STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review the facility failed to ensure treatment in a dignified manner for two residents (R#'s 17 and 70) of two residents reviewed for dignity, resulting in the potential for embarrassment. Findings include: On 6/30/25 at 11:29 AM, Certified Nursing Aide (CNA) 'B' was observed transporting R70 in their geri-chair. CNA 'B' was observed pulling the geri-chair in a forward motion as R70 was seated in the chair facing rearward. On 6/30/25 at 1:20 PM, an interview was conducted with CNA 'C' in the hallway outside of R17's room. CNA 'C' was asked if it was normal for R17 to have slept all morning and remain sleeping into the afternoon. CNA 'C' said sometimes it was her normal and some days she could be, moody. On 7/1/25 at 11:40 AM, an interview was conducted with the facility's Director of Nursing (DON) regarding language use and appropriate wheelchair transports. The DON said wheelchairs should not be pulled in a forward motion with the resident facing backward and staff were expected to treat residents in a dignified manner. A review of a facility provided policy titled, Quality of Life-Dignity was conducted and read, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality .

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an effective grievance resolution process to ensure prompt resolution of resident concerns for one (R56) of one resident reviewed for grievances, and seven of eight residents who wished to remain anonymous who attend the resident council interview. Findings include: On 6/30/25 at 10:45 AM, R56 was observed seated in a wheelchair in her room. When queried about the care in the facility, R56 reported she has had clothes and other belongings stolen from her room. R56 reported she caught another resident going through her drawers, the resident took one of her shirts out of the drawer, threw it on the bed, and the next morning R56 noticed a blue and purple shirt were missing. R56 said she has talked to a staff member who no longer worked at the facility about her concerns. Additionally, R56 reported her cellular phone charging cord was taken from her room while she was at therapy. R56 said it was found with a staff member. R56 reported she reported her concerns about her missing items to the Administrator, but has not received any follow up about what the facility was going to do about it. When queried about what was reported to the Administrator, R56 explained she went to the hospital a few months ago and when she returned, the luggage she had in her closet was unzipped and a purse, a wallet, and one hundred dollars was missing from it. R56 also reported a lavender blanket that had velvet on one side and lamb's wool on the other side. A review of R56's clinical record revealed R56 was admitted into the facility on 4/11/24 and readmitted on [DATE] after a hospitalization. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R56 had intact cognition. On 7/1/25 at 10:35 AM, all grievance and/or concern forms with any associated investigation or follow up for R58 since the last survey was requested from the Administrator. At 12:11 PM, the Administrator reported there were no grievances or concern forms on file for R56. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/25 at 12:35 PM, an interview was conducted with the Administrator. When queried about the facility's grievance process and how resident concerns were recorded, tracked, and resolved, the Administrator reported if a resident or family member expressed a complaint to anyone in the facility, they were asked if they wanted to file a formal grievance. If they want to file a grievance, then they were asked to complete a grievance form and the protocol was followed. If they said they did not want to file a formal grievance, the concern was discussed in morning meetings and the concern was looked into, but not documented. The Administrator further explained that staff are assigned to certain residents to complete quality rounds to see if they have any concerns. If concerns were brought up in quality rounds they were jotted down on the form and the resident was asked if they wanted to file a formal grievance. The Administrator was asked about any concerns reported to him by R56. The Administrator said R56 reported she was missing a black purse but did not wish to file a grievance. The Administrator reported they looked into the concern, but since R56 did not want to file a grievance, there is no documented investigation or follow up. The Administrator denied knowing anything about R56's missing blanket, wallet, or one hundred dollars and said there was nothing recorded on the inventory list that showed R56 had a black purse brought into the facility. The Administrator reported family denied knowing about a purse. However, the Administrator did not have any documented investigation or follow up to that concern. When queried about how the facility monitored for patterns of concerns if they were not documented, the Administrator did not offer a clear response. The Administrator followed up and said there was a progress note in R56's clinical record in April that said R56 did not express any concerns about financial safety. When queried about whether that was related to R56's concern about her missing purse, the Administrator said it was not and R56 reported the missing purse prior to that note. No documentation was provided to show what was done to try to resolve R56's concern about missing items, including a significant amount of money. On 7/2/25 at 9:30 AM, an interview was conducted with eight residents who either always or sometimes attended the resident council meetings. When queried about how the facility handled concerns or grievances either from the resident council or individually, multiple residents laughed. One resident said, They don't! It was explained by a resident that during resident council, the Activities Director recorded the concerns that were brought up, but some things remained ongoing concerns without any resolution. When asked to describe any concerns they felt were not resolved by the facility, seven of eight residents in attendance expressed issues with getting their clothing back from laundry in an appropriate manner. One resident said she labels all of her clothing with her name, but it often did not come back to her from laundry. Two other residents agreed that clothing does not always come back from laundry. Another resident said she had to remind the laundry staff all the time to bring back her clothing. Another resident expressed dissatisfaction with how her underwear was brought back on hangers underneath her other clothing. When queried about how long the issues with laundry had been going on, one resident said, It's ongoing. It has been going on for a long time. When queried about whether the facility provided a reasonable explanation for why concerns were not resolved, one resident said they do not get an explanation. At that time, the group was asked if they knew how to file a grievance individually if they had a concern about care and services in the facility. One resident said they will just tell their concern to whomever. Another resident said, you can express your concern, but it never seems to get fixed. Another resident said, One hand doesn't know what the other hand is doing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy titled, Grievance Guideline with an effective date of 11/28/27 revealed, in part, the following: .The objective of the grievance guideline is to ensure the facility makes prompt efforts to resolve grievances a resident may have. The intent of the grievance process is to support each resident's right to voice grievances (e.g. those about treatment, care, management of funds, lost clothing, or violation of rights) and to assure that after receiving a complaint/grievance, the facility actively seeks a resolution and keeps the resident appropriately apprised of its progress toward a resolution .The facility will train and designate an individual who is responsible for .Receive and track all grievances through to their conclusion .lead any necessary investigations by the facility .Work with facility staff utilizing root cause analysis processes for resolution of the grievance or concern .Complete written grievance resolutions/decisions to the resident involved .A grievance or concern can be expressed orally to the Grievance Official or facility staff or in writing using a grievance form .Any employee of this facility who received a complaint shall immediately attempt to resolve the complaint within their role and authority. If a complaint cannot be immediately resolved the employee shall escalate that complaint to their supervisor and the facility Grievance Official .The Grievance Officer will maintain a log of all grievances for a period of 3 years .