STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235289	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Borgess Place	3057 Gull Road Kalamazoo, MI 49048

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	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation, interview, and record review, the facility failed to consistently monitor and assess one resident (R100) of two residents reviewed for pressure ulcer care, resulting in the potential of slow healing wounds, and/or new pressure ulcers developing and the mismanagement of treatment and not receiving adequate care required to maintain or achieve their highest practicable physical well-being. Findings include: R100 According to the Minimum Data Set (MDS) dated [DATE], R100 scored 13/15 (cognitively intact) on her BIMS (Brief Interview Mental Status), indicated dependence on staff for all cares, and diagnoses that included a sacral pressure ulcer. Section E reported the resident did not reject care that was necessary to achieve goals for health and well-being. During an interview on 9/13/2024 at 11:28 AM, Family Member (FM) F stated, Someone from the family is with my mother (R100) to visit with her and feed her lunch and dinner Monday through Friday. And at least once a day for lunch or dinner on weekends. So, the family knows if she has had her brief changed during the day. I observed the wound on September 9 (2024). It was a hole in her bottom 1.9 cm x 2. cm + deep. She has always had open areas on her bottom and assumed it was because she sat in soiled briefs. In March of 2023 the Nurse Practitioner (NP) H diagnosed mother with a Kennedy ulcer. The next time I saw the wound was August 24 or 27 I observed the wound when she was being changed. The staff put her in the chair during the day. I do not request her to be in the chair. The small areas had healed up, but family feels the wound redeveloped because she was left wet and soiled. Family told the facility we want mother checked and changed every 2 hours. The facility is keeping a notebook on mom for when staff change her. I think that since the facility failed to keep my mother dry this large hole in her bottom developed. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy, Skin Protection Guideline, effective date: 07/07/2021, revealed, .to provide evidenced based practice standards for the care and treatment of skin. To ensure residents that admit and reside at our facility are evaluated and provided individualized interventions to prevent, reduce, and treat skin breakdown .First step in the prevention PU/PIs (pressure ulcer/pressure injury) is the identification of the resident at risk .followed by implementation of appropriate individualized interventions and monitoring for the effectiveness of the interventions .Our facility utilizes the BRADEN scale .an evidenced based tool that provides a scale to identify potential categories that would contribute to conditions for breakdown .Planning . an individualized plan of care will be developed based on known predicting factors for skin breakdown. The plan of care will be individualized: 1-upon admission, 2-reviewed quarterly, 3-updated with significant changes in condition, 4-with new or modified interventions .Interventions .for prevention, removing, and reducing predicting factors and treatment for skin may include .offloading devices .incontinence management .specified turning and repositioning .positioning .Turning and Repositioning Observation .pressure is the primary cause of pressure injuries .it is important to individualize each resident's turing and repositioning schedule . Review of R100's Braden Scale dated: -7/17/2022 score 14.0 Moderate Risk -9/19/2024 score 12.0 HIGH Risk. Review of R100's SNF (Skilled Nursing Facility) Notes for Wound Care dated weekly from 6/20/2024 to 9/12/2024, except for the week of 7/4/2024, indicated the resident was incontinent and required incontinence care with a sacral coccyx pressure ulcer. Care to be provided to the resident included changing positions often to keep pressure off the wound and spreading body weight evenly with the use of assistive devices. It was noted R100 did not have a resident-specific care plan developed for wound care needs. Review of R100's Care Plan, dated 9/17/24, indicated a Focus: needs assistance with ADLs due to Parkinson's, debility, and fatigue. The goal was for the resident was to maintain current level of function with interventions that did not include incontinence care. It was noted the survey date was 9/17/24. Review of R100's Care Plan, dated 9/9/24, did not include a