

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024
NAME OF PROVIDER OR SUPPLIER Clark Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 7433 North Clark Street Chicago, IL 60626	
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 - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49666</p> <p>Based on interview and record review, the facility failed to prevent and protect residents from resident-to-resident physical abuse. This failure affects two (R1, R5) residents out of seven residents reviewed for abuse. As a result of this failure, R2 hit R1 in the face with a shoe on 02/28/2024 resulting in R1 sustaining a facial laceration, being sent to the hospital, and requiring four sutures; facility failed to protect R5 from physical abuse by R4.</p> <p>Findings includes:</p> <p>Facility reported incident/FRI dated 02/28/2024 documents that the facility reported an altercation between R1 and R2. FRI documents that R1 reported R2 hit R1 with a shoe.</p> <p>R1's face sheet dated 03/26/2024 documents that R1 is a [AGE] year-old male with diagnoses not limited to: wernicke's encephalopathy, laceration without foreign body of other part of head, subsequent encounter, dysphagia, oral phase, epilepsy, unspecified, not intractable, without status epilepticus, major depressive disorder, recurrent, severe with psychotic symptoms, other hyperlipidemia, history of falling, basal cell carcinoma of skin of left lower eyelid.</p> <p>R1's MDS/Minimum Data Set, dated dated [DATE] documents that R1 has a BIMS/Brief Interview for Mental Status score of 9/15, indicating that R1 is moderately cognitively impaired.</p> <p>R1's hospital records dated 02/28/2024 documents that R1 was seen in the hospital and diagnosed with a facial laceration requiring four sutures.</p> <p>On 03/26/2024 at 12:07 PM observed R1 alert and responsive. Noted R1 with a scar on top of his nasal bridge/forehead. R1 said that he got stitches after his roommate (identified as R2) hit R1 with his own shoe. R1 states that the incident occurred in the facility. R1 states that R2 told R1 that he stunk and if R1 didn't get out of his bedroom, R2 and R1 were going to get into a fight. R1 states that staff were present but does not recall the staff's name. R1 states that R2 removed R1's shoe and swung it at R1 and then R2 was choking R1. R1 states that the staff member removed R2 away from R1. R1 remembers he then went to the hospital.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145507
		If continuation sheet Page 1 of 7

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Nurse's notes dated 2/28/2024 23:45 Note Text: On this day, the writer received the resident via transport and 2 assistants. The resident received discharge papers from the hospital stating that he received a CT/computerized tomography without any additional findings and that the resident needs to follow up with MD/medical doctor as soon as possible. After assessment, it was found that the resident had received 4 sutures to the left side of his forehead. The writer called back to the hospital and spoke to the charge nurse. The charge nurse stated that he did not receive any medication and no discharge orders. The resident did not complain of pain and was seen laying comfortably in bed. Will endorse to AM nurse to follow up with appointment.</p> <p>R2's face sheet dated 03/26/2024 documents that R2 is a [AGE] year-old male with diagnoses not limited to: other spondylosis, lumbar region, other psychoactive substance abuse with unspecified psychoactive substance-induced disorder, major depressive disorder, recurrent, mild, generalized anxiety disorder, other insomnia, essential (primary) hypertension.</p> <p>R2's MDS/Minimum Data Set, dated dated [DATE] documents that R2 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating that R2 is cognitively intact.</p> <p>R2's general progress note dated 2/28/2024 23:01 documents Note Text: R2 displayed verbal and physical aggression towards roommate. Roommate was sent out due to facial injury. R2 placed on 1:1 supervision. Doctor informed with order to send him to the hospital for psych evaluation with petition. Order noted and carried out. Report given to psych intake at hospital. R2 made aware going to hospital for psych evaluation. R2 emergency contact #1 informed. Ambulance informed of transportation.</p> <p>R2's social service note dated 2/28/2024 21:40 documents Note Text: On 2/28/24, a peer alleged that R2 tossed a shoe across the room and it brazed peer's face. Both residents were immediately separated by staff. R2 was placed on 1:1 monitoring until sent to the hospital for psych evaluation. Administrator, MD, and family member were notified. Police Department was also notified. Initial report was sent to state agency with final report to follow.</p> <p>R2's Medical Professional Progress note dated 3/1/2024 12:43 documents Note Text: Notified by nursing staff that on 2/28 nighttime, R2 displayed verbal and physical aggression towards his roommate. Roommate was sent out due to facial injury. R2 presented with verbal aggression toward staff and medication non-compliance. R2 was sent to the hospital for psychiatric evaluation and admitted with dx of aggressive behavior. The facility issued an IVD/involuntary discharge. R2 should not return to facility due to his behaviors and requires elsewhere placement.