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to report injuries of unknown origin to the Administrator/Abuse Coordinator for one (R38) of four residents reviewed for abuse. Findings include: On 6/30/25 at approximately 9:40 AM, it was reported by another resident that R38 often wandered into her room, has gotten into her bed, and threw water on her one time. On 6/30/25 at approximately 10:00 AM, R38 was observed ambulating in the hallways of the second floor unit. R38 was observed standing very closely in other people's space. When spoken to, R38 talked non-sensically. On 7/1/25 at 10:45 AM, R38 was observed wandering the second floor unit, up and down each hallway. At approximately 10:51 AM, R38 entered another resident's room and approached their bed. The other resident yelled, No! Get out! Get out and go to your room! R38 was observed trying to get into the bed of the other resident who was not in the room at that time. At approximately 10:53 AM, a staff member redirected R38 into their own room and closed the door. A review of R38's clinical record revealed R38 was admitted into the facility on 9/20/19 with diagnoses that included: metabolic encephalopathy (2024), dementia with behavioral disturbance, and Alzheimer's disease. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R38 had severely impaired cognition, wandering behaviors, and required supervision/touching assistance for walking. A review of R38's progress notes revealed the following: An Incident Note dated 3/9/25 at 5:05 PM (written on 3/10/25) that read, CNA (Certified Nursing Assistant) reports to writer that resident has a large bruise to the back of the right leg. Writer assess area and area was non painful to palpation. Earlier in the shift. Writer witnessed resident climb in the bed throwing both feet over foot board hitting the area where bruise is located. Ice applied to are to minimize swelling, left leg assessed for bruising as well and none noted at this time . A Health Status Note dated 3/10/25 at 10:03 AM that read, While standing at cart writer heard residents room door open accompanied by a noise upon observation resident was observed behind door holding the handle. when asked what occurred resident was unable to give a clear description. no other abnormalities seen in room. during end of shift resident began to developed a bruise to left eyebrow .DON (Director of Nursing) notified . On 7/1/25 at 10:34 AM, all incident reports with associated investigations for R38 for the past sex months were requested from the Administrator. A review of incident reports provided by the Administrator for R38 revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Skin incident report dated 3/9/25 at 1:00 PM noted, CNA reports to writer that resident has a large bruise to the back of the right leg. Writer assess area and area was non painful to palpation. Earlier in the shift. Writer witnessed resident climb in the bed throwing both feet over foot board hitting the area where bruise is located. Ice applied to are to minimize swelling, left leg assessed for bruising as well and none noted at this time . It was documented in the incident report that the incident was not witnessed and R38 was unable to give a description of what happened. There was no associated investigation provided with the incident report. A Skin incident reported dated 3/10/25 at 12:00 AM noted, While standing at cart writer heard residents room door open accompanied by a noise upon observation resident was observed behind door holding the handle, when asked what occurred resident was unable to give a description .during end of shift resident began to developed a bruise to left eyebrow . It was documented R38 was unable to give a description and the incident was not witnessed. It should be noted that the incident report was completed by a different staff member than the progress note. There was no associated investigation provided with the incident report. On 7/2/25 at 9:00 AM, the Administrator was asked to confirm if there were any associated investigations into the 3/9/25 and 3/10/25 incidents for R38. The Administrator reported there was no additional investigations for either date. On 7/2/25 at 1:09 PM, an interview was conducted with the Administrator/Abuse Coordinator. When queried about the facility's protocol for injuries of unknown origin, the Administrator reported if it could not be determined what happened, the injury was reported to the Administrator as soon as possible. Once it was reported to the Administrator, they started looking into what happened and if they were unable to determine the cause, it was reported to the State Agency. The incidents with R38 (bruise to back of leg on 3/9/25 and bruise on eyebrow on 3/10/25) were reviewed with the Administrator. When queried about whether those bruises should have been reported to him since R38 had a history of wandering, was not able to say what happened, and nobody witnessed the injuries directly, the Administrator reported they should have been reported to him so an investigation could be started to determine if it was an injury of unknown origin and if so, then reported to the State Agency. A review of a facility policy titled, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property, dated 11/28/27, revealed, in part, the following: .Injuries of Unknown Origin: AN injury should be classified as an injury of unknown source when both of the following conditions are met: .The source of the injury was not observed by any person or the source of the injury could not be explained by the resident .The injury is suspicious because of the extent of the injury of the location of the injury .or the number of injuries observed at one particular point in time or the incidence of injuries over time .Investigation of injuries of Unknown Origin or Suspicious injuries must be immediately investigated to rule out abuse .The facility will ensure that all alleged violations .including injuries of unknown source .are reported immediately . or not later than 24 hours if the vents that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials .in accordance to State law through established procedures .