STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235298	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Father Murray, A Villa Center	8444 Engleman Center Line, MI 48015

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation pertains to Intake 2699034Based on observation, interview, and record review, the facility failed to protect one resident (R904) from sexual abuse from another resident (R903) out of five reviewed for abuse. Findings include:A review of a Facility Reported Incident (FRI) noted the following, Incident summary: During post lunch rounds, resident [R904] observed in the room of [R903]. Both residents were engaged in oral sexual contact that was interrupted by the assigned CNA [Certified Nursing Assistant]. [R904] demonstrates cognitive impairments related to [their] dx. Both residents remain in the facility. No injury. Behavior did not progress beyond this contact. [R903] is currently under enhanced supervision until investigation is complete and care plan updates can occur.On 12/22/2025 at 11:07 AM, R903 was observed lying in bed. CNA A was noted to be sitting outside the door and stated they were R903's 1:1 assigned supervision. R903 reported they were friendly with R904 in the past, and they would speak often. R903 reported R904 came in their room and laid in their roommate's bed. R903 reported they asked if they could join R904 and they told them Yes. R903 stated that when the sexual contact occurred and R904 seemed as though they were enjoying themselves. R903 reported they did not think they were doing anything wrong because R904 said yes and seemed as if they were enjoying it.A review of the medical record revealed R903 admitted into the facility with the following medical diagnoses, Muscle Weakness and Major Depressive Disorder. A review of the most recent Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 13/15, indicating an intact cognition. R903 also required staff assistance with bed mobility and transfers.On 12/22/2025 at 11:15 AM, R904 was observed lying in bed and unable to recall the incident. R904 was asked if they felt safe in the facility and they stated, Yes.A review of the medical record revealed R904 admitted into the facility with the following medical diagnoses, Schizophreniform Disorder and Major Depressive Disorder. A review of the most recent MDS assessment revealed a BIMS score of 0/15 indicating impaired cognition. R904 also required staff assistance with bed mobility and transfers. R904 was also noted to have a Legal Guardian due to being deemed incompetent by the court system.On 12/22/2025 at 11:45 AM, an interview was conducted with Social Worker (SW) F. SW F reported they conducted a psychosocial on R903 and they were open and honest about the incident. SW F reported R903 was counseled about how to contain proper consent and who they should speak to if they want to pursue a romantic relationship with another resident. SW F reported that R903 voiced their understanding. On 12/22/2025 at 12:41 PM, a phone call was attempted to CNA C with no avail. A review of a written statement from CNA C dated 12/22/2025 noted the following, Employee was conducting post-lunch rounds and entered the room of [R903] at approximately 1:25 PM. Upon entering room, employee identified [R903] standing up in between bed 1 and 2, with [their] (male private part) in [R904's] mouth, engaged in sexual contact. Employee immediately said, what are you doing? [R903] was startled and tucked [their] privates back into [their] pants. Employee called for nurse who immediately entered the room. Employee reports [R904] was not fighting but was lying in bed receiving sexual contact. Employee immediately removed [R904] from the room. Employee reports [R903] was on 1:1 supervision after that. Employee reports [R904] was returned to [their] room and behaving normally after that.On 12/22/2025 at 12:38 PM, a phone call with Licensed Practical Nurse (LPN) E was attempted with no avail.On 12/22/2025 at 1:32 PM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA reported that R903 was going to remain on a 1:1 until they have a solid plan, whether that be discharge to another facility or back into the community. The NHA reported that neither resident has had an incident like this before. The NHA reported that R903 was counseled on proper consent and guardianship and that R903 voiced understanding. The NHA was asked about where staff was during this time being that R903's room is directly across from the nurse's station, and they reported they were picking up lunch trays on the floor. The NHA reported that the door was open, and the curtain was not closed during the incident according to CNA C.A review of a facility policy titled, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property noted the following, .It is the policy of the facility that each resident will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion .