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	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Zeeland	285 North State St Zeeland, MI 49464

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide sufficient staff to timely meet the needs for seven facility residents (R2, R15, R14, R95, R13, R48, and R6) and failed to respond effectively to the concern of the members of the Resident Council. Findings include.R48 Review of the Electronic Medical Record (EMR) reflected that R48 has pertinent diagnosis that includes absence of left leg below the knee, adjustment disorder w/ mixed anxiety and depressed mood, constipation, dependence on wheelchair and PTSD (Post Traumatic Stress Disorder). Review of the Minimum Data Set (MDS – a tool used to determine a resident's status) revealed R48 was cognitively intact. Section GG (functional Abilities and Goals) of this MDS reflected the Resident was dependent on staff for transfers, and bed mobility. During an interview on 05/04/2026 at 12:22 PM, R48 stated they don't have enough staff (especially on 3rd shift) I can't always choose when I want to go to bed because there are not enough staff. They try to accommodate us, but it is hard. R48 explained, I was tired and wanted to go to bed last night but was unable to because there wasn't enough staff. I didn't end up getting in bed until almost 2. We had one aide last night for 2 hallways and they had to pull an aide off the memory care unit to help. They just don't have enough staff at night for over 100 of us. R6 Review of the Minimum Data Set (MDS – a tool used to determine a resident's status) revealed R6 was cognitively intact. Section GG (functional Abilities and Goals) of this MDS reflected the Resident was dependent on staff for transfers, bed mobility. During an interview on 5/05/26 at 9:21 AM, R6's Guardian O revealed staffing has been short. Guardian O stated R6 has called me at night because staff were not answering his call light and it has been over an hour. I've tried to call the facility at night, but their phone system is a mess, and I've had to drive up (to the building) and ring the front door and wait for them to answer before I could get him help. During an interview on 05/06/2026 at 12:19 PM, NHA revealed they were working on staffing and states they can't control call ins. During the interview this surveyor revealed that many of the residents had complaints about call light (times), care and concerns with 3rd shift including concerns with Sunday night staffing (5/3/26). NHA revealed that 3rd shift was rough and stated we recently termed (terminated) 2 Aides together. These Aides' rode together and would show up late. They would leave/be gone from the building for periods of an hour to an hour half at a time during their shift. (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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the staff scheduled for 5/3/26 revealed for 3rd shift they had 3 nurses and 6 aides working from 10PM to 6AM for approximately 115 residents. R2 Review of the Electronic Medical Record (EMR) reflected R2 admitted to the facility 10/7/2025 with pertinent diagnoses that included bilateral below knee amputation and limitation of activities due to disability, Review of the Minimum Data Set (MDS – a tool used to determine a resident's status) dated 4/8/2026 revealed R2 was cognitively intact. Section GG (functional Abilities and Goals) of this MDS reflected the Resident was dependent on staff for transfers. On 5/4/2026 at 12:06 PM an interview was conducted with R2 in his room. R2 reported he required the use of a mechanical lift to transfer from his wheelchair to his bed. R2 reported he often had to wait, sometimes for an hour while sitting in his wheelchair for staff to transfer him back to his bed. R2 reported a spot on his bottom opened up a few days ago and a dressing had been applied. R15 Review of the Electronic Medical Record reflected R15 admitted to the facility 7/20/2025 with pertinent diagnoses that included: Paraplegia (loss or impaired use of extremities), Multiple Sclerosis (a chronic neurological disorder that affects the brain and spinal cord), Overactive bladder, and Repeated Falls. Review of the MDS dated [DATE] reflected R15 was cognitively intact. Review of the Activities for Daily Living (ADL's) Care Plan for R15 reflected two caregivers in room for ADLs and all contact. However, the Care Plan further reflected R15 had ongoing physical needs and required staff assistance with dressing, personal hygiene, transfers, and toileting. The ADL Care Plan reflected an intervention to Encourage resident to use call light when assistance is needed. The At Risk for Falls/Injury Care Plan reflected an intervention to Encourage resident to use call light. The episodes of incontinence Care Plan reflected Assist resident with toileting needs. On 5/5/2026 at 8:47 AM an interview was conducted with