

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  05/08/2024
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39592</p> <p>This citation pertains to Intake MI00143647</p> <p>Based on observation, interview and record review, the facility failed to treat a resident with dignity and respect for one (R73) of five resident reviewed for dignity. Findings include:</p> <p>On 5/6/24 at 10:42 AM, R73 was observed sitting in a wheelchair in their room. An aircast brace was observed on R73's left leg from the knee to the foot. R73 was asked about the care in the facility. R73 explained she had a lot of issues with a particular nurse, Licensed Practical Nurse (LPN) F, like LPN F would say they are drug seeking in front of other residents and staff when they ask for their pain medication and they felt it had affected how other staff treated them at the facility.</p> <p>Review of the clinical record revealed R73 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: traumatic subdural hemorrhage (brain bleed) with loss of consciousness, displaced trimalleolar fracture (three breaks in the ankle) and adult physical abuse, confirmed. According to the Minimum Data Set (MDS) assessment dated [DATE], R73 was cognitively intact.</p> <p>Review of R73's comprehensive care plan revealed a focus initiated 3/22/24 that read, The resident has actual acute pain r/t (related to) Emotional distress, Fracture LLE (left lower extremity), Postoperative surgical wound LLE, discomfort, Psychological distress, Trauma that had interventions that read in part, . Administer analgesia per orders. Give 1/2 hour before treatments or care . Anticipate the resident's need for pain relief and respond immediately to any complaint of pain .</p> <p>Review of progress notes by LPN F revealed:</p> <p>A General Note dated 3/28/24 at 4:48 PM that was struck out for Created in Error read in part, Resident continues to drug seek regarding (their) PRN (as needed) medication .</p> <p>A General Note dated 4/20/24 at 11:56 AM read in part, Writer is in the back set administering medications. (R73) is at the top of the ramp asking what time (they) got (their) medication, i [sic] rep;ied [sic] that i [sic] was passing [sic] medication that (they) would have to wait . Resident has been in a nasty attitude all morning. RN (Registered Nurse)(D) agreed to give (them) medication when its. [sic] time.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A General Note dated 4/21/24 at 3:51 PM read in part, .Resident disrespects care giver and denies the [sic] (they) has received care. Resident has been in a foul mood all weekend. Resident has no respect for caregivers or the writer. RN in house to administer (their) medications .</p> <p>A General Note dated 5/5/24 at 6:19 PM read in part, .Patient asked why writer had a problem with her (patient) acts as though (they) is writers only patient and that writer should ignore all the other patients, when writer doesn't do that, patient accuses writer of ignoring (them) and trating [sic] poorly, also states that writer has a poor attitude and is unprofessional. Patient also stated that when (they) needed writers help on a previous shift that writer ignored (them) walked past, with writer sayingcoming [sic] through. writer had done that but, patient hadn't asked for help . This am when writer attempted to give (6:00 AM) medications to patient and (their) pain medication patient refused (their) medications and said that (they) wanted to wait and (they) would get them prior to PT (physical therapy). Writer at (7:50 AM) wrier [sic] noticed patient following oncoming nurse and stating that (they) needed (their) pain medication now and started harrassing [sic] CENA (Certified Nursing Assistant) and nurse, patient didn't appear to be in the amount of pain (they) stated that (they) was in, no increased breathing, no facial grimacing, no crying, appeared rather relaxed in (their) wheelchair . Resident is in [NAME] [sic] of having a converstation [sic] withoutbecoming [sic] irritated and verey [sic] angry .</p> <p>On 5/7/24 at 2:45 PM, the Director of Nursing (DON) was interviewed and asked should documentation in the medical record contain subjective (influenced by personal feeling or emotions) information, or should be objective (factual evidence). The DON explained it was not appropriate to use subjective information in a progress note. When informed of LPN F's progress notes regarding R73, the DON had no explanation. The DON was asked if she had been aware of any personality conflict between R73 and LPN F. The DON explained she had not noticed any conflict.</p> <p>On 5/8/24 at 8:24 AM, LPN F was interviewed by phone and asked if there was a conflict between herself and R73. LPN F explained she did not have any problem with R73, in fact R73 had told their family they know what a good nurse she is. When asked about the subjective content in several of their progress notes, LPN F explained she knew subjective charting is a weakness of hers.</p> <p>Review of a facility policy Titled, Resident Rights revised February 2021 read in part, .These rights include the resident's right to: a dignified existence; be treated with respect, kindness, and dignity; .</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283</b></p> <p>Based on observation, interview, and record review the facility failed to ensure one resident (R12) was assessed for safe self-administration of medication of one resident reviewed for self-administration, with potential for inappropriate administration of medication.</p> <p>Findings include:</p> <p>R12</p> <p>R12 was a long-term resident of the facility originally admitted to the facility on [DATE]. R12 was recently admitted to hospital and readmitted back to the facility on [DATE]. R12's admitting diagnoses included Pneumonia, lung cancer and depression. R12 had multiple hospitalizations due to their diagnoses and comorbidities. Based on the Minimum Data Set (MDS) assessment dated [DATE], R12 had a Brief Interview for Mental Status (BIMS) assessment score of 15/15, indicative of intact cognition.</p> <p>An initial observation was completed on 5/6/24, at approximately 3:30 PM. R12 was observed sitting in their bed. An interview was conducted during this observation. R12 reported that they just got back from the hospital. R12 was receiving oxygen at 3litres/minute. R12 had an (Albuterol 0.5-2.5 mg/3ml.) inhaler on their bed side table. R12 was queried about the inhaler. R12 reported that they had always kept that inhaler themselves. When queried how often they had used it, R12 reported that they had used the inhaler whenever they had needed it.</p> <p>A follow-up observation was completed on 5/7/24, at approximately 9:45 AM. R12 was observed sitting on their bed and they were eating their breakfast and they reported that they needed their medication from the nurse. R12 had their (albuterol) inhaler on the bedside table. R12 confirmed that they used their inhaler as needed.</p> <p>Review of R12's Electronic Medical Record (EMR) revealed a physician order that read, Ipratropium-Albuterol inhalation solution 0.5-.2.5 (3) MG/ML - 3 ML inhale orally four times/day for COPD (Chronic Obstructive Pulmonary Disease). Further review of R12's EMR did not reveal any documentation that revealed R12's ability to self-administer their medication. R12's care plan did not reveal any care plan that R12 was able to self-administer their medication.</p> <p>An interview was completed with unit manager L on 5/7/24 at approximately 9:30 AM. Unit manager L was queried about the facility process for self-administration of medication. They reported that they were new to the position; not very familiar with the facility process and added that an assessment was completed.</p> <p>An interview with the LPN A on 5/7/24, at approximately 11:10 AM was completed in the hallway near the medication cart. LPN A was queried about R12's inhaler and if they had the medication in their cart. LPN A checked the cart and reported that they did not have the medication in the cart and confirmed that R12 was keeping the inhaler at their bedside and administering on their own.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with Director of Nursing (DON) was completed on 5/7/24 at approximately 11:50 AM. The DON was queried about the facility process for self-administration of medication and reported that they were completing the assessment to ensure that residents were able to safely administer medication per physician orders and they were completing a care plan. The DON was queried about R12's assessment and care plan. The DON checked the EMR for R12 and confirmed that they did not have one and they would follow up.</p> <p>A facility policy on self-administration of medication was requested via e-mail and was not received prior to the survey exit.</p>		

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<p>F 0560</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect a residents' right to refuse some types of non-requested transfers within the nursing home.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39592</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident, with a confirmed history of physical abuse, was not threatened to change rooms for staff convenience for one (R73) of one resident reviewed for room change. Findings include:</p> <p>On 5/6/24 at 10:42 AM, R73 was observed sitting in a wheelchair in their room. An aircast brace was observed on R73's left leg from the knee to the foot. R73 was asked about the care in the facility. R73 explained she had a lot of issues with a particular nurse, Licensed Practical Nurse (LPN) F and had asked not to have LPN F as their nurse, but had been told they would have to change rooms to not have LPN F as their nurse. R73 explained they loved their room, that it felt like it was their safe place and they did not want to change rooms, but also did not want LPN F as their nurse. When asked who had told them they had to change rooms to have a different nurse, R73 explained it had been the Administrator.</p> <p>Review of the clinical record revealed R73 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: traumatic subdural hemorrhage (brain bleed) with loss of consciousness, displaced trimalleolar fracture (three breaks in the ankle) and adult physical abuse, confirmed. According to the Minimum Data Set (MDS) assessment dated [DATE], R73 was cognitively intact.</p> <p>Review of R73's comprehensive care plan revealed a Focus initiated 4/22/24 that read, The resident has areas of Vulnerability r/t (related to) domestic physical abuse that had an intervention that read, Observe and provide a safe environment.</p> <p>On 5/7/24 at 1:37 AM, the Administrator was interviewed and asked if R73 had ever asked to not have LPN F as their nurse. The Administrator explained he did not remember R73 saying that. The Administrator was asked what would happen if R73 did request not to have LPN F as their nurse. The Administrator explained he would tell R73 they could change rooms. The Administrator was asked why R73 would have to change room to not have LPN F and explained they only had one nurse on R73's floor. When asked if another nurse in the facility could be utilized to accommodate R73's preferences. The Administrator explained they had not considered using other nurses for the R73.</p> <p>Review of a facility policy titled, Resident Rights revised February 2021 read in part, .These rights include the resident's right to: .exercise his or her rights as a resident of the facility and as a resident or citizen of the United States . be supported by the facility in exercising his or her rights .</p>

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>30675</p> <p>Based on interview and record review, the facility failed to ensure that grievances were promptly documented, investigated, tracked and resolved for residents that participate in the resident council.</p> <p>Findings include:</p> <p>On 5/7/24 at 9:30 AM, an interview was conducted with the Activity Director. When asked to review the resident council minutes, they reported there had been an accident and coffee had been spilled on some of the documents. When asked about whether there was any documentation of follow-up to the concerns/grievances identified in the past resident council meetings as that documentation was not included in the information provide for review, the Activity Director reported since last annual survey, they were putting concerns on grievance forms. When asked where those forms were kept and to provide for review, the Activity Director reported they would follow-up. There was no additional documentation or follow-up regarding the grievances provided by the end of the survey.</p> <p>Review of previous resident council minutes identified the following concerns:</p> <p>On 2/28/24:</p> <p>Nursing concerns included:</p> <p>Staff is on their phones too much</p> <p>There are still issues with the call lights not being answered in a timely manner when agency is in the building.</p> <p>Resident collectively feel that the aides and nurses need to be more involved in bringing residents to activities downstairs.</p> <p>Housekeeping/Laundry concerns included:</p> <p>.is missing a blue sweatshirt and gray jogging pants. Both are labeled with name and room number.</p> <p>.thinks the building needs to buy new linen, better pillows and update the rooms a little.</p> <p>On 3/27/24:</p> <p>.States that there isn't enough of nursing in the building and wants her pills for pain and nerves.</p> <p>Housekeeping/Laundry concerns included:</p> <p>.He is missing clothing, like his pink sweatshirt.</p> <p>(continued on next page)</p>

