| 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 | 06/09/2025 |

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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI00153405.<br><br>Based on observation, interview, and record review, the facility failed to ensure residents were cared for with dignity and respect for 3 (Resident #107, #110, and #117) of 8 residents reviewed for dignity, resulting in the potential for feelings of embarrassment, frustration, depression, loss of self-worth and an overall deterioration of psychological well-being.<br><br>Findings include:<br><br>Resident #107<br><br>Review of an admission Record revealed Resident #107 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dysphagia (difficulty swallowing).<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #107, with a reference date of 5/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 1/15 which indicated Resident #107 was severely cognitively impaired.<br><br>Review of Resident #107's Care Plan revealed, (Resident #107) has an actual ADL (activities of daily living ) self-care performance deficit . Interventions: .Dining: Resident requires feeding assistance x1. NO straws, single sips with chin tuck, clear oral cavity prior to another bite. Date initiated: 5/9/25 .<br><br>Resident #110<br><br>Review of an admission Record revealed Resident #110 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dementia.<br><br>Review of a MDS assessment for Resident #110, with a reference date of 4/22/25 revealed a BIMS score of 15/15 which indicated Resident #110 was cognitively intact.<br><br>Review of Resident #110's Care Plan revealed, (Resident #110) needs assistance with ADL care due to his decreased strength . Interventions: . Eating: (Resident #110) needs extensive assistance with 1 person staff assist for eating .Date initiated: 9/11/24 .<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #117<br><br>Review of an admission Record revealed Resident # 117 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dysphagia.<br><br>Review of a MDS assessment for Resident #117, with a reference date of 2/22/25 revealed a BIMS score of 4/15 which indicated Resident #117 was severely cognitively impaired.<br><br>In an interview on 6/4/25 at 9:33 AM, This writer asked Certified Nursing Aide (CNA) I if there were any residents on the unit she was working on that required assistance with eating. CNA I reported that she thought that Resident #107 might be a feeder. CNA I then asked Registered Nurse (RN) LL who the feeders were on the unit, and RN LL replied that the only feeders she knew of were Resident #107. It was noted that Resident #107 was sitting outside of the nurses station and within the distance to hear CNA I and RN LL call her a feeder.<br><br>In an interview on 6/4/25 at 10:09 AM, This writer asked Licensed Practical Nurse (LPN) JJ if there were any residents on the unit she was working on that required assistance with eating. LPN JJ reported to this writer that the only feeder she had on her unit was Resident #110. It was noted that LPN JJ had called Resident #110 a feeder outside of Resident #110's room, and had the potential to have been heard by Resident #110.<br><br>In a dining observation on 6/9/25 at 11:54 AM, CNA BB was training a new staff member. CNA BB walked over to a table where Resident #117 was sitting with three other residents and told the new staff member This is (Resident #117) and she is a feeder, so when her food gets here you will want to help her. CNA BB then pointed to another resident sitting at the table and told the staff member she was training, this is (Resident's name) and he is not a feeder, but he likes to sit at the feeder table. It was noted that CNA BB could be heard from across the dining room calling Resident #117 a feeder and there were 9 residents and three staff members in the room at the time.<br><br>Resident #107, Resident #110, and Resident #117 were unable to be interviewed. Using the reasonable person concept, though Resident #107 and Resident #117 had decreased ability to verbally express their own thoughts due to medical diagnoses, any reasonable person would likely feel a decreased sense of self-worth and frustration in the situation observed.<br><br>Review of the facility's Resident Rights policy dated 11/28/27 revealed, Purpose: It is the practice of this facility to provide for an environment in which residents may exercise their rights, each day. Our residents have certain rights and protections under Federal law. Our facility meets and provides these rights through care and related services at all times .Respect, Dignity and Self-Determination: The right to be treated with respect and dignity . |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff fully implemented the abuse policy and identiry and report allegations of neglect to the abuse coordinator in a timely manner for 1 (Resident #118) of 1 residents reviewed for abuse and neglect, resulting in the potential for continued violations involving neglect go unreported.<br><br>Findings include:<br><br>Review of an admission Record revealed Resident #118 was originally admitted to the facility on [DATE] with pertinent diagnoses which included depression and muscle weakness.<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #118, with a reference date of 4/11/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #118 was cognitively intact.<br><br>Review of Resident #118's Care Plan revealed, (Resident #118) has actual need for ADL (activities of daily living) self-care performance . Interventions: toileting: Check and change. Date initiated: 9/11/24 .<br><br>In an interview on 6/9/25 at 2:35 PM, Licensed Practical Nurse Manager (LPN-M) M reported that she was contacted on 6/8/25 by Certified Nursing Assistant (CNA) W regarding concerns that Resident #118 had not been checked on for an extended period of time. LPN-M M reported that Certified Nursing Assistant (CNA) S was responsible for caring for her Resident #118 that day, and while she was on break CNA W and CNA G answered Resident #118's call light to find her in a brief that was soiled with bowel movement. LPN-M M reported that CNA W and CNA G were concerned with the condition they found Resident #118 in, so they called her to report the concern. LPN-M M reported that she relayed the concern of Resident #118 being past due for care to Director of Nursing (DON) B and she did not know what DON B did about the concern.