

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of Zeeland		STREET ADDRESS, CITY, STATE, ZIP CODE 285 North State St Zeeland, MI 49464	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2666838Based on interview and record review, the facility failed to timely report allegations of abuse/neglect for 5 (R4, R5, R7, R9, and R10) of 10 residents reviewed. Findings include: F609 Resident #4 (R4)Review of a Face Sheet revealed R4 originally admitted to the facility on [DATE] and has pertinent diagnoses of Alzheimer's disease, dementia in lack of coordination. Resident #5 (R5)Review of a Face Sheet revealed R5 originally admitted to the facility on [DATE] and has pertinent diagnoses of alcohol induced dementia, Alzheimer's disease, psychotic disorder with delusions, and major depressive disorder. Resident #7 (R7)Review of a Face Sheet revealed R7 originally admitted [DATE] and has pertinent diagnoses of Alzheimer's disease, dementia with psychotic disturbances, and generalized anxiety disorder. Resident #9 (R9)Review of a Face Sheet for R9 revealed she originally admitted to the facility on [DATE] and has pertinent diagnoses of dementia with behavioral disturbances, major depressive disorder, and anxiety disorder. Resident #10 (R10)Review of a Face Sheet for R10 revealed she originally admitted to the facility on [DATE] and has pertinent diagnoses of Alzheimer's disease, dementia with mood disturbances, and generalized anxiety disorder. R5 and R10In an interview on 1/6/26 at 3:15 PM, CNA D reported she worked the day she documented R5 was sexually inappropriate and went on to describe walking into R5's room and saw R10 laying down in R5's bed with her pants slightly down to her hips and R5 was standing by her head with his pants lowered and his buttocks were exposed. CNA D reported she went to tell the nurse who then reported it to the Administrator. In an interview on 1/6/26 at 3:45 PM, the Nursing Home Administrator (NHA) reported she is aware of the incident between R5 and R10 but did not report it because she was at the facility within 30 minutes after being informed of the incident and was able to rule out any concerns right away. At this time, the Unit Manager/RN E entered the room and reported she remembered the incident between R5 and R10 at this time. There were no incident reports, statements, assessments or documentation in the EMR to show any incident had occurred or any notifications were sent to the physician or guardians. R4 and R5Review of a complaint reported to the State Agency revealed R5 entered R4's room and climbed into bed with her and did not want to leave the room. R4 was able to get out of bed to get help when the nurse came to her room and had to forcefully remove the resident. R5 has behaviors that staff cannot control. In an interview on 1/6/26 at 5:00 PM, the NHA reported she already provided any incident reports she had. When questioned about the incident of R5 climbing into R4's bed, the NHA reported that she had a soft file on that and did not report it to the State Agency. Review of the soft file regarding the incident between R4 and R5 revealed on 10/22/25 the NHA missed a call from the facility at 1:42 AM and again at 1:57 AM. The NHA returned the phone call at 2:46 AM and was notified of the incident between R4 and R5. It was reported that R5 climbed into bed between the wall and R4 and was pushing his back up against her moving her closer to the edge of the bed. R4 was worried about him potentially suffocating her baby doll and pushing her out of the bed. So,</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235347
		If continuation sheet Page 1 of 12

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>she got up and got the nurse. Review of two staff statements revealed R4 reported R5 called her a two-bit whore and then climbed into her bed. In an interview on 1/7/26 at 7:30 AM, the NHA reported she did not do an investigation regarding the incident between R4 and R5 but typed up a summary of the event the day before. In an interview on 1/8/25 at 9:13 AM, the NHA reported on 10/22/25 that the incident between R4 and R5 was relayed to her at 2:30 AM and was not fully informed of all the information regarding the verbal abuse and denied any physical abuse. The NHA reported she was looking for a willful intent and R4 was just fine and not upset. The NHA reported that she thinks the verbal abuse should have been reported. R5 and R9In an interview on 1/7/26 at 11:16 AM, RN H reported R5 walks aimlessly all-day night and can get aggressive when redirected by staff. One night RN H reported she called the guardian of R9 to inform her of a skin tear when the