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	08/13/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation pertains to Intake: 2569824Based on interviews and record review, the facility failed to protect the resident's right to be free from sexual abuse by staff for 1 (Resident #81) of 3 residents reviewed for abuse, resulting Resident #81 experiencing mental anguish, intimidation, and fear. Findings include: Resident #81: Review of an admission Record revealed Resident #81 was a female with pertinent diagnoses which included depression, and malaise (general feeling of discomfort). Review of a Brief Interview for Mental Status (BIMS) conducted on 5/1/2025, revealed, .BIMS score of 13 out of 15 which indicated Resident #81 was cognitively intact. Review of Care Plan for Resident #81 revised on 2/13/25, revealed the focus, .(Resident #81) has actual impairment to skin integrity to bilateral breasts and abd (abdominal) fold r/t (related to) yeast . with the intervention .antifungal treatment in place .Apply barrier cream per facility protocol to help protect skin from excess moisture .Monitor skin when providing cares, notify nurse of any changes in skin appearance . Review of Facility Reported Incident (FRI) received 7/12/2025, revealed, . Incident Summary: Resident reported that a couple weeks ago the treatment nurse touched her in her vaginal area. Residents were receiving treatment for fungal infection in groin and abdominal fold. The resident asked if she felt like the touching was sexual and she replied no, but she didn't like to be touched in that area. Resident stated she feels safe in facility.Police notified, Employee suspended.(Wound Nurse KKK) refused to provide a statement, he asked if he could record the conversation.is. (Resident #81) was recently being treated for a superficial mycosis fungal infection to her bilateral breast, abdominal folds and groin area twice a day, 7 days a week.Initial Complaint: On 7/12/2025 at approximately 10:30AM, Nurse Aide (CNA J) was giving (Resident #81) a shower in the spa room and mentioned ow much improvement her skin was showing. The areas to her breast, abdomen and groin had completely healed. (Resident #81) then stated to the Nurse Aide (CNA J) Yes, the wound care nurse comes to look at my skin, but I don't like the way he makes me feel. He makes me feel uncomfortable. He looks at my breast and he also put his finger in my vagina. I felt his fingers moving around. Nurse Aide (CNA J) immediately reported the allegation to the Nurse Manager (Licensed Practical Nurse (LPN) SS). The Nurse Aide (CNA J) and the Nurse Manager (LPN SS) instantly reported the allegation to Administrator. (Wound Nurse KKK), the Wound Care Director, was identified as the providing nurse. (Wound Nurse KKK), (who was not in the facility at the time the allegation was professed) was called by the Director of Nursing (DON) and suspended pending investigation. (Wound Nurse KKK) seemed surprised and confused hearing the news of the allegation.On 7/12/2025 the (Local) Police Department was called and the incident was reported. The Police came to the facility to interview (Resident #81). There was no further directives given by the Officers.On 7/14/2025 the (Wound Nurse KKK) came to the facility to speak with the Administrator and the Director of Nursing. At that time, the allegation was clearly explained to him. He then declined to respond to the allegation or to provide a statement. He left the facility and made no attempt to reach out again.On 7/14/2025 (Resident #81) was diagnosed with a Urinary Trach Infection (UTI).On 7/15/2025 the (Wound Nurse KKK) was terminated via telephone.Like residents were interviewed by Administration. There were no additional findings reported.Investigation Revealed: Upon hire, (Wound Nurse KKK)'s background check was clear. He completed education on Abuse and Neglect training prior to hire and again per the Company's guidelines.Action Taken: (Wound Nurse KKK) was immediately suspended pending investigation.The Licensed Nurse completed a full head-to-toe assessment on (Resident #81) which revealed no injuries. Her skin was clean, dry and intact and all areas with mycosis were healed.The (Local) Police Department was informed and interviewed (Resident #81) at the facility.Review of Statement submitted by CNA J dated 7/12/25, revealed, .When I was showering (Resident #81), I noticed her wounds under her breast looked so much better than when I noticed it a while back, I told her they look great. She stated, yes, the Wound Nurse KKK comes to look at them, but I don't like when he does, he makes me feel uncomfortable. I asked her why do you say that, she stated When he was looking at my breast and also put his finger in my vagina, I then asked if he was assessing her for something and she stated No I felt him moving his fingers around, I then asked if this was only one time, and when was the most recent, she stated It happened 2 times in the past month When he came last week he only looked at my breast. (Resident #81) also stated she didn't know who to tell and that she didn't want to get anyone in trouble . Review of Statement submitted by Resident #81, dated 7/12/25, revealed, .When the Wound Nurse KKK was assessing under my breast and groin he put his finger in my vagina on 2 occasions. I offered to lay down in bed and he insisted that I was fine, and he could do the assessment while I was in my

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2586142Based on interview, and record review, the facility failed to report 2 elopements and an allegation of abuse to the State Agency in a timely manner for 2 (Resident #73, Resident #66) of 3 residents reviewed for abuse and reporting, resulting in the potential for ongoing mistreatment, as well as additional incidents of elopements and alleged abuse to go unreported.Findings include: Resident #73 Review of an admission Record revealed Resident #73 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: parkinson’s disease (a disorder of the central nervous system that affects movement that may also cause hallucinations (sensory experiences that seem real but are created by the mind), metabolic encephalopathy (disorder that affects the brain’s function), weakness and anxiety (persistent state of worry). Review of a Minimum Data Set (MDS) assessment for Resident #73 with a reference date of 6/22/25, revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #73 was cognitively intact. Section “E” of the MDS revealed Resident #73 wandered 1 to 3 days during the assessment period. Section “GG” revealed Resident #73 required the use of a wheeled walker to safely ambulate. Review of a “Care Plan” for Resident #73 with a reference date of 1/6/25, revealed a focus/goal/interventions of: “Focus: (Resident #73) is an elopement risk/wanderer sundowner (phenomenon where those with cognitive impairments experience worsening of symptoms in the late afternoon or evening). Goal: The resident’s safety will be maintained…Interventions: exit and stairwell alarms…photo on wander list, staff aware of residents wander risk…wander ALERT personal safety device: Right ankle). In an interview on 8/11/25, at 2:26pm, Confidential Informant (CI) “DDD” reported they were caring for another resident in their room one afternoon, when they (CI “DDD”) looked outside and saw Resident #73 walking in the service driveway alone, without her walker. CI “DDD” reported this incident occurred “within the last few months”. CI “DDD” reported they ran outside and found Resident #73 alone, walking down the service drive, approximately 100’ from the emergency exit on her unit. CI “DDD” reported Resident #73 was not safe to leave the building alone because she was confused and lacked safety awareness. CI “DDD” reported LPN “MM” also responded to the situation and together they assisted Resident #73 back inside. CI “DDD” reported upon returning Resident #73 to the unit, she was approached by Nursing Home Administrator (NHA) “A” and DON “B” who instructed CI “DDD” not to document the incident in the electronic medical record (EMR). In an interview on 8/12/25 at 11:07am, LPN “MM” reported Resident #73 eloped from the building and was found alone, walking briskly down the service drive, approximately 100’ from the nearest exit. LPN “M” reported she was unsure of the date of the incident, but an incident report had been written. LPN “MM” reported she told NHA “A” Resident #73 had eloped and that the door alarm had been sounding for a few minutes, but she didn’t recognize the sound of the alarm from behind a closed resident door. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/12/25 at 11:50am, Family Member (FM) “CCC” reported the facility called her on two separate occasions to report Resident #73 had eloped from the building. FM “CCC” reported the first elopement occurred shortly after the resident was admitted to the facility on [DATE] and again, “sometime in the last few months”. In an interview on 8/13/25 at 12:48pm, NHA “A” reported Resident #73 exited the building on 4/23/25. NHA “A” reported the incident was not submitted to the state agency because she thought the incident was witnessed by staff. When further queried, NHA “A” reported she did not have any signed, documented staff interviews related to the incident and was not aware of any documentation of the event in the resident’s medical records. Review of an “Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property” facility policy with a reference date of 11/28/17, revealed “PURPOSE:…The Nursing Home Administrator or designee will report “abuse” to the state agency per State and Federal requirements immediately…REPORTING AND RESPONSE:…The facility will ensure that alleged violations involving abuse…neglect…mistreatment…are reported immediately, but not later than 2 hours…”. Resident #66 Review of an “admission Record” revealed Resident #66 was a female, with pertinent diagnoses which included: Alzheimer’s Disease (a form of dementia) with late onset, psychotic disorder with delusions due to known physiological condition, and visual hallucinations. Review of a “Facility Report Incident” (FRI) incident report revealed, “…Details Type of Alleged Incident: Abuse…Date/Time Incident Discovered 1/26/25 05:00 PM…Facility Investigator: (“Former Nursing Home Administrator” (FNHA) “EEE”) .Incident Summary: (Resident #66) is a long term care resident with medical history of dementia and depressive and psychotic disorders and a social history of sexual abuse in her past. (Resident #66) makes statements that (visitor name omitted), the husband of another long term care resident, touches her inappropriately. On 1/26/25 (Resident #66) told her nurse (“Licensed Practical Nurse” (LPN) “ZZ”) that (visitor name omitted) molested her…Submitted Date/Time: 1/27/25 11:43 AM…” In an interview on 8/13/25 at 12:05 PM, “Nursing Home Administrator” (NHA) “A” reported abuse allegations must be reported within 2 hours to the State. In an interview on 8/13/25 at 12:26 PM, FNHA “EEE”, when queried as to why the FRI reported on 1/27/25 at 11:43 AM for Resident #66 had not been reported to the State Agency within two hours of the Date/Time Incident Discovered on 1/26/25 at 5:00 PM, FNHA “EEE” reported she did not remember the details of reporting the incident to the State. FNHA “EEE” confirmed an allegation of abuse should be reported within 2 hours to the State.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** This citation pertains to intake #2586142Based on observation, interview, and record review the facility failed to: 1. provide an environment that was free from accident hazards for 2 residents (Resident #73 and Resident #40) of 5 residents reviewed for accidents. This deficient practice resulted in an elopement for Resident #73 and Resident #40 repeatedly walking unassisted thereby creating the potential for more than minimal harm. 2. To ensure wander alert equipment was working properly and effectively to ensure the safety of residents at risk for elopement. This deficient practice has the potential to impact 10 residents who currently require the use of personal wander alert devices and are at risk for elopement. Findings include: Resident #73 Review of an admission Record revealed Resident #73 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: parkinson’s disease (a disorder of the central nervous system that affects movement that may also cause hallucinations (sensory experiences that seem real but are created by the mind), metabolic encephalopathy (disorder that affects the brain’s function), weakness and anxiety (persistent state of worry). Review of a Minimum Data Set (MDS) assessment for Resident #73 with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #73 was cognitively intact. Section “E” of the MDS revealed Resident #73 wandered 1 to 3 days during the assessment. Section “GG” revealed Resident #73 required the use of a wheeled walker to safely ambulate. Review of a “Care Plan” for Resident #73 with a reference date of [DATE], revealed a focus/goal/interventions of: “Focus: (Resident #73) is an elopement risk/wanderer sundowner (phenomenon where those with cognitive impairments experience worsening of symptoms in the late afternoon or evening). Goal: The resident’s safety will be maintained…Interventions: exit and stairwell alarms…photo on wander list, staff aware of residents wander risk…wander ALERT personal safety device: Right ankle). Review of a “Wander/Elopement Risk Evaluation” with a reference date of [DATE] (Resident #73’s date of admission) revealed a score of “7”, low risk. Review of a “Wander/Elopement Risk Evaluation” with a reference date of [DATE] revealed a score of “14”, at risk. Review of “Physician’s Orders” for Resident #73 with a reference date of [DATE] revealed “Wander Device, Check Placement on right ankle every shift for elopement risk”. Review of a “Wander/Elopement Risk Evaluation” with a reference date of [DATE] revealed Resident #73 scored a “21”, high risk for elopement. In an interview on [DATE] at 2:51pm Certified Nursing Assistant (CNA) “C” reported Resident #73 frequently wandered around the building and could walk very fast. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 4:45pm, Director of Nursing (DON) “B” reported Resident #73 wandered frequently and got lost within the building. In an interview on [DATE] at 2:19pm, Licensed Practical Nurse (LPN) “Q” reported Resident #73 frequently wandered throughout the building, entered unauthorized areas such as the employee bathrooms and was exit seeking. In an interview on [DATE], at 2:26pm, Confidential Informant (CI) “DDD” reported they were caring for another resident in their room one afternoon, when they (CI “DDD”) looked outside and saw Resident #73 walking in the service driveway alone, without her walker. CI “DDD” reported this incident occurred “within the last few months”. CI “DDD” reported they ran outside and found Resident #73 alone, walking down the service drive of the facility, toward the front of the building, approximately 100’ from the emergency exit on her unit. CI “DDD” reported Resident #73 was not safe to leave the building alone because she got confused at times and lacked safety awareness. CI “DDD” reported LPN “MM” also responded to the situation and together they assisted Resident #73 back inside. CI “DDD” reported upon returning Resident #73 to the unit, she was approached by Nursing Home Administrator (NHA) “A” and DON “B” who instructed CI “DDD” not to document in the electronic medical record (EMR) regarding the incident. CI “DDD” reported following the incident, Resident #73’s room was moved because it was believed she exited the building through a door that was next to her room. In an interview on [DATE] at 11:07am, LPN “MM” reported Resident #73 eloped from the building and was found alone, walking briskly down the service drive, approximately 100’ from the nearest exit. LPN “M” reported she was unsure of the date of the incident, but an incident report had been written. When further queried about Resident #73’s elopement, LPN “MM” reported she was caring for a resident in room [ROOM NUMBER] when she heard a beeping alarm that sounded like a call light going off. LPN “MM” completed the cares and upon exiting room [ROOM NUMBER] noticed the beeping was much louder than a call light, at which time she recognized it as a door alarm. LPN “MM” reported she ran to the alarming door, went outside to the service driveway and saw CI “DDD” running toward Resident #73. LPN “MM” reported Resident #73 was approximately 100’ away from the door, walking briskly and that she had to run to catch up to the resident. Together, LPN “MM and CI “DDD” escorted Resident #73 back inside. LPN “MM” reported she told NHA “A” Resident #73 had eloped and that the door alarm had been sounding for a few minutes, but she didn’t recognize the sound of the alarm from behind a closed resident door. LPN “MM” reported she completed an incident report and assessed that Resident #73 was not injured. In an emailed response on [DATE] at 2:51pm, NHA “A” reported the facility had no incident reports related to Resident #73’s elopements. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 11:50am, Family Member (FM) “CCC” reported the facility called her twice since Resident #73’s admission to report the resident had eloped from the building. FM “CCC” reported the first elopement occurred shortly after the resident was admitted to the facility on [DATE] and again, “sometime in the last few months”. FM “CCC” reported she was the activated durable power of attorney (DPOA) for Resident #73 and did not want her to exit the building alone because she was not safe to do so. FM “CCC” stated “She (Resident #73) wanted to come to a facility rather go to her own home after a hospitalization in 1/25 because she recognized she needed to have someone care for her”. FM “CCC” reported during the most recent elopement, Resident #73 was hallucinating and thought she saw her deceased daughter outside so Resident #73 exited the building to try to catch her. FM “CC” reported after Resident #73’s first elopement, the facility had implemented the use of a personal safety wander alert anklet to maintain her safety. FM “CC” reported after the second elopement, the facility moved Resident #73 to a room that was not as close to an exit door. In an interview on [DATE] at 3:11pm, Resident #73 reported sometimes she “gets a little out of sorts” and becomes confused. Resident #73 recalled becoming confused in the last few months and confirmed that she exited the building alone after she believed she saw deceased relatives outside. Resident #73 lifted her pant leg and gestured toward her personal safety device on her left ankle, then stated “it’s to keep me safe”. During an observation on [DATE] at 12:17pm, a delayed egress door was located next to the room that Resident #73 occupied from [DATE]-[DATE]. The egress alarm activated when the release bar was pushed, the door unlocked and opened after 15 seconds. There was no wander alert detector on the door. Beyond the door, a short sidewalk led to an 8” curb between the service driveway and employee parking area. The sidewalk ended on a curve between the service driveway and the employee parking lot. The service driveway was also accessible by walking across an area landscaped with river rocks and thick grass. The service driveway was paved with 2” deep cracks that stretched across the width of the drive. A retaining pond, enclosed by a 4’ fence, was