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	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Silverbell Estates	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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 3006638.Based on interview and record reviews the facility failed to acknowledge, investigate and follow up on concerns reported by the family of one R404 of one resident reviewed for grievances.Findings included:A review of complaint submitted to the State Agency (SA) documented in part . $20.00. was missing from (R404) bedside drawer. the resident's cell phone was missing. these items went missing after (the complainant) complained to staff about the lack of care being provided to the resident. The complainant states she sent several emails to the head nurse, administrator, nursing staff and head office person, but had not received a response.A review of the medical record revealed R404 was admitted to the facility on [DATE], with diagnoses that included: hemiplegia (paralysis of one entire side of the body) and hemiparesis (muscle weakness or partial paralysis affecting only one side of the body) following intracerebral hemorrhage affecting the right dominant side and mild cognitive impairment. The resident was dependent on staff for all Activities of Daily Living (ADLs).An email thread submitted to the SA dated 4/23/26 at 9:03 AM, with confirmed receipt of the facility's Administration staff to have received it, documented in part, . Family is here to pick up belongings. Currently missing a phone, white extension cord and $20. Also he was sent to cardio with no shoes. Family attached please respond. This email response was documented by the facility's Social Service Director (SSD) D.On 6/2/26 at 12:54 PM, SSD D was interviewed and confirmed they had received an email from the family and forwarded to the correct parties. SSD D was asked to provide the email thread that revealed the parties the concern was forwarded to.A review of the email thread dated 4/23/26 provided by SSD D noted the Administrator to have been included on the email.On 6/2/26 at 12:48 PM, the Administrator and Director of Nursing (DON) were asked to provide all grievances and incident reports from admission to discharge for R404. A second request was at 1:54 PM. At 1:58 PM, the Administrator reported they had no grievances or incident reports for the resident.On 6/2/26 at 2:20 PM, the Administrator was interviewed and asked about the reported missing money, cell phone and care concerns. The Administrator stated in part . First of all, I never knew about any missing money or cellphone. When discussed that they were included in the email that reported the concerns to the facility, the Administrator stated they received one email and denied having been aware of the concerns.A review of the facility policy titled Grievance Guideline dated 11/28/17, documented in part . The facility grievance process will be overseen by the Administrator / designee who will be responsible for receiving and tracking grievances through their conclusion. A grievance or concern can be expressed orally to the Grievance Official or facility staff or in writing using a grievance form. Any employee of this facility who receives a complaint shall immediately attempt to resolve the complaint within their role and authority. If a compliant cannot be immediately resolved the employee shall escalate that complaint to their supervisor and the facility Grievance Official. the Grievance Official will review the grievance, determine immediately if the grievance meets a reportable complaint. The facility will strive for a prompt resolution outcome for all grievances or complaints rendered.No further explanation or documentation was provided for review by the end of the survey.

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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F 0686 Level of Harm - 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** This citation pertains to intake: 3006638.Based on interviews and record reviews the facility failed to ensure consistent and appropriate wound management by not completing an admission Braden assessment, not ensuring the timely implementation of wound treatments as ordered by the wound clinician, failing to consistently provide prescribed wound care treatments, failing to timely identify and report to the Physician of the worsening of the wound, and failing to complete labs as directed by the Physician for one (R404) of one resident reviewed for pressure wounds, which resulted in a change of condition and required prolonged hospitalization. Findings include:A review of a complaint submitted to the State Agency (SA) documented in part . the resident was admitted to the hospital with a major infection, rectal bleeding, and stage 3 (full-thickness loss of skin, in which fat may be visible in the ulcer) and stage 4 (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) bedsores with infection to the bone. The complainant states the doctors are trying to be hopeful but don't know if the resident will recover.On 6/1/26 at 10:12 AM, a telephone interview was conducted with the complainant. When asked, the complainant reported that R404 was still hospitalized at a higher acuity specialty hospital receiving intravenous antibiotics for their infection from their bedsore.A review of the medical record revealed R404 was admitted to the facility on [DATE], with diagnoses that included: hemiplegia (paralysis of one entire side of the body) and hemiparesis (muscle weakness or partial paralysis affecting only one side of the body) following intracerebral hemorrhage affecting the right dominant side and mild cognitive impairment. The resident was dependent on staff for all Activities of Daily Living (ADLs).A review of the admission skin assessments revealed two assessments completed. The first assessment dated [DATE] at 10:58 PM, documented the resident's skin integrity to be Intact. The second assessment dated [DATE] at 1:21 AM, documented the skin integrity to have Open areas.A review of a Nursing note dated 2/16/26 at 9:08 AM, documented in part . Resident with pressure wound. Small open area noted to coccyx.A review of the medical record revealed no documentation of an admission Braden to have been completed.A review of a facility policy titled Skin Protection Guideline dated 7/7/21, documented in part . Our facility utilizes the BRADEN Scale. It is an evidenced based tool that provides a scale to identify potential categories that would contribute to conditions for breakdown. Our facility may utilize the Braden Scale. Upon admission and re-admission.A review of the February 2026 Medication Administration Record (MAR) and Treatment Administration Record (TAR) documented . Wound Care for open area to sacrum: Cleanse sacrum with normal saline, pat dry, apply TAO (triple antibiotic ointment), cover with border foam dressing; one time a day. The first application of this order was noted at 2/18/26, two days after the resident admitted to the facility.A review of an admission Nutrition Assessment dated 2/17/26 at 10:59 AM, revealed no documentation of the identified coccyx/sacrum wound.A review of a facility policy titled Skin Protection Guideline dated 7/7/21, documented in part . The dietician will be notified. With changes in skin integrity.On 6/2/26 at 2:49 PM, Registered Dietician (RD) B was interviewed and asked how they obtain their information to complete the admission nutritional assessments. RD B explained they review the chart and hospital documentation. When asked why the admission nutritional assessment for R404 failed to identify their pressure wound and a collaborative interdisciplinary approach for wound healing, RD B replied they would like to look into their notes and follow back up. At 3:16 PM, RD B returned and acknowledged they failed to identify the wound on the admission assessment due to reviewing the admission skin assessment that noted the resident's skin to be intact.A review of a wound consultation dated 2/19/26, documented in part . Wound #1 Coccyx is a Stage 2 Pressure Injury Pressure Ulcer. Initial wound encounter measurements are 0.7cm (centimeters) length x 1cm width x 0.1 cm depth, with an area of 0.7 sq (square) cm and a volume of 0.07 cubic cm. There is a small amount of sero-sanguineous drainage (watery, clear, or slightly (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	yellow/tan/pin fluid separated from the blood and presents as drainage) noted. Plan. Cleanse wound with Normal Saline. Apply Calcium Alginate QDay (everyday)/PRN (as needed) Apply Triad Paste QDay/PRN - To periwound. Cover with secondary dressings. Plan of Care discussed with Treatment Nurse. Nursing home staff was instructed to monitor aforementioned wounds for erythema, purulent discharge, fever, any sign of infection, or any worsening of the documented wounds. Nursing home staff has been advised to contact the provider in the event of any of these changes become evident in the aforementioned wounds.A review of the Physician orders and TARs and MARs revealed the facility staff failed to implement the above order as instructed by the wound clinician.A review of the medical record revealed no explanation on why the order was not implemented. The facility staff continued to apply the triple antibiotic ointment to the wound.The resident was seen by the wound clinician on 2/26/26, 3/5/26 and 3/12/26. All consultations documented the order of . Cleanse wound with Normal Saline. Apply Calcium Alginate QDay/PRN, Apply Triad Paste QDay/ PRN - To periwound. Cover with secondary dressing.Despite the wound clinician orders for the wound the facility staff continued to apply the triple antibiotic ointment to the wound until 3/14/26.A review of the March 2026 MAR and TAR revealed no treatment applied to the residents wound on 3/15 or 3/16. On 3/17/26, the facility staff implemented the order as directed above by the wound clinician. The treatment was not applied on 3/18 or 3/19.A review of a Wound consultation dated 3/19/26, documented the following . Coccyx is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. measurements