| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235289 | A. Building<br>B. Wing | 02/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Villa at Borgess Place | 3057 Gull Road<br>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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>38384<br><br>This citation pertains to intake #MI00147450.<br><br>Based on interview and record review the facility failed to ensure that residents were free from significant medication errors in 1 of 3 residents (R101) reviewed for medication errors resulting in R101 receiving insulin that was not ordered causing dizziness and general malaise.<br><br>Findings include:<br><br>Review of R101's Incident Report dated 10/5/2024 at 12:03 PM reported a medication error had been reported with insulin being given incorrectly. R101 stated to Unit Manager (UM) E that he felt dizzy and knew his sugar (blood sugar) had been checked and was poked in his arm by a shot. No statements by staff or notifications had been found or listed.<br><br>Review of R101's MDS (Material Data Set) dated 11/22/24 revealed a BIMS (Brief Interview Status) of 10/15 indicating moderate cognitive function.<br><br>Review of R101's Diagnoses did not have diabetes mellitus documented.<br><br>Review of R101's Order Summary print date 2/11/25, did not have any insulin ordered for administration.<br><br>During an interview on 2/10/25 at 9:47 AM, Family Member (FM) C stated, My brother and I are the medical DPOA (Durable Power of Attorney) for (R101). On 10/5/24, (R101) did not have a roommate. I was told by the Unit Manager (UM) E, my father, (R101) was given insulin on 10/5/24. He is not a diabetic. I talked to my father (R101) about what happened, and he told me he got the shot at lunch time. He said a nurse came up to him and poked his finger. He asked the nurse why she was doing that and she told him she was checking his blood sugar. He said he told her he didn't have sugar (diabetes). The next thing he knew the nurse had poked him in the back of the arm. He said, Hey! What is that for! She said for diabetes. Again, he said, he told her he did not have diabetes. I stayed with him that evening. He told me he felt funny and did not feel right all the rest of the day and night. My father is a very smart man. People talk to him like he is slow because of his speech, but he is not. My father knows about diabetes and insulin because his wife and some of his kids had it. He was very upset the nurse did not listen to him and that he got it. He was afraid he was going to get very sick from the insulin.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235289 | A. Building<br>B. Wing | 02/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Villa at Borgess Place | 3057 Gull Road<br>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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 2/10/15 at 3:44 PM, R101 was in his room in a chair awake. The resident reported he does not have diabetes and does not get insulin. He remembered a nurse coming into the dining room at lunch time and BOOM, she put a needle in my arm and said it was insulin. I told her I do not get insulin and she walked away.<br><br>During an interview on 2/10/24 at 4:10 PM, Director of Nursing (DON) B stated, (R101) told a CNA (Certified Nursing Assistant H) that a nurse poked his finger and gave him a shot. After questioning his nurse that day, (LPN I), the facility found out she had given (R101) him about 20 some units of insulin. (R101) said he felt a little dizzy that first day. The insulin was probably for (R102). I believe the nurse gave (R101) the insulin to him in his room and his name was on the door. He knows his own name.<br><br>During an observation and interview on 2/11/25 at 6:00 AM, LPN/Charge Nurse J and LPN K were completing a narcotic medication count on the Enchanted medication (med) cart. LPN K stated, I am a permanent employee here at the facility. The Rights of medication administration are the right patient, the right route, the right medication, the right dosage, and the right time. The resident's pictures are on the computer and their name is next to the door of their room. Nurses get an in-service skills fair each year. LPN J agreed with LPN K.<br><br>During an interview on 2/11/15 at 6:05 AM, Registered Nurse (RN) L and LPN M were giving morning report to one another. RN L stated, The resident's picture is on their medical record screen. Before passing meds, the picture should be viewed, then you ask their name, and you can always double check their date-of-birth (DOB) in case there are residents with the same name. If the resident cannot answer you, go look at their picture or ask another staff who the resident is. LPN M agreed with RN L.<br><br>During an interview on 2/11/25 at 6:46 AM, (UM/RN) D stated, Expectations for medication administration check is for the nurse to check for the right medication for the medication administration three times. This includes name of med when pulling from cart, against computer order, and right before you give. To check if you have right resident, ask their name, picture on computer, and if the resident is not not coherent, ask another staff member. Expectations of agency staff are to use pictures on the computer and use good interview skills to ask residents who they are. The facility helps the agency nurses. Agency nurses tend to like working here. Our EMR (electronic medical record) system does have pictures that resemble residents to assist identifying them.<br><br>During an observation, interview, and record review on 2/11/25 at 7:46 AM, LPN/Charge Nurse J compiled morning medication for R101 from the Enchanted Gardens med cart. On the resident's eMAR was a current and clear picture of him. Medications the LPN gathered did not include insulin. LPN J reported R101 was not diabetic nor was her ordered insulin.<br><br>During an interview and record review on 2/11/25 at 1:55 PM Nurse Practitioner (NP) R stated, (R101) got the wrong insulin on 10/5/24. He should not have gotten the insulin; he does not take insulin. There were three residents in that area that got insulin including two-men (R102 and R103). One of the two men was African American. The third resident was a woman.