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop an integrated hospice care plan for one resident (R9) of one resident reviewed for hospice services resulting in the potential for unmet end of life care needs. Findings include: A review of R9's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: acute respiratory failure, high blood pressure, Alzheimer's disease and dementia. A review of a hospice contract indicated they admitted to hospice services on 2/10/25. A review of R9's hospice documentation revealed a care plan developed by the hospice company, however; a review of R9's facility care plans did not reveal a care plan for hospice services nor outline the coordination between the hospice company and the facility. On 7/2/25 at 11:40 AM, an interview was conducted with the facility's Director of Nursing (DON). They were asked if R9 should have a facility care plan that indicated R9 was on hospice and included interventions and coordination between the facility and the hospice company and the DON said they should have had one. A review of a facility provided policy titled, Careplan Standard Guideline dated 11/28/17 was conducted and read, .The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: 1. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure dressing changes were completed as documented for one (R55) of two residents reviewed for Skin Conditions. Findings include: On 6/30/25 at 10:03 AM, R55 was observed lying in his bed. A gauze dressing dated 6/25 was observed on R55's left wrist. R55 was asked what the dressing was for. R55 explained he must have hit his wrist on something, and the nurse had wrapped it up. R55 was asked if he knew how often the dressing was changed. R55 explained it had been a couple of days since it had been changed. Review of the clinical record revealed R55 was admitted into the facility on 8/20/24 with diagnoses that included: diabetes, Parkinson's disease and heart disease. According to the Minimum Data Set (MDS) assessment dated [DATE], R55 was cognitively intact. Review of R55's progress notes revealed a Skin Observation note dated 6/15/25 at 6:50 PM that read, CNA (Certified Nursing Assistant) alerted writer that resident arm was bleeding. Writer assessed arm resident stated he did not know how it happened. Left lower arm bleeding moderately due to resident [NAME] [sic] on blood thinners and small cut noted. Arm was cleaned with NS (normal saline), TAO (triple antibiotic ointment) applied andwrapped [sic]. Resident denied any pain. Review of R55's June 2025 Treatment Administration Record (TAR) revealed an order for Cleanse left lower arm with NS, apply TAO, and cover with dry dressing every day shift for skin tear Start Date 06/16/2025. The TAR was marked as completed, indicating the treatment was done, on 6/25/25, the date on the dressing. The TAR was also marked as completed on 6/26/25, 6/27/25, 6/28/25 and 6/29/25. On 6/30/25 at 12:53 PM, the Director of Nursing (DON) was interviewed and asked to verify the date on R55's left wrist dressing. The DON verified the date was 6/25. The DON was informed the TAR had been marked off every day since 6/25/25. The DON had no explanation. The DON was asked if the TAR could be marked as completed if the treatment was not done. The DON explained the TAR should only be marked as completed after the treatment was done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** R37 On 6/30/25 at 10:15 AM, R37 was observed lying in bed. R37 reported he was not feeling well at that moment and was going to the hospital. When queried about the care in the facility, R37 reported he wore a Life Vest (a wearable cardioverter defibrillator vest that continuously monitors for life-threatening irregular heart rhythms and automatically delivers shock treatment to save a person's life, if needed). R37 reported the vest was not removed because he was to wear it at all times. R37 reported the vest did not fit properly and was very tight which caused a big wound on the trunk of his body where the vest made contact with his skin. R37 reported the facility ordered a new vest, but he never received it. R37 reported the wound was painful and uncomfortable. An observation of the wound to R37's torso was not conducted as R37 left for the hospital shortly after the above interview and did not return prior to the end of the survey. A review of R37's clinical record revealed R37 was admitted into the facility on 6/10/25 with diagnoses that included: ischemic cardiomyopathy (damaged heart muscles that cannot pump blood properly). A review of a Minimum Data Set (MDS) assessment revealed R37 had intact cognition and no unhealed pressure ulcers or other skin impairments. A review of a Nursing Evaluation completed for R37 on admission on [DATE] revealed no documentation of skin impairment to R37's trunk/torso. A review of R37's Physician's Orders revealed an order for weekly skin check every Tuesday with a start date of 6/17/25. An order dated 6/12/25 revealed, Monitor every shift. Patient is to wear LifeVest at all times EXCEPT when showering/vigorous cardiac rehab . A review of a Skin Observation assessment dated [DATE] revealed no skin impairment to R37's trunk/torso was identified. A review of R37's progress notes revealed the following: An IDT (Interdisciplinary Team) Note dated 6/11/25 documented, .Skin rash under breast present upon admission. It should be noted that a skin rash under R37's breast was not documented on the admission Nursing Evaluation or Skin Observation form completed on 6/10/25. Further review of R37's Physician's Orders revealed no treatment orders to address the rash mentioned in that note. Further review of R37's clinical record revealed no further documented assessment of the rash, including the size, appearance, and where it was located (under left or right breast). There was no mention of R37's vest being too tight, as reported by R37. A Physician/PA (Physician Assistant)/NP (Nurse Practitioner) - Progress Note dated 6/11/25 revealed no documentation of any skin impairments. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	A Skin/Wound Note dated 6/18/25 documented, During shower this am an abrasion was observed under left abdominal fold r/t (related to) life vest. Skin also red moist and has mild order <sic> (odor). After shower area cleansed. Antifungal powder and camalseptine <sic> (an ointment used as a moisture barrier to calm skin irritation) applied. Treatment in place. All necessary parties notified. Further review of R37's Physician's Orders revealed an order dated 6/18/25 for Wound Treatment: Left Abdominal Fold Abrasion: 1. Cleanse area with NS (normal saline) 2. Pat Dry Apply Camalseptine <sic> and Antifungal powder and ABD (abdominal pad) for cushion .every day shift for Wound Care . A review of a Physician/PA/NP Progress Note dated 6/18/25 did not document any skin abnormalities or that R37's life vest did not fit properly. A review of a Weight Change Note dated 6/19/25 revealed R37 gained 4.5 pounds since admission nine days prior. It was noted R37 took a diuretic for edema and weight fluctuations were expected. A review of a consultation completed by the contracted wound care provider dated 6/20/25 revealed, .Wound Assessment(s) .Wound #1 Abdomen - LUQ is an acute Partial Thickness Abrasion .Initial wound encounter measurements are 1.5cm length x 13cm width with no measurable depth .There is a Scant amount of sero-sanguineous drainage (a combination of clear fluid and blood) noted .Wound bed has 100% pink, granulation, 20% slough (non-viable yellow, tan, gray, green or brown tissue) .Additional Orders .ABD DIRECT, OFFLOAD AREA NO ADHESIVE .Avoid direct pressure to wound site .OFFLOAD VEST OFF SITE . It should be noted that according to the State Operations Manual (Rev 229; Issued 4/25/25), if slough is present but does not obscure the depth of tissue loss, it is considered Full-thickness Skin loss and a Stage 3 Pressure Ulcer related to a medical device. A review of a Wound Assessment Details Report completed by Licensed Practical Nurse (LPN) 'O' on 6/27/25 revealed documentation that R37's wound was a Stage 1 facility acquired pressure ulcer (Intact skin with a localized area of non-blanchable erythema) that measured 13cm x 0.5 cm. The photo included on the