STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235514	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial, A Villa Center	26505 Powers Ave Dearborn Heights, MI 48125

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49102 This citation pertains to Intake MI00149869. Based on observation, interview, and record review, the facility failed to provide dignity during care for one resident (R216) of three residents reviewed for dignity. Findings included: On 2/25/25 at 12:03 PM, R216 was observed lying in their bed awaiting staff to assist with getting dressed for the day. R216 stated ,I need to be changed, my brief and bed are wet due to my indwelling catheter (a tube inserted into the bladder) is leaking. R216 appeared tearful and stated that ,I am sitting here wet and I am late for therapy. It's not supposed to be like this. It makes me feel ashamed because I cant help myself. On 2/25/25 the medical record for R216 was reviewed and revealed R216 was admitted to the facility on [DATE] with the diagnoses of cerebral infarction with right sided weakness, depression, anxiety and diabetes mellitus. A review of the most recent minimum data set assessment (MDS) dated [DATE] noted a Brief Interview of Mental Status (BIMS) assessment is a 14 indicating intact cognition. A review of the medical record reveal a physicians order stating two person approach during care routine. On 2/26/25 at 9:00 AM, R216 was observed lying in the bed watching television. R216 stated a nursing assistant had tried to change them without assistance instead of having two people. R216 stated, I was scared and didnt want to fall out of bed so I told them no, and demanded the nursing assistant stop and go get proper help. R216 stated when the nursing assistant went to get assistance, they were left partially exposed until the 2 nursing assistants returned to help finish getting them dressed. On 2/26/25 at 10:05 AM, the Director of Nursing (DON) was asked about this incident and confirmed that there had been an investigation into the allegations. DON stated a new nursing assistant had been assisgned to R216 and was not familiar with the care orders. The nursing assistant had left the resident to get the unit manager and assistance when providing care, saying staff should be aware of care orders when providing care. The facility's Resident Rights policy dated 11/28/2017 noted: Our facility will treat each resident with respect and dignity and care for each resident in a manner an in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Resident has the right to respect and dignity.

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 Based on observation, interview, and record review, the facility failed to properly assess one resident (R65) out of one reviewed for self administration of medications. Findings include: On 2/25/2025 at 2:02 PM, R65 was observed sitting in bed with two medicine cups in front of them. R65 was observed putting one pill in their mouth and then another. R65 was asked what they had just taken, and they responded, A gas pill and a pain pill. R65 stated the pain pill they had taken was Norco (Narcotic) and that they don't take it often because it makes them sleepy. No staff were noted to be in the room or surrounding the area by the room. R65 stated the staff usually just leave their pills with them because they know that they are going to take them. A review of the medical record revealed that R65 admitted into the facility on [DATE] with the following diagnoses, Cerebral Palsy and Anxiety Disorder. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 15/15 indicating an intact cognition. R65 also required staff assistance with bed mobility and transfers. Further review of the medical record revealed that R65 was prescribed Simethicone (Pill used for gas) once a day with meals and Norco, every six hours, as needed. No self administration assessment or care plan was noted in the medical record. On 2/26/2025 at 11:43 AM, an interview was conducted with Assistant Director of Nursing (ADON) A. ADON A stated the nurse should have been in the room with R65 while they were taking their medications, especially with a narcotic. A review of a facility policy titled, Self-Administration of Medications Management noted the following, When determining if self-administration is clinically appropriate for a resident, a licensed nurse will complete the Evaluation for Resident Self-Administration of Medications to aid in the determination of resident's ability to self-administer medication.