| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235347 | A. Building<br>B. Wing | 01/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Medilodge of Zeeland | 285 North State St<br>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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to intake # 2714532 and 2725669Based on interview and record review, the facility failed to promptly identify a change in condition and act upon those changes for 1 resident (Resident #1) out of 3 residents reviewed for quality of care, resulting in continued deterioration and subsequent death. Findings:Resident #1 (R1)Review of an admission Record revealed R1 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: stroke and palliative care. R1 was not his own responsible party and had a guardian in place.Review of the facility admission Agreement signed by R1's guardian on 5/2/25 revealed, VII. ADVANCE DIRECTIVE A resident has the right to formulate an advance directive with respect to the resident's desire to accept or refuse medical treatment.Review of R1's Advance Directives dated/signed by the guardian on 5/2/25 revealed R1 was a full code and was to receive cardiopulmonary resuscitation, a respiratory ventilator, artificial hydration, tube feeding, TPN, antibiotic therapy for infections, dialysis, maximum pain control, major surgery, and chemotherapy. R1 was to be transferred to an acute care hospital for inpatient treatment as well as the emergency department if necessary. Confirming that R1's wishes were to receive all avenues of care and treatment.Review of R1's communication Care Plan revealed, Resident is at risk for impaired communication related Dementia, Cambodian. Understands some English. Can answer simple questions with nod of head. Date Initiated: 07/18/2025. Request feedback, when needed, to ensure understanding.Use simple and direct communication (i.e., yes/no questions) to promote understanding, use gestures or pictures if necessary.Review of R1's urinary Care Plan revealed, Observe for signs/symptoms of UTI and report to Physician/PA (physicians assistant)/NP (nurse practitioner) (pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.) Date Initiated: 07/18/2025.Review of R1's August and September Medication Administration Record (MAR) and Pain Level Summary revealed only values of 0 (out of 10) indicating R1 did not typically experience pain or display symptoms of pain (a positive pain assessment would be abnormal for R1.)Review of R1's Hospice Note dated 9/4/25 at 11:20 PM revealed, .CHIEF COMPLAINT/REASON FOR PRN (as needed) VISIT: CHANGE IN MENTAL STATUS-GENITOURINARY (abnormal findings)-SIGNS AND SYMPTOMS OF INFECTION. URINE STRONG SCENTED AND DARK COLORED.UA (urinalysis) STRIP ABNORMAL, POSITIVE PROTEIN AND ELEVATED PH.INCREASED AGITATION AND BEHAVIORS, NOT EATING MUCH, SPITTING FOOD OUT.PATIENT CONTINUES TO HAVE INCREASED BEHAVIORS AND HAS BEEN SPITTING OUT HIS FOOD AND NOT EATING MUCH WHEN HE TYPICALLY EATS VERY WELL. UPON MY ASSESSMENT (R1) HAD A LOW GRADE FEVER OF 99.4 AND HIS PULSE WAS 102. WHEN PALPATING HIS ABDOMEN HE WHINCED AND PULLED MY HAND AWAY WHEN PALPATING HIS BLADDER. STAFF REPORTS HIS URINE HAS BEEN (sic) HAD A STRONG ODOR THE LAST FEW DAYS AND HAS BEEN DARK IN COLOR. UA (urinalysis) STRIP INDICATES A SMALL AMOUNT OF BLOOD IN HIS URINE IN ADDITION TO AN ABNORMAL SPECIFIC GRAVITY. SPOKE WITH DR. (name omitted) AND LEVAQUIN (antibiotic) 500MG 1 TIME DAILY FOR 7 DAYS<br><br>(continued on next page) |

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 |
|---|---|---|---|
| | 235347 | A. Building<br>B. Wing | 01/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Medilodge of Zeeland | 285 North State St<br>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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | HAS BEEN PRESCRIBED. DISCUSSED WITH FACILITY STAFF AND UNDERSTANDING WAS VERBALIZED. Confirming the facility staff were aware of a change in (R1's) condition for a few days and Levaquin has been prescribed.Review of R1's Electronic Medical Record (EMR) revealed no documentation that the practitioner or the guardian had been notified of the change in R1's condition prior to the hospice assessment on 9/4/25 despite identifying his symptoms a few days before.During an interview via email on 01/23/2026 2:53 PM, the Nursing Home Administrator (NHA) stated the facility staff follow McGeer Criteria for infections and would dip urine if residents are showing s/s (signs and symptoms) of infection. Check vitals, encourage fluids. Discuss with provider.On 01/22/2026 at 4:21 PM, a request for R1's UTI symptom tracking was requested. There was no documentation that the licensed nurses had been monitoring