guardian questioned RN H about an incident on Christmas Eve when she was told by R9 that R5 grabbed her by the neck and had her head against the wall and it hurt her neck. The guardian reported R9 told the same story to several family members. RN H reported she looked into the EMR to find any incident reports or documentation regarding the incident and could not find any. R5 was in the hallway talking about the incident to staff with tears in her eyes and reported LPN B put cream on her neck after the incident. RN H reported she told the NHA about it and the NHA told her they already knew about the incident and dealt with it. RN H reported there are too many behaviors on that unit and not enough staff. RN H reported a Risk Management form should have been completed and In an interview on 1/8/25 at 9:13 AM, the NHA reported she was not aware of any incident between R5 and R9. In an interview on 1/7/26 at 11:16 AM, RN H reported that she completed a Risk Management document when R7 had a scratch on her forearm after R9 walked past her. RN H documented it as a resident-to-resident incident and was later changed to an injury of unknown origin by management. RN H was told she could not document the incident as a resident-to-resident incident because she did not actually see R9 scratch R7 even though she was close by. RN H reported when she looked at the Risk Management report later, it was documented that R9 lost her balance and accidentally scratched R7. When asked if she did any other documentation regarding the incident, RN H reported she did not put in a witness statement because R7 and R9 were arguing back and forth and was waiting for her to calm down and that LPN B was closer to the situation trying to separate the residents and should have actually been the one to complete the Risk Management documentation. In an interview on 1/8/25 at 9:13 AM, the NHA reported she was not aware of any contact made R7 and R9 but is aware that R9 was getting worked up about having a roommate and that is when they made a room change for R7. Review of a policy titled Abuse, Neglect and Exploitation last reviewed/revised on 10/24/22 revealed: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.VII. Reporting/ResponseA. The facility will have written procedures that include:1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, orb. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.2. Assuring that reporter are free from retaliation or reprisal.3. Promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who reports a suspicion of a crime. This facility will post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if the employee believes the facility has retaliated</p> <p>(continued on next page)</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	against him/her for reporting a suspected crime and how to file such a complaint.4. Reporting to the state nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service.5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following:a. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences.b. Defining how care provision will be changed and/or improved to protect residents receiving services.c. Training of staff on changes made and demonstration of staff competency after training is implemented.d. Identification of staff responsible for implementation of corrective actions.e. The expected date for implementation; andf. Identification of staff responsible for monitoring the implementation of the plan.B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2666838Based on interview and record review, the facility failed to timely and thoroughly investigate allegations of abuse for 5 (R4, R5, R7, R9, and R10) of 10 residents reviewed. Findings include: Resident #4 (R4)Review of a Face Sheet revealed R4 originally admitted to the facility on [DATE] and has pertinent diagnoses of Alzheimer's disease, dementia in lack of coordination. Resident #5 (R5)Review of a Face Sheet revealed R5 originally admitted to the facility on [DATE] and has pertinent diagnoses of alcohol induced dementia, Alzheimer's disease, psychotic disorder with delusions, and major depressive disorder. Resident #7 (R7)Review of a Face Sheet revealed R7 originally admitted [DATE] and has pertinent diagnoses of Alzheimer's disease, dementia with psychotic disturbances, and generalized anxiety disorder. Resident #9 (R9)Review of a Face Sheet for R9 revealed she originally admitted to the facility on [DATE] and has pertinent diagnoses of dementia with behavioral disturbances, major depressive disorder, and anxiety disorder. Resident #10 (R10)Review of a Face Sheet for R10 revealed she originally admitted to the