

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Medilodge of Holland		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 East 16th Holland, MI 49423	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2664534Based on interview and record review, the facility failed to ensure medications were available and given within physician ordered parameters for two of three resident's (Resident 100 and Resident 109) reviewed for professional standards. Findings:Resident #100 (R100)Review of an admission Record revealed R100 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnosis of Parkinson's Disease and Dementia. Review of an Electronic Medication Administration Record (Emar) dated August 2025 revealed a medication order for R100 to take Namenda one 10 milligram (mg) tablet twice daily for Dementia. Documentation for administration of this medication to R100 reflected that the medication was not available starting the evening of August 12th and continued to be unavailable until the morning of August 22nd. Further review of the documentation revealed that a physician was not notified that the medication was unavailable for R100 and that the resident subsequently did not receive 19 doses of the Namenda. Resident #109 (R109)Review of an admission Record revealed R109 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses of hypertensive (related to high blood pressure) heart disease with heart failure, chronic kidney disease stage 3, and aortic valve stenosis (blockage). Review of an Emar dated December 2025 for R109 revealed the following physician order: Hydralazine 25 mg one tab by mouth every 12 hours for high blood pressure-HOLD for blood pressure less than 140/90, start date 12/02/25. Further review of the December 2025 Emar for R100 revealed that despite that nursing had documented blood pressures just prior to administration of the Hydralazine, the medication was given outside physician ordered parameters 16 times.During an interview on 12/26/25 at 11:30 AM, the Director of Nursing could not explain the unavailable Namenda and the Hydralazine being administered outside physician ordered parameters and indicated that this was not the professional standard for nurses.</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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights were within reach of residents for one of three residents (Resident#107) reviewed for call light placement. Findings:Resident #107 (R107)Review of an admission Record reflected R107 originally admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (left side paralysis following a stroke). Review of a Minimum Data Set (MDS) assessment dated [DATE] reflected R107 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10/15. The assessment reflected R107 needed setup or clean-up assistance to eat and with oral hygiene and was dependent on staff for toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. During an observation and interview on 12/26/2025 at 12:27 PM, R107 was observed in bed, the touch pad call light was out of reach. R107 reported that her call light is out of reach two to three times a day and that it is very frustrating.During an observation on 12/26/2025 at 12:30 PM, Medical Records (MR) staff member C came into R107's room at the surveyor's request and confirmed R107's call light was not within reach.Review of the facility Policy and Procedure Call Lights: Accessibility and Timely Response reflected .staff are educated in the proper use of the resident call system .and ensuring resident access to the call light.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2664534Based on observation, interview, and record review, the facility failed to secure prescription medications in two of four treatment carts and one of four medication carts, and for three of four residents (Resident R100, Resident R109, Resident 108) reviewed for medication storage. Findings:During an observation on 12/26/2025 at 12:43 PM, the treatment cart on the 400 hall was not locked. Upon review, the drawers contained prescription ointments, bandages and scissors. During an observation on 12/30/25 at 7:15 AM, the 200-hall treatment cart was not locked and contained prescription medications and treatments. During an observation on 12/30/25 at 9:02 AM, the 100-hall medication cart was unlocked and unattended by a nurse. During an observation on 12/26/25 at 3:30 PM a small plastic cup of prescription medications sat on top of the 100-hall medication cart and was not attended by a nurse. Resident #100 (R100)Review of an admission Record revealed R100 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses of Parkinson's and dementia. During a telephone interview on 12/26/25 at 11:20 AM, family member L stated while visiting in the past, R100's medications have been observed on the bedside table without a nurse present in the room. During an interview on 12/26/25 at 12:40 AM, R100 stated yes when asked if his medications are left on the table for him to take at a later time. Resident #109 (R109)Review of an admission Record revealed R109 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses of Alzheimer's disease.During an observation on 12/30/25 at 6:58 AM R109 laid in bed resting with his eyes closed. A small plastic cup containing pills sat on top of the over bed table. A nurse was not present in the room. Resident #108 (R108)Review of an admission Record reflected R108 admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (paralysis of the left side following a stroke), a history of brain cancer and cognitive communication deficit. Review of a Minimum Data Set (MDS) assessment dated [DATE] reflected R108 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15/15.During an interview on 12/26/2025 at 3:50 PM, R108 and their partner reported that nurses will leave R108's medication at the bedside from time to time. R108's partner reported that when this happens, I make sure she gets all the pills down. Review of the facility Policy and Procedure-Medication Storage revealed the following: All drugs and biologicals will be stored in locked compartments and .during a medication pass medications will be under the direct observation of the person administering medications.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow infection control practices for enhanced barrier precautions and medication administration for four of six residents (Resident #100, Resident #104, Resident #105, and Resident #106) reviewed for infection control. Findings:Resident #100 (R100)Review of an admission Record reflected R100 admitted to the facility 2/20/2025 with diagnoses that included neuromuscular dysfunction of the bladder. Review of a Care Plan initiated 2/20/2025, revised 10/14/2025 reflected that R100 required enhanced barrier precautions related to Foley catheter placement. During an observation on 12/26/25 at 12:40 PM, there was no signage on R100's room that indicated he required Enhanced Barrier Precautions (EBP) nor any Personal Protective Equipment (PPE) for staff to utilize when providing close contact care. Resident #104 (R104)Review of an admission Record reflected R104 admitted to the facility on [DATE] with diagnoses that included neuromuscular dysfunction of the bladder. Review of a Care Plan initiated on 11/28/24, revised 12/02/2024 reflected that R104 required enhanced barrier precautions related to an indwelling catheter. During an observation on 12/26/25 at 12:22 PM, there was no signage on R104's room that indicated that he required Enhanced Barrier Precautions (EBP) nor any Personal Protective Equipment (PPE) for staff to utilize when providing close contact care. Resident #105 (R105)Review of an admission Record reflected R105 admitted to the facility on [DATE] with diagnoses that included neuromuscular dysfunction of the bladder. Review of a Care Plan initiated on 1/02/2025, revised 5/01/2025 reflected R105 required enhanced barrier precautions related to indwelling catheter and a chronic wound. During an observation on 12/26/25 at 12:28 PM, there was no signage on R105's room that indicated he required Enhanced Barrier Precautions (EBP) nor any Personal Protective Equipment (PPE) for staff to utilize when providing close contact care. Resident #106 (R106)Review of an admission Record reflected R106 admitted to the facility on [DATE] with diagnoses that included cutaneous abscess of abdominal wall and encounter for attention to other artificial openings of digestive tract.Review of a Care Plan initiated on 11/15/2025, revised 11/17/2025 reflected R106 required enhanced barrier precautions related to a feeding tube. During an observation on 12/26/25 at 12:46 PM, there was no signage on R105's room that indicated she required Enhanced Barrier Precautions (EBP) nor any Personal Protective Equipment (PPE) for staff to utilize when providing close contact care. During an interview on 12/30/2025 at 9:54 AM, the Director of Nursing (DON) and Registered Nurse (RN) A reported they were both certified Infection Control Practitioners. The DON and RN A indicated that they were new to their roles and had conducted an audit of the building to identify all residents who required Enhanced Barrier Precautions (EBP). The DON and RN A confirmed that observations made on 12/26/2025 revealed that EBP had NOT been in place as required. When asked, RN A stated she had not reviewed physician orders or care plans as a part of the audit.Review of a policy Enhanced Barrier Precautions (EBP) revised 3/26/2024 reflected It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.During an observation on 12/26/25 at 3:36 PM, Registered Nurse (RN) K prepared medications for the resident residing in room [ROOM NUMBER] and popped a medication out of the card. The pill landed on top of the medication cart and RN K scooped the pill up using the medication card and placed the pill in the plastic medication cup that contained other medications. RN K then took the cup of medication to room [ROOM NUMBER] and administered them to the resident.</p>		