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	05/05/2026

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include:On 05/04/2026 at 8:45 AM on a kitchen tour with Dietary Manager (DM) S observed the walk-in freezer with frozen condensate build up on shelving and floor. Also observed the interior of the walk-in cooler door damaged with the surface material pulling away from the door creating an exposed sharp edge and the surface is no longer smooth and cleanable. When queried during these observations, DM S said that repair requests have been entered in the electronic maintenance tracking system for both issues.On 05/04/2026 at 9:50 AM observed Pinegrove dining room ice machine drain tray full of water and overflowing onto the floor surface. When queried, the Regional Dietary Manager (RDM) T brought the maintenance director (MD) K to also observe the backed-up drain. MD K indicated that it would be addressed right away.On 05/04/2026 at 9:55 AM observed Pinegrove dining room resident/personal food refrigerator holding at 47 F. This was indicated on the unit thermometer and verified with a digital thermometer. When queried about monitoring of this unit, RDM T brought the Director of Nursing (DON) who indicated they are considering relocating this unit out of the central dining area where it can be more closely monitored.According to the 2022 FDA Food Code section 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair.On 05/04/2026 at 9:00 AM Observed dried red-brown debris coating the top of the dish machine and the dish machine pressure and temperature gauges, both were missing plastic covers. When queried about this, DM S indicated they had been advised to not clean around the gauges because they could get damaged. Regional Maintenance Director (RMD) R indicated that the vendor for the dish machine should be contacted for service as this is a rented unit. Also observed at this time in the dish washing area: no caulk along the gap between the stainless drainboard area and the wall surface, several missing wall tiles behind the dish machine, and a buildup of a black substance on the wall along the top of the stainless drainboard surround area on the pre-wash side where there was no caulk.According to the 2022 FDA Food Code section 4-602.13 Nonfood-Contact Surfaces. NonFOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues.According to the 2022 FDA Food Code section 4-402.11 Fixed Equipment, Spacing or Sealing. (A) EQUIPMENT that is fixed because it is not EASILY MOVABLE shall be installed so that it is: .(3) SEALED to adjoining EQUIPMENT or walls, if the EQUIPMENT is exposed to spillage or seepage.According to the 2022 FDA Food Code section 6-501.11 Repairing. PHYSICAL FACILITIES shall be maintained in good repair.According to the 2022 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean.On 05/04/2026 at 11:45 AM observed approximately half of the domed plate covers being used for lunch service were heavily worn and the interior surface was peeling and no longer smooth and cleanable. When queried, DM S indicated replacement plate covers will be ordered this week. According to the 2022 FDA Food Code section 4-202.11 Food-Contact Surfaces. (A) Multiuse FOOD-CONTACT SURFACES shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfectionsOn (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	05/04/2026 at 3:45 PM observed the Beechwood dining room ice machine drain line was directly connected to the handsink wastewater discharge line. It was noted that this ice machine was temporarily out of order. When queried, RMD R indicated that the required air gap will be provided on this drain line prior to returning the unit to use. MD K followed up to indicate that a broken sensor pad was in the process of being replaced for this unit. According to the 2022 FDA Food Code section 5-402.11 Backflow Prevention.a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to properly dispose of waste and maintain the dumpster area to mitigate the presence of pests, potentially affecting all residents in the facility. Findings include:On 05/04/2026 at 9:40 AM observed the outside garbage enclosure with several items within and adjacent to the enclosure including a pile of approximately 10 wood pallets, a grill, a small refrigerator, and a cabinet unit. Also observed many pieces of loose litter items including food wrappers and used gloves on the ground in the adjacent wooded area. On 05/04/2026 at 3:45 PM interviewed maintenance director (MD) K about the items stored in and adjacent to the garbage enclosure and it was indicated that they were intended for disposal and would be removed as soon as possible, including large items into the dumpster as space was available.