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	04/21/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2972335Based on interview and record review the facility failed to provide Activities of Daily Living (ADL) care for one (#1) of three residents reviewed for ADL care.Findings Included:Resident #1 (R1)Review of the medical record demonstrated that R1 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), type 2 diabetes, staphylococcal arthritis (serious, rapid-onset infection of a joint cause by staphylococcus aureus bacteria) left shoulder, metabolic encephalopathy (a broad term for brain dysfunction), staphylococcal arthritis right knee, pancytopenia (simultaneous reduction of red blood cells, white blood cells, and platelets), abnormalities of gait and mobility, lack of coordination, dysphagia (difficulty swallowing), insomnia, vascular dementia with agitation, methicillin susceptible staphylococcus aureus (a type of bacterium resistant to many antibiotics), peripheral vascular disease (PVD), congestive heart disease(CHF), restless leg syndrome, hyperlipidemia (high fat content in blood), atrial flutter, hypertension, obesity, malignant neoplasm of upper lobed, left bronchus or lung (lung cancer), gastroesophageal reflux disease, and chronic kidney disease. Review of R1's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/14/2026, revealed R1 had a Brief Interview for Mental Status (BIMS) of 6 (severe impairment in cognitive function) out of 15. Review of Section GG- Functional Abilities of the MDS, with the same ARD, revealed R1 required partial/moderate assistance with eating, dependent for oral hygiene, dependent for toileting hygiene, dependent for shower/bathing, dependent for upper body dressing, dependent for lower body dressing, dependent for putting on/taking off footwear, and dependent for all transfers. R1 was discharged from the facility on 02/02/2026.On 04/17/2026 at 09:33 a.m. during a telephone interview, R1's family member K explained that R1 had not received assistance with his activities of daily living (ADL's) on a regular basis. R1's family member K also explained that R1 had informed him that he was not getting meals on a regular basis.Review of R1's medical record revealed plan of care documentation for ADL/GG (activities of daily living/functional abilities of the Minimum Data Set) hygiene (oral, toileting, personal) was blank on the following dates and times: 01/11/2026-6A-6P(6am to 6pm), 01/12/2026-6A-6P, 01/15/2026 - 6A-6P and 6p-6a, 01/16/2026-6A-6P, 01/17/2026- 6A-6P, 01/24/2026-6A-6P, and 01/31/2026 -6p-6a.Review of R1's medical record revealed plan of care documentation for ADL/GG (activities of daily living/functional abilities of the Minimum Data Set) Eating (ability, percentage eaten) was blank on the following dates and times 01/11/2026 - 0900/1300(1pm), 01/12/2026- 0900/1300, 01/15/2026-0900/1300, 01/16/2026-0900/1300, 01/17/2026- 0900/1300, 01/24/2026- 0900/1300, and 01/25/2026- 0900/1300. Review of the same document listed above, revealed NA (nonapplicable) was documented for the 6pm meal on the following dates: 01/11/2026 to 01/13/2026, 01/15/2026, 01/17/2026 - 01/25/2026, and 01/28/2026 -01/31/2026.On 04/21/2026 at 08:45 a.m. Director of Nursing (DON) B explained that certified nursing aides (CNA's) worked 6am to 6pm and 6pm to 6am (12 hours shifts). DON B explained that it was the facility expectation that Activity of Daily Living (ADL) task were to be completed each shift. DON B also explained that ADL care included hygiene (oral, toileting, and personal). DON B explained that it was the facility expectation that each CNA documented in the resident's plan of care (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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after ADL's were performed. DON B also explained that NA' s (nonapplicable) should not be documented in the resident's plan of care for any task. DON B explained that plan of care documentation for eating was to have been documented after all meals. DON B confirmed R1's medical record demonstrated blank documentation for ADL care (as listed above) and confirmed NA was documented for meals (as listed above) . DON B explained that blank documentation and documentation of NA did not demonstrate that the R1's had been provided ADL services on those dates and times. DON B explained that NA documentation had not demonstrated that R1 was provided meals.