resident-specific plan for incontinence care or wound care. Review of R100's Kardex (CNA guide for resident-specific cares) did not include care guides for incontinence or wound care. Observed on 9/17/2024 at 9:11 AM, R100 sitting flat on her bottom on a roho (brand of seat cushion) cushion in a recliner. Observed on 9/17/2024 at 9:35 AM, R100 sitting flat on her bottom on a roho cushion in a recliner. Observed on 9/17/2024 at 9:43 AM, R100 sitting flat on her bottom on a roho cushion in a recliner. During an observation and interview on 9/17/2024 at 1:05 PM, Family Member (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(FM) F stated, Mother (R100) has had sores, open sores, and rashes on and off her bottom since she came here. She has had a bandage on her bottom since before June (2024). Mother is to be laid down in bed after lunch and look, she is still sitting up and she is wet. I want her changed when she wets herself. I need to remind staff to lay her down. R100 stated, I like to lay down in bed after lunch. Observed resident sitting flat on her bottom in recliner on a cushion. The bed had an air mattress set at normal. In June (2024) the family talked about whether to send mother (R100) out to the wound clinic or have the wound NP (Nurse Practitioner) treat mother here in the facility. We felt it better for mother to have her treated here instead of going back and forth to the clinic and not sending her out all the time. The facility is to be keeping track of the wound. During an interview on 9/17/2024 at 1:21 PM, NP H stated, (R100) was admitted back in 2022, with skin breakdown. When she came in it looked like a Kennedy ulcer the shape and color of it up into her lower back. It was just surface skin breakdown at that time though. It would heal up then open. (R100) does not like to get out of her recliner but has agreed recently to lay down after lunch. It takes (R100) a long time to eat and should lay down after lunch. When the spot on (R100's) bottom started to open back up in June (2024) as a small spot and had slough to begin with. The facility brought in a contracted wound NP (NP G). The Unit Manager (UM) I keeps track of the wound measurements. During an interview on 9/17/2024 at 1:50 PM, UM I stated, (R100) has had some kind of skin issue on her bottom since the day she admitted in 2022. The facility has contracted a wound NP (NP G) that is essentially like a mobile wound clinic. Recently, (R100) has agreed to lay down during the day.(NP H) recommended (R100) be laid down to the family. Staff uses a care log of when staff goes into her room to provide care. The family was concerned that potentially staff was not going in as often as they should be. During an interview and record review on 9/17/2024 at 2:40 PM, Director of Nursing (DON) B stated while reviewing R100's wound records, According to (R100's) wound records the following was taken from the wound nurse's notes. A new wound NP started in June 2024. -7/17/2022, R100 was admitted with MASD (Moisture Acquired Skin Disease) on her bottom -4/18/2023, pressure on R100's bottom. It does not say anything else. -4/5/2024, a former Unit Manager, that is no longer here, improperly closed (R100's) wound, saying the wound had healed and no longer required treatment. She did have skin concerns at that time and opened up to a stage II . -6/20/2024 stage II sacral coccyx wound -6/27/2024 wound has serosanguineous (blood in fluid) drainage and is improving -7/4/2024 no documentation -7/11/2024 renamed wound from a stage 2 to a DTI (deep tissue injury) -7/18/2024 DTI that was debrided with NS (normal saline) and Santyl -7/25/2024 unstageable (US) wound debrided with Dakins Santyl (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/1 US (unstageable) Kennedy ulcer -8/5 US Kennedy ulcer -8/12 Kennedy ulcer -8/22 Kennedy ulcer stage 4 There is missing documentation for (R100's) wound. It was not consistently charted on. During an observation and interview on 9/17/2024 at 4:40 PM, R100 was sitting in her recliner, slightly tilted back. The resident reported she was laid down in bed after lunch today, sometime after 1:00 PM. Her brief was changed at that time and she had not been checked or changed since then. During an interview and record review on 9/17/2024 at 4:45 PM, Registered Nurse (RN) C reported after reviewing R100's medical record, the Unit Manager (UM) I had done R100's wound dressing change earlier that morning. She also reported she had not changed R100's dressing during the day because the wound had not gotten soiled due to it being a type of waterproof dressing. The