STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Green Lake Estates	6470 Alden Dr Orchard Lake, MI 48324

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 34208 This citation pertains to intake #MI00150928 Based on interview and record review, the facility failed to ensure freedom from misappropriation for one resident, (R302) of two residents reviewed for misappropriation, resulting in a staff member stealing R302's money. Findings include: On 3/27/25 at 9:50 AM, a review of a facility reported incident folder for R302 was completed. The folder contained investigation documentation that included a summary that read, .On 2/27/25 (R302) was brought to the Administrator's office by (Nurse 'D') .(R302) was crying when she entered the office .(Nurse 'D') reported (R302) was upset because she suspected her money had been taken .(R302) confirmed she was upset because she suspected money had been taken from her. (R302) reported she had spoken to her bank after having received and reviewed her bank statement. (R302) said she noticed transactions that she did not make because they happened outside the facility. (R302) had not left the facility, other than for hospital visits, since her admission in early May of 2024. (R302) stated, 'Certified Nurse Aide (CNA) 'C' took my money! She was the only one I gave my card to.' Administrator asked for clarification regarding why (R302) thought (CNA 'C') had taken her money and how she obtained (R302's) debit cart. (R302) reported that she had given the debit card to (CNA 'C') December 31. (R302) asked (CNA 'C') to withdraw $500 from (R302's) Checking account. (R302) stated, There more <sic> charges on here than I authorized. Continued review of the summary read, .On 2/27/25 facility administrator contacted (CNA 'C') via phone and informed her that allegations of misappropriation had been made against her .(CNA 'C') said: That's fine, but it (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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wasn't me, it was (CNA 'F'). Remember him, the tall, guy, aide? I drove him in my car to the gas station, he went to the ATM (automated teller machine), he got her cash, he went to (Grocery Store) and got her pop . Administrator spoke with (R302) later in the afternoon of 2/27. Administrator asked (R302) she remembered a CNA named (CNA 'F') .(R302) did recall the CNA. Administrator asked if (R302) had ever given (CNA 'F') her card. (R302) said, 'No, the ONLY person I gave my card to was (CNA 'C')' (R302) went on to say that (CNA 'C') used the card for things (R302) was not aware of These transactions were discovered upon review of the bank statements .Before Administrator could reach out to (CNA 'F') for comment, (CNA 'F') texted the administrator the following message: 'I had no involvement in the situation, but I also know how fast words travel. If there's anything I can clarify or any information I can provide to assist, I'd be more than willing to speak with you.' .Because (R302) denied ever giving (CNA 'F') her debit card, and (CNA 'F') reaching out, unprompted, to provide a statement after the administrator spoke with (CNA 'C') The Administrator had the impression that (CNA 'C') may be impeding the investigation by contacting potential witnesses .With the information collected from (R302), (CNA 'C'), witness statements, bank statements, and (Facility) policies, the Administrator had satisfactory information to terminate (CNA 'C's) employment . On 3/27/25 at 10:07 AM, an interview was conducted with the facility's Administrator regarding R302's missing money. The Administrator reported CNA 'C' withdrew more money than R302 asked them to and after reviewing the statements, the amount of money withdrawn compared to the amount of money CNA 'C' gave to R302 did not add up and some of the money was missing. The Administrator further reported in addition to ATM withdrawals, CNA 'C' also used the card for point of sale purchases near their home which is not near the the facility. The Administrator further reported CNA 'C' accepting R302's debit card was against the facility's code of conduct. A review of a facility provided policy titled, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property was conducted and read, .DEFINITIONS OF ABUSE AND NEGLECT .d. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident ' s belongings or money without the resident ' s consent .It is the policy of the Facility that each resident will be free from 'Abuse' .

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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. 34208 This citation pertains to intake #MI00150133. Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices related to transmission based precautions (TBP) for two residents (R#'s 300 and 307) of six residents reviewed for infection control. Findings include: R300 On 3/26/25 at 10:05 AM, R300 was observed seated in their wheelchair near the nursing station on the second floor. An interview was attempted, however; R300 did not offer any verbal response at the attempt. An observation of R300's room revealed no signage to indicate they were on any type of TBP or an isolation caddy hanging on the door containing personal protective equipment (PPE). Additional observations of the room on 3/26/25 at 1:38 PM and 3/27/25 at 10:00 AM continued to reveal no signage for TBP or isolation caddy on the door. On 3/26/25 at 12:00 PM a review of R300's physician's orders was conducted and revealed an active order dated 2/18/25 that read, Contact Isolation for Scabies. R307 On 3/26/25 at 9:55 AM, an observation of R307's room revealed an isolation caddy with PPE hanging on the door as well as a sign to indicate R307 was on both contact and droplet transmission based precautions. On 3/26/25 at 12:03 PM, Nurse 'G', R307's assigned nurse was asked why R307 was on contact and droplet precautions. After reviewing the orders Nurse 'G' said they did not know and would follow-up, however; they never followed up with an answer. On 3/27/25 at 10:00 AM, R307's room was observed to remain with the isolation caddy, and the contact and droplet signs posted to the door. On 3/27/25 at 11:10 AM, a review of R307's active, completed, and discontinued physician's orders was conducted and did not reveal any orders for transmission based precautions. On 3/27/25 at 11:53 AM, an interview was conducted with the facility's Director of Nursing and they said R300 should no longer be on TBP and the order should have been discontinued. They further indicated R307 should have had an order and indication for contact and droplet TBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility provided policy titled, Guideline for Standard and Transmission-based Precautions was conducted and read, .It is the practice of this facility to follow CDC (Centers for Disease Control and Prevention) established guidelines for determining the following: Standard and transmission-based precautions to be followed to prevent spread of infections. When and how isolation should be used for a resident, including but not limited to the following: 1. Type and duration of the isolation, depending upon the infectious agent or organism involved . The policy provided did not address whether there should be an order for the use of TBP.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 34208 This citation pertains to intake #MI00150133 Based on interview and record review the facility failed to ensure a stop date for antibiotic treatment for one resident (R#306) of three residents reviewed for antibiotic stewardship resulting in the resident receiving numerous additional doses of antibiotic medication. Findings include: On 3/26/25 at 12:30 PM, a review of R306's physician's orders and Medication Administration Record (MAR) for February 2025 and March 2025 was conducted and revealed Nurse Practitioner (NP) 'H' prescribed Ivermectin (antibiotic) on 2/10/25 for the treatment of possible scabies. The order indicated the medication was to be administered on day 1 (2/10/25), day 2 (2/11/25), day 8 (2/17/25), day 9 (2/18/25) and day 15 (2/24/25). It was noted the order did not include a stop date and the medication was continued to be given once daily (with the exception of a few refusals from R306) after day 15 until it was discontinued on 3/26/25. On 3/27/25 at 12:48 PM, a telephone interview was conducted with NP 'H' regarding R306's order for the Ivermectin antibiotic. They said they did not know why the medication was not stopped after day 15 but it should not have been given after that date. On 3/27/25 at 1:27 PM, an interview was conducted with the facility's Director of Nursing and they acknowledged the concern and indicated a stop date should have been included in the order. A review of a facility provided document titled, Infection Prevention and Control Manual for Antibiotic Stewardship & MDROs (multi-drug resistant organisms) was conducted and read, Stewardship involves identifying the microbe responsible for disease, utilizing evidence based definitions when indicated; selecting the appropriate antibiotic along with documentation indicating the rationale for use, appropriate dosing, route, and duration of antibiotic therapy; and to ensure discontinuation of antibiotics when they are no longer needed .