<br><br>(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<br>B. Wing | 02/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Villa at Borgess Place | 3057 Gull Road<br>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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R101's Progress Note dated 10/5/24 at 19:15 (7:15 PM) revealed, COMMUNICATION - with Family/NOK/POA (Next of Kin, Power of Attorney) Note Text: Spoke with (R101) earlier and explained we were going to monitor his blood sugar due to his report of receiving insulin. Called his daughter (FM C) and explained what had occurred and that we had monitored him this afternoon and he had been fine. His blood sugar never got below 115 which was right after lunch, and his vitals were fine. He did state he was dizzy .<br><br>Review of R101's Physician's Progress Note dated 10/7/24 at 14:05 (2:05 PM) revealed, Associated Diagnoses: Accidental medication error .was given another patient's insulin by mistake this weekend . Diagnosis: Accidental medication error .Plan: Medication error apparently he received short-acting insulin .<br><br>R102<br><br>Review of R102's Order Summary revealed,<br><br>-8/28/24 Glucose monitoring before meals and at bedtime for diabetes.<br><br>- Admelog Solo Inj 100U/ml inject 5 unit subcutaneously with meals for DM (Diabetes mellitus) equivalent to Humalog.)<br><br>Review of R102's MAR dated 10/1/24-10/31/24 reported the resident received<br><br>-in the morning Insulin Glargine-100 unit/ml solution pen-injector 24 units subcutaneously by LPN O<br><br>-in the morning Admelog Solo inj 100 unit/ml 5 units subcutaneously with meals by LPN O at 8:30 AM and at 12:30 PM by LPN I.<br><br>During an interview and record review on 2/11/25 at 9:33 AM, UM/LPN E stated, (LPN I) swore up and down to me she gave (R101) his correct meds on 10/5/25. She was an African American agency nurse. R101 is his own person and has good memory. He stated that his finger was poked with a machine and got a shot in his arm that morning. He told me a black lady that gave him his meds that morning was the one that poked his finger and gave him a shot. He insisted because the nurse who poked his finger had to have given him insulin. Upon assessing him he was light-headed and dizzy which would indicate he was given a med he was not used to. His blood sugar at that time was 115 and never dropped below that. I contacted the NP because the facility did not know whose meds or what meds he got. The NP had me look at other residents around him, R102 had not gotten his meds yet per the eMAR that morning and he was to receive insulin. The LPN was very confident she had not made a medication error. She swore that she did not give (R101) insulin that day and she had made no errors that morning. One of (R101's) fingers had a little red mark. (R101's) meds were signed out for that morning but (R102's) meds were not signed out that morning. There were two other diabetics that received insulin that morning, (R103) and a woman. (R103) was an African American male who got insulin that morning signed out by (LPN I). I reviewed (R102's) MAR for that day and saw (LPN I) had given him a couple of things in the morning but not insulin or all his pills. Review of R102's MAR dated 10/5/24 revealed LPN I signed out at 12:30 PM Admelog Solo Inj 100U/ml inject 5 unit subcutaneously.<br><br>(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<br>B. Wing | 02/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Villa at Borgess Place | 3057 Gull Road<br>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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 2/1125 at 1:10 PM, LPN O stated, I was told my UM E to go over to Enchanted unit about mid-morning to pass medications. One of the CNAs told me a nurse had taken a longer lunch than expected. So, it must have been closer to lunch. I know I had to pass meds and residents had complained they had not gotten their medications that morning. I know (R102). I recall (R101) got insulin and should not have. He was kind of out of it that day. I believe the other nurse gave him insulin and should not have. He told me about it; he said, I should not get insulin. The facility did checks blood sugars and monitored all the residents on the unit for side effects. I gave (R102) his insulin because he never received it that morning.<br><br>Review of R102's Medication Administration Record (MAR) dated 10/5/24 at 12:30 PM, reported LPN I tested the resident's blood sugar with a documented reading of 197 with 5 units of Admelog solo injectable 100U/ml insulin administered subcutaneously.<br><br>Review of R102's Medication Administration Audit Report, dated 10/5/2025, reported LPN I performed a blood sugar check on the resident at 1:02 PM and administered Admelog insulin subcutaneously at 1:03 PM. The closest medication LPN I had administered was a PO (by Mouth) medication at 12:57 PM.<br><br>Attempted on 2/11/25 at 8:34 AM, to contact LPN I via telephone and left a message to call back. No return call was made by end of survey 2/11/24 at 5:30 PM. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235289 | A. Building<br>B. Wing | 02/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Villa at Borgess Place | 3057 Gull Road<br>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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>38384<br><br>This citation pertains to intake #MI00147450.<br><br>Based on observation, interview, and record review, the facility failed to follow standards of practice for medication labeling, with the potential to cause side effects and infection control issues.<br><br>Findings include:<br><br>Review of R103's Medication Administration Record (MAR) dated 2/1/25 to 2/28/25 revealed, Lantus 100 unit/ml 8 units.