STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235325	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at City Center	11700 East Ten Mile Road Warren, MI 48089

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely submit a MDS (Minimum Data Set) assessment for five residents (R8, R30, R39, R88, R97) of nine residents reviewed for resident assessment. Findings Include:R8A record review revealed the MDS discharge assessment was 120 days overdue. Further review of the medical record noted R8 was admitted to the facility on [DATE]. R8 was discharged on 10/26/25. A review of the Minimum Data Set (MDS) assessment did not reveal a discharge MDS having been submitted. R30A record review revealed R30 was admitted to the facility on [DATE]. R30 was discharged on 12/7/25. A discharge MDS was not submitted.R39A record review revealed R39 was admitted to the facility on [DATE]. R39 was discharged on 12/7/25. A MDS was not submitted.R88A record review revealed R88 was admitted to the facility on [DATE]. R88 was discharged on 12/13/25. A MDS was not submitted.R97On 3/11/26, a record review revealed R97 was admitted to the facility on [DATE]. R97 was discharged on 12/8/25. A discharge MDS was not submitted.On 3/11/26 at 12:13 PM, an interview with Minimum Data Set (MDS) Nurse C revealed that R8, R30, R39, R88, and R97's discharge MDS's were not submitted.On 3/11/26 at 12:30 PM, an interview with MDS Supervisor B confirmed that R8, R30, R39, R88, and R97's discharge RAI were not submitted. MDS Supervisor B revealed their vacation was around the time the discharge MDS's were due.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a baseline care plan for one (R5) of six residents reviewed for baseline care plans. Findings include:A review of the record revealed R5 was admitted to the facility on [DATE] with relevant diagnoses of Intracerebral hemorrhage, Congestive Heart Failure, Benign Prostatic Hyperplasia and Urinary Retention. R5 was admitted with an indwelling urinary catheter and was on Enhanced Barrier Precautions (EBP). Further review of the Minimum Data Set Assessment (MDS) revealed R5 had a Brief Interview for Mental Status score of 13/15 indicating no cognitive impairment. Further review revealed R5 required partial/moderate assistance for upper body activities and substantial/maximum assistance for lower body activities including bathing and transfers. A review of the medical record revealed a baseline care plan that did not include the use of the indwelling catheter, infection control, activities of daily living, mobility or the level of assistance required. On 3/11/26 at 11:30 AM, in an interview with Licensed Practical Nurse-Unit Manager (LPN) D, she revealed the baseline care plan was not complete. A review of the policy titled Care plan Standard Guideline effective date 11/28/2017 revealed 1. The interdisciplinary team will collect and record data within 24 hours for the admission Baseline Care Plan. 2. The interdisciplinary team will continue develop a resident/client centered care plan that includes problem, need, or strength statements, measurable goal statements and resident/client specific interventions.The Baseline Careplan will 1. Be developed within 48 hours of a resident's admission .2. Include the inimum healthcare information necessary to properly care for a resident,,,

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement post fall interventions for one resident (R145) of three whose falls were reviewed. Findings include: On 03/10/2026 at 9:52 AM, R145 was observed to be off balance as they walked up the hallway from the nurse station. R145 approached the surveyor and commented they felt dizzy and reported they felt like they were drunk but had not been drinking. R145 then began to turn around and as R145 turned around to their right they fell toward the handrail. R145 caught themself on the handrail. Licensed Practical Nurse (LPN) L noticed walked up and took R145 by the hand. They walked back toward the resident's room and R145 was observed to be on their knees in the intersection of the hallways by the nurse station holding onto the nurses' hand. At that time two additional staff walked up to LPN L and R145 with a wheelchair and the staff assisted R145 up and to their room. At 1:25 PM, R145 was seen walking out of another resident's room. At 3:51 PM, R145 continued walking around, but appeared more stable. On 03/11/2026 at 8:21 AM, R145 walked in and out of their room three times in succession. R145 was dressed and had with shoes on. On 03/11/2026 at 1:56 PM, the Director of Therapy, reported R145 did not normally have issues with balance and had not heard about any change in elevation or fall for R145. On 03/12/2026 at 2:16 PM and 2:30 PM, the Unit Manager for the unit of R145 LPN M, was asked about the incident involving R145. LPN M initially reported they would look into it and reported that they had been made aware of it this day and the nurse reported R145 was losing their balance and was subsequently lowered to the floor. LPN M commented LPN L did not consider the incident a fall for R145. LPN M then reported any change in plane or condition would need to be documented and the physician and family called, and this was not done. A review of the record for R145 revealed R145 was admitted into the facility on [DATE]. Diagnoses included Difficulty Walking, Muscle Weakness, Lack of Coordination, and Dementia. The active care plan documented, has had an actual fall on10/10/25 . Anticipate and meet the resident's need . Medication review . offer rest periods during ambulation initiated 10/10/25 . Resident is a wanderer related to dementia . had an actual fall on 01/26/26 . educate resident on importance of complying with safety measures . encourage and offer rest periods during ambulation . x-ray of skull and right leg Date Initiated: 01/26/2026 . is a potential risk for falls . Date Initiated: 08/04/2025 . Anticipate and meet the resident's needs. Date Initiated: 04/22/2025 . No care plan intervention or review was documented. The most recent date from the care plan was 01/28/26 related to nutrition and the fall on 01/26/26. A review of the progress notes dated for 03/10/26 and 03/11/26 revealed no documentation for notification of the family or medical practitioner related to the incident. A review of the facility policy titled, Care Plan Guidelines dated, 11/28/17 revealed, Guideline: .The interdisciplinary team will continue (to) develop a resident/client centered care plan that includes problem, need, or strength statements, measurable goal statements and resident/client specific interventions . The care plan is to be revised to reflect the current status of the resident .