R15 in his room. E15 reported sometimes when he must use the bathroom staff tell him they must pick up meal trays instead. R15 reported this made him feel like he was the last priority. R15 stated that the facility was hurting for staff. R15 reported incidents when he initiated his call light that it was not unusual for staff to respond, turn off the call light, and tell him they would be back. R15 stated sometimes they come back. When asked how that made him feel R15 stated, like why a baby cries. R15 asked if he could be provided a catheter and indicated it would be for his convivence. R15 reported he preferred to wear two briefs because staff were not good about changing him. R15 added that he did not like it when he was changed and staff only put one brief back on him, R14 Review of the EMR Face Sheet reflected R14 originally admitted to the facility 5/12/2025 with pertinent diagnoses that included: Visual Loss Both Eyes (blind) Review of the Minimum Data Set (MDS) dated [DATE] reflected R14 was cognitively intact. This MDS reflected R14 was occasionally incontinent of bowel and bladder and required supervision with toileting and transfers. On 5/4/2026 at 9:00 AM an interview was conducted with R14 in his room. It was observed that his (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	call light was on, and the Resident was asked about staff's response to his call light. R14 stated I ain't going to say'. Then R14 reported that call light response was frequently 'forty-five minutes to an hour. R14 declined to discuss this further at this time. On 5/6/2026 at 12:40 PM a follow up interview was conducted with R14 in his room. The Resident was observed to be in a wheelchair at the side of his bed. R14 was prompted to revisit the call light issue previously reported. R14 reported that most of the time delayed call light response was at nighttime. R14 again reported that call light response times were often forty-five minutes to an hour. R14 was asked how he knew the time of the wait as he was blind? R14 reported he had a phone that told him the time, R14 was asked if staff ever gave him a reason for their delayed response. R14 reported staff said they were busy. R14 was asked how that made him feel when he had to wait so long. R14 stated it made him feel like how you don't want to feel. R14 reported he was supposed to be assisted with transfers, but he had self-transferred often. R14 indicated this was related to extended call light response waiting times. R14 reported. But they don't like it when I do . sometimes I fall. R95 Review of the EMR reflected R95 originally admitted to the facility 4/24/2025 and had current pertinent diagnoses that included Foot Drop, left Foot, and Abnormality of Gait and Mobility. Review of the dated 3/6/26 reflected R95 was cognitively intact. On 5/5/2026 at 9:58 AM during an interview conducted in her room, R95 reported she experienced extended call light response waiting times that can be an hour. R95 reported the waiting times for assistance were worse during the night. R95 reported she was a fall risk and was not supposed to go to the bathroom without help. R95 reported she has had accidents (wet herself) and indicated this was due to the extended wait times. R95 reported she didn't want to get anyone in trouble, that the staff were working hard but that the facility just needs more people. R13 Review of R13's face sheet dated 5/4/26 revealed he was [AGE] years old, admitted on [DATE] with diagnoses that included: diabetes mellitus, pressure ulcer right hip, stage 4, lack of coordination, and reduced mobility. R13 was his own responsible party. During an interview with R13 on 5/4/26 at 1:54 PM, in his room he complained about not having enough staff and having to wait a long time for his call light to be answered. R13 put on his call light for help with the Surveyor in the room. The staff responded in 8 minutes. However, 2 staff walked by the room and did not respond to the call light. The light was verified to be on and visible in the hall. When the Certified Nurse Aide responded she apologized and reported she had just returned from her lunch. During an interview with R13 in his room on 5/5/26 at 2:31 PM with Unit Manager (UM) J present R13 complained about staff not assisting him routinely turning in bed and coming into his room saying things about not getting paid enough and not having enough help. UM J side she would complete a concern form for R13. Review of R13's Grievance and Satisfaction Form dated 5/5/26 at 2:30 PM, revealed, UM J completed the form. Concerns with staff reporting short staffed and complaining about two person assist. Resolution, Explained to him staff will be educated on customer service. Resolution was dated 5/6/26 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as satisfied. Review of the facility Resident Council Minutes for 2/10/26 revealed, Current Situation/Concern. There