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	10/09/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 This citation pertains to Intake #MI00147108 Based on observation, interview and record review, the facility failed to ensure scheduled pain medication was available per physician orders and maintain accurate documentation of controlled substances for one (R601) of three residents reviewed for medications. Findings include: A complaint was filed with the State Agency (SA) that alleged in part, .(R601) has chronic pain . (R601) feels as though (they) must beg to get (their) medication . On 10/8/24 at 10:23 AM, R601 was observed lying in bed. R601 was asked about their pain medications. R601 explained the facility runs out of their Morphine and they have to go a couple days without it. Review of the clinical record revealed R601 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: primary generalized osteoarthritis, rheumatoid arthritis and chronic pain syndrome. According to the Minimum Data Set (MDS) assessment dated [DATE], R601 had moderately impaired cognition. Review of R601's chronic pain care plan dated 3/14/24 had an intervention that read, Administer analgesia (pain medication) as per orders . Review of physician orders for R601 revealed an order dated 9/19/24 for Morphine Sulfate ER (extended release) 60 mg (milligrams), give 1 tablet by mouth two times a day. Review of R601's October 2024 Medication Administration Record (MAR) revealed the administration box for Morphine Sulfate ER 60 mg was marked with code 9 indicating Other/See Progress Note on 10/4/24 for the bedtime dose, and on 10/5/24 for the morning dose. On 10/5/24 for the bedtime dose, the box was marked with code 2 indicating Drug Refused. Review of R601's progress notes revealed: An Administration note dated 10/4/24 at 11:17 PM read in part, Morphine Sulfate ER . Med not on hand or available in backup. Med is on reorder waiting on pharmacy. (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
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Administration note dated 10/5/25 at 11:07 AM read in part, Morphine Sulfate ER . Waiting to receive from the pharmacy . On 10/9/24 at 11:55 AM, the Director of Nursing (DON) was interviewed and asked if medications should ever run out before they are reordered. The DON explained medications should be ordered timely to ensure no doses are missed. The DON was asked when was R601's Morphine Sulfate ER reordered. The DON explained she would find out. Review of a Medication Monitoring/Control Record log for R601's Morphine Sulfate ER 60 mg revealed the medication was received on 10/5/24 by Licensed Practical Nurse (LPN) H. LPN H documented she removed one dose of the medication on 10/5/24 at 8:00 PM. There was no documentation of a dose of the medication having been wasted. On 10/9/24 at 12:30 PM, LPN H was interviewed by phone and asked about the discrepancy of the documentation between the Control Record log indicating that the medication was removed, but on the MAR it was documented R601 refused the medication. LPN H explained she had removed the medication, but R601 refused it so she had marked it as refused, but then R601 decided they would take it and she must have forgotten to change the MAR that the medication was given. On 10/9/24 at 12:35 PM, the DON explained R601's Morphine Sulfate ER was reordered on 10/3/24 on the midnight shift. According to the documentation, after the bedtime dose on 10/3/24, there was only one dose left. The DON was asked if medications should be reordered before there was only one dose left. The DON explained they did a narcotic audit every week, but R601's Morphine must have fallen through the cracks. When informed of the discrepancy between the Control Record log and the MAR, the DON explained that first LPN H should have asked R601 if they wanted to take the medication before she removed it, then LPN H definitely should have written a progress note that R601 did receive the medication. Review of a facility policy titled, Medication Ordering and Receiving from Pharmacy dated 4/2018 read in part, .Controlled substances are reordered when a 5-7 supply remains to allow for transmittal of the required written prescription to the pharmacist .