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207 Based on observation, interview, and record review, the facility failed to ensure that call lights were within reach for four residents (R71, R83, R86, and R115) of five reviewed for accomodation of resident needs. Findings include: Resident #86 (R86) On 2/24/25 at 8:10 AM, R86's call light was unable to be located in R86's room. R86 was interviewed about the location of their call light and was unsure of its location. On 2/25/25 at 12:41 PM, R86's call light was observed on the floor underneath the bed. Certified nursing assistant (CNA) F entered R86's room and was interviewed and asked where R86's call light was located. CNA F stated, It's right here and proceed to pick it up off of the floor and clipped it to R86's pillow. CNA F was further interviewed and asked where R86's call light should be located. CNA F indicated that [R86's] call light should be clipped to their pillow. A record review of R86's electronic medical record (EMR) revealed that R86 was most recently admitted to the facility on [DATE] with diagnoses that included Dementia and Muscle weakness. R86's most recent quarterly minimum data set assessment (MDS) dated [DATE] revealed that R86 had a Brief interview of mental status score (BIMS) of 3/15 which indicated a severely impaired cognition. R86 required supervision and cueing for all activities of daily living (ADLs). Resident #115 (R115) On 2/24/25 at 9:14 AM, R115's call light was unable to be located/observed in the their room. R115 was interviewed about the location of their call light and was unsure of its location. On 2/25/25 at 1:02 PM, No call light was observed in R115's room. R115 was interviewed about the location of their call light and stated, I don't have one. I could use one. On 2/25/25 at 1:07 PM, Nurse/RN (Registered Nurse) G was asked the location of R115's call light. Nurse G entered R115's room and stated, It looks like we are missing a call light. Nurse G indicated that that they would report this to maintenance and have them install a call light, Right away. On 2/26/25 at 9:54 AM, an observation was made of R115's call light cord and call light being draped over and behind a small table in R115's room located approximately three feet from where R115 was lying in their bed. The call light was behind the table and out of sight. On 2/26/25 at 10:02 AM, Unit Nurse Manager/LPN (Licensed Practical Nurse) (UNM) H was interviewed about their expectations for placement of residents' call lights in their rooms. UNM H indicated that during rounding staff should make sure that call lights are in place and within reach of the resident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A RR review of R115's EMR revealed that R115 was most recently admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease and Muscle weakness. R115's most recent quarterly MDS dated [DATE] revealed that R115 had a BIMS of 3/15 which indicated a severely impaired cognition. R115 required supervision to limited assistance for all ADLs other than eating. Resident #71 (R71) On 2/24/25 at 9:43 AM, R71's call light was observed to be on the floor underneath their bed. R71 was unable to reach or locate their call light when asked about it. On 2/25/25 at 1:26 PM, UNM/RN C was interviewed and asked about their expectation for placement of R71's call light. UNM C indicated that the call light should be clipped to [R71]. A review of R71's EMR revealed that R71 was most recently admitted to the facility on [DATE] with diagnoses that included Dementia and Muscle weakness. R71's most recent quarterly MDS dated [DATE] revealed that R71 had a BIMS of 7/15 which indicated a severely impaired cognition. R71 required extensive assistance for all ADLs other than eating. Resident #83 (R83) On 2/25/25 at 1:28 PM, R83 was interviewed and asked the location of their call light. R83 indicated that they did not know the current location of their call light. While in the room speaking to R83 an observation was made of R83's call light cord and call light being draped over the head of R83's bed out of reach of the resident. UNM C was requested to come to R83's room and was asked about the location of R83's call light. UNM C indicated that the call light should be clipped to [R83]. On 2/25/25 at 1:45 PM, R83 was further interviewed and asked if their call light is frequently out of reach for them. R83 responded, Not with the CNA that I have today, but with other CNAs, yes. A review of R83's EMR revealed that R83 was most recently admitted to the facility on [DATE] with diagnoses that included Kidney failure and Muscle weakness. R83's most recent quarterly MDS dated [DATE] revealed that R83 had a 15/15 BIMS which indicated an intact cognition. R83 required extensive assistance for all ADLs other than eating. On 2/26/25 at 1:01 PM, the Administrator (NHA) was interviewed and asked about their expectations for placement of resident call lights in their room. The NHA indicated that they should be within reach of the resident. A review of a policy titled Call Lights, Reviewed: 2/13/2021 stated the following, Purpose: It is the purpose of this facility to attend to our residents needs in a timely manner. Procedure: 1. Staff should ensure that the residents call light is located within easy reach of the resident .