound Care Nurse H couldn't assess him. Regional Director of Clinical D was giving answers prior to the DON B answering and writer asked to have DON B look at his medical record to help identify when that 3rd toe wound was identified. Writer asked DON B what her expectations would be if staff found a new skin concern. DON B stated they would put notes in the EMR, report to the floor nurse, they always put it on the communication board, write new orders, and at daily rounding, it would have been brought up at that time. DON B stated R70 was on LOA on 03/14/26. Assistant Director of Nursing (ADON) C stated R70 would refuse to have nurses do his dressing changes. During a record review of progress note written by Physician's Assistant (PA-C) O for 03/11/2026 at 14:54PM, Inspection: Eschar present on 2nd and 3rd toes on R foot. Patient is status post first toe removal. Incision there is well healed. He has an eschar on his third distal toe that seems to be irritated. +hammer toe second toe. No surrounding erythema. He does have global swelling to the foot which is very evident compared to contralateral side. He is slightly tender to palpation in the foot as well as the distal left lower leg. No streaking, no induration. Record review of nursing progress notes revealed skin assessments/wound care was provided to R70 on 03/01/26, 03/02/26, 03/03/26, 03/04/26 (x4), 03/05/26, 03/06,26, 03/07/26, 03/08/26, 03/09/26, 03/10/26, 03/11/26 at 13:05PM, 03/12/26 (x2), 03/13/26, 03/14/26 done at 8:22 AM before LOA. R70 returned to facility on 03/15/2026 at 15:20 AM from an overnight LOA. Wound care nurse H documented, .there was a new open area to his right foot 3rd toe. Resident wanted to be sent out to the hospital for wound evaluation due to diabetes Type 2. This writer called physician. Awaiting a call back at this time. Record review of R70's care plan intervention was to do a skin assessment weekly. Record review of nursing progress notes revealed R70 was admitted to the hospital on [DATE] through 03/23/2026. Per DC summary, resident underwent amputation of 2nd and 3rd toes and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Achilles tendon lengthening on 3/21 of the right foot and started on a 2-week course of oral antibiotics. Resident was wearing a boot to the right foot and had a wound vac to the right foot. Non-weight bearing (NWB) right foot. Resident was alert and oriented x4, able to make needs known. Provider notified of readmission, reviewed meds, orders entered. Record review of hospital coordination from emergency room to admission of R70. Right third toe infected ulcer with subcutaneous gas LRINEC score 3 Recurrent diabetic foot ulcer History of right first toe amputation in June Chronic ulcer on the second toe - CT shows soft tissue swelling and distal subcutaneous air without osteomyelitis - CRP elevated with no systemic signs of infection - Blood cultures show no growth till date follow up on the final blood cultures - Started zosyn and Zyvox - Podiatry consulted for debridement versus toe amputation - Wound care team consulted - HbA1c sent - strict glycemic control Sepsis Documentation: Provider assessment: Infection suspected Suspected source(s) of infection: Skin and Soft Tissue Musculoskeletal Assessment: Negative for back pain and neck pain. Skin: Positive for wound (Right third toe). Negative for rash. Neurological: Negative for dizziness, syncope and headaches. Skin Assessment: General: Skin is warm and dry. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Capillary Refill: Capillary refill takes less than 2 seconds. Findings: No rash. Comments: Right foot-great toe has been amputated, second toe has a healing wound, third toe has a wound with surrounding color changes in the toe. Color changes do not extend up the foot, there is no drainage coming from the wound site Clinical Impressions as of 03/15/26 21:32 PM, Wound infection. During an interview on 04/30/2026 at 1:27 PM, RN/Unit Manager E was asked about the wound care, and dressing changes she had completed on R70 dated 03/11/26 at 13:05 PM. RN/Unit Manager E stated she didn't recall, added her memory isn't that good. Writer asked about identifying a new wound on the 3rd toe and she stated she didn't recall. Writer asked what her expectations would be if a resident develops a new skin concern or wound, RN/Unit Manager E stated she would expect the staff to report that to floor nurse, herself as the unit manager or the Wound Care Nurse H. During an interview on 04/30/2026 at 1:47 PM, Registered Nurse (RN) S was asked about the assessment and wound care she provided on R70. RN S stated she remembered doing them but couldn't remember if it was on one toe and two toes. During an interview on 04/30/2026 at 1:54 PM, R70's family member T stated R70 showed her his foot. Family member T told him to go to ER, stated R70 told her he had a wound one on top of 2nd toe, one of bottom of 3rd toe, he was having severe pain, and he shouldn't have had pain due to neuropathy. Family member T stated she called the wound care nurse H who told her she didn't see this new wound a week ago, stated they did his dressing 2 x daily and it should have been identified. During an interview on 04/30/2026 at 2:09 PM, RN U stated she didn't see any new skin opened, he went on LOA and when he came back the next day, he told her he needed to go to the hospital because he had a new wound and it was painful. Writer asked RN U if she had looked at the entire foot when she did his dressing changes, she stated she usually does but didn't think she did so this time. During an interview on 04/30/2026 at 2:44 PM, writer asked wound care nurse H what the dark areas were at the tips of R70's 3rd and 4th toe on the right foot taken during the assessment and wound care pictures on 03/09/26. Wound care nurse H stated it must have been the lighting, writer zoomed in on the picture to show her the dark edges on both toes look like eschar (thick, dry, leathery form of black or brown necrotic tissue (dead tissue) that forms over a wound). Writer commented that it didn't look like poor lighting. Wound care nurse H stated she didn't see any concerns with those toes. R58 Review of the medical record revealed R58 was admitted to the facility on [DATE] with diagnoses that included traumatic subdural hemorrhage and dementia. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/26 revealed R58 scored 4 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool), had minimal difficulty hearing, and did not wear hearing aids. (continued on next page)