facility on [DATE] and has pertinent diagnoses of Alzheimer's disease, dementia with mood disturbances, and generalized anxiety disorder.R5 and R10Review of a Behavior Symptoms Task documentation by the Certified Nursing Assistants (CNA's) for R5 revealed on 12/28/25 he was documented as being sexually inappropriate. The document reveals other documented behaviors for 6 days out of the 30 day look back period that included behaviors of wandering, abusive language, threatening behavior, grabbing, pushing, yelling and screaming. In an interview on 1/6/26 at 3:15 PM, CNA D reported she worked the day she documented R5 was sexually inappropriate and went on to describe walking into R5's room (12/28/25) and saw R10 laying down in R5's bed with R10's pants slightly down to her hips and R5 was standing by her head with his pants lowered and his buttocks were exposed. CNA D reported she went to tell the nurse who then reported it to the Administrator. CNA reported the only body part she saw was R5's buttocks. In an interview on 1/6/26 at 3:30 PM, Unit Manager/Registered Nurse (RN) E reported she was not aware of any incidents of R5 being sexually inappropriate. When informed of the CNA documentation on 12/28/25, UM E was not aware of that being a documented task. UM E reported she was not aware of any incidents with R5 and R10 as described by CNA D. RN E did report she is aware of R5 wandering into other resident rooms and does expect staff to document behaviors in the electronic medical records (EMR). In an interview on 1/6/26 at 3:45 PM, the Nursing Home Administrator (NHA) reported she is aware of the incident between R5 and R10 but did not report it because she was at the facility within 30 minutes after being informed of the incident and was able to rule out any concerns right away. At this time, the Unit Manager/RN E entered the room and reported she remembered the incident between R5 and R10 at this time. There were no incident reports, statements, assessments or documentation in the EMR to show any incident had occurred or any notifications were sent to the physician or guardians. In an interview on 1/8/26 at 9:13 AM, the NHA reported R10 was in R5's bed and both of their pants were partially down on 12/28/25. The NHA reported she takes full responsibility for staff not documenting incidents on the computer and that it should have also reflected that the physician and guardians were notified. The NHA agreed that there was no documentation of interventions on the computer.R4 and R5Review of a complaint reported to the State Agency revealed R5 entered R4's room and climbed into bed with her and did not want to leave the room. R4 was able to get out of bed to get help when the nurse came to her room and had to forcefully remove the resident. R5 has behaviors that staff cannot control. In an interview on 1/6/26 at 5:00 PM, the NHA reported she already provided any incident reports she had. When questioned about the incident of R5 climbing into R4's bed, the NHA reported that she had a soft file on that and did not report it to the State Agency.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the soft file regarding the incident between R4 and R5 revealed on 10/22/25 the NHA missed a call from the facility at 1:42 AM and again at 1:57 AM. The NHA returned the phone call at 2:46 AM and was notified of the incident between R4 and R5. It was reported that R5 climbed into bed between the wall and R4 and was pushing his back up against her moving her closer to the edge of the bed. R4 was worried about him potentially suffocating her baby doll and pushing her out of the bed. So, R4 got out of bed to get the nurse. Review of two staff statements revealed R4 reported R5 called her a two-bit whore and then climbed into her bed. In an interview on 1/7/26 at 7:30 AM, the NHA reported she did not do an investigation regarding the incident between R4 and R5 but typed up a summary of the event the day before. During an observation on 1/7/26 at 8:00 AM, R5 was in bed with a sitter at his side for 1:1 supervision. The CNA did not know why R5 needed 1:1 supervision. LPN F reported she did not know why R5 required 1:1 supervision this day and reported it started the night before. LPN F reported it would be helpful to know why R5 required a 1:1 supervision and could not find any documentation in the EMR to clarify it. In an interview on 1/7/26 at 9:00 AM, CNA G reported she did work the night R5 climbed in bed with R4. CNA G remembered R4 came out of her room and yelled help me, help me, there is a man in my room and won't get out of my bed! He is calling me a f*ing whore and a little bitch. The nurse and another aide went to