<br><br>In an interview on 6/9/25 at 12:39 PM, LPN OO reported that she was one of the nurses that worked with CNA S on 6/9/25 and she had also contacted DON B about concerns with CNA S not completing care tasks that day. LPN OO reported that CNA S would frequently leave work for other staff, and residents had been complaining about long call light wait times. LPN OO reported that CNA S would frequently go missing and she took several breaks before any other staff on the unit had been able to take a break.<br><br>In an interview on 6/9/25 at 3:03 PM, LPN L reported that she had been approached by CNA G and CNA W to come assess the condition that they had found Resident #118 in. LPN L reported that Resident #118 was lying in her bed with a soiled brief with bowel movement that was coming out of the brief and onto her bed. LPN L reported that the brief Resident #118 was wearing had 5:18 AM written on it, indicating that Resident #118 had not had her brief changed since 5:18 AM. LPN L confirmed that Resident #118's care plan noted check and change for toileting, which indicated that staff should have been checking Resident #118's brief every two hours. LPN L reported that Resident #118 was found by CNA W and CNA G around 2:00 PM. LPN L reported that CNA W contacted LPN-M M regarding the concern that Resident #118 had been neglected.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 6/9/25 at 3:16 PM, CNA W reported that she had been covering CNA S unit while she was on break when she answered Resident #118's call light and found her in a soiled brief with bowel movement running down her leg and sheets. CNA W reported that Resident #118's brief had the time 5:18 AM written on it, and that Resident #118 had confirmed that she had not had any staff member come in to assist her throughout the day, and she had been laying in the soiled brief for a long time. CNA W reported that she went to get LPN L to report her concern and verify the concern of Resident #118's condition. CNA W reported that she and CNA G assisted Resident #118 in getting cleaned and changed and then she called LPN-M M because she had a concern that Resident #118 had been neglected.<br><br>In an interview on 6/9/25 at 3:25 PM, Resident #118 reported that she did have to lay in a soiled brief for a very long time on 6/9/25 because she had not staff come in to assist her. Resident #118 confirmed that CNA S had not been in her room to provide care for her that day. Resident #118 reported that she didn't like waiting for such a long time and hoping someone would care for her, but that was just how it is here.<br><br>This writer attempted to contact CNA S on 6/9/25 at 3:28 PM. CNA S was unable to be reached prior to survey exit.<br><br>This writer attempted to contact CNA G on 6/9/25 at 3:28 PM. CNA S was unable to be reached prior to survey exit.<br><br>In an interview on 6/9/25 at 4:16 PM, Director of Nursing (DON) B and Nursing Home Administrator (NHA) A reported that they were both aware of the staff concerns for Resident #118 not being given timely care on 6/9/25. DON B reported that she had been notified on 6/9/25 around 3:00 or 4:00 PM that CNA W went in to change Resident #118 because she was wet and there was a delay Resident #118 getting her brief changed. DON B reported that she was told that all other residents were assessed and staff did not find concerns. DON B reported that she spoke to CNA S and that CNA S had reported that Resident #118 had refused care in the morning, and she did not check on her later because she had a visitor. DON B reported that she notified NHA A later that evening. NHA A reported that she was under the impression that the concern had been addressed, and there was no need to conduct an investigation. DON B and NHA A confirmed that they were not aware that Resident #118's brief had 5:18 AM on it, and they were not aware of how soiled Resident #118 was when CNA G and CNA W checked on her. NHA A reported that if she had known the details of staff concerns, she would have immediately reported the allegation of neglect to the reporting agency and began an investigation. DON B and NHA A confirmed that they had not talked to Resident #118, or CNA G, CNA W, or LPN L about the concern.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's Abuse policy dated 11/28/17 revealed, Purpose: It is the practice of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property from abuse, neglect, misappropriation of resident property, and exploitation .An owner, licensee, Administrator, Licensed Nurse, employee or volunteer of a nursing home shall not physically, mentally or emotionally abuse, mistreat or neglect a resident. Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the Nursing Home Administrator .The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements immediately .DEFINITIONS OF ABUSE AND NEGLECT: .f. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . PROCEDURE: INTERNAL REPORTING: a. Employees must always report any abuse or suspicion of abuse immediately to the Administrator. **Note: Failure to report can make employee just as responsible for the abuse in accordance with State Law. The Administrator, will involve key leadership personnel as necessary to assist with reporting, investigation and follow up. c. The Administrator will report to the Medical Director . |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received care in accordance with professional standards in 3 (Resident #104, #105 and #107) of 18 residents reviewed for quality of care, resulting in 1.) Resident #104 missing medication for multiple days in a row 2.) Nursing staff omitting neurological (neuro) assessments and inaccurately documenting assessments as completed after a fall for Resident #105 and 3.) Resident #107 missing a re-weight check ordered by a physician. Findings include: Resident #104 Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 5/1/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #104 was cognitively intact. Review of Resident #104's Orders revealed, Systane Ophthalmic Solution 0.4-0.3 % (Polyethylene Glycol-Propylene Glycol (Ophth) (medication used to treat dry eyes) Instill 2 drop in both eyes three times a day for dry eye; left eye lid pain. Review of Resident #104's Medication Administration Record revealed that Resident #104's Order for the Systane Ophthalmic Solution 0.4-0.3 % was documented as not given at 6:00 AM, 2:00 PM, AND 11:00 PM on 6/6/25, and 6:00 AM at 6/7/25. On 6/7/25 at 2:00 PM, 11:00 PM, and 6/8/25 at 6:00 AM, and 2:00 PM were documented as administered. On 6/8/25 at 11:00 PM, and 6/9/25 at 6:00 AM, the order was documented as not given. Review of Resident #104's Progress Notes dated 6/6/25 at 14:57 (2:57 PM) revealed, Systane Ophthalmic Solution 0.4-0.3 % . Waiting for medication to arrive Review of Resident #104's Progress Notes dated 6/6/25 at 21:07 (9:07 PM) revealed, Systane Ophthalmic Solution 0.4-0.3 % . Waiting on it from the pharmacy .Review of Resident #104's Progress Notes dated 6/7/25 at 05:11 AM revealed, Systane Ophthalmic Solution 0.4-0.3 % . Waiting on the pharmacy to send .Review of Resident #104's Progress Notes dated 6/9/25 at 01:07 AM revealed, Systane Ophthalmic Solution 0.4-0.3 % . On order .Review of Resident #104's Progress Notes dated 6/9/25 at 05:03 AM revealed, Systane Ophthalmic Solution 0.4-0.3 % .On order .In an interview on 6/3/25 12:33 PM, Resident #104 reported that she had concerns with medications not being administered to her as ordered. Resident #104 reported that she felt that nursing staff were not always giving her the medications that she needed. In an interview on 6/9/25 at 2:07 PM, Licensed Practical Nurse (LPN) II reported that she had gotten in report that Resident #104's eye drops were on hold from the pharmacy. LPN II reported that nurses were able to reorder medications from the electronic health record, and that the medication would be delivered at the next shipment. LPN II reported that nurses should call the pharmacy if the medication is not delivered, so that the resident does not miss multiple doses. LPN II reported that Resident #104's might have been a stock med at the facility, and that she would need to check to see if the facility had the medication. In an interview on 6/9/25 at 2:35 PM, Licensed Practical Nurse Manager (LPN- M) M reported that the facility did not get Systane eye drops from the pharmacy, because this was an over the counter medication that the facility should have on stock. LPN-M M reported that if the facility did not have the stock med, nursing staff should have informed her so she could order it. LPN-M M reported that she had not been made aware that Resident #104 was missing the Systane eye drops. LPN-M M was unable to report why nurses had documented that Resident #104 had received the Systane eye drops on 6/7/25 at 2:00 PM, 11:00 PM, and 6/8/25 at 6:00 AM, and 2:00 PM , but then documented as waiting form the pharmacy again on On 6/8/25 at 11:00 PM, and 6/9/25 at 6:00 AM. LPN-M M confirmed that the nursing staff should have not documented that the medication was on hold from the pharmacy, as it was not. LPN-M M also confirmed that nurses should have informed her that Resident #104 had missed several doses of the medication.In an interview on 6/9/25 at 3:50 PM, LPN HH reported that she had cared for Resident #104 on 6/7/25 and 6/8/25. LPN HH reported that Resident #104 has complained about eye pain, and that she had placed a note for the provider to assess her eyes. LPN HH confirmed that Resident #104 did not receive the Systane eye drops on 6/7/25 and 6/8/25. When this writer queried about Resident #104's Medication Administration Record, LPN HH confirmed that she had documented Resident #104's Systane eye drops as administered on 6/7/25 and 6/8/25, and that this was inaccurate, and she must have made an error. Resident #105 Review of an admission Record revealed Resident #105 was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified abnormalities of gait and mobility and muscle weakness.Review of Resident #105 Incident Report dated 5/9/25 revealed, Nursing Description: CNA (Certified Nursing Assistant) came to this nurse to |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide assistance with toileting and eating for 2 (Resident #107 and Resident #118) of 9 residents reviewed for activities of daily living (ADL) care resulting in the potential for avoidable negative physical outcomes for resident's who are dependent on staff for assistance.<br><br>Findings include:<br><br>Resident #107<br><br>Review of an admission Record revealed Resident #107 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dysphagia (difficulty swallowing).<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #107, with a reference date of 5/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 1/15 which indicated Resident # 107 was severely cognitively impaired.<br><br>Review of Resident #107's Care Plan revealed, (Resident #107) has an actual ADL (activities of daily living ) self-care performance deficit . Interventions: .Dining: Resident requires feeding assistance x1. NO straws, single sips with chin tuck, clear oral cavity prior to another bite. Date initiated: 5/9/25 .<br><br>Review of Resident #107's Speech Therapy note dated 5/19/25 revealed, Precautions: Aspiration precautions; regular solids, feeding assistance, single sips . (Resident #107) was min-mod cues for slow rate, but was very agreeable and followed cues quickly; continues to require feeding assistance for cues to utilize swallow strategies, but family reports this is baseline d/t (due to) cognition. With thin liquids via straw (Resident #107) demonstrated throat clear x 2/8 single sip trials and x1/1 consecutive sip trials; improved success with single sips and faded from min-mod to min cues. Discussed D/C (discharge) from ST (speech therapy) and (Resident #107 and Resident #107's family member) in agreement as (Resident #107) is tolerating diet level well with feeding assistance, which is baseline.