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 This citation pertains to Intake: MI00149953 Based on observation, interview and record review, the facility failed to ensure a clean environment for one resident (R211 and R165) of 10 residents reviewed for home-like environment. Findings include: A review of the complaint submitted to the State Agency revealed the following, .The room that [R211] lives in is in poor condition. The heater is exposed and looks like it's falling apart. There is brown residue all over the ground under the bed . R211 On 2/24/25 at 7:30 AM, R211 was observed lying in bed, a tube feeding pole was observed as visibly soiled, with dried tube feed formula observed dried and caked to the floor. R211's bed was observed next to a heat vent that had a damaged base board exposing the coils. Attempts to interview R211 were unsuccessful, due to their cognition. A review of R211's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Cerebral Infarction and Gastronomy Status. Further review revealed they were severely cognitively impaired, and was total dependent on staff for activities of daily living. On 2/25/25 at 9:05 AM, 12:59 PM, and 3:12 PM, the dried tube feed formula observed on the floor in 2/24/25 remained on the floor. The damaged base board of the heat vent was also observed in the same condition. On 2/26/25 at 10:18 AM, the dried tube feed formula observed on the floor in 2/24/25 remained on the floor. The damaged base board of the heat vent was also observed in the same condition. R165 On 2/24/25 at 7:36 AM, R 165 was observed in bed asleep. A tube feeding pole was observed as visibly soiled, with dried tube feed formula observed dried and caked to the floor. A review of R165's medical record revealed they were admitted into the facility 12/18/24 with diagnoses that included Anoxic Brain Damage, Chronic Obstructive Pulmonary Disease, and Dysphagia. Further review revealed that the resident was significantly cognitively impaired, and was totally dependent on staff for activities of daily living. On 2/25/25 at 9:06 AM, 11:14 AM, 12:42 PM, and 3:12 PM, the dried tube feed formula observed on the floor in 2/24/25 remained on the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 11:13 AM, Maintenance Director M was asked about the exposed heat vents, and acknowledged this is an ongoing issue, and they make efforts to complete walk throughs regularly to identify issues. On 2/26/25 at 1:01 PM, the Nursing Home Administration (NHA) was informed of the observations made throughout the survey related to tube feeding liquid located on the floor, and explained it is her expectation the feed fluid is cleaning up by nursing and housekeeping when observed in the floor. A review of the facility's Accommodation of Needs and Preferences and Homelike Environment Guideline revealed, .7. The resident's environment will be maintained in a homelike manner to ensure appropriate housekeeping .

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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** 32220 Based on observation, interview and record review, the facility failed to ensure the proper setting for a specialty mattress (low air loss) was maintained for one resident (R34) of three reviewed who had a specialty mattress. Findings include: On 02/24/25 at 12:23 PM, 02/25/25 at 8:36 AM and 12:18 PM and on 02/26/25 at 7:55 AM, R34 was observed to be supine in bed and dressed in a hospital style gown. R34 had a power unit for the specialty mattress hooked to the foot of the bed. The weight setting on the power unit was set at 400 pounds. R34 did not appear to weigh 400 pounds. R34 did not respond to queries about positioning or comfort. R34 was not observed to reposition themselves in bed. On 02/26/25 at 11:05 AM, R34 was observed to be supine in bed. The mattress setting on the power unit was observed with Unit Manager, Licensed Practical Nurse (LPN) I. The weight setting was observed to be at 400. LPN I acknowledged the weight setting was likely too high. LPN I consulted with the wound care staff and reported the mattress should have been set at 200. It was further observed the mattress pump control panel had to be unlocked in order to change the setting. A review of the record for R34 documented R34 was admitted into the facility 10/28/2009. Diagnoses included Dementia, Stroke and Diabetes. The Minimum Data Set (MDS) assessment dated [DATE] indicated severely impaired cognition, limited range of motion for both legs and one arm, and that R34 was dependent on staff to roll left and right, to bathe and for hygiene. On 02/19/25 R34 was documented to have weighed 180.2 pounds. A physician order dated 02/21/25 documented, LAL (low air loss) mattress. Monitor pump to reflect resident's weight. A review of the February 2025 Administration Record (TAR) documented the setting had been checked by the nursing staff on 02/21 on the night shift and on 02/22. 