

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER The Villa at Silverbell Estates		STREET ADDRESS, CITY, STATE, ZIP CODE 1255 West Silverbell Road 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint #2582127. Based on observation, interview, and record review, the facility failed to report an injury of unknown origin to the Administrator/Abuse Coordinator within the required timeframe for one (R801) of two residents reviewed for abuse. Findings include: A review of a complaint submitted to the State Agency revealed an allegation that on 7/25/25 at 8:00 PM, R801 was observed to not be herself, she wasn't speaking and seemed to have a change in condition. It was alleged R801 had bruising around the resident's collar bone area. A full body assessment was completed, the Administrator was contacted, and R801 was sent to the hospital for further assessment. It was alleged R801 was dropped from the (mechanical) lift by (Certified Nursing Assistant - CNA 'B' earlier in the day. On 9/2/25 at 8:07 AM, an interview was conducted with the complainant. When queried about what happened with R801, the complainant reported they believed R801 was injuring while being given a shower by CNA 'B'. The complainant reported R801 had a broken collar bone and significant bruising on her body. When queried about whether R801 was able to say what happened, the complainant reported at the time of the injury, R801 had a change in condition and was not as responsive as they typically were. The complainant asked other staff if that was normal for R801 and they said it was not and R801 was sent to the hospital. On 9/2/25 at 10:18 AM, R801 was observed lying in bed. When asked if she recently had an injury, R801 reported she did. When asked how it happened, R801 stated, I fell. When asked for additional details and how the fall occurred, R801 stated, I don't remember. When asked what kind of injury she had, R801 stated, I don't remember but said it was her shoulder. A review of R801's clinical record revealed R801 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: dementia and contracture of the left hip. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had moderately impaired cognition, no behaviors, had impairment to one side in the lower and upper extremities, required substantial/maximal assistance for showers/bathing and rolling left and right, and was dependent on staff for assistance with standing from a sitting position, transferring from the chair to bed and the bed to chair, toilet transfers, and tub/shower transfers. It was documented that R801 did not walk. A review of R801's progress notes revealed a Health Status Note dated 7/25/25 at 2:45 AM, written by Licensed Practical Nurse (LPN) 'C', that noted, Writer was notified by aide that she observed skin discoloration on right arm and breast around to middle of back from shoulder to mid trunk. Colors ranging from yellow to dark purple. per resident no pain wasn't dropped, and she didn't fall or afraid to be at facility .sending resident to hospital .A review of a Facility Reported Incident (FRI) submitted to the State Agency revealed the incident occurred 7/25/25 at 2:30 AM and was discovered at the same time. The incident was reported to the State Agency on 7/25/25 at 2:36 AM. It was documented in the Investigation Summary that On July 25, 2025, during care, (R801) presented with discoloration to her chest and arm area. (CNA 'B') first noted the discoloration and notified her nurse immediately. (LPN 'C') was the assigned nurse. (LPN 'C') completed an assessment and reported the findings to the Administrator as an Injury of Unknown Origin .(R801) stated that she did not recall anything happening to her .Physician was notified, and order was obtained to have patient transferred to hospital for further evaluation related to discoloration and history of chronic fractures. (R801) was admitted to (hospital). All x-rays and MRIs were negative for acute fractures .received a blood transfusion for her anemia and re-admitted back to (facility) .A review of the nursing staff schedule, assignment sheets, and time punches for CNA 'B' for 7/24/25 and 7/25/25, revealed CNA 'B' was assigned to R801 on 7/24/25 during the afternoon shift and punched out at 10:30 PM, four hours prior to when LPN 'C' reported the injury to the Administrator (at 2:30 AM on 7/25/25). On 9/2/25 at 1:20 PM, an interview was conducted with CNA 'B' who was assigned to R801 on 7/24/25 during the afternoon shift. CNA 'B' acknowledged she was familiar with R801 and was assigned to her on 7/24/25. When queried about what happened during that shift, CNA 'B' reported she did not know what actually happened, but she noticed bruising to R801's arm. CNA 'B' asked another CNA if that was normal for the resident and they said it was. CNA 'B' reported another CNA assisted R801 into bed and CNA 'B' then undressed R801 to wash her up and put a gown on and I started freaking out because it (the bruising) was really bad. CNA 'B' said R801 had bruising to the right side of her arm, under her breast, and going down her back. CNA 'B' ran to get the nurse because she had not worked with R801 in a while and asked the nurse to assess the resident. CNA 'B' explained the nurse came to R801's doorway and did not enter the