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain general repair and safe conditions of the premises. This resulted in an increased potential for safety concerns and contamination and a possible decrease in satisfaction of living (including for residents R40 and R87). Findings Include: R87 On 5/3/26 at approximately 9:37 AM, R87 was observed lying in bed. An extension cord that was covered with plastic was plugged into the wall and ran across the resident bed. The resident reported that they use the extension cord to charge their cell phone. On 5/5/26 at approximately 1:16 PM, the extension cord was still plugged into the wall and lying on the resident's bed. R40 On 5/3/26 at approximately 9:53 AM, R40 was observed lying in bed. They had an extension cord plugged into the wall and their cell phone was attached to the cord that ran across their bed. On 5/3/26 at approximately 1:20 PM, the extension cord remained plugged into the wall and the resident's phone was attached. On 05/05/2026 at 11:05 AM observed an extension cord running from wall outlet to the bed for R87. On 05/05/2026 at 2:30 PM interviewed MD K and RMD R about personal extension cord use. RMD R said that maintenance staff keeps an eye out for extension cords used in resident rooms knowing families will bring them in. And indicated they would do a sweep to remove them and then return to families. On 05/05/2026 at 2:15 PM On a tour with Maintenance Director (MD) K and Regional Maintenance Director (RMD) R observed missing and damaged floor tiles and damaged concrete around the floor drain in the Oakland Hall central shower room. Also, observed the plastic molding at the wall base separated from the wall and some was missing. Observed throughout the facility in 4 unit hallways that many of the wooden handrails are worn such that the coating has eroded leaving an exposed surface that in some places is damaged and splintered. In several locations the handrail corner endcaps were missing leaving an exposed sharp corner. During these observations, all noted items were acknowledged by MD K and RMD R and it was indicated that needed repairs will get logged into the electronic tracking system and addressed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure irregularities identified by consultant pharmacist were addressed and noted in the resident's electronic record for five (R4, R6, R8, R11 and R36) of five residents reviewed for monthly medication regimen reviews (MRR). Findings Include:R6 A review of R6's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: type II diabetes, schizophrenia, and post-traumatic stress disorder Continued review of R6's clinical record revealed the following MRRs notes dated: 3/29/26, 2/24/26, 10/28/25, 9/10/25, and 8/24/25 documented See reports for comment. There was no documentation available in the resident's clinical record of what the reports documented and/or the physician response to the pharmacy recommendations. R8 A review of R8's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: senile degeneration of brain, type II diabetes and dementia. Continued review of R8's clinical record revealed the following MRR notes dated: 3/29/26, 2/26/26, 12/1/25. 12/28/25, 11/1/25, and 9/13/8/31 documented See reports for comment. There was no documentation available in the resident's clinical record of what the reports documented and/or the physician's response to the pharmacy recommendations. *It should also be noted that there were no MRRs noted for the months of January 2026 and October 2025. R4 A review of R4's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: senile degeneration of brain, type II diabetes and depressive disorder. Continued review of R4's clinical record revealed the following MRR note dated 3/29/26 documented See reports for comment. There was no documentation available in the resident clinical record of what the report documented and/or the physician's response to the pharmacy recommendation. R11 Review of the clinical record revealed R11 was admitted into the facility on 2/18/20 with diagnoses that included: paranoid schizophrenia, delusional disorders, vascular dementia, severe, with other behavioral disturbance, and generalized anxiety disorder. Further review of the pharmacy documentation included monthly pharmacy medication regimen reviews (MRR) from June 2025 to May 2026 that included two dates which documented See report for comment on 3/30/26 and 11/26/25. All other monthly reviews were noted as No irregularities noted. There was no documentation available in the resident's clinical record of what these reports documented, or what the Physician's response was to those recommendations. R36 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record revealed R36 was admitted into the facility on [DATE] with diagnoses that included: unilateral primary osteoarthritis right knee, type 2 diabetes mellitus with hyperglycemia, dysphagia oral phase, insomnia due to other mental disorder, anemia, essential hypertension, adjustment disorder with mixed anxiety and depressed mood, paranoid schizophrenia, moderate intellectual disabilities, chronic kidney disease, and acquired absence of left leg above knee. Further review of the pharmacy documentation included monthly pharmacy medication regimen reviews (MRR) from June 2025 to May 2026 that included five dates which documented