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow through on physician recommendations following a change in condition for one (R5) of three residents reviewed for laboratory services. Findings include: A review of a progress note dated 3/9/26 revealed R5 experienced a change in mental status (disorganized thinking) during a Physical Therapy (PT) treatment session and was returned to his room and Medical Doctor (MD) K was called. A progress note dated 3/9/26, revealed MD K was notified of the change in mental status for R5, and recommended a Complete Blood Count (CBC) and Urinalysis (UA). Review of the physician orders did not reveal an order or results for the CBC or UA. A review of the record revealed R5 was admitted to the facility on [DATE] with relevant diagnoses of Intracerebral hemorrhage, Congestive Heart Failure, Urinary Retention. R5 was admitted with a urinary catheter. Further review of the record revealed R5 had a Brief Interview for Mental Status score of 13/15 indicating no cognitive impairment. On 3/12/26 at 11:47 AM, in an interview with the Licensed Practical Nurse, Unit Manager (LPN) D revealed there were no physician orders or results entered for the recommended lab work. LPN D determined that the order into the lab system had been entered incorrectly.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident food preferences were honored for four residents (R32, R44, R65, R146), three anonymous residents, and three anonymous resident council group residents from a census of 137. Findings include: On 03/10/2026 at 9:05 AM, an anonymous resident reported the food was not grade A and was processed and overall did not care for it too much. The resident further reported dinner was the one to mostly come up cold. On 03/10/2026 at 9:23 AM, a second anonymous resident reported the food was good and bad but did not elaborate. On 03/10/2026 at 12:23 PM, the rice for R32 was served without gravy. R32 was asked if they received a regular or alternative menu and reported they did not but it would be good to have one. R32 reported the food for lunch was not hot and less than room temperature when served. LPN L was asked about the chance of getting gravy for the rice. LPN L reported that it was hit and miss on getting the kitchen on the phone. R32 reported they drink coffee because it is usually the one thing that was hot. On 03/11/2026 9:13 AM, R32 reported they were headed out for a doctor's appointment and would not likely get a warm lunch when they got back. R32 commented they had been told aides are not allowed to warm up food. At 12:25 PM R32 returned to their room and indicated they would not eat lunch. On 03/10/2026 at 12:35 PM, R146 reported concerns with day-to-day care. A sub style sandwich was observed on the bed. R146 reported they get one daily with lunch. R146 reported they used to have to order it but now it was on their meal ticket to be sent with lunch. ,R146 reported they would not eat the chicken and rice. R164 was asked about a menu and reported they did not have a menu. R146 commented they may get one sometimes but it was not a consistent practice and it would be nice to have one so they will know if going to like something or not. R146 noted that is why they have the sub ordered. On 03/10/2026 at 12:42 PM, R44 reported they had called down for a sub sandwich and had not received it. R44's roommate had sub and reported if you call early enough you can get one brought up. Neither resident had received a copy of the menu and commented it would be nice to have one. A [NAME] salad was brought up for R44. R44 commented it was OK but it was not a sub. On 03/10/2026 at 12:58 PM, R65 reported they felt they had received hot dogs too often as the alternative. R65 did not have a copy of the regular or the alternate menu. R65 noted that they would prefer a grilled cheese sandwich as an alternate choice. On 03/10/2026 at 5:12 PM, the pork chop was firm and slightly tough to cut, but easy enough to chew. On 03/11/2026 at 1:14 PM, Certified Nursing Assistant (CNA) O reported the kitchen does not always answer the phone so would then just go to the kitchen and ask for the resident request. CNA O reported it generally takes up to ten minutes to get the ordered food. CNA O also noted breakfast was the meal residents most often report as cold. On 03/11/2026 at 3:42 PM, CNA P reported some residents have requested more variety in the (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alternative menu. The current alternatives were reported as a hot dog, cheeseburger, salad or grilled cheese and sometimes resident can get a sub. On 03/11/2026 at 4:22 PM, a third anonymous resident reported it would be nice to have menu, but they were not really affected by not having one. On 03/12/2026 at 10:54 AM, the registered dietitian (RD) Q reported that if food preferences are communicated ahead of time and if available, residents can usually get what they want. On 03/12/2026 at 12:59 PM, Activity Staff R reported the most recent resident council had reported some cold food concerns but nothing about food preferences not honored. Staff F reported their practice had been to pass out menus to those residents who asked for one or if asked to bring one to a resident. Staff R pointed out the stack of weekly menus that had been printed out and put at the reception desk. On 03/12/2026 at 1:04 PM, the RDs reported the resident food preference information is started on admission and updated as requested and at least quarterly. A review of the Food Committee minutes dated 2/19/26 noted food is not hot but warm. A review of the facility policy titled, Resident Rights dated 11/28/17 documented the resident has The right to the reasonable accommodation of your needs so long as it doesn't endanger the health or safety of you or other residents. A review of resident council meeting notes for the months of November 2025 through February 2026, revealed resident concerns related to being uninformed of menu alternatives. On 3/11/26 at 1:30 PM, a resident council meeting was held with six group residents, and they were asked about alternative menu items being offered to them at the facility. Three group residents, who indicated that they resided on the second floor of the facility, revealed that they did not receive advance notice of alternative food items being offered during meals, on a daily basis. The three residents indicated that they were not provided with alternative food menus and expressed displeasure over not being able to plan their menu choices in advance.