

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/08/2026
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.			
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2994162 & 2999360. Based on interview and record review, the facility failed to maintain comfortable sound levels, ensure resident personal property was kept safe from loss, and provide person-centered care for 3 residents (Resident #87, #19, and Confidential Resident C) and residents involved in Resident Council, reviewed for homelike environment. This deficient practice has the potential to affect all 75 residents residing in the facility. Findings: Resident #87 (R87) Review of a Face Sheet revealed R87 was an [AGE] year-old female, admitted to the facility on [DATE], for short term rehab. R87 was her own decision maker. Review of R87's Nursing admission Evaluation dated 7/3/26 revealed R87 was alert and oriented and had no short-term or long-term memory problems. Review of R87's Nurses' Note dated 7/6/26 revealed, Nurse removed icy hot muscle rub from resident's room and explained why it could not be kept in her room. Informed resident that the medication would be locked in the medication cart with her name on it. Resident replied, this is ridiculous. During an interview on 7/7/26 at 9:55 AM, R87 reported that on the previous day, a facility staff member took my icy hot out of my bag without discussing it with me. Right in front of me. R87 verbalized that she did not appreciate the way the facility staff member treated her stating, don't take my sh*t unless you ask and the facility staff member could have talked it out and explained it to me before getting into her belongings and removing her personal item. R87 stated that she was extremely unhappy with staff stating, they lost their class. R87 was asked to elaborate on that statement and reported that 3rd shift staff were so loud in the hallway she was forced to keep her door shut but even with the door shut she could still hear staff loudly talking and interacting in the hallway which caused her to lose sleep. R87 went on to report that some of the facility staff were rough with care, specifically with turning her but did not report it as abuse but instead as rushed and thoughtless care and expressed that the staff were, b*tchy, crabby women. Resident #19 (R19) Review of a Face Sheet revealed R19 was a [AGE] year-old female, admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for R19, with a reference date of 4/24/26 revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated R19 had moderate cognitive impairment. During an interview on 7/6/26 at 10:40 AM, R19 stated, the aide (Certified Nursing Assistant [CNA]) (name omitted) is mean and rude to me. R19 reported she did not want that aide providing care for her and stated the aide made her feel bad. Review of R19's Quality Assistance Form dated 7/6/26 revealed a statement from R19 (name omitted) makes me feel like sh*t. Confidential Resident (CR) C Review of a Minimum Data Set (MDS) assessment for CR C, completed within the last 30 days revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated CR C was cognitively intact. During an interview on 7/6/26 at approximately 12:35 PM, CR C reported he wished to remain (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anonymous and stated that 3rd shift was not so nice. Review of the Resident Council Minutes revealed the following concerns: Handwritten notes for the meeting on 5/6/26 revealed, 8. Alarms for front door going and no one there to shut it off. 9. Clothes missing. Minutes dated 6/3/26 revealed, Old Business. Door alarms going off for long periods of time. New Business Door alarms still going off-need signs that are more visible with clear instructions. Laundry still going missing. CNAs on 3rd shift are very loud and walk into rooms without knocking first. Handwritten notes for the meeting revealed, .Aides 3rd shift not using indoor voices. Also entering without knocking. Residents deserve privacy and respect for sleep. Resident #42 (R42) Review of a Face Sheet revealed R42 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: multiple sclerosis. Review of a Minimum Data Set (MDS) assessment for R42, with a reference date of 5/1/26 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated R42 was cognitively intact. During an interview on 7/7/26 at 10:23 AM, R42 revealed he was the resident council president. R42 reported that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were proactive with addressing and quick to respond to the concerns identified during the resident council meetings, however, the noise levels and the missing laundry were consistently brought up during the monthly resident council meetings. R42 reported that the laundry tags (attached to resident clothing with their name) needed a resolution. During an interview on 7/8/26 at 2:19 PM, R42 confirmed that the complaints of the staff being too loud on 3rd shift as well as the excessive door alarms had also been ongoing unresolved concerns. During an interview on 7/7/26 at approximately 9:50 AM, Housekeeping Director (HD) H reported that they were having issues with the resident identifier tag staying on the clothing through the wash cycle which resulted in the inability to determine which clothing items belonged to the residents and the subsequent reports of missing items/clothing. Per the State Operations Manual, Of particular concern to comfortable sound levels is the resident's control over unwanted noise and a homelike environment is not achieved simply through enhancements to the physical environment. It concerns striving for person-centered care that emphasizes individualization, relationships and a psychosocial environment that welcomes each resident and makes her/him comfortable.