See report for comment on 2/26/26, 1/29,/26, 12/29/25, 12/17/25, and 6/24/25. All other monthly reviews were noted as No irregularities noted. There was no documentation available in the resident's clinical record of what these reports documented, or what the Physician's response was to those recommendations. On 5/3/26 at 12:42 PM, the facility was requested via email, Can you clarify where the pharmacy irregularities and physician follow-up documentation is kept? I don't see those scanned into the EMR. On 5/4/26 at 10:06 AM, the facility was requested via email, Can you also follow up regarding my request yesterday for the pharmacy medication regimen reviews and where that information is maintained? I haven't received any follow up yet. On 5/5/26 at 10:15 AM, the DON was asked about the facility's process of maintaining MRRs and the physician follow-up. The DON reported those should be scanned into the EMR. When informed there were several residents that did not have information available for review, the DON reported they had a new medical records clerk.On 5/5/26 at 10:21 AM, an interview was conducted with the Medical Records Director (Staff 'L'). When asked about their process for ensuring medical records were scanned into the electronic medical records (EMR), Staff 'L' reported they had recently started working at the facility and also functioned as the central supply and unit clerk but had many documents that needed to be scanned. Staff 'L' was provided with a list of residents and the specific dates that the MRRs were noted to See Report for R4, R6, R8, R11, and R36. On 5/5/26 at 10:30 AM, the Director of Nursing (DON) reported they wanted to get clarification of what the survey team was looking for and reviewed the documentation provided to Staff 'L'. The DON was informed about the lack of MRRs available in the EMR and they reported that documentation should be scanned under the miscellaneous tab. The DON was informed that documentation was not available and they reported they would work on providing that documentation. On 5/5/26 at 11:00 AM, the DON reported they had concerns with the documentation they obtained regarding the MRRs were only showing one for R36 for December and they would follow-up with the pharmacy to try to find out more details but also reported that prior to January 2026 they were not working in the facility at that time. On 5/5/26 at 3:00 PM, during the exit conference with the Administrator, DON, Assistant (ADON), and Corporate Clinical staff while concerns were discussed regarding MRRs, the DON and Corporate Clinical staff reported they were still gathering the information requested. The DON further reported most of the dates requested were prior to them starting at the facility as well as the need to scan in many documents via medical records. The facility team were informed that the MRR information should be provided to the survey team by (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the exit. The Corporate Clinical staff reported they had further information to provide and the DON also expressed concern they had reached out to the pharmacy for the dates provided earlier and was informed that there were no recommendations for those dates. The facility was informed that the dates requested were directly from the pharmacy documentation in the EMR which did not indicate there were no irregularity and did document to see their report. The facility expressed frustration in not having enough time to get everything together and were informed of the multiple requests since 5/3/26. They were informed they could provide the documentation they had at this time into the EGRESS system. There was no additional documentation provided for review. According to the undated facility policy titled, Pharmacy Services Overview: .Help establish procedures for condcuting the monthly medication regimen review (MRR) for each resident in the facility .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure medications and biologicals were appropriately stored in a safe/sanitary manner in one of two medication carts, and one of one treatment cart reviewed for medication storage. Findings include:On 5/3/26 at 8:30 AM, observation of the treatment cart in the hallway outside of the small dining room revealed the cart was unlocked and there were treatment/biological supplies were stored in the cart.On 5/4/26 at 9:41 AM, observation of the medication cart with Nurse ?F' revealed the following concerns:The drawer that contained several bottles of liquids was heavily soiled with sticky debris on the bottom of the drawer.A bottle of liquid nutritional supplement was labelled as opened on 4/15/26 and was observed to have a dark tan sticky substance around the lid and on the side of the bottle.The same dark tan, sticky substance was also observed covering a package of generic heartburn relief medication that was labelled as opened on 3/25/26 in another storage compartment of the same medication drawer.When asked about the soiled status and contents in the medication cart, Nurse 'F' reported they could not offer any further explanation but would have to follow-up to clean it up.On 5/5/26 at 8:35 AM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's process for monitoring medication carts to ensure they were maintained in sanitary manner, the DON reported each nurse is responsible for ensuring the carts are clean.According to the facility's policy titled, Medication Storage dated May 2022: .The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner .Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals shall be locked when not in use .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was accessible to the resident for three (R8, R47, and R93) of three residents reviewed for accommodation of needs. Findings include:R8 On 5/3/26 at approximately 9:27 AM, R8 was observed lying in bed. The resident was alert and able to answer some questions asked. R8 reported that they were very thirsty and wanted a soda pop. The resident was asked to press their call light for assistance. The resident reported that they did not have a call light. R8's roommate stated that they would press theirs. Two Certified Nursing Assistants (CNAs) identified as CNA P and CNA Q responded to R8's roommate's call light. Both CNAs could not locate the resident's call light and told the resident they could not provide a soda pop as R8 needed to give them money to purchase it. R8 did not have the money, and the CNAs left the room. The Administrator entered R8's room and R8 again asked for the soda pop and noted that they did not have a call light to press. The Administrator was able to locate the call light and reported that the call light was out of the resident's reach and should have been placed in reach of the resident. A review of R8's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: senile degeneration of brain, type II diabetes and dementia. R47 On 5/3/26 at 10:19 AM, R47 was observed lying in bed with the head of bed elevated. The call light was observed behind the head of the bed on the mechanical portions of the bed underneath and out of reach. When asked if they knew where their call light was if they needed to ask for assistance, R47 reported they couldn't find it and if they needed help, they wouldn't be able to right now. R93 On 5/3/26 at 10:21 AM, R93 was observed seated in a wheelchair to the left side of their bed. The call light was observed on the floor on the other side of the bed. The call light was not within reach of the resident. When asked how they would request assistance, R93 reported when they were in the bed, they usually could reach it but that they couldn't right now. On 5/3/26 at 10:22 AM, Certified Nursing Assistant (CNA 'E') was about to enter the room and when asked if they were assigned to R47's room, CNA 'E' reported they were and had just started their shift. CNA 'E' entered the room and began talking with both residents. When asked about the placement of the call lights for both R47 and R93, CNA 'E' stated, Oh, why all your call lights are not on you? They should be placed here (side of bed) where they are so they can reach it. On 5/4/26 at 3:01 PM, an interview was conducted with the Director of Nursing (DON). When asked what the facility's process was for call light placement, the DON reported the call lights should be within reach wherever the resident is within the room. When asked if they had identified any issues with call light placement prior to this survey, the DON reported they did not. According to the facility policy titled, Answering the Call Light dated 11/2013: .The purpose of this procedure is to respond to the resident's requests and needs .When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to consistently identify targeted symptoms and implement non-pharmacological interventions to manage impulsive and anxious behavior prior to the administration of multiple PRN (as-needed) anti-anxiety medication for one (R5) of one resident reviewed for chemical restraints, resulting in the resident being chemically restrained for staff convenience and the inability to monitor the effectiveness of the prescribed treatment due to lack of supporting documentation. Findings include:On 5/3/26 at 10:38 AM, R5 was observed self-propelling throughout the hallway while seated in a wheelchair. R5 was attempted to be interviewed but there was no response and then proceeded down the hallway. A staff member who observed this interaction expressed use of caution because R5 was easily agitated.Review of the clinical record revealed R5 was admitted into the facility on 1/5/26 and readmitted on [DATE] with diagnoses that included: unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, epilepsy unspecified intractable with status epilipticus, traumatic subdural hemorrhage with loss of consciousness, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, adjustment disorder with depressed mood, mild neurocognitive disorder due to known physiological condition without behavioral disturbance, insomnia, repeated falls, contracture right hand, other