<br><br>In an observation on 6/3/25 at 12:27 PM, Resident #107 was sitting in the bistro dining area at a table by herself attempting to eat lunch. Resident #107 had a plate with chicken and rice. Resident # 107 appeared to be struggling to bring the food to her mouth with her fork. Resident #107 was noted to be coughing frequently.<br><br>In an observation on 6/9/25 at 9:45 AM, Resident #107 was sitting in the bistro dining area at a table by herself. Resident #107 was holding an ensure (protein drink) in her hand and attempting to drink it. Resident #107 also had a water cup with a straw that she had attempted to drink out of. It was noted that there were no staff in the bistro assisting or supervising Resident #107. Resident #107 began coughing loudly after taking a drink of ensure, and after a few minutes, a staff member that was walking by checked on her.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 6/9/25 at 1:50 PM, Registered Nurse Unit Manager (RN-UM) N reported that Resident #107 varied on how much assistance she required with eating. RN-UM N reported that sometimes she required total assistance, and sometime she required supervision and queuing. RN-UM N confirmed that staff were always supposed to be near by Resident #107 when she was eating or drinking for supervision.<br><br>In an interview on 6/3/25 at 2:06 PM, Therapy Director (TD) TT reported that Resident #107 had received speech therapy services for dysphagia. TD TT confirmed that Resident #107 required supervision with eating and drinking.<br><br>In an interview on 6/9/25 at 4:16 PM, Director of Nursing (DON) B and Nursing Home Administrator (NHA) A were not able to report what kind of feeding assistance Resident #107 required. DON B confirmed that Resident #107's care plan indicated that she required feeding assistance x1. DON B was not able to report what the expectation was for staff supervision when Resident #107 was eating and drinking, and how close staff should be to her to monitor her.<br><br>Resident #118<br><br>Review of an admission Record revealed Resident #118 was originally admitted to the facility on [DATE] with pertinent diagnoses which included depression and muscle weakness.<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #118, with a reference date of 4/11/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #118 was cognitively intact.<br><br>Review of Resident #118's Care Plan revealed, (Resident #118) has actual need for ADL (activities of daily living) self-care performance . Interventions: toileting: Check and change. Date initiated: 9/11/24 .<br><br>In an interview on 9/9/24 at 2:35 PM, Licensed Practical Nurse Manager (LPN-M) M reported that she was contacted on 6/8/25 by Certified Nursing Assistant (CNA) W regarding concerns that Resident #118 had not been checked on for an extended period of time. LPN-M M reported that Certified Nursing Assistant (CNA) S was responsible for caring for her Resident #118 that day, and while she was on break CNA W and CNA G answered Resident #118's call light to find her in a brief that was soiled with bowel movement. LPN-M M reported that CNA W and CNA G were concerned that Resident #118 had not had her brief changed for an extended period of time.<br><br>In an interview on 6/9/25 at 12:39 PM, LPN OO reported that she was one of the nurses that worked with CNA S on 6/9/25 and she had also contacted DON B about concerns with CNA S not completing care tasks that day.<br><br>In an interview on 6/9/25 at 3:03 PM, LPN L reported that she had been approached by CNA G and CNA W to come assess the condition that they had found Resident #118 in. LPN L reported that Resident #118 was lying in her bed with a soiled brief with bowel movement that was coming out of the brief and onto her bed. LPN L reported that the brief had 5:18 AM written on it, indicating that Resident #118 had not had her brief changed since 5:18 AM. LPN L confirmed that Resident #118's care plan indicated check and change for toileting, which indicated that staff should have been checking Resident #118's brief every two hours.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 6/9/25 at 3:16 PM, CNA W reported that she had been covering CNA S unit while she was on break when she answered Resident #118's call light and found her in a soiled brief with bowel movement running down her leg and sheets. CNA W reported that Resident #118's brief had the time 5:18 AM written on it, and that Resident #118 had confirmed that she had not had any staff member come in to assist her throughout the day, and she had been laying in the soiled brief for a long time.<br><br>In an interview on 6/9/25 at 3:25 PM, Resident #118 reported that she did have to lay in a soiled brief for a very long time on 6/9/25 because she had not staff come in to assist her. Resident #118 confirmed that CNA S had not been in her room to provide care for her that day. Resident #118 reported that she didn't like being left to hope someone would care for her, but that was just how it is here.<br><br>This writer attempted to contact CNA S on 6/9/25 at 3:28 PM. CNA S was unable to be reached prior to survey exit.<br><br>This writer attempted to contact CNA G on 6/9/25 at 3:28 PM. CNA S was unable to be reached prior to survey exit.<br><br>Review of the facility's ADL policy dated 5/7/20, revealed, Purpose: Based on the comprehensive assessment of a resident and consistent with the resident ' s needs and choices, our facility provides necessary care and services to ensure that a resident ' s abilities in activities of daily living do not diminish unless circumstances of the individual ' s clinical condition demonstrate that such diminution was unavoidable . |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI00153113.Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent falls for 1 (Resident #105) of 3 residents reviewed for falls, resulting in a fall with major injury requiring hospitalization and surgical intervention for Resident #105 and potential for additional falls with injury. Findings include: Resident #105 Review of an admission Record revealed Resident #105 was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified abnormalities of gait and mobility and muscle weakness.Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 2/18/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #105 was cognitively intact. Review of Resident #105's Fall Risk Evaluation dated 9/9/24 revealed that Resident #105 had recent falls, generalized weakness and mobility, was taking an anti-epileptic (medication used to treat epilepsy or other seizure disorders) medication and was taking 9 or more medications which scored Resident #105 at a 13 (any score over 5 indicates high fall risk). Review of Resident #105's Care Plan revealed, (Resident #105) needs assistance with ADL (activities of daily living) self-care performance r/t (related to) fatigue, limited mobility . Intervention: Do not leave (Resident #105) unattended in the bathroom. Date initiated: 9/11/24 .Review of Resident #105 Incident Report dated 5/9/25 revealed, Nursing Description: CNA (Certified Nursing Assistant) came to this nurse to notify that resident had a fall. This nurse entered room and noted resident sitting upright, leaned to the right. CNA stated she had witnessed the fall . Resident had a small, slightly raised reddened area to top/back of the head. Resident c/o (complained of) lower back pain. Rated pain 8/10. Resident Description: . Resident stated I was brushing my teeth. I fell. My back and head hurts. I fell back. Immediate Action Taken: Received prn Norco (pain medication) at 2300 (11:00 PM), Bio freeze gel applied to lower back .At 7:15 (Family Member) notified. Wanted resident sent to the hospital. (Facility provider) gave the okay to send resident out for further evaluation Resident picked up and transported via (local EMS provider) at 08:15 AM . Review of Resident #105's Hospital Records dated 5/9/25 revealed, . Chief complaint: (Resident #105) presenting via EMS from facility for a fall that occurred yesterday . Given this morning he was still endorsing severe low back pain they are seeking medical attention currently. Patient is currently admitting to mild to moderate neck pain, headache, and severe low back pain. Low back pain exacerbated by any movement . ED Course: MRI (Magnetic Reasoning Imaging) lumbar spine with acute compression fracture at L3 and L4 (areas of the spine). CT (Computed tomography) lumbar spine with acute L3 and L4 compression fracture . Found to have an acute L3 and L4 superior endplate compression fracture. IR (interventional radiology) consulted, amenable to intervention. Noted to have fevers as well as hypoxic failure, undergoing infectious workup and found to have pneumonia. Completed antibiotics and improved. He also needed 5 days off Plavix (antiplatelet medication) in order to have IR address his vertebral fracture but he finally underwent intervention for that on 5/19/25 Procedure: L3/L4 verterbroplasty (Vertebroplasty is a procedure to treat compression fractures in the spine) .In an interview on 6/3/25 at 11:13 AM, Resident #105 reported that he was in his bathroom standing at the sink when he suddenly lost his balance and fell back. Resident #105 reported that Certified Nursing Assistant (CNA) Y was in his room with him, but she had left him in the bathroom by himself. Resident #105 confirmed that he was in a lot of pain after the fall so he he went to the hospital where is was discovered that he had fractures in spine and required surgery .In an interview on 6/3/25 at 11:48 AM, Licensed Practical Nurse (LPN) P reported that she was the nurse caring for Resident #105 the night that she fell. LPN P reported that CNA Y had told her to come assess Resident #105 because she had just witnessed him fall in his bathroom. LPN P reported that she was told by CNA Y that Resident #105 had slipped in his bathroom, and that she was not in the bathroom with Resident #105 when he fell. LPN P reported that Resident #105 was reporting pain in his back and head, so she gave him pain medication. LPN P confirmed that Resident #105 was in so much pain the following morning that the facility sent him to the hospital. LPN P confirmed that Resident #105 was not supposed to be left in the bathroom alone, because he was at high risk for falls. This writer attempted to contact CNA Y on 6/3/25 at 3:11 PM, 6/4/25 at 8:12 AM, and 6/9/25 at 9:38 AM. This writer was unable to speak to CNA Y prior to survey exit. In an interview on 6/5/25 2:26 PM, Nursing Home Administrator (NHA) A and Director of Nursing (DON) B reported that they had learned about Resident #105's fall on 5/9/25 and began an investigation into the fall. NHA A and DON B reported that they were able to identify that CNA Y had not followed Resident #105's |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Based on interview and record review, the facility failed to ensure residents received the correct foods as outlined on the planned, posted menu, resulting in dissatisfaction with meal service and feelings of frustration. This deficient practice has the potential to affect all residents who consume food from the kitchen, out of a total census of 77.Findings include:In an interview on 6/3/25 at 12:33 PM, Resident #104 reported that she had ongoing concerns with the food at the facility. Resident #104 reported that the facility often substituted what was on the menu without notice. Resident #104 reported that she was frustrated with how often the facility was messing up the food menu, and feeling she never knew what was going to be served. In an interview on 6/4/24 at 9:29 AM, Certified Nursing Assistant (CNA) I reported that residents frequently reported concerns about the food at the facility, and that it seemed like the facility was not able to serve what was on the menu