room then asked CNA 'B' to feel under</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint #2582127. Based on observation, interview, and record review, the facility failed to adequately assess the resident's skin and conduct a thorough assessment for a potential change in condition for one (R801) of two residents reviewed for abuse. Findings include: A review of a complaint submitted to the State Agency revealed allegations that on 7/25/25, when rounding on the residents, R801 appeared to not be herself, she wasn't speaking and seemed to have a change in condition. It was alleged R801 had bruising around the collar bone area and was sent to the hospital. On 9/2/25 at 10:18 AM, R801 was observed lying in bed. When asked if she injured herself recently, she said she did. When asked how it happened, she said she fell. When asked for more details she said I don't remember. When asked what kind of injury she had she said I don't remember but said it was her shoulder. R801 appeared contracted in the lower extremities as her legs were bent up toward her body. A review of R801's clinical record revealed R801 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: dementia and left hip contracture. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had moderately impaired cognition. A review of R801's progress notes revealed a note written by Licensed Practical Nurse (LPN) 'C' on 7/25/25 at 2:45 AM that noted, Writer was notified by aide that she observed skin discoloration on right arm and breast around to middle of back from shoulder to mid trunk. colors ranging from yellow to dark purple. per resident no pain wasn't dropped and she didn't fall or afraid to be at facility . sending resident to hospital . On 9/2/25 at 8:07 AM, an interview was conducted with LPN 'C'. When queried about R801, LPN 'C' reported when she worked on 7/24/25-7/25/25, R801 had an injury to her collar bone. LPN 'C' reported R801 was typically able to participate in conversations, but on that shift she was assessed to have a change in condition and was not as responsive as she usually was. LPN 'C' reported she confirmed the resident's presentation as being not typical with other staff who were more familiar with the resident. On 9/2/25 at 1:20 PM, an interview was conducted with CNA 'B' who was assigned to R801 on 7/24/25 during the afternoon shift. CNA 'B' acknowledged she was familiar with R801 and was assigned to her on 7/24/25. When queried about what happened during that shift, CNA 'B' reported she did not know what actually happened, but she noticed bruising to R801's arm and then when she provided care, she noticed bruising to the right side of her arm, under her breast, and going down her back and said it was really bad. CNA 'B' ran to get the nurse because she had not worked with R801 in a while and asked the nurse to assess the resident. CNA 'B' explained the nurse came to R801's doorway and did not enter the room, then asked CNA 'B' to feel under R801's arm for warmth and said it meant she did not fall and walked out of the room. CNA 'B' said she started asking R801 questions about what happened and R801 said she did not know. R801 said she did not have pain, but CNA 'B' said when her arm was moved or when touched it was obvious that she had pain. CNA 'B' said she told the next shift CNA what was going on and heard they sent the resident to the hospital the next day. When queried about the time when she notified the nurse, CNA 'B' reported it was around 7:00 or 8:00 PM. When queried about what the bruises looked like, CNA 'B' reported they were various colors that ranged from yellow, green, and burgundy. On 9/3/25 at 9:32 AM, an interview was conducted with CNA 'G' via the telephone. CNA 'G' confirmed she worked on 7/24/25 on the afternoon and midnight shifts. When queried about what happened with R801, CNA 'G' reported around shift change, at approximately 11:00 PM, the nurse on shift (LPN 'C') asked CNA 'G' if she was familiar with R801 and if how she was presenting was normal for the resident. CNA 'G' said when she saw R801 she was not in the condition she was usually in. CNA 'G' said R801 was not responding to staff's questions and appeared out of it. CNA 'G' reported R801 typically communicated with staff. CNA 'G' said she saw a dark colored bruise on her breast, back area, and collar bone area. CNA 'G' stated, I was really concerned about the resident. At that time, LPN 'C' called 911 and reported it to the Administrator. A review of an investigation conducted by the facility revealed statements written by staff that revealed the following: CNA 'G' - I was asked by (LPN 'C') to come in the room (R801) to assess the resident. (LPN 'C') look at the patient arm and noticed bruises on her left arm. (LPN 'C') observed the patients skin for assessment also (LPN 'C') pulled the gown down to look further and noticed a big bruise on her chest, left breast and also noticed a large lump on shoulder near chest area. She immediately contacted the administrator. (LPN 'C') asked multiple staff did anyone know how her patient status is and everyone said they don't know what was her status before this state that she was in. I told (LPN 'C') this was not her normal state she is usually very alert and responsive. And the patient</p>		