has been a long wait time for call-lights later in the evening. Review of the facility Resident Council Minutes for 3/10/26 revealed, Old Business Review: There has been a long wait time for call-lights later in the evening. Outcome: not resolved action needed. Review of the facility Resident Council Minutes for 4/14/26 revealed, New Business Review/Action Plan: Call-light response time is long for third shift, action taken grievance form. Review of Grievance and Satisfaction From dated 4/14/26 at 11:00 AM revealed, Call light response time longer at night (third shift) Administrator Notification section was dated 4/17/26, scheduler relooked at the 3rd shift schedule and revised based off acuity. Resolution revealed, restructured cna's to have a float aide between halls. Date Resident Notified of Resolution was 4/24/26 and it was marked as Resident was satisfied. No resident name or readable signature of a resident was provided. During the quality assurance (QA) review on 5/6/26 at 2:03 PM, the Nursing Home Administrator (NHA) was asked if she had the call light response time in QA and if she was resident council has listed this as a concern for February 2026, March 2026, and April 2026. The NHA said she was aware of the concerns and was aware none of the interventions/actions the facility has taken have resolved the concern.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a skin care plan for 1 Resident (R13) of 1 resident reviewed for skin care.Findings included: Review of R13's face sheet dated 5/4/26 revealed he was [AGE] years old, admitted on [DATE] with diagnoses that included: diabetes mellitus, pressure ulcer right hip, stage 4, lack of coordination, and reduced mobility. R13 was his own responsible party.R13 was observed in bed on 5/4/26 at 1:54 PM. He had an electrical motor attached to his mattress with the setting on firm. R13 did not know what his mattress setting should be. He knew he had sores on his butt and back but was not aware if they were healing. R13 was on his back in bed and there were no extra pillows visible to use for side to side turning. R13 was frustrated with his attempts to get staff to help get cleaned up and turned in bed. He complained about long-call light waits and staff complaining about being short staffed. R13 put on his call light for help at this time and it took 8 minutes for staff to respond. The Certified Nurse Aide (CNA) that responded apologized for the delay and reported she had been at lunch.During an interview with R13 in his room on 5/5/26 at 2:31 PM with Unit Manager (UM) J present, R13 complained about staff not assisting him routinely turning in bed and coming into his room saying things about not getting paid enough and not having enough help. R13 was on his back and reported he was on his back all day and only got turned one time at night. R13 could not roll in bed independently when asked to move himself. R13's motor to his mattress was unplugged and set at firm. UM J discovered the mattress had been unplugged and was not sure what setting the mattress needed. UM J said her expectation was for staff to turn him every two hours and place a pillow under one side of his back.During an interview with CNA N on 5/5/26 at 3:30 PM, he denied turning R13 and placing pillows under his side during care today. CNA N said he provided a bed bath after lunch on 5/5/26 around 1:30 PM and left him on his back.Review of R13's ADL (Activities of Daily Living) care plan dated 7/24/26 revealed, Bed Mobility: 2 person assist.Review of R13's impaired skin integrity care plan dated 7/18/25 revealed, Pressure Reducing Mattress (APM) initiated 7/29/26 (no setting indicated). Encourage resident to reposition self if able initiated 7/18/25, Assist resident with turning and repositioning at least every 2-3 hrs (hours) initiated 7/18/25.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to formulate and implement a plan of action to monitor, treat, and prevent the worsening of impaired skin for one Resident (R2) of two residents reviewed for impaired skin. Findings include:Review of the Electronic Medical Record (EMR) reflected R2 admitted to the facility 10/7/2025 with pertinent diagnoses that included bilateral below knee amputation and limitation of activities due to disability, Review of the Minimum Data Set (MDS - a tool used to determine a resident's status) dated 4/8/2026 revealed R2 was cognitively intact. Section GG (functional Abilities and Goals) of this MDS reflected the Resident was dependent on staff for transfers.On 5/4/2026 at 12:06 PM, an interview was conducted with R2 in his room. R2 reported he required the use of a mechanical lift to transfer from his wheelchair to his bed. R2 reported he often had to wait, sometimes for an hour while sitting in his wheelchair for staff to transfer him back to his bed. R2 reported a spot on his bottom opened up a few days ago and a dressing had been