

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145930	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER Goldwater Pontiac Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1225 South Ewing Drive Pontiac, IL 61764	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to timely notify a resident representative and physician of an allegation of abuse for one (R1) of 38 residents reviewed for abuse in the sample list of 38. Findings include: The facility's policy Physician-Family Notification - Change in Condition dated 11/13/18 documents the facility will notify the resident's representative and physician when there is an accident involving the resident that results in injury and has the potential for requiring physician intervention, when there is a significant change in the resident's health, mental, or psychosocial condition, or when there is a need to alter treatment significantly. On 11/25/24 at 10:03-10:20 AM R1 stated last Wednesday (11/20/24) R1 needed repositioned in bed, V4 and V5 Certified Nursing Assistants were rough and R1 felt R1's back and ribs pop when V4 and V5 jerked R1 over in bed. R1 stated V4 and V5 yelled at R1 too. R1 stated R1 reported this to an unidentified nurse that evening. R1 stated R1 had right side pain since the incident, x-rays were completed around midnight last night, and nothing was broken. V7 (R1's Family Member) stated R1 reported this incident to V7 on the morning of 11/22/24, a few hours later V7 posted this allegation on (social media platform) and then the facility contacted V7 about the incident. R1's Minimum Data Set, dated dated dated [DATE] documents R1 as cognitively intact. R1's Concern/Compliment Form dated 11/20/24 documents R1 stated V4 and V5 were being mean, had bad attitudes, and moved R1 in a rough fashion. This form documents staff were re-educated on customer service and to remember to be nice, smile, and be patient. There is no documentation in R1's medical record that this allegation was reported to V20 Medical Director/V21 (R1's Physician) and V7 prior to 11/22/24. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145930	Facility ID: 145930 If continuation sheet Page 1 of 7

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's initial report to the Illinois Department of Public Health dated 11/22/24 documents on 11/22/24 at 7:08 PM V7 posted on (social media platform) an allegation of abuse of R1 by V4 and V5 and the post was sent to V1 Administrator. This report documents R1's family and physician were notified. V1's typed notes dated 11/20/24 documents that afternoon R6, resident council president, reported to V1 that R1 said V4 and V5 were rude to R1, expected R1 to do things for herself, and were rough when they repositioned R1 in bed. This note documents V1, V10 Social Services Director, and R6 spoke to R1 who voiced the same concerns as reported to R6. V1's typed notes dated 11/22/24 document R1 told V1 that during the incident R1 felt a pop in her ribs, V1 offered to have x-rays done, V1 asked V12 Licensed Practical Nurse to assess R1 for injury, and V1 notified V7 to schedule a meeting to discuss R1's concerns. R1's Nursing Note dated 9:59 PM documents R1 was assessed and had no injury and no complaints of pain, V7 was notified, and a message was left for V21 to return call. R1's Nursing Note dated 11/22/24 at 10:01 PM documents V20 was notified of R1's abuse allegation and obtained new order for x-ray of right ribs. On 11/25/24 at 2:02 PM-2:20 PM V1 Administrator stated around 2:00 PM on 11/20/24 R6 said R1 reported V4 and V5 were rude to R1, expected R1 to do things for herself, and they were rough with R1. V1 stated V1 spoke with R1 and R1 reported the same things that R6 told V1. V1 stated V1 was out of the facility on 11/21/24, V1 followed up with R1 on 11/22/24, and at that time R1 reported that during the alleged incident R1 felt a pop in her ribs and was unable to shampoo R1's hair on 11/22/24, so V1 asked a nurse to assess R1. V1 stated on the evening of 11/22/24 V1 received a copy of V7's social media post alleging abuse of R1, and that is when V1 reported the incident and the nurse notified the physician that night.		