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2994162 & 2999360. Based on observation, interview, and record review, the facility: 1.) failed to ensure medications were administered and laboratory testing was completed in accordance with physician orders for 3 residents (Resident #4, #17, and #54), and 2.) failed to observe the consumption of medication for 1 resident (Resident #70), out of 18 residents reviewed for nursing professional standards of practice. Findings: Resident #4 (R4) Review of a Face Sheet revealed R4 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: Diabetes type 2. Review of R4's Order Summary dated 8/28/25 revealed, Hemoglobin A1C (laboratory testing for blood glucose levels over a period of time) every three months starting on the 4th for Diabetic Monitoring. Review of R4's Treatment Administration Record revealed the Hemoglobin A1C was documented as completed (a checkmark with nursing initials). Review of R4's Electronic Medical Record revealed no laboratory results for the Hemoglobin A1C documented as completed on 6/4/26. There was no documentation that the laboratory testing had NOT been completed or that the provider had been notified of the incomplete laboratory testing. Review of R4's Practitioner Progress Note dated 6/8/26 revealed, .General health maintenance-A1c and TSH (thyroid laboratory test) ordered for next lab day (6/11/26). Review of R4's Practitioner Progress Note dated 6/22/26 revealed, .A1c and TSH ordered for 6/11/26, not yet resulted. During an interview on 7/7/26 at 3:28 PM, the Director of Nursing (DON) confirmed that there had been no A1C or TSH laboratory testing on 6/4/26 or 6/11/26 and she placed a new order for both to be drawn on the next lab day. Review of R4's Order Summary dated 7/7/26 at 3:24 PM revealed, Labs: A1C and TSH next lab day. Resident #17 (R17) Review of a Face Sheet revealed R17 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: syncope (fainting) and heart failure. Review of R17's Order Summary dated 06/26/26 revealed, Midodrine HCl Oral Tablet 5 MG (Midodrine HCl) Give 1 tablet by mouth three times a day related to HYPOTENSION, UNSPECIFIED (I95. 9) Hold for SBP (systolic blood pressure [top number]) > (greater than) 120. To be administered at 8:00 AM, 12:00 PM, and 4:00 PM. Review of R17's Blood Pressure Summary and June Medication Administration (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record revealed: On 6/26/26 R17's blood pressure was 126/77 and the 4:00 PM dose of midodrine was administered. On 6/27/26 R17's blood pressure was 122/66 and the 8:00 AM dose of midodrine was administered. On 6/27/26 R17's blood pressure was not assessed prior to the 4:00 PM dose of midodrine. The blood pressure assessment from 12:00 PM (118/60) was documented and the 4:00 PM dose of midodrine was administered. On 6/28/26 R17's blood pressure was 127/71 and the 4:00 PM dose of midodrine was administered. Review of R17's Blood Pressure Summary and July Medication Administration Record revealed: On 7/1/26 R17's blood pressure was not assessed prior to the 12:00 PM dose of midodrine. The morning blood pressure assessment (130/80) was documented and the midodrine was administered. On 7/3/26 R17's blood pressure was not assessed prior to the 8:00 AM dose of midodrine. The blood pressure assessment from the 7/2/26 4:00 PM dose (108/62) was documented and the midodrine was administered. On 7/3/26 R17's blood pressure was 139/71 and the 4:00 PM dose of midodrine was administered. On 7/5/26 R17's blood pressure was 128/81 and the 8:00 AM dose of midodrine was administered. On 7/6/26 R17's blood pressure was 134/70 and the 4:00 PM dose of midodrine was administered. Review of R17's Electronic Medical Record revealed no documentation related to the administration of the midodrine outside of the ordered parameters. Resident #54 (R54) Review of a Face Sheet revealed R54 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: heart failure and hypertension (high blood pressure). Review of R54's Order Summary dated 5/8/26 revealed, Isosorbide Mononitrate ER Oral Tablet Extended Release 24 Hour 30 MG (Isosorbide Mononitrate) Give 1 tablet by mouth in the morning related to CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE (I50.22) Hold for SBP less than 110 and Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate) Give 1 tablet by mouth in the morning related to CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE (I50.22) hold for SBP less than 110 or HR less than 60. Review of R54's Blood Pressure Summary and Pulse Summary revealed R54 had not had his blood pressure or heart rate assessed since 6/19/26. