STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235380	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Rose City	517 West Page Street Rose City, MI 48654

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Number 3031745. Based on interview and record review, the facility failed to implement and operationalize policies and procedures to ensure that allegations of abuse were reported for one resident (Resident #701) of three residents reviewed.Findings include:Resident #701: Review of intake documentation dated as received on 5/26/26 revealed Resident #701 called a mental health/suicide hotline today due to suicidal thoughts. During the call, Resident #701 told the hotline worker that Certified Nursing Assistant (CNA) B grabbed them by the jaw and pushed them to the floor in the bathroom. The intake documentation indicated Resident #701 was experiencing pain from the incident. The intake was a referral from Adult Protective Services (APS) and did not specify the date the Resident called the hotline. A review of Facility Reported Incidents (FRIs) from May 2026 revealed no allegations of staff to CNA abuse had been reported by the facility. On 6/16/26 at 9:22 AM, Resident #701 was observed alone in their room, lying in bed and an interview was completed. When queried if they recalled calling a mental health or suicide hotline, Resident #701 replied, Yes because I feel suicidal and depressed. When asked if any facility staff had ever pushed them or hurt them, Resident #701 indicated they had. When queried what happened, Resident #701 stated, (CNA B) pushed me on the toilet and I pushed them back because I was defending myself and (CNA B) grabbed me by my jaw. Resident #701 proceeded to demonstrate how CNA B had grabbed their jaw by grabbing their own jaw in rough manner by placing one hand under the chin with the fingers around their jaw and lower face. When queried what they were doing before this happened and where they were, Resident #701 became visibly upset and stated, I want to go to a psych hospital, I want to talk to (Social Work Director [SWD] A). Resident #701 was reassured that SWD A to come talk to them and the Resident's room was exited. SWD A was located and informed of interview with Resident #701 and that the Resident asking for them. While walking to Resident #701's room with SWD A, the Resident was observed in the hallway and verbalized they were looking for SWD A. At 9:37 AM on 6/16/26, an interview was completed with Resident #701 and SWD A. Resident #701 told SWD A, I slapped (CNA B) and indicated it was self-defense. Resident #701 then told SWD A that CNA B had grabbed their jaw and pushed them. Resident #701 demonstrated how CNA B grabbed their face. SWD A asked Resident #701 where it happened and replied, I was in the bathroom. When queried regarding Licensed Practical Nurse (LPN) C and LPN D being in the bathroom, Resident #701 verbalized they had laughed. SWD A then asked Resident #701 when it had happened and the Resident stated, That was a couple weeks ago. That was a week ago. Resident #701's thoughts and verbalizations became very scattered and the Resident stated, I cant take it. I need to get my meds. SWD A assisted the Resident out of their office to find their nurse. An interview was conducted with SWD A on 6/16/26 at 9:47 AM. When queried if they were aware of the abuse allegation pertaining to CNA B and Resident #701 prior to today, SWD A stated, I did know about it. With further inquiry, SWD A verbalized the facility Administrator and Director of Nursing (DON) were also aware and stated, I think they did a soft file (internal investigation) about the allegation. Record review revealed Resident #701 was originally admitted to the facility on [DATE] with diagnoses which included Parkinson's disease, (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain, weakness, falls, schizoaffective, and bipolar disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and dependent upon staff for toileting and bathing. The MDS further detailed Resident #701 did not display any physical or verbal behaviors directed towards others but displayed other behavioral symptoms not directed toward others one to three days. Review of Resident #701's Electronic Medical Record (EMR) revealed the following documentation: - 5/24/26 at 10:16 AM: Behavior Note. Resident was being assisted to the bathroom by CNA. Upon applying brief, hit CNA in the face and was screaming. Resident stated didn't want brief applied. Resident was educated on the importance of having a brief on and allowed CNA to put apply brief. - 5/24/26 at 2:22 PM: Behavior Note. (Resident) frequently yelling out/screaming during shift. Refusing cares, verbally and physically abusive to staff. Making accusations against staff members, difficult to redirect at times. - 5/24/26 at 5:30 