specified disorders of brain.According to the Minimum Data Set (MDS) assessment dated [DATE], R5 had moderately impaired cognition, exhibited several mood concerns such as: had little interest or pleasure in doing things nearly every day, feeling down, depressed, or hopeless half or more of the past 14 days, trouble falling or staying asleep or sleeping too much nearly every day, feeling tired or having little energy half or more of the days, has poor appetite or overeating half or more of the days, trouble concentrating on things, such as reading the newspaper or watching television half or more of the days. There were no concerns identified with hallucinations or delusions, and behaviors.Review of the interdisciplinary progress notes included multiple EMAR (electronic medication administration record) entries of lorazepam medication being administered to R5 either orally, or via powder on the wrist. Most of the EMAR entries did not identify any details such as the specific behaviors that occurred, or what non-pharmacological interventions had been attempted (ie. combative - with no details of how, when and with who). There were a few entries that documented R5 had instances of falls that occurred after these administrations and some identified that due to R5 standing up from the wheelchair, or attempting to walk, the medication was administered. Additionally, there was no documentation to support why both the oral and powder lorazepam were administered at/near the same time in some instances.Progress notes entries included:An entry on 5/5/26 at 7:17 AM read, Resident had a witnessed fall at the nurse's station AT 0630. Resident stood up from his wheelchair in a very swift motion and dropped to the floor landing on his left knee.An entry on 5/4/26 at 11:20 PM an EMAR - Administration Note read, Lorazepam Powder Apply to bilateral wrist topically every 4 hours as needed for agitation/restlessness for 14 Days apply 0.5 mg to bilateral wrist (hairless area). There was no other documentation included of any details of behaviors, or what non-pharmacological approaches were used prior to administering this medication.An entry on 5/3/26 at 7:35 PM read, Writer observed resident on his knees in his room in front of his roommate's bed.An entry on 5/3/26 at 4:47 AM by Nurse ?N' read:Resident continues to be restless and agitated. Resident started to become combative due to trying to stand up and self transfer. PRN (as needed) administered. He was placed back in bed, in lowest position and is calm and cooperative at this time. Will continue to monitor.An entry on 5/3/26 at 4:00 AM EMAR - Administration Note read, Ativan Oral Tablet 0.5 MG Give 1 tablet by mouth every 12 hours as needed for agitation, restlessness for 14 Days. There was no supporting documentation of what specific behaviors occurred at the time of administration, or what (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-pharmacological interventions were attempted.An entry on 5/3/26 at 1:05 AM by Nurse ?N' read:Resident was continuously restless, agitated, fidgeting throughout the night. Resident was trying to self-transfer multiple times. PRN was administered, writer watched him until he fell asleep. He was put in bed, in lowest position, stable. No signs of distress noted at this time. Care continues.An entry on 5/2/26 at 11:34 PM an EMAR - Administration Note read, Lorazepam Powder Apply to bilateral wrist topically every 4 hours as needed for agitation/restlessness for 14 Days apply 0.5 mg to bilateral wrist (hairless area). There was no supporting documentation of what specific behaviors occurred at the time of administration, or what non-pharmacological interventions were attempted.An entry on 4/25/26 at 3:44 AM by Nurse ?O' read:Writer observed the resident exhibiting combative behaviors toward staff who were assisting in maintaining his safety. Writer attempted to redirect the resident by engaging him in conversation about his family, which led to the resident requesting to speak with his daughter.Review of R5's Medication Administration Records (MARs) revealed in addition to the scheduled anti-anxiety medication Buspirone HCL (hydrochloride) 15 MG (milligrams) give 1 tablet by mouth three times (TID) a day for Anxiety Disorder to be given at 9:00 AM, 1:00 PM, and 9:00 PM and had been increased from 10 MG TID on 4/24/26, the resident was also prescribed an oral and powder form of lorazepam (another anti-anxiety medication) on a PRN (as needed) basis. Further review of the documented administrations revealed R5 received multiple administrations which included both oral and powder administrations without adequate indication of use (order indicated this was for agitation/restlessness) or supporting clinical rationale.The MAR documentation from January 2026 - May 2026 revealed multiple orders for the lorazepam medication that were re-ordered every 14 days. The MAR documentation revealed R5 was administered the following 58 PRN doses of lorazepam (either oral, powder, or both) from 4/2/26 - 5/4/26:Lorazepam oral