on the opposite side of the drive. During an observation and interview on [DATE] at 8:47am, DON “B” toured the “Spiritual Garden”, a separate free-standing building, with this writer. DON “B” confirmed Resident #73 resided in this building now and her safety was maintained in part by use of a personal safety wander device. During the tour an exit door was noted in the service corridor. The service corridor was accessible through 2 unlocked, unalarmed double doors, the exit door (which led outdoors) was approximately 30’ beyond the double doors. The exit door had a wander guard detector and a delayed egress release bar. During an observation and interview on [DATE] at 8:55am, DON “B” activated the wander alert alarm at the exit door in the service corridor. The double doors leading to the service corridor were closed. The alarm was heard faintly by the surveyor while standing in the common area, in front of the nurse’s station. When queried, LPN “I” reported she could not hear the alarm as she stood next to the survey in front of the nurse’s station. LPN “I” was asked which residents in this building were at risk for elopement and how she would know. LPN “I” she would look in each resident’s electronic medical record to determine if they were at risk for elopement. LPN “I” listed residents she believed were at risk but did not include Resident #73. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 10:16am, DON “B” reported nurses were expected to use an electronic reader device each shift to ensure resident wander devices were working properly. DON “B” reported she thought the electronic reader devices were kept in the medication carts, but she was not sure. DON “B” reported she found a device reader at the front desk, but it was not charged. In an interview on [DATE] at 11:19am, Unit Manager/Registered Nurse (UM/RN) “N” reported nurses should check each resident’s wander alert device every shift using the reader device. In an interview on [DATE] at 10:10am, LPN “I”, who was assigned to care for Resident #73 on this date, reported she checked the placement of the resident’s personal wander device daily but did not know how to check the functionality of the device. LPN “I” searched her medication cart and reported there was no reader device. LPN “I” reported she called DON “B” and was told the device was in the main building but was not currently useable because the batteries were not charged. In an interview on [DATE] at 10:23am RN “NN” reported she thought it was the expectation that nurses use the electronic reader device once a week to ensure resident wander devices were working properly. RN “NN” reported the facility only had 1 reader and it was kept at the front desk. In an interview on [DATE] at 10:25am, LPN “MM” reported she never checked resident wander devices to ensure they were working. LPN “MM” stated “someone else does that and they’ll let me know if it’s not working”. LPN “MM” checked each compartment of her medication cart and stated, “there’s no device in here for that”. In an observation and interview on [DATE] at 2:20pm LPN “Q” reported she was not responsible for checking resident wander devices to ensure they were working properly. LPN “Q” stated “someone from management checks them daily”. LPN “Q” reported she did not know where to find a wander device reader. In an interview on [DATE] at 10:17am, Central Supply Clerk (CSC) “Y” reported when she previously worked as the scheduler, it was her responsibility to check resident wander devices daily to ensure they were working properly. CSC “Y” reported there had been a lot of staff turnover for the scheduler position, and although she was covering scheduling at this time, the position was no longer had the responsibility of checking resident wander devices. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 3:41pm Maintenance Director (MD) “GG” report the facility placed wander detector devices on 2 of the 5 exit doors of the main building of the facility to reduce the likelihood of resident elopements. MD “GG” reported residents at risk for elopement wore a bracelet that triggered the wander detector when the resident was within 15’ of the door, which cause an alarm to sound. MD “GG” reported the wander detector devices at the doors were supposed to be checked weekly and the checks were documented in a “door log”. MD “GG” reported the remaining doors of the facility were all equipped with delayed egress locks that when activated, would only open after the release bar was pressed for 15 seconds. MD “GG” reported maintenance staff ensured the delayed egress locks were activated once a day, 5 days a week. MD “GG” reported there was no logbook for checking the delayed egress doors and there was no plan in place for checking the doors when maintenance staff was not in the building. MD “GG” reported nurses and other staff members had keys to activate and deactivate the delayed egress alarms. Review of a “Door Logbook” revealed 5 occurrences in which the wander alert alarms were not checked every 7 days during the date range of [DATE]-[DATE]. During an observation on [DATE] at 3:41pm a red light shone on the delayed release bar of the exit door near the kitchen of the main building. When queried, MD “GG” reported the delayed egress alarm was not activated but should have been. In an interview on [DATE] at 12:07pm, NHA “A” reported she thought she may have a “soft file” regarding an “incident of wandering” for Resident #73. NHA “A” then provided a manilla folder with a single document titled “Verification of Investigation”. Review of a “Verification of Investigation” report with a reference date of [DATE] revealed “(Resident #73) was noted with wandering behaviors and wandered through egress door to outside…staff immediately responded to alarm and went to resident…modified interventions to the plan of care… Resident’s room will be moved…further away from outside access…”. In an interview on [DATE] at 12:48pm, NHA “A” reported Resident #73 exited the building on [DATE]. NHA “A” reported the incident was not submitted to the state agency as required because she believed the incident was witnessed by staff. When further queried, NHA “A” reported she did not have any signed, documented staff interviews related to the incident and was not aware of any documentation of the event in the resident’s medical records. NHA “A” confirmed documentation of the event should be in the resident’s medical record so staff could be aware of potential hazards for the resident. NHA “A” reported she had no awareness of an elopement that occurred shortly after Resident #73’s admission because it had not been documented. Review of Resident #73’s progress notes for [DATE]-[DATE] revealed no documentation of elopement(s). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an “Accidents” facility policy with a reference date of [DATE] revealed “Purpose: To ensure the environment is free from accident hazards over which the facility has control and provide supervision…to each resident to prevent avoidable accidents through a systematic approach. “Avoidable Accident” means that an accident occurred because the facility failed to: …evaluate/analyze hazards and eliminate them…implement measures to reduce risks…implement interventions/including adequate supervision and assistive devices to…reduce risk of an accident…assistive device refers to any item…that is used by, or in care of a resident to promote…the resident’s safety….a systematic approach identifies equipment and devices that are defective…are disabled/removed…and enables leadership and direct care staff to work together to communicate the observation of hazards, record resident specific information,…monitor data related to care processes that potentially lead to accidents…” Review of a “Wandering and Elopement Guideline” with a reference date [DATE] revealed “This facility will provide the least restrictive and safe environment for wandering residents at risk for elopement. Process: Upon admission…and upon change of condition our residents will be evaluated for potential elopement risk…Residents identified at risk will have an elopement risk bracelet application placed…Bracelets will be checked for placement and function every shift…” Resident #40 Review of an admission Record revealed Resident #40 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: weakness, reduced mobility, other muscle spasms, and cutaneous abscess of right foot (a localized collection of pus within the skin and underlying tissues). Review of a Minimum Data Set (MDS) assessment for Resident #40, with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #40 was cognitively intact (BIMS score 13-15 indicates no cognitive impairment); “Section GG- Functional Abilities- I. Walk 10 feet: Once standing the ability to walk at least 10 feet in a room, corridor, or similar space… Coded “04- defined as “Supervision or touching assistance- Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity. Assistance may be provided throughout the activity or intermittently.” On [DATE] at 8:03 am, Resident #40 was observed walking in the hallway towards her room. Resident #40 was walking unassisted with a two wheeled walker approximately 3 feet behind “Certified Nursing Assistant” (CNA) “L” as they returned to Resident #40’s room from the spa room. CNA “L” was walking in front of Resident #40 and did not have her in any direct visualization. Resident #40 was not wearing a gait belt. (a safety device used to assist individuals with mobility issues, worn by patients, and allows caregivers to safely move or support the patient while walking or transferring.) On [DATE] at 9:15 am, Resident #40 was observed walking alone with a two wheeled walker in the hallway outside of her room. No noted staff present in the hallway. On [DATE] at 10:29 am, Resident #40 was observed walking alone with a two wheeled walker in the hallway outside of her room. No noted staff present in the hallway. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 8:26 am, “Registered Nurse” (RN) “PPP” reported Resident #40 was “able to get up and walk around alone”. On [DATE] at 9:45 am, Resident #40 was observed walking out of her room into the hallway with her two wheeled walker alone. Resident #40 was overheard speaking to two transport individuals requesting the use of a wheelchair since going to the doctor was “too long of a walk for her to make without falling. ” RN “PPP” was observed entering Resident #40’s room, retrieving a wheelchair, and placing the wheelchair in the hallway for Resident #40 to sit in. Resident #40 was overheard stating “the last thing I want to do is fall and break something.” RN “PPP” looked at this surveyor and stated, “she can be up by herself.” Review of “Kardex” (a easily referenced key patient information system that originates from the patient’s nursing care plan) for Resident #40 with a review date of [DATE] revealed “…Mobility…Uses walker, uses wheelchair (foot pedals as needed), I use a wheelchair in hallways, walker in room with assist, (Name Omitted) Resident #40 can walk with stand by assist with two wheel walker and gait belt in room…” In an interview on [DATE] at 11:56 am, “Director of Rehab” (DOR) “FFF” reported that she was new to the director position and stated, “we are not great at getting evaluation information like transfer status to the floor and the nursing staff.” On [DATE] at 3:35 pm, Resident #40 was observed walking alone with a two wheeled walker in the hallway outside of her room. CNA “G and CNA “R” present in the hallway. No direct observation of Resident #40 by staff was noted. On [DATE] at 3:45 pm, Resident #40 was observed walking alone with a two wheeled walker in the hallway outside of her room. CNA “G” and CNA “R” were standing in the hallway observing Resident #40 from a distance while talking with this surveyor. In an interview on [DATE] at 3:45 pm, CNA “G” reported the management changes the resident’s care plan and doesn’t make sure we know it has been changed. CNA “G” reported the information for a resident’s transfer status was in the care plan and the Kardex but stated “who has time to check that every day?” In an interview on [DATE] at 3:45 pm, CNA “R” reported that Resident #40 walks in the hallway independently “all the time” and she does fine with it. In an interview on [DATE] at 3:45 pm, this surveyor walked next to Resident #40 in the hallway outside of her room and when queried, Resident #40 stated “I think I can be up walking in the hallway. The girls aren’t saying “(Name Omitted) get back to your room”. Resident #40 stated “I just look both ways and go for it. I’ll wait to hear if I’m not supposed to walk alone in the hallway.” (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 8:59 am, DOR “FFF” reported Resident #40 was evaluated by therapy on [DATE] and her current status was “supervision” for assistance. DOR “FFF” reported that Resident #40 required the wearing of a gait belt and staff presence when walking in the hallway; DOR “FFF” reported