assessment showed a linear wound with areas of full-thickness tissue loss, slough and scattered black, scab-like areas. A review of a consultation completed by the contracted wound care provider dated 6/27/25 revealed, Wound #1 Abdomen - LUQ is an acute Partial Thickness Abrasion .measurements are 0.5cm length x 13cm width x 0.1 cm depth .Wound bed is 90%, pink, granulation, 10% slough; no eschar . It should be noted in the photo taken on 6/27/25, there were scattered black, scab-like areas. A review of a IDT Note dated 6/25/25 revealed, .Life vest in place, (company name) contacted for new vest . On 7/2/25 at approximately 8:15 AM, an interview was conducted with the Assistant Director of Nursing (ADON). When queried if the facility had a Wound Care Coordinator, the ADON reported there was a nurse who rounded with the contracted wound provider once a week and the Director of Nursing (DON) was ultimately the person who oversaw wounds in the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/2/25 at 11:53 AM, an interview was conducted with the DON. When queried about how R37 got the wound to his LUQ, the DON said it was from rubbing from the life vest. When queried about how often R37's skin was monitored due to having a medical device (life vest) that was reportedly too tight according to R37, the DON reported at least weekly, but with the vest they should be checking every shift, if not more. At that time, the following was requested from the DON: Interventions in place upon R37's admission into the facility, interventions implemented upon identification of skin breakdown to prevent further breakdown or worsening of the existing wound, and when the new life vest was ordered. The DON said she would look into it. On 7/2/25 at 2:00 PM, a follow up interview was conducted with the DON. The DON reported R37's skin was not checked more frequently because the vest was only to be removed for showers. The DON reported due to the life vest, they were unable to put additional protective interventions in place. At that time, any Wound Assessment Detail Reports conducted prior to 6/27/25 were requested. On 7/2/25 at approximately 2:45 PM, the ADON reported R37 was admitted with some skin impairment to his LUQ. At that time, any documentation of the skin impairment on admission and any physician's orders to treat the area at that time were requested. No additional information was provided prior to the end of the survey. The ADON further reported R37 was fitted for the life vest at the hospital and could only be fit every three months per the life vest company. At that time, it was requested a second time to provide the date the life vest company was contacted to enquire about a better fitting vest. No additional information was provided prior to the end of the survey. The ADON was asked to provide the hospital discharge records, as they were not accessible in the medical record. The records were not provided prior to the end of the survey. A review of R37's care plans did not include any care plans related to R37's medical device related wound to the LUQ and did not include a care plan related to checking R37's skin underneath the left vest. A review of a facility policy titled, Prevention of Pressure Ulcers/Injuries revised 1/2019 read in part, .Risk Assessment .Areas of impaired circulation due to pressure fro positioning of medical devices .CNA's (Certified Nursing Assistants) will inspect the skin on a daily basis when performing or assisting with personal care or ADLs (activities of daily living) .General Preventive Measures: 6. Routinely screen and document the condition of the resident's skin for any signs and symptoms of irritation or breakdown. 7. Immediately report any signs of a developing pressure ulcer to the supervisor. 8. The care process should include efforts to stabilize, reduce or remove underlying risk factors .Risk Factor - Friction and Shear .Monitor the placement of splints and casts to assure they are not placing friction on the resident's skin . Based on observation, interview and record review, the facility failed to document accurate skin assessments, ensure timely identification of pressure ulcers, and implement effective interventions to prevent the development and worsening of a pressure ulcer, for two (R68 and R37) of two residents reviewed for pressure ulcers resulting in R68 acquiring multiple pressure ulcers first identified as Unstageable (obscured full-thickness skin and tissue loss) and/or Stage 3 (full-thickness skin loss) pressure ulcers and R37 acquiring a medical-device related pressure injury with full-thickness skin loss. Findings include: R68 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/30/25 at 10:30 AM, R68 was observed lying in bed. R68 was asked if he had any wounds or sores on his body. R68 explained he had wounds, some he had when he was admitted and some he acquired at the facility. R68 was asked if he could turn himself. R68 explained he could not turn himself, staff had to turn him. Review of the clinical record revealed R68 was admitted into the facility on 1/27/25 and readmitted [DATE] with diagnoses that included: quadriplegia, injury of cervical spinal cord and major depressive disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R68 was cognitively intact. Review of R68's skin impairment care plan revealed interventions that read in part, .Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration (excessive moisture exposure) etc. to MD (medical doctor). Date Initiated: 02/27/2025 . Monitor skin when providing cares [sic], notify nurse of any changes in skin appearance Date Initiated: 01/27/2025 . Review of R68's wound notes from a consultant Wound Care Provider revealed: 2/14/25 .Wound #3 Right Elbow is an acute Stage 3 Pressure Injury Pressure Ulcer . Initial wound encounter measurements are 2.4cm (centimeters) length x 1.2cm width .There is a Scant amount of sero-sanguineous (blood serum and red blood cells) drainage . Wound bed has 70%, pink, granulation (new connective tissue formed during the healing process), 30% eschar (dead or devitalized tissue, and may appear scab-like) . General Notes: Patient has a history of Stage 3 on elbow based on previous records at different facility . Wound #4 Left Scapula is an acute Stage 3 Pressure Injury Pressure Ulcer . Initial wound encounter measurements are 1.4cm length x 4cm width . 20% slough (non-viable yellow, tan, gray, green or brown tissue) . General Notes: Patient has a history of a stage 3 ulcer on L (left) scapula based on previous records . 2/28/25 .Wound #5 Right Ischial (lower part of the buttocks) is an acute Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer . Initial wound encounter measurements are 3. 4cm length x 2cm width . There is a Scant amount of sero-sanguineous drainage . 100% slough . 4/4/25 .Wound #7 Left Ischial is an acute Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer acquired on 03/30/25 . Initial wound encounter measurements are 3cm length x 1. 