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	12/10/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2668784Based on observation, interview, and record review the facility failed to maintain resident dignity in 2 (Resident #1 and Resident #3) of 5 sampled residents, resulting in feelings of humiliation, embarrassment, and shame. Findings include:Resident #1Review of an admission Record revealed Resident #1 was a female who admitted to the facility on [DATE] and had pertinent diagnoses which included: displaced intertrochanteric fracture of the left femur (fractured left hip) malnutrition, and chronic obstructive pulmonary disease (COPD- a chronic lung disease that restricts breathing).Review of a Social Service Evaluation with a date of 10/24/25 completed at admission for Resident #1 indicated Resident #1's Brief Interview for Mental Status (BIMS) score of 15/15 indicated Resident #1 was cognitively intact.In a telephone interview on 12/04/25 at 3:40 PM Family Member (FM) U reported during a visit with Resident #1, she had an episode of incontinence (a lack of control over voluntary urination) when she had to wait over an hour for her call light to be answered. FM U reported Resident #1 was embarrassed, humiliated, and frustrated that she had peed the bed. FM U reported Resident #1 apologized to staff for being a bother, and not being able to hold her urine when they arrived to answered her call light. In an interview on 12/08/25 at 10:51 AM Certified Nurse Assistant (CNA) L reported call lights should be answered when they are observed to be on. CNA L reported that call lights should be answered by everyone.In an interview on 12/09/25 at 3:08 PM Nurse Manager/Registered Nurse (NM/RN) S reported he had received a complaint from Resident #1's family related to long call light wait times. NM/RN S reported Resident #1's family was concerned with Resident #1's dignity if she urinated on herself. NM/RN S reported he reviewed the call light log and confirmed that Resident #1's call light had been on for 45 minutes one time and 1.5 hours another time during the time when the concern was voiced by family members.Review of Concern/Grievance Form for Resident #1 dated 10/27/25 revealed . date of occurrence 10/26 and 10/27.stated resident's call light was on for extended periods of time through the weekend (10/26 and 10/27) and this morning.call light log was pulled. Resident did have call light on for extended time.In an interview on 12/09/25 at 3:15 PM Nursing Home Administrator (NHA) A provided her computer with the call light log for Resident #1's call light during the dates of 10/26 and 10/27, NHA reported she was unable to print the information and provide it to surveyor.On 12/09/25 at 3:20 PM visual review of the call light log for Resident #1 during the dates of 10/26 and 10/27 revealed . on 10/26/25 at 5:11 AM the call light was on for 1 hour and 28 minutes and on 10/27/25 at 8:23 AM Resident #1's call light was on for 29 minutes.In an interview on 12/09/25 at 3:21 PM, NHA A reported call lights should be answered timely and 29 minutes and 1.5 hours was not considered timely. Resident #3Review of an admission Record revealed Resident #3 was a female who admitted to the facility on [DATE] and had pertinent diagnosis which included: minimally displaced zone 1 fracture of the sacrum (a break in the wedge-shaped bone (sacrum) at the base of the spine where the bone fragments have not significantly shifted or separated).Review of a Social Service Evaluation with a date of 12/5/25 completed at admission for Resident #3 indicated Resident #3's Brief Interview for Mental Status (BIMS) score of 15/15 indicated Resident #3 was cognitively intact.Review of Care Plan for Resident #3 revealed .Foley: Resident requires use of an indwelling catheter r/t (related to) .Keep drainage bag covered to promote privacy. with an initiation date of 12/04/25.On 12/08/25 at 11:05 AM, Resident #3 was observed as she exited her room while sitting in her wheelchair, her urine collection bag connected to a foley catheter was noted to be attached to the wheelchair and the urine was visible. There was no privacy bag or covering present on the urine collection