STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045370	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alma Nursing and Rehab	401 Heather Lane Alma, AR 72921

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 - Immediate jeopardy to resident health or safety 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** Based on interview and record review, the facility failed to identify an incident of sexual abuse and to ensure interventions were put in place and effectively implemented to prevent subsequent incidents from occurring to protect one (Resident #16) of one resident from further sexual abuse. It was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.10(c)(3) (Comprehensive Care Plans) at a scope and severity of J. The IJ began on 02/12/2026 at 10:35 AM, when Resident #89 was witnessed rubbing Resident #16's right inner thigh by facility staff. There were no interventions put in place to prevent subsequent incidents of sexual abuse to Resident #16. On 02/12/2026 at 7:35 PM, Resident #89 was witnessed with their hand inside Resident #16's brief. The Administrator and Director of Nursing (DON) were notified of IJ on 03/06/2026 at 2:22 PM. A removal plan was requested. The removal plan was accepted by the State Agency on 03/07/2026 at 1:20 PM. The findings include: Resident #16 A review of Resident #16's admission Record revealed the resident had diagnoses which included dementia, Alzheimer's Disease, cognitive communication deficit, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) affecting the left dominant side. A review of Resident #16's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/15/2026, revealed a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. Resident #16's MDS also revealed the resident was dependent with Activities of Daily Living (ADLs), eating, transfers, and mobility. Resident #89 A review of Resident #89's admission Record revealed the resident had diagnoses which included major depressive disorder, congestive heart failure, and kidney disease. A review of Resident #89's quarterly MDS, with an ARD of 12/15/2025, revealed a BIMS score of 13, (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	which indicated the resident was cognitively intact. Resident #89's MDS also revealed the resident used a wheelchair for mobility. A review of a Resident #89's Progress Notes, dated 02/12/2026 at 10:35 AM, indicated the Treatment Nurse saw Resident #89 sitting beside Resident #16 in the 300-Hall. She witnessed Resident #89 holding Resident #16's hand and rubbing Resident #16's right inner thigh. During an interview on 03/05/2026 at 1:30 PM, the Treatment Nurse indicated that on the morning of 02/12/2026, she did witness Resident #89 rubbing Resident #16's right inner thigh, while the residents were sitting in the 300-Hall. She indicated that as a result of this, she moved Resident #16 into the dining room with the Activity Director and reported the finding to the DON. She then explained after she informed the DON, the Treatment Nurse went back to providing resident care and reported she was unaware if any further interventions were put in place by the DON to protect Resident #16. A review of Resident #16's Skin Audit dated 02/12/2026 at 11:58 AM, indicated the Treatment Nurse completed a skin audit of Resident #16 with findings of scab to left temple, no s/s [signs/symptoms] infection noted, no drainage, bruise to left hand and wrist, no other skin issues noted at this time. During an interview on 03/05/2026 at 2:01 PM, the Administrator reported the first incident was not a concern for how it was described to her and stated, a CNA [Certified Nursing Assistant] was assigned to watch [Resident #89] before, and at change of shift, it was another CNA assigned. The Administrator then stated that record review and interviews did not reveal any one-on-one CNA duties, nor any assignment of staff, to watch Resident #89 after the first incident. During an interview on 03/05/2026 at 1:46 PM, the Activity Director indicated a CNA pushed Resident #16 into the dining room during an activity, on the morning of 02/12/2026. She reported the CNA told her what had happened (initial incident involving Resident #89) and told the Activity Director to make sure Resident #89 did not get near Resident #16. She indicated Resident #16 was present during the activity about an hour before the Activity Director wheeled Resident #16 back to the 300-Hall, and then unidentified CNAs took Resident #16 into Resident #16's room to