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	04/14/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. This citation pertains to Intake 2978833.Based on interview and record review, the facility failed to permit one resident (R700) out of three residents reviewed for discharges, to return to the facility after a hospitalization. Findings Include: A review of documentation submitted to the State Agency (SA) revealed the following, Complainant states the facility called the police and had [them] sent to the hospital for a psych (psychiatric) evaluation on the evening of 04/07/2026.The complainant states [they the hospital] cleared his evaluation and is ready to be sent back to the facility, but [facility] staff told the hospital they won't accept [them] back . On 4/16/26 at 10:32 AM, R700 remained hospitalized and was interviewed via phone. They explained they were transported to the local hospital and evaluated by psychiatric services. They explained they were cleared to return to the facility; however, they were informed by the hospital social worker the facility was not willing to take them back, rather they would be transferred to another facility located in a different city. R700 explained they wanted to return back to the facility as it has been their home for almost two years, and they were still at the hospital and are ready for discharge. R700 further explained they were also informed their personal belongings had been moved to the other facility and was concerned their belongings were missing.A review of R700's medical record revealed they were admitted into the facility on 6/21/24 and discharged from the facility on 4/7/26 with diagnoses which included, Quadriplegia, Depression, and schizoaffective disorder. Further review revealed the resident was cognitively intact and required assistance with activities of daily living (ADLs). On 4/14/26 at 11:18 AM, an interview was complete with the Nursing Home Administrator (NHA), and explained R700 behaviors began to appear manic within the last 3-4 weeks, where they were making accusations about employees and residents, stalking and causing havoc to the point the police had to be called three times as they were becoming a threat to other residents. The NHA further explained the resident was going to be transferred to the facility's sister facility as they could better manage the resident's behaviors, and their belongings had already been transferred there. The NHA was asked if there had been a discussion with the resident about this transfer, and indicated between the hospital liaison, corporate, and the resident's physician, this discussion was held and the resident agreed. On 4/14/26 at 2:51 PM, the Director of Nursing (DON) was asked about R700's discharge from the facility, and explained the resident began displaying symptoms of a psychotic break and was petitioned to the hospital. Regarding R700 returning to the facility, the DON explained the resident's physician thought the resident would receive better psychiatric care at their sister facility and the conversation regarding this was between the physician and the resident as the resident indicated they wanted to be transferred elsewhere. A review of the resident' progress notes did not note any arrests by the local police, documentation of the resident's agreeance to transfer to another facility or a change in the resident's ability to go out of the building for leave of absences alone due to their mental health. A review of local hospital documentation dated 4/8/26 revealed the social worker spoke to the DON who informed them the resident's physician wanted the resident transferred to their sister facility. The progress notes revealed the following, PSW (psychiatric social worker) spoke with patient who is refusing to go to [sister facility]. [R700] states that [they] will return to [home facility].Further (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of hospital documentation dated, 4/14/26 revealed the following, SW (social worker) met with pt (patient) at bedside this morning to discuss dc (discharge) plan, [sister facility] can accept the pt. Pt is refusing to go to this facility, [they] report [they] only want to go back to [home facility]. Per chart review they are not allowing [R700] to return .A review of the facility's Transfer and Discharge policy revealed the following, .The resident and representative will receive timely notification, adequate preparation, orientation and information to make the transfer as orderly and safe as possible. The notice contains information about the transfer and information about the resident's appeal rights If the transfer is due to an emergency, the notice will be issued as soon as practicable .

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. This citation pertains to Intake 2978833.Based on observation, interview, and record review, the facility failed to implement supervision interventions after an incident of alleged inappropriate touching for two residents (R705 and R706) of two reviewed for adequate supervision.Findings include: A review of documentation submitted to the State Agency (SA) revealed the following, Complainant states an unknown male resident on Unit 3 gave resident [R706] a bag of candies in exchange for allowing him to touch her inappropriately. The complainant states [they] witnessed the male resident's hand up [R706's] dress and [R706's] hand was on the outside of the male resident's pants near his genitals. On 4/14/26 at 11:18 AM, a request for documentation related to any incidents regarding R706 was requested and was provided with an investigation regarding inappropriate touching between two residents, R705 and R706 in exchange for candy. The conclusion of the facility's investigation was inconclusive.On 4/14/26 at 12:50 PM, R705 was interviewed regarding allegations that he touched R706 inappropriately in exchange for candy. R706 became defensive and explained they were in their room when R706 wheeled themselves into their room and started touching their snacks. R705 indicated he attempted to stop R706 because he was aware the resident isn't supposed to eat anything by mouth. He denied touching R706 anywhere on their body. A review of R705's medical record revealed they were admitted into the facility on 3/19/22 with diagnoses which included, Schizoaffective Disorder, Bi-Polar Disorder and Anxiety. Further review revealed the resident was cognitively intact and required assistance with activities of daily living.On 4/14/26 at 12:59 PM, R706 was interviewed and was able to communicate through the use of nodding their head and the use of hand gestures regarding the allegations of inappropriate touching, due to their speech impairment. R706 was able to communicate that she did touch R705 in his groin area, and that he also touched her in her groin area in exchange for candy. R706 was also able to communicate this type of incident occurred twice by holding up two fingers, and she did not feel safe in the facility because of R705. A review of R706's medical record was reviewed and revealed they were admitted into the facility on 9/8/14 with diagnoses which include, Vascular Dementia, Anxiety and Depression. Further review revealed the resident was cognitively intact and required assistance for activities of daily living. On 4/14/26 at 2:31 PM, an interview was completed with the NHA regarding the alleged incident between R705 and R706. The NHA explained the investigation was inconclusive as R705 stated it didn't occur, while R706 indicated that it did. Regarding interventions, the NHA indicated that facility staff are aware of the need to monitor both residents. On 4/24/26 at 2:40 PM, a phone interview was completed with the Director of Nursing (DON) regarding R705 and R706 and explained R705 stated touching didn't occur while R706 stated it did. Regarding interventions, the DON explained, the residents were both informed to stay out of each other's rooms.A review of both R705 and R706's current plans of care did not address increased supervision for either resident.A review of the facility's Care Plan Standard Guideline policy revealed the following, .Comprehensive Care plan. The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: 1. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being .