RN stated CNAs were to be checking on (R100's) brief every 2-hours and that the resident should be laid down periodically to relieve the pressure to her bottom. During an observation and interview on 9/18/2024 at 8:33 AM, R100 was supine in bed with the head-of-bed (HOB) more than 30 degrees and her knees bent with a pillow under them. This position would place pressure on the bottom/coccyx. The air mattress was set at Normal. The resident stated, I'm peeing, I want to be changed now. R100 weakly attempted to locate the call light with her hand but the call light was under the bed sheet across her torso. During an interview on 9/18/2024 at 8:40 AM, Licensed Practical Nurse (LPN) L stated, I will be changing (R100's) wound this morning. I will have a CNA change the resident and let them know she is wet. During an interview and record review on 9/18/2024 at 8:46 AM, NP G stated, I was asked to come to the facility in June 2024 to care for wounds. I first saw (R100) on 6/20 (2024) for a wound above her coccyx that was a stage II pressure ulcer. A stage II will be opened with some sort of drainage. R100's wound on 6/27 (2024) was a stage II with drainage. I did not see (R100) 7/4/24. The facility treated the resident that week. I do not see a skin evaluation for the resident that day so I cannot say the wound was evaluated. I saw the resident 7/11 (2024)with the wound no longer open but closed to a deep dark bruise. The wound went to a DTI (deep tissue injury). It means it was a stage II. A wound is considered a Kennedy ulcer when the wound rapidly declines and is deteriorating. A pressure ulcer does not decline quickly like a [NAME] does. (R100's) wound went in one week from a stage II to a Kennedy ulcer complete with slough, necrotic tissue, with opening and tunneling. On 7/18 (2024), the wound was a DTI. My notes are different than what the facility has on their wound sheet. I did not know (R100) was left wet and soiled. I only see her for wound care once a week. Being left wet and soiled could make the wound not heal as well. The wound bed should be maintained, meaning it should be dressed, not wet and is intact. Any time the dressing is saturated, the wound is compromised and should be changed. The resident should be offloaded when in bed or her chair and turned every 2 hours. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 9/18/2024 at 9:05 AM, R100 was in the same position in bed; supine with a blue cushion under the left side of her back, HOB raised, and knees bent. During an observation and interview on 9/18/2024 at 9:12 AM, CNA E came into R100's room and told LPN L she would come in to do incontinence care for the resident and assist with the wound dressing change, they could both then transfer R100 to her recliner for the morning. LPN stated she would be ready at 9:45 AM for the brief and dressing change. The resident was not repositioned or incontinence care given at this time. During an observation and interview on 9/18/2024 at 9:40 AM, R100 was supine in bed, HOB more than 30 degrees, blue cushion under left side of back. During an observation on 9/18/2024 at 10:00 AM, R100 received incontinence and wound care. After cares, she was transferred to a recliner in her room. It was noted, R100 waited 1 hour and 27 minutes to be changed. During an interview and record review on 9/18/2024 at 11:36 AM, DON B and UM I stated while reviewing R100's Skin Evaluation Record, (R100) wound was documented as being closed/healed on 4/5/2024 by a former Unit Manager. She should not have done that. Staff should have continued to monitor (R100's) wound. General skin checks are done every week for every resident. (R100's) wound had an area that was pinkish red the entire between April 5 and June 20 (2024). There was no open area until the resident was seen by the wound NP on 6/13/2024. On 6/13/2024 the area on her coccyx opened. The pinkish red area measured 13.1 cm x 13.6 cm x 0.1 cm. The open area measured 0.1 cm deep. There was no documentation of a wound from 4/5/2024 until really, 6/20/2024. During an observation and interview on 9/18/2024 at 12:34 PM, FM M stated while assisting R100 with her lunch, I've been here since 11:34 AM. No staff have come in to change mother's brief. Usually after lunch, staff will lay her down and change her brief at that time. Observed R100 sitting in a recliner flat on her bottom with nothing to assist her in off-loading from her bottom. During an observation and interview on 9/18/2024 at 1:34 PM, FM M stated, My mother has been left at times sitting in a soaked brief. I know that can't be good for the