STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235332	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westland, A Villa Center	36137 West Warren Westland, MI 48185

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. This citation pertains to intake M100152760: Based on observation, interview, and record review, the facility failed to prevent the misappropriation of medication for one (R703) of three residents reviewed for misappropriation of property. Findings include: Review of the identified intake revealed the facility reported to the State Agency (SA) that R703 had missing medication and their investigation determined that the medication had been diverted by Licensed Practical Nurse (LPN) A resulting in reports to the SA and local law enforcement. On 05/27/25 at 10:40 AM, R703 was interviewed in their room. They reported they had no concerns regarding missing any pain medication doses or being able to get their medication when they needed it. R703 was observed to demonstrate no overt signs of pain. R703 indicated no specific knowledge of their medication being missing at any point. On 05/27/25 at 12:01 PM, a call was placed to LPN A and a message requesting a return call was left. No return call was received by completion of the survey. On 05/27/25 at 12:45 PM, the facility Director of Nursing (DON) was interviewed and asked their understanding of how the medication diversion took place. The DON reported the alleged perpetrator had started a new Controlled Substance Shift Inventory and recorded a false number of medication blister packs so that when LPN A and LPN B completed the shift change medication count no discrepancy was initially identified. The DON reported that approximately two hours after the shift change R703 requested their pain medication and when LPN B attempted to retrieve it, the absence of the medication was identified. The DON reported the ensuing investigation revealed the Controlled Substance Shift Inventory which proceeded the new one that LPN A completed was missing as were the pharmacy controlled substance sheets that pertain to the missing medication. The DON reported the missing inventory sheet was found intact in the shred box and it did reveal a discrepancy in the number of controlled substance blister packs when compared to the new inventory made by LPN A. On 05/27/25 at 2:05 PM, the DON was interviewed and asked their expectation for comparing a new controlled substance inventory sheet to the previous inventory to confirm the transfer of accurate information and the DON reported that the oncoming nurse should verify the previous inventory against the new one when a new inventory is presented and acknowledged that in this case the oncoming nurse did not do so. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/27/25 at 2:50 PM, LPN B was interviewed via phone. LPN B reported they did recall the shift change with LPN A and stated they did complete a med count together. LPN B reported they did realize that a new controlled substance inventory had been started and that they asked LPN A about the previous inventory and LPN A told them they had put it in the nursing box. LPN B was asked if putting the previous inventory in the nurses box was normal procedure and they stated No, we normally only do that at the end of the month. LPN B acknowledged that this incident did not occur at the end of the month and therefore the previous inventory should have been available with the new inventory for review, however they did not pursue it further at that time. Review of the facility policy Controlled Substance Accountability Guideline revealed the following statement under Change of Shift Reconciliation: Two licensed nurses (the nurse arriving on duty and the nurse departing from duty) are required to conduct reconciliation (i.e., change of shift count) of controlled substances and sign a signature log attesting to the completion and accuracy of the count. The reconciliation process should include: - A count comparing the Controlled Substance Count Sheet Inventory Log (the master list of the individual count sheets) with the actual individual count sheets. Review of the facility policy Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property dated 11/28/17 revealed the statement It is the policy of this facility to prevent abuse by providing residents, families and staff information and education on how and to whom to report concerns, incidents and grievances without the fear of reprisal or retribution. The Definitions portion of the policy included Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident ' s belongings or money without the resident ' s consent.