PM: Behavior Note. Res came to desk stating wanted to die and to call crisis hotline. Call placed, res spoke to counselor, requested to be sent to hospital, stating was going to starve themselves to death or drown themselves in the toilet. After talking to counselor, res wheeled self back down to room with no further outbursts at this time. - 5/26/26 at 4:28 PM: Social Services. followed up with resident regarding weekend behaviors and concerns reported by staff. During the conversation, resident became tearful at times and was noted to become easily sidetracked from the topic being discussed. provided emotional support and verbal redirection, which was effective. Resident was cooperative with intervention and able to return to the conversation with prompting. Resident was observed out of room throughout the day visiting with staff appropriately. No signs or symptoms of acute distress noted during this shift. Resident denied any immediate needs or concerns when asked. Due to ongoing behavioral and psychiatric concerns, referral information was sent to 18 inpatient psychiatric facilities for review and possible placement. Staff will continue to monitor resident's mood, behaviors, and safety, and provide redirection and support as needed. Interdisciplinary team remains aware of resident status. On 6/16/26 at 10:39 AM, an interview was completed with the facility Administrator and DON. When queried if they were aware of Resident #701 making an allegation of abuse involving CNA B, both the Administrator and DON confirmed they were aware. When queried if the facility had completed an investigation, the Administrator stated, We didn't do an investigation really because it was witnessed by staff. Any facility investigation documentation related to the abuse allegation was requested at this time. An interview was conducted with CNA B on 6/16/26 at 11:04 AM. CNA B was asked what shift they normally work and replied, 6:00 AM to 6:30 PM. When queried if they recalled an incident involving Resident #701, CNA B verbalized they did and stated it was a couple weeks ago. When asked what happened, CNA B revealed Resident #701 was in the hallway yelling that they needed to be changed and they assisted the Resident into the big bathroom/shower room on the East End of the facility. CNA B revealed Resident #701 was on the toilet and stated, I had taken their brief off and went to get washcloths. (Resident #701) stood up and started yelling that they didn't want to. When asked what the Resident didn't want to do, CNA B indicated they were not sure if the Resident did not want to get washed up or if they did not want to get dressed. CNA B stated, (Resident #701) started yelling out and the nurses came in. CNA B continued, (Resident #701) hit me and told me they hated me. When asked what nurses came into the bathroom, CNA B revealed it was LPN C and LPN D. CNA B was then asked where they were when LPN C and LPN D entered the shower/bathroom and replied, I was standing in front of (Resident #701) putting their brief on while they were standing up. When asked if either nurse saw Resident #701 hit them, CNA B stated, I am not sure because I had my back to them and I had the curtain pulled. When queried regarding the Resident reporting an allegation of abuse, CNA B confirmed they were aware of the allegation and stated, Night shift said (Resident #701) called the suicide hotline and told them that I hit them. CNA B was asked when they were told that Resident #701 said they had hit them, CNA B responded, I'm not sure if it was that same day or the next day when I came in. When queried if the Administrator or DON had talked to them regarding the allegation, CNA B replied, They just pulled me aside and told me I would have to write a statement. When asked (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what day the Administrator and DON told them that, CNA B replied, I think it was the next day. When queried if they had touched the Resident's face and/or jaw at any time while assisting the Resident in the bathroom, CNA B responded, No. When asked if they pushed the Resident, CNA B stated, No. CNA B was then asked if Resident #701 had become unsteady and/or if they had a near fall in the bathroom where they had had to grab them, CNA B responded that they had not. When asked if they were instructed not to care for Resident #701 following the allegation, CNA B replied, No. CNA B verbalized the other CNA staff kinda took over caring for Resident #701 but they were never told they could or should not. When asked if they had been suspended pending an investigation of the allegation, CNA B replied, No. An interview was completed with Unit Manager LPN G on 6/16/26 at 11:35 AM. When queried if Resident #701 had reported an allegation of abuse to them, LPN G replied, (Resident #701) came by and said