STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on interview and record review, the facility failed to ensure that an annual review for mental disorder, intellectual disability or a related condition was completed with Level II Evaluation documentation for one resident (Resident #4) of three residents reviewed for mental disorder screening, resulting in the potential for services and care planning of Level II determination and recommendations not being implemented and a lack of emotional or mental health needs not met. Findings include: Resident #4: On 4/30/24 at 10:49 AM, a review of Resident #4's medical record revealed an admission into the facility on [DATE] with diagnoses that included delusional disorders, dementia, psychotic disorder, post-traumatic stress disorder (PTSD), and mood disorder. A review of Resident #4's ARR (Annual Resident Review-Form DCH-3877), dated 4/19/23, revealed the Section II-Screening Criteria that indicated the person has a current diagnoses of Mental Illness and Dementia and received treatment for Mental Illness and Dementia, routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days, and there is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgment. The form explained the Resident had MDD (major depressive disorder, PTSD, delusional disorder, dementia, Alcohol dependence - In Remission; the Resident was prescribed Seroquel (antipsychotic medication). According to michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/obra, 2024, .Under the PASARR program, all persons seeking admission to a nursing facility who are seriously mentally ill and/or have an intellectual/developmental disability are required to be evaluated to determine whether the nursing facility is the most appropriate place for them to receive services and whether they require specialized behavioral/mental health services. In addition, persons residing in a nursing facility who are seriously mentally ill and/or have an intellectual / developmental disability are required to undergo a similar review annually or when there is a significant change in condition to determine whether they continue to require the services of a nursing facility or whether they require specialized mental health services. The Level II evaluation and the evaluator's recommendations are reviewed by the State OBRA office and a final determination is made as to whether the person is appropriate for nursing facility admission/stay and whether specialized services mental health care is required. (continued on next page)

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
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #4's medical record of PASARR (Preadmission Screening (PAS)/Annual Resident Review (ARR) information revealed a letter from the Department of Health and Human Services, dated April 27, 2022. The letter revealed the following directions: (Area Community Mental Health Department) completed an OBRA (Omnibus Budget Reconciliation Act of 1987-sets federal standards of care for nursing homes) Level II Evaluation on the above-named individual and made a recommendation on placement and services. Based on the information provided by this agency, the State of Michigan Department of Health and Human Services made the following: . If the above-named individual remains in the nursing facility, a Level II Evaluation is needed by April 26, 2023 . Further review of Resident #4's medical record revealed no Level II Evaluation for April 2023 and the last PASARR review completed 4/19/23. An interview was conducted with Social Service Director (SSD) H regarding Resident #4's lack of the OBRA Level II Evaluation needed in April 2023 and lack of knowledge of potential services and care planning of Level II determination and recommendations the evaluation would indicate. The SSD indicated she was not in the SSD role at that time but indicated that Level II should have been done and should have been in the Resident's medical record. During the interview, the SSD phoned the Coordinator for the Michigan Department of Health and Human Services (Z) and questioned if the Level II Evaluation had been completed in April 2023. The Coordinator indicated it had been done, was not sent to the facility and would send a copy to the facility at this time. The Coordinator indicated the next Level II Evaluation was due this May. When queried, the SSD indicated the Level II Evaluation should have been in the Resident's medical record, it had been completed just not sent to us. A review of facility policy titled, Admission Policy, revealed, Policy Statement: Our facility admits only residents who's medical and nursing care needs can be met . 9. All new admissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process . z. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process . aa. Upon completion of the Level II evaluation, the State PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs. bb. The State PASARR representative provides a copy of the report to the facility via email .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on observation, interview and record review the facility failed to develop and implement a baseline care plan within 72 hours from admission for one resident (Resident #221) of 29 residents reviewed for baseline care plans, resulting in the potential for unmet care needs and social isolation. Findings include: Resident #221 (R221): R221 was admitted to the facility on [DATE], is [AGE] years old and has diagnoses of hypertension, dementia, Alzheimer's disease and rheumatoid arthritis. On 04/29/24 at 10:30 AM, R221 was observed sleeping in bed, dressed appropriately in pajamas, their hair was messy and there was a smell of urine noted in the room. On 04/30/24 at 09:59 AM , R221 was observed in bed eating breakfast, wearing appropriate clothing, their hair was messy and there was a smell of urine in the room. On 04/30/24 at 10:16 AM, a Wanderguard was observed on the right foot of R221. R221 was interviewed about why they have the Wanderguard on their foot. R221 stated they were unaware of why they have the Wanderguard on and didn't know what it was for. On 04/30/24 at 10:20 AM, record review revealed that R221 was on hospice services, there were no progress notes or rationale why a Wanderguard was placed and an assessment revealed an elopement score of 1.0 on admission (low risk for elopement). On 05/01/24 at 10:51 AM, record review revealed R221 has no care plans in place for Activities of Daily Living (ADL), Wanderguards or hospice care. On 05/01/24 at 11:30 AM, an interview was conducted with the Certified Nursing Assistant (CNA) providing care, CNA 'F' was asked what kind of assistance does R221 need and where would you and other staff look to know how much assistance R221 needs. CNA 'F' replied that R221 is an extensive one assist for dressing, eats independently and is a one assist for showers. CNA 'F' stated they would look in the Kardex(A component of the electronic charting that allows CNA's the ability to see the care needs of the resident, Kardex is populated from a completed care plan) and that the resident gets showers twice a week but cannot remember the shower days. On 05/01/24 at 11:50 AM, record review revealed no care plans related to ADL's and therefore no Kardex for the CNA's to reference for care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/24 at 02:07 PM, the Director of Nursing (DON) was interviewed about the Wanderguard on R221, the DON was asked if Resident #221 should have a care plan and justification for the Wanderguard. The DON stated yes there should be a care plan and reason for placement of the Wanderguard. The DON was asked if R221 should have a care plan for hospice care. The DON stated that a care plan is produced for hospice in 7-10 days. The DON was asked if hospice care should have a care plan and they stated yes, hospice should have its own care plan for the residents on hospice. On 05/01/24 at 02:14 PM, registered nurse (RN) 'D' was interviewed about R221 and why they had a Wanderguard on. RN 'D' stated that they did the admission and that R221 has the Wanderguard on due to family request because the resident was so close to an exit door. RN 'D' stated that she would go contact the family and see if they still want it in place since the resident was no longer in a room near an exit door. RN 'D' was asked if there should be a care plan, rationale and progress note for the Wanderguard and RN 'D' stated yes. On 05/02/24 at 12:55 PM an interview was conducted with the Minimum Data Set (MDS) Coordinator. The MDS Coordinator was asked why R221 didn't have care plans present in their health record. The MDS Coordinator stated the care plans are present now but isn't sure how they missed them this long. MDS Coordinator stated that a baseline care plan was completed in the assessment section of the health record. The MDS Coordinator was asked if the CNA's would be aware of this assessment and the information within it to provide care. The MDS Coordinator stated this information would not get relayed to the CNA's unless they asked their nurse. Review of the policy entitled Baseline Care Plans revised December 2016 revealed: Policy Statement: A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within Seventy-two (72) hours of admission. Policy Interpretation and Implementation: 1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within Seventy-two (72) hours of the resident's admission. 2. The Interdisciplinary Team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: a. Initial goals based on admission orders; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services; and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. PASARR recommendation, if applicable. 3. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. 4. The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 - Some	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** 49944 Based on observation, interview and record review, the facility failed to develop and implement comprehensive care plans for three residents (Resident #4, Resident #217, Resident #221) of 29 residents reviewed for comprehensive care plans resulting in the potential for unmet care needs, increased pain and pressure injury. Findings include: Resident #217 (R217): R217 was admitted to the facility on [DATE], is [AGE] years old and has diagnoses of weakness, anemia, hypertension, epilepsy and obstructive sleep apnea. On 04/30/24 at 11:01 AM, resident was observed laying in bed, nasal cannula in place and an oxygen concentrator beside the bed and functioning. R217 was asked if he is on oxygen all the time and R217 stated yes, even when they were at home prior to admission. On 04/30/24 at 02:59 PM, record review revealed that R217 did not have a care plan in place for the use of oxygen. On 04/30/24 at 03:00 PM, record review revealed a physicians order to start oxygen at 2L on 4/27/24. On 05/02/24 at 01:00 PM, an interview was conducted with the Minimum Data Set (MDS) Coordinator, the MDS Coordinator was asked who would update or create a care plan if a change was made to the residents care, such as implementing oxygen use. The MDS Coordinator responded that the nurse on the floor making the change would enter a care plan and then let them know so they can review the care plan for accuracy and make changes as necessary. The MDS Coordinator was asked how this care plan entry was missed and the MDS Coordinator replied, honestly it was an oversight but it was missed. Resident #221 (R221): R221 was admitted to the facility on [DATE], is [AGE] years old and has diagnoses of hypertension, dementia, Alzheimer's disease and rheumatoid arthritis. On 04/29/24 at 10:30 AM, R221 was observed sleeping in bed, dressed appropriately in pajamas, their hair was messy and there was a smell of urine noted in the room. On 04/30/24 at 09:59 AM , R221 was observed in bed eating breakfast, wearing appropriate clothing, their hair was messy and there was a smell of urine in the room. On 04/30/24 at 10:16 AM, a Wanderguard was observed on the right foot of R221. R221 was interviewed about why they have the Wanderguard on their foot. R221 stated they were unaware of why they have the Wanderguard on and doesn't know what it's for. