STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235653	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Capital Area	2100 E Provincial House Drive Lansing, MI 48910

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 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 interview and record review, the facility failed to obtain a physician order an advanced directive/ Do Not Resuscitate, for one resident (resident #8) of one reviewed. Findings include: Review of the clinical record, including the Minimum Data Set, dated [DATE] revealed Resident #8 was admitted to the facility on [DATE]. R8 scored 9 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS). Further record review revealed R8 had a full legal guardian in place to make health and medical care decisions. R8's advanced directives revealed the legal guardian signed an advanced directive form on [DATE] that reflected Do Not Resuscitate (DNR) / No CPR (cardiopulmonary resuscitation which is an emergency procedure that combines chest compressions and rescue breathing to restart a person's breathing and heartbeat. The form included 2 witnesses, and the Physician signature dated [DATE]. During a record review on [DATE] it was revealed there was no Physician order in place to implement the DNR. On [DATE] at 1:04 PM, during an interview with Social Services Assistant O she reported there should be a physician order that would reflect the wishes of the resident/guardian but could not comment any further as Social Worker P handles advanced directives.Social Woker P was not working during the survey time frame and unavailable to be interviewed. During an interview with Assistant Director of Nursing (ADON) E on [DATE] 2:50 PM reported the process was Social Worker P notifies her to have orders changed/updated, ADON E stated she did not recall Social Worker P notifying her that R8's guardian had signed any advanced directives.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to complete a change in condition, Minimum Data Set (MDS) Assessment for two (Resident #6 and Resident #15) of two residents reviewed for pressure ulcers. Findings include: Review of the medical record reflected R6 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included muscle weakness and anxiety. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/27/25, reflected R6 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the MDS indictors revealed that R6 was coded as having a tracheostomy. On 08/04/2025 at 12:19 PM, R6 was observed in her room watching television. No tracheostomy equipment was observed at the bedside, no tracheostomy was observed on R6. R6 denied having a tracheostomy. Review of R6's Five-day MDS revealed under Section O- Special Treatments, Procedures, and Programs, R6 required Tracheostomy Care. On 08/05/2025 at 3:27 PM, MDS Licensed Practical Nurse A stated that R6 does not require tracheostomy care and that the MDS was incorrect. Review of the medical record reflected that R15 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE]. Diagnoses of Traumatic Brain Injury, Schizoaffective Disorder, Dementia, Parkinson’s Disease, Muscle weakness, and Dysphagia. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/02/2025 revealed R15 had a Brief Interview of Mental Status (BIMS) of 12 (cognitively impaired) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R15 needs moderate assistance with eating and oral care. Dependent on showers, getting dressed, and all hygiene care, sitting to laying, laying to sitting, chair to bed, tub/shower transfers. During an interview and observation on 08/05/2025 at 9:22 AM, R15 lifted his feet up off the bed so this writer could see his pressure ulcer on his left heel. During an interview on 08/05/2025 at 9:24 AM, Registered Nurse (RN) “G” stated R15 did have a pressure ulcer on his heel, added she had not changed the dressing yet this morning. RN “G” stated they ask R15 if he would like lotion on his legs and feet, and if he does, they will apply it on him. During an interview on 08/05/2025 at 12:14 PM, Wound Care Nurse/Licensed Practical Nurse “J” stated R15's left heel pressure ulcer was now healed. Wound Care Nurse/Licensed Practical Nurse “J” stated she would do daily skin sweep, using a new skin assessment/sweep, asking 3 questions, was there new skin breakdown, if so, was a risk management started, was treatment started. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/05/2025 at 3:23 PM, Minimal Data Set (MDS) nurse “L” stated that MDS had a schedule on which resident was due for an assessment on which day. Writer asked how she gathered information for this assessment, she stated she went down to talk to the nurse, then the resident and or family. MDS nurse “L” stated when the next assessment was due, she read nursing progress notes and talks to the resident while they are out walking in the hall, getting around on the unit, during use of the bathroom, etc. MDS nurse “L” stated she used the skin assessment and communicated with the wound care nurse or provider. Writer asked MDS nurse “L” when R15’s left foot pressure ulcer developed. MDS nurse “L” stated 04/07/2025. Writer asked MDS nurse “L” if that would be a change in condition for a new pressure ulcer developed. MDS nurse “L” stated it should have been, but one did not get done. MDS nurse “L” added that an MDS assessment had to be done within 7 days of the change in condition, there was not a change in condition assessment 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, record review, the facility failed to update/revise individualized, person-centered care plans to reflect the changing care needs for 1 resident (R5) of 23 residents reviewed for care plans, resulting in the potential for unmet care needs. Findings include: Resident #5: Observation on 8/4/2025 during the initial screen process of the healthcare survey revealed Resident #5 to be located in the 300-unit hall resting in bed. Resident #5 had a perimeter mattress and bilateral fall mats placed at bedside. Resident #5 was able to make eye contact, although could not respond appropriately to surveyor questions. Record review of Resident #5's Minimum Data Set (MDS) dated [DATE] revealed an elderly resident with severe impaired cognitive ability of a Brief Interview of Mental status (BIMs) score of 1 out of 15. Medical diagnosis included dementia, anxiety and depression. Record review of Resident #5's care plans pages 1-42 noted on page 36 a care plan of: Resident resides on secure care unit (100-unit) for therapeutic environment related to dementia. Started 1/29/2025. In an observation, record review and interview on 08/06/2025 at 8:01 AM with Licensed Practical Nurse (LPN) I the 300-hall unit manager, of Resident #5 during wound observation revealed the resident was noted to reside on the 300-hall unit. Record review on 08/06/2025 at 8:05 AM with LPN I of Resident #5's care plans and medical record revealed on July 17th the resident was removed from the secured dementia 100-unit hall to the 300-unit hall. LPN I stated that the Interdepartmental team (IDT) team meets and reviews changes of the residents. The care plan update was missed. Record review of the facility 'Comprehensive Care Plans' policy dated 6/30/2022 revealed it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure activity of daily living skills were maintained for one of five residents reviewed (Resident #74). Findings include:Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] revealed R74 scored 12 out of 15 (cognitively intact) on the Brief Interview for Mental Status. Review of R74's care plan dated 6/24/25 revealed he required one person assist for hygiene, there was no documentation in R74's clinical record that reflected refused or was resistant to care. On 08/04/2025 at 11:14 AM, during the initial screening process Resident #74 was observed in dining/former therapy room, hair was observed greasy and not combed, mustache was very long and went into his mouth. R74 was observed wearing blue jogging pants with food and debris on them. On 08/05/2025 9:17 AM observed sitting at side of bed, wearing same soiled blue jogging pants as they day prior, R74's hair was observed messy and greasy, the same observation was made again on 8/05/25 at 1:25 pm 08/06/2025 10:23 R74 was observed in activities, hair was unkempt. At 10:26 am, during an interview with Certified Nursing Assistant (CNA) M stated R74 very cooperative, never refused care, change of clothes or showers. CNA M elaborated that R74 gets jealous when staff provided care or spent too much time with roommate. CNA M stated R74 had been asking about a haircut, but the facility has been without a beautician for about 6 months. On 08/06/2025 11:26 AM, during an interview with CNA and Restorative staff N she reported that during R74's restorative therapy session yesterday, R74 asked her for assistance with his facial hair as mustache was so long it was getting into his mouth. CNA and Restorative staff N stated R74 was very cooperative with care, and that he liked being with other people and liked attention and was desperate to get a haircut. On 08/06/2025 12:08PM during an interview with Assistant Director of Nursing (ADON) E she reported she was not aware that R74's mustache was so long he was growing into his mouth or that he was wearing the same dirty clothes for two days. ADON E stated R74's family wanted R74 to be Independent and do things himself but agreed it was ultimately facility's responsibility to ensure care needs were met.