that the day before they had an altercation with (CNA B). LPN G was asked what Resident #701 told them and stated, (Resident #701) said (CNA B) pushed them on the toilet and they started hitting (CNA B) in self-defense. When asked where the incident had occurred, LPN G replied, (Resident #701) said it happened in the big bathroom (shower room). LPN G stated, After (Resident #701) left my office, I went and talked to (the facility Administrator). When queried what time Resident #701 reported the incident to them, LPN G stated, It was early. I get here between 7:00 and 7:30 (AM) and it was like boom, before 8:00 (AM). An interview was completed with LPN C on 6/16/26 at 12:17 PM. When queried if they recalled an incident involving Resident #701 and CNA B, LPN C verbalized they did. LPN C was asked what happened and said, Me and (LPN D) were at the nurses' station and we heard blood curdling screams from the shower room. LPN C indicated they went into the shower room and saw CNA B attempting to put a brief on Resident #701. When queried what they first saw upon entering the shower room, LPN C stated, Resident #701) was sitting on the toilet, (CNA B) bent down trying to put on brief and (Resident #701) slapped (CNA B) in the face. When queried if Resident #701 said anything to them, LPN C stated, No. When queried if they heard CNA B say anything to Resident #701, LPN B replied, I don't think so. Maybe just like I gotta put your brief back on, I got you all cleaned up. When asked if they were present in the room with Resident #701 and CNA B the entire time care was provided, LPN C responded they were not. On 6/16/26 at 12:29 PM, an interview was completed with LPN D. When asked if they recalled an incident involving Resident #701 and CNA B, LPN B responded they did. When queried what they observed, LPN D revealed they were sitting at the nurses' station and heard screaming from the shower room. LPN D indicated they went to the shower room and saw (Resident #701) standing there yelling at (CNA B). When queried if they saw CNA B push, grab, or hit Resident #701, LPN D responded they did not. When asked if they were present in the shower room the entire time care was being provided, LPN D responded they were not. An interview was completed with LPN K on 6/16/26 at 1:09 PM. When queried if they recalled an incident involving Resident #701 and CNA B, LPN K stated they heard about it but didn't do anything with it because it was vague. When asked what they heard, LPN K revealed they heard Resident #701 said CNA B hit them when they were on the phone with the suicide hotline. When queried if other staff were aware of the allegation, LPN K stated, Everybody heard about it. An interview was completed with the Administrator and DON on 6/16/26 at 4:00 PM. When queried why the abuse allegation was not reported to the State Agency, the Administrator stated, Because (Resident #701) recanted and there was no abuse. With further inquiry, the Administrator stated Resident #701 has a history of changing their story. When queried where Resident #701 calls the suicide helpline from, the DON and Administrator revealed they call from the nurses' station phone. When asked if the Resident requires assistance to call the hotline, the Administrator replied, Yes, sometimes we have to hold the phone because (Resident #701) shakes. When asked how staff were aware of the incident, prior to LPN G reporting the allegation to them, neither the Administrator nor the DON provided an explanation. When queried when an allegation of abuse should be reported, the Administrator and DON both indicated allegations should be reported immediately. When asked who the nurse and/or staff member was that assisted Resident #701 to call (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the suicide hotline, the Administrator revealed they did not know. With further inquiry, the DON stated, We will educate staff regarding reporting, but we addressed it as soon as we found out. When queried again why the allegation was not reported, the Administrator reiterated there was nothing to report because the Resident recanted the allegation. When asked why Resident #701 verbalized an allegation of abuse when interviewed today if they recanted their allegation, the Administrator did not provide further explanation. Review of facility policy/procedure entitled, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property (Effective 11/28/17) revealed, It is the practice of the facility to encourage and support. reporting of suspected acts of abuse. G. Reporting and Response. It is the policy. that ?abuse' allegations are reported. will ensure that all alleged violations. are reported immediately, but not later than 2 hours after the allegation is made. Procedure: Internal reporting. Employees must always report and ?abuse' or suspicion