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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** 40385 Based on interview and record review the facility failed to timely notify the administrator, state survey agency, and local law enforcement of an allegation of abuse for one (R1) of 38 residents reviewed for abuse in the sample list of 38. Findings include: The facility's Abuse Prevention, Identification, and Reporting Program Policy and Procedure dated 9/10/19 documents employees are required to immediately report any potential/actual abuse or mistreatment that they observe, hear about, or suspect to the facility's Administrator. This policy documents the Illinois Department of Public Health will be notified within several hours of the reported allegation, not to exceed 24 hours, and other external agencies will be notified such as local/state law enforcement as indicated based on the nature of the allegation, physical injuries, and as required per state/federal regulations. On 11/25/24 at 10:03-10:20 AM R1 stated last Wednesday (11/20/24) R1 needed repositioned in bed, V4 and V5 Certified Nursing Assistants were rough and R1 felt R1's back and ribs pop when V4 and V5 jerked R1 over in bed. R1 stated V4 and V5 yelled at R1 too. R1 stated R1 reported this to an unidentified nurse that evening. R1 stated R1 had right side pain since the incident, x-rays were completed around midnight last night, and nothing was broken. V7 (R1's Family Member) stated R1 reported this incident to V7 on the morning of 11/22/24, a few hours later V7 posted this allegation on (social media platform), and then the facility contacted V7 about the incident. On 11/25/24 at 12:01-12:17 PM R6 stated on 11/20/24 around 12:30 PM V19 Housekeeper said R1 wanted to speak with R6. R6 stated R1 told R6 that V4 and V5 were being very rough and abusive to R1. R6 stated R6 asked what R1 meant, and R1 said V4/V5 told R1 to turn and pulled on R1 while attempting to reposition R1 as R1 was holding onto the bed rail. R6 stated R1 said V4/V5 moved R1's legs back and R1 felt R1's back crack. R6 stated R6 reported this to V1 within 15 minutes, they went to speak to R1 together, and R6 said V4/V5 brutally hurt R1, they cussed R1 out, they were aggressive and mean to R1 as they jerked R1 around and yelled at R1. R6 stated R1's story changed and R1 denied the staff cussed at R1 when asked by V1. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact. R6's MDS dated [DATE] documents R6 as cognitively intact. R1's Concern/Compliment Form dated 11/20/24 documents R1 stated V4 and V5 were being mean, had bad attitudes, and moved R1 in a rough fashion. This form documents staff were re-educated on customer service and to remember to be nice, smile, and be patient. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's initial report to the Illinois Department of Public Health dated 11/22/24 documents on 11/22/24 at 7:08 PM V7 posted on (social media platform) an allegation of abuse of R1 by V4 and V5 and the post was sent to V1 Administrator. V1's electronic mail dated 11/22/24 at 9:47 PM documents V1 submitted the initial report of R1's abuse allegation to the state survey agency. There is no documentation that this allegation was reported to local law enforcement. V1's typed notes dated 11/20/24 documents that afternoon R6, resident council president, reported to V1 that R1 said V4 and V5 were rude to R1, expected R1 to do things for herself, and were rough when they repositioned R1 in bed. This note documents V1, V10 Social Services Director, and R6 spoke to R1 who voiced the same concerns as reported to R6. V1 and V2 Director of Nursing spoke with V4 and V5 who stated that R1 refused to let go of the bed rail when they attempted to reposition R1, R1 was upset and started screaming at them, and R1 kicked them out of R1's room. On 11/25/24 at 11:14 AM V4 stated around 6:00 AM on 11/20/24 R1's call light was on and R1 requested to be repositioned in bed. V4 stated V4 attempted to use a cloth incontinence pad to reposition R1, but the pad pulled out from under R1, so V4 went to ask V5 for assistance. V4 stated V4 and V5 were on each side of R1's bed and attempted to turn R1, but R1 would not let go of the bed rail. V4 stated R1 was afraid of falling, but we explained to R1 that we wouldn't let her fall, and we were able to get the cloth pad underneath of R1. V4 stated R1 needed to be scooted up in bed and V4 and V5 used the cloth pad to pull R1 up in bed. V4 stated R1 got upset with V4 and V5, you could just tell it in R1's voice that R1 was not happy with us. V4 stated R1 is sensitive and has a history of back problems. V4 stated later that day the nurse told us that R1 no longer wanted V4 or V5 in R1's room and V4 and V5 went immediately to talk to V2. V4 stated that afternoon V1 spoke with V4 and V5 about the incident. On 11/25/24 at 11:25 AM V5 described R1's incident on 11/20/24 as described by V4. V5 stated R1 was not very happy with V4 and V5, and R1 said to V4/V5 that they were purposefully hurting R1, broke R1's back and ribs, and that R1's ribs popped. V5 