R4's room to address the situation. R5 had to be forcefully removed from her room. CNA G reported she was told by the nurse not to document anything about the incident as instructed by the NHA. In an interview on 1/8/25 at 9:13 AM, the NHA reported on 10/22/25 that the incident between R4 and R5 was relayed to her at 2:30 AM and was not fully informed of all the information regarding the verbal abuse and denied any physical abuse. The NHA reported she was looking for a willful intent and R4 was just fine and not upset. The NHA reported that she thinks the verbal abuse should have been reported. R5 and R9 in an interview on 1/7/26 at 11:16 AM, RN H reported R5 walks aimlessly all-day and night and can get aggressive when redirected by staff. One night RN H reported she called the guardian of R9 to inform her of a skin tear when the guardian questioned RN H about an incident on Christmas Eve when she was told by R9 that R5 grabbed her by the neck and had her head against the wall and it hurt her neck. The guardian reported R9 told the same story to several family members. RN H reported she looked into the EMR to find any incident reports or documentation regarding the incident and could not find any. R9 was in the hallway talking about the incident to staff with tears in her eyes and reported LPN B put cream on her neck after the incident. RN H reported she told the NHA about it and the NHA told her they already knew about the incident and dealt with it. RN H reported there are too many behaviors on that unit and not enough staff. RN H reported a Risk Management form should have been completed. In an interview on 1/7/26 at 4:00 PM, LPN B reported he was on break on 12/24/25 when he was informed by the CNA that R9 made allegations that R5 grabbed her by the neck but the CNA did not witness it. LPN B reported he texted the NHA at 7:57 PM to inform her of the incident. The NHA asked him if R9 had any marks on her and he said no. The NHA then told LPN B she will investigate it in the morning. In an interview on 1/8/25 at 9:13 AM, the NHA reported she was not aware of any incident between R5 and R9. R7 and R9 in an interview on 1/7/26 at 11:16 AM, RN H reported that she completed a Risk Management document when R7 had a scratch on her forearm after R9 walked past her. RN H documented it as a resident-to-resident incident and was later changed to an injury of unknown origin by management. RN H was told she could not document the incident as a resident-to-resident incident because she did not actually see R9 scratch R7 even though she was close by. RN H reported when she looked at the Risk Management report later, it was documented that R9 lost her balance and accidentally scratched R7. When asked if she did any other documentation regarding the incident, RN H reported she did not put in a witness</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>statement because R7 and R9 were arguing back and forth and was waiting for her to calm down and that LPN B was closer to the situation trying to separate the residents and should have actually been the one to complete the Risk Management documentation. In an interview on 1/8/25 at 9:13 AM, the NHA reported she was not aware of any contact made R7 and R9 but is aware that R9 was getting worked up about having a roommate and that is when they made a room change for R7. Review of a policy titled Abuse, Neglect and Exploitation last reviewed/revised on 10/24/22 revealed: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation. 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence). 3. Investigating different types of alleged violations. 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2666838Based on observation, interview and record review, the facility failed to develop individualized interventions, review and revise care plans, and provide adequate supervision for 5 residents (R4, R5, R7, R9, and R10) of 10 residents reviewed for dementia care.Findings include:Resident #4 (R4)Review of a Face Sheet revealed R4 originally admitted to the facility on [DATE] and has pertinent diagnoses of Alzheimer's disease, dementia and lack of coordination. Resident #5 (R5)Review of a Face Sheet revealed R5 originally admitted to the facility on [DATE] and has pertinent diagnoses of alcohol induced dementia, Alzheimer's disease, psychotic disorder with delusions, and major depressive disorder. Resident #7 (R7)Review of a Face Sheet revealed R7 originally admitted [DATE] and has pertinent diagnoses of Alzheimer's disease, dementia with psychotic disturbances, and generalized anxiety disorder. Resident #9 (R9)Review of a Face Sheet for R9 revealed she originally admitted