8cm width . There is a Scant amount of sero-sanguineous drainage . Wound bed has 40%, pink, granulation, 60% eschar . Review of R68's progress notes revealed no documentation of skin impairment prior to the Consultant's wound notes on 2/14/25, 2/28/25 and 4/4/25. Including between 3/30/25 and 4/4/25. Review of R68's Skin Observation documentation revealed no identification of a new skin impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/2/25 at 10:09 AM, the Director of Nursing (DON) was interviewed and asked how often skin checks should be completed. The DON explained the Skin Observation should be done weekly. The DON was asked why of the 22 weeks R68 had been at the facility, only nine Skin Observation's had been completed. The DON offered no explanation. The DON was also informed of the nine Skin Observations completed, none had identified any new skin impairment. The DON made no reply. The DON was asked about R68's wounds being identified when they were at Unstageable or Stage 3. The DON explained Wounds #3 and #4 were called Stage 3 because they had been at a Stage 3 prior and had reopened. The DON was informed the Consultant had documented that fact, however was asked why Wound #3 was documented as having granulation tissue and was 30% eschar and Wound #4 had 20% slough, which indicated both wounds had been present for a while. The DON offered no explanation. The DON was asked about Wound #5 that was first documented by the Consultant as an Unstageable with 100% slough. The DON offered no explanation. The DON was asked about Wound #7 in which the Consultant had documented was acquired on 3/30/25 but there was no documentation found in R68's record. The DON offered no explanation. The DON was asked if there were pictures of R68's wounds prior to the most recent Consultant's visit. The DON had the ability to access prior pictures and showed the first picture of R68's Wound #7 taken on 4/4/25 which appeared to be almost completely covered in black eschar. The DON was asked if the pressure ulcer in the picture should have been identified and documented before it looked like the image in the picture. The DON agreed there should have been identification before the wound was at that extent. When asked if R68 required total assistance of staff for care, the DON agreed. The DON was asked if staff were changing, bathing and turning R68 should the wounds have been identified and documented on before they were Unstageable and/or Stage 3. The DON acknowledged the concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number: MI00151566 Based on observation, interview, and record review, the facility failed to provide adequate supervision and implement effective interventions to prevent accidents and failed to assess and determine the root cause of a fall for three (R13, R38, and R72) of six residents reviewed for accidents and supervision, resulting in R13 eloping from the facility, R38 repeatedly entering other residents' rooms and the potential for avoidable accidents. Findings include: R13 On 6/30/25 at 10:13 AM, a resident was observed in R38's room and attempted to get into R38's roommate's bed. At that time, Licensed Practical Nurse (LPN) 'P' was asked if the resident in the room was R38's roommate. LPN 'P' reported the resident was R13 and they should not be in that room. At that time, LPN 'P' asked another staff member to get R13 out of the room. A review of R13's progress notes revealed the following: On 1/5/25, R13 was aggressive, combative, attempted to push other residents in their wheelchairs, was pushing on the door leading to the stairs, and was unable to be redirected. On 6/5/25 at 6:52 PM, it was documented R13 refused to be changed, was consistently trying to leave the floor, and eloped and walked down the stairs from 2nd floor to basement and stated, 'she didn't want to come back' while hitting the nurse and other staff . A review of R13's clinical record revealed R13 was admitted into the facility on [DATE] with diagnoses that included: adjustment disorder with mixed anxiety and dementia with behavior disturbance. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R13 had severely impaired cognition and no behaviors including wandering. R13 required supervision/touching assistance while walking. On 7/1/25 at 10:35 AM, all incident reports with associated investigations for R13 for the past six months were requested from the Administrator. A review of an investigation conducted by the facility regarding R13 revealed the following: An incident report dated 6/5/25 at 3:39 PM that noted, Resident observed having exit seeking behaviors. She then is seen at door causing alarm to sound but is redirected. Another alarm sounds and resident is in stairwell. Maintenance assistance alerts staff and tries to redirect resident however resident gets combative and proceeds to push her way through the door leading outside. Resident remained combative stating, 'I want to go for a ride father'. She was then guided into the building via wheelchair. It was documented R13 was located in rear of facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A typed summary (unsigned and undated) noted, At approximately 3:56pm on June 5th, the 2 North stairwell door alarm sounded. A CNA (Certified Nursing Assistant) attending to the residents on that hall silenced the alarm approximately 30 seconds after the alarm was triggered .At approximately 3:57 (pm) the North stairwell exit door alarm was triggered. The assistance maintenance director (Maintenance Assistant - MA 'Q') immediately entered the stairwell and encountered the resident and began to attempt to redirect her back to the building. (R13) was combative and argumentative about returning to the building. The Maintenance Director (MD 'R') witnessed this occurrence and called a 'Code White' over the PA system. All staff responded appropriately and promptly. Nursing staff arrived with a wheelchair and escorted (R13) back into the building at approximately 3:59pm .The CNA that silenced the door alarm without checking the surroundings was educated and provided disciplinary action . An undated statement written by MA 'Q' documented, I (MA 'Q') was moving a bed to (room number) while I heard North stairwell alarmed. I proceeded to run down the north stairwell to outside. I intercepted the resident. I stood between them and the street while (Regional Maintenance Director, RMD 'S') called for assistance. I stayed in front of her until help arrived and was able to take her back inside. An undated, signed statement, written by Licensed Practical Nurse (LPN) 'M' documented, I had just come back to the floor when the alarm went of <sic> and then it had went silent. Minutes later the basement alarm went off and maintenance staff left the floor and told us it may be resident. We all went assist with getting her from outside and bringing her back up. An Employee Discipline Form for CNA 'T' dated 6/5/25 read, CNA responded to door alarm at 3:55 pm on North hall. Alarm was disengaged by CNA without properly checking stairwell or investigating who set alarm off. A review of a Wander/Elopement Risk Evaluation dated 6/1/25 for R13 revealed R13 was at risk to wander/elope. It was documented R13 was physically able to leave the building on their own, independently mobile, ambulatory, cognitively impaired, attempted to exit the unit or facility, made repetitive statements about 'going home' and/or packing belongings, and wandered aimlessly about the facility. A review of R13's care plans revealed a care plan initiated on 2/20/25 and 6/1/25 (four days prior to R13 exiting the building) that noted, (R13) is an elopement risk/wanderer. The only intervention in place prior to 6/5/25 was on 2/20/25 and it noted, Staff aware of residents wander risk. Further review of R13's progress notes revealed On 7/1/25 at 2:08 PM, an observation of the north stairwell was conducted. The North stairwell was located at the end of the North hallway on the second floor. The door required a code to open the door without setting off an alarm or if the handle was pressed for 15 seconds, the door would open and an alarm would sound which required a code to disengage. To get to the door that exited to the outside of the building, there were two flights of stairs that went down to another emergency exit that required a code or 15 second delay which would set off the alarm. Once outside, the door will not open without a code. Upon exiting the door, there was a grassy and wooded area straight ahead which had a steep drop off. To the right of the door was a shed with large equipment outside of it and a sidewalk which led to the employee parking lot. The parking lot, which was at a decline, led to a street. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/25 at approximately 1:10 PM, an interview was attempted with MA 'Q'. The Administrator reported they went home ill. At that time, an interview was requested from RMD 'S' and the Administrator reported MD 'R' was the person who responded to the door alarm when R13 left the building. On 7/2/25 at 1:22 PM, an interview was conducted with MD 'R'. When queried about what happened with R13 on 6/5/25, MD 'R' reported they were working on the second floor with MA 'Q' when they heard the alarm go off for the maintenance door in the basement that led to the outside. MA 'Q' explained when the alarm went off, it announced which door was breached. MA 'Q' ran down the hallway and MD 'R' went the opposite way through the maintenance door. MD 'R' reported RMD 'S' was outside of the building and MA 'Q' stopped R13 in the parking lot and MD 'R' called a 'Code White and said it was not a drill. RMD 'S' called the receptionist and informed them R13 was out of the building. According to MD 'R', R13 was combative and had known behaviors where if she saw a car, she went toward it. Nursing came out and calmed her down and got her back inside via wheelchair. On 7/2/25 at 1:33 PM, an interview was conducted with RMD 'S'. When queried about what happened with R13 on 6/5/25, RMD 'S' reported he was outside working on the generator when he saw MA 'Q' coming behind R13 out of the corner of his eye. Then MD 'R' was behind them and went in and called a code. MA 'Q' was holding R13's arms and RMD 'S' called the receptionist for assistance from a nurse. Then a nurse came out and all the staff came out and they took over and got R13 back inside. R38 On 6/30/25 at approximately 9:40 AM, it was reported by another resident that R38 often wandered into her room, has gotten into her bed, and threw water on her one time. On 6/30/25 at approximately 10:00 AM, R38 was observed ambulating in the hallways of the second floor unit. R38 was observed standing very closely in other people's space. When spoken to, R38 talked non-sensically. R38 was not wearing shoes and was observed wearing a soft helmet. On 6/30/25 at 1:45 PM, an interview was conducted with R38's resident representative (RR) who reported R38 had a fall while wandering around the unit. RR reported R38 walked up and down the small flight of stairs leading to the third floor, lost balance and hit her head on the stairs. R38 was transferred to the hospital where she required stitches. RR reported R38 had dementia and appeared to be weaker than before. RR wondered if something could be done to prevent R38 from accessing the stairs. On 7/1/25 at approximately 8:30 AM, R38 was observed entering another resident's room during medication pass. On 7/1/25 at 10:45 AM, R38 was observed wandering the second floor unit, up and down each hallway. Multiple staff were observed talking amongst themselves at the nurse's station. A wet floor sign was observed tipped over and laid across the end of the 2 North hallway. R38 was observed walking up and down the hallway and stepped over the sign. R38 was not wearing shoes and was not wearing a helmet as observed the previous day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/25 at approximately 10:51 AM, R38 entered another resident's room and approached their bed. The other resident yelled, No! Get out! Get out and go to your room! R38 was observed trying to get into the bed of the other resident who was not in the room at that time. At approximately 10:53 AM, a staff member heard the other resident yelling and redirected R38 into their own room and closed the door. On 7/1/25 at 10:55 AM, R38 was observed lying in bed and appeared to be sleeping. The door to R38's room was difficult to open and required considerably force to push it open. A review of R38's clinical record revealed R38 was admitted into the facility on 9/20/19 with diagnoses that included: metabolic encephalopathy (2024), dementia with behavioral disturbance, and, Alzheimer's disease. A review of a MDS assessment dated [DATE] revealed R38 had severely impaired cognition, wandering behaviors, and required supervision or touching assistance for walking. A review of R38's care plans revealed a care plan initiated on 11/25/24 that noted, .tends to wander without purpose into other resident's rooms . An intervention initiated on 11/25/24 noted, Document 30 minutes checks post wandering into a resident's room. A review of R38's full clinical record revealed no progress notes or documentation by the CNAs in the Behavior Task of R38 being found in two residents' rooms on 7/1/25. 30 minute checks were not documented in the clinical record as specified on R38's care plan. On 7/2/25 at 8:15 AM, an interview was conducted with Registered Nurse (RN) 'U'. When queried about where 30 minute checks for R38 were documented after she was found in other residents' rooms, RN 'U' reported she did not know and would have to check with the manager. RN 'U' said she would do a skin check if R38 was found in another resident's room in case someone hit her. RN 'U' stated, I work midnights so you will have to check with the managers. On 7/2/25 at 8:20 AM, an interview was conducted with the Assistant Director of Nursing (ADON). When queried about what was in place to prevent R38 from wandering into other resident's rooms, the ADON reported the staff were supposed to redirect her when wandering. When queried about the 30 minute checks and where they were documented, the ADON reported that if the nurse was alerted, they would document on a form kept at the nurse's station. The ADON checked the first floor nurse's station and there were no forms for R38. The ADON reviewed R38's clinical record and reported there were no documented wandering behaviors or alerts in the clinical record. The ADON reported the CNAs documented behaviors in their tasks and the nurses should document in the progress notes in order to track behaviors and implement new interventions, if needed. On 7/2/25 at approximately 8:30 AM, an interview was conducted with second floor unit manager, LPN 'I'. When queried about where R38's 30 minute checks were documented, LPN 'I' said there was nobody on 30 minute checks on the second floor. LPN 'I' was not aware R38 was found in two different residents' rooms on 7/1/25. A review of R38's incident reports for the past six months revealed R38 tripped over a wheelchair in the hallway and fell on 5/25/25, fell near the steps near the nurse's station on the second floor and hit her head resulting in bleeding and a hospital transfer on 6/1/25, and fell while wandering back and forth on the hallway on 6/3/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/25 at approximately 12:03 PM, an interview was conducted with the Director of Nursing (DON). When queried about what was done to look into R38's wandering behaviors to prevent her from entering other residents' rooms, the DON did not offer a response. When queried about what was in place to prevent falls while wandering for R38, the DON reported after the last fall they implemented a soft helmet. When queried about why R38 had not been wearing the helmet, the DON reported she may have refused. When asked where that would be documented, the DON reported she did not know. A review of a facility policy titled, Safety and Supervision of Residents, dated July 2027, revealed, in part, the following, .Implementing interventions to reduce accident risks and hazards shall include .Ensuring that interventions are implemented .Documenting interventions . A review of a facility policy titled, Missing