of ?abuse' immediately to the Administrator. Report the results of all investigations to the administrator or his or her designated representative and to other officials. including immediate reporting to the State Survey Agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake 3031745. Based on interview and record review, the facility failed to ensure allegations of abuse were thoroughly investigated and residents were protected from further potential abuse for one (#701) of three residents reviewed. Findings include:Review of intake documentation dated as received on 5/26/26 revealed Resident #701 called a mental health/suicide hotline today due to suicidal thoughts. During the call, Resident #701 told the hotline worker that Certified Nursing Assistant (CNA) B grabbed them by the jaw and pushed them to the floor in the bathroom. The intake documentation indicated Resident #701 was experiencing pain from the incident. The intake was a referral from Adult Protective Services (APS) and did not specify the date the Resident called the hotline. On 6/16/26 at 9:22 AM, Resident #701 was observed alone in their room, lying in bed and an interview was completed. When queried if they recalled calling a mental health or suicide hotline, Resident #701 replied, Yes because I feel suicidal and depressed. When asked if any facility staff had ever pushed them or hurt them, Resident #701 indicated they had. When queried what happened, Resident #701 stated, (CNA B) pushed me on the toilet and I pushed them back because I was defending myself and (CNA B) grabbed me by my jaw. Resident #701 proceeded to demonstrate how CNA B had grabbed their jaw by grabbing their own jaw in rough manner by placing one hand under the chin with the fingers around their jaw and lower face. When queried what they were doing before this happened and where they were, Resident #701 became visibly upset and stated, I want to go to a psych hospital, I want to talk to (Social Work Director [SWD] A). Resident #701 was reassured that SWD A to come talk to them and the Resident's room was exited. SWD A was located and informed of interview with Resident #701 and that the Resident asking for them. While walking to Resident #701's room with SWD A, the Resident was observed in the hallway and verbalized they were looking for SWD A. At 9:37 AM on 6/16/26, an interview was completed with Resident #701 and SWD A. Resident #701 told SWD A, I slapped (CNA B) and indicated it was self-defense. Resident #701 then told SWD A that CNA B had grabbed their jaw and pushed them. Resident #701 demonstrated how CNA B grabbed their face. SWD A asked Resident #701 where it happened and replied, I was in the bathroom. When queried regarding Licensed Practical Nurse (LPN) C and LPN D being in the bathroom, Resident #701 verbalized they had laughed. SWD A then asked Resident #701 when it had happened and the Resident stated, That was a couple weeks ago. That was a week ago. Resident #701's thoughts and verbalizations became very scattered and the Resident stated, I can't take it. I need to get my meds. SWD A assisted the Resident out of their office to find their nurse. An interview was conducted with SWD A on 6/16/26 at 9:47 AM. When queried if they were aware of the abuse allegation pertaining to CNA B and Resident #701 prior to today, SWD A stated, I did know about it. With further inquiry, SWD A verbalized the facility Administrator and Director of Nursing (DON) were also aware and stated, I think they did a soft file (internal investigation) about the allegation. Record review revealed Resident #701 was originally admitted to the facility on [DATE] with diagnoses which included Parkinson's disease, pain, weakness, falls, schizoaffective, and bipolar disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and dependent upon staff for toileting and bathing. The MDS further detailed Resident #701 did not display any physical or verbal behaviors directed towards others but displayed other behavioral symptoms not directed toward others one to three days. Review of Resident #701's Electronic Medical Record (EMR) revealed the following documentation: - 5/23/26 at 10:12 AM (Saturday): Behavior Note. (Resident) cont. (continue) with multiple verbal/physical behaviors this am. Observed ambulating down hall, refusing assist from staff, yelling and swearing at them. Redirection difficult and unsuccessful. cont. on and off with said behaviors throughout early am. At approx. 0730 (AM) became upset, yelling out ?I want the f*ck out of here! I'm going to kill myself!'