02/23, 02/24 and 02/25 on the day and night shift. A review of the facility Skin Protection Guideline dated 07/07/21 documented, Purpose: To provide evidenced based practice standards for the care and treatment of skin. To ensure residents that admit and reside at our facility are evaluated and provided individualized interventions to prevent, reduce and treat skin breakdown . Interventions for prevention, removing and reducing predicting factors and treatment for skin may include: Selection of an individualized support surfaces for bed and seating to enhance pressure redistribution .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 40384 Based on observation, interview and record review, the facility failed to document interventions, and prevent the development of a pressure ulcer (damage to skin from prolonged pressure to skin), for one resident (R165), of four residents reviewed for pressure ulcers. Findings include: On 2/24/25 at 7:36 AM, R165 was observed asleep in bed. A positioning wedge was noted on the resident's left side, feet elevated with pillows. A review of R165's medical record revealed they were admitted into the facility 12/18/24 with diagnoses that included Anoxic Brain Damage, Chronic Obstructive Pulmonary Disease, and Dysphagia. Further review revealed that the resident was significantly cognitively impaired, and was totally dependent on staff for activities of daily living. Further review of R165's medical record revealed a Nursing Evaluation dated 12/19/24 documented the resident had a stage 2 pressure sore (Partial-thickness skin loss with exposed dermis) to their left buttock, left heel very dry and cracked, right heel very dry and cracked, and scar on their chest from prior surgery. Further review of R165's medical record revealed the following progress note: 12/19/2024 15:25 (3:25pm) Skin/Wound Note (Narrative) Wound Care New Admission Skin observation . Bilateral Buttock: Blanchable redness, MASD (moisture associated skin damage). treatment-cleanse with ph balance, pat dry and apply triad cream. A review of R165's physician orders noted the following interventions for R165's skin integrity: Order: 12/26/24 Foam boots as tolerated every day and night shift for prevention. Order: 12/24/24 LAL (low air loss) mattress. Monitor pump to reflect resident weight every day and night shift for monitoring. A review of R165's care plan revealed the following, Focus: The resident has potential for impairment (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to skin integrity r/t (related to) decreased mobility and dependence on staff for pressure offloading and repositioning, anti-coagulant use, TF (tube feeding) to meet nutrition and hydration needs .Entire skin is highly moist, Dated Initiated: 12/19/2024 .Interventions: Apply barrier cream per facility protocol/PRN (as needed) Date Initiated: 12/19/2024. Encourage that heels are elevated while resident is lying in bed as tolerated Date Initiated: 12/19/2024. Dietary Consult as needed. Date Initiated: 12/19/2024 Monitor skin when providing cares, notify nurse of any changes in skin appearance. Date Initiated: 12/19/2024. Use draw sheet when turning/repositioning. Date Initiated: 12/19/2024. Use pillow/cushion for pressure offloading and repositioning as needed. Date Initiated: 12/19/2024. Lotion to dry skin PRN. Date Initiated: 12/19/2024. Skin assessments to orders and PRN. Date Initiated: 12/19/2024. Turn and reposition every 2 hours as tolerated. Date Initiated: 12/19/2024. A review of R165's January (2025) Treatment Administration Record (TAR) revealed the orders for the monitoring of the LAL and the application of the foam boots were not documented as completed for 12 days. Further review of the resident's medical record revealed the following progress note, 1/7/2025 13:59 (1:59pm) Skin/Wound Note(Narrative). Resident has new unstageable (pressure injury) to coccyx. Further review revealed the following wound care progress note dated 1/7/25, .Sacrum is an acute unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 6cm (centimeters) length x 9cm width x 0.2 cm depth, with an area of 54sq (square) cm and a volume of 10.8 cubic cm . On 2/26/25 at 10:29 AM, the Assistant Director of Nursing (ADON)/Wound Care Nurse was asked about the development of R165's unstageable wound, and explained when the resident was admitted , they had a deep tissue injury (DTI) on their buttocks and sacrum, which opened two weeks after admission. She further explained the resident's skin has a lot of moisture and has poor tissue perfusion. The ADON was asked about R165's interventions upon admission