

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235514	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2025
NAME OF PROVIDER OR SUPPLIER Imperial, A Villa Center		STREET ADDRESS, CITY, STATE, ZIP CODE 26505 Powers Avenue 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2648112. Based on observation, interview, and record review, the facility failed to identify elopement risk and implement interventions to safeguard one (R901) of one resident, resulting in R901 exiting the front door of the facility on 9/8/25 and again on 10/11/25 without staff awareness of the resident's whereabouts. The Immediate Jeopardy (IJ) was identified on 9/8/25 at 4:08 PM, as a result of failure to identify an elopement risk resident and implement interventions to prevent further elopement leading to a second time exiting the facility and the likelihood of other residents affected due to lack of assessment that could lead to serious harm, injury, impairment or death. Findings Include: The Administrator was notified of the Immediate Jeopardy (IJ) on 10/23/25 at 10:30 a.m. The Immediate Jeopardy began on 9/8/25. A plan to remove the immediacy was requested. The IJ was removed on 10/11/25, based on the facility's implantations of the plan of removal as verified by the Surveyor on site. Although the IJ was removed, the facility's deficient practice was not corrected and remained isolated with potential harm. A review of a complaint called into the State Agency noted, [R901] was let out the front door (on 10/11/25) by the receptionist. The receptionist thought [R901] was a visitor and let [R901] out the front door. [R901] doesn't even look like a visitor and [R901] is confused all the time. They finally found [R901] walking down the street. On 10/22/25 at 10:30 AM, R901 was observed walking around on the secure unit speaking loudly and at times knocking hard on a locked door. At 10:49 AM, Receptionist B was asked if they were working on 10/11/25 when R901 exited the facility and reported they were not at work that day and said the receptionist on duty (Receptionist A) at the time thought R901 was a visitor and buzzed (deactivating the alarm and unlocking on the front door) and let them out. At 10:52 AM, Receptionist A was asked about the 10/11/25 incident with R901 exiting the facility. Receptionist A confirmed they buzzed R901 out the front door saying they thought R901 was a visitor explaining they were a new hire and didn't know all the residents. The receptionist went on to say R901 appeared at the front door with a jacket on their forearm and thought they saw a visitor's ID tag on their shirt when later they found out R901 was outside. Receptionist A explained this was not the first time R901 left the building and had done so during Receptionist G's shift but was unable to recall the date. On 10/23/25 at 10:36 AM, Receptionist G confirmed R901 exited the facility on 9/8/25 at approximately 4:08 PM, when the resident walked out following kitchen staff when they (Receptionist G) buzzed the staff out. Receptionist G was asked what they did after noticing R901 left out the building and reported they called Supervisor C. On 10/23/25 at 12:04 PM, the Receptionist Supervisor (Supervisor C) was queried regarding R901 exited out of the building on 9/8/25. Supervisor C confirmed R901 was buzzed out by Receptionist G. Upon being notified, Supervisor C went outside and found R901 standing at the end of the walkway under the car port and along with the Assistant Nursing Home Administrator E (ANHA E), assisted R901 back into the building. The supervisor was queried about R901's subsequent exit from the facility on 10/11/25 and explained they received a call from the facility during the afternoon shift that R901 was buzzed out by Receptionist A. On 10/23/25 at 12:47 PM, the ANHA E was asked about R901 exiting the building on 9/8/25, and the ANHA E explained R901 was found under the car port with Supervisor C around 3:30 PM. The ANHA E further explained that the incident was reported to the DON (Director of Nursing), as a request was made to have the DON bring a wheelchair in order to assist with escorting R901 back into the building. A review of R901's medical record revealed, R901 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Schizophrenia (mental health disorder), and noted with severely impaired cognition, a high fall risk, and behaviors needing redirection. An admission elopement risk assessment dated [DATE] indicated R901 as low risk for elopement. No elopement risk assessment was completed/updated, or care plan was developed with interventions to safeguard the resident from further exiting attempts following the residents exit from the facility on 9/8/25. A nursing progress note dated 9/26/25 documented. Resident redirected. A nursing progress note dated 9/28/25 documented, Resident continues to have behaviors. Resident is very loud and experiencing auditory and visual hallucinations related to (r/t) schizophrenia diagnosis. Resident has to be constantly redirected. No elopement risk assessment was completed/updated following identified behavior of needing constant redirection. On 10/22/25 at 2:59 PM, Certified Nurse Assistant (CNA) F, who was familiar with R901 was queried. CNA F reported they were driving to the facility (on 10/11/25) when they observed R901 standing in the road at a stop sign, with their head down. CNA F explained they recognized the resident to be R901. CNA F said they got out of their car</p>		