R1's symptoms. The NHA was unable to provide documentation of R1's symptom tracking.During an interview on 01/23/2026 at 3:41 PM, the Director of Nursing (DON) reported that their EMR did not prompt licensed nurses to complete symptom charting/UTI charting, and the licensed nurses were expected to complete physical assessments for residents following professional standards of practice. The DON reported that the facility CNAs had a habit of not charting on their residents until the end of their shift which may have been why there was no documentation for the last time R1 was observed responsive.Review of R1's Hospice Current Ordered Medication dated 9/4/25 at 3:28 PM revealed, PROBLEM: NEW NAUSEA.START ONDANSETRON (Zofran) 4 MG TABLET-1 TABLET, 4 TIMES DAILY PRN (as needed).Reason: For Nausea and vomiting with a start dated of 9/4/25.Review of R1's Hospice Current Ordered Medication dated 9/4/25 at 11:51 PM revealed, .Levaquin 500mg 1x per day x7 days for UTI symptoms. Goals: Improve patient behaviors and decrease UTI symptoms. with a start date of 9/5/25.During an interview on 01/22/2026 at 3:16 PM, Registered Nurse (RN) A reported that when hospice prescribed a medication it was then transcribed by the licensed nurses in the EMR Order Summary and the pharmacy would deliver it. If medications were ordered late in the day, pharmacy may not deliver them that same day, but the medications would be delivered by the next morning. RN A reported that some antibiotics were immediately available in the facility's medication storage but was unsure if Levaquin and Zofran were included. RN A confirmed that if R1's Levaquin and Zofran were ordered late on 9/4/25 they should have been delivered the morning of 9/5/25.Review of R1's Order Summary and Medication Administration Record revealed the Levaquin and the Zofran had not been transcribed or administered from the time it was prescribed by hospice on 9/4/25 until his death. There was no documentation for a rationale for the delay in treatment or provider notification that it had not been administered as ordered.During an interview via email on 01/23/2026 at 12:00 PM, the NHA stated, For the orders, they were not received by the facility until 9/5. I was the one who found them on the fax on 9/6. Since then, we have been able to give hospice providers access to chart in (the EMR) and able to input orders for our providers to review and approve.During an interview on 01/23/2026 at 3:41 PM, the DON confirmed the Levaquin had not been administered and the order had been delayed. The DON reported that the licensed nurse should have transcribed the antibiotic once the order was received or at least notified the oncoming nurse or the Unit Manager that hospice was prescribing an antibiotic to ensure there was follow through with the orders.A request for a printout of medications available in the facility's medication storage was requested on 01/23/2026 at 2:25 PM. The document was not received prior to survey exit.Review of R1's Nurses' Note dated 9/5/25 at 5:28 AM revealed, Hospice nurse in last night (9/4/25) to see resident.Had T (temperature) 99.4 and acknowledged pain with palpitation (sic) . Indicating the information documented in the note was obtained from the hospice assessment approximately 6 hours prior. There was no documentation that the nurse had completed a physical assessment to ensure R1's condition had not deteriorated at that time.Review of R1's EMR revealed no documentation<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235347 | A. Building<br>B. Wing | 01/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Medilodge of Zeeland | 285 North State St<br>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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | that the nurse obtained updated vital signs or that they had completed a comprehensive physical assessment to ensure R1's condition had not deteriorated at that time There was no documentation that R1's guardian was notified of the resident's change of condition or included with his care and treatment by providing translations services in order to complete an accurate and comprehensive assessment despite the known communication barrier.Review of R1's pain Care Plan revealed, Resident pain threshold is 0 (zero) Date Initiated: 08/06/2025. Administer medications per orders and observe for side effects and effectiveness. Notify the Physician/NP/PA if current pain medication is ineffective or if the resident is experiencing side effects. Date Initiated: 07/18/2025Review of R1's EMR and Medication Administration Record revealed no documentation that R1 was administered Tylenol 650mg which was ordered every 4 hours as needed