applied.Review of the EMR document titled Skin Assessment dated 4/23/2026 reflected no to new abnormal skin areas.Review of the Skin Assessment dated 4/30/2026 reflected yes to new abnormal skin areas. The document reflected Red area noted on upper coccyx. Skin is blanchable, appears to be related to shearing. The documented reflected Area cleaned, a foam border dressing applied. The document reflected yes to treatment initiated. The documentation did not reflect measurements were obtained of the Red area.Review of the EMR Progress Notes for R2 did not reflect the Medical Provider has been contacted and informed about the newly identified impaired skin. Review of the Doctor's Orders for R2 did not reflect a treatment had been implemented for dressing changes or monitoring of the impaired skin on the coccyx.Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for April and May 2026 did not reflect routine dressing changes or monitoring of the coccyx area of R2 had been implemented.Review of the Care Plan for R2 did not reveal any revisions that alerted staff that a focus area of impaired skin had been identified or that new interventions were implemented to improve or prevent worsening of the area.On 5/6/2026 at 12:57 PM an observation and interview were conducted in the room with R2 and Unit Manager (UM) J. The coccyx area of R2 was exposed and revealed a round dressing dated 5/4. UM J removed the dressing to reveal purulent drainage approximately the size of a quarter was observed on the dressing. The non-blanchable reddened area appeared as an abrasion and was photographed, measured (1.92 centimeters (cm) x 1.96 cm), and redressed using a hydrocolloid dressing. Following the observation UM J reported she would update the Doctor's Orders for care of the wound. UM J was asked how nurses would have known to change the dressing as no prior Doctor's Order had been in place. UM J confirmed that no Doctor's Order for dressing changes had been in the EMR and stated, I can't answer that. UM J was informed that the Care Plan for R2 had not been revised to include the area identified on 4/30/2026. UM J indicated the Care Plan would be revised to reflect current care and that the Medical Provider would be contacted.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed ensure the safety of 2 two residents (R40) for safe bed mobility and for (R7) to prevent numerous falls, of 12 reviewed for accident hazards.Findings include:R7 Review of Face Sheet revealed Resident #7 re-admitted to the facility on [DATE], with pertinent diagnoses of Parkinson's Disease with Dyskinesia, anemia, bipolar disorder and encounter for palliative care. A review of R7's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 4/29/26, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 99 which revealed R7 was unable to complete the assessment/interview. Review of R7's Electronic Medical Record (EMR) reflected Resident had fallen from his bed seven times in the last 6 months. Review of R7's Care Plan Interventions for falls included, Utilize positioning devices such as pillows and wedges for safe positioning. Date Initiated: 04/13/2026. - Low bed Date Initiated: 07/24/2025 Revision on: 04/13/2026. - Mat to floor next to bed Date Initiated: 07/24/2025 Revision on: 04/13/2026. -Monitor my position to reduce the risk of sliding/falling Date Initiated: 07/24/2025 Revision on: 01/26/2026 - Observe for changes in mobility Date Initiated: 07/18/2025 - Perimeter overlay mattress to assist with positioning. Date Initiated: 07/24/2025 Revision on: 05/05/2026 - Place the call light within reach, though the resident may not be cognitively intact to use it. Date Initiated: 07/18/2025 Revision on:04/23/2026 - Quarter side rails Date Initiated: 05/03/2026 Revision and Resolved on 5/05/26. Review of Fall dated 10/21/2025 at 14:00 reflected, resident was getting up to go to the bathroom. Resident was found on the floor next to his bed and bedside table in close proximity to the bed. Noted no injuries. Review of Fall dated 1/20/2026 at 01:00, revealed, Resident observed lying face down on the floor between the bed and wall. Incont. (incontinent) of bowel. Indwelling Foley cath (catheter) was pulled taut causing pain/bleeding d/t position of resident. Resident stated he was on the floor but did not know how he got there. C/O pain at indwelling foley site. Balloon deflated and large amount of bright red blood instantly noted flowing into tubing and bag. Foley removed. Bleeding continued for approximately 5-10 minutes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Fall dated 2/27/26 at 22:30, revealed aide came to this nurse as resident was on floor. When this nurse came to the room resident was lying on their back, on the floor facing the doorway. This nurse assessed resident vitals stable (104/61p,97 O2, 72p, 18r, 97.9 t) no injuries noted. Was able to move all extremities. Hoyer used to get resident