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	05/14/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 3012716.Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse for one resident (R57) by another resident (R102). Findings include:On 05/13/2026 at 2:12 PM, along with the facility's administrator, a review of video footage from an incident which occurred on 5/3/2026 at approximately 9:50pm between R57 and R102 was performed. The video revealed the two residents appearing to be arguing and engaging in an angry confrontation. R57 visually (angry facial expression and moving arms about) became agitated by the conversation with R102 and subsequently grabbed R102's phone which was on their lap. R57 then started walking away from R102. R102 was then noted to follow R57, running into them with their electric wheelchair, making contact causing R57's pants to fall down. R57 then struck out at R102 with the back of their hand. The residents were then separated by staff. , an interview was conducted with the facility administrator while viewing the video footage noted above. The administrator described the situation they saw on the video; that R102 ran into R57 with their electric wheelchair, which tangled R57's pants and caused them to fall down while R57 attempted to swat R102 away. On 05/13/2026 at 11:00 AM, an interview was conducted with R57. They stated that during the incident, R102 tried to run them over with their wheelchair so R102 got slapped. R57 further stated that R102 was verbally insulting and egging them on for two hours, and said that R102 goes around bothering everybody, they were just the first that slapped R102. R57 stated they were insulted again by R102 in the hallway when going to the vending machine yesterday, but there was no physical contact. When asked if they felt safe from having further problems with R102, R57 nodded yes. A review of R57's electronic medical record (EMR) revealed they were admitted into the facility on 4/8/2026 with diagnoses of hemiplegia and hemiparesis (one-sided muscle weakness or paralysis) following cerebral infarction (stroke), Type 2 Diabetes, and muscle wasting/atrophy. A review of R57's most recent Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Further review of R57's EMR did not reveal any care plans for behavioral issues.On 05/13/2026 at 11:09 AM, an interview was conducted with Licensed Practical Nurse (LPN) Unit Manager (UM) H. LPN UM H stated they have not witnessed R57 display any aggressive behavior towards staff or other residents.On 05/12/2026 at 9:09 AM, R102 was observed exhibiting loud cursing and derogatory language directed towards the surveyor and facility staff in the hallway near R102's room. As R102 moved past the surveyor in their electric wheelchair, they struck the surveyor's laptop with their hand. They were also observed to be playing loud music in a disruptive manner on a portable speaker.On 05/13/2026 at 11:42 AM, an interview was conducted with R102. When asked about the altercation with R57 on 5/3/2026, they stated that R57 punched them in the face and threatened to kill them. R102 said that during the incident, they were questioning R57 about their health problems, as R102 stated they did not believe R57 had really had a stroke and said R57 was upset because it was like I was busting their game. R102 said they were being followed and threatened by R57, and that R57 was behind them and hit them. R102 stated they then tried to get away but couldn't move fast enough and tried to push R57 away. R102 said they shut (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	off their wheelchair to prevent hurting anyone, and that's when they were struck by R57 and choked.Review of the video footage from the incident noted above did not support the statements of R102 being hit from behind or choked by R57.A review of R102's EMR revealed they were admitted into the facility on 6/21/2024 with diagnoses of quadriplegia (paralysis of body and limbs) C-1 through C-4 (first four vertebrae of the spine) incomplete, unspecified psychosis, and generalized anxiety disorder. A review of R102's most recent MDS dated [DATE] revealed a BIMS score of 13, indicating intact cognition.A review of R102's care plan revealed The resident has a behavior problem cursing, screaming, and other unpredictable behaviors r/t schizoaffective and depressive disorders, with interventions including Psychiatric/Psychogeriatric consults as indicated, Evaluate resident for changes in pain levels and if appropriate request a scheduled pain medication from Physician, If reasonable, discuss The resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident, and Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes.A psychiatry encounter note dated 5/7/2026 revealed Behavioral concerns remain significant. Additional reports indicate ongoing agitation and impulsive behaviors, including a recent altercation in the dining room where the patient threw a drink at another resident. [R102] has also made threatening statements toward peers, including comments about physically harming another individual with a baseball bat.On 05/13/2026 at 11:23 AM, an interview was conducted with LPN J. LPN J stated they have witnessed R102 showing verbal aggression towards staff and other residents all the time. They further stated that R102 will sometimes follow other residents and insult them