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>.She is missing clothing. Feels her room need to be cleaned better and the floors need to be cleaned.</p> <p>On 4/4/24:</p> <p>Nursing concerns included:</p> <p>.would like the midnight staff to be quieter in the halls when he is trying to sleep.</p> <p>Business Office concerns included:</p> <p>.stated that she is extremely upset about her new patient liability and believes that she should be able to keep all of her money. She feels that it is unfair that she should have to pay to live here because her insurance should cover everything.</p> <p>On 5/7/24 at 10:30 AM, a resident council interview was conducted with 11 residents who wished to remain anonymous. When asked about concerns discussed at previous resident council meetings and whether there had been any follow-up or resolution to those grievances, nine of the residents reported there was no follow-up. Several residents reported they were told their items that were missing would be replaced, but there was no follow-up. Several residents also reported ongoing concerns with staffing, long response to call-lights especially on the weekends and food concerns.</p> <p>On 5/7/24 at 2:00 PM, the Administrator was asked about the lack of resident council concern/grievance follow-up and acknowledged the concern with grievances, but was unable to offer any further explanation.</p> <p>According to the facility's policy titled, Grievance Guideline dated 11/28/2017:</p> <p>.Resident Council .All grievances identified during the Resident Council meeting will be submitted immediately to the Grievance Official for investigation and resolution. Reporting of resolution outcome will be given to the Resident Council per protocol .</p>

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30675</p> <p>Based on interview and record review the facility failed to ensure that resident rights to private and confidential mail delivery was maintained for all residents that reside within the facility.</p> <p>Findings include:</p> <p>According to the facility policy titled, Resident Rights dated Revised February 2021:</p> <p>.Federal and state laws guarantee certain basis rights to all residents of this facility. These rights include the resident's right to .exercise his or her rights as a resident of the facility and as a resident or citizen of the United States .access to a telephone, mail and email .communicate in person and by mail, email and telephone with privacy .</p> <p>According to MCL-Section 445.33, Sec. 3 2019, Act 48, Eff. [DATE]:</p> <p>.Taking, holding, concealing, or destroying mail addressed to another person; prohibited conduct; violation as a crime; penalties; applicable whether alive or deceased .</p> <p>On [DATE] at 10:30 AM, a resident council interview was conducted with 11 residents who wished to remain anonymous. When asked about whether they received their mail timely, and unopened, several residents reported concern. One resident reported, I'm missing one piece of mail. They say they can open in the mail in the packet (admission packet). This resident showed a copy of their admission packet provided by the facility which read, .Authorization to Inspect and Open Official Correspondence .I understand that I have the right to receive my personal mail delivered to me unopened. However, I also do not want important mail affecting my financial or legal affairs to get lost or misplaced. Consequently, I hereby agree to and authorize representatives of this facility to inspect, open and remove the contents of the following mail, realizing that I will be informed of issues deemed necessary: Social Security Checks, Pension Checks, Veteran's Administration Checks, Correspondence for Michigan Department of Public Aid, Social Security, Medicare Insurance, Doctor and Hospital Bills . There were two boxes to choose either Yes, I give my permission to allow the Facility to open my mail and then deliver it to me. Or No, I do not want the Facility to open my mail. It shall be delivered to me unopened. Several other residents began voicing concerns and questioned how that was allowed, since it was a Federal Offense to open other people's mail.</p> <p>On [DATE] at 11:19 AM, an interview was conducted with the Administrator. When asked about their facility admission contract including the choice to have the facility open mail or not, and how that was determined to be approved, the Administrator reported the mail shouldn't be opened and if they can't open it themselves, they can ask for help. The Administrator further reported they were not aware that was in the admission agreement.</p> <p>(continued on next page)</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On [DATE] at 11:31 AM, an interview was conducted with the Admissions Director (Staff 'E'). When asked about the facility's process for whether staff open residents' mail, Staff 'E' reported they don't open mail unless we can justify a need to. When asked about the admission agreement that has residents and/or their representatives sign that it's ok to open mail, they reported that was a typo and would follow-up. When asked to read the same verbiage as above, Staff 'E' acknowledged the agreement, and reported they were not responsible for the contents of the admission contract and was unable to offer any further explanation.</p>		

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<p>F 0577</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>30675</p> <p>Based on observation, interview and record review, the facility failed to ensure residents and visitors had access to previous survey results, resulting in residents and visitors being uninformed of deficiencies identified in the facility. This had the potential to affect all residents who resided in the facility.</p> <p>Findings include:</p> <p>According to the facility policy titled, Resident Rights dated Revised February 2021:</p> <p>.Federal and state laws guarantee certain basis rights to all residents of this facility. These rights include the resident's right to .examine survey results .</p> <p>On 5/7/24 at 10:30 AM, a resident council interview was conducted with 11 residents who wished to remain anonymous. When asked about whether they knew where they could access and review the facility's survey binder which included past reports of non-compliance and findings from the State Agency, none could identify where or that anyone had discussed this with them previously.</p> <p>On 5/7/24 at 11:10 AM, Receptionist 'U' was asked where the facility's survey binders were kept and they denied being aware of what that was. When asked about the signage on the wall next to the desk that read, The following items are available for inspection. Please ask the Administrator, [name of Administrator]: 5 YEARS OF SURVEY REPORTS, 3 YEARS OF HEARING NOTICES, SERVICES AND RATES CHARGED, LISTING OF INDIVIDUALS WITH PROPRIETARY INTEREST, LIST OF LICENSED PERSONNEL, ADMISSION CONTRACT Receptionist 'U' stated they guess they would call him (Administrator).</p> <p>On 5/7/24 at 11:40 AM, the Administrator was asked about the facility's process for the past survey information and reported they had some in their office and the Director of Nursing had one in her office. The Administrator was asked to observe the posting in the front lobby next to the receptionist desk and confirmed the posting. The Administrator then reported the survey binder had been removed temporarily and wasn't put back. When asked if it was temporary, why was the signage indicating they had to ask the Administrator, and they reported they weren't sure what had happened and Receptionist 'U' should've know as they were in that role for about three years.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30675</p> <p>This citation pertains to intake #MI00141921.</p> <p>Based on interview, and record review, the facility failed to ensure medications were administered and/or the physician was notified of the late administration according to professional standards of practice for one (R72) of one resident reviewed for medication administration.</p> <p>Findings include:</p> <p>Review of complaints filed with the State Agency included allegations that medications were not being administered per physician orders.</p> <p>On 5/7/24 at 10:30 AM, during the confidential resident council meeting, several residents voiced concerns that they frequently received their medications late on the first floor.</p> <p>On 5/7/24 at 11:00 AM, R72 reported concerns with not getting their scheduled medications and asked, Is it my job to ask for my scheduled medications? I was supposed to take them at 9:00 AM but I still haven't received any for today.</p> <p>According to the profile information, R72 was their own responsible party.</p> <p>According to the Minimum Data Set (MDS) assessment dated [DATE], R72 had no communication concerns, and received high-risk drug class medication which included diuretic, antiplatelet, and hypoglycemic medication.</p> <p>On 5/7/24 at 11:09 AM, review of R72's Medication Administration Records (MARs) revealed that none of the 9:00 AM medications had been documented as administered yet. Additionally, there was no documentation the physician had been notified and/or approved the medication to be given outside the scheduled administration time.</p> <p>Review of the physician orders and MAR revealed the following nine medications were prescribed to be administered at 9:00 AM but contained blank entries:</p> <ol style="list-style-type: none"> <li>1) Clopidogrel Bisulfate Oral Tablet 75 MG Give 75 mg by mouth one time a day for blood clots (an antiplatelet medication).</li> <li>2) Metformin HCl (Hydrochloric Acid) (an anti-diabetic medication) Oral Tablet 1000 MG Give 1000 mg by mouth two times a day for DM (Diabetes Mellitus) (at 9:00 AM and 5:00 PM).</li> <li>3) Glipizide Oral Tablet (an anti-diabetic medication) 10 MG Give 10 mg by mouth one time a day for edema &lt;sic&gt;</li> <li>4) Pioglitazone HCl (Hydrochloric Acid) (an anti-diabetic medication) Oral Tablet 45 MG Give 45 mg by mouth one time a day for DM.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5) Lisinopril (used to treat high blood pressure) Oral Tablet 10 MG Give 10 mg by mouth one time a day for HTN (Hypertension).</p> <p>6) Carvedilol (used to treat high blood pressure) Oral Tablet 12.5 MG Give 12.5 mg by mouth two times a day for HTN Take 1 tablet po (by mouth) bid (twice daily) with meals (at 9:00 AM and 5:00 PM).</p> <p>7) Aspirin Oral Capsule 81 MG (Milligrams) Give 81 mg by mouth one time a day for pain.</p> <p>8) Psyllium (used to treat constipation) Oral Capsule 400 MG Give 1 capsule by mouth one time a day for constipation.</p> <p>9) Fluticasone Propionate Nasal Suspension (used to treat allergies) 50 MCG (Micrograms)/ACT (Actuation) 2 sprays in each nostril one time a day for sneezing, itchy, or runny nose shake gently. Before first use, prime pump. After use, clean tip and replace cap.</p> <p>Further review of the clinical record revealed R72 was admitted into the facility on [DATE] with diagnoses that included: atherosclerotic heart disease of native coronary artery without angina pectoris, radiculopathy, major depressive disorder single episode, generalized anxiety disorder, type 2 diabetes mellitus without complications, ulcerative colitis, unstable angina, low back pain, other chronic pain, other chest pain, hypomagnesemia, benign prostatic hyperplasia with lower urinary tract symptoms, acute on chronic systolic heart failure, hyperlipidemia, ischemic cardiomyopathy, and essential hypertension.</p> <p>On 5/7/24 at 11:16 AM, an interview was conducted with Nurse 'C' who reported they were from a Staffing Agency (had been observed coming on duty earlier at 8:15 AM). When asked about whether they had completed administering resident's morning medications, Nurse 'C' reported they weren't sure how many residents they had left, but further expressed concern that they had 34 residents (actual census was 30 as total for unit is 32) and all had vitals and blood pressures to be done. When asked about R72, Nurse 'C' confirmed they had spoken to the resident earlier when the resident had asked them about the medication.