STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	334158	A. BUILDING _____ B. WING _____	3/5/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF CAPITAL AREA	2100 E PROVINCIAL HOUSE DR LANSING, MI 48910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Medilodge of Capital Area was surveyed for an Abbreviated survey on 3/5/25. MI00150466 MI00150230 MI00150369 Census=115	F0000		
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00150230 Based on observation, interview and record review, the facility failed to follow Physician's Orders for medications for one Residents (Resident #10) of 4 reviewed for physician orders. Findings include: Review of the medical record reflected R10 was admitted to the facility on 1/23/25, with diagnoses that included type two diabetes and cirrhosis of the liver. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/14/25, reflected R10 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R10 no longer resided in the facility.	F0684		

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

Electronically Signed | 03/28/2025

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.

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	Review of the physician orders revealed an order initiated on 1/26/25 for Lactulose oral solution 10 grams (GM)/15 milliliters (ML) to be administers three times a day. Review of the Physician orders revealed an order initiated on 1/24/25 for Glimepiride Oral tablet 2 milligrams (mg) to be administered one time a day and an order for Isosorbide Dinitrate oral tablet 10 mg to be administered three times a day. Review of a Quality Assurance form dated 1/29/25 revealed R10's family member had a concern stating "the following medications were not available, glimepiride, isosorbide, lactulose. All of [R10's] other medications were pulled from backup (backup supply). Review of the Medication administration record for January confirmed R10's Lactulose, Glimepiride, and Isosorbide Dinitrate were not consistently administered on 1/28/25 and 1/29/25. Review of Nurses Note dated 1/29/25 at 5:53 PM revealed R10's glimepiride, lactulose, and isosorbide medications were delivered from pharmacy. Review of a Interdisciplinary Progress Note dated 1/31/24 at 12:17 PM revealed R10 "did not get consistent doses of her lactulose, glimepiride, and Isosorbide since admission. Medications have been delivered now, and resident is on continuous monitoring ...". Phone calls were placed to speak to the staff that did not provide the medication, however, phone calls were not returned by survey exit. In an interview on 3/5/25 at 10:36 AM, Director of Nursing (DON) "B" stated that she had			

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	discovered the concern when R10's family filled out a Quality Assurance form. DON "B" stated that she called the pharmacy regarding the missing medication and the pharmacy provided the facility with a STAT delivery of the missing medications. DON "B" stated that the expectation would have been to pull the medication from backup or ensure that the timely delivery of medication occurred. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included ensuring that all new admissions had received their medication per ordered, conducting facility wide education which included ensuring medications were available and notifying the Physician for missed medication doses, and auditing carts to ensure completeness. The concern was brought to Quality Assessment and Process Improvement to monitor compliance. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.			