

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER The Villa at Green Lake Estates		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 #2714636 Based on interview and record review, the facility failed to report an allegation of abuse/neglect for one resident (R906) of two residents reviewed for abuse/neglect/mistreatment. Findings include: On 6/9/26 a concern submitted to the State Agency (SA) was reviewed which alleged R906 was neglected by facility staff on 1/7/26. On 6/9/26 the medical record for R906 was reviewed and revealed the following: R906 was initially admitted to the facility on [DATE] and had diagnoses including Obesity and Heart failure. A review of R906's MDS (minimum data set) with an ARD (assessment reference date) of 1/9/26 revealed R906 needed assistance from facility staff with most of their activities of daily living. R906's BIMS score (brief interview of mental status) was 14 indicating intact cognition. A review of R906's progress notes revealed the following: 1/7/2026 at 07:00 . pt (patient) was refusing care, using aggressive language towards staff, removing brief to urinate and defecate on bed. Contacted 911 with false allegations about CNAs (Certified Nursing Assistants) (police report # [police report # and name of responding officer]). refusing to use call light for assistance and saying no one came to change him but wouldn't allow staff to change him when rounding. pt (patient) was refusing care and stating the staff were ignoring his requests to be change but pt did not use call light to call for assistance and refused to use the call light at all. Made false allegations of neglect and called 911 and said the staff were abusing him by neglecting him . 1/7/2026 at 09:17 *IDT (Interdisciplinary Team Note) .Writer spoke with [R906] regarding potential care concerns. [R906] informed writer about concerns regarding two elderly women he claimed provided care to him the night before. [R906] went on to say they changed his bed and cleaned water he had spilled on himself. He told them he had to have a bowel movement, and they replied that they couldn't help with that, but that they would let his nurse and CNA know. [R906] stated he waited too long but could not recall approximate wait time. [R906] stated he then contacted the police because he believed he had been forgotten. Writer was informed earlier in the morning that [local police department] arrived at the facility at approximately 6:33am. [R906] stated that the male aide was 'running his mouth to the cop' while [R906] was giving his statement. [local police officer] departed the facility at approximately 6:38am. Writer asked [R906] if he would like to provide any further details regarding why he contacted the police rather than using his call light for assistance. [R906] stated he believed the staff were blocking his light from working. 1/7/2026-encounter Date of Service: 01/07/2026 Visit Type: Initial Consult .Details: .Psychiatric Evaluation .The patient was observed in the dining area and was agreeable to meeting with the provider. Privacy and confidentiality were maintained. He was alert and oriented to person, place, and time. Initially, he appeared guarded and visibly upset regarding events that occurred overnight. The patient reported that he felt neglected by staff overnight, stating that he remained incontinent for several hours and felt his needs were not addressed, which prompted him to contact emergency services. He expressed significant frustration and anger related to this perceived lack of care. Nursing documentation indicates that staff attempted to provide care during overnight rounds, but the patient was refusing assistance at times, using aggressive language, and making repeated (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	calls to emergency services with allegations that staff were not responding to the call light. Facility administration is aware of the situation. During the interview, the patient was irritable and anxious when discussing these events, and some confusion was noted, particularly in his interpretation of staff interactions. Despite this, he was able to provide coherent information and did not demonstrate psychotic thought content. He denied auditory or visual hallucinations and denied suicidal or homicidal ideation. No aggressive behavior was observed during the evaluation. The patient reports that he normally sleeps well at home but has not been sleeping since admission, which he attributes to distress over the overnight incident .On 6/9/26 at approximately 9:17 a.m., the facility Administrator (Abuse Coordinator) was interviewed pertaining to the allegations of R906 alleging they were neglected/abused on 1/7/26. The Administrator reported they did not report the allegations to the State Agency but did complete an investigation. The Administrator was asked why they did not report R906's allegations to the SA, and they indicated they did their investigation and did not find the allegations were substantiated. The Administrator was queried if allegations of neglect and abuse should be reported State Agency for review, and they reported again that they had done an investigation into the allegations and felt they were unsubstantiated.On 6/9/26 at approximately 10:53 a.m., Nurse A was queried regarding the progress note they had written on 1/7/26 in R906's medical record pertaining to the allegations of abuse/neglect. Nurse A reported they were the Nurse for R906 at the time the allegation made and that R906 was reporting he was being neglected by the CNA's that were assigned to their room because they were not helping him with changing his brief. Nurse A reported R906 was not using their call button for assistance but was calling out for the aide to help. He ended up calling the police because he felt he was being ignored by the staff and neglected. Nurse A indicated they tried to go into R906's room, but they would only let the Nurse in because he was angry at the aide. Nurse A indicated they filled out a statement pertaining to R906's allegations of neglect and handed to the administrator so they could do what they needed to do. On 6/9/26 a facility document titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property was reviewed and revealed the following: Purpose: It is the practice of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property from abuse, neglect, misappropriation of resident property, and exploitation. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3013247Based on observation, interview and record review the facility failed to provide appropriate catheter care for one resident (R913), of two residents reviewed for catheters. Findings include:Clinical record review revealed R913 was admitted to the facility on [DATE] for long term care with a medical history of prostate cancer, neuromuscular dysfunction of the bladder and required a Suprapubic (SP) indwelling urinary catheter (surgically placed urinary catheter inserted directly through the abdomen). A Brief Interview of Mental Status (BIMS) conducted on 5/11/26 indicated R913 had moderate cognitive impairment.The State Agency received a concern that alleged the facility failed to provide appropriate and adequate catheter care according to the residents plan of care and physician orders. On 6/8/26 at 10:20 AM, Family Member F was contacted by phone confirming the allegations and said they would be at the facility after 1:00 PM to visit with R913.Clinical record review of R913's care plan initiated on 3/25/26 included interventions to place a T-drain gauze (pre-cut gauze designed to fit around tubing), maintain a closed drainage system, monitor for decreased urine output, monitor patency of the catheter, and notify the provider of abnormal findings.A nursing progress note dated 6/8/26 at 6:16 AM, authored by Registered Nurse (RN) G, documented R913 had urine leaking around their catheter from the suprapubic site and they would notify the physician.An attempt to interview RN ?G' via telephone was conducted on 6/8/26 at 10:47 AM and 6/9/26 at 9:41 AM. Voice messages were left, no return call for an interview was received by the end of this survey.On 6/8/26 at 10:20 AM, Medical Director (MD) D was interviewed by phone. They were asked if anyone from the facility had made them aware of R913's leaking catheter and they indicated no one had. During the interview, MD D reviewed the on-call service notes from 6/8/26 and further confirmed no provider was contacted. When asked if they were notified, what would the instruction be for R913? MD D said R913 had a complicated Urology history and was seen by their Urologist on 6/2/26 at which time they had the SP catheter exchanged. MD D further said they would have instructed nursing to call R913's Urologist and follow their recommendations.On 6/8/26 at 2:03 PM, R913 gave permission for observation of their SP catheter site with Family Member ?F' present. It was observed R913's waistband and abdominal area of their pants was wet as well as wetness observed on their incontinence brief. An odor of urine was present. The insertion site was observed with no T-drain gauze dressing, and the tubing and collection bag were observed dry with no urine in them. Family Member ?F' was observed speaking in a frustrated tone the staff did not notify them of the leaking and R913 should have to be sent to urology.On 6/8/26 at approximately 2:10 PM, FM F was followed to the nurse's station and observed with frustration informing Unit Manager Licensed Practical Nurse (LPN) E that R913 was wet with urine and there is leaking from the SP catheter. FM F was also observed telling LPN E R913 needed to be cleaned and they (FM F) would be calling the Urologist and R913 would probably have to be sent out to the ER (emergency room).On 6/9/26 at 8:38 AM during a clinical record review with the Director of Nursing (DON), they confirmed R913 had to be sent to the hospital on 6/8/26 around 5:30 PM to have their SP catheter assessed by their Urologist. At the time of the record review with the DON, they were informed MD D was not contacted per the nursing documentation in the 6/8/26 progress note at 6:16 AM, and they acknowledged the concern.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number: 2714799 Based on interview and record review, the facility failed to ensure a physician's order was in place for an abdominal binder and implement effective interventions to prevent dislodgement of a feeding tube for one (R907) of one resident reviewed for tube feeding, resulting in a hospital transfer to reinsert the feeding tube. Findings include: A review of a complaint submitted to the State Agency revealed an allegation that R907 had multiple episodes of feeding tube dislodgement and the facility did not continue the use of an abdominal binder that was placed in the hospital. A review of R907's clinical record revealed R907 was admitted into the facility on 5/5/25, readmitted on [DATE], and discharged on 12/16/25 with diagnoses that included: vascular parkinsonism, hemiplegia, and aphasia. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R907 had severely impaired cognition, no behaviors, and received 51 percent or more of fluid and nutrition via a feeding tube. R907 was transferred to the hospital on [DATE] and 11/28/25 due to feeding tube dislodgement. A review of R907's care plans revealed a feeding tube care plan with the following intervention initiated on 10/21/25 and resolved (discontinued) on 11/26/25: Abdominal binder as tolerated. A review of R907's Physician's orders revealed no order for an abdominal binder. A review of a Care Plan Progress Note dated 10/24/26 noted, Abdominal binder in place. A review of a General Note dated 10/8/25 revealed, Aide observed resident's peg (Percutaneous Endoscopic Gastrostomy) tube (feeding tube surgically placed into the stomach to deliver nutrition) pulled out and notified writer .Notified on call provider. Provider gave order to send resident out to hsp (hospital) for peg tube replacement . A review of progress notes from 10/20/25 revealed R907's feeding tube was dislodged and replaced in the facility with placement verified by X-ray. A review of a Health Status Note dated 11/28/25 revealed, At approximately 1130 (AM) writer enters resident's room reconnect resident to his continuous TF (tube feeding) after CNA (Certified Nursing Assistant) gets him dressed and for the day and place him in his w/c (wheelchair). Writer observes peg tube dislodged from abdomen. Medical Director notified and gives orders to transfer resident to (hospital) non emergency . On 6/8/26 at 1:31 PM, an interview was conducted with the Director of Nursing (DON). When queried about what was required to be in place in order to utilize an abdominal binder, the DON reported a care plan and physician's order. The DON was asked to provide information about when R907's abdominal binder was implemented and why (per the progress note that mentioned it was in place on 10/24/25), clarification about whether there was a physician's order, and why the abdominal binder was discontinued per the care plan on 11/26/25. The DON reported she was not the DON at that time but would look into it. On 6/8/26 at 3:56 PM, the DON followed up and reported the abdominal binder was added to R907's care plan on 10/21/26 after the feeding tube was dislodged and they replaced it in the facility. The DON reported on 11/26/25, the facility had to resolve all the care plans and start new ones due to a change in the system library which was a result of a change in ownership. However, a new care plan intervention for the abdominal binder was not put into place. The DON reported she did not find a physician's order for the abdominal binder and there should have been one. The DON said there was a lot of communication via email regarding R907's abdominal binder, but it should be documented in the medical record. The DON reported she would follow up with any additional information. On 6/9/26 at approximately 1:00 PM, the DON reported she was unable to provide any additional information about when the binder was supposed to be implemented, if it was implemented, or why it was discontinued. When queried about what was in place to prevent the third feeding tube dislodgement on 11/28/25 (since 10/8/25), the DON was unable to offer a response.		