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R54's June and July Medication Administration Record revealed that from 6/19/26 to 7/7/26 all doses of Isosorbide and Metoprolol were administered. Review of R54's Electronic Medical Record revealed no documentation for the lack of blood pressure and heart rate assessments prior to the administration of R54's isosorbide and metoprolol. During an interview on 7/7/26 at 8:08 AM, Registered Nurse (RN) A reported that if the provider ordered parameters, the relevant vital signs are to be obtained prior to the administration of the medication. The nurse is responsible for reviewing the order prior to medication administration to ensure all necessary vital signs are obtained. During an interview on 7/7/26 at 8:13 AM, Licensed Practical Nurse (LPN) E reported that for medications ordered with parameters, the Electronic Medication Administration Record provides an area to input the supplementary documentation (vital signs, blood sugar, pain level, etc) and rationales for withholding the medication (if applicable). LPN E reported that a progress note should be completed if the medication was not administered. During an interview on 7/8/26 at 10:40 AM, the Director of Nursing (DON) confirmed R17 and R54's medication errors: not obtaining vital signs prior to the administration of medications, reusing vital sign assessments, and administering medications outside of parameters. Resident #70 (R70) During an observation on 07/06/26 at 9:56 AM, R70 sat on the edge of the bed and a plastic cup that contained pills sat on the overbed table in front of her. During an interview at the same time, R70 indicated that staff often leave her medications for her to take later, including her eye drops. Review of the Electronic Health Record (EHR) revealed R70 had not been assessed and approved to administer her own medications independently. Review of the facility policy Medication Administration, last reviewed 1/17/23, revealed .medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards . (step 15) observe the resident consumption of the medications. Resident #75 (R75) During an interview on 7/7/26 at 8:32 AM, LPN E reported that R75 preferred to take medications slowly, at her own pace, and would often ask the nurse to leave the medications at her bedside so R75 could take her medications at her own leisure. LPN E reported that leaving medications at the bedside was against the facility policy, however, other people (nurses) leave them for her and leave the room. Review of the facility policy, Medication Administration last reviewed and revised 1/17/23 revealed, .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Professional standards such as Nursing: Scope and Standards of Practice (American Nurses Association [ANA], 2021) apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications .1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication.Responsibilities of medication administration include knowing medication therapeutics, assessing a patient before administration, calculating doses, administering medications using the seven rights, monitoring and evaluating medication effects, and assessing a patient's ability to self-administer medications. [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain general cleanliness and repair of facility. This resulted in an increased potential for contamination and a possible decrease in satisfaction of living for residents. Findings Include: On 07/07/2026 at 9:30AM, observed in the 300-hallway shower room, black mildew-like growth, on the caulk (six to eight inches in length) on either side of the corner of the shower at the bottom juncture of the floor and wall. The wall covering directly beneath the shower head was bulging out from the wall, the wall surface below the covering felt solid. Housekeeping Director (HD) H stated that housekeeping had submitted a work order for the caulk to be replaced. Senior Maintenance Director (SMD) J stated they were aware of work order for the caulking in the shower room. On 07/07/2026 at 9:36AM, observed in the 100-hallway shower room, black mildew-like growth, on the caulk, in the shower area and the wall covering in shower area was bulging out from the wall. SMD J confirmed there was a work order for the caulking in the shower room.