</p> <p>R2's nurse's notes dated 1/3/2024 08:14 documents Behavior: R2 is verbally abusive towards the writer because he was asked not to dump water inside the garbage can in the hallway. R2 is very demanding, wants everything his way and if it is not done R2 gets mad and ready to curse the staff out. Sometimes R2 is cussing his roommate, demanding the roommate to shower, because he claimed that he did not see the roommate when he took his shower, even though roommate took shower on the scheduled day. If he does not want any resident as a roommate R2 may pour water in the bed or spray the room just to make the roommate to be uncomfortable. Non-Pharmacological Interventions: Educated and encouraged R2 that he needs to be calm and be nice to staff and to his roommate, Social Worker made aware. Pharmacological Interventions:</p> <p>Summary/Outcome remarks: R2 is unable to be redirected.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R2's care plan dated 02/28/2024 documents in part that R2 is care planned for presence of abuse and neglect factors . care plan documents A peer alleged that R2 tossed a shoe across the room and it brazed peer's face.</p> <p>R2's care plan dated 04/18/2023 documents in part that R2 act(s) in self-defeating ways and engages in behavior to attempt to intimidate, antagonize, and provoke others. Behavioral symptoms include Acting territorial and not allowing peers in certain areas . He has behaviors of not getting along with roommates and will confabulate stories.</p> <p>R2's abuse assessment dated [DATE] written by V7 (Social Worker) does not document that R2 has a history or presence of behaviors such as aggression, disrespect, and/or abrasive/inappropriate behavior.</p> <p>R2's involuntary discharge form dated 02/28/2024 documents R2 was discharged from the facility due to the safety of individuals in the facility being endangered.</p> <p>On 03/26/24 at 1:52 PM V4 (Social Worker) states that he was on the 5th floor, walking down the hallway when V4 heard a commotion. V4 states that he opened the door which was slightly cracked opened and V4 saw R1 right in front of the door, bleeding from his face. V4 states that he observed R1 with his right shoe off. V4 stated that he saw R2 also inside the room next to R2's bed. V4 stated R1 and R2 were already separated. V4 stated it is a 4 bedroom, R1's bed is bed four, R2's bed is bed three. V4 states one of the other roommates was not in the room. V4 states that he does not remember if the 4th roommate was in the room. V4 states that there were no staff in the room. V4 states that he then yelled out for help. V4 states that when R1 and V4 were walking to the nurse's station, V4 asked R1 what happened and V4 states that R1 responded that he got hit with a shoe. V4 states that he observed the nurse cleaning R1's wound. V4 states that he called the administrator to report the allegation. V4 states that the administrator is the abuse coordinator. V4 states 911 was called. V4 states that he called the facility's security and V4 states that R2 was brought to the first floor for 1:1 with the security guard. V4 states that he did not witness the altercation between R1 and R2.</p> <p>On 03/26/24 at 2:11 PM surveyor inquired to V4 what would happen if a resident's abuse assessment were not accurate. V4 states that this would lead one to think that the resident has no behaviors present. V4 states that this can lead to an incident or a situation that could have been prevented.</p> <p>On 03/26/2024 at 2:41 PM V7 (Social Worker) states she made rounds on the floor and met with R1 to follow up on what had happened the night before. V7 states that R1 informed her that R2 came to R1 and told R1 that he smelled. V7 states that V7 asked R1 how he got the injury and V7 states that R1 informed her that R1 told R2 to go away, and that is when R2 tossed a shoe at R1. V7 states that R2 is usually verbally aggressive towards staff and V7 states that R2 always is feeling superior to others. V7 states that one thing R2 does is complains that R2's roommate's smell. V7 states that every time there is a new roommate, R2 complains about the roommate. V7 states that she has had to move two residents for R2 to make him peaceful. V7 states that R2 would say he liked clean people. V7 states she was made aware that R2 sprayed air freshener at his roommates.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Facility document dated 07/14/2023, titled Abuse and Neglect documents in part, Policy statement: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment . Prevention: Have procedures to: Identification, assessment, care planning for intervention, and monitoring of residents with needs and behaviors that might lead to conflicts or neglect.</p> <p>45001</p> <p>Facility Reported Incidents, date of occurrence 3/15/2024, documents in part: On 3/15/24 at around 8:45pm, R5 reported to V4(Social Worker) that R4 had struck R5 on the left ear.