STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235596	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Willow Place	8380 Geddes Road Ypslianti, MI 48198

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act. for one (R2) of three residents reviewed. Review of the medical record reflected R2 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included generalized anxiety disorder. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/20/26, reflected R2 scored 6 out of 15 (severe impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).On 4/16/26 at 9:53 am, R2 was observed in her room sleeping. R2 recalled an incident where someone grabbed her legs and squeezed her ankles but could not recall any further details.Review of a Facility Reported Incident revealed a staff to resident physical abuse allegation occurred on 4/2/26 at 2:29 am, was discovered on 4/2/26 at 2:56 PM, and submitted to the Michigan Facility Reported Incident for Long Term Care system on 4/2/26 at 7:57 PM.Review of a Nurses note dated 4/2/26 at 11:40 am revealed writer alerted that resisnt [sic] reported to visitor that she was being held down by a staff member on night shift.Review of an Incident Report dated 4/2/26 at 11:30 am revealed writer alerted that resisnt [sic] reported to visitor that she was being held down by a staff member on night shift.Notified Administrator.Review of a witness statement for R2 dated 4/2/26 stated resident reported CNA F had been pushing on her during care to visitor.In an interview on 4/16/26 at 2:04 PM Licensed Practical Nurse (LPN) E stated she was notified of the physical abuse allegation around 11:30 am-12:00 PM and immediately called the abuse coordinator, Nursing Home Administrator A.On 4/16/26 at 2:23 PM Certified Nursing Assistant (CNA) F stated she has been working at the facility for about a month and that their typical assignment consisted of nine to eighteen residents. CNA F confirmed that she was working during the shift and was the staff member that R2 made the abuse allegation on. CNA F stated that she was unaware of the allegation until she received a call and was told that R2 stated that CNA F beat her.In an interview on 4/16/26 at 2:33 pm, Nursing Home Administrator (NHA) A stated that she learned of the abuse allegation around 11:00 am or 12:00 pm and immediately started the investigation process. NHA A stated she then conducted much of the investigation including conducting interviews before submitting the allegation to the State Agency which she reports was much later into the night. When asked what the guidelines were for reported abuse allegations to the State agency, NHA A stated immediately but up to 24 hours. When asked if other residents that were assigned to CNA F were assessed or interviewed to ensure that they were not potentially affected, NHA A stated that they were not.Per the State Operations Manual Appendix PP regarding investigating abuse allegations, conducting observations of the alleged victim, including identification of any injuries as appropriate, the location where the alleged situation occurred, interactions and relationships between staff and the alleged victim and/or other residents.Review of the facilities Abuse Policy titled Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property with an effective date of 11/28/17, Section G: Reporting and Response reflected .the facility will ensure that all allegations involving abuse, neglect, exploitation, or mistreatment including injuries of unknown origin are (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported immediately but not later than 2 hours after the allegation is made.Per the same Abuse Policy, under section F. Procedure subpart a. Procedures must be in place to provide the resident with a safe, protected environment during the investigation.examine, assess, and interview the resident and other residents potentially affected.Review of the facilities abuse allegation investigation revealed a lack of evidence that any other residents were interviewed or assessed that night to ensure that they did not experience any physical abuse to ensure no other residents were potentially affected.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a thorough abuse investigation was conducted in one (R2) of three reviewed for abuse. Findings include:Review of the medical record reflected R2 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included generalized anxiety disorder. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/20/26, reflected R2 scored 6 out of 15 (severe impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).On 4/16/26 at 9:53 am, R2 was observed in her room sleeping. R2 recalled an incident where someone grabbed her legs and squeezed her ankles but could not recall any further details.Review of a Facility Reported Incident revealed a staff to resident physical abuse allegation occurred on 4/2/26 at 2:29 am, was discovered on 4/2/26 at 2:56 PM, and submitted to the Michigan Facility Reported Incident for Long Term Care system on 4/2/26 at 7:57 PM.Review of a Nurses note dated 4/2/26 at 11:40 am revealed writer alerted that resisnt [sic] reported to visitor that she was being held down by a staff member on night shift.Review of an Incident Report dated 4/2/26 at 11:30 am revealed writer alerted that resisnt [sic] reported to visitor that she was being held down by a staff member on night shift.Notified Administrator.Review of a witness statement for R2 dated 4/2/26 stated resident reported CNA F had been pushing on her during care to visitor.In an interview on 4/16/26 at 2:04 PM Licensed Practical Nurse (LPN) E stated she was notified of the physical abuse allegation around 11:30 am-12:00 PM and immediately called the abuse coordinator, Nursing Home Administrator A.On 4/16/26 at 2:23 PM Certified Nursing Assistant (CNA) F stated she has been working at the facility for about a month and that their typical assignment consisted of nine to eighteen residents. CNA F confirmed that she was working during the shift and was the staff member that R2 made the abuse allegation on. CNA F stated that she was unaware of the allegation until she received a call and was told that R2 stated that CNA F beat her.In an interview on 4/16/26 at 2:33 pm, Nursing Home Administrator (NHA) A stated that she learned of the abuse allegation around 11:00 am or 12:00 pm and immediately started the investigation process. NHA A stated she then conducted much of the investigation including conducting interviews before submitting the allegation to the State Agency which she reports was much later into the night. When asked what the guidelines were for reported abuse allegations to the State agency, NHA A stated immediately but up to 24 hours. When asked if other residents that were assigned to CNA F were assessed or interviewed to ensure that they were not potentially affected, NHA A stated that they were not.Per the State Operations Manual Appendix PP regarding investigating abuse allegations, conducting observations of the alleged victim, including identification of any injuries as appropriate, the location where the alleged situation occurred, interactions and relationships between staff and the alleged victim and/or other residents.Review of the facilities Abuse Policy titled Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property with an effective date of 11/28/17, Section G: Reporting and Response reflected .the facility will ensure that all allegations involving abuse, neglect, exploitation, or mistreatment including injuries of unknown origin are reported immediately but not later than 2 hours after the allegation is made.Per the same Abuse Policy, under section F. Procedure subpart a. Procedures must be in place to provide the resident with a safe, protected environment during the investigation.examine, assess, and interview the resident and other residents potentially affected.Review of the facilities abuse allegation investigation revealed a lack of evidence that any other residents were interviewed or assessed that night to ensure that they did not experience any physical abuse to ensure no other residents were potentially affected.