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the resident's current advance directive was accurately reflected in the medical record for 1 of 3 residents (Resident #88) reviewed for the implementation of advance directives. Findings: Resident #88 (R88) Review of a Face Sheet revealed R88 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: cerebral infarction (stroke) affecting the right dominant side and vascular dementia. Further review of the Face Sheet revealed R88 had a legal guardian. Review of R88's Advanced Directives Acknowledgements/CPR (Cardiopulmonary resuscitation) Consent signed and dated by R88's legal guardian on [DATE] revealed, No Resuscitation; In the event of a cardiac arrest, I am requesting a DNR (Do Not Resuscitate) order be issued. Review of R88's Do-Not-Resuscitate Order/Guardian Consent signed and dated by R88's legal guardian on [DATE] revealed the guardian consent to authorize no resuscitation in the event R88's heart should stop. Review of R88's Order Summary dated [DATE] revealed, Full Resuscitation. Review of R88's Electronic Medical Record (EMAR) revealed a banner with pertinent resident information which included reflected Code Status (Advance Directives) Full Resuscitate. During an interview on [DATE] at 9:24 AM, the Director of Nursing (DON) reported that the Unit Manager was responsible for ensuring the advance directive forms were completed as well as ensuring the EMAR accurately reflected the resident's/guardians wishes. The DON confirmed that R88's EMAR was inaccurate. During an interview on [DATE] at 2:44 PM, the DON reported she updated R88's code status order and ensured all applicable documentation had been scanned into R88's EMAR. Review of the facility policy, Residents' Rights Regarding Treatment and Advance Directives last reviewed/revised [DATE] revealed, .9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 1.) implement the facility policy for the prevention and treatment of pressure injuries, and 2.) ensure skin integrity/pressure injury assessments were comprehensive and complete for 1 of 3 residents (Resident #88), reviewed for pressure injury prevention and treatment. Findings:Resident #88 (R88)Review of a Face Sheet revealed R88 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: cerebral infarction (stroke) affecting the right dominant side and vascular dementia.Review of R88's Hospice Note dated 6/24/26 and faxed to the facility on 6/26/26 revealed, (R88) is an [AGE] year old female admitted to hospice 7/10/25 with cerebrovascular disease .Ability to speak is declining .She is dependent for all ADLs (Activities of Daily Living): feeding, dressing, transfers, continence, bathing.Hoyer lift for transfers.Requires total assist for feeding, dressing, and hygiene.Incontinent of bladder and bowel .Poor appetite, she is eating less at meals and is more often refusing meals. Worsening dysphagia.Skin changes: left heel pressure injury has resolved .Summary of declines noted this certification period .decreased verbalization .speech limited to a few intelligible words such as what.Review of the Initial Social Service History dated 7/7/26 revealed R88 had severe cognitive impairment and was rarely/never understood due to a cerebral infarct affects residents ability to respond, vascular dementia, and dysphagia (difficulty swallowing).Review of R88's Nursing admission Evaluation dated 6/29/26 redness to buttocks .type-Pressure . There was no specific location of the pressure injury (left, center, or right buttock), no measurements, or descriptions of the wound.Review of R88's Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 7/4/26 revealed a score of 17 indicating R88 was at a mild/low risk for pressure injuries. R88 was not identified as high risk (score of 12 or less). The following was documented for R88's Braden Scale:Sensory Perception: no impairment-Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort. (Slightly limited was not selected despite the known decline in speech/communication and her advanced dementia).Moisture: occasionally moistActivity: chair fastMobility: slightly limited-Makes frequent though slight changes in body or extremity position independently. (Very limited was not selected despite her dependence on 2 staff for bed mobility, transferring, and personal hygiene).Nutrition: adequate-Eats over half of most meals. Eats a total of 4 servings of protein each day. (Very poor was not selected despite that advancement of her dysphagia, weight loss, and poor intake noted in the hospice assessment dated [DATE]).Friction and Shear: potential problem-Moves feebly or requires minimum assistance. (Problem was not selected despite her dependence on 2 staff for bed mobility and transferring).During an observation and interview on 7/6/26 at 11:33 AM, R88's Legal Guardian (LG D) and Certified Nursing Assistant (CNA) B were in the room discussing R88's skin breakdown. R88 was sitting up in a wheelchair with a throw pillow behind her back and did not have a pressure reducing device in place. There were no pillows, wedges, or other offloading devices observed in R88's room to assist with repositioning/offloading pressure while R88 was in bed (to offload pressure to R88's buttocks, hips, or other bony prominences excluding her heels/feet). CNA B stated that R88's bottom is getting worse and she was now getting the pink cream applied which was used for residents with the open ones (pressure injuries). Previously, the white cream was applied as a barrier. CNA B reported that hospice staff would be at the facility for R88 that day (7/6/26) and she would be requesting a pressure mattress. Following that interaction, CNA B exited the room.LG D also reported that she had concerns with