bag. Resident #3 was addressed by Licensed Practical Nurse (LPN) P and LPN P instructed Resident #3 to return to her room as she needed a privacy bag applied to her wheelchair to cover her urine collection bag. Resident #3 stated I wish I had that yesterday. I went to therapy yesterday and I ran into a friend from church and my pee bag was out for everyone to see, I was so embarrassed. Resident #3 was observed to be flushed in the face, emotional, and crying when communicating this information to LPN P.In an interview on 12/08/25 at 11:06 AM LPN P reported that all urine bags should have a privacy covering.In an observation and interview on 12/08/25 at 1:23 PM, Resident #3's urine collection bag was in a privacy bag. Resident #3 reported it was very embarrassing and humiliating when you run into someone you know, and they see your urine in a bag. Resident #3 was observed to be flushed in the face, emotional and crying when discussing this experience.In an interview on 12/09/25 at 2:28 PM NM/RN S reported he recalled seeing Resident #3's catheter on the far side of the bed, but he was unsure if there was a privacy bag on her

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a baseline care plan was developed for 1 (Resident #3) of 5 sampled residents resulting in the potential for unmet care needs.Findings include:Resident #3Review of an admission Record revealed Resident #3 was a female who admitted to the facility on [DATE] and had pertinent diagnosis which included: minimally displaced zone 1 fracture of the sacrum (a break in the wedge-shaped bone (sacrum) at the base of the spine where the bone fragments have not significantly shifted or separated).Review of a Social Service Evaluation with a date of 12/5/25 completed at admission for Resident #3 indicated Resident #3's Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #3 was cognitively intact.On 12/8/25 at 11:05 AM Resident #3's door frame to her room was observed to have signage present indicating that Resident #3 was in Enhanced Barrier Precautions (EBP). In an interview on 12/8/25 at 1:23 PM Resident #3 reported some of the staff wear gown when helping her and sometimes they don't. Resident #3 reported she did not know why the staff wore the gown when caring for her.Review of Care Plan for Resident #3 revealed .Foley: Resident requires use of an indwelling catheter r/t (related to) . with an initiation date of 12/4/25, there was no noted documentation for Resident #3 to be in Enhanced Barrier Precautions.In an interview on 12/9/25 at 9:13 AM Registered Nurse (RN) DD reported residents who had indwelling catheters required EBP and it should be on the care plan.In an interview on 12/9/25 at 9:30 AM Certified Nurse Assistant (CNA) E reported Resident #3 was in EBP because she had an indwelling catheter. CNA E reported the nurses put EBP on the resident's care plans and Kardex (medical-patient information allowing nurses to easily reference key patient information from the care plan). When asked, CNA E reported she knew Resident #3 was in EBP when she saw the resident's catheter tubing, she was unsure if EBP was on Resident #3's care plan.Review of Kardex on 12/8/25 for Resident #3 revealed no noted documentation of EBP.In an interview on 12/9/25 at 10:30 AM Assistant Director of Nursing/Infection Preventionist (ADON/IP) D reported it was a team effort to create care plans, but nursing managers should be the ones to create the care plans.In an interview on 12/9/25 at 11:42 AM Director of Nursing (DON) B reported her expectations were that EBP were part of a resident's baseline care plan if it was indicated. DON B reported Resident #3 should have had EBP in her baseline care plan and confirmed that she had created Resident #3's EBP care plan that day, 5 days after Resident #3 admitted to the facility.Review of facility policy Careplan Standard Guideline with an effective date of 11/28/17 revealed .The interdisciplinary team will collect and record data within 24 hours for the admission baseline Care Plan.it is the practice of this facility to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care. The baseline careplan will . be developed within 48 hours of the resident's admission.