staff did not have to touch her when she was walking, but they did need to observe/supervise her when she walked in the hallway. DOR “FFF” reported Resident #40 was not independent in walking in the hallway. Review of “Physical Therapy PT evaluation and Plan of Treatment” for Resident #40 dated [DATE] revealed “…new goal Resident will be able to function and ambulate (walk) independently on the hallway with her 2WW (two wheeled walker) safely > (greater than) 150 feet and back (target date [DATE]) …baseline… currently ambulating with 2WW at supervision…” In an interview on [DATE] at 1:16 pm, “Nurse Manager/Licensed Practical Nurse” (NM/LPN) “M” reported that therapy department did not have access to update care plan interventions, and any changes should be made by nursing staff and/or nurse managers. NM/LPN “M” reported she received an email if therapy made changes to a resident’s transfer status and the floor nurse received a communication form from the therapy department if changes were made. In an interview on [DATE] at1:30 pm, CNA “F” reported Resident #40 was independent now. When queried about how CNA “F” knew that Resident #40 was independent, CNA “F” stated “she shows me she is independent when she does things for herself.” In an interview on [DATE] at 1:35 pm, CNA “EE” reported Resident #40 staff needs to be in the room when Resident #40 was doing ADLs (activities of daily living), but she would walk the unit by herself. CNA “EE” reported Resident #40 has a “walking routine” that she completed with therapy during her sessions and she would practice it when she wasn’t working with therapy by walking around the unit by herself. In an interview on [DATE] at 2:27 pm, “Director of Nursing” (DON) “B” reported her expectations were that care plans were updated when needed and consistently done quarterly with the quarterly assessments. DON “B” reviewed Resident #40’s care plan and confirmed Resident #40 should have a gait belt on and staff standing by; Resident #40 should not be walking independently in the hallway.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2586142Based on observation, interview, and record review, the facility failed to maintain complete and accurate medical records in 5 of 18 residents (Resident #10, #99, #100, #73 & #47) reviewed for accuracy of medical records, resulting in inaccurate treatment records and the potential for providers to not have an accurate picture of resident status and condition.Findings include: According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing.High-quality documentation is necessary to enhance efficient, individualized patient care. Quality documentation has five important characteristics: it is factual, accurate, complete, current, and organized . Accessed from: Kindle Locations 24106-24108). Elsevier Health Sciences. Kindle Edition. Resident #10: Review of an admission Record revealed Resident #10 was a female with pertinent diagnoses which included paralysis on her right dominant side, stroke, long term use of insulin, pain in right shoulder, tube feeding, NPO (nothing by mouth), and nerve pain. In an interview on [DATE] at 2:11 PM, Licensed Practical Nurse (LPN) D reported in the medication administration and treatment administration records (MAR TAR) if a resident refused, the nurse would document the refusal in there. For some refusals, it would bring up a note for the nurse to document or the nurse could create their own note for the progress notes. In an interview on [DATE] at 2:15 PM, LPN PP reported in the MAR/TAR, if a resident refused they would select refused and put in a progress note for the resident's refusal. Review of Treatment Administration Record (TAR) for [DATE], revealed, .Acetaminophen Tab 325 mg .Give 2 tablet via peg tube every 6 hours for pain . On [DATE]: missing notation of administration of medication and pain level assessed. Review of Treatment Administration Record (TAR) for [DATE], revealed, .one time a day for Pleasure . Resident to have ice cream once daily. Sitting up at a 90 degree angle, and can be fed by nurse, SLP (speech language pathologist) or trained activity staff only .Trained activity staff are: (First name), (First name), and (First name) .For pleasure feeding On [DATE]: missing notation of administration for administration of pleasure feeding for Resident #10. Review of Treatment Administration Record (TAR) for [DATE], revealed, .Enteral Feed Order at bedtime Change drain sponge around G tube q (every) HS (hour of sleep) . On [DATE]: missing notation of administration for Bedtime drain sponge change around G tube for Resident #10. Review of Treatment Administration Record (TAR) for [DATE], revealed, .Acetaminophen Tab 325 mg .Give 2 tablet via peg tube every 6 hours for pain . On [DATE]: missing notation of administration of medication and pain level assessed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Treatment Administration Record (TAR) for [DATE], revealed, .Insulin Glargine-yfgn 100 UNIT/ML Solution pen-injector .Inject 30 unit subcutaneously two times a day related to TYPE 2 DIABETES MELLITUS WITH OTHER DIABETIC KIDNEY COMPLICATION (E11.29) . On [DATE]: missing notation of administration of medication at bedtime and results of blood sugar check. In an interview on [DATE] at 2:19 PM, Unit Manager (UM) “N” reviewed Resident #10's MAR/TAR and reported if an entry was not there, it was assumed it was not done as the staff could not be sure the resident had received the medication or treatment. UM N reported the Director of Nursing (DON) created a report in the electronic medical record to audit if a medication or treatment was missing. UM N reported that the nurse who was assigned to the resident during the missing documentation would be contacted to determine if this was just an omission or the medication/treatment was not completed. UM N reviewed Resident #10's MAR/TAR for June, July and August. UM N reported if the sponge was not changed on the G-tube this could cause infection. UM N reported if scheduled pain medication was missed the resident's pain could get out of control and the facility could have trouble getting it back under control. UM N reported that if the blood sugar and insulin were not completed it could have significant consequences for the resident. In an interview on [DATE] at 2:43 PM, Director of Nursing (DON) “B” reported every morning the clinical staff reviewed the progress notes from the day prior. DON “B” reported when she was a floor nurse she would put in a progress note and noted on the MAR/TAR the resident had refused the medication or treatment as she was unsure of the policy. Resident #99 (R99) / Resident #100 (R100) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R99 admitted to the facility on [DATE] with pertinent diagnoses including spinal fracture and alcohol abuse. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R99 was cognitively intact (13 to 15 cognitively intact). R99 had a previous admission at the facility from [DATE] to [DATE]. During an observation on [DATE] at 8:18 AM, Certified Nursing Assistant (CNA) “KK” was sitting outside R99’s bedroom door. CNA “KK” stated that R99 was on a 1:1 observation at all times for several days but she didn’t know why. During an interview on [DATE] at 8:38 AM, R99 stated that he was on 1:1 observation since he went into a resident’s room (R100) the other day. During an interview on [DATE] at 8:31 AM CNA “RR” said that she thought R99 was on 1:1 observation since he was inappropriate with a female resident. During an interview on [DATE] at 8:37 AM, Licensed Practical Nurse (LPN) “T” stated that R99 was on 1:1 observation but she didn’t know why. Review of R99’s chart revealed a behavior note documented by Licensed Practical Nurse (LPN) “LLL” from a previous admission dated [DATE] “Location/Cause: Resident room, passing AM medication Behavior: Resident grabbing at nurses breast and groin, started fondling self. Description of behavior: sexually inappropriate. Behavior/Intensity: Non Pharmacological Interventions: spoke with resident stated I am your nurse and this is not appropriate to grab me.” (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on [DATE] at 12:28 PM, LPN “LLL” stated that the incident occurred when she was taking R99’s vitals. LPN ‘LLL” said she told her supervisor about the incident and documented the behavior in a progress note. LPN “LLL” said that R99 was sexually inappropriate and was often seen touching his private area in his bed. During an interview on [DATE] at 12:49 PM, Nurse Manager (NM) “N” stated that R99 was on 1:1 since [DATE] since he was found in R100’s room. NM “N” said R100 was next to his room and she was moved immediately afterwards. During a telephone interview on [DATE] at 11:57AM, LPN “OO” stated that she was working the day of the incident with R99 and R100. LPN “OO” said that FM “VV” told her what happened and that R99 was not observed touching R100. Then, she notified Director of Nursing (DON) “B” and DON “B” contacted NHA “A”. LPN “OO” said she didn’t complete an incident report or complete any charting related to incident since NHA “A” came in and she thought she would take care of it. During an interview on [DATE] at 8:24 AM, RN “NN” stated that when she walked into R99’s room several times he appeared to be masturbating. She also said he likes to brush up against staff but she hadn’t observed any behaviors with residents. RN “NN” stated that management knew about R99’s sexual behaviors since Wound Care Nurse (WCN) “S” told some staff to keep an eye on R99 since he was on the Michigan Sex Offender Registry List. During an interview on [DATE] at 9:02 AM, WCN “S” reported that she knew R99 was on the Michigan Sex Offender Registry List since he came from another facility where she worked at. WCN “S” stated that some staff were aware of R99 being on the list and his behaviors since she told some CNAs and the nurse when she had to do a skin assessment on R99 upon his admission. Review of both R99’s and R100’s charts revealed that there was no documentation of the incident on [DATE]. Review of R99’s chart revealed no behaviors documented since admission. Review of Social Services Evaluation completed on [DATE] by Social Service Assistant (SSA) “HH” revealed “…. Screening for Abuse/Neglect…8. History of or presence of behaviors, such as provoking, aggressive manner, manipulative, derogatory, disrespectful, obnoxious, abhorrent, insensitive, attention seeking, and/or otherwise abrasive/inappropriate behavior: Yes…9. History of mistreating others (i.e. verbal/physical/sexual/ financial exploitation) and/or information presented by a reliable source that indicates there is a history of mistreating others: Yes” During an interview on [DATE] at 10:37 AM, Social Worker Director (SWD) “FF” and Social Worker Aide (SSA) “HH” stated that they were not aware of the incident between R99 and R100 on [DATE] since they weren’t part of the investigation, they only knew R99 had a 1:1 staff observation. Social Worker Director (SWD) “FF” and Social Worker Aide (SSA) “HH” also noted that the behavior log didn’t document any of the behaviors R99 was exhibiting with staff. SSA “HH” acknowledged this. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:44 AM, NHA “A” stated that she did not have an incident report for the (R99) and (R100) incident on [DATE] or an incident report from the previous admission from [DATE] with LPN “LLL”. NHA “A” acknowledged that there was no documentation in R99’s or R100’s chart regarding the incident on [DATE]. Resident #73 Review of an admission Record revealed Resident #73 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: parkinson’s disease (a disorder of the central nervous system that affects movement and may also cause hallucinations (sensory experiences that seem real but are created by the mind), metabolic encephalopathy (disorder that affects the brain’s function), weakness and anxiety (persistent state of worry). Review of a Minimum Data Set (MDS) assessment for Resident #73 with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #73 was cognitively intact. Section “E” of the MDS revealed Resident #73 wandered 1 to 3 days during the assessment period. Section “GG” revealed Resident #73 required the use of a wheeled walker to safely ambulate. Review of a “Care Plan” for Resident #73 with a reference date of [DATE], revealed a focus/goal/interventions of: “Focus: (Resident #73) is an elopement risk/wanderer sundowner (phenomenon where those with cognitive impairments experience worsening of symptoms in the late afternoon or evening). Goal: The resident’s safety will be maintained…Interventions: exit and stairwell alarms…photo on wander list, staff aware of residents wander risk…wander ALERT personal safety device: Right ankle). In an interview on [DATE], at 2:26pm, Confidential Informant (CI) “DDD” reported they were caring for another resident in their room one afternoon, when they (CI “DDD”) looked outside and saw Resident #73 walking in the service driveway