sore she has. Staff has not been in to check on my mother's brief since I've come in at around 11:30 this morning. My sister has really been on staff to make sure my mother is not sitting in a wet brief and needs to be checked on more often. Observed R100 sitting in a recliner flat on her bottom with nothing to assist her in off-loading from her bottom. During an observation and interview on 9/18/2024 at 1:50 PM, CNA E came into R100's room and stated to family she would come back in to transfer the resident to her bed and change her when the family was ready to leave for the afternoon. The CNA reported she had not changed R100 since she was sat up in the recliner at 10 am that morning. Observed R100 sitting in a recliner flat on her bottom with nothing to assist her in off-loading from her bottom. During an observation and interview on 9/18/2024 at 4:30 PM, R100 was sitting in a recliner in her room visiting with FM P. Family Member stated, When I came in a bit ago, staff came in to get my mother out of bed and into her chair. I believe they changed her at that time because I left the room for privacy. Observed R100 sitting in a recliner flat on her bottom with nothing to assist her in off-loading from her bottom. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R100's Staff Contact Hours (documented times staff repositioned and/or checked and changed resident) during survey 9/17/2024 at 00:00 AM until 9/18/2024 at 2:00 PM. 9/17/2024 -00:00 AM eye drops administered, no documentation of check/change -6:30 AM check/change documentation of resident being dry -8:30 AM feeding -7:30 AM wound care, repositioned, Time was noted to be one hour after the previous eating assistance -9:42 AM morning medications -10:20 AM Just checking on her no documentation if dry or soiled -11:10 AM medication -11:19 AM medication and water -1:16 PM adjusted glasses -3:30 PM gave drink of water -4:53 PM checked on, sitting with daughter -6:30 PM changed and transferred to bed. -8:30 PM checking on patient -10:30 PM check/changed/repositioned 9/18/2024 -00:30 AM check/changed/repositioned -02:30 AM check/changed/repositioned -04:30 AM check/changed/repositioned -6:00 AM check/changed/ sleeping in bed -6:00 AM morning medications given -7:00 AM vitals no concerns (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8:30 AM medications no concerns -10:00 AM wound care no concerns -11:00 AM medications no concerns -12:00 PM checking on her no concerns -1:30 PM medications no concerns -2:00 PM assisted with brief change and back into bed no concerns

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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** 38384 Based on observation, interview, and record review, the facility failed to ensure a gait belt was used during transfers for two of two residents (R100 and R102) reviewed for safe transfers, resulting in the potential for a fall or fall with injury. Findings include: R100 According to the Minimum Data Set (MDS) dated [DATE], R100 scored 13/15 (cognitively intact) on her BIMS (Brief Interview Mental Status), indicated dependence on staff for all cares, and diagnoses that included Parkinson's disease. Review of R100's Care Plan, dated 9/17/24, indicated a Focus needs assistance with ADLs due to Parkinson's, debility, and fatigue. The goal was for the resident was to maintain current level of function with interventions that included Transfers .requires 2 person moderate to maximum physical assistance. It was noted the survey start date was 9/17/24. During an observation on 9/17/24 at 9:35 AM R100 was transferred to a recliner next to her bed. Certified Nursing Assistant (CNA) E did not use a gait belt on R100 during the transfer. During an observation on 9/18/2024 at 10:20 AM, CNA E and Licensed Practical Nurse (LPN) L sat R100 up in her bed and transferred the resident into a recliner. Requiring them to walk the resident and pivot to sit in recliner. No gait belt was used to transfer R100. During an interview on 9/18/24 at 10:30 AM, CNA E stated, (R100) cannot walk any more. She is getting weaker. In the last six months she had really declined. Staff used to walk her to the bathroom. Then she went to therapy because she was getting weak and used a wheelchair to use the bathroom. Now, 6 months later she cannot walk. (LPN L) and I did not use a gait when we transferred (R100) from her bed to recliner. I do not use a gait belt while transferring a resident between the bed and chair. If I am to transfer them farther than that, I use a gait belt. During an interview on 9/18/2024 at 11:00 AM, Unit Manager (UM) I stated, (R100) does not walk any longer. She was seen by therapy and went from using a walker to a wheelchair, but with her decline in health due to Parkinson's, she has lost most of her strength. She requires two staff to help transfer her and one person to feed her. A gait belt should be used even for a transfer from bed to recliner or wheelchair. During an interview on 9/18/2024 at 12:26 PM, UM N stated, Gait belts should be used for any resident that requires assistance. During an observation and interview on 9/18/2024 at 2:01 PM, LPN L and CNA E assisted R100 from a recliner to her bed. Neither staff applied a gait belt to the resident to safely assist the resident during the transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/18/2024 at 3:45 PM, CNA E stated, (R100) is an extensive of two staff for transfers. She has gotten weaker over the last six months and can no longer walk distances. I have not used a gait belt when transferring her. R102 According to the Minimum Data Set (MDS) dated [DATE], R102 was unable to complete his BIMS (Brief Interview Mental Status), required maximal assist to rise from a sitting position and walk once standing at least 10 feet, with diagnoses that included muscle weakness, age-related physical debility, and repeated falls Review of R102's Care Plan, dated 9/9/2024, revealed a Focus identifying the resident was at risk for falls with a Goal of the resident would be free of minor injury implementing Interventions of anticipating and meeting the resident's needs. During an observation on 9/18/24 at 9:42 AM, R102 was transferred into a recliner from his bed by CNA E without the use of a gait belt. During an interview on 9/18/2024 at 12:00 PM, Director of Nursing (DON) B stated, A gait belt should be used when every resident is transferred and not independent. During an interview on 9/18/2024 at 3:45 PM, CNA E stated, (R102) is an extensive of one staff to help steady him and assist him to stand up. I have not used a gait belt on him to go from his Broda chair to toilet or recliner to his bed or the opposite. If I were to walk any distance with him, then yes, I would use a gait belt. Review of facility policy, Gait Belt Use effective Date: 11.28.17, revealed, Purpose: A gait belt is a safety device made of cloth that buckles securely around a resident's waist. The device provides a secure grasping surface to aid during transfer and ambulation. Commonly used for residents who are at risk for falls and those who require assistance during transfer. A gait belt can support a lower to the floor if the resident begins to fall or loses balance during transfer or ambulation. When combined with proper body mechanics a gait belt improves caregiver safety and prevents back injury . Prior to gait belt utilization review the resident plan of care to validate use of the gait belt is not contraindicated .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation, interview, and record review, the facility failed to ensure adequate infection control practices were put in place to ensure proper PPE (Personal Protection Equipment) provided for two of two residents (R100 and R102) reviewed for infection control, resulting in an increased potential of cross-contamination of disease in a vulnerable population. Findings include: R100 According to the Minimum Data Set (MDS) dated [DATE], R100 scored 13/15 (cognitively intact) on her BIMS (Brief Interview Mental Status), indicated dependence on staff for all cares, and diagnoses that included Parkinson's disease and sacral pressure ulcer. Section E reported the resident did not reject care that was necessary to achieve goals for health and well-being. Review of R100's Order Summary, dated 8/1/2024, Coccyx wound . Review of R100's Order Summary, dated 8/27/2024, Enhanced Barrier Precautions due to wound Review of R100's Care Plan, dated 9/9/24, did not include a resident-specific plan for Enhanced Barrier Precautions. Review of R100's Kardex (CNA guide for resident-specific cares), undated, did not include care guides for incontinence or wound care. During an observation on 9/17/24 at 9:35 AM a CDC (Centers for Disease Control) Enhanced Barrier Precautions (EBP) signage was on the door frame of R100's room. The signage recommended that staff providing direct care to residents with and including pressure ulcers wear PPE including gown and gloves. The resident was receiving morning cares including incontinence care from Certified Nursing Assistant (CNA) E. The CNA was not wearing a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, interview, and record review