STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235461	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Pine Place	4800 Clintonville Rd Clarkston, MI 48346

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3006555 and 3009286. Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse by staff for one resident (R802) of two residents reviewed for abuse/neglect/mistreatment.Findings include:On 5/13/26 a facility reported incident (FRI) that was submitted to the State Agency was reviewed which alleged R802 was victim of verbal abuse by a facility staff member on 4/27/26.On 5/13/26 the medical record for R802 was reviewed and revealed the following: R802 was initially admitted to the facility on [DATE] and had diagnoses including Dementia, Morbid obesity and Chronic obstructive pulmonary disease. A review of R802's MDS (minimum data set) with an ARD (assessment reference date) of 3/11/26 revealed R802 needed assistance from facility staff with most of their activities of daily living. R802's BIMS score (brief interview for mental status) was 11 indicating moderately impaired cognition.On 5/13/26 at approximately 9:57 a.m., R802 was observed in their room, laying in their bed. R802 was queried regarding the facility reported incident on 4/27/26 and they indicated they could not recall the event.On 5/13/26 a review of the FRI investigation involving R802 and bus driver A (BD A) was conducted and revealed the following: NHA (Nursing Home Administrator) was informed of an alleged verbal abuse from employee to resident by Office Manager D (OM D) from [local Dermatology office] reports she and her staff witnessed our bus driver, BD A, being verbally abusive towards R802 during his appointment. Investigation initiated, employee suspended pending investigation .Investigation-Witness Statements:OM D- As [R802] was waiting to be called back for his appointment, several of my staff members witnessed the caretaker being very verbally abusive to him. She was speaking to him in a very loud and condescending tone, in addition to telling him to stop talking when he was engaged in a conversation with another individual. At one point, there seemed to be a verbal altercation between them, the caretaker got loud and asked [R802], Are you able to walk on your 2 feet? and carried on about his inability to walk. She finally said that they were leaving without being seen. [R802] attempted to object, but the caretaker would not listen. She rescheduled the appointment and left at around 3:05pm. When leaving she wheeled him to the parking lot and left him there for a few minutes [NAME] he got the van. She eventually got out and loaded him into the van and they left. Several of my staff members witnessed the behavior/interaction were visibly shaken because of it. I can only imagine how other patients in the waiting room. This kind of behavior is unacceptable and not allowed in our medical practice. [R802] has an appointment on Monday. We will gladly see him and treat his concerns, but unfortunately the caretaker that accompanied him today is not welcome to our facility anymore.Scheduler B- On April 27th I was walking in the reception area to get paper and I saw that [BD A] was visibly upset and I asked her if she was ok. [BD A] began telling me Mother******* don't have paperwork, face isn't washed, and they are not paying me no CNA (Certified Nursing Assistant) money. I'm trying to fill out paperwork for him and the mother**** can't hear s***. I'm sick of this s**** .Receptionist E- On 4/27 I received a call from the doctor's office, in which the incident took place regarding the bus driver, [BD A]. The nature of the incident wasn't clear to me at that time but based on the manager's reaction I gathered she may have (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	been involved in some kind of altercation involving the resident. When [BD A] returned, she was in a bad mood and was loudly complaining and cursing about the appointment. Between what the managers said, and what [BD A] said, she seemed to be upset about the state of the resident (unclean) and having to fill out unexpected paperwork at the doctor's office.Conclusion: Upon review of resident, staff interviews and review of the details involving the incident, the facility does substantiate verbal abuse. [BD A] left the facility following the incident stating that she resigned effective immediately. The NHA [Nursing Home Administrator] made several attempts to contact [BD A] and obtain a statement from her about the reported incident and [BD A] has not responded .On 5/13/26 at approximately 11:04 a.m., the facility investigation was reviewed with the administrator (abuse coordinator) the NHA indicated that the incident was substantiated and that OM B had to reason to call and lie that BD A was being verbally abusive to R802. The NHA reported that due to the multiple witnesses, disciplinary actions were taken and BD A was not willing to provide a statement. TDB A was reported to the registration agency for the abuse and is no longer employed by the facility. All facility staff had been re-educated on Abuse and Abuse reporting, and a compliance date was provided for 4/29/26. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included having the perpetrator not employed by the facility and re-educating all employees on abuse. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.