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 - Some	On 04/30/24 at 10:20 AM, record review revealed that R221 was on hospice services, there were no progress notes or rationale why a Wanderguard was placed and an assessment revealed an elopement score of 1.0 on admission (low risk for elopement). On 05/01/24 at 10:51 AM, record review revealed R221 has no care plans in place for activities of daily living (ADLs), Wanderguards or hospice care. On 05/01/24 at 11:30 AM, an interview was conducted with the Certified Nursing Assistant (CNA) providing care, CNA 'F' was asked what kind of assistance does R221 need and where would you and other staff look to know how much assistance R221 needs. CNA 'F' replied that R221 is an extensive one assist for dressing, eats independently and is a one assist for showers. CNA 'F' stated they would look in the Kardex(A component of the electronic charting that allows CNA's the ability to see the care needs of the resident, Kardex is populated from a completed care plan) and that the resident gets showers twice a week but cannot remember the shower days. On 05/01/24 at 11:50 AM, record review revealed no care plans related to ADL's and therefore no Kardex for the CNA's to reference for care. On 05/01/24 at 02:07 PM, the Director of Nursing (DON) was interviewed about the Wanderguard on R221, the DON was asked if Resident #221 should have a care plan and justification for the Wanderguard. The DON stated yes there should be a care plan and reason for placement of the Wanderguard The DON was asked if R221 should have a care plan for hospice care. The DON stated that a care plan is produced for hospice in 7-10 days. The DON was interviewed and asked if hospice care should have a care plan and they stated yes. Hospice should have its own care plan for the residents on hospice. On 05/01/24 at 02:14 PM, Registered Nurse (RN) 'D' was interviewed about R221 and why they had a Wanderguard on. RN 'D' stated that they did the admission and that R221 has the Wanderguard on due to family request because the resident was so close to an exit door. RN 'D' stated that she would go contact the family and see if they still want it in place. RN 'D' was asked if there should be a care plan, rationale and progress note for the Wanderguard and RN 'D' stated yes. On 05/02/24 at 12:55 PM an interview was conducted with the MDS Coordinator. The MDS Coordinator was asked why R221 didn't have care plans present in their health record. The MDS Coordinator stated the care plans are present now but isn't sure how she missed them this long. MDS Coordinator stated that a baseline care plan was completed in the assessment section of the health record. The MDS Coordinator was asked if the CNA's would be aware of this assessment and the information within it to provide care. The MDS Coordinator stated this information would not get relayed to the CNA's unless they asked their nurse. 37771 Resident #4: On 4/30/24 at 10:49 AM, a review of Resident #4's medical record revealed an admission into the facility on [DATE] with diagnoses that included delusional disorders, dementia, psychotic disorder, post-traumatic stress disorder (PTSD), and mood disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 - Some	A review of Resident #4's medical record of PASARR (Preadmission Screening (PAS)/Annual Resident Review (ARR) information revealed a letter from the Department of Health and Human Services, dated April 27, 2022. The letter revealed the following directions: (Area Community Mental Health Department) completed an OBRA (Omnibus Budget Reconciliation Act of 1987-sets federal standards of care for nursing homes) Level II Evaluation on the above-named individual and made a recommendation on placement and services. Based on the information provided by this agency, the State of Michigan Department of Health and Human Services made the following: . If the above-named individual remains in the nursing facility, a Level II Evaluation is needed by April 26, 2023 . and Results of the Determination: The individual may continue to reside in a nursing facility and may choose to receive specialized mental health/developmental disabilities services. The local community mental health service agency will discuss with the individual, the individual's legal representative and the nursing facility a plan for the provision of specialized services . Review of Resident #4's medical record revealed a lack of documentation of the Level II Evaluation with determination and recommendations required April 2023. A review of Resident #4's care plan lacked a Focus, Goal and Interventions for care planning for PASARR yearly evaluations, need for Level II Evaluation and/or listed determinations and recommendations from the Level II Evaluations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake Number MI00143170. Based on observation, interview and record review, the facility failed to review and revise care plans with resident changes to ensure interventions necessary for care and services were provided for one resident (Resident # 56) of 29 residents reviewed for care plans, resulting in the potential for unmet care needs. Findings Include: Resident #56: Accidents On 4/29/2024 at 12:15 PM during a tour of the facility, Resident #56 was observed lying in bed, alert and talkative. Her bed was in a very low position near the floor. Her lunch tray was present and sitting on the bedside table, which was positioned much higher than the resident's height in the bed. Resident #56 was observed attempting to roll over in bed to reach her tray that was on the bedside table. She couldn't reach it and continued to lean over and reach up in an attempt to reach the tray. A staff member was notified in the hallway that the resident needed assistance. A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #56 was admitted to the facility on [DATE] with diagnoses: heart failure, diabetes, atrial fibrillation, hypertension, depression, arthritis, obesity and history of falls. The MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 2/15. A review of the progress notes indicated Resident #56 had fallen eight times at the facility from 9/2023-4/29/2024 including: 9/8/2023, 9/28/2023, 10/10/2023, 12/5/2023, 1/10/2023, 1/23/2023, 4/21/2023, 4/29/2023 A record review of the progress notes indicated Resident #56 fell and fractured her left femur on 1/23/2024. She was transferred to the hospital on 1/23/2024 after the fall for pain in her left knee, admitted to the hospital and returned to the facility on [DATE]. The resident did not have surgical repair of the fracture and returned with a left knee immobilizer in place. On 5/6/2024 at 9:56 AM, wound care was observed for Resident #56 with Nurse D. She said the resident had developed a pressure ulcer/ left outer ankle at the facility from the left knee immobilizer not fitting well and on the right outer ankle from immobility and pressure lying in bed. A review of the Care plans for Resident #56 revealed the following: After Resident #56 fell on [DATE] the Care plan was updated with an intervention Anticipate and meet my needs; Be sure my call light is in reach .prompt response. 9/14/2024 I need a safe environment . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After the resident fell on [DATE], there was no update to the Care plan. After the resident fell on [DATE], there was no update to the Care plan to aid in preventing future falls. After the resident fell on [DATE], the Care plan was updated with, Educate the resident /family/caregiver about safety reminders and what to do if a fall occurs; dycem to wheelchair. After the resident fell on [DATE] the Care plan was updated with ,PT evaluate and treat as ordered or prn (as needed); Call daughter to try and alleviate resident anxiety. The next fall was on 1/23/2024 and the resident fractured their left femur. The intervention was I am at risk for falls related to confusion and anxiety; Bed to be in low position at all times when care is not being provided; I am at risk for falls rt confusion and anxiety. After the resident fell on [DATE] the Care plan interventions were, Monitor me, due to high fall risk; Encourage resident to keep the bed at 30 degrees related to resident sliding. The resident interventions were basic fall prevention strategies and often not initiated until after the resident had fallen multiple times. The resident was At risk for fall . months before she fell and fractured her left femur, but the intervention was initiated on 4/21/2024. After several of the falls, no new interventions were identified and the resident continued to fall. On 5/06/24 at 4:16 PM, during an interview with the Director of Nursing/DON and Administrator, Resident #56's falls were reviewed. The resident's Care plans were reviewed and discussed the lack of interventions to aid in preventing falls. The DON said the Care plans were completed by the MDS coordinator and nurses and she was looking into them. A review of the facility policy titled, Care Plans, Comprehensive Person-Centered, dated December 2016 provided, A comprehensive, person-centered care plan that includes measurable goals, objectives, and timetables to meet the resident's physical, psychosocial and functional needs . The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . Reflect currently recognized standards of practice for problem areas and conditions . Assessment of residents are ongoing and care plans are revised as information about the residents and the residents conditions change . The Interdisciplinary Team must review and update the care plan: . When the desired outcome is not met .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 - Minimal harm or potential for 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** 37666 Based on observation, interview and record review, the facility failed to ensure that interventions were in place to prevent facility-acquired pressure ulcers for one resident (Resident # 56) of four residents reviewed for pressure ulcers, resulting in Resident #56 developing two facility-acquired pressure ulcers. Findings Include: Resident #56: Pressure Ulcer/Injury On 4/29/2024 at 12:15 PM during a tour of the facility, Resident #56 was observed lying in bed, alert and talkative. Her bed was in a very low position near the floor. The resident was asked if she had any wounds and said yes and pointed at her feet. A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #56 was admitted to the facility on [DATE] with diagnoses: heart failure, diabetes, atrial fibrillation, hypertension, depression, arthritis, obesity and history of falls. The MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 2/15. A record review of the progress notes indicated Resident #56 fell and fractured her left femur on 1/23/2024. She was transferred to the hospital on 1/23/2024 after the fall for pain in her left knee, admitted to the hospital and returned to the facility on [DATE]. The resident did not have surgical repair of the fracture and returned with a left knee immobilizer in place. On 5/6/2024 at 9:56 AM, wound care was observed for Resident #56 with Nurse D. She said the resident had developed a pressure ulcer/ left outer ankle Stage 2 at the facility from the left knee immobilizer not fitting well and a Stage 2 on the right outer heel from immobility and pressure lying in bed. Both wounds were reddened and with peeling denuded skin. A record review of the progress notes and assessments indicated Resident #56 developed a Stage 2 pressure ulcer on her left lateral malleolus/ankle after wearing a left knee immobilizer due to a fall at the facility that caused a left femur fracture. On 3/7/2024 the resident had a dark scab on the left ankle. A Skin and Wound Evaluation for Resident #56 dated 3/26/2024 identified a Stage 2 facility acquired pressure ulcer on the left lateral malleolus. The wound measured 1.6 cm length x 0.9 cm width. A Skin and Wound Evaluation for Resident #56 dated 4/30/2024 revealed a Stage 2 facility acquired pressure ulcer that measured 1.3 cm length x 0.8 cm width. There was no assessment for the right outer heel wound. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 - Minimal harm or potential for actual harm Residents Affected - Few	A review of the physician orders for Resident #56 identified an order for Heel boots while in bed as tolerated, dated 3/27/2024. They were ordered after the Stage 2 pressure ulcer to the left lateral malleolus had developed. An order for the right heel was dated 4/28/2024, Cleanse right heel with normal saline, pat dry apply optifoam every day shift every 3 days for wound care. There was an order to check circulation of the resident's left lower extremity dated 1/26/2024, but no order to assess and ensure the left knee immobilizer was in proper position to aid in preventing skin breakdown. A review of the facility policy titled, Pressure Ulcer/Injury Risk Assessment, dated revised July 2017 provided, The purpose of this procedure is to provide guidelines for the structured assessment and identification of resident at risk of developing pressure ulcers/injuries . The purpose of a structured risk assessment is to identify all risk factors . Risk factors that increase a resident's susceptibility to develop or to not heal PU/PI (pressure ulcer/pressure injury) include . Impaired/decreased mobility and decreased functional ability . Once the assessment is conducted and risk factors are identified and characterized a resident-centered care plan can be created to address the modifiable risks for pressure ulcers/injuries .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 - 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** 37666 This Citation pertains to Intake Number MI00143170. Based on observation, interview and record review, the facility failed to ensure appropriate interventions were in place and supervision was provided to prevent a fall with injury for one resident (Resident #56) of 3 residents reviewed for falls, resulting in Resident #56 falling out of bed and suffering a femur fracture. Findings Include: Resident #56: Accidents On 4/29/2024 at 12:15 PM during a tour of the facility, Resident #56 was observed lying in bed, alert and talkative. Her bed was in a very low position near the floor. Her lunch tray was present and sitting on the bedside table, which was positioned much higher than the resident's height in the bed. Resident #56 was observed attempting to roll over in bed to reach her tray that was on the bedside table. She couldn't reach it and continued to lean over and reach up in an attempt to reach the tray. A staff member was notified in the hallway that the resident needed assistance. The resident was identified A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #56 was admitted to the facility on [DATE] with diagnoses: heart failure, diabetes, atrial fibrillation, hypertension, depression, arthritis, obesity and history of falls. The MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 2/15. A review of the progress notes indicated Resident #56 had fallen seven times at the facility from 9/8/2023-4/29/2024 including: 9/8/2023, 9/14/2023, 9/28/2023, 12/5/2023, 1/23/2023, 4/21/2023, and 4/29/2023. A review of the Incident and Accident Reports for each fall, indicated the falls occurred in the late afternoon, evening and night. 9/8/2023 at 5:09 PM: Was called to room [ROOM NUMBER], observed resident sitting on the floor in front of w/c (wheel chair), legs straight out in front of her . 9/14/2023 at 5:15 PM: Writer called into room regarding resident being observed on the floor. Staff entered room and resident was sitting on her buttocks leaning against her bed with feet in front of her . 9/28/2023 at 5:00 PM: Writer to room rounding on resident, observed resident on floor between beds laying parallel to beds face up flat on back . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 - Actual harm Residents Affected - Few	12/5/2023 at 5:50 PM: Writer went to dining room after code green called overhead to dining room. Found resident lying on left on the floor in front of wheel chair . small skin tear on left elbow . 1/23/2024 at 12:25 AM revealed the following: Writer called to residents room to find resident on the floor face down. Resident had pulled side rail off of bed prior to falling on the floor. Resident assessed for injuries. Resident noted with edema and bruising to forehead. Small scrape to left knee . abrasion left knee, bruise top of scalp . A record review of the progress notes indicated Resident #56 fell and fractured her left femur on 1/23/2024 at 12:25 AM. She was transferred to the hospital on 1/23/2024 after the fall, for pain in her left knee. She was admitted to the hospital and returned to the facility on [DATE]. The resident did not have surgical repair of the fracture and returned with a left knee immobilizer in place. 4/21/2024 at 1:40 AM: Resident sitting on floor next to bed leaning against bed . 4/29/2024 at 10:25 PM: Writer called to resident's room. Resident on floor next to bed. Lying on her side . Each of the falls, that Resident #56 had, were unwitnessed. On 5/6/2024 at 9:56 AM, wound care was observed for Resident #56 with Nurse D. She said the resident had developed a pressure ulcer/ left outer ankle at the facility from the left knee immobilizer not fitting well and on the right outer ankle from immobility and pressure lying in bed. The resident was crying out in pain when turned and repositioned. Nurse D said the resident did not have surgical repair of the left femur fracture and had pain at times. A review of the Care plans for Resident #56 revealed the following: After Resident #56 fell on [DATE] the Care plan was updated with an intervention Anticipate and meet my needs; Be sure my call light is in reach .prompt response. 9/14/2024 I need a safe environment . After the resident fell on [DATE], there was no update to the Care plan. After the resident fell on [DATE], there was no update to the Care plan to aid in preventing future falls. After the resident fell on [DATE], the Care plan was updated with, Educate the resident /family/caregiver about safety reminders and what to do if a fall occurs; dycem to wheelchair. After the resident fell on [DATE] the Care plan was updated with ,PT evaluate and treat as ordered or prn (as needed); Call daughter to try and alleviate resident anxiety. The next fall was on 1/23/2024 and the resident fractured their left femur. The intervention was I am at risk for falls related to confusion and anxiety; Bed to be in low position at all times when care is not being provided; I am at risk for falls rt confusion and anxiety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 - Actual harm Residents Affected - Few	After the resident fell on [DATE] the Care plan interventions were, Monitor me, due to high fall risk; Encourage resident to keep the bed at 30 degrees related to resident sliding. The resident interventions were basic fall prevention strategies and often not initiated until after the resident had fallen multiple times. The resident was At risk for fall . months before she fell and fractured her left femur, but the intervention was initiated on 4/21/2024. After several of the falls, no new interventions were identified and the resident continued to fall. There was no mention of ensuring supervision for Resident #56 to aid in preventing falls, as each fall was unwitnessed. There was also no mention of the time of day that the falls occurred, many were around meal time or late in the day. On 5/06/24 at 4:16 PM, during an interview with the Director of Nursing/DON and Administrator, Resident #56's falls were reviewed. The fall prevention interventions were reviewed for Resident #56. The DON said she was aware that the resident had multiple falls including the fall with fracture and was looking into it. A review of the facility policy titled, Accidents and Incidents- Investigating and Reporting, dated revised July 2017 provided, All accidents and incidents involving residents . shall be investigated and reported to the Administrator . Incident/Accident reports will be reviewed by the Safety Committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. A review of the facility policy titled, Safe Environment, dated revised July 2017 provided, . Resident safety and supervision and assistance to prevent accidents are facility- wide priorities . The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision . Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on observation, interview and record review the facility failed to ensure the maintenance and removal of a Percutaneuous Endoscopic Gastrostomy (PEG) Tube for one resident (Resident #59) of one resident reviewed for PEG Tubes, resulting in unmet care needs and feelings of hopelessness. Findings include: Resident #59 (R59): R59 is [AGE] years old, was admitted to the facility on [DATE] with diagnoses of Guillain-Barre syndrome, acute respiratory failure, dysphagia, heart failure and hypertension. On 04/29/24 at 02:07 PM, R59 was observed laying in bed, watching TV, eating snacks and drinking a pop. R59 was asked about their PEG Tube and if there were any plans for removal since they were on a regular diet now and not utilizing it. R59 stated that the tube was supposed to come out but that someone in the facility dropped the ball and no one scheduled transportation for the appointment for removal. R59 stated that now it might be June before the PEG tube is removed. R59 was asked how long they had been waiting for the PEG tube to be removed and they stated it had been since February of this year (2024). R59 stated it seems like this thing (PEG Tube) will never come out. Observation of the room revealed no supplies to flush the PEG tube. On 04/29/24 record review revealed a progress note dated 02/19/24 indicated that the physician gave approval to have the PEG tube removed due to eating whole foods again. On 04/30/24 at 12:01 PM, resident was observed laying in bed and watching TV. R59 was asked if they had their PEG tube flushed last night Resident stated that the nurse on duty last night flushed their PEG tube but that is the first time in weeks since it has been flushed and they didn't want it done since it had been so long, but the nurse insisted. A piston syringe and basin was observed next to the bed dated 04/29/24, these supplies were not present yesterday during rounds and observation. On 05/01/24 at 11:02 AM, the Director of Nursing (DON) approached this surveyor in the hallway and stated that R59 is currently out on an appointment to have her PEG tube removed. On 05/01/24 at 11:24 AM, R59 was observed sitting up in their bed and had just gotten back from their appointment. R59 was asked how the appointment went and did they get the PEG tube removed. R59 states that they went and saw their neurologist today and it was not a GI appointment to get the PEG tube removed. R59 was asked if nursing staff flushed the PEG tube last night. R59 states that nurses did not flush the PEG tube last night, 4/30/24 and there is currently no dressing on it. Observed no dressing over the PEG tube site and no supplies in the room to flush the PEG tube. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/24 at 11:52 AM, an Interview was conducted with the Registered Dietitian (RD) about the PEG tube for R59 and why they still had a PEG tube in place. RD stated that the resident had an appointment canceled by [NAME] hospital for the removal of the PEG tube and it had to be rescheduled. The RD was asked if they think R59's weights were stable and the RD believes since 02/9/24 they have been stable and R59 has gained weight. The RD was asked if they would feel comfortable if R59 were to have their PEG tube removed. The RD stated they are comfortable with R59 not having a PEG tube in anymore. On 05/01/24 at 11:59 AM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA was asked why R59 still had their PEG tube in, despite R59 wanting it removed and the physician giving an order to remove it. The NHA said R59's appointment is now scheduled for June 4th and that the facility finds it tough to find stretcher transport which is what the resident would need. The NHA stated again that the main reason R59 hasn't gone for the removal of the PEG tube is due to transportation issues. On 05/01/24 at 12:05 PM, an interview was conducted with the DON about why R59 still has their PEG tube in place. The DON stated they told R59 that if the PEG tube is not stitched in they can remove the PEG tube for them. The DON stated the plan as of right now is to pull the PEG tube in the facility if it is cleared by the Gastroinstestinal (GI) physician. The DON stated the main reason the PEG tube has not been removed is because the residents weights have not been stable. On 05/01/24 at 12:14 PM, record review of R59's weights was conducted. 4/25/2024 12:24 138.0 Lbs Mechanical Lift jshapardon (Manual) 4/18/2024 10:32 138.0 Lbs Mechanical Lift (Manual) 3/1/2024 07:43 135.0 Lbs Mechanical Lift (Manual) 2/23/2024 11:44 132.5 Lbs Mechanical Lift (Manual) 2/16/2024 18:23 132.2 Lbs Mechanical Lift (Manual) 2/9/2024 20:08 132.2 Lbs Mechanical Lift (Manual) On 05/06/24 at 02:17 PM, R59 stated her PEG tube removal appointment is scheduled for May 28, 2024. R59 was asked when was the last time someone flushed her PEG tube. R59 stated that the last time it was flushed was last week and not since then. Observation of the room revealed no piston syringe located in the room to flush the PEG tube. On 05/07/24 at 09:43 AM, R59 was asked if the PEG tube was flushed last night or this morning and R59 stated no it wasn't. Observation of the room revealed no piston syringe present to flush the tube. On 05/07/24 at 09:58 AM, record review revealed a progress note from the RD dated 01/23/24 that stated, . resident is transitioning to an all oral diet, so she has declined her enteral feedings over the past week in an attempt to build an appetite. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/24 at 10:05 AM, record review revealed a progress note from the RD dated 01/31/24 that stated, . most recent wt. shows a wt. gain of 5.8 lbs in the last 6 days. BMI is in a healthy range at 21.2. Resident said she is waiting to hear when they can pull out my PEG tube. On 05/07/24 at 10:10 AM, record review revealed a progress note from the RD dated 02/10/24 that stated, . per nursing and dietary staff observations, resident continues her pattern of grazing throughout the day, which is promoting wt. maintenance/gain. Recommend enteral feeding orders be dc'd and PEG tube pulled as per residents wishes. Medical providers notified via tiger text today. On 05/07/24 at 10:15 AM, record review revealed a progress note from the RD dated 02/18/24 that stated, recommendation sent today via tiger text to medical provider/MD to D/C enteral orders and schedule appmnt. for PEG removal, as per resident's wishes. On 05/07/24 at 10:20 AM, record review revealed physician orders on 02/19/24 and 02/25/24 to discontinue the PEG tube. On 05/01/24 at 11:21 AM, review of the electronic health record (EHR) revealed a physician visit progress note from 03/07/24 that stated to schedule PEG tube removal with GI. Record review of the EHR also revealed R59 was started on an oral diet on 1/28/23 and the last 30 days of food acceptance records (FAR) reveals that R59 consumes 75-100% of meals. Review of the policy entitled Enteral Nutrition revised November 2018 revealed: 7. The decision to continue or discontinue the use of the feeding tube is made through collaboration between the interdisciplinary team, the provider and the resident. 11. The Nurse confirms that orders for enteral nutrition are complete. Complete orders include: a. The enteral nutrition product; b. Delivery site (tip placement); c. The specific enteral access device (nasogastric, gastric, jejunostomy tube, etc.; d. Administration method (continuous, bolus, intermittent); e. Volume and rate of administration; f. The volume/rate goals and recommendations for advancement toward these; and g. Instructions for flushing (solution, volume, frequency, timing and 24-hour volume). 17. Residents receiving enteral nutrition are periodically reassessed for the continued appropriateness and necessity of the feeding tube. Results of these assessments are documented and any changes are made to the care plan. Input from the resident or legal representative is included in the assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 This Citation Pertains to Intake Numbers MI00137112, MI00139663, MI00140315, and MI00143170. Based on observation, interview and record review, the facility failed to ensure sufficient nursing staff to meet the needs of six residents (Resident #2, Resident #24, Resident #59, Resident #60, Resident #118 and Resident #167), of 11 residents reviewed for staffing, and a Confidential Group of Residents, potentially effecting all 62 residents who reside in the facility, resulting in staff verbalization of being unable to adequately provide timely care and/or supervision, residents' voicing frustration with long call light response times, a lack of supervision for residents' safety and the potential of unmet care needs. Findings include: Resident #2: On [DATE] at 2:46 PM, during the initial tour of the facility, Resident #2 was interviewed. The Resident was asked about concerns they had. The Resident reported not getting the help she needs to eat. The Resident indicated they would put the call light on and doesn't get it answered. Resident #24: A review of Resident #24's medical record revealed an admission into the facility on [DATE] and readmission on [DATE] with diagnoses that included cataracts, dementia, schizophrenia, anxiety disorder, and heart disease. A review of the MDS assessment revealed the Resident had a BIMS score of ,d+[DATE] that indicated severely impaired cognition and was independent with eating and oral hygiene and dependent with toileting hygiene, and bathing. On [DATE] at 9:48 AM, an observation was made of Resident #24 lying in bed, no clothes on but had a brief on. The Resident's body was positioned crooked in the bed. The Resident was interviewed and answered limited simple questions. The Resident was asked about their call light, and he indicated he used it all the time. When asked where it was located, the Resident had a cord that was on the wall with the bed next to the wall. The Resident reached for the cord and reported he could not reach for it and stated, It hurts to do that. I can't get it. Does not matter, it doesn't work anyway. The end of the cord with the call light apparatus was observed to be on the floor and not within reach of the Resident. The Resident was asked about the call light not working. The Resident reported that staff don't answer it when he uses it and that he has to wait a long time. Resident #59: On [DATE] at 2:03 PM, during the initial tour of the facility, Resident #59 was asked about concerns they had regarding staffing. The Resident indicated the facility can't seem to keep staff. They bring them in and then they quit. The Resident reported that every shift struggles and it depended on staff call-ins and indicated they believed they were short staffed with CNA's (certified nursing assistants). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #167: A review of Resident #167's medical record revealed an admission into the facility on [DATE] with diagnoses that included chronic respiratory failure, weakness, diabetes, heart failure and tracheostomy status. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of ,d+[DATE] that indicated intact cognition. [DATE] 09:35 AM, an interview was conducted with Resident #167. The Resident had a tracheostomy but was able to answer questions and engage in conversation. The Resident complained that the call light when they used it took a long time to answer. When asked if they had to wait more than a half an hour the Resident nodded their head and said yes. Confidential Staff Interviews: An interview was conducted with Confidential Staff (CS) GG regarding sufficient staffing concerns. The CS was asked about sufficient staffing on the day shift. The CS indicated that three nurses were scheduled for the day shift but often they had only two nurses on. The CS indicated that if there was a call in or no show, the position would not be filled, and they would work with the two nurses on. The CS indicated that someone would help with medication pass but then the two nurses on split the Residents with a census in the 60's and stated, It's a lot. They try to get someone to cover, if no on picks it up, they go with just the two nurses, and reported that after about 10:00 AM, there were only two nurses on with difficulty with supervision on Residents, answering the phones, finding coverage for the next shift. When asked if they felt it was safe the CS stated, No, I do not, and indicated issues with falls, hospital transfers, potential choking in the dining room, late medication pass and blood sugar monitoring. The CS was asked about the night shift. The CS indicated that they usually had two nurses on and four CNA's but have had three CNA's and reported it had happened that they only had two CNA's through the night. An interview was conducted with Confidential Staff (CS) HH regarding sufficient staffing concerns. The CS was asked about sufficient staffing on the day shift. The CS indicated that there was not sufficient staffing and stated, They try to hire people, none of them stay. Staff come and see what it is like and then they don't stay. When asked if call-ins were covered, the CS indicated that they usually run short or mandated to stay to cover at least a couple hours of the next shift. The CS reported there had been only two CNA's on the night shift and stated, That has happened with just two CNA's. They had a call in, and no one would pick up. The CS reported issues with not enough staff that include checking and changing incontinence care that was more than two hours or could not get done and then stay to help the next shift, longer call light response. The CS reported the CNA's do their best, care not up to par, they are running all the time. When asked if Nurses assist the CNA's, the CS reported that some try to help but they are swamped with their own work, they don't have time to answer call lights. If something happens, it's a bad night. An interview was conducted with Confidential Staff (CS) X regarding sufficient staffing concerns on the night shift. The CS indicated that four CNA's were staffed but the shift usually had three CNA's and stated, They aim for four, and they had a couple nights where they only had two CNA's. The CS reported that they don't cover the call-ins, all the time. The CS reported difficulties when working short staffed of call lights not answered timely, staff supper busy, check and change rounds get done then it was time to do it again. When asked about call light wait times, the CS reported sometimes call lights were on for more than a half an hour. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Confidential Staff (CS) II regarding sufficient staffing concerns on the night shift. The CS stated, We could use extra. Staffing is there, but people call in, some will stay over to help. The CS reported the late call-ins or no-call-no-shows were a problem because the shift had already started, and the CNA's would work with only three on instead of the four that they try to schedule. On [DATE] at 3:03 PM, an interview was conducted with Scheduler Q for the sufficient staffing task of the survey. The Scheduler was asked about average census and reported an average of 59 to 63 and up to 66. The Scheduler was asked about the staffing goals for the shifts and the Scheduler reported day shift nurses they schedule three, CNA's five to seven with 5 on assigned units and 2 shower aides with the shifts being from 6 am to PM. If census is below 63 then they will run with 5 aides on the floor once showers are done. Ideal staffing for night shift was two nurses scheduled and if the census was above 65 then two 12 hours from PM to 6:30 am and a nurse for the PM to 1 shift and if census was 66 or higher then run the 3rd nurse for the 12 hours. For CNA's on the night shift, four CNA's for 12-hour shifts. On [DATE] at 11:54 AM, the staffing on the Assignment Sheets and schedule provided by the facility, for the end of February and beginning of March, were reviewed with Scheduler Q. The following was revealed: -[DATE], census 62, had three CNA's from PM to 11 P. -[DATE], census 62, had three CNA's covering the night shift from PM to 6 am. -[DATE], census 62, had one 12-hour CNA and two CNA's split the shift with two other CNA's, giving a total of three CNA's on through the shift that did not meet ideal staffing requirements. -[DATE], census 63, had three CNA's from PM to 10:15 PM. -[DATE], census 62, with 4 CNA's on from 6 am-PM and 3 CNA's from PM-PM. When asked about this day the Scheduler stated, No one to come in and no one to work, and reported that sometimes they will pull the Restorative CNA. When asked how often the Restorative CNA was pulled to take an assignment, the Scheduler reported it depended on staffing and stated, Some weeks none, sometimes two to three times a week. The Scheduler stated that for ,d+[DATE] call ins were an issue. Try to find coverage, sometimes able, sometimes not. Four CNA's had called in for day shift and one CNA called in for night shift. There were three CNA's that were assigned an assignment and a fourth CNA on the assignment sheet with two of the CNA's not starting the shift until 8:30 leaving only two CNA's on until 8:30 PM. The Scheduler was asked if the day shift and night shift meet the ideal staffing. The Scheduler indicated no, it did not. -[DATE], census 63, with two CNA's from 1 to 6 am. -[DATE], census 61, with two CNA's from 1 to 6 am. -[DATE], census 62, with three CNA's on from PM to 12 am, two CNA's from 12 am to PM, and three CNA's from 2 am to 6 am. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Scheduler was asked about meeting ideal staffing on multiple days reviewed. The Scheduler reported that call-ins were an issue, and that finding coverage was difficult, day shift could pull a CNA like from Restorative CNA or the office assistant, a Nurse to do medication pass in the morning, and sometimes mandating staff to stay over. The Scheduler indicated that ideal scheduling for night shift CNA's was to have four on for census above 60 and stated, try to find coverage sometimes able sometimes not. 37666 A review of the facility policy titled, Safe Environment, dated revised [DATE] provided, . Resident safety and supervision and assistance to prevent accidents are facility- wide priorities . The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision . Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs . Resident #118: A record review of the Face sheet and MDS assessment indicated Resident #118 was admitted to the facility on [DATE] with diagnoses: history of a Stroke, history of falls, weakness, arthritis, dementia, depression, hypertension, history of seizures and atrial fibrillation. The MDS assessment dated [DATE] revealed the resident had severe cognitive decline with a BIMS score of ,d+[DATE] and the resident needed assistance with all care. A record review indicated Resident #118 fell on [DATE] at approximately 10:30 AM, in her room, hit her head, and was bleeding. The Emergency Medical Services/EMS was called and the resident was sent to the hospital. On [DATE] at 1:41 PM, the DON and Administrator were interviewed about Resident #118 falling. The DON said the incident was not reported to the State Agency and the facility had a soft file for the investigation. The incident was reviewed during the interview. The DON said the resident fell on [DATE], hit her head, and her roommate called for help. The DON said she was present in the facility and assisted the resident. She said the residents head was bleeding a lot; she held it while the resident was transferred. When the resident was in bed, she wrapped the wound above the right eye with gauze and then EMS came. She said the resident was sent to the hospital and later died . Further review of the Incident Investigation for Resident #118 on [DATE] identified the following: An interview with Occupational Therapy Assistant CC by the DON on [DATE], At about 11:30 AM, resident (roommate of Resident #118) was in the main hall yelling that someone had fallen in her room. Myself and (Nurse Aide) P entered the room to find (Resident #118) laying on the floor next to the side of her bed. (Nurse Aide P) told me to get a nurse because (Resident #118) was bleeding . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] 03:40 PM, interviewed Nurse BB, she said she was working the day the resident fell on [DATE], she stated, It was tragic, as the resident hurt herself, was bleeding a lot and went to the hospital and died . She said the resident had prior falls. She was unsure of interventions for the resident to prevent falls, she would need to look it up. She said there had been a lot of resident falls. She said that on that day [DATE] there were 2 nurses working on the dayshift. They divided half of the building each and she said it was very busy. The nurse said there were usually 3 nurses assigned on the day shift. A review of the staffing assignments for [DATE] on the day shift indicated 2 nurses were assigned to cover the Main Hall, East Hall and North Halls with another nurse assigned to assist from 2:00 PM-6:30 PM. The wound nurse was assigned to assist on the floor until 11:00 AM. The facility normally had a nurse assigned to each hall on the dayshift 6 AM to 6:30 PM. There was 1 Nurse Aide assigned to the East Hall for approximately 20 residents. Resident #118's room was on the East Hall, and she fell at approximately 10:30 AM. 49944 Resident #60: On [DATE] ay 01:18 PM, R60 was interviewed about call light response time in the facility. R60 stated that after PM it is difficult to get help and after midnight you can forget about getting any help. R60 stated that they believe that if they were to fall out of bed after midnight that they wouldn't be found for a long time. R60 stated that some nursing staff are bad and some are good. R60 wonders what the midnight staff is doing, R60 stated that they never see the nursing staff go by their room at night and If they put their call light on after midnight the minimum wait is 30 minutes. R60 went on to say that nursing staff will speak to them from the door and tells them that they have a lot of people ahead of him and they will get to them when they can. R60 also stated that he calls the NHA at home if he needs any help and staff isn't providing it on midnights. On [DATE] at 02:08 PM, R60 was observed laying in bed watching TV. R60 has not been observed turning his call light on during the survey. R60 was asked if he uses his call light more at night then during the day and he said yes. When R60 was asked why they use their call light more on the night shift then the day shift. R60 stated they don't use their call light much during the day because they are content watching You Tube and don't require much assistance. R60 followed this statement up by stating at night if you want something you are in big trouble, they will not come to help you. Facility A review was conducted of the daily staffing postings for the facility and it revealed inaccuracies in the daily staff posting hours and the actual scheduled/worked hours. On [DATE] the posted working hours for Certified Nursing Assistants (CNA's) was 36 hrs from 6:00 am-6:fpm, a review of the staff sign in sheet revealed that there were only 28 hrs worked in that time frame. One of the three CNA's scheduled worked a 4hr shift but it was counted as 12hrs on the daily posting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] the posted working hours for CNA's was 94 hrs from 6:00 am-6:fpm, a review of the staff sign in sheet revealed that there were only 72 hrs worked in that time frame. There were only 6 CNA's scheduled for 12hrs shifts that day. On [DATE] the posted working hours for CNA's was 36 hrs from 6:00 am-6:fpm, a review of the staff sign in sheet revealed that there were only 28 hrs worked in that time frame. On [DATE] the posted working hours for CNA's was 46 hrs from 6:fpm-6:00 am, a review of the staff sign in sheet revealed that there were only 36 hrs worked in that time frame. There were 3 CNA's scheduled for 12hr shifts for that day. On [DATE] the posted working hours for CNA's was 70 hrs from 6:00 am-6:fpm, a review of the staff sign in sheet revealed that there were only 60hrs worked in that time frame. There were 5 CNA's scheduled for 12hr shifts and one restorative CNA scheduled for a 10hr shift, however, the restorative CNA is not on the sign in sheet and did not take an assignment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 37771 Based on observation, interview and record review, the facility failed to ensure that the required posting of daily nurse staffing was accurate and updated, resulting in a lack of accurate documentation of daily staffing and a lack of accurate accessible staffing information availability to all 62 residents residing in the facility, residents' representatives, staff, and visitors. Findings include: On 5/2/24 at 3:03 PM, an interview was conducted with Scheduler/CNA Supervisor Q regarding the required nurse staffing hours postings. Postings for 4/29/24, 4/30/24 and 5/1/24 were reviewed with the Scheduler of the number of CNA's that were indicated on the postings. The Scheduler indicated that the CNA's in the office were counted in the postings but did not have an assignment and would pick up on the floor when tasks were needed to be completed. When questioned if on 5/1/24 the CNA did direct resident care, the Scheduler stated, No, they did not. The Scheduler indicated that they did not have assignments on the floor and helped out when needed or took an assignment when there was a hole in the assignments but were still counted in the direct care staffing hours when they did not take an assignment and worked in the office. A review of the Facility documents