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent the development of facility-acquired pressure ulcer injuries for one resident (R5) of three residents reviewed, resulting in facility-acquired (in-house) development of pressure ulcer/injuries, pain, discomfort, and likelihood for prolonged illness or hospitalization. Findings include: Resident #5:Record review of Resident #5's Minimum Data Set (MDS) dated [DATE] revealed an elderly resident with severe impaired cognitive ability of a Brief Interview of Mental status (BIMs) score of 1 out of 15. Medical diagnosis included dementia, anxiety and depression. Section M: Skin noted a stage II pressure ulcer upon re-entry to the facility.Observation on 08/05/2025 at 9:19 AM of Resident #5 was lying in bed on her back. Resident was noted to have a small green positioning wedge device pushed off the bed and on the floor. Record review of Resident #5's 'Skin/Wound' assessments revealed on 5/16/2025 a Right Gluteal 100% epithelial measuring length 0.9cm X width 0.7cm X depth 0. 1cm. Record review of Resident #5's Skin/Wound' assessment dated [DATE] revealed the right gluteal pressure ulcer resolved. Observation on 08/05/2025 1:09 PM Resident #5 is lying flat on her back there are no pillows in the room to use as positioning devices. Resident sleeping with bilateral fall matts at bedside. [NAME] positioning wedge located under residents left arm. Record review of Resident #5's July 14th, 2025 'Skin/Wound' assessment noted a pressure ulcer stage III full thickness skin loss sacrum, in-house acquired measuring length 1.2cm X width 1.1cm X depth 0.1cm 100% granulation (tissue) light exudate (drainage) of serous fluid. Form noted: Resident had a recent decrease in mobility. Record review of resident #5's nursing progress notes from April 1st 2025 through August 5th 2025 revealed that there was no mention of sacrum area skin redness, if it was blanchable, or if there was any missing dermis until July 14th when there is a Stage III full thickness pressure ulcer noted. In an observation and interview on 08/06/2025 at 8:01 AM with Licensed Practical Nurse (LPN) I 300-hall unit manager an observation of # #5s bilateral heels, observation of sacrum region with no dressing noted to the area. Record review of Resident #5's medical record with LPN I revealed the sacrum pressure ulcer wound started while the resident resided on the secured dementia unit on 7/14/2025 and then on 7/17/25 the resident was moved off the secured unit to the 300-unit hall. LPN I was asked about Resident #5's new stage III pressure ulcer found on July 14th going from intact skin to a stage III with no notes. LPN I stated that there should have been a red area noted first. LPN I described the pressure ulcer Progression of skin with pressure, stating first is redness stage I Blanchable, then Stage II still redness with denuding of dermis, and at Stage III full thickness loss of tissue with open area. In an interview and record review on 08/06/2025 at 8:45 AM with Licensed Practical Nurse (LPN)/Wound Care (LPN) J reviewed Resident #5's medical record. LPN J Stated on July 14th, 2025, it was reported that resident #5 had a stage III pressure ulcer. LPN J described the pressure ulcer Progression of skin injury. LPN J stated that Resident #5's Stage III pressure ulcer was not a Kennedy ulcer, and that now that the area had already been open it will re-open. LPN J was asked if the pressure ulcer was Avoidable? LPN J stated yes, we should have caught that earlier, we could have caught it and put the air mattress in place sooner. Air mattress was placed on 7/17/2025, I first saw the pressure ulcer on the 14th. Wound rounds are on Mondays and we do the treatments and photos on those days. In an interview and record review on 08/06/2025 at 9:29 AM with Registered Nurse (RN) Assistant Director of Nursing (ADON) presented an AdHOC quality assurance protected form and timeline for Resident #5's facility acquired pressure ulcer. This reflected on 5/21/2025 right gluteal stage II pressure ulcer upon return from hospital. Which resolved 6/2/2025. On 7/14/2025 staff identified stage III wound to sacrum region, and the facility educated the Interdepartmental team (IDT) team/Managers for interventions to be put in place prior to this time. In an interview and record review on 08/06/2025 at 10:13 AM with Registered Nurse (RN) Assistant Director of Nursing (ADON) stated when resident #5 came back from the hospital, the resident was put an low air loss (LAL) mattress in place on 5/20/2025 and the facility had healed the stage II pressure ulcer from the hospital, then management changed Resident #5's mattress to a perimeter mattress on 6/15/2025. Observation on 08/06/2025 at 10:35 AM of Resident #5 was observed seated up in a high back wheelchair in the activities room with no cushion noted to chair, seated on her bottom with legs extended out in front of her. Record review of the facility's 'Pressure Ulcer/Skin Breakdown-Clinical Protocol' dated 3/20/2024 revealed a resident receives care consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individuals clinical condition demonstrates that they were unavoidable; and a resident with