R88's care over the weekend and reported that she was unable to visit with R88 (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Saturday (7/4/26) but when she arrived to the facility on Sunday (7/5/26) at approximately 4:30-4:45 PM she observed R88 in bed crying and was informed by facility staff that R88 had not been out of bed that day. LG D stated, she likes to sleep in but not like that. LG D reported that while visiting with R88 on 7/5/26 it was identified that R88's skin breakdown on her bottom had worsened, further stating, that sore was not there on Friday (when she had last visited and observed R88's skin.) LG D reported that R88 was at high risk for skin breakdown due to her history of wounds, her reliance on 2 staff members to assist with bed mobility and transferring, her incontinence of bowel and bladder, her inability to make her needs known (repositioning and/or pain), and the ongoing decline of her health. LG D reported she was upset that not only had R88 been left in bed all day but also because of the lack of interventions implemented which resulted in the worsening of R88's skin breakdown. LG D reported that CNA B wrote down directions for R88's preferences and needs which was then posted in R88's clothes closet for staff to reference the morning of 7/6/26. Review of the care tips hung in R88's closet included the following handwritten directions .Please turn (R88) completely on her side (every 2 hours). New/old sore is getting worst (sic). Apply pink cream to open sores-white cream to red spots.During an observation and interview on 7/8/26 at 8:42 AM, CNA B reported that she had worked with R88 on Saturday (7/4/26), was off on Sunday (7/5/26), and had identified that R88's skin breakdown had progressively worsened on Monday (7/6/26) when she returned to work. CNA B confirmed R88 did not have a pressure reducing cushion for her wheelchair and obtained one on Monday to prevent additional deterioration of the breakdown as LG D required R88 to be up in her wheelchair for a set amount of time each day. CNA B began performing incontinence care for R88 and rolled her on her side to expose the area of breakdown for observation. CNA B pointed to the area of R88's coccyx/sacrum and stated, now she has an open area further stating that prior to her return to work on 7/6/26 the skin breakdown wasn't pink (referring to the wound bed) and wasn't open. CNA B reiterated that the skin breakdown wasn't like this when she got here (admitted). CNA B was asked to describe R88's skin breakdown prior to Sunday (7/5/26) and she reported that R88 had areas of dark pigmentation and fragile skin (scar tissue from previous pressure injuries) and then pointed to the current area of breakdown and stated, it was a small little poke and confirmed the area had increased in size. CNA B was asked to provide a size comparison and established that prior to 7/5/26 the open area was the size of a #2 pencil poke (like the dot it would leave on a piece of paper) and it was now the size of the #2 eraser.CNA B reported that the white cream was applied to pink areas (areas of redness) and the pink cream was applied when it opens for pressure injuries/skin breakdown. CNA B reported that she had immediately notified Registered Nurse (RN) A on Monday 7/5/26 of R88's breakdown and had him put in for (order) pink cream.Review of R88's Order Summary dated 7/6/26 at 12:30 PM revealed, Cleanse MASD (Moisture Associated Skin Damage) to bilateral buttock and coccyx with soap and water, pat dry, apply antifungal powder and zinc oxide every morning and bedtime and as needed. Confirming R88's skin breakdown had worsened which required ordered treatment.Review of R88's Wound Assessments revealed no wound assessment/measurements were completed on 7/5/26 following the identification of the worsening of the skin breakdown or on 7/6/26 following the treatment order change (as of 7/8/26 at 9:00 AM).Review of R88's Electronic Medical Record revealed no documentation of the worsening of R88's skin breakdown or that the provider was notified of the worsening of R88's skin breakdown or the need for a change in treatment.Review of the Physician Communication Book (not part of the legal medical record but utilized to communicate non-emergent concerns with the provider) revealed no entries related to the worsening of R88's skin breakdown.Review of R88's Weekly Skin Assessments revealed no assessment was completed on 7/6/26 as required (as of 7/8/26 at 9:00 AM).Review of (continued on next page)		

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 07/08/2026
