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	05/14/2025

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 0684 Level of Harm - 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** 40384 Based on interview and record review, the facility failed to transfer one (R901) of one resident to a higher level of care after complaints of unresolved, severe abdominal pain resulting in hospitalization . Findings include: On 5/14/25 at 9:23 AM, an interview was completed with Family Member A who explained on 5/6/25, R901 contacted them at approximately 5:00pm stating they were experiencing abdominal pain and the nurse provided them with a laxative. Family Member A further explained at approximately 1:26am, R901 again contacted them via phone screaming out in pain stating their abdomen continued to hurt. Family Member A further explained, they and R901 were advised by facility nursing staff the resident only wanted pain medication and if they were to leave the facility, they would have to sign out against medical advice (AMA), or if they left via EMS (emergency medical services), the resident would risk losing their bed. Family Member A explained R901 remained in the facility for 12 hours in pain and was eventually transferred to the hospital after contacting 911 on their own. Family Member A further explained R901 was admitted into the hospital for an ischemic bowel with bowel infarction (narrowing or blockage of one or more of the arteries or veins that supply the small intestine). A review of R901's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease, Alcohol Induced Pancreatitis, Anxiety, Diaphragmatic Hernia without Obstruction or Gangrene. Further review revealed the resident was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, and bathing. On 5/14/25 at 10:43 AM, Registered Nurse (RN) B was asked about the onset of R901's abdominal pain, and explained it started after dinner between 5-6:00pm on 5/6/25. A review of R901's medical record revealed the following progress notes: 5/6/2025 19:05 (7:05pm) Health Status Note . Resident c/o (complain of) of Bilateral Upper quadrant excoriated abdominal pain. followed by N/V (nausea and vomiting). Emesis x 2 (vomiting two times) noted. PRN (as needed) famotidine (acid reducer) and lactulose (used to treat constipation) given unsuccessful. Zofran (prevents nausea and vomiting) unsuccessful. Daughter at bedside. MD (medical doctor) called, new order for one time enema and stat abdominal X-ray received. Will carry on and monitor for any change in the POC (plan of care). (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 0684 Level of Harm - Actual harm Residents Affected - Few	5/7/2025 02:01 (2:00am) Note Text: Resident complaining of stomach pain. Screaming out, and having diarrhea. [physician] notified at start of shift. At approx (approximately) 0130 (1:30am) residents daughter called and asked if she could send resident to the hospital. [Physician] notified of situation, one time dose of narcotic pain medication ordered at this time. Resident accepted pain medication, but continues to scream out in pain. Supervisor and DR (doctor) aware. X-ray results pending at this time. 5/7/2025 02:39 (2:39am) Health Status Note. Resident called EMS (emergency medical services) for abdominal pain and wants 6am scheduled pain meds at 1am. Then resident said I am going AMA with my sister I don (do) not want any meds from your facility. Asked [physician] for break through pain med, Resident took her pain med and calm down. Sister called from home and said she is coming to take resident to hospital or sign AMA papers. She arrived to see resident, seen they were comfortable and left after talking to her. 5/7/2025 07:12 (7:12am) Health Status Note. Resident called 911 to go to [hospital]. Complaints of stomach pain and diarrhea. Resident has been yelling out through out entire shift, stating that the pain medications are not working. Complaints of hot/cold, sweating and chills. Resident was given Imodium after normal findings in xray results and a one-time dose of Methadone (controlled substance) at 0200 (2:00am) per DR (doctor) order. Resident was requesting 0600 (6:00am) dose of Methadone, DR declined dose because of 0200 dose that was given. At that time, resident called 911 for an ER (emergency room) visit. Verbal report given to EMT/paramedics and RN at [hospital] . 5/7/2025 07:49 (7:49am) Health Status Note. Resident call again 911 this morning and transfer herself to [hospital] . On 5/14/25 at 11:49 AM, an interview was completed with Licensed Practical Nurse (LPN C) regarding R901, and they explained upon starting their 7:00pm shift on 5/6/25, R901 was back and forth to the bathroom with explosive diarrhea as they complained about severe abdominal pain that continued throughout the duration of her shift that ended at 7:00am on 5/7/25. LPN C explained at approximately 1:00am she was provided with an order to provide R901 with their 6:00am pain medication and explained the medication wasn't effective, as the resident continued with pain. LPN C was asked why R901 wasn't sent to the hospital and explained the nurse supervisor didn't agree the resident needed to go to the hospital, and somehow, EMS was sent away. On 5/14/25 at 1:18 PM, an interview was completed with Nurse Supervisor D regarding R901. Nurse Supervisor D confirmed the resident transferred herself to the hospital the morning of 5/7/25, and explained the resident had complaints of pain, and was asking for their pain medications earlier than what was ordered, but had been provided earlier per order from the physician. Nurse Supervisor D explained she was informed by the floor nurse that the resident slept throughout the night. However, acknowledged the resident's daughter arrived to the facility at approximately 2:00am where there was discussion regarding the resident leaving the facility AMA or going to the hospital. Nurse Supervisor D was asked about 911 being called to the facility, and explained if a resident contacts 911, they will in turn call the facility before coming out to ensure it's a legitimate emergency. Nurse Supervisor D was asked multiple times if she spoke to emergency services regarding R901 and stated, I don't know. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/14/25 at 1:29 PM, an interview was completed with Staff E, and was asked about the night of 5/6/25, when R901's daughter arrived at the facility at approximately 2:00am. Staff E explained the daughter called the front desk and asked about being able to visit as R901 had been complaining of pain. Staff E explained the daughter arrived and eventually left. Staff E explained the supervisor noted that R901 is not leaving, they just want pain medication. On 5/14/25 at 1:54 PM, an interview was completed with the Director of Nursing (DON) regarding R901 and asked why the resident wasn't sent to the hospital, and explained she was informed there wasn't a change in the resident's vitals and the resident slept throughout the night which wouldn't have prompted the facility to send the resident to the hospital. Regarding the resident calling 911 on their own, the DON explained 911 typically responds to calls from residents but acknowledged that they will at times call the facility regarding the concerns prior to arrival. A review of R901's hospital records dated 5/7/25 revealed a CT scan noting acute nausea, vomiting, with constipation .distended small bowel loops throughout the left upper quadrant and midline pelvis which demonstrate marked wall edema .these findings are worrisome for ongoing or impeding ischemia . A review of the facility's Transfer and Discharge policy did not address the resident't right to contact emergency medical services.