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	06/11/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake number: MI00153419. Based on observation, interview, and record review, the facility failed to thoroughly assess and determine the root cause of a skin impairment for one (R801) of one resident reviewed for skin management. Findings include: A review of a complaint submitted to the State Survey Agency (SSA) revealed an allegation that staff were rough when transferring them to the wheelchair and have caused injury to their arms and legs. An unannounced, onsite investigation was conducted on 6/10/25 and 6/11/25. On 6/10/25 at 9:25 AM, R801 was observed lying flat on their back in bed. R801 sat up in bed and the left hand was observed to be held tightly against their chest. It was unknown if they were able to straighten their arm. R801 was able to move the right arm freely. At that time R801 was interviewed about the care in the facility. R801 reported they wanted to get out of the facility and said they hated it there. R801 reported staff were rough with them when they put them in the wheelchair and sometimes it hurt their arms. R801 reported they did not report it to anyone because it made them feel anxious was afraid they would get in trouble. At that time, R801's arms were visible and did not appear bruised or with any skin impairments. A review of R801's clinical record revealed R801 was admitted into the facility on 3/12/24 and readmitted on [DATE] with diagnoses that included: hemiplegia and bipolar disorder. A review of R801's Minimum Data Set (MDS) assesment dated 3/14/25 revealed R801 had intact cognition, no behaviors, and was dependent on staff assistance for chair to bed and bed to chair transfers.

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake number: MI00153419. Based on observation, interview, and record review, the facility failed to provide medically related social services for one (R801) of one resident reviewed for mood and behaviors who had a history of self harm and repeatedly contacted 911(emergency medical services). Findings include: A review of a complaint submitted to the State Agency revealed allegations of being treated badly by the staff at the facility and as a result had thoughts of suicide and thoughts of homicide towards the staff. On 6/10/25 at 9:10 AM, an interview was conducted with the Administrator who reported they were not aware of any suicidal or homicidal ideations expressed by R801. On 6/10/25 at 9:25 AM, R801 was observed lying flat on their back in bed. R801 had a long, scruffy beard and wore a hospital gown. When queried about the care in the facility, R801 reported they hated it at the facility and wanted to get out of there. R801 reported the staff were rough when they provided care and did not like to talk to people about their concerns because they did not want to get in trouble. R801 reported they called 911 often, was on a waiting list for housing for Veterans, and wanted to go outside to smoke. R801 stated, I would rather be dead, than be here! R801 reported they had not talked to anyone from the social services department in a while. A review of R801's clinical record revealed R801 was admitted into the facility on 3/12/24 and readmitted on [DATE] with diagnoses that included: hemiplegia, hemiparesis, and bipolar disorder. A review of a Minimum Data Set Assessment (MDS) assessment dated [DATE] revealed R801 had intact cognition and no behaviors. A review of R801's Social Service Notes revealed the last note was dated 3/18/25 and read, Writer met with resident due to increased behaviors, resident explained they get agitated but don't now why, resident agreed to be seen by psych (Psychiatrist). Psych to follow. A review of R801's progress notes from 2/2025 through 3/18/25 revealed R801 had multiple incidents of resisting care, screaming at staff, and agitation. Further review of R801's progress notes after 3/18/25 revealed the following: R801 had a psychiatric evaluation on 3/31/25. At that time R801 had feelings of anxiety and depression and exhibits moments of irritability and impulsivity .via verbal outbursts in (nursing home) when making requests from staff .reports frequent sleep disturbance on most nights . R801 called 911 on: -4/9/25 because felt like he was having a stroke/heart attack, -5/6/25 because they were in pain, (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/22/25 due to shoulder pain, -5/31/25 due to chest pain, and -6/2/25 for groin and arm pain. R801 was transferred to the hospital on most of those dates and returned to the facility the same day besides the on 5/6/25 when they were admitted to the hospital until 5/11/25. There was no documentation of any discussion with R801 to determine why they kept calling 911. A review of R801's psychiatric evaluation notes revealed they were seen by psychiatric services on 4/9/25 and 5/9/25 but there was no mention of R801 calling 911 and going to the hospital. On 5/22/25, prior to R801 calling 911, it was documented that R801 continued to scream even after staff did every task (R801 demanded, changed, water, snack, repositioned, calling 911 several times, very agitated, using vulgar language to staff) . On 6/2/25, it was documented in a Health Status Note the physician was notified of R801's call to 911 to be transferred to the hospital. The physician ordered a Full Psych Eval from the hospital prior to returning to the facility for possible guardianship. R801 returned to the facility the same day. R801 called 911 on 6/3/25 for chest pain and the physician (MD) ordered R801 to be sent to a specific hospital. R801 returned the same day. On 6/3/25 at 2:25 PM, approximately four hours after R801 returned to the facility from the hospital, the following was documented, Writer called 911 to get transferred to the hospital due to abdominal pain. Resident was observed by staff member hitting themself in the stomach . R801 returned to the facility on 6/3/25 at 8:00 PM. On 6/6/25, it was documented in a progress note R801 asked to be changed, during peri care residents bottom sheet was wet. They did not want their bottom sheet changed and started to yell and bang their head against the wall .MD notified ordered to transfer resident to ER (Emergency Room) for Psych Eval (evaluation) . It was documented in a Transfer to Hospital . note on the same date that R801 was being transferred for psych eval due to self harm. Further review of R801's progress notes revealed continued documentation of R801 calling 911 to be transferred to the hospital. A review of a psychiatric evaluation note dated 6/9/25 revealed no documentation of R801's continued 911 calls and hospital transfers or the incidents of self harm on 6/3/25 (punching self in the stomach) and 6/6/25 (banging head on the wall). Further review of R801's Social Service Notes revealed no additional follow up from social services since 3/28/25 when it was identified R801 had increased behaviors. There were no notes from social services that addressed R801's incidents of self harm. A review of R801's care plans revealed the following: (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan initiated on 4/30/24 that noted, The resident is resistive to care .chooses to call 911 for shoulder pain .verbally aggressive with staff . No additional interventions were implemented since 7/19/24. No care plan was developed or implemented after R801 exhibited self harming behaviors (hitting self in stomach and hitting head on the wall). On 6/10/25 at 10:04 AM, an interview was conducted with the Director of Nursing (DON). When queried about any behaviors exhibited by R801, the DON stated, They just call 911 all the time. It is becoming an issue for the doctor. When queried about why R801 called 911, the DON stated, They don't say why they are calling, they just call. The DON reported staff could be in the room and as soon as they leave, EMS showed up. The DON reported Physician 'D' wanted R801 to have a cognitive test because they can't make their own decisions. When queried about any assessment from social services or nursing, psych services, or the physician that documented any discussion about the root cause of why R801 called 911 all the time, the DON reported R801 did not give a reason. No documentation was provided to show that was discussed with R801. On 6/10/25 at 12:28 PM, an interview was conducted with Social Services Director (SSD 'B'). SSD 'B' reported they started working in the facility a little over one month ago. When queried about how the social services department was involved in developing and implementing interventions for behaviors, SSD 'B' reported they started a new behavior management program recently. When queried about how the social services department was notified of any new or increased behaviors from residents, SSD 'B' reported they look at nursing documentation or was verbally notified by nursing staff. When queried about knowledge of any suicidal ideations or self harming behaviors, SSD 'B' reported they were not aware of those things, only that the resident called 911 a lot and had frequent yelling. On 6/10/25 at approximately 1:00 PM, an interview was conducted with the Administrator who was over the social services department. The Administrator reported he was not aware of any self harming behaviors exhibited by R801 and there should have been documented follow up and interventions in place after he returned to the facility from the hospital.