

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 12/17/2025
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 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. (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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(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	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake #2685189Based on observation, interview and record review the facility failed to ensure a safe transfer via a Hoyer lift for one (R701) out of two residents reviewed for falls, resulting in R701 sustaining a fracture to the right femur that required surgery and an extensive hospital stay. Findings included: Based on observation, interview and record review the facility failed to ensure a safe transfer via a Hoyer lift for one (R701) of two reviewed for falls, resulting in a fall with fracture to the right femur, pain and Hospital stay. Findings include:On or about 11/21/25 a FRI (Facility Reported Incident) was reported to the State Agency (SA) that noted on 11/21/25, R701 was being transferred from their bed to a wheelchair via a Hoyer lift and the sling snapped and the resident fell to the floor. R701 complained of pain , x-rays were ordered, and the resident was sent to the Hospital.Hospital records dated 11/21/25 were reviewed and documented, in part: (R701) .is coming from (facility) for concerns of right femur fracture. She was in a Hoyer lift when it broke, causing her to fall to the floor. Patient states that she fell about 2 feet. Additional orthopedic hospital records noted: The patient sustained a mechanical fall landing from a Hoyer lift directly onto the hip with immediate onset of pain and inability to ambulate prompting a visit to our emergency room where she was diagnosed with a closed, displace R (right) proximal femur fracture.no issues with the hip prior to this incident.Physical Exam: Gen: alert and oriented.we discussed their signs, symptoms and imaging at length. We discussed surgical versus conservative measures. At this time, the recommendation was made to proceed with surgical management in the form of R hip nail to avoid complications associated with conservative management including bed sores.On 12/17/25 at approximately 10:11 AM, R701 was observed lying in bed. The resident was alert and able to answer questions asked. R701 was asked about the accident that occurred on 11/21/25. They reported that there was something wrong with the Hoyer lift and they fell and fractured their hip and had to stay in the hospital. R701 noted that they were still in pain, but it was getting better.A review of R701's clinical record revealed R701 was initially admitted to the facility on [DATE] with diagnoses that included: fracture right femur, morbid obesity, type II diabetes and schizoaffective disorder. The resident most recent BIMS (Brief Interview for Mental Status) score was 15/15 (intact cognition). A review of the facility's Incident/Accident (IA) report and accompanying interviews documented the following:11/21/25: Incident Summary: On 11/21/25 at 10:43 AM, staff was transferring (R701) from the bed to the wheelchair with a Hoyer lift. While transferring the Hoyer sling snapped and resident fell to the floor. Certified Nursing Assistant (CNA) A statement: I.worked on 11/21/25 on the day shift. I was assigned to (R701)I had an orientee (CNA B) , we went into the resident room to get her up for the day, we used the Hoyer lift, while we were transferring her from the bed to the wheelchair the Hoyer sling snapped. I did notice when I put the sling under her is <sic> wasn't that much room. I did not notice the sling had frayed edges. After she fell the nurse came and assessed she was right outside the door.CNA B statement: I.worked 11/21/25 on the day shift, I was orienting with (CNA A) and I went into the room to get the resident up, she was being transferred from the bed to the wheel chair with a Hoyer lift, when we were transferring her the slip snapped and the resident fell to the floor. *It should be noted that an attempt to contact CNA B was made on 12/17/25 at approximately 11:06 AM. A voice message was left. No contact was made with CNA B prior to the exit.On 12/17/25 at approximately 11:31 AM, a phone interview was conducted with CNA A. CNA A was asked about the incident involving R701 on 11/21/15. They reported they were assigned to R701. They were working with CNA B who was in training. They wanted to transfer the resident from their bed to their chair. They went and grabbed a Hoyer sling from the laundry area as that is where the slings were kept. They noted that they did not really take a good look at it before they placed it underneath the resident. They then hooked it to the lift and tried to get R701 out of bed and the sling tore and the resident fell to the floor. They immediately grabbed a nurse to come assess the resident. CNA A reported that after the incident they saw that the sling was old and slightly ripped. They noted that they received education as to the use of Hoyer lift including the slings.On 12/17/25 at approximately 11:50 AM, Laundry Staff 'C and Laundry Manager (LM) D were interviewed in the laundry room. They both reported that they were not employed by the facility but worked for a contracted laundry service. When asked about how Hoyer slings are cared for LM D stated that they had a number of slings that are washed in the laundry room and then pointed to an area where they are stored. LM D stated that they were made aware of the incident that occurred with R701 and currently they changed their protocol regarding Hoyer sling care. They stated they look them over carefully and if they are</p>		