. began to scream loudly and went back to room. nurse was then called (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to res room. Upon entering room, this nurse observed bed remote cord loosely looped around (Resident's) neck. Staff removed cord and all other cords removed from room.new order to ship res to ER. - 5/24/26 at 10:16 AM (Sunday): Behavior Note. Resident was being assisted to the bathroom by CNA. Upon applying brief, hit CNA in the face and was screaming. Resident stated didn't want brief applied. Resident was educated on the importance of having a brief on and allowed CNA to put apply brief. - 5/24/26 at 2:22 PM (Sunday): Behavior Note. (Resident) frequently yelling out/screaming during shift. Refusing cares, verbally and physically abusive to staff. Making accusations against staff members, difficult to redirect at times. - 5/24/26 at 5:30 PM (Sunday): Behavior Note. Res came to desk stating wanted to die and to call crisis hotline. Call placed, res spoke to counselor, requested to be sent to hospital, stating was going to starve themselves to death or drown themselves in the toilet. - 5/26/26 (Tuesday): Physician/NP/PA Progress Note. Late Entry. Encounter for ER visit on 4/23 (sic) for behavioral concerns of suicidality. seen today for a significant change in condition evaluation following an ER transfer prompted by escalating behavioral disturbances and expressed suicidal ideation. has a history of borderline personality disorder with longstanding behavioral episodes; however, behaviors have significantly escalated over recent days. has exhibited frequent verbal and physical aggression toward staff including screaming, profanity, striking a CNA during ADL care, and refusing cares. Between episodes, transitions rapidly to a calm, pleasant demeanor - smiling and engaging cooperatively with peers and staff. has been observed ambulating independently and refusing staff assistance, with redirection largely ineffective during acute episodes. The precipitating event for ER transfer occurred when (Resident) yelled out that wanted to kill herself, followed by staff discovering a bed remote cord loosely looped around her neck. The cord was immediately removed, and all cords were removed from room. - 5/26/26 at 4:28 PM (Tuesday): Social Services. followed up with resident regarding weekend behaviors and concerns reported by staff. During the conversation, resident became tearful at times and was noted to become easily sidetracked from the topic being discussed. provided emotional support and verbal redirection, which was effective. Resident was cooperative with intervention and able to return to the conversation with prompting. Resident was observed out of room throughout the day visiting with staff appropriately. No signs or symptoms of acute distress noted during this shift. Resident denied any immediate needs or concerns when asked. Due to ongoing behavioral and psychiatric concerns, referral information was sent to 18 inpatient psychiatric facilities for review and possible placement. Staff will continue to monitor resident's mood, behaviors, and safety, and provide redirection and support as needed. Interdisciplinary team remains aware of resident status. Further review of progress note documentation in Resident #701's EMR revealed the Resident had previously attempted and/or became physically aggressive with a staff member on 2/7/26 and 5/16/26. An interview was conducted with Human Resources (HR) Director E on 6/16/16 at 10:37 AM. During the interview, the Administrator called HR Director E's phone and was heard asking if they had a statement from CNA B related to Resident #701's allegation of abuse. Director E responded by saying they did not complete interviews related to abuse investigations. On 6/16/26 at 10:39 AM, an interview was completed with the facility Administrator and DON. When queried if they were aware of Resident #701 making an allegation of abuse involving CNA B, both the Administrator and DON confirmed they were aware. When queried if the facility had completed an investigation, the Administrator stated, We didn't do an investigation really because it was witnessed by staff. Any facility investigation documentation related to the abuse allegation was requested at this time. An interview was conducted with CNA B on 6/16/26 at 11:04 AM. CNA B was asked what shift they normally work and replied, 6:00 AM to 6:30 PM. When queried if they recalled an incident involving Resident #701, CNA B verbalized they did and stated it was a couple weeks ago. When asked what happened, CNA B revealed Resident #701 was in the hallway yelling that they needed to be changed and they assisted the Resident into the big bathroom/shower room on the East End of the facility. CNA B revealed Resident #701 was on the toilet and stated, I had taken their brief off and went to get washcloths. (Resident #701) stood up and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	started yelling that they didn't want to. When asked what the Resident didn't want to do, CNA B indicated they were not sure if the Resident did not want to get