Person/Elopement, revised 1/2020, revealed, in part, the following, . Should an alarm on one of the external exits to the facility be sounded, staff shall immediately respond to determine the cause of the alarm . R72 Record review revealed R72 was a long-term resident of the facility, admitted on [DATE]. R72's admitting diagnoses included catatonic schizophrenia, major depressive disorder, and muscle weakness. Based on the Minimum Data Set (MDS) assessment dated [DATE], R72 had Brief Interview for Mental Status (BIMS) score of 15/15, indicative of intact cognition, despite their diagnoses. R72 needed partial (<50%) to substantial (>50%) staff assistance with their mobility and transfers. R72 also had a legal public guardian. A complaint received by the State Agency revealed that R72 had a fall in the room and did not get timely assistance from the staff. An initial observation was completed on 7/1/25 at approximately 11:10 AM. R72 was observed lying on their bed. They had a facility provided (hospital) gown on. An interview was completed during this observation. R72 verbalized that they were in a nursing home and they wanted to go home. When they queried if they had any falls, R72 reported that they had one fall when they tried to get up and walk. R72 added that they had waited for 45 minutes to get help and staff assisted them to bed after. Review of R72's Electronic Medical Record (EMR) revealed a note dated 3/4/25 titled Behavior narrative note that read, Patient found lying parallel to her bed during rounds prior to dinner. She stated that she was just sitting. Writer asked multiple times if she had fallen and she stated 'no, I slid down to the floor'. Focused assessment performed prior to being transferred back to bed by staff . There was no evidence of any post incident assessment in the EMR. There was no evidence of any notification to R72's physician and legal guardian of the incident. A request for an incident and accident report with facility investigation for R72's incident from 3/4/25 was sent via e-mail to the facility administrator on 7/1/25. The facility administrator replied back on 7/2/25 and reported that they did not have an incident report or investigation/root cause analysis for the event. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R72's progress notes from admission to current date did not reveal any ongoing behaviors as noted under the progress notes dated 3/4/25. R72's care plan for falls and behaviors did not reflect any updates on or after 3/4/25. An intervention dated 1/30/25 under fall care plan read Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter and/or remove any potential causes if possible . An intervention under psychotropic medication use read monitor resident for safe ambulation, encourage proper footwear when up . dated 3/7/25. An interview with a Certified Nursing Assistant (CNA) N who was assigned to care for R72 was completed on 7/2/24 at approximately 8:45 AM. CNA N reported that they had been working at the facility for approximately four years and they usually worked in the set where R72 was residing and were familiar with resident's routine. CNA N was queried if they exhibited any behaviors and they reported that had preferred to stay in their room doing their own routine. When questioned if R72 had any falls, CNA N added that they recalled having one incident a couple of months ago, not on their shift; had heard from other staff, but they were not very sure. An interview with the Assistant Director of Nursing (ADON) was completed on 7/2/25 at approximately 10:30 AM. They reported that they had been in the role for approximately a month. The ADON was queried about the facility process if a resident was observed on the floor and reported that they had slid to the floor. They reported that would be considered as a fall and they would complete an assessment, incident report and complete an investigation. They were questioned about R72's incident and rationale for why it was documented as a behavior note and why there was no incident report and investigation not completed. The ADON reported that they were unable to provide any further explanation and agreed on the concerns. They are addressing these concerns now with their team. An interview with LPN O was completed on 7/2/25 at approximately 10:50 AM. LPN O was assigned to care for R72 on 3/4/25 and had completed the behavior narrative note. They were queried about the incident and their focused assessment. They reported that they had added that under behavior as they were instructed by the management. When asked further they added that any self-reported incidents were documented under behavior narrative note and they were asked to show in the EMR where they had documented their focused assessment. LPN O added that they assessed the resident but there was no other documentation. When questioned further on their rationale they reported that they understood the concern. On 7/2/25 at approximately 11:40 AM, the Director of Nursing (DON) was interviewed regarding the facility process. The DON reviewed the EMR for R72 and reported that the incident on 3/4/25 was a fall event and the staff should have followed their facility processes. They added they would check for the reports (incident and investigation) and would report back later. Later, the DON confirmed that they did not have any further information and agreed with the concern. A facility provided document titled Fall Evaluation Safety Guideline with a revision date of 11/28/17 read in part, Purpose: To consistently identify and evaluate residents at risk for falls and those who have fallen to treat or refer for treatment appropriately and develop an organization-wide ownership for fall prevention to: 1. To achieve each resident's maximum potential of physical functioning (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. To prevent or reduce injuries related to fall. 3. To enhance resident dignity and self-worth 4. To rehabilitate residents to their fullest potential of function Falling is an unintentional change in position coming to rest on the ground floor or onto the next lower surface. The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall regardless of which setting it may have occurred. An intercepted fall occurs when the resident would have fallen if he or she or someone else had not caught him or herself. Any failure to maintain an appropriate lying, sitting or standing position resulting in a resident's sudden, unintentional relocation either to the ground or into contact with another object below his or her starting point defines falling. The intent of this guideline is to ensure this facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident as identified through the following process: i. Identification of hazards and risks ii. Evaluation iii. Implementation iv. IV. Monitoring v. Analysis Fall Evaluation: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A fall evaluation is used to identify individuals who have predicting factors for falls. This evaluation is completed upon admission, quarterly, annually and with a significant change in condition. Fall prevention is achieved through an IDT1 approach of managing predicting factors and implementing appropriate interventions to reduce risk for falls .