for pain following the hospice assessment. Indicating R1's pain was identified and documented but not acted upon.Review of R1's Medication Administration Record revealed R1 received a dose of Ativan 0.5 mg (every 4 hours as needed for anxiety) on 9/5/25 at 3:06 PM. R1's Orders - Administration Note revealed that at 3:58 PM the medication was effective. There was no documentation describing a physical assessment or follow-up from his identified pain. Additionally, there was no documentation of the behaviors and/or anxiety symptoms R1 was displaying that required the use of Ativan or if the behaviors were related to increased pain.Review of R1's behavior Care Plan dated 7/18/25 revealed, Resident has behavior(s) related to Dementia, GAD (generalized anxiety disorder). Will refuse cares.Approach resident in a calm manner to avoid frustration and behavior escalation; If resident becomes agitated and shows signs of escalation, reapproach later.Evaluate for verbal and non-verbal signs and symptoms relating to pain: grimacing, guarding, crying, moaning, increased anxiety.Review of R1's Nurses' Note dated 9/5/25 at 9:58 PM revealed, Resident refused assessments. T.98.3. Although the nurse was able to obtain R1's temperature, there were no additional assessments completed for R1 on 9/5/25 (the assessment could have included visual cues that R1 was experiencing continued pain and/or decline by observing him guard an area of discomfort, grimace, cry, display increased/new behaviors, the presence of vomiting, diaphoresis, change of baseline physical abilities/function, etc. A focused assessment can be performed using nursing observations and clinical judgement until a comprehensive assessment can be completed).Review of R1's EMR revealed no documentation that a facility nurse attempted to reapproach and complete an assessment to ensure there was no further deterioration in his health. There was no documentation that R1's guardian was notified of his refusal of care/assessment or that she was included in his care (translation services) or treatment options (transfer to hospital, comfort care, etc). There was no documentation that the licensed nurses ensured R1 received a dose of Levaquin as ordered.Review of R1's incontinence Care Plan dated 7/18/25 revealed, Check at regular intervals and change as needed.During an interview via email on 01/23/2026 at 2:53 PM, the NHA stated the facility staff complete rounds on residents and the best practice is every 2 hours. Review of R1's CNA Task documentation revealed there was no CNA documentation of care provided to R1 on 9/5/25 from 6:00 PM through 9/6/25 6:00 AM.Review of R1's Nurses' Note dated 9/6/2025 at 4:46 AM revealed, CNAs (Certified Nursing Assistants) were doing rounds and found resident deceased at 0420. Hospice (name omitted), Provider and Manager on call notified. Hospice will call family and funeral home. Hospice nurse (name omitted) will be arriving after 6am. Review of R1's EMR revealed no documentation that R1's had been assessed by a licensed nurse or observed by the CNAs for approximately 6 hours and 45 minutes prior to finding him unresponsive.Review of R1's Nurses' Note written by RN A and dated 9/6/2025 revealed, CNAs were doing rounds when the (sic) observed the resident unresponsive and cold to the tough (sic), No pulse. I immediately assessed the resident showing signs of irreversible death, including no pulse, yellow skin and cold to the<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235347 | A. Building<br>B. Wing | 01/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Medilodge of Zeeland | 285 North State St<br>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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | touch, mottling and blood pooling and eyes fixed and dilated. When laid flat to evaluate, resident has large amounts of dark rust colored liquid draining out of his mouth all over the bed. When turned onto his side the resident projected the fluid onto the wall and all over the bed. Hospice, Unit Manager and Provider notified. Hospice notified family and funeral home. The last documentation where R1 was observed responsive was on 9/5/25 at 9:58 PM.During an interview on 01/23/2026 at 10:30 AM, the DON and NHA reported that following R1's death it was identified that RN A did not perform CPR due to the presence of signs of irreversible death. (Per the State Operations Manual obvious clinical signs of irreversible death are rigor mortis, dependent lividity, decapitation, transection, or decomposition.)During an interview on 01/23/2026 at 11:43 AM, CNA B reported that she was working for the first time on R1's unit and was on orientation at the time R1 