washed up or if they did not want to get dressed. CNA B stated, (Resident #701) started yelling out and the nurses came in. CNA B continued, (Resident #701) hit me and told me they hated me. When asked what nurses came into the bathroom, CNA B revealed it was LPN C and LPN D. CNA B was then asked where they were when LPN C and LPN D entered the shower/bathroom and replied, I was standing in front of (Resident #701) putting their brief on while they were standing up. When asked if either nurse saw Resident #701 hit them, CNA B stated, I am not sure because I had my back to them and I had the curtain pulled. When queried regarding the Resident reporting an allegation of abuse, CNA B confirmed they were aware of the allegation and stated, Night shift said (Resident #701) called the suicide hotline and told them that I hit them. When queried if the Administrator or DON had talked to them regarding the allegation, CNA B replied, They just pulled me aside and told me I would have to write a statement. When asked what day the Administrator and DON told them that, CNA B replied, I think it was the next day. When queried if they had touched the Resident's face and/or jaw at any time while assisting the Resident in the bathroom, CNA B responded, No. When asked if they pushed the Resident, CNA B stated, No. CNA B was then asked if Resident #701 had become unsteady and/or if they had a near fall in the bathroom where they had had to grab them, CNA B responded that they had not. When asked if they were instructed not to care for Resident #701 following the allegation, CNA B replied, No. CNA B verbalized the other CNA staff kinda took over caring for Resident #701 but they were never told they could or should not. When asked if they had been suspended pending an investigation of the allegation, CNA B replied, No. The facility investigation documentation related to the abuse allegation was received from the Administrator on 6/16/26 at 11:30 AM. The investigation documentation included the following: - Unsigned Phone Statement from LPN D dated 5/26. The statement detailed, (CNA D) and (CNA C) at desk- heard (Resident #701) yelling. Both went down to (Resident's) room. (Resident #701) was standing up with (CNA B) in bathroom. (Resident #701) was yelling because didn't want their pants pulled up. (CNA B) told (Resident #701) needed pants pulled up in order to go out into hallway. (Resident #701) allowed (CNA B). Was calm. (Resident #701) proceeded to hallway. Voiced no complaints about (CNA B) throughout shift.The statement did not include the date that the incident occurred.- Unsigned Phone Statement from LPN C dated 5/26. The statement detailed, (LPN C) was sitting at nurses station and read resident yelling. Upon entering (Resident #701's) room, (CNA B) was in bathroom with (Resident #701) attempting to pull up brief and (Resident #701) started hitting (CNA B) in the face while yelling. (LPN C) intervened and assisted with getting brief on. Resident then come out into hallway and was calm. Resident never reported (CNA B) hit them or was rough with them during cares.The statement did not include the date that the incident occurred. - Typed Statement, dated 5/26/26, and signed by SWD A. The statement specified, SWD met with (Resident #701) and (Regional Corporate Administrator F) in the administrative office to address a reported allegation involving staff. (Resident #701) stated that a staff member (CNA B) pushed them and grabbed their face while assisting them to the toilet and that other staff members (LPN C) were present and did not intervene. When further explored for clarification, SWD asked resident to confirm the accurate of the report and encouraged honesty to ensure appropriate follow-up. Resident then stated, No indicating the allegation was not accurate. Resident later expressed apology for stating the allegation and repeated that they like the staff member. During conversation, resident was intermittently tearful and easily distracted.The signed statement did not include a time of the interview. An interview was completed with Unit Manager LPN G on 6/16/26 at 11:35 AM. When queried if Resident #701 had reported an allegation of abuse to them, LPN G replied, (Resident #701) came by and said that the day before they had an altercation with (CNA B). LPN G was asked what Resident #701 told them and stated, (Resident #701) said (CNA B) pushed them on the toilet and they started hitting (CNA B) in self-defense. When asked where the incident had occurred, LPN G replied, (Resident #701) said it happened in the big bathroom (shower room). LPN G was queried regarding (continued on next page)

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	235380	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Rose City	517 West Page Street Rose City, MI 48654