lie down. During an interview on 03/05/2026 at 9:59 AM, the DON indicated that on 02/12/2026, the Treatment Nurse reported to her that she witnessed Resident #89 rubbing Resident #16's leg. The DON stated, it raised a flag for me. She indicated the Treatment Nurse took Resident #16 to the dining room where an activity was taking place because (Resident #16) cannot speak for [themself]. The DON then indicated she reported the incident to the Advanced Practice Registered Nurse (APRN) and the Administrator. The DON stated she alerted the staff to ensure Resident #89 did not go near Resident #16. The DON reported she did not have any documentation for telling the staff about the alert. She indicated she spoke with Licensed Practical Nurse (LPN) #22 and stated, [LPN #22], please make sure the staff CNAs on the hall are aware. The DON revealed to protect Resident #16 from further incident, there should have been one person right there watching Resident #89. During a phone interview on 03/05/2026 at 11:00 AM, CNA #28 indicated during her 7:00 PM to 7:00 AM shift on the 300-Hall on 02/12/2026, Resident #89 was removed from Resident #16's room three times: -She reported in the first incident at an unknown time, Resident #89 was just inside the door of Resident #16's room and CNA #29 wheeled Resident #89 back out. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-She reported during the second incident, CNA #28 observed Resident #89 inside Resident #16's room and Resident #89 had a hand over Resident #16, but was not touching Resident #16, from what CNA #28 could see. She reported CNA #29 removed Resident #89 from Resident #16's room. CNA #28 then left to go find the nurse on 300-Hall (LPN #30) to report this incident to. -She reported the third incident happened when she left to find LPN #30 to report the second incident to, when CNA #29 found Resident #89 in Resident #16's room with a hand in Resident #16's brief. CNA #28 reported after the third incident, while assisting CNA #29 change Resident #16's brief, she saw a tear in Resident #16's eye and stated, we [the CNAs] were bothered by it. During a phone interview on 03/05/2026 at 11:30 AM, CNA #29 reported she worked the 3:00 PM to 11:00 PM shift on the 300-Hall on 02/12/2026. She reported Resident #89 went into Resident #16's room, I believe there was two times. She reported the last time Resident #89 was found in Resident #16's room was about 7:30 PM, when she saw Resident #89's hand in Resident #16's brief. She reported she told Resident #89 they had to leave the room, adding that Resident #89 wore gardening gloves for wheeling their wheelchair. She noted Resident #16 was incontinent of bowel at the time, and CNA #29 revealed they observed poop on [Resident #89's] gloves when Resident #89 removed their hand from Resident #16's brief. CNA #29 then reported that she found out 02/13/2026, that an (unknown) nurse was supposed to tell 300-Hall, LPN #30 about the morning incident on 02/12/2026 and LPN #30 was supposed to tell the CNAs on the 300-Hall. She stated, after she found out that she should have been told about the morning incident, I reported to the DON that day [02/13/2026], that no one told us [CNAs] about the morning incident on 02/12/2026. She stated of not being informed, that Resident #89 already had an incident with Resident #16, it was a very deep miscommunication, because hey, maybe we need to do a one on one indicating if she had known there had already been an incident with Resident #89 and Resident #16, she would have known to closely watch Resident #89. During an interview on 03/05/2026 at 3:12 PM, LPN #22 reported she worked the 3:00 PM to 11:00 PM shift, on the 400 and 100-Halls on 02/12/2026. She reported that the DON told her about Resident #89 rubbing Resident #16's thigh, and because of that, to keep a closer eye on [Resident #89]. LPN #22 reported she told LPN #30 (the nurse on the 300-Hall) about Resident #89 rubbing the inner thigh of Resident #16 in a morning incident on 02/12/2026. LPN #22 reported she met with LPN #30 in the medication room and told LPN #30 to keep a closer eye on Resident #89. During a follow-up phone interview on 03/06/2026 at 8:48 AM, CNA #28 reported she did not know anything about another incident with Resident #16 and Resident #89 earlier in the day on 02/12/2026. She reported no one had given her any instructions about specifically watching Resident #16 and Resident #89. During a phone interview on 03/06/2026 at 11:43 AM, LPN #30 reported she