often. CNA I reported that it seemed like the facility was not ordering enough food, and they would run out of food all the time. In an interview on 6/4/25 at 9:35 AM, Registered Nurse (RN) LL reported that the facility was running out of food a lot, and residents were getting food served to them that was not on the menu. RN LL reported that the kitchen was supposed to go by the resident's meal ticket for what they had ordered, but it seemed like they did not do that because residents often got food that they had not ordered. RN LL reported that she had residents complain to her about the food not reflecting what was supposed to be served from the menu. In an interview on 6/4/25 at 9:42 AM, Resident #116 reported that she several concerns with the food at the facility. Resident #116 reported that she would often receive food that was not what she ordered, or what was supposed to be served on the menu. Resident #116 reported that for breakfast that morning, french toast and sausage was on the menu, but she got a fried egg instead. Review of the facility's Weekly Menu indicated that in 6/4/25 the breakfast menu item was noted to be French toast-2 slices and sausage patty- 1 each .In an interview on 6/4/25 at 10:03 AM, CNA BB reported that the facility was frequently serving food that was not on the menu, and residents were often frustrated with this. CNA BB confirmed that the facility did not serve french toast in the morning like the menu had listed. In an interview on 6/4/25 at 10:24 AM, Resident #114 reported that she had concerns with the food at the facility. Resident #114 reported that she never knew what was going to be served, because the facility staff wouldn't always follow the menu. In an interview on 6/4/25 at 11:58 AM, Resident #111 reported that she had concerns with the food at the facility. Resident #111 reported that the facility was often not serving what was on the menu. Resident #111 reported that she frequently attended resident council meetings, and that residents had brought up food concerns, and many residents were upset about the food being served was not on the menu. Resident #111 reported that she was very frustrated the food at the facility. In an interview on 6/4/25 at 1:16 PM, Resident #113 reported that the facility was often not serving food that was on the menu, and the facility was not giving resident's notice of changes in the menu. In an interview on 6/2/25 at 1:36 PM, Dietary Director (DD) RR reported that the facility food menu was created by corporate leadership, and that the facility had been running into issues with not having the food available for the alternate menu options, and sometimes what is supposed to be on the main menu. DD RR reported that she would order food twice a week from the authorized food store, and that the store was frequently not able to fulfill the entire order. DD RR reported that when the food order was missing items, she could only go to a local store and purchase specific items that were not delivered, so the facility would just go without the remainder of food items that she was not authorized to purchase. DD RR confirmed that on 6/1/25 the facility was supposed to serve fried chicken, but a dietary aide had pulled the wrong chicken, so they had to serve orange chicken instead. DD RR reported that on 6/4/25 that the facility was supposed to serve french toast, but the same dietary aide did not pull the bread for the cook to prepare, and the cook refused to cook something that was not prepped for her, so she cooked eggs instead. DD RR confirmed that the kitchen staff did not notify the residents of the menu change. Review of the facility's Menu Substitution Log revealed that on 5/23/25, the facility substituted cod for tilapia. On 5/28/25, the facility substituted Turkey and swiss sandwich for ham and cheese. On 6/3/25, the facility substituted fried chicken for orange chicken. On 6/4/25, the facility substituted a a biscuit for french toast, and on 6/8/25, the facility substituted sherbet for apple crisp. In an interview on 6/4/25 at 3:42 PM, CNA U reported that the facility was frequently serving food that was not on the menu. CNA U reported that it was frustrating for nursing staff because residents would get mad at them when they delivered their meal trays, and it was out of their control. CNA U reported that she felt like the kitchen was running out of food nearly every day. In an interview on 6/4/25 at 3:57 AM, Resident |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI00152495 and MI00153405.<br><br>Based on observation, interview, and record review, the facility failed to ensure resident food preferences and portion sizes at meals were consistently honored, for 7 (Residents #104, #110, #111, #112, #113, #114, and #116 ) of 18 residents reviewed for food concerns, resulting in resident/representative complaints of food choices not being honored and the potential for decreased meal enjoyment, feelings of frustration, and the potential for weight loss and nutritional decline.<br><br>Resident #104<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 5/1/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #104 was cognitively intact.<br><br>Review of Resident #104's Meal Ticket revealed, Diet order: Regular texture. Regular diet. Allergies: Cinnamon. Dislikes: Citrus, spicy foods, BBQ, biscuits and gravy, cabbage, coleslaw, onions, pepper, sausage, potatoes .<br><br>In an interview on 6/4/24 at 12:33 PM, Resident #104 reported that she had ongoing concerns with the kitchen and food. Resident #104 reported that the facility cannot get my diet right and that the kitchen would frequently serve her food that she could not eat or did not like. Resident #104 reported that she felt like the facility was not taking her cinnamon allergy seriously.<br><br>In an interview on 6/9/25 at 12:26 PM, Certified Nursing Assistant (CNA) U reported that either 6/7/25 or 6/8/25, the kitchen had served food with cinnamon in it to Resident #104. CNA U reported that Resident #104 found the cinnamon, and called her to take it back to the kitchen and request something else. CNA U reported that Resident #104 was very frustrated, and that the kitchen often serves food residents cannot have or do not like.