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #701's emotional state when they told them what happened and stated, (Resident #701) was very upset. LPN G continued, (Resident #701) told me that they didn't want (CNA B) to take care of them. With further inquiry, LPN G revealed Resident #701 seemed concerned that they were going to get in trouble for hitting (CNA B) because they kept saying it was self-defense, it was self-defense. LPN G was asked if Resident #701 told them if anyone else was present when the incident occurred, LPN G responded that they did not. LPN G then stated, After (Resident #701) left my office, I went and talked to (the facility Administrator). When queried if they provided a written statement related to the allegation, LPN G replied, No, I don't think so. When queried what time Resident #701 reported the incident to them, LPN G stated, It was early. I get here between 7:00 and 7:30 (AM) and it was like boom, before 8:00 (AM). When asked the date or day of the week Resident #701 reported the allegation to them, LPN G revealed they were not sure. When queried regarding Resident #701's normal behavior and if they tend to change their recollection of events over time, LPN G stated, Yeah. (Resident #701) is consistently inconsistent. LPN G was asked if CNA B was working on the day that Resident #701 reported the abuse allegation to them and replied, I think so, yes.A review of staffing assignment sheets was completed. Per the staffing assignment sheets provided, CNA B, CNA H, CNA I and CNA L worked 5/25/26 on Resident #701's unit during the day shift.The staffing sheet for 5/26/26 revealed CNA B and CNA I were also assigned to Resident #701's unit during the day shift. An interview was completed with CNA H on 6/16/26 at 11:54 AM. When queried if they recalled an incident involving Resident #701 on May 24th or May 25th, CNA H stated, (Resident #701) was having one of those days. When asked to clarify what that meant, CNA H responded that the Resident was up and down and yelling. When asked if they heard or seen anything involving Resident #701 in the bathroom, CNA H responded that they had not witnessed anything. When asked if they had ever seen Resident #701 be violent towards staff, CNA H responded, No. When queried if they recalled working on 5/25/26, CNA H responded that they did not. An interview was completed with CNA I on 6/16/26 at 12:00 PM. When queried if they recalled an incident involving Resident #701 and CNA B in the shower/bathroom, CNA I indicated they were aware and stated, I worked the next day. When queried how they were made aware of the incident, CNA I replied, Nurse informed me of the incident and said to do cares in pairs with (Resident #701) for now. When queried what time the nurse told them that, CNA I replied, That was like at 6:00 AM. CNA I stated, The nurse said that they had called the suicide hotline (with Resident #701). When asked the name of the nurse who had told them that, CNA I responded, (Nurse M). An interview was attempted to be completed with Nurse M on 6/16/26 at 12:10 PM. A voicemail with return phone number was left but a return call was not received by the conclusion of the survey. An interview was completed with LPN C on 6/16/26 at 12:17 PM. When queried if they recalled an incident involving Resident #701 and CNA B, LPN C verbalized they did. LPN C was asked what happened and said, Me and (LPN D) were at the nurses' station and we heard blood curdling screams from the shower room. LPN C was asked to clarify where the shower room was and indicated it is the main shower room on the unit. LPN C revealed there are toilets in the shower room that residents use. LPN C indicated they went into the shower room and saw CNA B attempting to put a brief on Resident #701. LPN C stated, We talked to (Resident #701) and told them that they really needed to put on their brief. When queried what they first saw upon entering the shower room, LPN C stated, Resident #701) was sitting on the toilet, (CNA B) bent down trying to put on brief and (Resident #701) slapped (CNA B) in the face. When queried if Resident #701 said anything to them, LPN C stated, No. When asked if CNA B said anything to Resident #701, LPN B replied, I don't think so. Maybe just like I gotta put your brief back on, I got you all cleaned up. LPN B was asked if they assisted CNA B with Resident #701's care and/or to get them dressed at this time and replied they did not. LPN C stated they just talked to the Resident. When asked if they were present in the room with Resident #701 and CNA B the entire time care was being provided, LPN C responded they were not. On 6/16/26 at 12:29 PM, an interview was completed with LPN D. When asked if they recalled an incident involving Resident #701 and CNA B, LPN B responded they did. When queried (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what