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2988571Based on observation, interview, and record review the facility failed to promote the healing of an existing pressure ulcer and to prevent pressure ulcer development for one resident (#3) out of three residents reviewed resulting in a stage 2 pressure ulcer (partial-thickness skin injury) developing to an unstageable pressure ulcer(a full-thickness tissue loss where the depth is covered by eschar or slough tissue), the development of a new unstageable pressure ulcer, and the resident experience a pain level of 9 out of 10 (pain scale 1 - least pain and 10 being the most pain).Findings Included:Resident #3 (R3)Review of the medical record demonstrated that R3 was admitted to the facility on [DATE] with diagnoses that included encounter for surgical aftercare following surgery on the circulatory system, muscle disorder, difficulty in walking, lack of coordination, abnormal posture, cognition communication deficit, dysphagia (difficulty swallowing), atherosclerotic heart disease (plaque buildup in coronary arteries), hypertension, gastro-esophageal reflux, irritable bowel syndrome, overactive bladder, constipation, peripheral vascular disease (PVD), pneumonia, urinary retention, osteoarthritis (degenerative wear of bone joints), mild cognitive impairment, hyperlipidemia (high fat content in blood), and osteoporosis (bone weaking). Review of R3's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/26/2026, revealed R3 had a Brief Interview for Mental Status (BIMS) of 9 (moderate cognitive impairment) out of 15. Review of section M-Skin Conditions, of the MDS with the same MDS, revealed R3 had one unstageable pressure ulcers upon admission. R3 was discharged to the hospital 04/14/2026 and readmitted [DATE].On 04/21/2026 at 01:41 p.m. during observation and interview R3 was observed lying down in bed. R3 explained that she had a wound on her coccyx and had developed another wound on the left side of her buttock. R3 explained that her bottom felt as if it was on fire. R3 rated the pain, on her bottom, to be a 9 on a scale of 1 to 10, with one being the least and 10 being the worst. An air mattress pump was observed at the foot of the bed and appeared to be operational.Review of R3's medical record revealed Wound Assessment Details document for a wound on R3's sacrum, which was present on admission. The Wound Assessment Details, dated 03/22/2026 revealed a stage 2 pressure ulcer on R3's sacrum measuring 0.7cm(centimeters) length, 0.5cm width, 0.2cm depth, and 0.35cm2 surface area. The same document revealed the wound as having 100% epithelial tissue.The Wound Assessment Details, dated 03/23/2026, revealed an unstageable pressure ulcer on R3's sacrum measuring 2.0cm length, 1.3cm width, and 0.2cm depth. And 2.60cm2 surface area. The same document revealed the wound as having 20% intact skin, 20% epithelial tissue, and 60% slough (dead tissue).The Wound Assessment Details, dated 03/30/2026, revealed an unstageable pressure ulcer on R3's sacrum measuring 6.8cm length, 5.0cm width, 0.2cm depth, and 34.00 cm2 surface area. The same document revealed the wound as having 20% intact skin, 20% epithelial tissue, and 60% slough tissue. No Wound Assessment Details was provided for the date of 0407/2026.Review of the Wound Assessment Details, dated 04/13/2026, revealed an unstageable pressure ulcer on R3's sacrum measuring 8.50cm length, 8.50cm width, 0.10cm width, and surface area of 72.25cm2. The same documentation did not reveal any evaluation of the intact skin or slough.Review of R3's medical record revealed Wound Assessment Details document for a wound on R3's dorsal sacral area, which was documented as facility acquired. The Wound Assessment Details document, dated 04/07/2026 revealed an unstageable pressure ulcer on R3's dorsal sacral area measuring 2.8cm (centimeters) length, 2.20cm width, 0.10cm in depth, and 6.16cm2 in surface area. The same documentation revealed the wound had 90% non-granulation tissue and 10% slough (dead tissue).Review of the Wound Assessment Details document, dated 04/13/2026, revealed an unstageable pressure ulcer on R3's dorsal sacral area measuring 4.20cm length, 2.70cm width, 0.10cm depth, and 11.24cm2 surface area. The same documentation did not reveal any evaluation of the intact skin or slough. Review of Wound Physician Assistant PA documentation, dated 04/13/2026, revealed .Wound bed has 100% slough, no (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	eschar and no epithelization (healing tissue) present.Review of the R3's facility incident report, dated 04/06/2026, revealed During wound rounds, noted to have open are to dorsal sacrum, assessed with Wound PA. No route cause analysis was provided at the time of survey.Review of R3's plan of care revealed a problem statement, initiated 04/20/2026 Skin: Resident has actual skin breakdown r/t(related to) coccyx. The care plan did not include any interventions to treat or prevent further decline of the wound or interventions to prevent further skin breakdown. R3's plan of care, initiated 03/20/2026 entitled, Skin: Resident