STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235463	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at the Park	111 Ford Avenue Highland Park, MI 48203

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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 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. This citation pertains to complaint 1310450 Based on observation, interview, and record review, the facility failed to ensure two confidential residents were treated with dignity and respect from a total census of 106. Findings include:A review of the intake 1310450 revealed that several residents had concerns about the Activity Director (AD) and their interaction with the residents. One concern stated that the AD is rude, mean, disrespectful and uses profanity towards residents, anytime the residents ask for anything, the AD gets mad and cuts off the television as punishment. On 9/15/25 at 10:00 AM, an activity was observed occurring on the second floor. The activity staff was observed setting up resident for games and preparing music for an exercise activity. On 9/15/25 at 11:05 am, a confidential meeting of residents was held in the second-floor dining room. During the meeting, nine residents spoke of dissatisfaction with the AD saying . they don't know what they are doing . they talk to us mean . talk to us inappropriate .we don't have activities for our age. We need better games . the activities can be better, and we can have more fun. During the meeting, residents also stated they have notified the administrator, and nothing has been done. On 9/17/25 while touring the facility, a resident who wished to remain confidential stated they had a problem with the AD. The resident stated, I don't like the AD, their attitude is bold, and they talk to us crazy when we go out and smoke, and they have discussed other residents' business with other residents. On 9/17/25 at 12:50 PM, an interview was held with a certified nursing assistant (CNA) who wished to remain confidential, said they had witnessed the AD to withhold cigarettes or not provide activities on both floors and speak rudely to residents. On 9/17/25 at 2:00 PM an interview was held with the AD to discuss concerns. The AD revealed they were new to the position at the building and had been working there since March. Their experience included having worked as an activity assistant at several other buildings. The AD stated the building and some of the residents are challenging, and they (the residents) were used to the prior director and now they are adjusting to changes. On 09/17/25 at 2:25 PM, the Director of Nursing (DON) was queried about the resident's concerns with the AD and indicated they were not aware of any pertinent concerns, but the Regional Director was. On 09/17/25 at 3:00 PM, the Regional Director was queried about the resident's concerns with the AD and stated that changes were coming. A review of the facility policy titled Dignity revealed the following: It is the policy of this facility to assure residents are treated in a manner that preserves the resident's dignity and promotes a quality life experience. PROCEDURE: 1. All residents will be treated with respect. 2. Resident's preferences will be taken into consideration for all aspects of care and honored to the extent practicable.

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. Based on observation, interview, and record review, the facility failed to properly assess one resident (R1) out of one reviewed for self-administration of medications. Findings include:On 9/15/2025 at 9:00 AM, R1 was observed in their room, sitting in a wheelchair and eating breakfast. R1 was observed to have two Albuterol Sulfate inhalers at their bedside, as well as eye drops. R1 was asked if they use the inhalers, and they stated yes, I use them as prescribed.A review of the medical record revealed R1 admitted into the facility on 9/5/2025 with the following diagnoses, Chronic Obstructive Pulmonary Disease and Obstructive Sleep Apnea. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status score of 13/15 indicating an intact cognition. R1 also required staff assistance with bed mobility and transfers.On 9/17/2025 at 8:51 AM, a medication observation was completed with Licensed Practical Nurse (LPN) E. LPN E was asked about the inhalers at R1's bedside. LPN E grabbed the inhalers and asked R1 where they got them from. R1 stated they gave the inhalers to them at the hospital and brought them back when they returned on 9/5/2025. LPN E stated the inhalers were empty and discarded of them at their cart.On 9/17/2025 at 10:45 AM, an interview was conducted with the Director of Nursing (DON). The DON stated to have medications at bedside they have to obtain a physician's order and an education form depending on the medication, as well as the person.A review of a facility policy titled, Self-Administration of Medication noted the following, .2.If a resident requests self-administration of respiratory inhalant only, complete the Self-Administration Evaluation of Respiratory Inhalants form. 3. Determination of the residents' ability to self-administer medication by the IDT (Interdisciplinary Team) will be documented in the resident's medical record and on the care plan. The documentation will also include the participation of the resident and resident representative, if applicable, in the assessment and care plan process.