and indicated the resident had foam boots, triad treatments and a distribution mattress. The ADON was asked about the missing documentation on the resident's TAR, she indicated that she would address this with management. On 2/26/25 at 2:08 PM, the Director of Nursing (DON) was asked about the development of R165's sacrum wound, and explained that upon admission, the resident's skin was already compromised and the wound on the resident's sacrum was a DTI and not MASD. The DON further explained the wound care team documented this incorrectly, and were later educated. A review of the facility's Skin Protection Guideline revealed the following, Purpose: To provide evidenced based practice standards for the care and treatment of skin. To ensure residents that admit and reside at our facility are evaluated and provided individualized interventions to prevent, reduce and treat skin breakdown .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32220 Based on observation, interview, and record review, the facility failed to ensure resident inhalers were dated when open in two of six medication carts. Findings include: On 02/26/25 at 9:10 AM, the Unit C back cart was observed with Licensed Practical Nurse (LPN) J. A Breo Ellipta inhaler was not dated when opened on the inhaler and was without a resident identifier and an Incruse inhaler was not dated when opened and was without a resident identifier. LPN J acknowledged the inhalers did not have an open date. On 02/26/25 at 9:26 AM, the Unit C Front cart was observed with Licensed Practical Nurse (LPN) K. Two Trelegy inhalers were observed to not be dated when opened on the inhaler and were without a resident identifier and one Incruse inhaler did not have a resident identifier on the actual inhaler. LPN K reported an open date was required on the inhaler. A review of the policy titled Medication Storage in the Facility dated April 2018 revealed, .Drugs dispensed in the manufacturer's original container will carry the manufacturer's expiration date. Once opened, these will be good to use until the manufacturer's expiration date is reached unless the medication is: 1. In a multi-dose injectable vial. 2. An ophthalmic medication. 3. An item for which the manufacturer has specified a usable life after opening . A review of the prescribing information from the Incruse manufacturers web site https://gskpro.com revealed, .Safely throw away INCRUSE ELLIPTA in the trash 6 weeks after you open the tray or when the counter reads 0, whichever comes first. Write the date you open the tray on the label on the inhaler . A review of the prescribing information from the Breo manufacturers web site www.mybreo.com revealed, ' . Safely throw away BREO ELLIPTA in the trash 6 weeks after you open the tray or when the counter reads 0, whichever comes first. Write the date you open the tray on the label on the inhaler . A review of the prescribing information from the Trelegy manufacturers web site https://gskpro.com revealed, .Safely throw away TRELEGY ELLIPTA in the trash 6 weeks after you open the tray or when the counter reads 0, whichever comes first. Write the date you open the tray on the label on the inhaler .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 Based on observation, interview, and record review, the facility failed to ensure personal protective equipment (PPE-gown, mask, gloves, etc.) was used for one covid positive resident (R577) out of one reviewed for isolation precautions. Findings include: On 2/26/2025 at 9:47 AM, R577's door was noted to have PPE on the outside, as well as a droplet and contact precaution sign. Nurse Practitioner (NP) D was observed to be in the room talking to R577, no PPE was noted to be on. A review of the medical record revealed R577 admitted into the facility on [DATE] with the following medical diagnoses, Covid-19 and Muscle Weakness. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 13/15 indicating an intact cognition. R577 also required staff assistance with bed mobility and transfers. On 2/26/2024 at 9:48 AM, Licensed Practical Nurse (LPN) B was asked if R577 was positive for COVID-19. LPN B stated to their knowledge R577 was positive for covid and still required precautions. LPN B stated NP D should have put on their PPE prior to entering the room. On 2/26/2025 at 9:50 AM, NP D was observed walking out of R577's room. NP D was asked if they were aware R577 was covid positive and on droplet precautions. R577 stated they did not make note of the signs on the door and would check and see if R577 was still on precautions for covid. On 2/26/2025 at 11:39 AM, an interview was conducted with Assistant Director of Nursing (ADON) A, who also serves as the Infection Control Preventionist. ADON A stated R577 is covid positive and still on isolation precautions and NP D should have been wearing their full PPE. ADON A stated an education was provided to NP D, as well as another vendor that comes into the facility. A review of a facility policy titled, Personal Protective Equipment Guideline did not address droplet precautions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235514	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial, A Villa Center	26505 Powers Ave Dearborn Heights, MI 48125