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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to obtain vision services for one (R7) of two reviewed.Findings include: Review of the medical record reflected R7 admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD), diabetes, legal blindness and presence of an artificial eye. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/17/26, reflected R7 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool), had impaired vision without corrective lenses and no natural teeth or tooth fragments (edentulous). According to the medical record, R7 was her own responsible party. On 04/28/2026 at 2:55 PM, R7 was observed seated in a wheelchair, in her room. R7 stated about one month prior, she had asked to be put on the dental and vision services lists. R7 reported her left eye was a prosthetic, and she had 20 percent vision in her right eye. R7 reported she needed glasses and did not have any. R7's Care Plan reflected visual impairment related to being legally blind and a prosthetic left eye. An intervention, dated 2/11/26, reflected, Arrange a consultation with the eye care provider as needed. An MD History and Physical Note for 3/26/26 reflected R7 would like to see the optometrist and dentist. In an interview on 04/29/2026 at 10:16 AM, Social Worker (SW) F reported the vision services provider visited the facility every four to six weeks and was scheduled to visit on 5/11/26. SW F read the list of residents that were to be seen on 5/11/26, and the list did not include R7. SW F reported she had not been notified of R7's request to see the vision services provider, nor was an order placed in R7's medical record. In an interview with Director of Nursing (DON) B and Regional Director of Clinical (RDC) D on 04/30/2026 at 11:13 AM, it was reported the facility changed provider groups on 3/1/26. With ancillary services, such as vision services, an order was to be placed in the medical record, then SW would add the resident to the list for services. It was reported the providers had not been adding the orders to the medical record.