<br><br>Resident #110<br><br>Review of an admission Record revealed Resident #110 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dementia.<br><br>Review of Resident #110's Meal Ticker revealed, Diet Order: Regular Texture, Regular Diet. Dislikes: chocolate.<br><br>In an interview on 6/4/25 at 2:57 PM, Family Member (FM) E reported that they had ongoing concerns with the kitchen and food that they served. FM E reported that the facility did not honor resident food preferences, and that Resident #110 did not like chocolate, but they observed chocolate being served to Resident #110 on multiple occasions. FM E reported that Resident #110 was also supposed to get a sandwich with each meal, but the kitchen was not always providing the sandwich. FM E reported that Resident #110 loves hamburgers, but the kitchen was often out of hamburgers, so they could not serve them, even though they were supposed to be available on the alternate menu.<br><br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 6/4/5 at 3:42 PM, CNA U reported that Resident #110 was supposed to get a sandwich with his meal tray at lunch and dinner because he would often not want to eat the main course. CNA U reported that the kitchen frequently forgot to put that on the tray, and when she would go to the kitchen and ask for it, the kitchen staff would accuse the aides of taking the sandwich and refuse to make another one. CNA U reported that the kitchen staff were hard to deal with, and that it made things harder for the nursing staff because they would have to serve residents meal trays that were inaccurate, so the residents would be upset with them, and then the kitchen staff would be difficult and not want to correct the errors. CNA U reported that residents frequently voiced concerns over getting small portions, being served food that they did not like, and not having alternate meal options available.<br><br>Resident #111<br><br>Review of a MDS assessment for Resident #111, with a reference date of 3/28/25 revealed a BIMS score of 15/15 which indicated Resident #111 was cognitively intact.<br><br>Review of Resident #111's Meal Ticket revealed, Diet Order: Regular texture. No salt added. Notes: Large portions breakfast. Dislikes: mushrooms .<br><br>In an interview on 6/4/25 at 1:00 PM, Resident #111 reported that she had a lot of concerns with the food at the facility. Resident #111 reported that she had talked to the kitchen manager about her concerns, but she did not feel like the food concerns were being addressed. Resident #111 reported that the facility often did not have the alternate menu options available. Resident #111 reported that she wanted a cheeseburger 5/29/25 or 5/30/25 and they told her that they were out of burgers. Resident #111 reported that the facility's portion sizes were too small, and she showed this writer a picture of a eggs and a waffle she had received the week prior. The amount of eggs looked to be about 1/4 of a cup worth. Resident #111 reported that she was supposed to get large portions at breakfast, but she usually did not.<br><br>Resident #112<br><br>Review of a MDS assessment for Resident #112, with a reference date of 3/12/25 revealed a BIMS score of 9/15 which indicated Resident #112 was moderately cognitively impaired.<br><br>Review of Resident #112's Meal Ticket revealed, Diet Order: Regular Texture. Regular Diet. Allergies:Mushroom. Notes: Send cheeseburger when fish is on the menu. Likes: grilled cheese, hot dogs. Dislikes: fish/seafood. Chicken.<br><br>In an interview on 6/4/25 at 9:29 AM, CNA I reported that she had noticed that the kitchen would frequently run out of food and they were not able to provide alternate menu items. CNA I also reported that residents had reported getting too small of portions of food, and that she had observed that as well. CNA I reported that on 6/3/25, Resident #112 had asked for a cheeseburger or chicken tenders, but the kitchen was out, so they sent her half of a peanut butter and jelly sandwich. CNA I reported that Resident #112 was very upset by this, and that she was upset for her, because that was not enough food for Resident #112.<br><br>(continued on next page) |

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|---|---|
| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 6/4/25 at 3:57 PM, Resident #112 reported that she had ongoing food concerns at the facility. Resident #112 confirmed that the night before she had ordered a cheeseburger with fries, and the kitchen was out so they sent her half of a peanut butter and jelly sandwich. Resident #112 reported that was not enough food for her. Resident #112 reported that on the morning of 6/4/25 she had asked for coffee and toast, and she did not got either, but that the kitchen sent her eggs. Resident #112 reported that she often got food that she disliked, and that the alternate menu options were hardly ever available. Resident #112 reported that she felt like the portion sizes were usually too small.<br><br>Resident #113<br><br>Review of a MDS assessment for Resident #113, with a reference date of 5/1/25 revealed a BIMS score of 15/15 which indicated Resident # 113 was cognitively intact.<br><br>Review of Resident #113's Meal Ticket revealed, Diet Order: Regular Texture. Consistent Carbohydrates. No added salt . dislikes: peas, pears.<br><br>In an observation and interview in the dining room on 6/2/15 at 11:50 AM, Resident #113 was served a plate with a small pork chop, a small side of rice approximately 1/4 of a cup, and three small zucchini slices. Resident #113 reported that the facility often served small portions.<br><br>In a follow up interview on 6/4/25 at 1:16 PM, Resident #113 reported that he did have some food concerns. Resident #113 reported that he was often served food he did not like. Resident #113 reported that he was served the pear desert at lunch today and he does not like pears. Resident #113 confirmed that he had been told several times that what he had ordered was out, and the kitchen often also ran out of the alternate menu options as well.