to the facility on [DATE] and has pertinent diagnoses of dementia with behavioral disturbances, major depressive disorder, and anxiety disorder. Resident #10 (R10)Review of a Face Sheet for R10 revealed she originally admitted to the facility on [DATE] and has pertinent diagnoses of Alzheimer's disease, dementia with mood disturbances, and generalized anxiety disorder. R5 and R10In an interview on 1/6/26 at 3:15 PM, CNA D reported she worked the day she documented R5 was sexually inappropriate and went on to describe walking into R5's room and saw R10 laying down in R5's bed with her pants slightly down to her hips and R5 was standing by her head with his pants lowered and his buttocks were exposed. CNA D reported she went to tell the nurse who then reported it to the Administrator. During an observation on 1/6/26 at 9:38 AM, R5 was observed walking around inside room [ROOM NUMBER] (a resident's room that was not his). He then came out into the hallway and walked down the hall to the common area wandering around unsupervised. The resident whose room he had entered was not in the room. During an observation on 1/6/26 at 12:01 PM, R5 was observed wandering inside another resident's room [ROOM NUMBER], and then walked out the door. He then went to the nurse's medication cart and started shuffling through papers before he was redirected to the dining room. R5 was not being supervised before this. Review of a Behavior Symptoms Task documentation by the Certified Nursing Assistants (CNA's) for R5 revealed on 12/28/25 he was documented as being sexually inappropriate. The document reveals other documented behaviors for 6 days out of a 30 day look back period that included behaviors of wandering, abusive language, threatening behavior, grabbing, pushing, yelling and screaming. There was not any documentation in the Nursing Progress notes that addressed these behaviors and there were not any changes to R5's care plan. In an interview on 1/6/26 at 3:10 PM, Licensed Practical Nurse (LPN) B reported R5 was on 15-minute checks as far as he knew on 1/4/26 and came off the 15 minutes checks on 1/5/26 but did not know why he was being monitored for frequent checks. LPN B was not aware of R5 having any sexually inappropriate behaviors with any other residents. LPN B did say if there were any incidents, the NHA (Nursing Home Administrator) and family/guardians should be notified. No documentation in the EMR (electronic medical record) indicating why R5 was on 15-minute checks. In an interview on 1/6/26 at 3:15 PM, CNA D reported she worked the day she documented R5 was sexually inappropriate. CNA D reported she walked into R5's room and saw R10 laying down in R5's bed with her pants slightly down to her hips. R5 was standing by R10's head with his pants lowered and his buttocks were exposed. CNA D reported she went to tell the nurse who then reported it to the Administrator. No changes or updates to the care plan were made for R5 or R10 regarding the incident and no documentation was made in the EMR. In an interview on 1/6/26 at 3:30 PM, Unit Manager/Registered Nurse (RN) E reported she was not aware of any incidents of R5 being sexually</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>inappropriate. When informed of the CNA documentation on 12/28/25, RN E was not aware of that being a documented task. RN E reported she was not aware of any incidents with R5 and R10 as described by CNA D. RN E did report she was aware of R5 wandering into other resident rooms and does expect staff to document behaviors in the EMR. In an interview on 1/6/26 at 3:45 PM, the Nursing Home Administrator (NHA) reported she was aware of the incident between R5 and R10. At this time, the RN E entered the room and reported she remembered the incident between R5 and R10 at this time. There were no incident reports, statements, assessments or documentation in the EMR to show any incident had occurred. Review of a Risk Management report provided by the NHA for R10 revealed on 12/28/25 there was an incident where R10 was in R5's room where his pants were down. Document shows it is not part of the medical records. In an interview on 1/8/26 at 9:13 AM, the NHA reported R10 was in R5's bed and both of their pants were partially down on 12/28/25. The NHA reported she takes full responsibility for staff not documenting incidents in the computer and that it should have also reflected that the physician and guardians were notified. The NHA agreed that there was no documentation of interventions in the computer. The NHA understood the importance of documentation as a way of communication of resident behaviors for staff. When questioned about good