identified as BIPA (Benefits Improvement and Protection Act of 2000), was used as the documentation of the required posted nursing staffing hours. Multiple BIPA's reviewed for the accuracy of the required nursing staff hours did not match the assignment sheets that were provided by the facility for accuracy of the required posting of nursing staffing hours. On 5/6/24 at 11:54 AM, a review with Scheduler Q of the inaccuracy of the posted nursing staffing hours compared to the assignments was conducted. The Scheduler reported that the BIPA program they used would not allow certain split shifts to be documented correctly and would document whole shifts hours when there was a partial shift worked that made the document an inaccurate representation of the actual nursing staffing hours. For example, the BIPA on March 2, 2024, showed the hours for the CNA's on PM-6 am as 40 hours. The Scheduler indicated that a CNA had started at 8 PM and reported the program put it in as 12 hours and stated, so the hours are off. This is where the error comes from our system. The Scheduler was asked about a CNA that worked the office that was counted in the direct care staffing hours. The Scheduler reported CNA W was an assistant in the front office, she did not have an assignment but would come out on the floor to assist the staff. The Scheduler indicated that the front office assistant did not always help out on the floor but was counted as direct care staff on the BIPA. On March 1, 2024, the CNA hours for 6 am to 6:30 PM was for the office assistant/CNA and the Scheduler indicated that the CNA did not have an assignment for direct care on that day. On March 1, 2024, the CNA hours on 1 to 6:30 am was listed as 8 hours but review of the assignment with the Scheduler indicated the CNA had only worked 4 hours. On February 29, 2024, the day shift CNA hours were calculated to be about 45 hours total on the assignment sheet, but the BIPA that was used as the required staff posting indicated 48 hours. On February 26, 2024, the CNA's for PM to 6 am were documented as 4 CNA's with a total of 32 hours, but there was a call in for a CNA and the posted nursing staffing hours was not updated to reflect the call in with 3 CNA's working for that time period, with a total of 28 hours. The Scheduler indicated the call-ins, and no shows were not always updated on the BIPA form. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Daily Posting On 5/6/24 at 10:00 AM, an observation was made of the nursing hours posting by the front office that was dated for 5/3/24. The posting had not been changed to reflect the staffing for the weekend. On 5/6/24 at 12:38 PM, an interview was conducted with the Scheduler Q and the Director of Nursing (DON). When queried about the required Nursing staff posting, the Scheduler indicated she had left it on her desk for the weekend but that it didn't always get posted on the weekends. The DON indicated that when the Scheduler was not here on the weekends, it has to be posted daily. We have to have a system, so the posting is up daily even on the weekends.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to 1) Ensure proper labeling of medical supplies and eye drops, 2) Ensure that treatment carts contained dressing supplies, 3) Ensure that needles and prescription treatment medications were properly secured and 4) Ensure that narcotic medication was properly disposed of, in two of three medication carts, one of one medication rooms and two of two treatment carts reviewed for proper labeling of medications, storage and expired medication/supplies, resulting in the potential for a resident to receive medication or medical supplies with decreased efficacy, drug diversion, ingestion of medicated substances and inaccurate urinalysis results. Findings include: On [DATE] at 8:04 AM, an observation was made of the treatment cart in the Main Hall area that was not attended by a nurse, to be left unlocked and not secured. Nurse EE returned to the area. When queried about the unlocked treatment cart, the Nurse indicated the treatment cart should be locked and secured the treatment cart. The treatment cart had supplies for wound dressings and prescription wound and skin treatments. On [DATE] at 9:16 AM, an observation was made of the treatment cart in the hall near room [ROOM NUMBER]. The Wound Care Nurse D had done a wound treatment in room [ROOM NUMBER] and the cart was left unattended and unlocked. The Wound Care Nurse stated, That's on me. I should have locked it. The cart had supplies for wound dressings and prescription wound and skin treatments. An observation was made of laboratory supplies to draw blood that included needles for blood draws. The supplies had not been secured in the cart. The Nurse reported she was drawing blood and that was the supplies to draw the blood. The Nurse placed the needles inside the treatment cart and secured the lock on the cart. On [DATE] at 9:22 AM, an observation was made of the treatment cart in the Main Hall area that was left unattended and not locked. The Nurse returned to the area and was questioned about the unsecured treatment cart. The Nurse reported that someone else was in the cart and had not locked it. A review of the items in the treatment cart revealed wound packing strips, opened and without an open date. There was no manufactures expiration date on the container. Eucerin cream container was found to be opened with out an expiration date and no open date. When asked the Nurse reported there should be an open date on the container. Peroxide bottle was found to be opened without and open date, manufactures date indicated an expiration date on [DATE]. On [DATE] at 10:33 AM, the North Medication cart was reviewed with Nurse A. An observation was made of Refresh Tears, opened and did not have an open date. The Nurse was unsure when the eye drops had been opened. A review of the North Hall medication room was reviewed with the Nurse. An observation was made of urinalysis test strips opened with a date of [DATE]. The container of the test strips indicated they were good for 90 days once opened. The Nurse indicated she would discard the test strips. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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	On [DATE] at 4:11 PM, an interview was conducted with the Director of Nursing (DON) and a review of the treatment carts left unattended and not secured was reviewed. The DON was asked about the eye drops and reported that the eye drops should be dated with and open date and stated, They are good for 30 days, they should have a date of when opened. Regarding the wound packing strips, the DON stated, When you open them you should have an open date, and reported there were stickers that should be placed with an open date and discard date. On [DATE] at 4:19 PM, the Main Medication cart was reviewed with Nurse DD. Three pills were observed on the side of the narcotic storage of the medication cart. The medication was identified as two oxycodone (an opioid medication to treat pain) and the third medication was identified as Gabapentin (often used to treat neuropathic pain). The three medications were identified to be controlled substances that were to be counted/wasted by two nurses. The DON was notified. On [DATE] at 4:47 PM, the DON reviewed narcotic sheets for recently wasted medications of the medications found on the side of the medication drawer. The DON stated, They should be getting rid of them if they wasted them. A review of facility policy titled, Storage of Medications, revealed, Policy Statement: The facility shall store all drugs and biological's in a safe, secure, and orderly manner . 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner . A review of facility policy titled, Administering Medications, revealed, .9. The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container . A review of facility policy titled, Discarding and Destroying Medications, revealed, .8. Destruction of a controlled substance must render it non-retrievable, meaning that the process permanently alters the physical or chemical properties of the substance so that it is no longer available or useable, and cannot be illegally diverted .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 37666 Based on interview and record review the facility failed to ensure that residents, responsible parties and staff had a clear understanding of the facility's binding arbitration agreement prior to the resident or responsible party signing it, which could lead to the resident not being fully informed of their rights. Findings Include: Arbitration On 4/29/2024 at 10:08 AM, during Entrance Conference with the Administrator, she was asked if the facility offered Arbitration agreements to the residents. She said the facility did offer them on admission, but she didn't think any resident had signed one or if they had it wasn't many. She said the Admission's department reviewed the Arbitration agreement with the resident or responsible party on admission, but they did not have to sign it. She said as far as she knew there had been no disputes ending in arbitration. On 4/29/2024 at 11:00 AM, the Business office assistant E was interviewed, she said she reviewed arbitration agreements with the residents/responsible parties on admission and thought a couple people had signed them, she said she didn't really understand them, but reviewed the information with the resident/responsible party. Copies of the signed Arbitration agreements was requested at that time. On 4/29/2024 at 1:00 PM, the Business office assistant E provided a large stack of documents and said they were Arbitration agreements and that all residents had signed them: copies of the documents were requested at that time. Upon review of the Arbitration agreements signed by the residents and responsible parties, the document was 4 pages in length and concluded with The undersigned hereby fully understand and agree to the foregoing Notice and Agreement. The individual executing this Notice and Agreement on behalf of Alternate Pharmacy hereby represents and warrants that he/she is duly authorized by Alternate Pharmacy to execute this Notice and Agreement on its behalf. However, the initial beginning of the Arbitration Agreement does not mention a Pharmacy and repeatedly references the facility. The document was confusing in its content. There were 2 versions of the Arbitration agreement: One titled, Voluntary Arbitration Agreement, without a pharmacy reference dated effective March 15, 2019 and One titled, Voluntary Arbitration Agreement, with a pharmacy reference dated effective 5/22/2023. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/06/24 at 3:55 PM, the Administrator was interviewed about the arbitration agreements, related to some residents/ families and the staff not fully understanding the Arbitration Agreements. She was also asked how the staff were able to offer explanations if needed to resident or resident representatives if they had questions about the Arbitration agreements. The Administrator said they were discussing posting signs for residents families related to the arbitration agreements. She said there were actually several different staff members that had been presenting the agreements to the residents. This was noted on the signature page of the agreements. The Administrator said the documents were included in the admission packet and there were many documents on the day of admission that were reviewed and some needed signatures. The Administrator was unsure if each staff member who was reviewing the Arbitration agreements with the residents/representatives had received education on the subject. A policy for Arbitration agreements was requested and not received prior to exit. 49944 On 04/30/24 at 04:32 PM, an interview with R44 was conducted about arbitration agreements at the facility. R44 was asked if they fully understood what an arbitration agreement was and if it was explained thoroughly to them before they signed it. R44 says they understand what arbitration agreements are and what they mean. R44 was asked if they knew that arbitration agreements were in every admission packet. R44 stated no and that most residents are not in the best shape (state of mind) when they come in to the facility and it should be explained better. R44 was asked if the arbitration agreement was thoroughly explained to them and R44 said no it wasn't. On 05/06/24 at 02:54 PM, an interview was conducted with R62. R62 was asked about the arbitration agreement they signed upon admission to the facility and if they understood what it was. R62 stated that they believed the arbitration agreement was about them having the right to refuse care. R62 was asked if the agreement was explained to them before they signed it. R62 stated that the arbitration agreement was not explained to them before signing. On 05/06/24 at 03:01 PM, an interview was conducted with R47. R47 was interviewed about arbitration agreements, if they had signed one and if they understood what they signed. R47 stated that they didn't believe they had signed an arbitration agreement while in the facility and therefore did not know what they were. Record review of signed arbitration agreements revealed that R47 had signed an arbitration agreement while in the facility. Resident Council: During the resident council meeting, there was a question about arbitration agreements presented to the group. Overall the resident council group seemed confused as to what arbitration agreements are. Some of the residents present remembered signing the agreement but agreed they could not remember what they signed and that it might not have been explained well enough. Multiple other residents had no idea what the surveyor was talking about and had no idea what an arbitration agreement was.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 - Few	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** 49944 Based on observation, interview and record review the facility failed to ensure proper communication and documentation of hospice services for two residents (Resident #38, Resident #221) of three residents reviewed for hospice services, resulting in the absence of progress notes, assessments and care plans in the medical record. Findings include: Resident #221 (R221): R221 was admitted to the facility on [DATE], is [AGE] years old and has diagnoses of hypertension, dementia, Alzheimer's disease and rheumatoid arthritis. R221 is receiving hospice services as of 03/15/24. On 04/30/24 at 09:59 AM , R221 was observed in bed eating breakfast, wearing appropriate clothing, their hair was messy and there was a smell of urine in the room. R221 was asked if they were on hospice services at the facility. R221 replied yes and continued to eat breakfast R221 was asked if anyone from the hospice company came to visit them. R221 replied that they believe people from hospice come to visit them but they are unsure when they come to visit. On 05/01/24 at 01:10 PM, record review of the electronic health record (EHR) revealed there were no hospice care plans, no treatment notes and no progress notes from the hospice company present. R221 has been on hospice services since 03/15/24. On 05/01/24 at 02:04 PM, the social services director (SSD) was interviewed and asked where this surveyor could locate hospice progress notes and care plans for R221. SSD stated that the Hospice Company has their own documentation system and that they will fax over notes and care plans to be scanned in and they should be located in the miscellaneous. tab in the EHR. The SSD reviewed the EHR and stated they could not locate any progress notes or care plans for R221. The SSD was asked why there were no progress notes or care plans from the Hospice Company in the EHR. The SSD did not know why but was going to find out. On 05/01/24 at 02:12 PM, the Director of Nursing (DON) was interviewed and asked when they would expect there to be a hospice care plan in the EHR. The DON stated that the care plan is usually produced for hospice in 7-10 days. The DON was asked when the hospice company would send over treatment notes from their visits with the resident. The DON stated that the hospice company will fax treatment notes to the facility as they are completed and the facility scans them in to the EHR. The DON reviewed the EHR and noted that there were no progress notes, treatment notes or hospice care plans scanned in from the hospice company. The DON stated they would get the progress notes as quickly as possible. On 05/01/24 at 04:00 PM, the DON provided the surveyor with all of the hospice notes that had been faxed over to the facility right then, but not yet uploaded to the EHR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 - Few	The Hospice Company contract states that: Section 3.5 hospice shall promote open and frequent communication with facility and shall provide the facility with sufficient information to ensure that the provision of facility services under this agreement is in accordance with the hospice patients plan of care, assessments, treatment planning and care coordination. At a minimum hospice shall provide the following to facility for each hospice patient residing at facility: (a) Plan of care, medications and orders: The most recent plan of care, medication information and hospice physician orders specific to each hospice patient residing at the facility. The policy entitled Hospice Program revised July 2017 reads: 12. The facility collaborates with outside Hospice Vendors and is responsible for the following: a. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services; b. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family; c. Ensuring that the LTC facility communicates with the hospice medical director, the resident's attending physician, and other practitioners participating in the provision of care to the resident as needed to coordinate the hospice care with the medical care provided by other physicians; d. Obtaining the following information from the hospice: (1) The most recent hospice plan of care specific to each resident; (2) Hospice election form; (3) Physician certification and recertification of the terminal illness specific to each resident; (4) Names and contact information for hospice personnel involved in hospice care of each resident; (5) Instructions on how to access the hospice's 24-hour on-call system; (6) Hospice medication information specific to each resident; and (7) Hospice physician and attending physician (if any) orders specific to each resident. e. Ensuring that our facility staff provides orientation on the policies and procedures of the facility, including resident rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to the residents. 37666 Resident #38: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 - Few	Hospice and End of Life During a tour of the facility on 4/29/24 at 12:23 PM, Resident #38 was observed sitting in a chair in her room. A family member was at the bedside and said the resident recently began Hospice services for a recent diagnosis of lung and stomach cancer that had metastasized (spread to other areas of the body). Upon review of the Hospice notes for Resident #38 in the medical record it was noted there were some missing notes from 4/11/2024-5/5/2024, specifically the nurses and nurse aide notes that detailed the care provided to the resident. A review of the physician orders for Resident #38 indicated she admitted to Hospice services on 2/27/2023 and admitted to the facility on [DATE]. On 5/2/2024 at 4:00 PM, during an interview with the Director of Nursing, she was asked about the Hospice services for Resident #38. She said the Hospice nurse came to see the resident at least once a week and she would request the Hospice notes to be sent over from the Hospice service. They were not in the medical record. On 5/06/24 at 9:12 AM, the Hospice nurse was observed visiting Resident #38 with the wound nurse. She said the resident had 2 reddened areas on the coccyx. The Nurse said the resident had been bed bound and most recently started sitting up in a Geri chair. The Hospice nurse said she ordered a gel cushion for the resident's and treatment with a barrier cream for the coccyx. On 5/6/2024 at 7:02 AM, the facility received faxed documents from the Hospice service from 4/11/2024-4/30/2024, that included team, nurse and nurse aide separate notes. The notes had not been a part of the resident's facility medical record to ensure coordination of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review, the facility failed to ensure Infection Prevention and Control standards of practice were followed for Transmission- Based Precautions (TBP), resulting in the potential for the spread of infection, which could cause serious illness. Findings Include: FACILITY Infection Control On [DATE] at 3:00 PM, during a tour of the facility with Infection Prevention and Control/IPC Nurse JJ, it was identified that several rooms with Enhance Barrier Precautions in place had expired hand sanitizer dated expired on ,d+[DATE] and ,d+[DATE] and one was empty. Also during the tour, the residents on the North Hall had clearly identified precautions in place with available Personal Protective Equipment/PPE, however on the East hall, some rooms with several residents sharing the room had Contact precautions on the door with no indication for which resident was in precautions. The signs did not clearly indicate the necessary PPE needed to care for the residents. For those residents needing Contact precautions, there was no waste receptacle outside the door to dispose of the clear bags holding the isolation gowns. The Infection Prevention Nurse said some of the residents were supposed to be in Enhanced Barrier Precautions and some in Contact. She said she would clarify the precautions. On [DATE] at 11:17 AM, the Infection Prevention and Control program was reviewed with IPC Nurse JJ the Director of Nursing and Nurse A. The IPC Nurse JJ said she had rounded on the halls to ensure PPE and hand sanitizer was available for those residents in precautions. She said education was provided to staff related to which Transmission based precautions the resident was in and what PPE was needed. A review of the facility policy titled, Isolation-Categories of Transmission-Based Precautions, dated revised [DATE] provided, . Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others . The facility will implement a system to alert staff to the type of precaution resident requires. This facility utilizes the following system for identification of Contact Precautions for staff and visitors: Signage from the CDC indicating both type of precaution and PPE required. The facility will also ensure that the resident's care plan and care specialist communication system indicates the type of precautions implemented for the resident . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled, Isolation- Initiating Transmission-Based Precautions, dated revised [DATE], provided, Transmission-Based Precautions will be initiated when there is reason to believe that a resident has a communicable infectious disease .When Transmission-Based Precautions are implemented, The Infection Preventionist (or designee) shall: Ensure that protective equipment (i.e Gloves, gowns, masks, etc.) is maintained near the resident's room . Post the appropriate notice on the room entrance door . Ensure that an appropriate linen barrel/hamper an waste container with appropriate liner are place in or near the resident's room . 