<br><br>Resident #114<br><br>Review of a MDS assessment for Resident #114 , with a reference date of 5/7/25 revealed a BIMS score of 13/15 which indicated Resident # 114 was cognitively intact.<br><br>Review of Resident #114's Meal Ticket revealed, Diet Order: Regular Texture, Regular Diet . No dislikes were noted on the ticket.<br><br>In an interview on 6/4/25 at 10:24 AM, Resident #114 reported that she had concerns with food at the facility. Resident #114 reported that the portion sizes served were often too small, and that the facility often ran out of alternative food menu items as well.<br><br>In an interview and observation on 6/9/25 at 12:31 PM, Resident #114 was sitting up in her bed eating her lunch. Resident #114 had one piece of bread with deli turkey and gravy, half of a sweet potato, and a small serving of mixed veggies. The mixed veggies looked to be the size of 1/4 of a cup. Resident #114 reported that she did not feel like half of a sweet potato and the mixed veggies was enough food for her.<br><br>Resident #116<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 | 06/09/2025 |

| 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 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a MDS assessment for Resident #116, with a reference date of 4/30/25 revealed a BIMS score of 15/15 which indicated Resident #116 was cognitively intact.<br><br>Review of Resident #116's Meal Ticket revealed, Diet order: Not listed. Dislikes: Not listed Standing order: 8 fl oz sugar free juice.<br><br>In an interview on 6/4/25 at 9:42 AM, Resident #116 reported that she had concerns with the facility's food. Resident #116 reported that she was a diabetic and required no sugar on her cereal, but every morning since she was admitted , the kitchen would bring her cereal with sugar on it, and she was also getting juice with sugar. Resident #116 reported that the facility often ran out of food, and the alternate menu items were not always available.<br><br>In an interview on 6/4/25 at 9:35 AM, Registered Nurse (RN) LL reported that residents were frequently voicing concern over the food, and she also felt that they had a lot of issues with the food/kitchen staff. RN LL reported that she saw a lot of small portions, and that the kitchen ran out of food a lot, so residents were not getting what they ordered. RN LL reported that she frequently observed residents being served food that they disliked too.<br><br>In an interview on 6/4/25 at 9:59 AM, Licensed Practical Nurse (LPN) PP reported that she had observed small portions at dinner on 5/30/25. LPN PP reported that the kitchen had served pea salad with tuna and two crackers. LPN PP reported that a lot of residents complained about the meal and asked for an alternative, but the facility was out of hamburgers or hot dogs, so they could not get anything else. LPN PP reported she felt bad for the residents because that was definitely not enough food, and they did not have appropriate alternatives.<br><br>In an interview on 6/4/25 at 10:03 AM, CNA BB reported that residents were frequently reporting concerns about food, especially that they did not have alternate menu items available. CNA BB reported that she observed residents getting food that they disliked.<br><br>In an interview on 6/2/25 at 1:36 PM, Dietary Director (DD) RR reported that the facility food menu was created by corporate leadership, and that the facility had been running into issues with not having the food available for the alternate menu options, and sometimes what is supposed to be on the main menu. DD RR reported that she would order food twice a week from the authorized food store, and that the store was frequently not able to fulfill the entire order. DD RR reported that when the food order was missing items, she could only go to a local store and purchase specific items that were not delivered, so the facility would just go without the remainder of food items that she was not authorized to purchase. DD RR reported that nursing staff were supposed to fill out the meal tickets for residents that day before, but they were not always doing that, so the kitchen was running into serving residents food that they did not like, and then having to make them something different. DD RR reported that another issue that the kitchen would run into is that they had to rely on the nursing staff to ensure that the meal tickets had everything from the side of the cart that meal trays were delivered on, and not all staff were doing that. DD RR reported that her food budget was created from the census from the previous month, and that she felt that the facility had enough food to provide adequate portion sizes. DD RR' reported that the staff serving food used portion spoons to know how many ounces to serve, and that the spoons were color coded for the ounces.<br><br>(continued on next page) |

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|---|---|
| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview and observation on 6/9/25 at 11:38 AM, Dietary Aide (DA) SS reported that when he served food, he just used the spoons that the cooks used. DA SS was not able to report how the spoons measured ounces of food. DA SS reported that he did not know how the cooks determined portion sizes. DA SS was observed using a small ladle to place vegetables onto meal trays while serving lunch. DA SS reported that the facility would often run out of hamburgers, hot dogs, and chicken- especially when the facility served fish, because it seemed like most of the residents did not like fish. DA SS confirmed that last week the facility did not have all of the alternate food menu items available the previous weekend, and the week before they were out of chicken tenders.<br><br>In an interview on 6/4/25 at 2:26 PM, Nursing Home Administrator (NHA) A and Director of Nursing (DON) B reported that they were not aware of the food concerns in the facility. |