</p> <p>On 5/7/24 at 11:30 AM, an interview was conducted with the Director of Nursing (DON). The DON was informed of the concerns with residents complaining in the resident council their medications were frequently late on the first floor and they acknowledged the concern and reported other staff such as the Unit Manager should be available to help when needed. The DON was informed of the concern that R72 and several others from the first floor had expressed concern with getting their medications late.</p> <p>On 5/7/24 at 12:27 PM, the DON was asked about the facility's process for when medications were going to be administered late and reported the nurses have an hour before and an hour after the scheduled time, then needed to reach out to the physician to see if they can extend, still give, or hold the medication. When asked about nurse staffing for the first floor and whether the facility had considered increasing, the DON reported there had been discussion. When informed of the concerns regarding the observation and interview with staff and residents earlier, they reported other Nursing staff should be assisting when needed. The DON was asked how many residents required more than one person assistance on the first floor, and reported they would follow-up.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/7/24 at 1:45 PM, further review of R72's clinical record revealed the above 9:00 AM medications were now documented as administered by Nurse 'C'. There was no documentation that the attending physician had been notified and/or approved the late administration or what to monitor for. The documentation reflected no late entries and showed as if it had been administered at 9:00 AM.</p> <p>On 5/8/24 at 3:07 PM, the DON reported that on 5/7/24, the census for first floor was 30, and when Nurse 'C' reported they had 34 residents, that was not correct since the unit only held a maximum of 32. The DON further reported that there were 11 of the 30 residents that required two person assistance with care needs.</p> <p>On 5/8/24 at 3:50 PM, review of the progress notes and physician orders revealed there was still no notification to the resident's physician of the late administrations, despite bringing to the facility's attention on 5/7/24.</p> <p>According to the facility's policy titled, Administering Medications dated Revised April 2019:</p> <p>.Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions .Medications are administered in accordance with prescriber orders, including any required time frame .Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include .enhancing optimal therapeutic effect of the medication .preventing potential medication or food interactions .honoring resident choices and preferences, consistent with his or her care plan .Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) .If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose . This policy did not address nursing staff contacting the Physician to inform of late and/or missed administration.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30675</p> <p>This citation pertains to intake #MI00143647.</p> <p>Based on observation, interview and record review, the facility failed to provide timely incontinence care for (R9), and provide routine showers for (R56) from five residents reviewed for Activities of Daily Living (ADL), and multiple residents that attended the confidential resident council meeting.</p> <p>Findings include:</p> <p>Review of a complaint reported to the State Agency included allegations that residents were left sitting in their wet/soiled briefs for long periods of time.</p> <p>R9:</p> <p>On 5/6/24 from 10:42 AM to 12:39 PM, continuous observations were made of R9 without staff checking for, or providing incontinence care.</p> <p>On 5/6/24 at 10:42 AM, R9 was seated in a wheelchair just inside the room. When asked how they were doing, R9 reported they were brought back to their room because they were wet (urinary incontinence). R9 further reported they had been waiting a while and it was uncomfortable.</p> <p>On 5/6/24 at 10:50 AM, Certified Nursing Assistant (CNA 'V') brought an ice cart just outside R9's room. CNA 'V' was observed asking R9 why they were brought back to their room and proceeded to push the resident further into the room, next to their bed, turn the television on and provide a cup of water. CNA 'V' was not observed asking or checking anything regarding incontinence care.</p> <p>On 5/6/24 at 12:39 PM, R9 was now observed in the main dining room.</p> <p>On 5/6/24 at 1:00 PM, CNA 'V' (who was assigned to R9) was asked about whether they had toileted the resident prior to taking them to the dining room, CNA 'V' stated She didn't say anything to me. She's a sit to stand (type of mechanical lift) so would need two people. I'll get her as soon as we're done in here (lunch meal). CNA 'V' was informed that the resident had been complaining of being wet and uncomfortable much earlier and had reported someone had brought them to their room for being wet. CNA 'V' denied being made aware by anyone that the resident was wet. When asked how often residents should be checked for incontinence CNA 'V' reported that should be every two hours and acknowledged that had not been done for R9.</p> <p>On 5/7/24 at 8:20 AM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's process for providing incontinence care to residents, the DON reported should be at least every couple hours.</p> <p>Review of the clinical record revealed R9 was admitted into the facility on [DATE] with diagnoses that included: unspecified dementia without behavioral disturbance, Alzheimer's disease, and glaucoma.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to the Minimum Data Set (MDS) assessment dated [DATE], R9 had moderate difficulty hearing with no hearing aid, usually makes self-understood and usually understands others, had clear speech, scored 12/15 on the Brief Interview for Mental Status exam (which indicated moderately impaired cognition), had no behavior concerns, was always incontinent of bowel and bladder, and was not on a toileting program.</p> <p>Review of R9's care plan included:</p> <p>An ADL care plan initiated 10/28/23 that identified interventions for:</p> <p>Toileting: Resident requires physical assistance. Initiated on 12/12/23.</p> <p>An incontinence care plan initiated 10/28/23 that identified interventions for:</p> <p>Provide pericare after each incontinent episode. Initiated on 10/28/23.</p> <p>Resident Council interview:</p> <p>On 5/7/24 at 10:30 AM, a resident council interview was conducted with 11 residents who wished to remain anonymous. When asked about whether they had concerns regarding not receiving showers or having to wait prolonged periods of time for toileting/incontinence care, nine of the 11 residents reported ongoing concerns. Responses included:</p> <p>Showers are only once a month.</p> <p>They (nursing staff) come in the middle of the night around 3:00/4:00 AM to tell me I'm getting a shower.</p> <p>I had a cast on my foot and when I finally got it off, they said I missed my scheduled day and I couldn't get one. Told me it wasn't my day.</p> <p>According to the facility's policy titled, Bowel and Bladder Management dated 11/28/2017:</p> <p>.Urinary incontinence is the involuntary loss or leakage of urine .The resident's plan of care will be individualized to address the issue, goals and appropriate interventions .</p> <p>49272</p> <p>R56</p> <p>On 5/6/24 at 9:57 AM, R56 was observed sitting up in a wheelchair. R56 reported only receiving 2 showers since their admission (on 4/11/2024) and expressed displeasure related to missing scheduled showers.</p> <p>Review of the clinical record revealed R56 was admitted to the facility on [DATE] with diagnoses that included: muscle weakness and polyarthritis.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to the Minimum Data Set (MDS) assessment dated [DATE], R56 scored 15/15 (which indicated intact cognition).</p> <p>On 5/8/24 at 12:31 PM, DON was queried regarding their current process for documenting resident showers. The DON reported that resident showers should be documented in the electronic health record but they are also documented on paper (shower sheets).</p> <p>A review of the R56's shower task report and of the paper shower sheets provided by the DON revealed resident received one shower on 4/27/24 and refused one shower on 4/24/24. No additional showers were documented and no rationale was provided for the missed showers.</p> <p>A review of the facilities Shower/Tub Bath policy revealed in part The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observed the condition of the resident's skin. The facility provides person centered care thus the resident chooses the type of bath and the preferred time and frequency they receive their shower or bath. The facility encourages the resident to take a minimum of 2 showers or baths a week. Based on this there may not be a printed bath schedule. Baths or showers are documented in point of care or care tracker.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283</b></p> <p>Based on observation, interview and record review, the facility failed to consistently implement interventions to prevent the development of a new pressure ulcer and/or worsening of one facility acquired pressure ulcer for one resident (R42) and failed to ensure skin assessments were completed for one (R9) of three residents reviewed for pressure ulcer prevention and management.</p> <p>Findings include:</p> <p>R42</p> <p>R42 was long-term resident of the facility, originally admitted to the facility on [DATE]. R42 was recently readmitted after an extended hospital stay due to pneumonia from 2/4/24 and 4/8/24. R42's admitting diagnoses included chronic obstructive pulmonary disease (COPD), heart failure, respiratory failure, and kidney failure. Based on the Minimum Data Set (MDS) assessment dated [DATE], R42 needed substantial staff assistance to roll/reposition in bed and they were dependent on staff assistance with a Hoyer (total body lift) to get in and out of their bed. R42 had a Brief Interview of Mental Status (BIMS) score of 14/15, based on an assessment dated for 4/9/24, indicative of intact cognition.</p> <p>An initial observation was completed on 5/6/24, at approximately 10 AM. R42 was observed laying on their bed, on their back. R42 was laying on a regular mattress and the bed had two assist bars/rails. R42's feet were resting flat on the mattress. There was a wheelchair parked across the bed and there was an heel offloading boot on the chair. There was a low air loss mattress placed against the wall between R42 and their roommate's bed. During this observation an interview was completed. R42 reported they recently returned from the hospital. A staff member arrived during the interview.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A follow up observation was completed at approximately 11:15 AM. R42 was observed on the bed, laying on their back as in the same position before. One heel boot was on the chair across from the bed and the low air loss mattress was on the floor against the wall, between the two beds. R42 was queried about if they could move their legs and roll/reposition in their bed, they reported that they needed help. They were able to partially slide and bend their knees and hips but not able to totally offload their heels. When queried if they could roll their body, R42 reported that they needed staff assistance and they could do a little. They were unable to roll their trunk or use their upper extremities to reach the assist bars and reposition. R42 reported that they used assist bars/rails when staff were assisting them. R42 had one extra regular size pillow between the assist bar and their body. There were no positioning wedges/assistive devices to off load bony prominences on the back while they were in bed. R42 was queried about the low air loss mattress that was placed against the wall. R42 reported that mattress was for them. The mattress was delivered a few days ago, and staff were supposed to change it today. When queried if staff were putting their heel boots on, R42 reported that they have not had the boot on for the last several days. There was only one boot on the chair, R42 reported that they did not know where the other boot was. Later that day, another follow-up observation was completed at approximately 3:00 PM and 4:40 PM. R42 was observed in their bed in a regular mattress, heels not supported. The low air loss mattress and one heel boot were in the same location as earlier. During the observation at 4:40 PM, R42 was queried why the mattress was not on their bed. R42 reported that they were not sure. R42 also added that they needed two staff members to assist them out of bed. R42 reported that they were not able to taste the food and they had lost weight.