<br><br>During an observation, interview, and record review on 2/11/25 at 7:12 AM, Licensed Practical Nurse (LPN) Charge Nurse J compiled morning medications for R103 from the Enchanted Gardens med cart. On the resident's eMAR (electronic medication administration record) was a current and clear picture of him. Medications that the LPN gathered included Lantus 100 units/ml (millimeter) injectable pen. Approximately 80-90 units were left in the pen which originally held 100 units. The pen was labeled with the resident's name but was not labeled with the date it was opened nor the date the medication was to expire once opened. LPN J reported the insulin should have an open date for the integrity of the medication and did not know why there was not one. She further reported she had worked the day before and administered the insulin to R103 from the same pen but did not notice it was not labeled with either date. The LPN then retrieved a new Lantus insulin pen from the back-up medication refrigerator, labeled it, and administered the medication to R103. LPN J stated once opened, the insulin was good for 28 days. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235289 | A. Building<br>B. Wing | 02/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Villa at Borgess Place | 3057 Gull Road<br>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 0940<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop, implement, and/or maintain an effective training program for all new and existing staff members.<br><br>38384<br><br>This citation pertains to intake # MI00147450.<br><br>Based on interview, and record review, the facility failed to maintain an effective training program for agency staff consistent with their role in the facility to ensure the safety of resident in 1 of 3 residents (R101) reviewed for medication administration, resulting in R101 receiving an unordered medication and sustaining dizziness and overall malaise.<br><br>Findings include:<br><br>Review of R101's Incident Report dated 10/5/2024 at 12:03 PM reported a medication error had been reported with insulin being given incorrectly. R101 stated to Unit Manager (UM) E that he felt dizzy and knew his sugar (blood sugar) had been checked and was poked in his arm by a shot. No statements by staff or notifications had been found or listed.<br><br>Review of R101's MDS (Material Data Set) dated 11/22/24 revealed a BIMS (Brief Interview Status) of 10/15 indicating moderate cognitive function.<br><br>Review of R101's Diagnoses did not have diabetes mellitus documented.<br><br>Review of R101's Order Summary print date 2/11/25, did not have any insulin ordered for administration.<br><br>During an interview on 2/10/15 at 3:44 PM, R101 was in his room in a chair awake. The resident reported he does not have diabetes and does not get insulin. He remembered a nurse coming into the dining room at lunch time and BOOM, she put a needle in my arm and said it was insulin. I told her I do not get insulin and she walked away.<br><br>During an interview on 2/10/24 at 4:10 PM, Director of Nursing (DON) B stated, (R101) told a CNA (Certified Nursing Assistant H) that a nurse poked his finger and gave him a shot. After questioning his nurse that day, (LPN I), the facility found out she had given (R101) him about 20 some units of insulin. (R101) said he felt a little dizzy that first day. The insulin was probably for (R102). I believe the nurse gave (R101) the insulin to him in his room and his name was on the door. He knows his own name.<br><br>During an interview on 2/10/24 at 4:10 PM, Director of Nursing (DON) B stated, On October 5, 2024, (Licensed Practical Nurse (LPN) I) was working first shift at the facility. I believe the nurse gave (R101) a medication (insulin) to him that was not his while in his room and his name was on the door. (LPN I) worked for a staffing agency that did not give her orientation to our facility. We did not give her orientation either. That day (October 5, 2024) was (LPN I's) first shift working at the facility.<br><br>(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<br>B. Wing | 02/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Villa at Borgess Place | 3057 Gull Road<br>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 0940<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 2/11/25 at 8:29 AM, Assistant Director of Nursing (ADON)/Staff Development C stated, The agency nurses do not typically get orientation or training from the facility before starting to work with residents. Agency staff come from an as needed last minute need to cover cares type of agency for residents. The agency that supplies the nurses takes care of the requirements and competencies the nurses need to work. I do not know exactly what it all includes. Licensed Practical Nurse (LPN) I came from an on-demand staffing agency and just walked in the building and started working. (R101) told a CNA (Certified Nursing Assistant he got insulin when he does not get that medication.<br><br>Review on 2/11/24 at 10:41 AM, LPN I's agency staffing company's Acknowledgement Form acknowledged on 6/8/24 the licensed nurse did not receive training from the agency but had attended or read educational in-service trainings which did not include medication administration.<br><br>During an interview on 2/11/25 at 12:45 PM, ADON/Staff Development C stated, The facility as the on-call physician call list in the nursing stations and the contractual nurse would have to ask someone where it is located. The abuse coordinator contact number is posted but I'm not sure where. Contractual staff (agency) do not get badges with the abuse coordinator's other contact numbers, so they would have to ask facility staff in the building. For assistance, agency nurses would call the on-call manager from the nursing station. If the agency nurse is behind in passing meds, they can call the on-call or ask another nurse for help. Weekends there is no management, not as many nurses or CNAs in the facility. If needing help with dementia care the contractual nurse would have to look at the care plans. They get report when coming in from the off-going nurse and can ask questions at that time. The nurse would have to reach out to who is in the building for assistance.<br><br>On 2/11/25 at 1:07 PM, Staff Coordinator for Staffing Agency was left a message to return message. No message was returned by end of survey 2/11/25 at 5:30 PM. |