worked on the 300-Hall on 02/12/2026 during the 3:00 PM to 11:00 PM shift. She reported she was aware of the incident where Resident #89 had a hand in Resident #16's brief and revealed she called the Assistant Director of Nursing (ADON), the DON, the Administrator, and the police to report the incident. She reported that she found out about the initial, 02/12/2026 at 10:35 AM incident (when Resident #89 was rubbing on (Resident #16's) leg), after the later incident when Resident #89 had a hand in Resident #16's brief had already occurred on 02/12/2026. She stated, I was like WHAT?! She indicated if she had known about the incident earlier in the day, she would have kept (Resident #89) one-on-one supervision until we could get it figured out and talk with administration about what to do. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #89 Behavior Note dated 02/12/2026 at 11:55 PM, indicated at 8:30 PM a body audit of Resident #16 was performed by LPN #30 with another nurse present. Results of the body audit indicated no bruises or redness or scratches noted to victims body. Victim unable to recall and or state events of incident. This note also indicated families of both parties were notified at 8:43 PM and [Resident #89] was on one-on-one supervision. Resident #89 verbalized, .I know what I did was wrong and I won't do it again . During a phone interview on 03/06/2026 at 12:53 PM, the APRN indicated facility staff had informed her that on 02/12/2026 at 10:35 AM, Resident #89 had touched or patted Resident #16. The APRN reported she spoke with both resident representatives and spoke with the Medical Director (MD). The APRN indicated the MD recommended starting a new anti-depressant medication for Resident #89. She then reported she found out later about the 7:30 PM incident on 02/12/2026. A review of Resident #16's APRN Note dated 02/13/2026 at 9:41 AM, indicated the APRN had a visit with Resident #16 and the APRN evaluated the resident with no overt evidence of active bleeding, visible external trauma, bruising or laceration noted at the time of my assessment. She indicated the resident had no acute distress. During a phone interview on 03/06/2026 at 1:10 PM, the MD indicated he was made aware of the incident when Resident #89 was observed rubbing the inner right thigh of Resident #16 and that he spoke with the APRN about starting Resident #89 on an anti-depressant medication, with the rationale that a side effect of the anti-depressant medication was a decrease in sexual desire. He reported that rubbing another resident's thigh was very inappropriate and hypersexual. The MD then indicated he was notified about the 7:30 PM incident on 02/12/2026 and it was his understanding Resident #89 would be on one-to-one until they were transferred. A review of Resident #89's February Medication Administration Record/Treatment Administration Record revealed an order dated 02/12/2026 at 11:40 AM, for a new anti-depressant medication. The first dose was documented given at 8:00 AM on 02/13/2026. During a phone interview on 03/06/2026 at 10:35 AM, Officer #31 reported getting to the facility on [DATE] just before 10:00 PM. He reported that he tried to interview Resident #16 and the resident was not oriented and did not verbalize anything. He reported while he was in the room with Resident #16, the nurse asked Resident #16 did something happen to you? Officer #31 reported that in response Resident #16 moved their hand and was making a grabbing motion at their waistline. He reported a staff member removed Resident #89's soiled glove from the trash to show the officer. Officer #31 then reported he interviewed CNA #28 and CNA #29. He indicated the CNAs reported Resident #89 had been in Resident #16's room three times that night [02/12/2026]. The first time, Resident #89 got just inside Resident #16's room. The second time, Resident #89 was found in Resident #16's room and Resident #89 had Resident #16's shirt pulled up. The third time, Resident #89 was in Resident #16's room with their hand in Resident #16's brief. He reported that after the second time Resident #89 was found in Resident #16's room, CNA #28 and CNA #29 indicated to him that both of them went to get the nurse. He stated, It bothers me one did not stay with the female resident. Because this form of inappropriate, unwanted sexual contact would reasonably cause severe psychosocial harm, it can be determined that the reasonable person in the resident's position would have experienced severe psychosocial harm- dehumanization, and humiliation- as a result of the sexual abuse, placing Resident #16 at risk for serious injury, serious harm, serious impairment or death. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Sexual fondling was defined by Legal Information Institute 34 USC 30309(11) as touching of the private body parts of another person (including . inner thigh) for the purpose of sexual gratification. A review of an in-service dated 03/18/2025, for Resident Rights and Abuse, Neglect, Misappropriation and Exploitation among other subjects was signed as attended by DON (ADON at the time), CNA #28, and LPN #22. LPN #30 and CNA #29 were not listed. A review of an in-service dated 06/17/2025, for 7 forms of abuse was signed as attended by CNA #29, LPN #22, and the DON. LPN #30 was not listed, and the in-service was not signed as attended by CNA #28. A review of an in-service titled Freedom from Abuse, Neglect, Misappropriation and Exploitation Competency Staff Training dated 09/23/2025, (page 13, extended survey #18 in-service abuse) indicated, Residents have the right to be free from abuse, neglect, misappropriation and exploitation. The facility must promote the residents' rights. Facility staff must be able to identify potential abuse and know what to do to protect residents. This in-service was signed as attended by CNA #29, CNA #28, LPN #22, DON, Treatment Nurse, A review of an in-service dated 03/06/2026, for Identifying Sexual Abuse, defined Sexual abuse as non-consensual sexual contact of any type with a resident. A review of an undated facility policy titled Abuse Investigation, & Reporting Policy, section II staff training and competency indicated the facility would conduct in-service programs at least annually for all employees .and the proper procedures for identifying, reporting and preventing abuse of residents. Section III of the policy indicated all alleged, witnessed or suspected resident maltreatment, including sexual abuse .shall be immediately reported to administrator or immediate supervisor and investigated by facility management. Section VI indicated residents' care plans will address interventions designed to prevent occurrences and the resident's physician will be notified of the investigation and to implement actions to prevent a recurrence. Section IX indicated sexual abuse was defined as sexual activity, sexual contact .with another person who was not the actor's spouse and who was incapable of consent because he or she was mentally defective, mentally incapacitate or physically helpless. The IJ was removed on 03/09/2026 at 11:40 PM, after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began on 03/09/2026 at 11:50 AM, when on 03/06/2026, at 4:15 PM, it was determined on 02/12/2026 at 10:35 AM, Element 1: Resident #89 was observed rubbing Resident #16's right inner thigh by facility staff. On 02/12/2026 at 7:35 PM Resident #89 was found, by facility staff, in Resident #16's room with a hand inside Resident # 16's brief. Progress note dated 02/12/2026 indicated Resident #16 was taken to dining room where activities were being conducted. APRN visit dated 02/13/2026 at 09:41 AM indicated the visit was medically necessary to evaluate resident post report of another resident being found in Resident #16's room with hand inside Resident #16's brief. One-on-One Supervision document for Resident #89 with staff statements one-on-one supervision was conducted with Resident #89 from 02/12/2026 to 02/13/2026 at 10:43 AM when Resident #89 departed facility to Senior Care. All staff in-service conducted on 02/13/2026 including cover page, Abuse Investigation & Reporting Policy, and sign in sheet. In-Service Identifying Sexual Abuse dated 03/06/2026 and sign in sheet. Mental Health evaluation dated 03/06/2026 by nurse practitioner. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Element 2: Resident interviews conducted on 03/06/2026. Resident body audits conducted 02/12/2026 to 02/16/2026. Body audits conducted on 03/06/2026. Element 3: Expanded in-service education on Identifying Sexual Abuse and Mandated Reporting. Element 4: QA monitoring of orientation education. No new hires since IJ identified. Interview with Administrator. A total of 26 staff interviews were conducted with staff from all shifts to verify training had been completed. The staff interviewed included Administrator, Director of Nursing, Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants, Housekeeper, Dietary Aide, Laundry Aide, Dietary Manager, medical director, floor tech, transport aide, MDS Coordinator, HR Director, Medication Aide Certified (MAC), Medical Records. The staff interviewed verified they had been trained on Abuse, Neglect, types of abuse, identifying sexual abuse, how to report, and who to report to. A review of in-service sheets provided indicated 120 of 122 had been provided training. Those staff who were not physically present to receive the in-services were provided with the in-service prior to the start of their next shift.