STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235347	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Zeeland	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. This citation pertains to intake #2735204Based on interview and record review, the facility failed to provide dignified care to one Resident (R105) of four residents reviewed for quality of care. Findings include Review of the admission record for R105 reflected the Resident originally admitted to the facility 9/23/2015 and had current pertinent diagnoses that included: quadriplegic (paralysis of all four limbs), Traumatic Brain Injury, and Hydronephrosis (urine cannot properly drain from the kidneys). Review of the Minimum Data Set (MDS) (a tool used to assess a resident's care needs) dated 2/12/2026 reflected a Brief Interview for Mental Status (BIMS) (a scale used to assess a resident's cognitive status) score of 11 out of 15 which indicated R105 was moderately cognitively impaired.During an interview conducted 3/3/2026 at 1:45 PM, Unit Clerk (UC) I reported R105 was transported by facility staff to the hospital every two weeks for a routine procedure.On 3/4/2026 at 8:30 AM, an interview was conducted with Transportation Nurse Aide (TNA) J who reported the hospital is a seventeen minute drive from the facility. TNA J reported residents are prepared for transportation by floor staff and usually are ready to leave timely.Review of the medical records obtained from the hospital dated 2/3/2026 reflected that R105 arrived at the hospital for a routine urinary procedure that was scheduled for 9:00 AM. The documentation reflected an entry by Hospital Registered Nurse (HRN) G that on arrival R105 was very upset. The documentation reflected R105 reported to HRN G that facility staff made him sit in his wheelchair all night. The entry reflected R105 had multiple pressure injury wounds to his buttocks and was Found to have old and new stool saturating the dressings and the wounds. The hospital medical record from this appointment reflected a different hospital staff member changed three dressings that were Soiled (with) stool and that R105 presented with Entire buttocks area bilaterally very red.On 3/2/2026 at 10:41 AM, an interview was conducted with R105. R105 reported that the night prior to the regular procedure at the hospital facility staff refused to put him in bed and he had to sleep in his power chair. R105 reported the next morning he had asked staff several times to be cleaned up as he had soiled himself. R105 reported facility staff did not provide the care requested prior to leaving for his appointment and remained soiled until hospital staff cleaned him.On 3/3/2026 at 3:27 PM, a telephone interview was conducted with HRN G who reported she was present on 2/3/2026 for the procedure for R105. HRN G reported that R105 smelled strongly of stool and that R105 reported he had slept in his chair the night before. HRN G reported that R105 had stated that facility staff refused to put him into his bed or to change and clean him prior to leaving for the appointment. HRN G reported she and other staff cleaned the Resident of old and new stool and removed and replaced the stool-saturated dressings on the wounds on the Residents backside. HRN G reported the smell permeated the hospital unit and indicated R105 expressed embarrassment and frustration at the situation.During an interview conducted 3/3/2026 at 1:53 PM, Licensed Practical Nurse (LPN) O reported a transport log is provided for residents who have off-site appointments scheduled. LPN O reported he passes the information onto the Certified Nurse Aides (CNA) who make sure the resident is ready when Transportation staff come to take the resident. LPN O reported he does not remember anything unusual of the appointment of R105 on 2/3/2026. LPN O reported R105 is incontinent of stool and often does not know if he has soiled (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 B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Zeeland	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	himself. LPN reported at times R105 had refused to get out of his chair and into the bed.On 3/4/2026 at 10:21 AM, an interview was conducted with Nurse Practitioner (NP) K. NP K reported that approximately one to two months ago R105 was refusing to sleep in his bed claiming the mattress was uncomfortable. NP K indicated the issue has since been resolved. NP K acknowledged that R105 was incontinent of stool and must be placed in his bed using a mechanic lift to be changed. NP K reported that R105 might not have been checked if soiled prior to leaving for the appointment but that he was capable of letting staff know he was soiled.Review of the EMR Progress Notes did not reflect documentation that R105 had left the facility for an appointment on 2/3/2026 or that the Resident had refused to go to bed or refused care on 2/2 or 2/3/2026. Further review of the EMR revealed a Bed Hold Policy (a document associated with an offsite transfer) had been issued on 2/3/2026 but no documentation of the transfer. Review of the EMR document titled Task B&B Bowel Elimination reflected R105 had a bowel movement on 2/2/2026 at 8:55 PM and a bowel movement on 2/3/2026 at 5:59 PM. The documentation does not reflect a bowel movement was documented between those times or around the time R105 was transferred to the hospital for an appointment. Review of the EMR document for R105 titled Task: Monitor Behavior Symptoms that included the behaviors of Transferring Behaviors and Rejection of Care reflected No Data Found.On 3/4/2026 at 12:09 PM, a follow up interview with R105 was conducted. R105 was asked if he had asked to be cleaned up before going to the hospital for his appointment on the day in question. R105 stated Yes, I always ask. R105 reported he was in the hall in his chair and had asked two different staff members to clean him but that he went to his appointment soiled. R105 reported that hospital staff were upset that he was sent dirty and stated he had sat in his stool for a long time.