tablet 0.5 MG on:4/2 at 3:38 PM4/3 at 8:11 PM4/4 at 9:33 AM4/5 at 12:55 AM4/9 at 5:15 AM, and 8:54 PM4/10 at 7:41 PM4/11 at 3:35 PM4/13 at 3:31 AM4/13 at 7:33 PM4/15 at 12:06 AM, and 9:37 PM4/16 at 2:17 PM4/18 at 8:27 AM4/20 at 2:34 PM4/21 at 2:48 AM, and 8:21 PM4/22 at 12:40 PM4/23 at 4:56 AM, and 9:25 PM4/24 at 12:29 PM4/25 at 5:56 PM4/26 at 11:06 AM4/29 at 8:33 AM4/30 at 1:20 PM5/2 at 12:38 AM, and 3:00 PM5/3 at 4:00 AM, and 9:38 PM Lorazepam Powder apply to bilateral wrist topically every 4 hours as needed for agitation/restlessness for 14 Days apply 0.5 mg to bilateral wrist (hairless area) was given on:4/10 at 8:00 AM4/11 at 3:35 PM, and 11:34 PM4/12 at 5:19 AM, 10:25 AM, and 7:18 PM4/13 at 12:42 AM4/14 at 9:43 PM4/15 at 9:38 PM4/16 at 10:12 AM, and 7:56 PM4/19 at 12:10 AM, and 3:23 PM4/20 at 1:39 PM4/22 at 8:42 AM, and 7:33 PM4/23 at 2:47 PM4/25 at 12:48 AM, and 2:18 PM4/26 at 12:14 AM4/27 at 3:50 PM5/1 at 8:54 AM, and 7:44 PM5/2 at 12:46 AM, 7:57 AM, 7:28 PM and 11:34 PM5/3 at 9:38 PM5/4 at 11:20 PM On 5/5/26 at 12:48 PM, an interview was conducted with the Director of Nursing (DON) and Assistant DON. When asked to explain the facility's process for administering PRN psychotropic medication, the DON reported the nurses should be documenting why they were giving it in the EMAR note. When asked if they should be attempting non-pharmacological interventions, the DON reported they should and that should also be documented. When asked about the lack of clinical rationale for the order for lorazepam for agitation/restlessness, the ADON acknowledged the concern and reported those were symptoms and not an indication and further expressed that would have to get clarified. When asked about the clinical rationale, the DON reported R5 has had an increase in restless behaviors since a seizure and hospitalization. When asked about clinical rationale and who was following these medications, the DON reported that was their psych provider. When asked to review the most recent psych evaluation which was from 4/2/26, the DON reported there might be others that are not scanned into the EMR and was asked to provide any additional documentation of clinical rationale from the providers (there was no further documentation provided). The DON confirmed there was no mention of R5's use of lorazepam or clinical rationale including specific targeted behaviors and justification and reasoning with using duplicate anxiolytic medication for the scheduled and PRN powder and oral anti-anxiety medication.The DON was asked why they were utilizing anti-anxiety medication for someone that is (continued on next page)

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	05/05/2026

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at high fall risk and has multiple attempts to get up unassisted and is at risk for continued falls if drowsy, weak and the DON reported that since the seizure, R5 had been more restless, combative with staff and held an emergency care conference with the family in which they identified the resident prefers to be more isolative than with others. When asked why that was not incorporated into the documentation and plan of care, the DON offered no further explanation.The DON was asked to review the nursing documentation for the administrations and acknowledged some staff were documenting minimal details, but that most of the administrations had no supporting documentation.According to the facility's policy titled, Psychotropic Medications Guideline dated 5/30/2025: .The resident should not start medication that is not required to treat a resident's medical symptoms, and which may cause symptoms consistent with sedation.Psychotropic medications should be the last resort for treatment and not used for staff convenience.Prior to the initiation of psychotropic medication, the facility shall document behavioral and nonpharmacological interventions unless contraindicated.If psychotropic medications are initiated or increased, the medical record should show a rationale for the change in the medication regimen and a new consent obtained.Appropriate monitoring will be documented.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop an individualized care plan to address a resident's use of psychotropic medication and specific targeted behaviors, and non-pharmacological interventions for one (R5) of 18 residents reviewed for care planning. Findings include:On 5/3/26 at 10:38 AM, R5 was observed self-propelling throughout the hallway while seated in a wheelchair. R5 was attempted to be interviewed but there was no response and then proceeded down the hallway. A staff member who observed this interaction expressed use of caution because R5 was easily agitated.Review of the clinical record revealed R5 was admitted into the facility on 1/5/26 and readmitted on [DATE] with diagnoses that included: unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, epilepsy unspecified intractable with status epilepticus, traumatic subdural hemorrhage with loss of consciousness, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, adjustment