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to formulate an accurate advance directive for one resident (R70) of four residents reviewed for advance directives. Findings include:A review of R70's medical record revealed they were initially admitted into the facility on 7/10/20 and readmitted on [DATE] with diagnoses of End Stage Renal Disease, Diabetes, and Muscle Weakness. Further review revealed the resident was cognitively intact and required extensive assistance for activities of daily living. Further review of R70's medical record's face sheet revealed the resident's code status was Do Not Resuscitate (DNR, an order which instructs medical professionals not to attempt cardiopulmonary resuscitation). Further review of R70's medical record revealed a document dated for 3/25/25 and titled, Code Status Elective Form which outlined the following, In the event I experience pulseless, cardiopulmonary arrest, (witnessed or unwitnessed), I request the following. The space for Do Not Resuscitate was checked and circled. In addition, the document was signed by the resident's previous guardian, whose guardianship was terminated on 2/10/23 per documentation located in the resident's medical record. In addition, the form was signed by the facility's previous social worker, and the space available for two witnesses were blank. Also noted on the document was the following statement, For residents in (name of state) .please proceed to DNR order form.Further review of the medical record did not reveal any additional documentation or orders for the resident having a code status of DNR. On 9/17/25 at 12:18 PM, R70 was observed laying in their bed and asked if anyone had ever spoken to them about an advance directive, in which they stated no.On 9/17/25 at 1:08 PM, the Nursing Home Administrator (NHA) was asked about social work services being addressed in Quality Assurance and acknowledged that social work services is an area which has been identified as an area needing improvement. On 9/17/25 at 2:52 PM, Social Services Director C was asked about the advance directive for R70, and explained the process and documentation needed for a DNR order. Social Services Director C further explained she would look further into R70's advance directive.A review of the facility's Advance Directive and Care Planning policy revealed the following, C. Facility staff will provide the resident and/or resident representative with written description of the facility's practice to implement an advance directive. (Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements are met). The facility will identify the primary decision-maker (e.g. assess the resident's decision-making capacity and identify or arrange for an appropriate legal representative for the resident assessed as unable to make relevant health care decisions). i. If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility will provide advance directive information to the individual's resident representative in accordance with State law. ii. In the event that the resident condition changes, based on regular comprehensive assessment or change in resident status review, and theresident is able to receive such information; the resident will be provided with written description of the facility's practice to implement an advance directive.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide follow-up to the PASARR (preadmission screening/annual resident review-Form 3877) for one sampled resident (R42) of four reviewed for PASARR concerns, resulting in the potential for unmet care needs. Findings include: A review of the clinical record revealed R42 was admitted into the facility on [DATE] with the following diagnoses Epilepsy, Depressive Disorder, Dementia and Focal Traumatic Brain Injury. A review of the clinical record showed that the resident was cognitively intact. A review of R42's PASARR Level I Screening form, indicated Yes was checked in section two for questions one through four and included, The person screened shall be determined to require a comprehensive Level II OBRA (Omnibus Budget Reconciliation Act) evaluation if any of the above items are 'Yes' unless a physician, nurse practitioner or physician's assistant, certifies on form DCH-3878 that the person meets at least one of the exemption criteria. The form indicated, If any answer to items 1-6 in section II is 'Yes' send ONE copy to the local Community Mental Health Services Program (CMHSP) with a copy of form DCH-3878 if an exemption is requested . The 3877 was incomplete and there was no 3878 or referral for a level II evaluation. On 9/17/25 at 2:20 PM, the Social Service Director was queried regarding the 3877/3878's for R42 and stated, The previous Social Worker completed the 3877, but it is unknown about the 3878. No further explanation was provided.On 9/17/25 at 2:16 PM, the facility's PASARR policy was requested and not received by the end of the survey.