</p> <p>On 5/7/24, at approximately 8:50 AM, R42 was in their bed and staff were assisting them. The low air loss mattress was on the floor, placed against the wall. A few minutes later staff members had left the room. When observed, R42 was lying on a regular mattress, both heels were flat on the bed. The (one) heel bot was on the chair across from the bed, same place as yesterday. R42 was queried about the low air loss mattress. R42 reported that they were waiting for the staff to replace the mattress. At approximately 9:20 AM, CNA (Certified Nursing Assistant) X was in R42's room and they reported that they were waiting for another staff member to assist them to get R42 out of bed.</p> <p>Review of R42's Electronic Medical Record (EMR) revealed that R42 had a facility acquired stage 2 pressure ulcer on their coccyx. A practioner progress note dated 5/3/24 at 14:26 titled pressure ulcer unavailability read in part Coccyx (tail bone area) pressure: Length = 0.8, Width =0.8, Depth=01, stage II, Right buttock - abrasion: length - 1.0, width = 3.3, depth = 0.1 Resident has Hgb (hemoglobin) 7.5, weakness, poor skin turgor. Resident educated on importance of eating all meal .low air loss, reposition as tolerated .wound incidence is unavoidable due to identified risk factors: obesity, diabetic complications factors, vascular complicating factors, incontinence, non-compliance, impaired mobility . It must be noted that ordered low air loss mattress from 5/3/24 was not implemented until 5/7/24.</p> <p>Reviewed of R42's Braden (a scale to identify the risk for pressure ulcer) Score between 4/8/24 and 5/6/24 revealed a scores between 14-16, indicative of moderate risk. A Registered Dietician (RD) comprehensive assessment dated [DATE] revealed that R42 had significant weight loss since readmission to the facility that was not planned. R42 had decreased appetite and was receiving supplements and they were monitoring their intake and weight.</p> <p>Review of R42's care plan revealed the interventions for the actual skin impairment on their coccyx and R buttock that included keep boots on while in bed for protection, encourage/assist with turning and repositioning, identify potential causative factors and eliminate/resolve where possible.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of wound care practioner note dated 4/26/24 revealed the treatment plan that included, turn-reposition every 2 hours; avoid direct pressure to the wound site, facility pressure injury prevention protocol, offload bilateral heels.</p> <p>Review of R42's Kardex (care plan/care card that provides resident specific care information to CNAs) did not reveal any resident specific information such as heel boots, turning and repositioning, low air loss mattress etc.</p> <p>An interview was completed with the covering unit manager L on 5/7/24, at approximately 9:20 AM. Unit manager L reported that they were covering for the 2nd floor unit manager. Unit manager was queried about R42 and what were the interventions that place for the pressure ulcer to prevent worsening. They reported that turning schedule, seating schedule, barrier cream, and low air loss mattress or any appropriate pressure revolving surface etc. Unit manger L was queried why the low air loss mattress that was ordered was not in place. Unit manager L reported that they did not realize that mattress was for R42. They added that R42 was out of bed during lunch on 5/6/24, had they known yesterday they have notified maintenance to replace it while R42 was sitting up in their wheelchair. Unit manager was queried about the offloading heel boots that were not on during multiple observations. Unit manager L reported that they understood the concern and they would check and make sure the heel boots were on.</p> <p>An interview was a completed with CNA X on 5/7/24 at approximately 9:40 AM. CNA X confirmed that they were assigned to care for R42 for that shift and they were not a facility employee and they are working through an agency. CNA X reported that prior to this shift they had worked at the facility a few different times. CNA X was queried how did know what type of care/assistance they needed to provide for their assigned residents. They reported that they received information from the CAN who worked the previous shift during their rounding at the start of their shift. When queried further they reported that they can also check their Kardex via their electronic charting system. CAN X was queried about the heel boots for R42 and they reported they did not receive any information on boots. During this interview covering unit manager for 2nd floor L came in an notified the CNA X to make sure that R42 had heel their boots on bed.</p> <p>An interview with maintenance director Y was completed on 5/7/2, at approximately 10 AM, while they were in R42's room, replacing the mattress. Maintenance Director Y was queried about the mattress and when they had arrived. They reported it was since 5/3/24. Maintenance director was queried about the facility notification/communication process. They reported that they had an electronic notification system to initiate all maintenance requests and they were not being sued consistently by the staff. They were not able to replace it on 5/3/24 and they did not work the weekend. When queried if they had any support to assist with any maintenance needs on weekends, they stated that they did not have an assistant and they were covering for any maintenance needs on weekends. They also reported that they were not aware when R42 was out of bed yesterday.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with Director of Nursing (DON) was completed on 5/7/24, at approximately 11:25 AM. DON was queried on the facility process for prevention and or worsening of pressure ulcer for residents who were at risk. DON reported that completed the Braden assessment and monitored weekly and if a resident had wound they were followed by the wound care practioner. They also added that were implementing repositioning every 2 hours or as needed, positioning wedges, heel protectors, barrier cream etc. Surveyor shared the observations with the DON and queried why the interventions that were ordered for R42 were not implemented and how did they ensure that they were followed through. DON reported that should have been implemented and they were making sure that they were in place by rounding. DON reported that they understood the concern and they would follow up.</p> <p>A facility provided document titled Skin Protection Guideline read in part,</p> <p>To provide evidence-based standards for care and treatment of skin.</p> <p>To ensure residents that admit and reside at our facility are evaluated and provided individualized interventions to prevent, reduce and treat skin breakdown.</p> <p>Guideline:</p> <p>Our facility a process to identify residents with risk or at risk for developing a pressure injury.</p> <ol style="list-style-type: none"> <li>1. Upon admission/ readmission</li> <li>2. Transfer out/In</li> <li>3. With significant changes in condition</li> <li>4. Routinely through the MDS Assessment Process</li> </ol> <p>Planning:</p> <p>Interventions for prevention, removing and reducing the predicting factors for skin breakdown. The plan of care will be individualized:</p> <ol style="list-style-type: none"> <li>1. As part of the admission process</li> <li>2. Reviewed quarterly.</li> <li>3. Updated with significant changes in condition.</li> <li>4. With new or modified interventions.</li> </ol> <p>Interventions:</p> <p>Interventions for prevention, removing and reducing predicting factors, and treatment for skin may include (this list ins not all inclusive):</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> <li>1. Selection of an individualized support surface for bed and seating to enhance pressure re- distribution.</li> <li>2. Specified through clinical evaluation.</li> <li>3. Adaptive equipment and seating support to encourage correct anatomical alignment.</li> <li>4. Elevating heels (off-loading all pressure) for residents that cannot turn and reposition themselves or for residents that have diminished sensory perception of lower extremities that may affect an independent ability to turn, reposition, and off-load pressure .</li> </ol> <p>30675</p> <p>R9</p> <p>On 5/6/24 at 10:42 AM, R9 was observed sitting in their wheelchair just inside the room. When asked how they were doing, R9 reported they were brought back to their room because they were wet (urinary incontinence) and pointed to their peri area. R9 further reported they had been waiting a while and they were uncomfortable.</p> <p>On 5/6/24 at 10:50 AM, Certified Nursing Assistant (CNA 'V') entered the room and asked the resident Why they bring you back in your room? Why they bring you back in here? CNA 'V' then proceeded to move the resident further into their room next to their bed, pass ice water and exited the room.</p> <p>Continuous observations of R9 from 10:42 AM to 12:30 PM revealed no nursing staff had offered, checked, or assisted with any toileting and/or incontinence needs.</p> <p>On 5/6/24 at 12:39 PM, R9 was now observed seated at a table in the main dining room with other residents eating lunch.</p> <p>On 5/6/24 at 1:00 PM, CNA 'V' was asked if they were assigned to R9 and confirmed they were. When asked about whether they had toileted R9 prior to taking them to the dining room for lunch, CNA 'V' stated, She didn't say anything to me. She's a sit to stand so would need two people. I'll get her as soon as we're done in here. CNA 'V' was informed that R9 had been complaining of being wet and uncomfortable a while earlier and had also reported someone had brought them to their room for being wet. CNA 'V' denied anyone letting them know of that. When asked even if they weren't told, how often should they be checking residents for incontinence, CNA 'V' reported that should be every two hours and acknowledged that had not been done for R9.</p> <p>On 5/7/24 at 8:20 AM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's process for providing incontinence care to the residents, the DON reported should be at least every couple hours.</p> <p>Review of R9's clinical record revealed the last documented (most recently completed) skin evaluation was 2/29/24. According to the physician orders included an order on 10/30/23 for, Skin Checks Weekly - complete Skin Evaluation in (electronic clinical record) on admission and weekly on assigned day - every evening shift every Wed for skin check.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the clinical record revealed R9 was admitted into the facility on [DATE] with diagnoses that included: unspecified dementia without behavioral disturbance, Alzheimer's disease, nutritional deficiency, adjustment disorder with anxiety, glaucoma, and unspecified atrial fibrillation.</p> <p>According to the Minimum Data Set (MDS) assessment dated [DATE], R9 had moderate difficulty hearing with no hearing aid, usually makes self understood and usually understands others and had clear speech, had moderately impaired cognition, had no behavior concerns, was always incontinent of bowel and bladder, and not on a toileting program, did not have a pressure ulcer, but was at risk.</p> <p>On 5/8/24 at 10:11 AM, the facility was requested to provide any skin assessments for R9 since February 2024. Review of the Evaluations and Misc tab in the EMR revealed no assessments. The Skin &amp; Wound tab revealed a Braden score of 14 (moderate risk of developing pressure ulcers) from 2 months ago.</p> <p>On 5/8/24 at 10:35 AM, an observation of R9's skin was conducted with Nurse 'D' and revealed no concerns with skin care at this time.</p> <p>On 5/8/24 at 11:00 AM, further review of the physician orders included an order for Skin Checks Weekly - complete Skin Evaluation in (electronic health record) on admission and weekly on assigned day every day shift every Wed for skin check Open and document assessment under eval tab had been initiated on 5/7/24 to start on 5/8/24 (after concern was identified during the survey).</p> <p>On 5/8/24 at 11:25 AM, the DON was asked about R9's lack of skin assessments from 3/1/24 until 5/8/24 and the DON confirmed R9 had no skin assessments during this time and acknowledged they were worried of what would be found when the skin assessment was completed earlier and was happy to hear there wasn't any breakdown at this time. They did acknowledge the concern with lack of monitoring and reported they would have to continue to follow-up.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>30675</p> <p>Based on observation, interview and record review, the facility failed to ensure an environment was free from accident hazards regarding storage of sharps (blood sugar testing lancets) in one of four medication carts reviewed for medication storage. This has the potential to affect multiple residents on the first floor.</p> <p>Findings include:</p> <p>On 5/7/24 at 8:15 AM, observation of the first floor medication cart revealed concerns with storage of sharps. There was a small, white plastic container with a handle (no covering/lid) that contained several items including approximately 40 individual blood sugar testing lancets. There was no nurse in view of the cart, or surrounding area.</p> <p>On 5/7/24 at 8:18 AM, Nurse 'W' who was currently assigned to this medication cart and Nurse 'C' (Agency Nurse arriving to start shift and take over the medication cart) approached the cart and were asked about the storage of the lancets. Nurse 'W' reported they should be in the cart and was unable to explain why they were stored in the storage container on the top of the cart.</p> <p>On 5/7/24 at 8:19 AM, the Director of Nursing (DON) was informed of the observations of the storage of lancets and reported those should not have been stored on top of the cart. The DON then directed Nurse 'W' if they could place the storage container in the medication cart.</p> <p>On 5/8/24 at 5:15 PM, the Corporate Clinical Support Staff questioned the concern with the storage of the lancets and was informed of the observations and unsafe, hazardous environment due to the sharps stored on top of the medication cart.</p> <p>According to the facility's documentation provided for storage of sharps, the Medication Storage Checklist Tool dated 6/2023 did not address the facility's process for storage of lancets (sharps) before use.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39592</p> <p>This citation pertains to Intake MI00144347</p> <p>Based on observation, interview and record review, the facility failed to ensure complete and accurate documentation of intermittent (straight) catheterization for one (R74) of two residents reviewed for catheters. Findings include:</p> <p>On 5/6/24 at 11:39 AM, R74 was observed sitting in a wheelchair in their room. R74 was asked about care at the facility. R74 explained early that morning, they were having difficulty urinating, they were locked-up and it was very uncomfortable, so they asked if the nurse could straight catheterize (cath) them, the midnight nurse told them they would have to wait for the day nurse to do it as it was almost shift change . and when the day nurse finally did, it took more than one urinal to hold it all. It should be noted that the urinal in R74's room held 1000 milliliters (ml) or 1 liter (L).</p> <p>Review of the clinical record revealed R74 was admitted into the facility on [DATE] with diagnoses that included: quadriplegia incomplete (weakness but not total paralysis), neuromuscular dysfunction of bladder and retention of urine. According to the Minimal Data Set assessment dated [DATE], R74 was cognitively intact.</p> <p>Review of R74's physician orders revealed an order with a start date of 4/17/24 that read, Straight catheterize resident Q6hrs (every six hours) if bladder scan over 250ml (milliliters), if bladder scan unavailable straight catheterize resident Q6hrs.</p> <p>Review of R74's May 2024 Treatment Administration Record (TAR) revealed a checkmark, indicating the treatment was completed on 5/6/24 at 8:00 AM by Registered Nurse (RN) D. There was no documentation of the amount of urine that was obtained from the procedure.</p> <p>On 5/6/24 at 12:53 PM, RN D was interviewed and asked if he had performed a straight cath on R74 that morning. RN D explained he had done it first thing that morning and had gotten 1200 ml of urine. RN D was asked where the amount of urine obtained from a straight cath was documented. RN D explained the nurse would have to put it in a progress note. RN D was asked if they had received any report from the midnight nurse about R74. RN D explained the midnight nurse had told him that she had gotten 900 ml at 9:00 PM the night before.</p> <p>Further review of R74's Treatment Administration Record revealed on 5/5/24 both the 4:00 PM and the 8:00 PM boxes for the straight cath were left blank, indicating they were not done.</p> <p>On 5/6/24 at 1:24 PM, the Director of Nursing (DON) was interviewed and asked if the amount of urine obtained from a straight cath should be documented. The DON explained the amount should be documented so the doctor would be aware of how much urine was being retained without catheterization. When informed of the lack of documentation of amounts of urine for R74, the DON explained she would look into it.</p> <p>No further documentation was provided prior to the end of the survey.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283</b></p> <p>Based on observation, interview, and record review the facility failed to have a system in place prior to installing assist bars/rails to ensure appropriate consent, assessment, and physician orders were completed with ongoing monitoring and assessment for eight (R32, R42, R9, R14, R21, R25, R26, R57, and R74) resulting in the potential for inappropriate use and or injury from the device. This deficient practice has the potential to affect all 76 residents of the facility.</p> <p>Findings include:</p> <p>R32</p> <p>R32 was a long-term resident of the facility. R32 was admitted to the facility on [DATE]. R32's admitting diagnoses included Gout, insomnia, restlessness, and viral hepatitis. Based on the Minimum Data Set Assessment (MDS) dated [DATE], R32 had Brief Interview of Mental Status (BIMS) score of 8/15, indicative of moderate cognitive impairment. R32 had assist rails/bars on their bed. Review of R32's Electronic Medical Record (EMR) did not reveal any initial/follow-up assessment(s) and clinical rationale for use of assist bars/rails in bed. There was no consent and no physician orders for use of assist rails/bars. There was no care plan that indicated the need for the device in their bed.</p> <p>R42</p> <p>R42 was long-term resident of the facility, originally admitted to the facility on [DATE]. R42 was recently readmitted after an extended hospital stay due to pneumonia from 2/4/24 and 4/8/24. R42's admitting diagnoses included chronic obstructive pulmonary disease (COPD), heart failure, respiratory failure, and kidney failure. Based on the Minimum Data Set (MDS) assessment dated [DATE], R42 needed substantial staff assistance to roll/reposition in bed and they were dependent on staff assistance with a Hoyer (total body lift) to get in and out of their bed. R42 had a Brief Interview for Mental Status (BIMS) score of 14/15, based on an assessment dated for 4/9/24, indicative of intact cognition. R42 had assist rails on their bed. Review of R42's EMR did not reveal any initial/follow up assessment(s) and clinical rationale for use of assist bars/rails in bed. There was no consent and no physician orders for use of assist rails/bars. There was no care plan that indicated the need for the device in their bed.</p> <p>R21</p> <p>R21 was a long-term resident of the facility, originally admitted on [DATE]. R21's admitting diagnoses included stroke, diabetes, and cancer. Based on the MDS assessment dated [DATE], R21 had a BIMS score of 15, indicative of intact cognition. Review of R21's EMR did not reveal any initial/follow up assessment(s) and clinical rationale for the use of assist bars/rails in bed. There was no consent and no physician orders for use of assist rails/bars. There was no care plan that indicated the need for the device in their bed.</p> <p>R14</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R14 was a long-term resident of the facility, originally admitted on [DATE]. R14's admitting diagnoses included depression, anxiety disorder, and failure to thrive. Based on MDS assessment dated [DATE], R14 had a BIMS score of 15, indicative of intact cognition. Review of R14's EMR did not reveal any initial/follow up assessment(s) and clinical rationale for use of assist bars/rails in bed. There was no consent and no physician orders for use of assist rails/bars.</p> <p>R25</p> <p>R25 was a long-term resident of the facility, originally admitted on [DATE]. R25's admitting diagnoses included polyneuropathy (disease affecting nerves of many parts of the body), depression, anxiety, and arthritis. Based on MDS assessment dated [DATE], R25 had a BIMS score of 15, indicative of intact cognition. Review of R25's EMR did not reveal any initial/follow up assessment(s) and clinical rationale for use of assist bars/rails in bed. There was no consent and no physician orders for use of assist rails/bars. There was no care plan that indicated the need for the device in their bed.</p> <p>R9</p> <p>R9 was a long-term resident of the facility, originally admitted on [DATE]. R9's admitting diagnoses included brain dysfunction and dementia. Based on the MDS assessment dated [DATE], R9 had a BIMS score of 12/15, indicative of moderate cognitive impairment. Review of R9's EMR did not reveal any initial/follow up assessment(s) and clinical rationale for use of assist bars/rails in bed. There was no consent and no physician orders for use of assist rails/bars. There was no care plan that indicated the need for the device in their bed.</p> <p>R26</p> <p>R26 was a long-term resident of the facility, originally admitted on [DATE]. R26's admitting diagnoses included stroke, Peripheral Vascular Disease (lack of circulation/progressive disease of blood vessels) and heart disease. Based on MDS assessment dated [DATE], R26 had a BIMS score of 13/15, indicative of intact cognition. Review of R26's EMR did not reveal any initial/follow up assessment(s) and clinical rationale for use of assist bars/rails in bed. There was no consent and no physician orders for use of assist rails/bars.</p> <p>R57</p> <p>R57 was a long-term resident of the facility, originally admitted on [DATE]. Based on the MDS assessment dated [DATE], R57 had a BIMS score of 10/15, indicative of moderate cognitive impairment. Review of R57's EMR did not reveal any initial/follow up assessment(s) and clinical rationale for use of assist bars/rails in bed. There was no consent and no physician orders for use of assist rails/bars.</p> <p>R74</p> <p>R74 was admitted to the facility on [DATE]. R74's admitting diagnoses included spinal cord injury and arthritis. Based on MDS assessment dated [DATE], R74 had a BIMS score of 14/15, indicative of intact cognition. Review of R74's EMR did not reveal any initial/follow up assessment(s) and clinical rationale for use of assist bars/rails in bed. There was no consent and no physician orders for use of assist rails/bars. There was no care plan that indicated the need for the device in their bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was completed with the Director of Rehab (DOR) Z on 5/7/24, at approximately 1:10 PM. DOR Z was queried about the process for assist bar/rail evaluation and they reported that physical (PT) and occupational therapy (OT) addressed the need for assist bars during their evaluations after admission to the facility. If there is a need, they were notifying maintenance via the facility's electronic notification system and nursing team. DOR Z was queried how they were addressing the need for residents who were admitted /readmitted and they were not appropriate for therapy or did not receive any therapy services, DOR Z did not provide any response. DOR Z was queried specifically on where in therapy evaluation they had documented the clinical rationale and the needs for assist bars/rails in the bed and asked to show the surveyor on R42's evaluation. DOR Z shared the PT and OT evaluations and reported that they did not document the need in their OT evaluation and they had thought PT was documenting on their evaluation.</p> <p>An interview with physical therapist AA was completed on 5/7/24, at approximately 1:25 PM. DOR Z was present during the interview. Physical therapist AA was queried about their documentation of their assessment and clinical rationale of assist bars/rails during PT evaluation. Physical therapist AA reported that they did not document in their evaluation. They added if they felt there is a need for assist rail/bars they just notified maintenance and nursing; did not have any documentation on the need for assist rails/bars on their assessment.</p> <p>An interview with Director of Nursing (DON) was completed on 5/7/24, at approximately 11:35 AM. DON was queried about the facility process to assess and document the rationale and need for assistive rails/bars in bed. The DON reported that therapy was completing the assessment and would notify maintenance for installation. The DON was queried about the informed consent, physician orders and care plan for the device and they reported that the nursing team followed-up and completed the rest of the documentation. The DON was queried specifically on R42 and they had checked the EMR and notified that they did not find any documentation. The DON shared a blank evaluation that should have been completed. The DON was notified of the concern and other residents with assist rails/bars that did not have any documentation that included initial/ongoing assessment(s), consent, physician order and care plan. The DON reported that they understood the concern and would follow up with their team.