</p> <p>According to R4's face sheet, 3/26/24, R4 is a [AGE] year-old resident. R4's diagnoses include but are not limited to major depressive disorder, chronic obstructive pulmonary disorder, violent behavior, and generalized anxiety disorder. According to R4's MDS (Minimum Data Set) dated 3/13/2024, Brief Interview for Mental Status score indicates R4 is cognitively intact.</p> <p>According to R4's care plan, R4 presents with a difficult or troubled past secondary to severe mental illness, chronic health conditions, hemiplegia, hemiparesis, spinal stenosis, seizures, and paraplegia. R4 presents with risk factors related to acting as a recipient or perpetrator of mistreatment and/or neglect, exploitation, psychiatric history, and present mental health symptoms.</p> <p>A peer alleged that R4 was physically aggressive towards the peer. R4 was placed on 1:1 monitoring until sent to the hospital for psych evaluation, 12/7/23. R4 has and has a history of problems with anxiety and severe mental illness and healthcare workers. R4 has been noted with several behaviors related to verbal aggression towards staff when redirected. R4 also has behaviors of videoing staff without their consent or permission, 12/13/23. R4 has a history of criminal behavior. Convictions: aggravated battery/Peace Officer, aggravated battery/nurse. R4 is on adult probation and is currently on parole, 12/10/23.</p> <p>According to R4's Social Services, Abuse, Neglect, Exploitation, Trauma, and Identified Offender assessment, 3/12/2024, R4 presents at risk for being abused or for being an abuser. This is due to R4's behavioral history, substance abuse history, as well as R4's current diagnosis.</p> <p>According to Progress Note, 3/15/2024 22:58, R4 is verbally and physically aggressive towards staff members with an allegation of physical abuse towards one resident. R4 is using inappropriate language and threatening staff. Refused to be redirected. In need of immediate hospitalization to prevent harm to self and others. Placed on 1:1 supervision. Doctor informed with order to send R4 to the hospital on involuntary petition for psychiatric evaluation.</p> <p>Medical Professional Progress Note, 3/18/2024 11:46, documents in part: Notified by staff that resident (R4) was verbally aggressive and loud toward staff. There is an allegation of physical abuse toward a peer resident. R4 was sent to the hospital and admitted with diagnosis of aggression. Due to the safety needs of others, R4 would benefit from elsewhere placement.</p> <p>Behavior Note dated 3/8/2024 18:21, documents in part: Resident (R4) was very abusive towards staff and continue to videotape everyone on the floor, claims that R4 is an advocate to other residents even if the resident is on fluid restriction. They are entitled to give them anything they want.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Behavior Note, 1/27/2024 00:31, documents in part: Resident (R4) noted verbally and physically aggressive towards staff. Refused to be redirected. R4 called police on staff. Resident stated, I am going to set the facility ablaze.</p> <p>R4's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents, 3/18/2024, reads in part: the safety of individuals in this facility is endangered.</p> <p>According to R5's face sheet, 3/26/24, R5 is a [AGE] year-old resident. R5 diagnoses include but are not limited to obesity, major depressive disorder, generalized anxiety disorder, atherosclerotic heart disease of native coronary artery, asthma, cirrhosis of liver, localized swelling, mas and lump, lower limb, bilateral. According to R5's MDS, 3/6/2024, Brief Interview for Mental Status score, R5 is cognitively intact.</p> <p>According to R5's care plan, R5 presents with a host of medical problems and a psychiatric, substance abuse history. R5 is at risk for becoming a recipient or perpetrator of abuse and/or neglect. R5 alleged that a peer was physically aggressive towards R5, 9/9/22.</p> <p>According to R5's Social Services, Abuse, Neglect, Exploitation, Trauma, and Identified Offender assessment, 3/7/2024, R5 is at risk for being abused or for being the abuser, this is due to R5's medical diagnosis as well as R5's behavioral history.</p> <p>Health Status Note, 3/15/2024 22:06, documents in part: Resident (R5) alleged that a peer struck R5 on the left ear. Both residents were immediately separated by staff. Full body assessment done, no injury. No changes in ROM/range of motion. No loss of consciousness. Denied pain. R5 stated, I am fine. Vital Signs stable. Police Department notified.</p> <p>On 3/26/24 at 1:54 PM, V4 (Social Worker) stated I was not on the 2nd floor when the incident happened. V8 called me and said we have a situation and asked for my help. When I arrived on the 2nd floor, security was talking to R4. I talked to R5. R5 alleged R4 was upset and hit R5. R5 said R4 hit R5 on the head like a punch. R5 said, I want R4 arrested, I already called police. I did not speak to R4 before R4 left the facility. I gave the involuntary petition to the ambulance. The ambulance transported R4 to the hospital.