are 5cm length x 5.4cm width x 0.1cm depth, with an area of 27 sq cm and a volume of 2.7 cubic cm. The wound is deteriorating. Multiple scattered lesions. Wound is deteriorating. Plan. Cleanse wound with Normal Saline. Apply Calcium Alginate QDay/PRN - Plus Santyl, Apply Triad Paste QDay/PRN - To periwound. Wound is deteriorating. Please closely monitor. Will add Santyl to treatment plan. Will order sacral x-ray to R/O (rule out) osteo, CBC with total protein/albumin to assess nutritional status and consult dietary. Cover with secondary dressing. Plan of Care discussed with Treatment Nurse. Nursing home staff was instructed to monitor aforementioned wounds for erythema, purulent discharge, fever, any sign of infection, or any worsening of the documented wounds. Nursing home staff has been advised to contact the provider in the event of any of these changes become evident in the aforementioned wounds.A review of the medical record revealed no documentation of the facility staff identifying or reporting the worsening of the wound until identified and documented by the would clinician on 3/19/26.A review of the facility policy titled Skin Protection Guideline dated 7/7/21, documented in part . Monitoring of Skin Integrity. Skin will be observed daily during care by the nursing assistants. Should there be a change in skin integrity, the nurse will be notified for continued evaluation. If a skin concern or change is observed. The Notification of Change Guideline will be followed. Physician consulted and orders will be transcribed for treatment. The plan of care will be modified based upon root cause analysis investigation.A review of the progress notes revealed the following:On 4/19/26 at 3:49 PM, a Nursing note documented . Resident had complaints of not feeling well and is lethargic. Resident B/p (blood pressure) was 95/52, (medication name) was given b/p was rechecked 117/64. On call Doctor was contacted. gave orders for CBC & BMP, and to continue to monitor his blood pressure.A review of the medical record revealed the CBC & BMP was never completed as directed by the Physician.On 4/20/26 at 2:54 PM, a Nursing note documented . patient being transferred to hospital from dialysis center. Dialysis center was called multiple times time with no response.A review of the medical record revealed no documentation of a dialysis communication note for the date of 4/20/26.On 6/2/26 at 12:29 PM, the facility's Wound Nurse (WN) C was interviewed and asked about their responsibilities as the Wound Nurse. WN C reported they round with the wound doctor every Thursday. WN C reported they complete the wound treatments as they round and if the wound doctor changes the resident's treatment they change the treatments as ordered by the wound doctor. WN C explained they usually would change all treatment orders the following day after the wound rounds. When asked about the Braden assessments, WN C reported that Braden (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	assessments should be done on admission and weekly for four weeks after. At this time WN C was asked to have the Director of Nursing (DON) join the interview. The DON explained how they were newly hired at the facility and started employment almost two weeks prior to this survey. At 12:41 PM, WN C and the DON was interviewed together. WN C and the DON were both asked about the admission Braden for R404, the consistently delayed implementation of the treatment ordered by the wound clinician for the coccyx/sacrum wound, the identified missed days of treatment to the wound, the failure of the facility staff to identify & report the worsening of the wound and the ordered CBC and BMP that was not completed. WN C and the DON stated they would look into the concerns and follow back up.On 6/2/26 at 2:02 PM, a second interview was conducted with the DON and WN C . They confirmed they were unable to find an admission Braden assessment and were unable to provide an explanation or documentation for review on the additional concerns noted above. The DON stated that the resident was known to be non-compliant with care. It was discussed that the medical record contained one note of the resident to have refused treatment changes to their wounds. The DON and WN C acknowledged the concerns and were unable to provide any additional explanation or documentation.Further review of the medical record revealed preadmission documents provided to the facility from the transferring hospital upon R404's admission to the facility that noted the following: . Discharge Info. Wound Pressure Injury 02/05/26 Coccyx. Wound Length (cm) 20. Wound Width (cm) 20. Wound Surface Area. 314.16. Slough (%) 50. Pressure Injury Stage U (unstageable).On 6/2/26 at approximately 2:10 PM, the DON and WN C was asked about the hospital documentation of the identified unstageable pressure injury and the facility's assessment to have initially identified a stage II for the same area, with treatment of only triple antibiotic ointment to have been applied and neither provided an explanation or further documentation for review.