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220 This citation pertains to Intake: MI00149953 Based on observation, interview, and record review, the facility failed to ensure room furnishings were maintained for ten of ten resident rooms (416, 417, 418, 419, 420, 423, 425, 430, 436, and 440) on Unit D and one (R47) of one resident reviewed for homelike environment. Findings include: On 02/24/25 at 7:23 AM during the initial screening of residents the following was observed: The end cap for the hand rail at left side room of 418 was missing; In room [ROOM NUMBER], a piece of vertical trim approximately four feet long was missing off the left hand corner of the wall as the room is entered. The trim had been laid on the floor behind the door. In room [ROOM NUMBER] the baseboard heater cover was hanging down to the floor on right side behind bed one; In room [ROOM NUMBER] the cover was off the baseboard heater behind the head of both resident beds the entire length of the wall, the sheetrock at the left side of the window, had crumbled away. The window was open about one inch and the fan on the floor had a build up of dust; In room [ROOM NUMBER] the edge molding was missing from the corner at right side of the closet for bed one; In room [ROOM NUMBER] the bathroom had a crack in the ceiling which appeared to have been patched but not painted and the cover for the baseboard heater was off and on the floor: In room [ROOM NUMBER] seven vertical holes were observed in the wall behind the television which was extended on an arm away from the wall; Above the doorway for room [ROOM NUMBER], 14 feet of crown molding was away from the ceiling and wall with the nails visible behind it; In room [ROOM NUMBER] the baseboard heater appeared to be without a cover along the entire length behind the head of the resident's beds: In room [ROOM NUMBER] the cover for the baseboard heater was angle down near the center area; In room [ROOM NUMBER], the cover for the baseboard heater was observed to hang down in middle area and a metal strap was holding the right side to the unit. On 02/26/25 at 11:30 AM, the identified environmental concerns were observed with and acknowledged by the Maintenance Director. A review of the closed work orders from the maintenance reporting log dated 12/01/24 to 02/25/25 documented one heating register repair on unit C out of the 200 work orders listed. Unit D included the 400 numbered rooms. 44750 R47 On 2/25/2025 at 2:28 PM, R47 was observed in bed laying down. Their nightstand was noted to be missing the covering for the drawer and all items inside the nightstand were visible. R47 stated their nightstand had been in that condition for quite some time and they were unsure how it came to look like that. R47 stated they had asked numerous times for the nightstand to be either fixed or replaced and it still had not been done. R47 stated they have not heard anything about when it would be fixed or replaced. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235514	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial, A Villa Center	26505 Powers Ave Dearborn Heights, MI 48125

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the medical record revealed that R47 admitted into the facility on [DATE] with the following medical diagnoses, Muscle Weakness and Contracture, Left Wrist. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 15/15 indicating an intact cognition. R47 also required staff assistance with bed mobility and transfers. On 2/26/2025 at 11:13 AM, an interview was conducted with Maintenance Director (MD) E. MD E stated they do room rounds everyday and see if a drawer is broken and needs to be either replaced or fixed. MD E stated the floor staff also lets them know when something needs to be fixed and put it into TELS. MD E stated they would go and look at the drawer in R47's room. A review of a facility policy titled, Accommodation of Needs and Preferences and Homelike Environment Guideline noted the following, The objective of the accommodation of resident needs and preferences is to create an individualized, home-like environment to maintain and/or achieve functioning, dignity, and well-being to the extent possible in accordance with the resident's own needs and preferences . A homelike environment is one that de-emphasizes the institutional character of the setting . A determination of homelike should include the resident's opinion of the living environment .