</p> <p>A facility provided document titled Bed Rail Device Guideline read in part,</p> <p>Purpose: It is the practice of this facility to identify and reduce safety risks and hazards commonly associated with bedrail use. A dual faceted approach will be used to achieve sustainable quality outcomes, including 1. Regular bed maintenance and 2. Individual bed rail evaluations. In response to the requirement of providing for a safe clean comfortable and homelike environment the facilities regular maintenance program will include regular inspection of all bed systems (example rails, positioning bars frames and mattresses and operational components) to ensure they are clean, comfortable, and safe.</p> <p>The facility will also ensure individual resident bed rail evaluations are performed on a regular basis. Individual bedrail evaluations will include data collection analysis and determination of potential alternatives to bed rail use. When bed rails are deemed necessary and appropriate the facility will provide education to the resident are representative pertaining to the risk and benefits of bedrail use. The facilities priority is to ensure safe and appropriate bed rail use .</p> <p>Resident Evaluation:</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility serves A diverse population, including those individuals who meet the criteria for skilled care under Medicaid and Medicare guidelines. While the population is diverse, individual residents differ in their needs, preferences, and vulnerabilities.</p> <p>a. Before admission, prospective residents will be screened to help determine if care needs may necessitate specialized needs (example bariatric equipment) or accessories example bed rails.</p> <p>b. Upon admission, readmission or change of condition, residents will be screened to determine:</p> <ol style="list-style-type: none"> <li>1.level of independence with bed mobility</li> <li>2. bed comfort level.</li> <li>3. if the bed meets manufacturers recommendations and specifications pertaining to the resident height and weight</li> <li>4. asses the need for special equipment or accessories example bed rails.</li> </ol> <p>c. Evaluate the resident to identify appropriate alternative prior to installing bed rails.</p> <p>d. Evaluate the resident for risk of entrapment from bed rails prior to installation.</p> <p>e. Bed rails will not be used when used for convenience or discipline.</p> <p>f. The facility will document ongoing need for use of bed rail and the least restrictive alternative.</p> <p>g. Review the risk and benefits with the resident and resident representative.</p> <p>h. Obtain informed consent.</p> <p>i. Obtain physician order for medical symptom evaluated and the need for bedrail use.</p> <p>j. The resident care plan will include the use of bed rails as evaluated .</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30675</p> <p>This citation pertains to intake #MI00141921.</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff was provided for the residents that resided on the first floor (including R72 and multiple residents from the confidential resident council meeting), resulting in delayed medication administration and increased potential for unmet care needs.</p> <p>Findings include:</p> <p>Review of allegations reported to the State Agency included complaints of not having adequate nursing staff to provide timely care and assistance.</p> <p>Review of the resident council minutes included the following concerns:</p> <p>On 2/28/24, .there are still issues with the call lights not being answered in a timely manner when agency is in the building .</p> <p>On 3/27/24, .States that there isn't enough of nursing in the building .</p> <p>On 5/7/24 at 10:30 AM, during the confidential resident council meeting, residents were asked if they felt there was adequate nursing staff to meet their needs. Nine of the 11 residents in attendance reported ongoing concerns. Several residents voiced concerns that they frequently received their medications late on the first floor, and many expressed concerns with continued delayed call light response due to not having sufficient nursing staff. Other resident responses included:</p> <p>My food is cold, it waits 40 minutes in hallway because staff get to it in time.</p> <p>I'm on the first floor and showers are only given once a month.</p> <p>The worst nursing staff are the contracted agency staff. They're always in the hallways on their phones.</p> <p>They go in my room and hide out. Found them when I returned to my room.</p> <p>R72</p> <p>On 5/7/24 at 11:00 AM, R72 reported concerns with not getting their scheduled medications and asked, Is it my job to ask for my scheduled medications? I was supposed to take them at 9:00 AM but I still haven't received any for today.</p> <p>According to the profile information, R72 was their own responsible party.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  The Villa at Green Lake Estates		STREET ADDRESS, CITY, STATE, ZIP CODE  6470 Alden Dr Orchard Lake, MI 48324	
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to the Minimum Data Set (MDS) assessment dated [DATE], R72 had no communication concerns, and received high-risk drug class medication which included diuretic, antiplatelet, and hypoglycemic medication.</p> <p>On 5/7/24 at 11:09 AM, review of R72's Medication Administration Records (MARs) revealed that none of the 9:00 AM medications had been documented as administered yet. Additionally, there was no documentation the physician had been notified and/or approved the medication to be given outside the scheduled administration time.</p> <p>Review of the physician orders and MAR revealed the following nine medications were prescribed to be administered at 9:00 AM but contained blank entries:</p> <ol style="list-style-type: none"> <li>1) Clopidogrel Bisulfate Oral Tablet 75 MG Give 75 mg by mouth one time a day for blood clots (an antiplatelet medication).</li> <li>2) Metformin HCl (Hydrochloric Acid) (an anti-diabetic medication) Oral Tablet 1000 MG Give 1000 mg by mouth two times a day for DM (Diabetes Mellitus) (at 9:00 AM and 5:00 PM).</li> <li>3) Glipizide Oral Tablet (an anti-diabetic medication) 10 MG Give 10 mg by mouth one time a day for edema &lt;sic&gt;</li> <li>4) Pioglitazone HCl (Hydrochloric Acid) (an anti-diabetic medication) Oral Tablet 45 MG Give 45 mg by mouth one time a day for DM.</li> <li>5) Lisinopril (used to treat high blood pressure) Oral Tablet 10 MG Give 10 mg by mouth one time a day for HTN (Hypertension).</li> <li>6) Carvedilol (used to treat high blood pressure) Oral Tablet 12.5 MG Give 12.5 mg by mouth two times a day for HTN Take 1 tablet po (by mouth) bid (twice daily) with meals (at 9:00 AM and 5:00 PM).</li> <li>7) Aspirin Oral Capsule 81 MG (Milligrams) Give 81 mg by mouth one time a day for pain.</li> <li>8) Psyllium (used to treat constipation) Oral Capsule 400 MG Give 1 capsule by mouth one time a day for constipation.</li> <li>9) Fluticasone Propionate Nasal Suspension (used to treat allergies) 50 MCG (Micrograms)/ACT (Actuation) 2 sprays in each nostril one time a day for sneezing, itchy, or runny nose shake gently. Before first use, prime pump. After use, clean tip and replace cap.</li> </ol> <p>Further review of the clinical record revealed R72 was admitted into the facility on [DATE] with diagnoses that included: atherosclerotic heart disease of native coronary artery without angina pectoris, radiculopathy, major depressive disorder single episode, generalized anxiety disorder, type 2 diabetes mellitus without complications, ulcerative colitis, unstable angina, low back pain, other chronic pain, other chest pain, hypomagnesemia, benign prostatic hyperplasia with lower urinary tract symptoms, acute on chronic systolic heart failure, hyperlipidemia, ischemic cardiomyopathy, and essential hypertension.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/7/24 at 11:16 AM, an interview was conducted with Nurse 'C' who reported they were from a Staffing Agency (had been observed coming on duty earlier at 8:15 AM). When asked about whether they had completed administering resident's morning medications, Nurse 'C' reported they weren't sure how many residents they had left, but further expressed concern that they had 34 residents (actual census was 30 as total for unit is 32) and all had vitals and blood pressures to be done. When asked about R72, Nurse 'C' confirmed they had spoken to the resident earlier when the resident had asked them about the medication.</p> <p>On 5/7/24 at 11:30 AM, an interview was conducted with the Director of Nursing (DON). The DON was informed of the concerns with residents complaining in the resident council their medications were frequently late on the first floor and they acknowledged the concern and reported other staff such as the Unit Manager should be available to help when needed. When asked if they had ever considered an additional nurse, the DON reported it had been discussed but nothing had been done yet. The DON was informed of the concern that R72 and several others from the first floor had expressed concern with getting their medications late.</p> <p>On 5/7/24 at 1:45 PM, further review of R72's clinical record revealed the above 9:00 AM medications were now documented as administered by Nurse 'C'. There was no documentation that the attending physician had been notified and/or approved the late administration or what to monitor for. The documentation reflected no late entries and showed as if it had been administered at 9:00 AM.</p> <p>On 5/7/24 at 12:27 PM, the DON was asked about the facility's process for when medications were going to be administered late and reported the nurses have an hour before and an hour after the scheduled time, then needed to reach out to the physician to see if they can extend, still give, or hold the medication. When asked about nurse staffing for the first floor and whether the facility had considered increasing, the DON reported there had been discussion. When informed of the concerns regarding the observation and interview with staff and residents earlier, they reported other Nursing staff should be assisting when needed. The DON was asked how many residents required more than one person assistance on the first floor, and reported they would follow-up.</p> <p>On 5/8/24 at 3:07 PM, the DON reported that on 5/7/24, the census for first floor was 30, and when Nurse 'C' reported they had 34 residents, that was not correct since the unit only held a maximum of 32. The DON further reported that there were 11 of the 30 residents that required two person assistance with care needs.</p> <p>According to the facility's policy titled, Staffing dated Revised 4/2017:</p> <p>.Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services .</p> <p>According to the facility's policy titled, Administering Medications dated Revised April 2019:</p> <p>.Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions .Medications are administered in accordance with prescriber orders, including any required time frame .Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) .</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>39592</p> <p>On 5/7/24 at 8:24 AM, LPN F was interviewed by phone and asked how many nurses were usually assigned to the 1st floor of the facility. LPN F explained there was always only one nurse assigned to the 1st floor. LPN F was asked if morning medications were able to be passed to all residents on the 1st floor without being late. LPN F explained to get the medications done on time, she would have to start passing medications as soon as she arrived (day shift start time was 7:00 AM), but if there were any fires (issues requiring her attention) to be put out, the medications would be late. LPN F was asked if there were any ancillary or floor nurses that would help pass medications. LPN F explained the Unit Manager would help if there was an admission, but no one helped pass medications.</p> <p>On 5/8/24 at 9:15 AM, Registered Nurse (RN) D was interviewed and asked if there were ever more than one nurse assigned to the 1st floor. RN D explained there was always just one nurse on the 1st floor. RN D was asked if morning medication were able to be passed on time to all residents on the 1st floor. RN D explained he had to get started on medication pass as soon as he could, he was usually done with medications by 11:00 AM however, the cut off time for medications was 11:30 AM.</p> <p>Review of a facility document titled, Medication Pass Times revealed morning medication time was 9:00 AM. It should be noted, giving medications before 8:00 AM would be considered early administration, and giving medications after 10:00 AM would be considered late administration.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30675</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident prescribed psychotropic medication (Antipsychotic/AP) had adequate indication for use, appropriate consent to receive the medication, clinical rationale to support continued use in absence of mood/behavior symptoms, as well as identify and monitor resident specific behaviors and approaches for one (R179) of five residents reviewed for unnecessary medication, resulting in unnecessary use of psychotropic medication and the inability to monitor the effectiveness of the prescribed treatment due to lack of supporting documentation.