alone, without her walker. CI “DDD” reported this incident occurred “within the last few months”. CI “DDD” reported they ran outside and found Resident #73 alone, walking down the service drive of the facility, toward the front of the building, approximately 100’ from the emergency exit on her unit. CI “DDD” reported Resident #73 was not safe to leave the building alone because she got confused at times and lacked safety awareness. CI “DDD” reported LPN “MM” also responded to the situation and together they assisted Resident #73 back inside. CI “DDD” reported upon returning Resident #73 to the unit, she was approached by Nursing Home Administrator (NHA) “A” and DON “B” who instructed CI “DDD” not to document in the electronic medical record (EMR) regarding the incident. CI “DDD” reported following the incident, Resident #73’s room was moved because it was believed she exited the building through a door that was next to her room. In an interview on [DATE] at 11:07am, LPN “MM” reported Resident #73 eloped from the building and was found alone, walking briskly down the service drive, approximately 100’ from the nearest exit. LPN “M” reported she was unsure of the date of the incident, but an incident report had been written in the resident’s electronic medical record. LPN “MM” reported she told NHA “A” Resident #73 had eloped. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 11:50am, Family Member (FM) “CCC” reported the facility called her on two separate occasions to report Resident #73 had eloped from the building. FM “CCC” reported the first elopement occurred shortly after the resident was admitted to the facility on [DATE] and again, “sometime in the last few months”. In an interview on [DATE] at 3:11pm, Resident #73 reported sometimes she “gets a little out of sorts” and becomes confused. Resident #73 recalled becoming confused in the last few months and confirmed that she exited the building alone after she believed she saw deceased relatives outside. Resident #73 lifted her pant leg and gestured toward her personal safety device on her left ankle, then stated “it’s to keep me safe”. Review of Resident #73’s progress notes for [DATE]-[DATE] revealed no documentation of elopement(s). In an emailed response on [DATE] at 2:51pm, NHA “A” reported the facility had no incident reports related to Resident #73’s elopements. In an interview on [DATE] at 12:07pm, NHA “A” reported she thought she may have a “soft file” regarding an “incident of wandering” for Resident #73. NHA “A” then provided a manilla folder with a single document titled “Verification of Investigation”. Review of a “Verification of Investigation” report with a reference date of [DATE] revealed “(Resident #73) was noted with wandering behaviors and wandered through egress door to outside…staff immediately responded to alarm and went to resident…modified interventions to the plan of care… Resident’s room will be moved…further away from outside access…”. In an interview on [DATE] at 12:48pm, NHA “A” reported Resident #73 exited the building on [DATE]. NHA “A” reported the incident was not submitted to the state agency as required because she believed the incident was witnessed by staff. When further queried, NHA “A” reported she did not have any signed, documented staff interviews related to the incident and was not aware of any documentation of the event in the resident’s medical records. NHA “A” reported she had no awareness of an elopement that occurred shortly after Resident #73’s admission because it also was not documented in the medical record. NHA “A” confirmed that each resident’s medical record should contain all the information necessary for staff to maintain the resident’s safety, including past elopements. Resident #47 Review of an admission Record revealed Resident #47 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: CVA (cerebral vascular accident/ stroke), hemiplegia of the left side (inability to move the left side of the body), peg-tube (percutaneous endoscopic gastrostomy tube- a tube inserted into the stomach to provide artificial nutrition) and aphasia (a disorder that affect show a person communicates). Review of “Treatment Administration Record” (TAR) for Resident #47 for the month of [DATE] revealed: (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	08/13/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	“…Wound Treatment- Left heel: apply betadine, cover with abd (abdominal) pad and kerlix (a long continuous wrap of gauze) every day shift for wound management with a start date of [DATE] and a D/C (discontinuation) date of [DATE]… there was no noted, documentation for completion on [DATE], [DATE] nor [DATE]… Wound treatment: cleanse buttocks with normal saline and pat dry, apply maxsorb (an alginate material that absorbs drainage and turns into a gel that creates a moist wound environment for healing) to wound and cover with boarder gauze once per day and as needed if dressing becomes soiled every day shift for MASD (moisture associated skin damage) with a start date of [DATE] and a D/C date of [DATE], there was no noted documentation for completion on [DATE], the date was blank . Ammonium Lactate External Lotion 5% .Apply to arms and legs topically every morning and at bedtime for dry skin with a start dates of [DATE]… there was no noted documentation for completion on [DATE] at bedtime… Heel protectors to prevent decubitus ulcers on the heels two times a day with a start date of [DATE] and a D/C date of [DATE] with no noted documentation of completion on [DATE] at 2000 (8 pm)… Reposition resident every 2-3 hours and PRN (as needed); use wedge cushion at resident’s bedside to assist with repositioning every 3 hours for MASD, pressure ulcer prevention with a start date of [DATE] with no noted documentation of completion on [DATE] 21:00 (9:00 pm), [DATE] at 0000 (12:00 am) and 0300 (3:00 am)…” During an observation on [DATE] at 11:49 am, “Licensed Practical Nurse” (LPN) “T” was observed performing oral suctioning on Resident #47. Review of the “TAR” for Resident #47 revealed “…May suction as needed as needed for secretions with a start date of [DATE] and the only noted documented date of suctioning was [DATE]…” During an interview on [DATE] “Nurse Manager/Registered Nurse” (NM/RN) “N” reported that dressing changes and treatments should be documented in the record. NM/RN “N” reported that documentation was required when performing oral suctioning for Resident #47. NM/RN “N” stated “If it wasn’t documented, it wasn’t done”.