communication and the effects on resident care, the NHA agreed that good communication could result in better care, outcomes, and meaningful interventions. R4 and R5 Review of a complaint reported to the State Agency on 11/12/25 revealed R5 entered R4's room (date not specified) and climbed into bed with her and did not want to leave the room. R4 was able to get out of bed to get help when the nurse came to her room and had to forcefully remove the resident. R5 has behaviors that staff cannot control and are told not to document resident behaviors. In an interview on 1/7/26 at 9:00 AM, CNA G reported she did work the night R5 climbed in bed with R4. CNA G remembered R4 came out of her room and yelled help me, help me, there is a man in my room and won't get out of my bed! He is calling me a f*ing whore and a little bitch. The nurse and another aide went to R4's room to address the situation. R5 had to be forcefully removed from R4's room. CNA G reported she was told by the nurse not to document anything about the incident by the NHA. Review of the soft file (not part of the medical records) provided by the NHA regarding the incident between R4 and R5 revealed on 10/22/25, R5 climbed into R4's bed and laid between the wall and R4. R5 was pushing his back up against her, moving her closer to the edge of the bed. R4 was worried about him potentially suffocating her baby doll and pushing her out of the bed. So, R4 got out of bed to get the nurse. Review of two staff statements revealed R4 reported R5 called her a two-bit whore and then climbed into her bed. This information was not documented in the EMR, and no care plan interventions were made. During an observation and an interview on 1/7/26 at 8:00 AM, R5 was in bed with a sitter at his side for 1:1 supervision. The CNA did not know why R5 needed 1:1 supervision. In an interview on 1/7/26 at 8:05 AM, LPN F reported she did not know why R5 required 1:1 supervision this day and reported it started the night before. LPN F reported it would be helpful to know why R5 required a 1:1 supervision and could not find any documentation in the EMR to clarify it. R5 and R9 Review of a complaint reported to the State Agency on 11/12/25 revealed R5 entered another resident's room that belonged to 2 female residents and held the door closed so staff could not enter. It took 4-5 staff members to get the resident out of the room and the police were called to assist. In an interview on 1/7/26 at 9:00 AM, Certified Nursing Assistant (CNA) G reported sometime between November and December, R5 barricaded himself in R9's room, who also had a roommate, by putting a chair up against the door and sat in the chair for a long time. Staff were not able to get into the room and the police were called. The door had to be forcefully pushed open. R9 did not want to go back to her room for a long time. There was no documentation in the EMR regarding this incident. In an</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Medilodge of Zeeland		STREET ADDRESS, CITY, STATE, ZIP CODE 285 North State St Zeeland, MI 49464	
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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>interview on 1/7/26 at 11:16 AM, RN H reported R5 walks aimlessly all-day and night and can get aggressive when redirected by staff. One night RN H reported she called the guardian of R9 to inform her of a skin tear when the guardian questioned RN H about an incident on Christmas Eve. The Guardian reported R9 accused R5 of grabbing her by the neck and had her head against the wall and it hurt her neck. The guardian reported R9 told the same story to several family members. RN H reported she looked in the EMR to find any incident reports or documentation regarding the incident and could not find any. RN H reported then R9 was in the hallway talking about the incident to staff with tears in her eyes and reported LPN B put cream on her neck after the incident. RN H reported she told the NHA about it and the NHA told her they already knew about the incident and dealt with it. RN H reported there are too many behaviors on that unit and not enough staff. RN H reported a Risk Management form should have been completed. In an interview on 1/7/26 at 4:00 PM, LPN B reported he was on break on 12/24/25 when he was informed by the CNA that R9 made allegations that R5 grabbed her by the neck, but the CNA did not witness it. LPN B reported he texted the NHA at 7:57 PM to inform her of the incident. The NHA asked him if R9 had any marks on her and he said no. The NHA then told LPN B she will investigate it in the morning. The EMR did not reflect any documentation or acknowledgement of