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility document review, facility policy review, it was determined that the facility failed to ensure one (Resident #50) of one resident reviewed was not pulled backwards in a wheelchair. The findings include: A review of Resident #50's admission Record indicated the resident admitted on [DATE], with diagnoses that included anxiety, depression, abnormalities of gait and mobility, restlessness, and agitation. A review of Resident #50's quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 01/19/2026, revealed a Brief interview of Mental Status score of 06, which indicated the resident had severe cognitive impairment. Resident #50's MDS also revealed the resident used a manual wheelchair for mobility. A review of Resident #50's Care Plan Report, initiated on 01/08/2026, revealed the resident had a restorative nursing program need related to other abnormalities of gait and mobility, generalized muscle weakness, and repeated falls. Resident #50's Care Plan Report also specified interventions which included, allow resident adequate time to complete tasks. A review of the facility's OLTC [Office of Long-Term Care] Incident and Accident Report, dated 12/19/2025 at 3:00 PM, revealed Certified Nursing Assistant (CNA) #2 reported that CNA #1 was being aggressive with Resident #50. CNA #1 indicated that CNA #2 was pushing Resident #50 away from the dining room table in a wheelchair. Resident #50 did not want to leave the dining room and was in their wheelchair leaning forward when CNA #2 put their forearm across the resident's chest to get the resident to sit up. A review of an untimed OLTC Witness Statement Form, dated 12/19/2025 and signed by CNA #2, revealed CNA #1 was trying to remove Resident #50 from the dining room. The resident planted their feet on the floor, and CNA #1 pulled Resident #50 backwards. CNA #2 then indicated that Resident #50 was leaning forward and CNA #1 put their arm around the resident, to keep them from falling. A review of an OLTC Witness Statement Form, dated 12/19/2025 and signed by CNA #3 at 12:40 PM, indicated that Resident #50 was finished eating, and CNA #1 went to take the resident back to the hall. Resident #50 would not lift their feet up. A review of an OLTC Witness Statement Form, dated 12/19/2025 and signed by CNA #2 at 12:52 PM, indicated that CNA #1 was aggressive with Resident #50. CNA #1 told Resident #50 that [pronoun] was through and needed to go. The resident was fighting and asking for help. CNA #1 turned Resident #50 backwards and dragged them. Resident #50 was reaching for help. CNA #1 reached around and jerked the resident back. A review of an OLTC Witness Statement Form, dated 12/19/2025 and signed by Licensed Practical Nurse (LPN) #5 at 2:00 PM, indicated that CNA #1 was observed pulling Resident #50 backward in their wheelchair. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an OLTC Witness Statement Form, dated 12/19/2025 and signed by Registered Nurse (RN) #4 at 3:55 PM, indicated CNA #1 was pushing Resident #50 down the hall. CNA #1 was heard telling Resident #50 I'm tired of fighting this . A review of a [City] Police Department Incident Report dated 12/19/2025 at 4:29 PM, indicated that Police Officer #6, and Police Officer #7 reviewed the facility video footage of the incident between Resident #50 and CNA #1. Officer #6 indicated that CNA #1 was clearly observed on the video pulling Resident #50 backwards in their wheelchair. During an interview on 03/05/2026 at 3:55 PM, LPN #5 indicated that whenever the residents were finished eating, the staff removed them from the dining room. LPN #5 stated that Resident #50 did not want to leave the dining room and was trying to stand up while CNA #1 was pushing Resident #50. LPN #5 then stated that CNA #1 turned the resident's wheelchair around and started to pull the wheelchair backwards. CNA #1 was behind Resident #50, and she had her arm across the resident's chest with her hand on Resident #50's shoulders pulling the resident back in their wheelchair. LPN #5 indicated that she was in the middle of the 200-Hall at the nurse's station. LPN #5 indicated that CNA #1 said Resident #50 was finished eating but did not want to leave the dining room. LPN #5 confirmed that Resident #50 was a fall risk and that the resident had an alarm on their wheelchair. LPN #5 revealed that it was the residents' right to stay in the dining room after they finished eating, if they chose. LPN #5 further indicated that the incident was immediately reported, and that an in-service was completed on not pulling residents backwards in a wheelchair. During a phone interview on 03/06/2026 at 10:22 AM, CNA #1 indicated she had asked for help in the dining room multiple times. CNA #1 indicated that she asked CNA #2 to help her, and she was mad at CNA #2. CNA #1 indicated that Resident #50 was leaning forward, so the CNA put her hands across Resident #50's chest to keep them from falling. CNA #1 confirmed that she may have started pushing Resident #50's wheelchair backwards but eventually started pushing the wheelchair the other way. CNA #1 indicated that she was informed by the Administrators Assistant, and the Director of Nursing that she was not supposed to push the resident backwards and was educated to not push Resident #50 backwards anymore. CNA #1 indicated an in-service was completed on pushing a resident backwards. CNA #1explained she was pushing Resident #50 backwards in the wheelchair because the resident had their feet planted on the floor. CNA #1 then indicated that she knew it was wrong for pulling the Resident #50 backwards in their wheelchair. During a phone interview on 03/06/2026 at 10:44 AM, CNA #1 indicated that she did not know why Resident #50 planted their feet on the ground while CNA #1 was pushing the resident. During a phone interview on 03/06/2026 at 11:11 AM CNA #2 indicated that Resident #50 was sitting in the dining room happy after she had finished eating. CNA #2 then indicated that CNA #1 asked Resident #50 if they had finished eating, and the resident told CNA #1, no. CNA #2 revealed that CNA #1 pulled Resident #50 back in the wheelchair, and Resident #50 said no, I don't want to go back to my room. CNA #2 indicated that if the resident had fallen, it would have been worse since CNA #1 was pulling the resident backwards. CNA #2 then revealed that Resident #50 was saying help me and pulling on everything while CNA #1 was pulling the resident in the wheelchair. During an interview on 03/06/2026 at 4:35 PM, the Administrator indicated that CNA #1 was suspended based on an allegation that CNA #2 felt CNA #1 was too rough with Resident #50. The Administrator indicated that there was an allegation that Resident #50's feet were planted on the floor. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an in-service titled Abuse completed with all staff on 12/19/2025, indicated when a resident did not want to follow instructions, leave and come back at a different time; If feeling frustrated or impatient with a resident leave and ask a co-worker to take over for you; Do not push a resident backwards in wheelchair, and do not hold any resident down in a wheelchair; If any of the above negative behaviors are seen, report it immediately. A review of an Employee Memorandum signed by CNA #1 on 12/22/2025, revealed CNA #1 received a written warning for violating Resident #50's rights. The written warning indicated that CNA #1 pushed the resident away from the dining room table when the resident was not ready to leave. CNA #1 then pushed the resident backwards in their wheelchair. The written warning then indicated that residents should not be taken from the dining room if they are not ready to leave. The written warning lastly indicated that staff should get someone else to help when/if they begin to feel frustrated with a resident. A review of an in-service on Resident Rights was completed on 12/22/2025 with CNA #1. The policy indicated that residents should be free from abuse and neglect, including corporal punishment, involuntary seclusion, and the use of restraints as a punishment, The policy indicated that residents should be treated with consideration, respect and full recognition of dignity and individuality. A review of the facility's policy titled Resident Rights, revised 11/22/2016, indicated Each and every resident in the facility has the right to be treated with consideration, respect and full recognition of dignity and individuality.