was found unresponsive. CNA B stated when they were performing post-mortem care and rolled him to his side his back was purple. It wasn't red.it was purplish.During an interview on 01/22/2026 2:52 PM, CNA D reported that R1's unit was her assigned unit and she worked from 6PM on 9/5/25 to 6AM on 9/6/25. CNA D reported that at the start of her shift, when she was receiving report, CNA F reported to her that R1 was declining. CNA D reported that prior to his death he was displaying more symptoms of pain and had become more behavioral. CNA D stated, We had a concern because he wasn't eating. He wouldn't let us help feed him and we reported that to the nurses. CNA D reported that the expectation was to assess the residents during rounds every 2 hours. CNA D reported that he would sleep with a sheet over his head and because he had a history of behaviors, they would carefully check his brief for incontinence without disturbing him. She believed she last checked on R1 around 1:00 AM on 9/6/25. CNA D reported that on her next round she found R1 unresponsive in his bed and he was cold to the touch and was covered in dark colored fluid that had come from his mouth and stated, it was a gruesome scene. CNA D reported that during postmortem care she noted that his back was a deep dark purple color. Indicating he had not been rounded for more than 3 hours despite reporting she was aware of his deteriorating health status.During an interview on 01/22/2026 at 3:16 PM, RN A reported that she assumed care of R1 around 10:00 PM on 9/5/25 but had not been notified of any order changes or a decline in his health or newly identified pain. RN A reported that R1 mostly stayed in his room and was unsure when he went to bed as the CNAs had already assisted him to bed by the time she arrived to the unit. RN A reported that she would periodically check in on residents, but the CNAs monitor residents during their rounds. RN A reported she was unsure when the CNAs last observed him/rounded on him but was told by CNA D that she went in to check and change R1 but she didn't want to disturb him or wake him, so she quickly checked his brief to see if it was wet and crept out.RN A reported the CNAs had called for her to assess R1 and she could tell he had passed and stated, he was way gone.he was gone for a while. RN A reported that R1's eyes were fixed and dilated, his skin was waxy in appearance, and he was covered in brown liquid that had been coming from his mouth. RN A reported that when they (RN A, CNA B, and CNA D) rolled R1 to his side a significant amount of additional brown liquid came spewing from his mouth, and she observed his back with pooled blood. RN A reported a code was not called and CPR was not initiated because R1 was way beyond resuscitation.During an interview on 01/23/2026 at 10:47 AM, RN A clarified that she documented blood pooling in her nursing note regarding the identification of lividity. RN A reported R1's back was dark red in color and there was significant pooled blood observed on his back underneath his skin. RN A reported she did not know when R1 passed but it had been quite some time prior to finding him at 4:20 AM.Review of the National Library of Medicine article Evaluation of Postmortem Changes dated 5/1/23 revealed, Livor mortis, also known as postmortem hypostasis or postmortem lividity, is a passive process of blood accumulating within the blood vessels in the<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235347 | A. Building<br>B. Wing | 01/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Medilodge of Zeeland | 285 North State St<br>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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | dependent parts of the body as a result of gravity, causing a discoloration of the skin that varies from pink to dark purplish. It begins to be apparent about an hour after death, is well-formed in about 3 to 4 hours after death, and gets fixed in about 6 to 8 hours after death. Almulhim AM, [NAME] RG. Evaluation of Postmortem Changes. 2023 May 1. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. PMID: 32119351.Review of the facility policy Notification of Changes last reviewed/revised 8/29/24 revealed, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification. Circumstances requiring notification include. 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complications. 3. Circumstances that require a need to alter treatment. This may include: a. New treatment .Additional considerations.2. Residents incapable of making decisions: a. The representative would make any decisions that have to be made. b. The resident should still be told what is happening to him or her. |