</p> <p>Findings include:</p> <p>On 5/6/24 at 10:19 AM, R179 was observe laying in their bed. The resident reported they were in the facility for some therapy after recently falling and fracturing several ribs prior to admission.</p> <p>Review of the clinical record revealed R179 was initially admitted into the facility on [DATE] with diagnoses that included: spinal stenosis, multiple fractures of ribs, vascular dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, restlessness and agitation, and altered mental status.</p> <p>According to the profile section of the electronic medical record (EMR), R179 was listed as their own responsible party. There were no power of attorney documents in the clinical record, nor any documentation R179 had been deemed incompetent. The social service assessment was incomplete and flagged in the EMR as being two weeks late.</p> <p>According to the Minimum Data Set (MDS) assessment dated [DATE], R179 scored a 12/15 on the Brief Interview for Mental Status exam (which indicated moderately cognitively impaired), has little interest or pleasure in doing things for 7-11 days, has trouble falling or staying asleep, or sleeping too much for 2-6 days, feeling tired or having little energy for 7-11 days, feeling bad about yourself - or that you are a failure or have let yourself or your family down for 12-14 days (nearly every day), had trouble concentrating on things, such as reading the newspaper or watching television for 7-11 days (half or more of the days), moving or speaking so slowly that other people could have noticed, or the opposite - being so fidgety or restless that you have been moving around a lot more than usual for 2-6 days (several days), with a total mood severity score of 11; has no hallucinations or delusions; has no behavior concerns; received antipsychotic medication that were received on a routine basis only, with no gradual dose reduction (GDR) attempted and no physician documentation that a GDR was clinically contraindicated.</p> <p>Review of R179's physician orders included an antipsychotic medication that was present upon admission for Seroquel Oral Tablet 25 MG (milligrams) (Quetiapine Fumarate) Give 0.5 tablet by mouth at bedtime for Depression - to be given at 9:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plans revealed there was a care plan for R179's use of psychotropic medication that read, The resident uses psychotropic medications r/t (related to) dementia. This was initiated on 4/23/24.</p> <p>There was no identified resident-specific detail of clinical rationale for use of the antipsychotic medication, or what the target behaviors were for staff to monitor. (This would usually be identified on the social service assessment.)</p> <p>On 5/7/24 at 8:44 AM, an interview was conducted with the Social Service Director (SSD) who reported they had worked at the facility for about two years. When asked when social service evaluations should be completed, as R179's currently flagged it was now 15 days overdue, the SSD reported that should be completed within 72 hours. When asked why that had not been completed yet for R179, the SSD offered no explanation.</p> <p>When asked about R179's use of Seroquel for dementia and whether that was an appropriate indication, the SSD reported that was not.</p> <p>When asked about the consent for use of an antipsychotic medication, the SSD confirmed R179's spouse had signed a generic form with no identification of clinical rationale, or resident-specific targeted behaviors to monitor for. When asked why the resident's spouse signed, when the resident was not yet deemed incompetent, the SSD reported they thought psych had deemed the resident incompetent but that information was not in the clinical record.</p> <p>When asked who was responsible for identifying and implementing care plans for residents on psychotropic medication, the SSD reported that was social work and confirmed the care plan initiated did not identify any details for R179.</p> <p>The SSD was requested to provide any additional information to support why R179 was prescribed an antipsychotic medication, or any other supporting documentation. (There was no Behavior and Psychotropic Medication Evaluation provided by the end of the survey.)</p> <p>On 5/7/24 at 9:42 AM, the SSD provided additional documentation which included a competency evaluation by the facility's contracted Psychologist 'T' from 4/29/24 that indicated they felt the resident was not competent.</p> <p>The SSD also reported that the Medical Director (also R179's attending physician) evaluated R179 on 4/30/24 and felt the resident was competent and disagreed with Psychologist 'T'.</p> <p>Further review of the Medical Director's documentation included:</p> <p>On 4/30/24, .Mental capacity assessment: I have seen psychiatrist assessment suggesting that the patient does not have medical decision-making capacity. Understanding that the patient's cognition may wax and wane, during today's examination and Mini-Mental status examination, I did not find sufficient evidence to indicate that the patient does not have mental capacity necessary for medical decision-making . There was no specific documentation as to the specific clinical rationale with targeted behaviors, symptoms for use of the antipsychotic medication.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the clinical record on 5/8/24 at 12:23 PM revealed R179's there was no additional documentation or completed assessment since the discussion with the SSD on 5/7/24. Review of the social service assessment now indicated it was 16 days overdue, and the care plan had not been updated/ revised to include specific details for R179's use of antipsychotic medication, or consent obtained from the resident for continued use of the antipsychotic medication.</p> <p>According to the facility's policy titled, Psychotropic Medication Management dated 11/28/2017:</p> <p>.An antipsychotic (or neuroleptic) is a psychiatric medication primarily used to manage psychosis (including delusions or hallucinations), as well as disordered thought), particularly in schizophrenia and bipolar disorder .Interview resident, family or resident representative for insight into potential casual factors of mood, behavior or sleep issues/changes .If resident is currently receiving a psychoactive medication, the data collection and completion of the Behavior and Psychotropic Medication Evaluation will be completed after admission .The analysis will include review of current, if any, mood, behavior or sleep tracking, tracking and trending and review of potential antecedents, and factors such as frequency, time of day, intensity, location, and considerations listed .If medication is ordered, an appropriate diagnosis will be obtained .Risks and benefits will be explained and a copy provided to resident and/or responsible party .Informed consent including effects and potential side effects will be obtained from resident and/or resident representative for each psychoactive medication .Appropriate monitoring for mood/behavior/sleep, along with monitoring for side effects and medication efficacy, will be reviewed and/or initiated .Care plan will be initiated or revised to reflect pharmacological and individualized non-pharmacological interventions along with monitoring for efficacy .Resident and resident representative will be involved in the development of the care plan, to include conditions, risks, needs, behaviors, preferences, measurable goals and individualized interventions .</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30675</p> <p>This citation pertains to intake #MI00143647.</p> <p>Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen and ensure food items were labeled, dated and discarded when expired. This deficient practice had the potential to affect all residents that consume food from the kitchen.</p> <p>Findings include:</p> <p>On [DATE] from 9:08 AM - 10:00 AM, during an initial tour of the kitchen with Certified Food Manager (CFM 'N'), the following items were observed:</p> <p>There were personal items (bags and sweatshirts/jackets stored on top of the containers for bulk oatmeal. CFM 'N' reported those should not be stored on top of the food storage bins.</p> <p>According to the 2017 FDA Food Code section ,d+[DATE].11 Miscellaneous Sources of Contamination, FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - ,d+[DATE].</p> <p>The bin which contained white located near the desk of CFM 'N' was observed with the scoop stored inside the bin, with the handle resting in the rice. CFM 'N' confirmed the scoop should not have been stored inside the rice.</p> <p>According to the Food &amp; Drug administration (FDA) 2017 Model Food Code, Section ,d+[DATE].12 In-Use Utensils, Between-Use Storage, During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: .(B) In FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD with their handles above the top of the FOOD within containers or EQUIPMENT that can be closed, such as bins of sugar, flour, or cinnamon;</p> <p>When asked about the dish machine, CFM 'N' reported the high-temp dish machine has not been working for about two weeks. They reported a part was on order. When asked what their staff have been doing while waiting for the new part, CFM 'N' reported their staff were washing over here (dish machine area) and pointed to a hose in a bottle of bleach. When asked to explain further, CFM 'N' reported that had been set up by [Name of contracted equipment provider]. When asked since the conversion of the dish machine from high-temp to chemical, what were they doing to monitor the solution to ensure it was effectively sanitizing, CFM 'N' reported they had questioned it themselves but was told by [Name of contracted equipment provider] that wasn't needed. When asked to confirm how long the dish machine had been converted, CFM 'N' reported about a week. When asked what had been used prior to that, CFM 'N' reported they had used the three-compartment sink as well as disposable products.</p> <p>CFM 'N' was asked to provide any monitoring of the dish machine and the log revealed it was last completed on [DATE]. They confirmed there was no monitoring following this. They also reported there were no testing strips available to test the current chemical set-up.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>There were several red buckets with sanitizer solution stored in the three-compartment sink. Review of the last documented monitoring of the solution was on [DATE] at lunch. CFM 'N' confirmed the log was not completed for last night's dinner, or today's breakfast, and was unable to offer any explanation.</p> <p>According to the 2017 FDA Food Code section ,d+[DATE].14 Sanitizing Solutions, Testing Devices, A test kit or other device that accurately measures the concentration in mg/L of SANITIZING solutions shall be provided.</p> <p>According to the 2017 FDA Food Code section ,d+[DATE].116 Warewashing Equipment, Determining Chemical Sanitizer Concentration, Concentration of the SANITIZING solution shall be accurately determined by using a test kit or other device.</p> <p>According to the 2017 FDA Food Code section ,d+[DATE].11 Hot Water and Chemical, After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in: .(2) A contact time of at least 7 seconds for a chlorine solution of 50 mg/L that has a PH of 10 or less and a temperature of at least 38 C (100 F) or a PH of 8 or less and a temperature of at least 24 C (75 F).</p> <p>The ice machine cleaning log was last documented as completed on [DATE]. When asked how often this should be done, CFM 'N' reported that was to be done at least quarterly and was done by their Maintenance staff. Observation of the inside seal of the ice machine door with a flashlight revealed a build-up of pink/brownish colored debris. CFM 'N' confirmed the same observation and stated, Oh I see yes.</p> <p>The juice machine was observed with a vent on the side of the machine and an internal filter that was covered with thick, heavy dust debris. When asked who was responsible for cleaning/servicing the juice machine, CFM 'N' reported that was the juice company and they came once a week on Tuesdays. When asked if they came weekly, how did the debris accumulate, they were not able to offer any further explanation.</p> <p>According to the 2017 FDA Food Code section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, .(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>The walk-in freezer temperature monitoring log was last documented as done on [DATE]. There was a large plastic tray of pre-scooped individual ice cream containers. CFM 'N' removed the tray from the storage shelf and the tray was observed to have a small piece of paper that indicated it had been prepared on ,d+[DATE] with a use by date of ,d+[DATE]. CFM 'N' reported that should've been discarded.</p> <p>The walk-in refrigerator temperature log was last documented as completed on [DATE] for the morning shift. There were several large containers (80 oz) of Small Cottage Cheese stored on a shelf. Two of the containers had a manufacturer's printed use by date of [DATE] (one container was opened, one was unopened). The third container had a manufacturer's printed use by date of [DATE]. When asked who monitors the food for labeling, dating, and discarding of expired foods, CFM 'N' reported between their staff and them, they should've caught that.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>According to the 2017 FDA Food Code section ,d+[DATE].17: Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.</p> <p>On [DATE] at 12:00 PM, additional observation of the kitchen revealed the high-temp dish machine had been converted back to regular function. Per the Dining Area Manager (Staff 'M'), they reported the [Name of contracted equipment provider] had put in a heating element to temporarily correct the issue until the actual part is replaced. Staff 'M' further reported staff had to run the dish machine five times before using, in order to get it to maintain the higher temperature. Staff 'M' then proceeded to start to run the dish machine several times and after running, reported there was still an issue (not getting up to required sanitizing temperature) and that it had worked earlier.</p> <p>On [DATE] at 12:09 PM, [Name of contracted equipment provider] employee and Staff 'M' ran a test of the machine and confirmed the test strip did not turn black like it should and reported it would need further work.</p>