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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. Based on interview and record review, the facility failed to develop comprehensive care planned interventions to reflect the resident's current status for two residents, (R6 and R13) of two residents reviewed for care plans. Findings include:R6A review of R6's medical record revealed they were admitted into the facility on 8/21/24 with diagnoses which included Dementia, Anxiety, and Adult Failure to Thrive. Further review revealed the resident was cognitively impaired and required extensive assistance with activities of daily living. Further review of the medical record revealed a document titled, (Name of department of correction) Parole Order revealing R6 was under the supervision of the department of corrections as a parolee until 8/21/26. A review of the resident's care plan did not address the resident's current status as a parolee. R13A review of R13's medical record revealed they were admitted into the facility on 6/20/25 with diagnoses which included BI-Polar Disorder, Post-Traumatic Stress Disorder (PTSD), Schizoaffective Disorder, and Acute Cystitis with Hematuria. Further review revealed the resident had a significantly impaired cognition and required assistance for activities of daily living. Further review of the resident's medical record revealed a care plan outlining the following, Focus: The resident has a mood problem r/t (related to) Bipolar disorder, PTSD, Schizoaffective disorder, Bipolar. Date Initiated: 06/20/2025 Interventions: SLEEP: Evaluate resident for possible sleeping pattern changes and intervene as appropriate. Date Initiated: 06/20/2025 . Further review of the care plan did not reveal any additional interventions related to the resident's behavioral needs. On 9/17/25 at 1:08 PM, the Nursing Home Administrator (NHA) was asked about social work services being addressed in Quality Assurance and acknowledged that social work services is an area which has been identified as an area needing improvement. On 9/17/25 at 2:16 PM, the facility's Care Plan policy was requested and not received by the end of the survey.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on interview and record review, the facility failed to ensure behavioral services were provided for one sampled resident (R42) of eight residents reviewed for behavioral services.Findings include:A review of the clinical record revealed R42 was admitted into the facility on 11/1 9/24 with the following diagnoses Epilepsy, Depressive Disorder, Dementia and Focal Traumatic Brain Injury. A review of the clinical record showed that the resident was cognitively intact.A review of R42?s clinical record revealed that on 11/20/24 a physician order for psych to evaluate and treat and on 6/29/25 another order was written for psychiatry consult to re-evaluate and treat bipolar/mood disorder and competency evaluation. Further review of R42 Clinical record revealed the following behavioral narrative notes:-11/25/24 -verbally aggressive towards staff.-12/7/24 - Resident confused refuses to stay in bed, puts self in wheelchair.-1/4/25 -Resident was seen throwing themself on the floor intentionally attempting to hurt/harm themself.-1/18/25 - Resident refused activities of daily living (ADL) care and to be put in bed.-3/1 5/25 - Resident calling staff out of their names because they didn't want another resident to get any coffee.-3/22/25 - Resident verbally aggressive with staff after dinner.-5/23/25- Resident was yelling and cursing at staff while they were assisting them because they stated they don't need help and can walk by themself.-7/5/25 - Resident cursed and shouted at staff unprovoked.-9/7/25 - R42 was involved in a resident-to-resident incident stemming from calling another resident out their name.Further review of the clinical record failed to show any follow up notes or consultations from psychology or behavioral services to address resident behaviors.On 9/16/25 at 10:00 AM a request was made for the most recent psychology evaluation and behavioral service notes for R42.At 2:30 PM, the Social Service Director (SSD) stated that there were no psychology notes or behavioral notes available.On 9/17/2025 at 11:03 AM, an interview with SSD occurred and they were queried about the behavioral services orders not being followed and missing services. The SSD stated that behavioral services and psychology services should have been implemented.On 9/17/25 at 12:43 PM, an interview with Director of Nursing (DON) was held and they were queried about the expectations of completion of physician orders to evaluate and treat and follow up behavioral services. They reported the expectation is for all physician orders to be followed.At 2:16 PM, the facility's Behavioral Services policy was requested and not received by the end of the survey.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to review the pharmacist's identified irregularities and document the action taken or not taken to address the irregularities for two residents (R2 and R6) out of three reviewed for Medication Regiment Reviews (MRRs). Findings include: R2 A review of the medical record revealed R2 admitted into the facility on 8/14/2020 with the following medical diagnoses, Paranoid Schizophrenia and Neuroleptic Induced Parkinsonism. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 5/15 indicating an impaired cognition. R2 also required staff assistance with bed mobility and transfers. Further review of the medical record revealed the following progress note from the pharmacist, Effective date: 4/16/2025 10:59:00.MRR completed.See report for comment. On 9/16/2025 at 11:35 AM, a request for the full MRR report was requested from the facility. On 9/17/2025 at 8:24 AM and 1:16 PM, a second and third request was made for the full MRR and not received by the end of survey. R6 A review of R6's medical record revealed they were admitted into the facility on 8/21/24 with diagnosis which included Dementia, Anxiety, and Adult Failure to Thrive. Further review revealed the resident was cognitively impaired and required extensive assistance with activities of daily living. A review of MRRs completed for R6 on 3/14/25 and 4/16/25 revealed the following recommendation, Recommend a Valproic Acid Level every 6 months secondary to Valproic Acid therapy. Both recommendations did not reveal a response from the prescriber, nor did the medical record reveal lab results for Valproic Acid levels. Further review of R6's medical record revealed the resident had the following order initiated on 12/12/24, Valproic Acid Oral Solution 250 MG (milligrams)/5ML (milliliters) (Valproate Sodium). Give 3.5 ml every morning and at bedtime for Mood disorder. This order was discontinued on 4/25/25. On 9/17/25 at 10:40 AM, the Director of Nursing (DON) was asked about the pharmacy recommendations not being addressed and explained they would look into. No further information was provided by the end of survey. A review of the facility's Drug Remine Review policy revealed, .3. Irregularities identified will be documented on a separate, written report and sent to the attending physician, medical director, and director of nursing, listing the resident name, relevant drug and irregularity the pharmacist has identified. If in the professional judgement of the pharmacy consultant that an irregularity requires urgent action, the pharmacy consultant will immediately report the irregularity to the Director of Nursing and/or Unit Charge Nurse and the attending physician by phone .5. The attending physician will document in the resident record that the identified irregularity has been reviewed and what, if any action has been taken to address it. If the physician chooses not to act upon the pharmacy consultant recommendations, the physician must document rationale as to why the change is not indicated in the resident record

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review, the facility failed to provide 80 square feet of living space per bed in 21 of 36 resident rooms. Findings include:On 09/17/2025 at 01:45 PM, an environmental tour of resident room minimum square footage requirements (80 square feet per bed) was conducted by this surveyor. The following rooms were noted: 102: Three bed ward (216 square feet)103: Two bed ward (155 square feet)104: Two bed ward (149 square feet)105: Four bed ward (291 square feet)106: Four bed ward (289 square feet)107: Four bed ward (291 square feet)108: Four bed ward (288 square feet)112: Four bed ward (282 square feet)115: Four bed ward (283 square feet)119: Four bed ward (288 square feet)201: Three bed ward (220 square feet)202: Three bed ward (219 square feet)203: Two bed ward (155 square feet)204: Two bed ward (152 square feet)207: Four bed ward (291 square feet)209: Four bed ward (291 square feet)211: Four bed ward (288 square feet)212: Four bed ward (294 square feet)214: Four bed ward (289 square feet)218: Four bed ward (272 square feet)219: Four bed ward (287 square feet) On 09/17/2025 at 2:00 PM, R32 was interviewed in their room which they share with three other residents. They were asked how they felt about the available space in their room and they stated It's too tight. I've talked to them about it before but they don't do anything. R32 reported that the room does have three residents at times rather than four but described the space as essentially the same either way as the fourth bed always remains in the room whether it's occupied or not. On 09/17/2025 at 2:13 PM, the facility Administrator (NHA) and the Regional Director of Operations (RDO) were interviewed and queried regarding any plan to address the rooms requiring waivers. The RDO indicated the governing company had requested the facility submit a proposal for reduction of beds which will potentially lead to reduction or elimination of rooms requiring waivers. The RDO indicated the facility planned to submit such a proposal. The RDO indicated the facility surveys the residents intermittently regarding their comfort level with the room arrangement in order to address any individual concerns that may indicate the need for a room change. A Resident's Rights policy/procedure was requested from the facility at 02:16 PM on 09/17/2025 and was not received by the time of survey exit.