has potential for skin breakdown r/t mobility deficits. Interventions with this plan of care revealed When care is done being provided, please ensure that air mattress function is back to alternating setting and the state feature is off (initiated 03/20/2026), alternating air mattress (initiated 03/20/2026), assist and encourage resident to turn and reposition frequently and prn (initiated 03/20/2026). Plan of care revealed problem statement, initiated 04/07/2026, Skin: Resident has pressure ulcer to sacrum. No new interventions were added to the plan of care after development of new wound.Review of provided document entitled Wound Care: Pressure Injury Unavoidable Evaluation, dated 04/07/2026, listed pressure injury being acquired to coccyx on 04/06/2026. Same document list Risk Factors: immobility, chronic bowl incontinence, chronic heart disease, weight loss/poor nutrition. The section of the documents for wt. loss was not completed. Same document revealed Summary section that that had a physician signature that was blank. Review of R3's physician orders revealed an order, dated as discontinued on 03/20/2026, Pressure reducing mattress. Review of R3's physician orders also revealed an order, dated active on 04/20/2026, Pressure reducing mattress. Further review of physician orders revealed an order dating 03/21/2026 to 04/02/2026 cleanse wound on coccyx with normal saline, pat dry, apply calcium alginate and 4x4 bordered gauze and an order dating 04/02/2026 to 04/07/2026 cleanse wound on coccyx with normal saline, cleanse with 1/2 strength dakins pat dry, apply calcium alginate and 4x4 bordered gauze. The next physician order for 04/08/2026 to 04/15/2026 cleanse wound on coccyx with normal saline, cleanse with 1/2 strength Dakin's pat dry, apply medihoney, calcium alginate and 4x4 bordered gauze. No order for the lateral sacrum was found.Review of R3s' medical record for wound care orders on 04/21/2026 at 11:45 a.m. did not reveal that any treatment orders for R3's wounds. Review of R3's April Treatment Record (TAR) did not demonstrate that any treatment had been completed on R3's sacral dorsal wound.On 04/21/2026 at 11:57 a.m. Director of Nursing (DON) B was asked to review R3's medical record and provide documentation that interventions were in place prior to the development of the dorsal sacral wound. DON B explained that she could not demonstrate that any interventions had been in place prior to the development of the unstageable dorsal sacral wound on 04/07/2026. DON B explained that an order was not written until 04/07/2026 for the alternating pressure mattress even though it had been listed on the plan of care on 03/20/2026. DON B was asked to provide documentation that R3's dorsal sacral wound had an order for treatment when the wound was identified on 04/06/2026. DON B could not provide an order for treatment of R3's dorsal sacral wound. DON B could not explain why preventative measure had not been put in place to prevent the further development of a pressure wound for R3. DON ?B could explain why a treatment order had not been written for R3's dorsal sacral wound that developed on 04/07/2026. DON B confirmed that no wound treatment orders had been written upon R3's return to the facility on [DATE] and could not offer an explanation.On 04/21/2026 at 02:03 p.m. Wound Nurse (WN) G was explained that she would be completing the wound dressings for R3. WN G was followed into the room of R3. All wound care supplies were observed on top of a barrier on the over bed table. R3 was observed lying in bed. WN G explained to R3 that she would be completing her dressing to her bottom. Registered Nurse (RN) I (in room to assist) removed the dressing that was on R3 buttock. The dressing was dated 04/20/2026. R3 was observed to have what appeared to be an unstageable wound to her coccyx and to her left sacral area, with both having eschar (dead tissue) present in the wound beds. The removed dressing was observed to contain red drainage. The removed foam dressing was covering both the wound to the coccyx and to the left dorsal sacral wound. WN G (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	measured the left dorsal sacral wound which was 5.0 cm (centimeter) length, 4.0cm width, and 0.3cm depth. The WN G then took picture of the left dorsal sacral wound. Wound bed was observed to be red around the edges and black eschar tissue was observed. WN G explained that the wound was unstageable and the wound had 65% eschar. WN G was then observed complete the treatment according to the current order. WN G was observed to measure the coccyx wound which measured 10.0cm length, 9.0cm width, and 1cm depth. The coccyx wound was observed to have eschar present. WN G explained that the wound had approximately 85% eschar present. WN G then preformed the treatment to the coccyx per the physician orders.