even after the targeted resident tries to walk away. LPN J said that staff attempt to redirect R102 and walk alongside them when they start displaying these behaviors.On 05/13/2026 at 11:38 AM, an interview was conducted with Certified Nursing Assistant (CNA) K. CNA K stated R102 is on one-on-one supervision, and they follow people and constantly insult and nitpick other staff and residents. When this behavior occurs, CNA K said that staff will redirect the resident, take them for a walk, or offer them to get something to eat. CNA K stated other residents in the building have complained about R102's behavior.On 05/14/2026 at 9:50 AM, an interview was conducted with LPN UM H. LPN UM H stated the expectation for managing R102's behaviors was one-on-one monitoring, especially in the hallways. Staff should encourage R102 and their targeted resident to be separated, and if R102 continues to follow them, that resident should be removed from the situation and administration should be notified. On 05/14/2026 at 10:43 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that staff are to deescalate and separate residents who are having a verbal altercation for safety, and to report to management what happened so next steps like psychiatric consults and behavior plans can be assessed. On 5/14/2026 at 11:21 AM, CNA R, who was assigned as the one-on-one aide for R102 during the time of the incident, was called for an interview but did not answer or have a voicemail set up.On 05/14/2026 at 10:01 AM, residents that attended the resident council meeting reported a patient at the facility that was going around harassing others by recording from the outside window into their bedrooms, saying all kinds of things to people, and trying to run over others with their electronic wheelchair. The patient was later identified as R102 by the residents. Review of a facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property with an effective date of 11/28/2017 revealed It is the policy of the Facility that each resident will be free from Abuse . Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for Protection.

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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 comprehensive care plans for Post-Traumatic Stress Disorder (PTSD) and discharge planning care plans for three residents (R5, R112 and R223) out of three reviewed for care plans. Findings include: R5 On 5/12/2026 at 10:00 AM, R5 was observed sitting in their wheelchair. R5 stated they do not have any problems in the facility; however, they sometimes get depressed. R5 reported they do speak to psychiatric services inside the facility. A review of the medical record revealed R5 admitted into the facility on 9/2/2020 with the following medical diagnoses Post-Traumatic Stress Disorder and Major Depressive Disorder. A review of the Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status score of 14/15 indicating an intact cognition. R5 was also coded on the MDS as having PTSD as an active diagnosis. Further review of R5's did not reveal a care plan for PTSD. On 05/14/2026 at 12:00 PM, an interview was conducted with Social Worker (SW) B. SW B reported they have only been in the facility for four weeks. Upon medical record review, SW B confirmed they did not see a developed care plan with goals and interventions addressing R5's PTSD. R223 A review of the facility electronic medical records revealed, R223 was admitted in the facility on 01/12/26 and discharged on 02/17/26. Diagnoses included Debility, Muscle Wasting and High Blood Pressure. The Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition and substantial/maximal or dependence on staff assistance for most activities of daily living. R223 was a one-person assist and was alert and oriented. A review of the care plans initiated 01/13/26 revealed no care plan for discharge planning. On 05/13/2026 at 4:00 PM, Licensed Practical Nurse (LPN) N reported they recalled R223 discharged to home and had been at the facility for intravenous (IV) antibiotics. R112 On 05/13/2026 at 8:34 AM, R112 reported a concern for a delay in their discharge to an apartment and their discharge had been cancelled four times. On 05/13/2026 at 12:00 PM, the Corporate Social Worker reported there was a plan in place to discharge R112 on 05/15/26 pending final details for care post discharge. A review of the facility electronic medical record revealed R112 was admitted into the facility 03/23/26. Diagnoses included Heart Failure and Dialysis. The Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition and setup or partial/moderate staff assistance for most activities of daily living. A review of the care plans initiated 03/24/26 revealed no care plan for discharge planning. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/2026 at 1:59 PM, the discharge process and the care plan records for R112 and R223 were reviewed with the Director of Nursing (DON) who reported the Social Worker was the person who initiated the discharge care plan, and it was generally completed at admission and updated as needed. The DON confirmed no discharge care plan had been initiated for R112 nor R223. A review of the facility Transfer and Discharge Guideline dated 11/28/27, revealed, .the facility staff will reevaluate the resident's care plan to determine if changes to the care plan will help meet the resident's needs .