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2668784Based on observation, interview, and record review the facility failed to ensure that professional standards of nursing practice were maintained by following physician orders in 1 (Resident #1) of 4 residents reviewed for professional nursing standards and physician orders resulting in laboratory diagnostic testing not being completed as ordered. Findings include:Resident #1Review of an admission Record revealed Resident #1 was a female who admitted to the facility on [DATE] and had pertinent diagnoses which included: displaced intertrochanteric fracture of the left femur (fractured left hip) malnutrition, and chronic obstructive pulmonary disease (COPD- a chronic lung disease that restricts breathing).Review of a Social Service Evaluation with a date of 10/24/25 completed at admission for Resident #1 indicated Resident #1's Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #1 was cognitively intact.In a telephone interview on 12/4/25 at 3:40 PM Family Member (FM) U reported Resident #1 did not have the recommended laboratory testing done to monitor a new condition of anemia (blood disorder characterized by low red blood cells or hemoglobin leading to reduced oxygen delivery to the body's tissues) that resulted from the surgery Resident #1 underwent to repair her broken hip. Review of Order Summary for Resident #1 revealed Laboratory- cmp cbc 10/29/2025. (complete metabolic panel a blood test that measures protein and electrolyte levels in the blood) and (a complete blood count a blood test that measures red blood cells, white blood cells, hemoglobin and platelets) which was entered on 10/27/25 by Nurse Practitioner (NP) BB.Review of Order Summary for Resident #1 revealed CBC, CMP, TSH FT4 today; call report to me, one time only for anemia; weakness; post op; wt (weight) loss for one day. which was entered by Medical Doctor (MD) CC on 10/31/25. Review of Order Summary for Resident #1 revealed cmp, cbc TSH (a blood test that measures thyroid -stimulating hormone levels to assess thyroid function) FT4 (a blood test to measure the level of T4 in the blood used for thyroid function assessment) one time only on 11/5/25 for med monitoring, verbal order created on 11/1/25.Review of Medication Administration Record (MAR) for Resident #1 for October 2025, revealed CBC, CMP, TSH FT4 today; call report to me, one time only for anemia; weakness; post op; wt loss for one day.ordered to be completed on 10/31/25, was blank, there was no documentation indicating the lab draw was completed.In an interview on 12/8/25 at 11:00 PM, Licensed Practical Nurse (LPN) P reported the providers order admission baseline labs when residents are admitted .In an interview on 12/8/25 at 1:54 PM, LPN Q reported the provider usually orders a CBC and CMP to be drawn for baseline labs on the next lab day after admission. LPN Q reported the lab day was on Wednesdays. LPN Q reported the provider may order labs on a day when the lab did not provide services to the building, and the labs would need to be drawn by a qualified nurse working in the building. In an interview on 12/9/25 at 9:13 AM, Registered Nurse (RN) DD reported most labs were drawn by the lab nurse, weekly on Wednesday, but if the order for a lab was on a different day, the responsibility was then the nurses in the building. Review of Medication Administration Record (MAR) for Resident #1 for November 2025, revealed CBC, CMP, TSH FT4 today; call report to me, one time only for anemia; weakness; post op; wt loss for one day.ordered to be completed on 11/1/25, was documented as 9- see progress note.Review of EMAR (electronic medication administration record) administration note for Resident #1 dated 11/1/25 revealed CBC, CMP, TSH FT4 today; call report to me, one time only for anemia; weakness; post op; wt (weight) loss for one day. incorrect date rescheduled for routine med management lab date Wednesday.In an interview on 12/8/25 at 10:08 AM Nurse Manager/Registered Nurse (NM/RN) R confirmed Resident #1 had laboratory orders and she was unable to locate any results. NM/RN R reported it did not appear Resident #1's ordered labs had been completed.In an interview on 12/9/25 at 1:00 PM, Director of Nursing (DON) B reported it appeared Resident #1's ordered labs had not been completed. DON B reported she was unable to locate any results.In an interview on 12/9/25 at 1:03 PM, Regional Nurse Consultant (RNC) Y confirmed Resident #1 had labs ordered on both 10/29/25 and 10/31/25 and neither time was the order completed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm 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 proper management of an indwelling urinary catheter in 1 (Resident #3) of 1 resident reviewed for an indwelling urinary catheter resulting in the potential for unmet care needs.Findings include:Resident #3Review of an admission Record revealed Resident #3 was a female who admitted to the facility on [DATE] and had pertinent