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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 follow acceptable infection control procedures for one resident (#3) of three residents observed during clean dressing changes.Findings Included::Resident #3 (R3)Review of the medical record demonstrated that R3 was admitted to the facility on [DATE] with diagnoses that included encounter for surgical aftercare following surgery on the circulatory system, muscle disorder, difficulty in walking, lack of coordination, abnormal posture, cognition communication deficit, dysphagia (difficulty swallowing), atherosclerotic heart disease (plaque buildup in coronary arteries), hypertension, gastro-esophageal reflux, irritable bowel syndrome, overactive bladder, constipation, peripheral vascular disease (PVD), pneumonia, urinary retention, osteoarthritis (degenerative wear of bone joints), mild cognitive impairment, hyperlipidemia (high fat content in blood), and osteoporosis (bone weaking). Review of R3's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/26/2026, revealed R3 had a Brief Interview for Mental Status (BIMS) of 9 (moderate cognitive impairment) out of 15. Review of section M-Skin Conditions, of the MDS with the same MDS, revealed R3 had one unstageable pressure ulcers upon admission. R3 was discharged to the hospital 04/14/2026 and readmitted [DATE].On 04/21/2026 at 01:41 p.m. during observation and interview R3 was observed lying down in bed. R3 explained that she had a wound on her coccyx and had developed another wound on the left side of her buttock. On 04/21/2026 at 02:03 p.m. Wound Nurse (WN) G was explained that she would be completing the wound dressings for R3. WN G was followed into the room of R3. All wound care supplies were observed on top of a barrier on the over bed table. R3 was observed lying in bed. WN G explained to R3 that she would be completing her dressing to her bottom. Registered Nurse (RN) I was observed sanitizing hands and then placed on a gown and gloves. Certified Nursing Aide (CNA) J was observed sanitizing hands and then placed on a gown and gloves. RN I and CNA J rolled R3 to her right side. RN I performed peri care and incontinent bowel movement care. RN I removed her soiled gloves, sanitized her hands, and then removed the dressing that was on R3 buttock. The dressing was dated 04/20/2026. R3 was observed to have what appeared to be an unstageable wound to her coccyx and to her left sacral area, with both having eschar (dead tissue) present in the wound beds. WN G was observed sanitizing hands, then placed gloves and gown on. WN G then took picture of the left dorsal sacral wound. WN G removed her gloves and sanitized her hands and replaced gloves. WN G was then observed to rinse wound with wound wash and wipe with 4x4 gauze, then patted it dry with 4x4 gauze and applied the ordered dressing. WN G was then observed to pick up the phone to take a picture of the wound on the coccyx. WN G removed gloves and proceed to cleanse the coccyx wound with wound cleanser and wiped with a 4 x 4 gauze. WN G was observed to apply ordered dressing. WN G then was observed placing the phone (used to acquire wound pictures) into her pocket without cleaning. WN G then removed her gloves and gown and sanitized her hands.On 04/21/2026 at 02:50 p.m. Director of Nursing (DON) B was asked to explain her expectation and professional practice of a clean dressing change. DON B explained that all supplies would be gathered prior to performing the treatment, according to physician orders. DON B explained that the supplies would be placed on a clean barrier. DON B explained that the nurse would wash her hands, place on gloves, and a gown. DON B explained that the old dressing would be removed, then the nurse would remove the soiled gloves, sanitize her hands, and place on new gloves. DON B explained that then the wound area would be cleansed, in accordance with physician orders, and the nurse would remove the soiled gloves, sanitize her hands, and place on new gloves. DON B explained that the wound pictures would be obtained now and measurements would be taken, then the nurse would remove the soiled gloves, sanitize her hands, and place on new gloves. DON B explained that the dressing would be applied according to physician orders at this point. DON B explained once the treatment had been completed the nurse would sanitize the phone and place on barrier. DON B explained then the nurse would (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remove her gloves, remove her gown, and wash/sanitize her hands. DON B explained that it was professional standards to perform each step for each individual wound site.