STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235262	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Hickory Haven	3310 W Commerce Rd Milford, MI 48380

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 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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 0604 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint #2649116 and Incident #2652020.Based on observation, interview, and record review, the facility failed to ensure physical restraints were not utilized for staff convenience to restrict movement of the resident's arms for one (R801) of three residents reviewed for abuse, resulting in a severely cognitively impaired resident's shirt sleeves being tied together to prevent them from grabbing onto staff causing psychosocial harm using the reasonable person concept. Findings include: A review of a complaint submitted to the State Agency (SA) revealed an allegation that R801, who had severe dementia and could not communicate, had her sleeves tied together by Certified Nursing Assistants (CNAs) 'C' and 'D' in order to treat her.A review of a second complaint submitted to the SA revealed an allegation that R801, who had Alzheimer's Disease and did not have the capacity to make decisions, had the hands of her sleeves tied together by staff on 10/15/25 because she was aggressive and agitated. It was alleged staff left the room for at least an hour and left R801 in restraints, unattended. It was alleged there were concerns R801 was not being aggressive or agitated when she was restrained because she had never behaved in that manner. It was noted R801 was prescribed Ativan (a medication used to treat anxiety) and Morphine (a medication used to treat severe pain) as comfort medications if she became aggressive or agitated that they were not given. On 10/29/25, an onsite investigation was conducted.On 10/29/25 at 8:50 AM, R801 was observed lying in bed. R801 appeared thin and frail. An interview was attempted. R801 made eye contact but was not able to answer any questions. A review of R801's clinical record revealed R801 was admitted into the facility on 4/11/25 and readmitted on [DATE] with diagnoses that included: Alzheimer's Disease. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had severely impaired cognition, unclear speech, did not have any behaviors during the assessment period, and was dependent on staff for all activities of daily living (ADL), transfers, and bed mobility. R801 signed onto hospice services on 5/20/25. A review of R801's progress notes revealed an Interdisciplinary Documentation note dated 10/21/25 that read, On 10-14-2025 (R801) had an incident that was reported to the (SA) as she was observed with her shirt sleeves to be tied together. Upon identification the nurse did evaluate her and she had no injuries from the incident .Through staff interviews and investigation of the incident it was identified that she has increased behaviors and can be combative with care at times .Further review of R801's progress notes revealed no documentation of behaviors exhibited by R801 on 10/14/25, the night of the incident mentioned above. A review of a Facility Reported Incident (FRI) investigation submitted to the SA revealed the following Investigation Summary:On 10/14/25 around 10:10 PM-11PM, (CNA 'C') tied (R801's) shirt sleeves together in attempt to prevent (R801) from physically scratching, hitting or pinching (CNA 'C') during care. (R801) is care planned for 2 assist with bed mobility, but (R801) instead provided care by herself and tied the sleeves together instead of having a second staff assist and distract. Staff untied (R801's) shirt sleeves around 11PM .The documented Allegation Details noted, DHCS (Director of Health Care Services) received a voice mail message on 10/15/25 from (CNA 'G') that a resident (R801) was noted with her shirt sleeves tied together. The CNA reported that resident was unable to move her arms. The nurse was notified and untied the resident.On 10/29/25 at 11:35 AM, an interview was conducted with CNA 'C' via the telephone. CNA 'C' confirmed she was no longer employed by the facility. When asked why, CNA 'C' reported she was not sure. When queried about what happened with R801 on 10/14/25, CNA 'C' reported herself and CNA 'D' went into R801's room to do a last check and change (at the end of the afternoon shift). CNA 'C' reported CNA 'D' wiped her down while R801 was lying on her back. CNA 'C' explained R801 had an indwelling urinary catheter and CNA 'D' was wiping down her front. CNA 'C' further reported R801 began scratching at CNA 'D' and scratching at her (CNA 'C'), digging her finger nails into CNA 'C' and was combative. CNA 'C' reported R801 had the same reaction when nurses did her wound treatments. CNA 'C' explained she then put the end of her sleeves together so she couldn't scratch us. CNA 'C' reported they were about to weigh R801 using the mechanical lift and Registered Nurse (RN) 'F' entered the room and asked CNA 'C' and CNA 'D' to stop providing care to R801 and assist with another resident who was trying to get out of bed. CNA 'C' further reported they stopped what they were doing, left the room to attend to the other resident, and forgot to go back to (R801) and she was left with her sleeves tied. CNA 'C' reported she notified RN 'F' that R801 was fighting with them during care, but no direction was given. CNA 'C' explained she did not think tying R801's sleeve together was a restraint, and she was just trying to look out for her (CNA 'C') and CNA 'D's safety. On