on 9/18/24 at 9:50 AM, reviewed with Licensed Practical Nurse (LPN) L R100's treatment orders on computer. After gathering treatment supplies, LPN L and CNA E entered R100's room. On the door frame was CDC (Centers for Disease Control) signage for Enhanced Barrier Precautions. The signage stated for direct resident cares including wound care, gown, and gloves should be worn. Just inside the room was an isolation cart and two-colored waste containers. One container was red for hazardous waste, the other container was yellow for resident laundry. The LPN and CNA removed the resident's brief that had urine in it but was not saturated. Several small areas of skin breakdown were noted on each buttock with a dressing that did not have labeling or dating on it on the resident's left lower back about 2-3 inches higher than the coccyx. The LPN removed the dressing then pulled out the packing from inside the wound which was saturated with light colored serosanguinous drainage. The area around the wound was a darker purple spreading out into a lighter color in the shape of a circle. On the other side of resident's coccyx and back was a circle shape in a lighter red color. The wound was round, about the size of a 50-cent piece and deep. Tunneling was noted inside the wound. The LPN cleaned and dressed the wound. CNA E provided incontinence care with assistance from LPN L. After care was given to the resident, The LPN stated, I asked when I first started working here two-weeks ago about the EBP signage. An aide (CNA) told me to treat the signage as Universal precautions. I did not wear a gown when I did (R100's) wound dressing change today. Two-weeks ago I changed (R100's) wound dressing and did not wear a gown then either. CNA E stated, (R100) always lays down after lunch about 1:30 in the afternoon after her family leaves. She is a two-person transfer and is checked and changed about every 2 hours. Neither LPN L nor CNA E wore a gown per CDC EBP during incontinence or wound care. During an interview and record review on 9/18/2024 at 10:30 AM, CNA E stated while standing outside of R100's door with EBP signage on the door frame, with an isolation cart, and two-plastic containers, one yellow, one red for hazardous wasted and laundry, inside the door, I do not wear a gown when I go into a room with that sign. The CNA looked at the sign and then at the surveyor and went to another resident's room. During an interview on 9/18/2024 at 12:00 PM, Director of Nursing (DON) B stated, Staff have not had education on wound dressings since I have been here starting in June 2024. The Infection Control Preventionist has not done training with staff either. There is no staff development/educator here at the facility. Agency nurses sometimes shadows nurses but not all the time. They should know infection control practices before they come work here at the facility. The importance of EBP signage is to let staff know that a resident has something indwelling in their body, including wounds. Staff should be wearing their PPE when doing direct cares. All staff should know what to do with the EBP signage. During an interview on 9/18/2024 at 12:26 PM, Unit Manager/LPN (UM) N stated, Per CDC, EBP significance is to cut down on super bugs that cause infection. When a resident is at increased risk, like having a pressure sore, a gown and gloves should be worn with attention to handy hygiene. R102 According to the Minimum Data Set (MDS) dated [DATE], R102 was unable to complete his BIMS (Brief Interview Mental Status), with diagnoses that included a stage 2 sacral pressure ulcer. Review of R102's Order Summary, dated 8/26/2024, revealed, Enhanced Barrier Precautions for resident care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235289	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Borgess Place	3057 Gull Road Kalamazoo, MI 49048

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R102's Care Plan, dated 9/9/24, did not include a resident-specific plan for Enhanced Barrier Precautions. During an observation on 9/18/24 at 9:42 AM, R102 received morning cares including incontinence care from CNA E who did not wear PPE gown while performing cares. During an interview on 9/18/2024 at 1:56 PM, CNA E stated, I took (R102) to the bathroom after lunch. The wound is on his bottom is looking better. I have not been wearing a gown when providing cares for him. According to Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes | LTCFs | CDC, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents at increased risk of MDRO acquisition (e.g., residents with wounds .