up from the floor. Resident placed back in bed. On call nurse notified, . Resident description: I slid out of bed. Review of Fall dated 3/08/2026 at 04:30, revealed CNA notified this nurse that the resident was found on the floor. Upon arrival, resident observed lying facedown on the floor next to the bed. Resident rolled out of bed. Resident Description: I just fell it happens. Immediate Action Taken, Skin assessment completed. No skin issues noted. Bilateral knees slightly red; no bruising observed. No open areas or swelling noted. Bed placed in lowest position, call light within reach. Fall precautions reinforced. Review of the Nurses' Note dated 3/08/2026 at 05:33, reflected, CNA notified this nurse that the resident was on the floor. Upon arrival resident observed lying face-down on the floor next to the bed. Skin assessment completed. No new skin issues noted. Bilateral knees slightly red; no bruising observed. No open areas or swelling noted. Resident assisted back to bed using Hoyer lift with the assistance of 3 CNAs and this nurse to ensure safe transfer. Safety mattress straps adjusted, bed placed in lowest position, call light in reach. On call nurse and NP (Nurse Practitioner) notified. Family to be notified by first shift nurse for better hours to call for non-emergency. Review of Nurses' Note dated 3/08/2026 at 16:42 reflects, Res. Guardian/Conservation (Name of) was called and updated of Res. crawling out of bed last night and was Thankful. Review of Fall dated 3/08/2026 at 20:44, revealed resident had, small lump to back left of head. Interventions listed in the 3/08/2026 fall document included Collaborate with Hospice regarding routine medication (Ativan). Review of Nurses Progress Notes dated 3/08/2026 at 23:48 reflects, Resident roommate wheeled over to this nurse and informed that resident was on the floor in their room. At the same time a CNA also came to notify this nurse of same incident. Together we entered room observed resident on the floor next to his bed laying on his back with his head in the direction of the foot of the bed. Hoyered into bed. Difficult to get true assessment of ROM (Range of Motion) due to extremities movements. Initially, small lump felt to back of head, however not felt when reassessed. Per hospice, unless change of condition, okay to not due routine VS (Vital Signs) or neuro checks. Review of Physician Progress Note dated 3/9/2026 at 15:03, . Recurrent falls. (3/8 x2) has scoop mattress, unclear how he is rolling OOB (Out of Bed) No injury. Medications are reviewed. No prn morphine prior to fall, but noted prn Ativan prior to 2044 fall 3/8. Review of 4/09/2026 at 09:13, Interdisciplinary Progress Note Late Entry reflected, Review fall out of bed, bed low, perimeter mattress, continues to be physically active in bed with no purposeful movement. Assist with bed mobility to keep pulled up in bed. Mat on floor. Assist with positioning. Review of 4/9/2026 at 09:31, Interdisciplinary Progress Note reflected, Ativan increase due to constant body movement, causing him to be all over his bed, mat on floor, perimeter mattress. Assist with bed mobility. Noted increase in Ativan has decreased his uncontrolled movements. Care plan updated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of 4/9/2026 at 09:43, Interdisciplinary Progress Note reflected perimeter mattress, floor mat and mattress secured. Ativan has been changed to routine, noting decrease in his unvoluntary movements causing him to move in bed. Care Plan updated. Review of R7's Revised Care Plan failed to reflect any fall interventions/changes to care plan between 4/4 - 4/12/2026. Review of 4/10/2026 16:19 Nurses' Notes reflected, (Name of Resident) is very active today in his bed, needing to be repositioned frequently as he gets to the end of the bed, or cross ways. Perimeter on mattress, doesn't utilize the call light. He is answering back by just repeating what was said to him. He has been removing his brief at times, which is a new behavior. Review of Fall dated 4/11/2026 at 16:53, reflects the resident was, In bed, restless. Review of intervention revealed, When he is restless, will bring him out by nurses' station in gerichair. Review of Nurses' Notes dated 4/11/2026 at 17:03, reflected, Roommate of resident notified staff that the resident was on the floor. Resident observed lying diagonally on floormat next to bed, with his head under the bed. Assessed for injury and pain, none found observed. Used Hoyer to get patient back in bed, he had bm (bowel movement) and was very restless. A review of Fall dated 5/3/2026 at 01:55, reflected resident was Lying in bed. He had told CNA that his roommate wanted the TV off, but resident wanted it on. He was attempting prior to this fall to get up to play soccer (what he stated to CNA). He also requested CNA to help him have a BM at last interaction prior to fall. Review of Nurses' Notes dated 