diagnosis which included: minimally displaced zone 1 fracture of the sacrum (a break in the wedge-shaped bone (sacrum) at the base of the spine where the bone fragments have not significantly shifted or separated).Review of a Social Service Evaluation with a date of 12/5/25 completed at admission for Resident #3 indicated Resident #3's Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #3 was cognitively intact.On 12/8/25 at 11:05 AM, Resident #3 was observed to have a urine collection bag on the side of her wheelchair. Review of Physician Orders for Resident #3 on 12/8/25 revealed no orders noted related to an indwelling/foley catheter.Review of Care Plan for Resident #3 revealed .Foley: Resident requires use of an indwelling catheter (a tube placed directly into the bladder to drain urine) r/t (related to).keep drainage bag lower then level of bladder. keep drainage bag covered to promote privacy.monitor for s/s (signs and symptoms UTI (urinary tract infection) . provide catheter care and empty bag every shift and as needed. with an initiation date of 12/4/25.Review of Health Status Note for Resident #3 dated 12/4/25 at 20:19 (8:19 pm) revealed .patient has a foley catheter in place .Review of Nursing Bladder and /or Bowel Evaluation for Resident #3 dated 12/5/25 at 01:36 AM revealed .reason for evaluation was admission, bladder continence status was urinary catheter.supporting diagnosis for the catheter is other-sacral fx (fracture).In an interview on 12/8/25 at 1:23 PM, Resident #3's reported she had no idea why she had the catheter, and she did not have one before going to the hospital. Resident #3 reported the first few days she was at the facility; no one emptied her urine bag. Resident #3 stated it seemed like they didn't even know I had a catheter. In an interview on 12/9/25 at 9:38 AM Licensed Practical Nurse (LPN) O reported the admitting nurse was who should verify a residents admission orders. LPN O reported the admitting nurse should give a resident's admission orders to the facility providers, the providers should confirm and/or change any orders and then sign for the orders they want in place, and after that the nurse mangers were to review the resident's orders to make sure they were accurate. LPN O reported resident admission orders were essentially triple checked for accuracy. In an interview on 12/9/25 at 9:45 AM Nurse Manager/Registered Nurse (NM/RN) R reported physician orders were required for a resident who had an indwelling urinary catheter/foley catheter.Review of Order Summary for Resident #3 on 12/9/25 revealed .Foley catheter care every shift.Foley catheter - change PRN (as needed).Foley Catheter Sioze- 16 Fr (French); Balloon 10 mL (milliliters) for a diagnosis of retention. all orders were noted to be entered on 12/9/25.In an interview on 12/9/25 at 11:42 AM Director of Nursing (DON) B reported nurse managers were responsible to verify that all resident orders were correct and in place. DON B reported nurse managers were responsible for their assigned units, and they need to verify that the orders are in and correct, as well as care plans and care plan interventions. When queried, DON B reported she added physician orders related to Resident #3 indwelling catheter care today. DON B reported that orders for Resident #3's catheter should have been in place when she admitted on [DATE].In an interview on 12/9/25 at 2:28 PM NM/RN S stated I remember her (Resident #3) having a catheter, it was on the other side of the bed, but I never followed up on the orders for it. When queried, NM/RN S reported he did not know why Resident #3 had an indwelling urinary catheter.Review of facility policy Urinary Indwelling Catheter Management Guidelines with an effective date of 11/28/17 revealed .Indwelling catheters may be associated with significant complications.Indwelling catheter evaluations and a Medical Necessity for Indwelling catheter evaluation will be completed .upon admission with observation of an indwelling urinary catheter.Physician orders should reflect these recommendations.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure proper management of a PICC (Peripherally Inserted Central Catheter - intravenous tube used for prolonged vascular access) in 1 (Resident #5) of 1 resident reviewed for a PICC resulting in the potential for unmet care needs.Findings include:Resident #5Review of an admission Record revealed Resident #3 was a female who admitted to the facility on [DATE] and had pertinent diagnosis which included: intraspinal abscess and granuloma (a localized collection of pus around the spinal canal, typically resulting from infections, and a mass of tissue that forms as a response from inflammation). On 12/10/25 at 1:00 PM, Licensed Practical Nurse (LPN) M was observed in Resident #5's room disconnecting IV (intravenous) tubing from a PICC line in Resident #5's left arm.Review of Order Summary for Resident #5 printed on 12/10/25 at 13:48 (1:48 PM) revealed no noted documented