</p> <p>On 3/26/24 at 3:00 PM, V11 (Social Worker) stated I have been the social worker for the second floor for four years. I was not here when the incident happened. From what I heard there was an alleged altercation between R4 and R5. R4 was sent to the hospital. I was informed R4 will not be returning to the facility. R4 was involuntary discharged . I got reports of R4 being verbally aggressive towards staff, using gender and racial slurs. I did not get reports from residents of any issues with R4. R4 was sent out before for verbal aggression toward staff. R5 does not have behaviors. R5 is polite and gets along with residents and staff. R4 and R5 never really interacted, they were not in the same room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/26/24 at 3:52 PM, R5 was observed in room sitting in a wheelchair with R5's mother visiting. R5 stated, on 3/15, R4 was screaming and cussing at the nurse (V12) regarding another resident being in pain. R4 was calling V12 every name in the book including b####h. V12 took medication into the resident's room and R4 followed V12. R5 went to the nursing station to get security, I said call 911. V10 (Registered Nurse) was at the nursing station. R5 called 911. Facility security came to the floor. R5 said R4 hit R5 two times on the left ear. R5 did not feel pain at the time. R5 noticed ringing in the left ear after everything had calmed down. R4 was recording everything. I saw the video on the internet.</p> <p>On 3/26/24 at 4:12 PM, V10 (Registered Nurse) stated V10 heard R5 screaming that R5 was attacked by R4. I was passing medications on the other side of the unit. I tried to put my body between R4 and R5 to protect R5 from R4. R4 is stronger than R5. R5 is in a wheelchair. R4 can walk. R5 was screaming R5 was already hurt three times by R4. R4 was saying it doesn't matter if R4 goes to jail because R4 already killed a man. R4 was filming with a cell phone. V10 stated V10 did not see R5 get hit. R4 was sent to the hospital. V10 stated R4 has a behavior problem. This was not the first time they had an altercation.</p> <p>On 3/26/24 at 5:00 PM, V8 (Nursing Supervisor) stated I did not witness anything. I was told R4 was verbally and physically aggressive toward V12 (Registered Nurse). I saw R4 with aggression, so I removed R4 and put R4 on 1:1 with security. I called the ambulance to send R4 out for aggressive behavior. The police came and I told them I got an order from the doctor to send R4 out for aggressive behavior. Later, R5 alleged R4 struck R5.</p> <p>On 3/26/24 at 8:15 PM, V12 (Registered Nurse) stated one of my patients shares a room with R4. I was going to assess my patient in the room. I wheeled the patient into the room. I was inside the room. R4 was verbally abusive following me and forcefully closed the door on me. R4 was outside of the room. I don't know why R4 was cussing at me and verbally abusive. R4 said R4 was recording this. I did not pay R4 no mind. I was not looking at R4, so I did not see R4 recording. After I finished with my patient I went and told V8 that R4 was verbally abusive and banged the door on me. Someone called the ambulance and R4 went to the hospital. I'm not sure why R4 went to the hospital it might be because R4 was verbally abusive to me. Both R4 and R5 were my patients that evening.</p> <p>On 3/27/24 at 9:20 AM, V13 (Certified Nursing Assistant) stated I'm always working on the second floor. I heard the argument between both of them (R4 and R5). I was in a resident room with a total care resident. They were on the other side of the unit. I could hear loudness, arguing. I know their voices. I went to get security after coming out of the room. I told them R5 and R4 were getting loud and to come diffuse the situation. Security came up and I went about my business to finish my resident.</p> <p>On 3/27/24 at 3:15 PM V1 (Administrator) and V2 (Assistant Administrator) stated V1 is the abuse coordinator. In the event I'm not available V2 gets the calls. We just had abuse training in January. Any instance of abuse staff should report immediately to us. Then we report to the State Agency within two hours. V4 said there was an alleged physical abuse toward R5 from R4. R5 told V4 that R5 was hit in the ear. The nurse assessed R5. R5 refused to be sent to hospital. R4 and R5 were separated immediately. R4 was sent to the hospital for behavior. R5 called the police. Ambulance also came. R4 was IVD (Involuntary discharged) due to behavior toward staff. In general, if a resident is verbally aggressive or abusive toward staff, it is possible for them to become aggressive to other residents.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Facility policy Abuse and Neglect, 7/14/23, documents in part: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. Abuse is willful infliction of mistreatment, injury, unreasonable confinement, intimidation or punishment. Abuse assumes intent to harm, but inadvertent or careless behavior done deliberately that results in harm may be considered abuse. Types of abuse: 1. physical, 2. verbal, 3. mental, 4. sexual, 5. neglect (including medical neglect), 6. theft/misappropriation of property/financial abuse, 7. Involuntary seclusion, 8. exploitation, 9. injury of unknown origin.		