disorder with depressed mood, mild neurocognitive disorder due to known physiological condition without behavioral disturbance, insomnia, repeated falls, contracture right hand, other specified disorders of brain.According to the Minimum Data Set (MDS) assessment dated [DATE], R5 had moderately impaired cognition, exhibited several mood concerns such as: had little interest or pleasure in doing things nearly every day, feeling down, depressed, or hopeless half or more of the past 14 days, trouble falling or staying asleep or sleeping too much nearly every day, feeling tired or having little energy half or more of the days, has poor appetite or overeating half or more of the days, trouble concentrating on things, such as reading the newspaper or watching television half or more of the days. There were no concerns identified with hallucinations or delusions, and behaviors. However, there was documentation during this time of multiple administrations of as needed (PRN) anti-anxiety medication according to the medication administration records.Review of the current physician orders included scheduled anti-anxiety, anti-depressant and multiple PRN anti-anxiety medications.Review of the care plans revealed there were none initiated for R5's use of multiple psychotropic medications, including any specific targeted behaviors and non-pharmacological approaches to be attempted.On 5/5/26 at 12:48 PM, an interview was conducted with the Director of Nursing (DON) and Assistant DON to discuss the concerns regarding R5's use of multiple lorazepam orders, what the resident specific targeted behaviors were and what non-pharmacological interventions were identified to implement when needed. When asked about the lack of a care plan to address R5's use of psychotropic medication, the DON and ADON reviewed the medical record and confirmed there was none initiated and would put one in place now. When asked who was responsible to ensure this was completed, the DON reported they held weekly at-risk meetings with the MDS nurse, social worker and dietary staff to review and was unable to offer any further explanation as to why this was not done for R5. According to the facility's policy titled, Behavior Management Program dated 11/28/2017: .Ongoing evaluation of potential risks and care plan effectiveness is part of the overall treatment plan for all residents .Continue or change and update care plan accordingly .Care plan interventions are updated and made available to care giving staff .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to implement Enhanced Barrier Precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms) and engage gown and glove use during high contact resident care for wound care dressing changes for one (R72) of one reviewed for Enhanced Barrier Precautions. Findings include.Clinical record review revealed R72 was admitted to the facility for long term care on 7/24/23 with a medical history of Chronic Obstructive Pulmonary Disease (COPD) malnutrition, and peripheral vascular disease. A Brief Interview of Mental Status (BIMS) dated 2/2/26 scored 8/15 indicating R72 had mild cognitive impairment.On 5/03/26 at 10:03 AM, during initial pool interview, R72 was observed with their right foot elevated on a thick folded blanket dressed in white gauze and closed with tape. When inquired, R72 said they had a sore on their ankle, and the Nurses are putting medications on it. Upon exiting the room there was no signage observed for R72 on Enhanced Barrier Precautions (EBP).Record review revealed on 4/24/26 R72 was identified with an open vascular wound to their right outer ankle. Review of the care plan and orders for EBP were not documented.On 4/25/26 orders were implemented to apply Santyl Ointment (topical medication used to remove dead or damaged tissue from wounds) apply to right ankle topically every day shift for wound care, cleanse open area with normal saline apply Santyl to wound bed and cover with moistened gauze with Dakins (antiseptic medication) and cover with gauze.On 5/4/26 at 1:35 PM, an observation of Licensed Practical Nurse (LPN) B was conducted changing the right foot dressing. LPN B was observed not donning Personal Protective Equipment (PPE), specifically a gown. The soiled gauze dressing was removed, and LPN B hair was observed draping loosely over and touching into the removed soiled dressing.When questioned if R72 was on precautions for the dressing change, LPN B stated they did not have an active infection and did not require enhanced barrier precautions. LPN B indicated there was no sign and PPE cart in front of the room which is how they would know R72 was on precautions.On 5/4/26 at 2:10 PM, the Director of Nursing (DON) and Infection Control Register Nurse (RN) C were interviewed and questioned if Enhanced Barrier Precautions were indicated for R72's right wound dressing. Both acknowledged wound care that required dressing changes were to be on enhanced barrier precautions. The DON acknowledged R72 was not on precautions.