37771 Resident #44: Transmission Based Precautions A review of Resident #44's medical record revealed an admission into the facility on [DATE] and readmission on [DATE] with diagnoses that included cellulitis of left lower limb, diabetes, sepsis, chronic obstructive pulmonary disease, pressure ulcer Stage IV, colostomy status, and dependence on supplemental oxygen. The Resident had a Foley catheter. The Resident had a transfer to the hospital and returned on [DATE] with a diagnosis of cellulitis in the leg with an intravenous catheter for IV (intravenous) antibiotic treatment. A review of Resident #44's orders in the medical record revealed the Resident had an order for Enhanced Barrier Precautions for wounds/catheter use, with a revision date on [DATE]. On [DATE] at 12:39 PM, an observation was conducted of Resident #44 laying on their bed. A sign on the door indicated the Resident was on transmission-based precautions for Contact Precautions and did not indicate which Resident, bed 1 or bed 2 was assigned Contact Precautions. A caddy was on the door that had PPE (personal protection equipment) of gowns and gloves. Staff was observed to go into the room without putting on a gown and gloves. This surveyor donned the PPE to interview Resident #44 and their roommate. Upon leaving the room, there was no garbage available to dispose of the PPE at or near the exit of the room. The only garbage available in the room was a small garbage on the other side of Resident #44's bed from the doorway and near the bedside table. There was no garbage in the bathroom. Upon leaving the room, there was no hand sanitizer readily available outside the Resident's room. At [DATE] at 12:44 PM, an observation was made of Nurse AA going into Resident #44's room with insulin to be administered. The Nurse entered the room without putting on PPE but had grabbed a gown out of the caddy on the door and shut the door without putting on the PPE prior to entering the room. The Nurse was observed leaving the room with the PPE on, took off the PPE in the hallway and put it into a red bag that was in the caddy. The Nurse took the red bag and the insulin to the medication cart where she opened the drawer and put the insulin into the medication cart drawer. The Nurse was observed to not wash hands or use hand sanitizer after removing the PPE. This surveyor asked a CNA, who was observed to enter and exit the room without putting on or doffing PPE, if one of the Residents were on Contact Precautions as was posted on the door of the room. The CNA reported that they thought it was for the IV and that PPE was not needed to be put on when entering the room. The sign on the door that indicated Contact Precautions was pointed out, but the CNA indicated she didn't know. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 3:59 PM, a review of Resident #44's orders in the medical record revealed the Resident had an order for Enhanced Barrier Precautions for wounds/catheter use, with a revision date on [DATE]. On [DATE] at 11:20 AM, an observation was conducted with Wound Care Nurse D of the dressing change to Resident #44's pressure ulcer to the buttock area. Upon approaching Resident #44's room, the Nurse was asked if the Resident was on Enhanced Barrier Precautions as ordered or on Contact Precautions as the sign on the Resident's door indicated. The Nurse indicated the Resident was on enhanced precautions. When shown the sign on the door that indicated Contact Precautions, the Nurse was unsure and indicated to follow the contact precautions sign posted on the door. After the dressing change was completed, an observation was made of no garbage receptacle readily available prior to exiting the room. There was a garbage that was positioned near the wall between the two Resident beds and had Resident items blocking easy access to the wastebasket. The Nurse doffed her PPE and was given a bag to put the discarded PPE into. The Nurse returned with a waste bag to have this surveyor discard the PPE. There was no hand sanitizer readily available after exiting the room. On [DATE] at 12:13 PM, an interview was conducted with the Director of Nursing regarding Resident #44's confusion on if the Resident was on Enhanced Precautions or Contact Precautions. The DON reviewed the medical record and reported the Resident was not infected with a MDRO (multi-drug resistant organism), had been on antibiotics but completed the course of treatment, and indicated the Resident should have been on Enhanced Precautions not the Contact Precautions. The DON indicated that the Contact Precaution sign was taken down the day before. An observation was made of Resident #44's room with the Contact Precaution sign on the door. The DON removed the sign and put up an Enhanced Precaution sign. When asked what the staff should be following, the DON indicated that staff should be following the directions of the posted signage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to ensure that a safe environment was maintained, with call lights accessible to residents and that an oxygen tank was stored properly for four residents (Resident #4, Resident #12, Resident #24, and Resident #44) of five residents reviewed for safe and sanitary environment and four residents reviewed for respiratory care, resulting in residents' feeling of frustration, the inability to call for assistance, and the potential for unmet care needs. Findings include: Resident #4: On 4/30/24 at 10:49 AM, a review of Resident #4's medical record revealed an admission into the facility on [DATE] with diagnoses that included delusional disorders, dementia, psychotic disorder, post-traumatic stress disorder (PTSD), and mood disorder. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status score of 6/15 that indicated severely impaired cognition, was independent in eating and toileting hygiene and needed supervision or touching assistance for oral hygiene, bathing self, dressing and personal hygiene. On 4/29/24 at 10:08 AM, an observation was made of Resident #4 sleeping on their bed, dressed. The call light device was under the head of the bed near the wall on the floor and not within reach for the Resident. The Resident was then seen after the first observation to be ambulating out of the room and into the hall. On 4/30/24 at 12:13 PM, an observation was conducted of Resident #4 lying in bed, awake. The Resident was asked questions and answered some questions and engaged in limited conversation. An observation was made of the Resident's call light on the floor. The Resident was asked how he was doing and reported he was resting his back. When asked if he used the call light, the Resident reported he uses the call light if he needs something. When queried if he knew where his call was, the Resident indicated he could not find it. CNA (certified nursing assistant) I comes in the room and was asked about the call light. The CNA retrieved it from the floor and reported it falls off the bed, it has no clip. When asked where a clip can be obtained, the CNA reported she would see about getting one and places the call light on the bed within reach of the Resident. On 5/1/24 at 2:22 PM, an observation was made of Resident #4's room with Unit Manager K of the call light on the floor. The call light did not have a clip and the Unit Manager reported she would get a clip for the light to be secured to the bed. The Unit Manager reported the call lights should be in reach for the Residents. Resident #12: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #12's medical record revealed an admission on 11/1/22 with diagnoses that included atrial fibrillation, psychosis, mood disorder, delusional disorders, and diabetes. A review of Resident #12's MDS assessment revealed a BIMS score of 11/15 that indicated moderately impaired cognition. On 4/29/24 at 10:16 AM, an observation was made of Resident #12 dressed and walking into their room while an interview was conducted with the Resident's roommate. The Resident was encouraged into the conversation by the roommate and Resident #12 answered questions and engaged in conversation. The Resident sat on their bed during the conversation facing the roommate towards the window. The Residents were asked if they had a call light within reach. Resident #12 looked at the curtain on the other side of the bed that was partially pulled separating the other roommate's bed. Resident #12 stated, They will clip it on the curtain but it's not there. I don't know where it is. Upon following the cord from the wall, an observation was made of the call light clipped on the privacy curtain on the other side, not visible or in reach for the Resident. On 4/29/24 at 2:08 PM, an observation was made of Resident #12's call light clipped to the privacy curtain on the other side from Resident #12's bed, not visible or within reach for the Resident. A CNA came into the room, was notified of the call light not in reach for Resident #12 and the CNA retrieved it from the other side of the curtain and clipped the call light to the bed that was within reach for the Resident. Resident #24: A review of Resident #24's medical record revealed an admission into the facility on [DATE] and readmission on 3/29/23 with diagnoses that included cataracts, dementia, schizophrenia, anxiety disorder, and heart disease. A review of the MDS assessment revealed the Resident had a BIMS score of 7/15 that indicated severely impaired cognition and was independent with eating and oral hygiene and dependent with toileting hygiene, and bathing. On 4/29/24 at 9:48 AM, an observation was made of Resident #24 laying in bed, no clothes on but had a brief on. The Resident body was positioned crooked in the bed. The Resident was interviewed and answered limited simple questions. The Resident was asked about their call light and he indicated he used it all the time. When asked where it was located, the Resident had a cord that was on the wall with the bed next to the wall. The Resident reached for the cord and reported he could not reach for it and stated, It hurts to do that. I can't get it. Does not matter, it doesn't work anyway. The end of the cord with the call light apparatus was observed to be on the floor and not within reach of the Resident. Resident #44: On 4/29/24 at 1:10 PM, an observation was made of Resident #44's room with a small oxygen tank inside a cloth basket positioned on top of plastic bins. The oxygen tank was laying in the basket with the top of the oxygen tank up and over the top of the basket. The gage on the tank registered there was oxygen in the tank. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235654	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Lapeer Nursing & Rehabilitation	239 S Main St Lapeer, MI 48446

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/24 at 4:28 PM, an observation was made with the Director of Nursing (DON) of Resident #44's room with the oxygen tank inside the basket on top of the plastic bins. The DON was queried and reported the tanks, large of small should not be stored like this, and that they should be placed in a holder. The DON and surveyor went to the dining room where Resident #44 was at. The Resident had a large tank on the back of their wheelchair. The DON asked the resident about the smaller tank. The Resident explained that it had been there since he moved to that room, staff had brought it over from his other room and it had been in the basket. A review of Resident #44's progress notes revealed a Room Move Note, dated 4/19/24, that the resident had changed rooms.