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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 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)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint #2649116 and Incident #2652020.Based on observation, interview, and record review, the facility failed to report an allegation of abuse to the Abuse Coordinator and State Survey Agency within the required timeframe for one (R801) of three residents reviewed for abuse, resulting in a delay in investigation and the alleged perpetrators continuing to work with the victim. Findings include:A review of a complaint submitted to the State Agency (SA) revealed an allegation that R801, who had severe dementia and could not communicate, had her sleeves tied together by Certified Nursing Assistants (CNAs) 'C' and 'D' in order to treat her.A review of a second complaint submitted to the SA revealed an allegation that R801, who had Alzheimer's Disease and did not have the capacity to make decisions, had the hands of her sleeves tied together by staff on 10/15/25 because she was aggressive and agitated. It was alleged staff left the room for at least an hour and left R801 in restraints, unattended. It was alleged there were concerns R801 was not being aggressive or agitated when she was restrained because she had never behaved in that manner. It was noted R801 was prescribed Ativan (a medication used to treat anxiety) and Morphine (a medication used to treat severe pain) as comfort medications if she became aggressive or agitated that they were not given. On 10/29/25, an onsite investigation was conducted.On 10/29/25 at 8:50 AM, R801 was observed lying in bed. R801 appeared thin and frail. An interview was attempted. R801 made eye contact but was not able to answer any questions. A review of R801's clinical record revealed R801 was admitted into the facility on 4/11/25 and readmitted on [DATE] with diagnoses that included: Alzheimer's Disease. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had severely impaired cognition, unclear speech, did not have any behaviors during the assessment period, and was dependent on staff for all activities of daily living (ADL), transfers, and bed mobility. R801 signed onto hospice services on 5/20/25. A review of R801's progress notes revealed an Interdisciplinary Documentation note dated 10/21/25 that read, On 10-14-2025 (R801) had an incident that was reported to the (SSA) as she was observed with her shirt sleeves to be tied together. Upon identification the nurse did evaluate her and she had no injuries from the incident .Through staff interviews and investigation of the incident it was identified that she has increased behaviors and can be combative with care at times .A review of a Facility Reported Incident (FRI) investigation revealed the following was submitted to the SA on 10/15/25 at 8:30 PM, Staff alleges mistreatment of resident . It was documented the incident occurred on 10/14/25 at 11:00 PM, approximately 22 hours before the incident was reported to the SA. Further review of the FRI investigation revealed an Investigation Summary that noted the following:On 10/14/25 around 10:10 PM-11PM, (CNA 'C') tied (R801's shirt sleeves together in attempt to prevent (R801) from physically scratching, hitting or pinching (CNA 'C') during care. (R801) is care planned for 2 assist with bed mobility, but (R801) instead provided care by herself and tied the sleeves together instead of having a second staff assist and distract. Staff untied (R801's) shirt sleeves around 11PM .The documented Allegation Details noted, DHCS (Director of Health Care Services) received a voice mail message on 10/15/25 from (CNA 'G') that a resident (R801) was noted with her shirt sleeves tied together. The CNA reported that resident was unable to move her arms. The nurse was notified and untied the resident.On 10/29/25 at 11:35 AM, an interview was conducted with CNA 'C' via the telephone. CNA 'C' confirmed she was no longer employed by the facility. When asked why, CNA 'C' reported she was not sure. When queried about what happened with R801 on 10/14/25, CNA 'C' reported herself and CNA 'D' went into R801's room to do a last check and change (at the end of the afternoon shift). CNA 'C' reported CNA 'D' wiped her down while R801 was lying on her back. CNA 'C' explained R801 had an indwelling urinary catheter and CNA 'D' was wiping down her front. CNA 'C' further reported R801 began scratching at CNA 'D' and scratching at her (CNA 'C'), digging her finger nails into CNA 'C' and was combative. CNA 'C' reported R801 had the same reaction when nurses did her wound treatments. CNA 'C' explained she then put the end of her sleeves together so she couldn't scratch us. CNA 'C' reported they were about to weigh R801 using the mechanical lift and Registered Nurse (RN) 'F' entered the room and asked CNA 'C' and CNA 'D' to stop providing care to R801 and assist with another resident who was trying to get out of bed. CNA 'C' further reported they stopped what they were doing, left the room to attend to the other resident, and forgot to go back to (R801) and she was left with her sleeves tied. 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