the alleged incident. In an interview on 1/8/25 at 9:13 AM, the NHA reported she was not aware of any incident between R5 and R9. Review of the Care Plan for R5 with a focus of Resident has behaviors related to alcohol dependence with alcohol induced persisting dementia, psychotic disorder with delusions due to known physiological condition as evidenced by: exit seeking, wandering throughout the facility with no sense of direction initiated on 10/13/25 revealed no meaningful, person centered interventions or revisions to address behaviors or wandering. Review of the Care Plan in its entirety for R5 revealed no person-centered interventions or provisions to care addressed R5's behaviors and the resident-to-resident incidents. In an interview on 1/8/26 at 9:13 AM, the NHA reported she was not fully informed of all the information regarding the incidents with R5 and R9 and was not able to provide the documentation indicating that R5 was being frequently monitored after the incidents. The NHA agreed that appropriate documentation and investigation could drive the plan of care. R7 and R9 In an interview on 1/7/26 at 11:16 AM, RN H reported that she completed a Risk Management document when R7 had a scratch on her forearm after R9 walked past her. RN H documented it as a resident-to-resident incident and was later changed to an injury of unknown origin by management. RN H was told she could not document the incident as a resident-to-resident incident because she did not actually see R9 scratch R7 even though she was close by. RN H reported when she looked at the Risk Management report later, it was documented that R9 lost her balance and accidentally scratched R7. When asked if she did any other documentation regarding the incident, RN H reported she did not put in a witness statement because R7 and R9 were arguing back and forth and was waiting for them to calm down. RN H reported that LPN B was closer to the situation trying to separate the residents and should have actually been the one to complete the Risk Management documentation. Review of a Nursing Progress note dated 10/27/25 for R7 revealed: Many behaviors during night shift. Resident in and out of bed (complaining of) having a roommate and roommate's TV being too loud. Asking who are the idiots that make these decisions in her life. Asking why staff is treating roommate better than she is being treated. Refused to take (nighttime) meds because resident claimed she already took them because she takes care of her own medications. Unable to redirect. Review of a Psychiatry Progress note dated 11/16/25 for R7 revealed she struck another resident telling them to leave her room. She reported that her roommate was yelling when it was time to sleep. Another resident tried to take her walker and (R7) tried to take her walker and (R7) resisted and was struck in the face by another resident. Facility staff</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>report angry outburst and fixating on trying to leave. Review of the Care Plan for R7 revealed no person-centered revisions documented reflecting the scratching incident or behaviors since admission. In an interview on 1/8/25 at 9:13 AM, the NHA reported she was not aware of any contact made R7 and R9 but was aware that R9 was getting worked up about having a roommate and that is when they made a room change for R7.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>This citation pertains to intake #2666838Based on interview and record review, the facility failed to implement and maintain a system for complete and accurate medical records for 5 (R4, R5, R7, R9, and R10) of 10 residents reviewed for medical records.Findings include:Review of the electronic medical records (EMR) for R4, R5, R7, R9 and R10 revealed a lack of documentation regarding the following incidents: R4Review of a Risk Management document dated 12/28/25 for R4 revealed No documentation regarding the incident on 12/28/25 when R4 was observed in R5's room laying on his bed exposing himself to her. No documentation indicating the physician or the guardian was notified or what interventions were put into place. R5Review of the EMR for R5 revealed no daily behavior documentation or documentation regarding resident-to-resident incidents on 10/22/25, 12/24/25, 12/28/25. Review of a Behavioral Health progress note dated 12/24/25 for R5 revealed: Previously, patient demonstrated significant behavioral disturbances including yelling/screening, kicking/hitting, pushing, grabbing, wandering, abusive language, threatening behavior, and sexually inappropriate behavior. No documentation on the facilities behalf in the EMR to reflect any of these