STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235396	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Silverbell Estates	1255 W Silverbell Rd Orion, MI 48359

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 - Few	Provide and implement an infection prevention and control program. 47283 This Citation Pertains to Intake #: MI00145908 Based on observation and interview, the facility failed to store tracheostomy supplies in a clean and sanitary condition for one (R903) of one Resident reviewed for infection control resulting in the potential to cause an infection(s) for a compromised resident with multiple comorbidities. Findings include: A record review revealed R903 was a long-term resident of the facility. R903's diagnoses included intracranial hemorrhage (brain bleed), seizures, and respiratory distress. R903 was breathing through tracheostomy (a surgical opening created into the trachea (windpipe) from outside the neck to assist with breathing). R903 was receiving their nutrition and hydration through Percutaneous Endoscopic Gastrostomy (PEG - A percutaneous endoscopic gastrostomy tube is a feeding tube surgically placed through abdomen into the stomach) tube. R903 needed staff assistance for most of their Activities of daily Living (ADLs) such as mobility, toileting, dressing etc. R903 had family member appointed as their guardian. On 8/13/24 at approximately 11:35 AM, an observation was completed. R903's door had signage that read they were under enhanced barrier precautions and a cart with Personal Protective Equipment (PPE) was outside the room. R903 was observed in the bed. An open cardboard box with tracheostomy mask tubing (blue aerosol tubing) was observed on the floor across from the bed adjacent to the bathroom door. There was an open trash can next to the cardboard box. The box had multiple packages of blue tracheostomy mask tubes. There was an open package and the tubing was out of the package and part of the tube was resting on top the open trash can. The surveyor stayed in the room for a few minutes. At approximately 12:00 PM, the surveyor observed Certified Nursing Assistant (CNA) A walked into R903's room. The surveyor walked into R903's room and queried about the cardboard box with tracheostomy mask tubes that was on the floor and about the open tubing that was touching the trash can. CNA A reported that they should not be on the floor and they would take care of it. At approximately 12:10 PM, CNA A came back and reported to the surveyor that they have moved the box off the floor and they had placed the box in R903's closet. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 - Few	An interview with LPN B was completed on 8/13/24, at approximately 12:30 PM. Licensed Practical Nurse (LPN) B was assigned to care for R903. LPN B was queried about the surveyor's observation of a cardboard box that was on the floor with an open tube that was in contact with the trash can. This Surveyor walked into R903's room with LPN B and observed the box that was stored in R903's closet. LPN B reported that supplies should not be stored on the floor and clean supplies should have been sealed in the bag. They also reported that they would discard the supplies. Review of R903's Electronic Medical Record (EMR) revealed that R903 had multiple hospitalization s including a recent hospitalization with an UTI (Urinary Tract Infection) with intra venous (IV) antibiotic therapy. An interview was completed with Director of Nursing (DON) on 8/13/24 at approximately 12:45 PM. The DON was notified of the observations and queried on the facility protocol. The DON reported they should not be stored on the floor and clean tubing must be in a sealed bag. The DON reported that the supplies were delivered yesterday. When queried about why the staff who had been caring for R903 had not addressed the box since they were delivered, including the staff member who had opened the box and had left an open tube that was in contact with the trash. The DON reported that they understood the concern and they had addressed it with their staff. The DON also reported that staff had discarded the supplies and they were placing an order for new tracheostomy mask tubes. According to Centers for Disease Control and Prevention's Sterilizing practices from the Guideline for Disinfection and Sterilization in Healthcare Facilities, Medical and surgical supplies should not be stored under sinks or in other locations where they can become wet. Sterile items that become wet are considered contaminated because moisture brings with its microorganisms from the air and surfaces. Closed or covered cabinets are ideal but open shelving may be used for storage. Any package that has fallen or been dropped on the floor must be inspected for damage to the packaging and contents (if the items are breakable). If the package is heat-sealed in impervious plastic and the seal is still intact, the package should be considered not contaminated .