they observed, LPN D revealed they were sitting at the nurses' station with LPN C and heard screaming from the shower room. When asked, LPN D revealed Resident #701 was using the toilet located in the main shower room on the unit. LPN D verbalized they went to the shower room and saw (Resident #701) standing there yelling at (CNA B). When queried what they saw when they entered the shower room, LPN D stated, If I remember correctly, (Resident #701) was standing up and (CNA B) was bent down. LPN D was asked what occurred and if they provided any assistance and replied, (CNA B) said everything was fine and we (LPN C and LPN D) went out. When asked how Resident #701 was when they came out of the shower/bathroom, LPN D stated, (Resident #701) was still crying. When asked, LPN D stated, (Resident #701) never said anything to me about what happened. LPN D was then asked if they saw Resident #701 hit CNA B and stated, Not that I remember. When queried if they saw CNA B be physically aggressive and/or physically abusive to Resident #701, LPN D verbalized they did not. When asked if they were present in the shower room the entire time care was being provided, LPN D responded they were not. An interview was conducted with CNA M on 6/16/26 at 12:43 PM. When queried if they were aware of an incident involving Resident #701 and CNA B in the shower/bathroom, CNA M responded, I did not see it, but I heard about it. When queried what they heard, CNA B refused to answer stating they did not want to spread gossip. An interview was completed with LPN K on 6/16/26 at 1:09 PM. When queried if they recalled an incident involving Resident #701 and CNA B, LPN K stated they heard about it but didn't do anything with it because it was vague. When asked what they heard, LPN K revealed they heard Resident #701 said CNA B hit them when they were on the phone with the suicide hotline. When queried if other staff were aware of the allegation, LPN K stated, Everybody heard about it. A follow-up interview was completed with SWD A on 6/16/26 at 2:10 PM. When queried what day and time they were notified of the abuse allegation pertaining to Resident #701 and CNA B, SWD A revealed it was the date of their note and stated, I did it in the morning, not sure what exact time. When asked who notified them of the allegation, SWD A replied, I was alerted in the morning. Report is at 9:00 AM, I'm unsure if it was before or after (report) that I talked to (Resident #701). An interview was completed with the Administrator and DON on 6/16/26 at 4:00 PM. When queried where Resident #701 calls the suicide helpline from, the DON and Administrator revealed they call from the nurses' station phone. When asked if the Resident requires assistance to call the hotline, the Administrator replied, Yes, sometimes we have to hold the phone because (Resident #701) shakes. When asked who the nurse was that assisted the Resident to contact the suicide helpline when they told the helpline about the abuse allegation, the Administrator stated they did not know. The Administrator and DON were then asked how staff were aware of the abuse allegation prior to Resident #701 reporting the allegation to LPN G, the Administrator and DON did not provide an explanation. When queried why they did not talk to other staff and residents as part of a comprehensive investigation, the Administrator responded that Resident #701 recanted and there was no abuse. When queried if individuals who experience abuse may recant their allegation due to fear of retaliation, a response was not provided. When asked why Resident #701 verbalized an allegation of abuse when interviewed today if they recanted their allegation, the Administrator did not provide further explanation. The Administrator and DON then revealed that Resident #701 has been going through a mental health crisis, and the facility is attempting to find psychiatric inpatient placement. When asked if increasing resident behaviors has the potential to increase the risk of abuse, the DON confirmed and verbalized understanding. When queried why the investigation completed did not include an interview with the alleged perpetrator, the Administrator revealed they were unable to locate the form. When asked why the phone interview forms for both LPN C and LPN D specified the incident occurred in the Resident's room bathroom when all the staff verbalized it occurred in the main shower/bathroom, the Administrator revealed they thought it had happened in their Resident's room but did not provide further explanation. When asked if the alleged perpetrator, CNA B was suspended and removed from the building immediately when they were notified of the allegation, the Administrator stated, No. When asked why not, the (continued on next page)

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