behaviors. Review of a Behavior Symptoms Task documentation by the Certified Nursing Assistants (CNA's) for R5 revealed on 12/28/25 he was documented as being sexually inappropriate. The document reveals other documented behaviors for 6 days out of the 30-day look back period that included behaviors of: wandering, abusive language, threatening behavior, grabbing, pushing, yelling and screaming. No Nursing documentation or follow up to the CNA documentation documented. In an interview on 1/6/26 at 3:15 PM, LPN B reported he was unaware of any sexual inappropriateness regarding R5 and that he would document in the EMR if there were any inappropriate behaviors and inform the guardian. In an interview on 1/6/26 at 3:30 PM, Unit Manager/Registered Nurse (RN) E reported she was not aware of any incidents of R5 being sexually inappropriate. When informed of the CNA documentation on 12/28/25, UM E was not aware of that being a documented task. UM E reported she was not aware of any incidents with R5 and R10 as described by CNA D. RN E did report she is aware of R5 wandering into other resident rooms and does expect staff to document behaviors in the electronic medical records (EMR). During an observation on 1/7/26 at 8:00 AM, R5 was in bed with a sitter at his side for 1:1 supervision. The CNA did not know why R5 needed 1:1 supervision. LPN F reported she did not know why R5 required 1:1 supervision this day and reported it started the night before. LPN F reported it would be helpful to know why R5 required a 1:1 supervision and could not find any documentation in the EMR to clarify it. In an interview on 1/7/26 at 11:16 AM, RN H reported R5 walks aimlessly all-day night and can get aggressive when redirected by staff. One night RN H reported she called the guardian of R9 to inform her of a skin tear when the guardian questioned RN H about an incident on Christmas Eve when she was told by R9 that R5 grabbed her by the neck and had her head against the wall and it hurt her neck. The guardian reported R9 told the same story to several family members. RN H reported she looked into the EMR to find any incident reports or documentation regarding the incident and could not find any. R9 was in the hallway talking about the incident to staff with tears in her eyes and reported LPN B put cream on her neck after the incident. RN H reported she told the NHA about it and the NHA told her they already knew about the incident and dealt with it. RN H reported there are too many behaviors on that unit and not enough staff. RN H reported a Risk Management form should have been completed. R9In an interview on 1/7/26 at 11:16 AM, RN H reported that she completed a Risk Management document when R7 had a scratch on her forearm after R9 walked past her. RN H documented it as a resident-to-resident incident and was later changed to an injury of unknown origin by management. RN H was told she could not document the incident as a resident-to-resident</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>incident because she did not actually see R9 scratch R7 even though she was close by. RN H reported when she looked at the Risk Management report later, it was documented that R9 lost her balance and accidentally scratched R7. When asked if she did any other documentation regarding the incident, RN H reported she did not put in a witness statement because R7 and R9 were arguing back and forth and was waiting for her to calm down and that LPN B was closer to the situation trying to separate the residents and should have actually been the one to complete the Risk Management documentation. Review of a Nursing Progress noted dated 12/29/25 for R9 revealed: Res Observed standing in her doorway of her room with a skin tear to her right forearm. Area cleaned and Band-Aid applied. Res Stated it was from a scratch. No follow up assessment/documentation. In an interview on 1/8/25 at 9:13 AM, the NHA reported she was not aware of any contact made R7 and R9 but is aware that R9 was getting worked up about having a roommate and that is when they made a room change for R7. R7Review of the Monitor Behavior Symptoms task documentation with a 30-day look back revealed no behaviors documented on 12/29/25 as indicated in the above incident with R7. No behaviors documented for the 30-day time period. Review of the Nursing Progress notes for R7 revealed no documentation indicating R7 had any behaviors or concerns on 12/29/25. R10Review of the EMR for R10 revealed no documentation on 12/28/25 regarding the incident when R10 was in another resident room in his bed sleeping when another male resident was inappropriately dressed standing in front of her.</p>		