5/03/2026 at 03:31 revealed, While rounding on floor, CNA found resident lying on his stomach on the floor on the Mat beside his bed, naked, and having a BM. This nurse went into room and observed resident on floor as stated above with head where head of the bed would be. VSS, no visible sign of injury. Resident stated he did not hit his head and that he has no new pain present from fall. Resident is able to move all extremities. Resident was lifted off floor using two CNA's and a Hoyer lift. Resident was then laid back in bed. Review of Nurses' Notes dated 5/05/2026 at 09:51 revealed, IDT: review fall out of bed, refused change call light to touch pad, bed repositioned in room, NP reviewed medications, continue check and change for incontinence with repositioning. Perimeter mattress on bed with mat on floor. During an observation of R7's on 05/05/2026 at 3:19 PM, reflected the resident's bed was pushed up against the wall with a fall mat next to the bed no quarter rails observed. R7 states he is locked in bed and needs to get out. This surveyor asks resident to push his call button so his aide would come. R7's mattress at the foot of the bed on his right side was angled, smushed, and slumped towards the floor. Resident had slid down in his bed, and both of his legs were angled off the right side towards the floor. Perimeter overlay was not observed on resident's mattress. In an interview on 5/05/2026 at 3:22 PM, R7 stated he needs to get out of bed. On 5/05/2026 at approximately 3:26 PM, DON walked-in to answer R7's call light. This surveyor asked DON if residents sloped mattress could be contributing to his falls? DON stated she would check on it and would go find assistance to help get resident out of bed. (continued on next page)

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	235347	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Zeeland	285 North State St Zeeland, MI 49464

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/05/2026 at approximately 3:50PM, R7 was dressed and staff were assisting resident into a wheelchair. Observation of R7's bed on 05/06/2026 at 3:00 PM revealed a new mattress had been provided. Further observation revealed the sides/edges around the perimeter were built-up approximately 3 inches to assist in preventing the resident from slipping out of bed. During an interview on 05/06/2026 at 4:14 PM, DON stated for (Name of R7) We provided a new mattress w/ perimeter overlay, keeping his bed low. R40 Review of R40's face sheet dated 5/5/26 revealed she was admitted to the facility on [DATE] and diagnoses included: Hemiplegia and hemiparesis following nontraumatic intercranial hemorrhage (brain injury causing lack of movement), seizures and gastrostomy status (tube fed). R40 was not her own responsible party. On 5/5/26 at 11:47 AM Certified Nurse Aide (CNA) I was observed providing incontinence care for R40. CNA I did not have any assistance providing R40 with the incontinence care which required her to roll R40 from side to side in the bed to clean her, change her brief and the pad in bed. Every time R40 was rolled to her left side it was away from CNA I and no one was on the other side of the bed to provide safety or assistance. When CNA I completed care for R40 she was asked when she was trained as a CNA was, she provided education about rolling dependent residents away from her in bed. CNA I responded it is not allowed and confirmed it was a safety concern as the resident can roll out of bed. Review of R40's Activities of Daily Living (ADL) last revised on 3/4/26 revealed, bed mobility 2 person assist, Resident is dependent on staff for mobility. During an interview with the Director of Nursing (DON) on 5/6/26 at 11:59 AM, the DON was informed of the observation when CNA I provided incontinence care for R40 independently and rolled R40 away from her in bed during care. The DON reviewed R40's care plan and said R40 required assistance of 2 staff with bed mobility. The DON confirmed it was not safe to provide care alone with the potential of the resident rolling out of bed. The surveyor questioned if this was covered during the CNA training and competency. The DON believed it was and commented it was just understood. Review of the facility, Nursing Assistant Orientation/Competency Skills Checklist did not reveal anything about the bed mobility for dependent residents. There was no indication in the safety portion of document there was a concern about safety or that 2-person assistance was required with bed mobility for dependent residents Review of the Michigan Nurse Aide Candidate Handbook effective April 1, 2022, revealed, page 43, position a dependent resident in bed on side: 6. Directs RN (Registered Nurse) Test Observer to stand on the side of the bed opposite working side of the bed to provide safety.