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NAME OF PROVIDER OR SUPPLIER  The Villa at Green Lake Estates		STREET ADDRESS, CITY, STATE, ZIP CODE  6470 Alden Dr Orchard Lake, MI 48324	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49272</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices with regards to Enhanced Barrier Precautions (EBP), and linen storage for eight of eight residents (R34,R21,R62,R57,R33,R74,R55 and R29) reviewed for EBP. Findings include:</p> <p>A review of the facility's Enhanced Barrier Precautions policy revealed in part Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply .Gloves and gown are applied prior to performing the high contact resident care activity .EBPs are indicated (when contact precautions do not other apply) for residents with wounds and/or indwelling devices regardless of MDRO colonization .Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE (personal protective equipment) required.</p> <p>R34</p> <p>On 5/6/24 at 9:50 AM, R34 was observed lying in bed with a large dressing on their right, lower leg. No signs were observed in or around R34's room announcing EBP, no PPE was observed readily available for staff to use. No PPE use was observed throughout the survey.</p> <p>Review of the clinical record revealed R34 was admitted into the facility on [DATE] with diagnoses that included: right foot compartment syndrome and peripheral vascular disease. According to the MDS (minimum data assessment) dated 4/22/24, R34 was cognitively intact and had a surgical wound.</p> <p>Review of R34's physician orders and care plans revealed no order or interventions for EBP.</p> <p>R21</p> <p>On 5/6/24 at 10:23 AM, R21 was observed lying in bed, they reported having a colostomy bag. No signs were observed in or around R21's room announcing EBP, no PPE was observed readily available for staff to use. No PPE use was observed throughout the survey.</p> <p>Review of the clinical record revealed R21 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: colostomy and surgical site infection following. According to the MDS assessment dated [DATE], R21 was cognitively intact.</p> <p>Review of R21's physician orders and care plans revealed an order assessment of colostomy bag but no order or interventions for EBP.</p> <p>R62</p> <p>On 5/5/24 at 10:47 AM, R62 was observed lying in bed with a tube feeding pump and pole at the bedside. No signs were observed in or around R62's room announcing EBP, no PPE was observed readily available for staff to use. No PPE use was observed throughout the survey.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the clinical record revealed R62 was admitted into the facility on [DATE] with diagnoses that included: quadriplegia, dysphagia and traumatic brain injury. According to the MDS assessment dated [DATE], R62 had severely impaired cognition.</p> <p>Review of R62's physician orders and care plans revealed an order for monitoring tube feeding site and orders for daily tube feeding but no order or interventions for EBP.</p> <p>On 5/7/24 at 11:17 AM, DON was asked if they were aware of the Enhanced Barrier Precautions changes that went into effect on April 1, 2024. They confirmed they were aware and knew which residents it would apply to (they verbalized several types of residents that would meet criteria for EBP including anyone with an open wound, tube feeding, catheter). When asked if they had any residents currently on EBP they indicated they did not. When asked if they had any residents that should be on EBP they replied, probably yes. They indicated that the role of ensuring proper precautions are in place is their responsibility along with Unit Manager L (who was in training to assume the role of Infection Preventionist).</p> <p>At the time of survey exit no residents had been properly identified or labeled as being in Enhanced Barrier Precautions.</p> <p>39592</p> <p>R57</p> <p>On 5/6/24 at 10:18 AM, R57 was observed lying in bed. A catheter bag was observed hanging from the bed. No signs were observed in or around R57's room announcing EBP, no PPE was observed readily available for staff to use. Throughout the entirety of the survey no staff was observed wearing PPE when providing direct care to R57.</p> <p>Review of the clinical record revealed R57 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: Fournier gangrene (necrotizing fasciitis of the scrotum, penis or perineum) and uropathy (blockage in the urinary tract). According to the MDS assessment dated [DATE], R57 had moderately impaired cognition and had an indwelling catheter.</p> <p>Review of R57's physician orders revealed no order for EBP.</p> <p>R33</p> <p>On 5/6/24 at 10:30 AM, R33 was observed sitting in a wheelchair in their room. A catheter bag was observed hanging from the wheelchair. No signs were observed in or around R33's room announcing EBP, no PPE was observed readily available for staff to use. Throughout the entirety of the survey no staff was observed wearing PPE when providing direct care to R33.</p> <p>Review of the clinical record revealed R33 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: history of prostate cancer, hydronephrosis (excess urine accumulation in kidney) and neuromuscular dysfunction of bladder. According to the MDS assessment dated [DATE], R33 had severely impaired cognition, and had an indwelling catheter.</p> <p>Review of R33's physician orders revealed no order for EBP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R74</p> <p>On 5/6/24 at 11:39 AM, R74 was observed sitting in a wheelchair in their room. R74 was asked about care at the facility. R74 explained they did require intermittent catheterization occasionally. No signs were observed in or around R33's room announcing EBP, no PPE was observed readily available for staff to use.</p> <p>Review of the clinical record revealed R74 was admitted into the facility on [DATE] with diagnoses that included: quadriplegia incomplete (weakness but not total paralysis), neuromuscular dysfunction of bladder and retention of urine. According to the MDS assessment dated [DATE], R74 was cognitively intact.</p> <p>Review of R74's physician orders revealed no order for EBP.</p> <p>47283</p> <p>R55</p> <p>On 5/6/24 at 10:45 AM, R55 was observed lying in bed. R55 was receiving their nutrition and hydration via Percutaneous Endoscopic Gastrostomy (PEG tube - a tube surgically placed directly on the stomach to receive nutrition and hydration). No signs were observed in or around R55's room announcing EBP, no PPE was observed readily available for staff to use. Throughout the entirety of the survey no staff was observed wearing PPE when providing direct care to R55.</p> <p>Review of the clinical record revealed R55 was a long-term resident admitted into the facility on [DATE]. R55's diagnoses included: Parkinson's disease, dementia, and failure to thrive. According to the MDS assessment dated [DATE], R55 had severely impaired cognition and dependent on staff assistance for all Activities of Daily Living and mobility. Review of R55's physician orders revealed no order for EBP and there was no care plan indicating that EBP were in place.</p> <p>On 5/7/24, at approximately 2:10 PM an interview was completed with LPN A. LPN A was queried if staff were following any special precautions while providing direct care to R55 and LPN A reported that they were not and they also added that they did not have any residents on their unit who were under any precautions.</p> <p>30675</p> <p>R29</p> <p>On 5/6/24 at 11:42 AM, R29 was observed lying in bed with a catheter drainage bag secured to the side of the bed. No signs were observed in or around R29's room announcing EBP, no PPE was observed readily available for staff to use. No PPE use was observed throughout the survey.</p> <p>Review of the clinical record revealed R29 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: leukemia, displacement of nephrostomy catheter, tubule-interstitial nephritis, retention of urine, sepsis, and disorder of urea cycle metabolism. According to the MDS assessment dated [DATE], R29 had severely impaired cognition and had an indwelling catheter.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R29's physician orders and care plans revealed an order for use of a suprapubic urinary catheter but no order or interventions for EBP.</p> <p>Storage of Linens:</p> <p>On 5/6/24 at 10:59 AM, observation of the small blue linen cart stationed just outside room [ROOM NUMBER] revealed there were multiple items (briefs, gloves, toothbrushes, toothbrush covers, wipes, lotions, and alcohol wipes) stored on the cart with the clean linens.</p> <p>Several staff were observed repeatedly retrieving items from the cart throughout continued observations.</p> <p>On 5/7/24 at 2:51 PM, observation of two linen carts on the first floor revealed continued storage of personal care items, briefs, wipes, stored directly with the linens on both carts. One of the carts also contained a (used) white Styrofoam cup.</p> <p>On 5/7/24 at 3:03 PM, Unit Manager 'L' was asked to observe the linen carts and confirmed the same observations as above. When asked about whether these items should be stored with the linens, Unit Manager 'L' reported they weren't sure as they had not been at the facility long, and deferred to the Director of Nursing (DON).</p> <p>On 5/7/24 at 3:07 PM, the DON was asked to observe the linen carts and confirmed the same observations above. The DON reported the various non-linen items should not be stored on the linen cart and began to remove the white cup and personal care items. When asked if they had identified any concerns with linen storage previously, the DON reported they did not.</p> <p>According to the facility's policy titled, Linen and Laundry dated 5/2022:</p> <p>.The nursing staff places clean linen on the covered nursing cart to pass linen .Linen must remain covered at all times until is is placed into the residents' room . This policy did not address the storage of any non-linen items with the linens.</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>39592</p> <p>Based on observation, interview, and record review, the facility failed to provide 80 square feet per resident in multiple resident rooms for 26 of 42 resident rooms (#s: 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, and 213, ), resulting in the potential for inadequate space. Findings Include:</p> <p>On 5/6/24 at 2:30 p.m , a review of the facility bed count information sheets and observations of Medicare/Medicaid resident rooms revealed the following:</p> <p>ROOM# SQ. FT. # OF BEDS</p> <p>101 156 2</p> <p>102 147 2</p> <p>103 147 2</p> <p>104 148 2</p> <p>105 147 2</p> <p>106 148 2</p> <p>107 147 2</p> <p>108 147 2</p> <p>109 147 2</p> <p>110 155 2</p> <p>111 154 2</p> <p>112 145 2</p> <p>113 145 2</p> <p>201 156 2</p> <p>202 148 2</p> <p>203 148 2</p> <p>204 148 2</p> <p>(continued on next page)</p>

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F 0912  Level of Harm - Potential for minimal harm  Residents Affected - Some	205 148 2  206 148 2  207 148 2  208 148 2  209 148 2  210 154 2  211 155 2  212 145 2  213 146 2  Individual interviews conducted with residents revealed no complaints regarding the size of their room. The health and safety of the residents were not affected by the room size.