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R88's risk for and actual impaired skin integrity Care Plans revealed no new or modified interventions following the identification of the worsening of R88's skin breakdown and had not been revised since 6/30/26. Review of R88's Skin Issue assessment dated [DATE] at 1:43 PM revealed, New skin Issue. Location: Buttocks - generalized. Issue type: Moisture associated skin damage (MASD). Progress: Monitoring: Wound healed or closed with continued monitoring. MASD: IAD Incontinence Associated Dermatitis. Wound was present on admission. It is unknown how long the wound has been present. Signs and symptoms of infection: None. Painful: No. Staged by: In-house nursing. Length (cm): 5.59 Width (cm): 6.8 Depth (cm): 0. Surrounding tissue: Blanching. Erythema. Fragile. Scarring. Additional care: Pressure reducing device for chair. Turning/repositioning program. Positioning wedge. Pressure reducing device for bed. Skin issue notification: Guardian. Provider. Wound nurse. Dietitian. hospice. The extent of the worsening of the skin breakdown cannot objectively be determined due to the lack of the initial measurements upon admission. During an interview on 7/8/26 at 9:24 AM, the Director of Nursing (DON) reported she was aware that R88's treatment order changed on 7/6/26 but was only notified that the skin breakdown had the appearance of yeast and therefore antifungal treatment was included. The DON confirmed R88's skin assessment was not completed on 7/6/26. During an interview on 7/8/26 at 10:45 AM, the DON reported that measurements of the areas of skin breakdown should have been obtained on admission as well as on 7/6/26. She confirmed that R88 was at a high risk for pressure injuries/skin breakdown and a risk assessment for an unavoidable pressure injury should have been completed and her care plan should have reflected that risk with high-risk interventions implemented at that time. During an interview on 7/7/26 at 8:28 AM, LPN E reported that if a new skin injury or the worsening of a previous injury was identified, the nurse caring for the resident would immediately notify the unit manager. The unit manager and Infection Control Preventionist would then assess and document on the skin injury, implement an appropriate order, notify the family and provider, and implement and/or update interventions on the resident's care plan. Review of the facility policy, Pressure Ulcer/Skin Breakdown-Clinical Protocol last reviewed/revised 3/20/24 revealed, .5. Initial screen. All PU/PI (pressure ulcer/pressure injury) or other skin related issues are measured and documented (electronic medical record). 7. Weekly skin evaluation/assessment by the licensed nurse on residents who have no current PU/PI. 8. Change of condition/New Skin Alteration: Notify physician and Resident Representative of all new and/or non-healing/worsening PU/PIs. 18. The physician will help the staff review and modify the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions.		

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NAME OF PROVIDER OR SUPPLIER Medilodge of Holland		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 East 16th Holland, MI 49423	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to accurately document the administration of narcotics for 3 of 3 residents (Resident #29, Resident #39, and Resident #65) reviewed for narcotic reconciliation. Findings: Resident #29 (R29) During an interview on 07/06/26 at 11:00 AM employee 0 stated that R29 had left the building that morning (7/6/26) at 8:40 AM and was transported to the hospital. Review of an Individual Patient's Narcotic Record reflected documentation that R29 received one tab of oxycodone 15 milligrams (MG) at 9:30 AM on 07/06/26 (when R29 was not in the building). During an interview on 07/06/26 at 11:25 AM, Registered Nurse (RN) Q reviewed the above mentioned document for R29 and stated that the incorrect time was documented. Resident #39 (R39) Review of an Individual Patient's Narcotic Record on 07/06/26 at 11:07 AM reflected documentation that R39 received one dose of morphine sulfate 20 MG at 12:00 PM on 07/06/26. During an interview on 07/06/26 at 11:25 AM, RN Q reviewed the above documentation for R39 and indicated that documentation reflected when the medication was scheduled to be given, not when it was actually administered to R39. During an observation on 07/06/26 at 11:32 AM, the bottle of liquid morphine sulfate ordered for R39 was checked (in the presence of the Director of Nursing (DON)) to ensure the remaining medication in the bottle matched the remaining amount documented on the Individual Patient's Narcotic Record. The documented amount of morphine sulfate remaining was 14.5 milliliters (ML's) and the visualization of the remaining amount in the bottle was approximately 16.5 ML's. The DON stated that the discrepancy should have been reported and corrected. Resident #65 (R65) Review of an Individual Patient's Narcotic Record on 07/06/26 at 11:09 AM reflected documentation that R65 had received one dose of Norco 10-325 MG's at noon on 07/06/26. During an interview on 07/06/26 at 11:25 AM, RN Q reviewed the above documentation for R65 and indicated that documentation reflected when the medication was scheduled to be given, not when it was actually administered to R65. RN Q acknowledged that the documentation should match the time given. During an interview on 07/06/26 at 11:27 AM, the Director of Nursing indicated that the expectation for documentation of all administered controlled substances was to document the precise time the medication was administered to the resident.		