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep an accurate tube feeding record for 1 resident (R40) of one resident reviewed for tube feeding.Findings included: Review of R40's face sheet dated 5/5/26 revealed she was admitted to the facility on [DATE] and diagnoses included: Hemiplegia and hemiparesis following nontraumatic intercranial hemorrhage (brain injury causing lack of movement), seizures and gastrostomy status (tube fed). R40 was not her own responsible party.R40 was observed in bed on 5/4/26 at 11:30 AM. R40's tube feeding was running at 65 ml(milliliters)/hour (hr). The bottle was dated 5/3/26. The tube feed bottle held 1000 ml. There was approximately 950 ml still in the bottle. (There was no indication what time the feeding started).During an interview with Licensed Practical Nurse (LPN) H on 5/5/26 at 11:39 AM, LPN H said the 2nd shift nurse started R40's tube feeding and the 1st shift nurse turned off the pump and disconnected the tube feeding. LPN H reported R40's feeding was competed earlier today, and she had already disconnected it. LPN H had no idea why R40's pump was still running on 5/4/26 at 11:30 AM with the bottle almost full. LPN H did not provide care for R40 on 5/4/26 and was not given any information in the shift report.R40 was observed in bed on 5/6/26 at 8:01 AM with her tube feeding running. The bottle was dated 5/5/26, starting time 20:00 (8:00 PM). The bottle held 1000 ml and approximately 550 ml was remaining. LPN H was at the bedside and when asked about the inconsistency of the end times for R40's tube feeding she reported there are days when she must let the tube feed run all day and LPN H reported she thought the tube feeding was just started late. LPN H said she reported this to her supervisors but denied documenting the late feedings in R40's medical record.During an interview with Registered Dietitian (RD) F on 5/6/26 at 8:30 AM, RD F reviewed R40 enteral feeding monthly notes and confirmed R40 had a 10.7-pound weight loss in March 2026 and R40's April weight was stable. RD F was not aware the nurses were not documenting when R40's tube feeding was not being completed on time or if they received the full amount. RD F did not know why R40 had a 10.7-pound weight loss in March 2026.During an interview with the Director of Nursing (DON) on 5/6/26 at 8:43 AM, the observations and interviews of the inconsistent tube feedings for R40 were reviewed. The DON said Licensed Practical Nurse (LPN) F documented on the Medication Administration Record (MAR) that he did the tube feeding on 5/3/26 at 8:00 PM. The DON had no idea why the tube feeding bottle that was dated 5/3/26 would still have 950 ml still in it on 5/4/26 at 11:30 AM if it had been started as documented on 5/3/26 at 8:00 PM.The Surveyor attempted to call LPN F on 5/6/26 at 8:47 AM and left a voice message to return the call. LPN F did not return the call prior to exit.Review of R40's May 2026 MAR (Medication Administration Record) revealed an order for, Enteral Feed Order at bedtime related to GASTRSTOMY STATUS Cyclic Enteral Feeding: Formula: Jevity 1.2; rate; 65ml/hr; start at 2000 (8:00 PM) and run until 1000 ml's has infused; Flush with water: Amount 55ml q (every) hour while running. LPN F documented his initials in the boxes for May, 2,3, and 4th.Durning an interview with the DON on 5/6/26 at 3:05 PM, the DON said she spoke to LPN F, and he said he started R40's tube feeding around 10:15 PM on 5/3/26 and he was not aware of the tube feeding not being competed on time. LPN F did report that the tube feeding does get paused sometimes. The DON confirmed she could not locate any documentation related to run time issues for R40's tube feeding.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have a contract and followed the policies and procedures to coordinate hospice services and care for 1 (R 39) of 2 residents reviewed for hospice services. Findings include: Review of a Face Sheet Revealed R39 had received hospice services. Review of an Order Summary for R39 revealed an order for hospice dated 7/11/25. In an interview on 5/4/26 at 11:44 AM, the Power of Attorney (POA) for R39 reported the resident was on hospice and was having some depression since her husband died and not eating well. R39 was on hospice and not sure when hospice would come out to visit R39. The POA for R39 reported that the resident could be strong willed at time and hard to deal with because of her cognitive decline. Review of the Electronic Medical Records (EMR) for R39 revealed the last scanned in document dated 3/18/26 was from the Chaplain for spiritual care. The last Hospice Nurse visit was documented on 3/10/26 in the progress notes. Review of the Order Summary for R39 revealed on 3/18/26 an order for Hydroxyzine 100 mg by mouth at bedtime. (Different than the Hospice medication list.)-Nitrostat sublingual, every 5 hours as needed for chest pain. (Not on the Hospice medication list.)-Lidocaine Pain Relief Patch 4%, once a day for pain in lower back. (Not on the Hospice medication list.)