order for a PICC line or a noted order for monitoring the site of the PICC line.During an interview on 12/10/25 at 2:15 PM Resident #5 reported she came to the facility on [DATE] and already had to go back to the hospital to have her IV line replaced. Resident #5 reported she needed to have antibiotics through her IV for a week or two for her blood infection. Resident #5's dressing covering her PICC line was observed to be dated 12/7/25, Resident #5 reported they applied that dressing at the hospital when they put the new one in.Review of Nursing Admission for Resident #5 dated 12/5/25 at 17:58 (5:58 PM) revealed .IV present, in right upper arm, size-NA, Length- NA, Arm Circumference-NA, observation of IV site- clean and dry.Review of Transfer to Hospital or other Facility note for Resident #5 dated 12/6/25 at 8:34 AM revealed . redness, swelling on left upper arm around PICC, reason for transfer, redness, swelling on left upper arm around PICC.In an interview on 12/10/25 at 1:22 PM, Nurse Manager/Registered Nurse (NM/RN) S reported Resident #5 had a PICC line for 8 weeks of antibiotic therapy. NM/RN S reported he was not sure if a physician order was needed for a PICC line. NM/RN S reported he had no idea when the dressing should be changed on a PICC line.In an interview on 12/10/25 at 2:23 PM Director of Nursing (DON) B reported PICC line dressing should be changed every 7 days and there should be orders in place for that dressing change. DON B reported a PICC must have an order from a physician and there should also be orders in place to monitor the PICC line. Review of facility policy Guidelines for Preventing Intravenous Catheter Related Infection with a date of May 2022, revealed .surveillance.observe insertion site.on every shift, on admission, and with dressing changes. change.dressing on CVAD (central venous access device (included a PICC line)). every 5 to 7 days or PRN (as needed) if damp, loosened, or visibly soiled.monitor the catheter site visually during dressing changes. Palpate catheter-skin junction site for tenderness at least daily through the intact dressing.Documentation.the following should be recorded in the resident's medical record: objective information regarding appearance of insertion site, catheter, and dressing.2. Any interventions that were done.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure proper use of personal protective equipment (PPE) during cares while in enhanced barrier precautions for 1 (Resident #5) of 3 residents reviewed for PPE use during cares while in enhanced barrier precautions (EBP), resulting in the potential for the introduction of and/or the spread of infection.Findings include:Resident #5Review of an admission Record revealed Resident #3 was a female who admitted to the facility on [DATE] and had pertinent diagnosis which included: intraspinal abscess and granuloma (a localized collection of pus around the spinal canal, typically resulting from infections, and a mass of tissue that forms as a response from inflammation). On 12/10/25 at 12:59 PM, observed signage outside of Resident #5's room indicated enhanced barrier precautions were in place during cares for Resident #5. The sign indicated that staff were to wear a gown and gloves when providing high contact care for Resident #5.On 12/10/25 at 1:00 PM, Licensed Practical Nurse (LPN) M was observed in Resident #5's room disconnecting IV (intravenous) tubing from a PICC (peripherally inserted central catheter, an intravenous access in the upper arm used for long term antibiotic administration) line in Resident #5's left arm. LPN M was not wearing a gown. Review of Orders for Resident #5 revealed .Enhanced barrier precautions (EBP) wound and PICC line.for infection control. with a start date of 12/05/25.Review of care plan for Resident #5 revealed .Resident requires Enhanced Barrier Precautions r/t (related to) PICC line. initiated on 12/07/25In an interview on 12/10/25 at 1:01 PM, LPN M reported Resident #5 was in EBP due to a PICC line in her left arm. LPN M reported she should wear a gown when working with Resident #5's PICC line. LPN M confirmed she did not wear a gown when she disconnected Resident #5's IV line and she should have.In an interview on 12/10/25 at 1:50 PM, Nursing Home Administrator (NHA) A reported LPN M should have worn a gown when caring for Resident #5's PICC line.In an interview on 12/10/25 at 2:23 PM Director of Nursing (DON) B reported Resident #5 was in EBP due to her PICC line, and her expectations were that staff wore PPE when in contact with Resident #5's PICC line. Review of facility policy Personal Protective Equipment Preventative Approach Guideline with an effective date of 7/13/2022 revealed .Enhanced Barrier Precautions .refer to the use of gown and gloves during high-contact resident care activities that provide the opportunity for transfer of MDROs (Multi-Drug Resistant Organisms).examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: .device care or use: central line.