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interviews, the facility failed to properly date (Insulin) and appropriately store medications in one out of four medication carts resulting in the potential for harm due to unsafe medication administration and decreased efficiency. Findings include: During an observation completed on the 2-West medication cart on 7/1/25 at approximately 11:30 AM with Licensed Practical Nurse (LPN) M, an opened undated Humalog (Insulin) was located on the top drawer. When questioned, LPN M reported that it should have been dated. They confirmed that that the insulin pen was open and they were unsure why it was not dated. Further observation of the medication cart revealed five unidentifiable loose pills on the drawer. They were unsure how it happened and added that management was checking the medication carts weekly. They reported that they were a new nurse. During an interview with 2nd floor unit manager (UM) I on 7/2/25 at approximately 9:15 AM, the observations from 7/1/25 were shared. UM I reported that insulin should have been dated as soon as they were opened and staff should follow the facility process when they pull medications from the packages and should not be any loose pills on the cart. They were notified of the concerns and reported that they understood the concerns. On 7/2/25 at approximately 11:45 AM, the Director of Nursing (DON) was notified of the concerns with 7/1/25 observations of the 2-West medication cart. The DON reported that staff were expected to follow their facility processes and understood the concerns. A facility provided document titled Medication Storage in the Facility with a revision date of April-2018 read in part, Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures: A. The provider pharmacy dispenses medications in containers that meet regulatory requirements, including standards set forth by the United States Pharmacopeia (USP). Medications are kept in these containers. Nurses may not transfer medications from one container to another or return partially used medication to the original container. B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. D. Orally administered medications are kept separate from externally used medications and treatments such as suppositories, ointments, creams, vaginal products, etc. Eye medications are stored separately per facility policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Except for those requiring refrigeration or freezing, medications intended for internal use are stored in a medication cart or other designated area. F. Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart . Expiration Dating (Beyond-use dating): A. Expiration dates (beyond-use date) of dispensed medications shall be determined by the pharmacist at the time of dispensing. B. Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date. C. Certain medications or package types, such as IV (intravenous) solutions, multiple dose injectable vials, ophthalmic, nitroglycerin tablets, blood sugar testing solutions and strips, once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency. 1) Drugs re-packaged by the pharmacy staff will generally carry an expiration date (beyond- use date) as follows: (Note: the pharmacist determines the exact date based upon a number of factors as well as applicable law or regulation). When the beyond-use dating for a medication identifies a month and year, the medication can be used through the last day of the month. a. Blister-pack cards and medication vials - 12 months from the date of dispensing (where the manufacturer's expiration date is longer than 12 months). If the manufacturer's expiration date is less than 12 months, the expiration date on the label will be the manufacturer's date. b. Medications in multi-dose packaging will have a beyond-use dating of 60 days or the manufacturer's expiration date if less than 60 days. c. Drugs dispensed in the manufacturer's original container will carry the manufacturer's expiration date. Once opened, these will be good to use until the manufacturer's expiration date is reached unless the medication is: 1. In a multi-dose injectable vial 2. An ophthalmic medication (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. An item for which the manufacturer has specified a usable life after opening D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1) The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a date opened and expiration notation line). The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure coordinated hospice service visits for one resident (R9), of one resident reviewed for end of life care, resulting in the potential for unmet end of life care needs. Findings include: On 7/2/25 at 12:57 PM, a review of R9's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: dementia, acute respiratory failure, high blood pressure, and Alzheimer's disease. Continued review of the record revealed they admitted to Hospice Services on 2/10/25. On 7/2/25 at 8:40 AM, 10:10 AM, 11:25 AM and 11:40 AM requests were made for the facility to provide R9's Hospice staff visit schedule with the defined discipline of whom was visiting (nurse, aide, social services, spiritual staff, etc). On 7/2/25 at 1:54 PM a copy of the visit schedule was provided, however the copy provided was grainy and difficult to read. The schedule included names of contracted hospice staff but it did not indicate the discipline of whom was visiting as requested. The schedules and Hospice progress notes for nurses revealed a nurse visit on 4/22/25 and the next one occurring on 5/2/25, 10 days later. The notes further indicated a Hospice nurse visit on 5/13/25, another visit in May that was not dated, and the next visit occurring on 6/12/25, revealing only three nurse visits in a one month period. Continued review of the notes for the Hospice Aide visits was conducted and revealed one visit in February 2025, four visits in March 2025, three visits in April 2025, no visits for May 2025 and four visits for June 2025. On 7/2/25 at 10:00 AM, an interview was conducted with Social Worker 'D'. They were asked who monitored to ensure Hospice staff were performing their scheduled visits and said they did not know but would find out. Social Worker 'D' did not follow up with who was responsible for ensuring the provision of Hospice services by the end of the survey. On 7/2/25 at 11:40 AM, an interview was conducted with the Director of Nursing (DON) regarding the provision of Hospice services and oversight. The DON indicated the Hospice staff and facility staff should be following the care plans. At that time, the DON was asked about the absence of a facility initiated care plan for R9's Hospice services and said they should have one in place. A review of a facility provided policy titled, Hospice Program was conducted and read, .10. In general it the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs .13. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 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 and resident dissatisfaction. Findings Include: On 7/1/25 at approximately 11 AM, a review of the facility bed count information sheets and observations of Medicare/Medicaid resident rooms measurements provided by the facility administrator revealed the following: ROOM# SQ. FT. # OF BEDS 101 149.46 2 102 148.4 2 103 148.4 2 104 148.4 2 105 148.4 2 106 148.4 2 107 148.4 2 108 148.4 2 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	109 148.4 2 110 149.46 2 111 149.46 2 112 149.46 2 113 149.46 2 201 149.46 2 202 148.4 2 203 148.4 2 204 148.4 2 205 148.4 2 206 148.4 2 207 148.4 2 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	07/02/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	208 148.4 2 209 148.4 2 210 149.46 2 211 149.46 2 212 148 2 213 148.4 2 Individual and group 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. During an interview with the facility administrator on 7/2/25 at approximately 1:20 they were queried about the room waiver and their plans. The administrator reported that there were no plans for any expansion of the North halls, or make them in to single rooms. There were plans for some aesthetic changes to the rooms. They added that they would discuss with their corporate team.