-Lisinopril (blood pressure medication) 2.5 mg, once a day for hypertension. (Not on the Hospice medication list.)-Med Pass 2.0 (nutritional supplement), one time a day. (Not on the Hospice medication list.) Review of the Hospice Medication list with a printed date of 4/27/26 for R39 revealed the following:-Hydroxyzine 50 mg (milligrams), 2 tablets, 3 times daily for anxiety. Total dose 100 mg.-Bio freeze 4% topical gel, 2 inches, every 4 hours as needed, apply to back and right shoulder. (Not on the facility MAR.)-Levsin 0.125 mg, 1 tablet every 2 hours as needed for secretions. (Not on the facility MAR).-Nystatin (antifungal) 100,000 unit/gram topical powder, apply twice daily to affected area under breast. (Not on the facility MAR.)-Promethazine 25 mg, every 6 hours as needed for nausea or vomiting. (Not on the facility MAR.) Review of the Hospice IDG (Inner Development Goals) Comprehensive Assessment and Plan of Care Update Report dated 4/10/26 and signed as acknowledged on 5/1/26 for R39 revealed the Hospice Physician reviewed the Medication profile for effectiveness of drug therapy, drug side effects, drug interactions, and duplicate drug therapy. -Visit frequency from a Registered Nurse was once a week, the Social Worker visit was once a month, the Chaplain visit was 1-2 times a month. Review of a Physician Progress Note dated 4/7/26 for R39 revealed the Practitioner acknowledged R39 was on hospice and had dementia with behavioral disturbances. On high sedative burden with polypharmacy. [Quetiapine (antipsychotic), Trazodone (antidepressant), Sertraline (antidepressant), Mirtazapine (antidepressant), and Hydroxyzine ((Non-[NAME] Antihistamine FDA (Food and Drug Administration) approved for anxiety)] . Reassess need for multiple sedating nighttime agents. Monitor behaviors with hospice collaboration. 3/18 Consent obtained to GDR (gradual dose reduction) hydroxyzine. 4/7 Will attempt to obtain consent for continued GDR on hydroxyzine 2/2 high anticholinergic burden. Did well with previous GDR. During an interview on 5/6/26 at 2:45 PM, the Assistant Director of Nursing/Registered Nurse (RN) K could not locate a hospice schedule for the residents receiving hospice services on the locked unit. RN K stated that hospice nurses are expected to check in with the facility nurse upon arrival and use the EMR to document their visits. RN K confirmed she could not find any recent hospice documentation showing when hospice staff visited or whether they identified changes, concerns, or cares provided for R39. During an interview on 5/6/26 at 2:50 PM, Licensed Practical Nurse (LPN) L stated that the hospice staff check in with him when they arrive to coordinate resident care and review medications and any changes that need attention. LPN L added that he does not document their visits but signs an electronic acknowledgement from the hospice staff. Review of the Hospice Care Plan for R39 revealed: Administer medications as ordered and observe for effectiveness (7/10/25), Notify [Hospice Facility] of any changes of (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition or updates (7/10/25).During an interview on 5/6/26 at 3:20 PM, the Nursing Home Administrator (NHA) stated that the Hospice Nurse is responsible for documenting directly in the facility's EMR and confirmed the last documented visit occurred on 3/10/26. The NHA also reported that the Social Worker serves as the facility's Hospice Care Coordinator. Review of a Hospice Policy last reviewed/revised dated 10/26/23 revealed: When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being.The facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care.The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals, and recognized standards of practice in consultation with the residents attending physician/practitioner and resident's representative, to the extent possible. The plan of care will identify the care and services that each entity will provide in order to meet the needs of the resident and his/her expressed desire for hospice care.The facility will communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility.The facility will monitor and evaluate the resident's response to the hospice care plans.The facility will maintain communication with hospice as it relates to the resident's plan of care and services to ensure each entity is aware of their responsibilities. The plan of care will include directives for managing pain and other uncomfortable symptoms and will be revised and updated as necessary. The facility will monitor for medications and medical supplies to ensure they are provided by hospice as indicated in the plan of care for palliation and management of the terminal illness. Review of the Facility Hospice Contract provided by the NHA dated 4/30/24 revealed that this facility was not listed as a participating facility in the contract agreement.