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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. Based on observation, interview, and record review, the facility failed to properly label medications in one of two medication carts reviewed.Findings include:On 4/30/2026 at 2:16 PM, an observation was made of the 200-hall medication cart with Licensed Practical Nurse (LPN) R. The top drawer was found to contain a vial of Novolog insulin for R27. The vial was observed to have been open and was stored inside a prescription bottle, neither the prescription bottle it was stored in or the vial itself were labeled with an open date or expiration date (based on the open date). LPN R reported the expectation is insulin should be labeled with an open date upon being opened and should be considered expired 30 days after being opened. LPN R reported the vial would need to be disposed up since there was not a way to determine when it was opened/when it expired.On 4/30/2026 at 2:42 PM, during an interview with Director of Nursing (DON), it was reported that the expectation for labeling insulin is that each one is labeled with an open date and each medication cart has a list of medication expirations on it for staff to reference. DON reported that the floor nurses are responsible for cleaning the medication carts and pulling expired medications, management audits them approximately twice per month and pharmacy does once a month.A review of the facilities policy, titled Medications and Biologicals-Labeling of documented in part All medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices.Labels for multi-use vials must include: The date vial was initially opened or accessed (needle-punctured); all open or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.According to the U.S. Food and Drug Administration Website (https://www.fda.gov/drugs/emergency-preparedness-drugs/information-regarding-insulin-storage-and-switchir Insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59 F and 86 F for up to 28 days and continue to work.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Campus Area	2815 Northwind Drive 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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain dental services for two (R7 and R58) of two reviewed.Findings include: Review of the medical record reflected R7 admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD), diabetes, legal blindness and presence of an artificial eye. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/17/26, reflected R7 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool), had impaired vision without corrective lenses and no natural teeth or tooth fragments (edentulous). According to the medical record, R7 was her own responsible party. R7's payor source was listed as Medicaid, effective 3/13/26. On 04/28/2026 at 2:55 PM, R7 was observed seated in a wheelchair, in her room. R7 stated about one month prior, she had asked to be put on the dental and vision services lists. R7 reported having only one tooth and needing dentures. R7's Care Plan reflected they had a dental problem related to no natural teeth and no dentures. An intervention, dated 2/11/26, reflected to refer to dental services as needed. An MD (medical doctor) History and Physical Note for 3/26/26 reflected R7 would like to see the optometrist and dentist. In an interview on 04/29/2026 at 10:16 AM, Social Worker (SW) F reported the dentist visited the facility every four to six weeks and was scheduled to visit on 5/1/26. SW F read the list of residents that were to be seen on 5/1/26, and the list did not include R7. SW F reported she had not been notified of R7's request to see the dentist, nor was an order placed in R7's medical record. In an interview with Director of Nursing (DON) B and Regional Director of Clinical (RDC) D on 04/30/2026 at 11:13 AM, it was reported the facility changed provider groups on 3/1/26. With ancillary services, such as dental services, an order was to be placed in the medical record, then SW would add the resident to the list for services. It was reported the providers had not been adding the orders to the medical record. R58 Review of the medical record revealed R58 was admitted to the facility on [DATE] with diagnoses that included traumatic subdural hemorrhage and dementia. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/26 revealed R58 scored 4 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and did not have broken or loosely fitting dentures. Review of the Nursing admission Evaluation dated 6/8/24 revealed R58 wore upper and lower dentures. In a telephone interview on 04/28/2026 at 10:28 AM, R58's Guardian G reported R58 had dentures that were too large and therefore she could not wear her dentures. Guardian G reported they had brought this concern up to Social Worker (SW) F, but nothing was done. (continued on next page)

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

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

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/29/2026 at 10:39 AM, R58 was observed lying in bed. R58 did not have dentures in her mouth. When asked about her dentures, R58 reported she did not wear them because they irritated her and were uncomfortable. R58 reported her dentures were loose and she could not recall the last time her dentures fit well. Review of R58's care plans revealed R58 had upper and lower dentures and staff was to encourage R58 to wear her dentures. The care plans revealed refer to dental services as needed. In an interview on 04/29/2026 at 10:16 AM, SW F reported the dentist was in the facility every four to six weeks. SW F reported they did not think R58 had ever seen the dentist at the facility. SW F reported they were not aware of any concerns with R58's dentures, but if they were made aware of poorly fitting dentures, they would add R58 to the dentist list. SW F reported they had never seen R58 wear her dentures. In an interview on 04/29/2026 at 10:42 AM, Unit Manager (UM) E reported that according to R58's care plans, R58 had dentures. UM E reported she did not recall R58 wearing her dentures but was unsure why R58 did not wear them. In an interview on 04/30/2026 at 8:21 AM, Certified Nursing Assistant (CNA) Q reported R58 did not wear her dentures, and she was not aware of the reasoning. In an interview on 04/30/2026 at 11:12 AM, Director of Nursing (DON) B reported she was not even sure if R58 had dentures because R58 did not wear dentures. Assistant Director of Nursing (ADON) C and DON B reported they were not aware of any concerns with R58's dentures not fitting properly. On 04/30/2026 at 11:12 AM, ADON C reported they checked R58's room and R58 did have dentures in a denture cup. Review of the Nurses' Note dated 4/29/26 at 11:05 AM revealed Resident reported dentures are uncomfortable/not fitting properly .notified [Social Work] to have resident seen by dentist.