stated V4/V5 stopped what they were doing, asked R1 how they could help, and exited the room to notify V11 Licensed Practical Nurse (LPN) of the situation. V5 confirmed V5 would consider R1's statements to be an abuse allegation. V5 stated that is why V5 reported to V11. V5 stated V5 has received abuse training and confirmed abuse allegations should be reported to V1. V5 stated V11 said to use two staff for R1's cares. V5 stated at 10:30 AM V11 said R1 no longer wanted V4 and V5 to provide R1's cares, and around 3:00 PM that day V1 and V2 discussed the incident and V5 was told this wouldn't be considered abuse, that it would be considered a grievance. On 11/25/24 at 11:42 AM V11 LPN stated R1 was upset on the morning of 11/20/24, but V11 was unsure of the specifics other than R1 stated R1 didn't like it here. V11 asked V4 and V5 to talk to R1 and they said they were using two staff for R1's cares and were going to talk to V2. V11 stated later that day another resident (R6) went into R1's room to speak with R1. V11 stated V4 and V5 did not report to V11 anything involving R1 that day. On 11/25/24 at 12:43 PM V13 Certified Nursing Assistant stated on 11/20/24 at 6:00 PM R1 told V13 R1 had a problem with the dayshift Certified Nursing Assistants that day, R1 said R1's right side hurt because the staff had pulled on R1, and R1 was still hurting the next day. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/24 at 2:02 PM-2:20 PM V1 Administrator stated around 2:00 PM on 11/20/24 R6 said R1 reported V4 and V5 were rude to R1, expected R1 to do things for herself, and they were rough with R1. V1 stated V1 spoke with R1 and R1 reported the same things that R6 told V1. V1 stated R1 denied being fearful of V4/V5 or that they intentionally hurt R1. V1 stated V1 interviewed V4 and V5 that day, who said that R1 would not let go of the siderail while they attempted to reposition R1. V1 stated V1 was out of the facility on 11/21/24, V1 followed up with R1 on 11/22/24, and at that time R1 wanted to know why V4 and V5 weren't terminated. V1 stated at that time R1 reported that during the alleged incident R1 felt a pop in her ribs and was unable to shampoo R1's hair on 11/22/24, so V1 asked a nurse to assess R1. V1 stated on 11/22/24 at 7:08 PM V1 received a copy of V7's social media post alleging abuse of R1, and that is when V1 reported the incident to the state survey agency at 9:47 PM. V1 stated V1 did not notify the local law enforcement, V1 should have, and V1 will do that today. V1 stated V1 did not report R1's concerns on 11/20/24 because V1 felt at that time there was no abuse allegation and that it was more of a customer service issue since V1 investigated and R1 said that it wasn't intentionally done to hurt R1 and R1 was not fearful. V1 was asked what would be the expectation of staff if during cares R1 voiced to staff that the staff were intentionally hurting R1, R1 broke R1's back and ribs, and R1's rib popped. V1 confirmed this would be considered an abuse allegation. V1 stated V4 and V5 should have stopped providing R1's care and reported R1's allegation to V1. V1 was unaware that R1 made these statements during R1's care. V1 confirmed if R1's statements were reported to V1 on 11/20/24, V1 would have initiated the steps that were taken on 11/22/24.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to prevent further abuse from occurring by allowing employees (V4 and V5 Certified Nursing Assistants) unrestricted access to residents following an abuse allegation. This failure has the potential to affect 36 residents (R1, R3, R4, R5, R7-R38) of 38 residents reviewed for abuse in the sample list of 38. Findings include: The facility's Abuse Prevention, Identification, and Reporting Program Policy and Procedure dated 9/10/19 documents employees will be immediately removed from work following an allegation of abuse/mistreatment and will not be allowed to return until the investigation results have been reviewed by the administrator. On 11/25/24 at 10:03-10:20 AM R1 stated last Wednesday (11/20/24) R1 needed repositioned in bed, V4 and V5 were rough and R1 felt R1's back and ribs pop when V4 and V5 jerked R1 over in bed. R1 stated V4 and V5 yelled at R1 too. R1 stated R1 reported this to an unidentified nurse that evening. R1 stated R1 had right side pain since the incident, x-rays were completed around midnight last night, and nothing was broken. On 11/25/24 at 12:01-12:17 PM R6 stated R6 stated on 11/20/24 around 12:30 PM V19 Housekeeper said R1 wanted to speak with R6. R6 stated R1 told R6 that V4 and V5 were being very rough and abusive to R1. R6 stated R6 asked what R1 meant, and R1 said V4/V5 told R1 to turn and pulled on R1 while attempting to reposition R1 as R1 was holding onto the bed rail. R6 stated R1 said V4/V5 moved R1's legs back and R1 felt R1's back crack. R6 stated R6 reported this to V1 within 15 minutes and they went to speak to R1 together, and R1 said V4/V5 brutally hurt R1, they cussed R1 out, they were aggressive and mean to R1 as they jerked R1 around and yelled at R1. R6 stated R1's story changed and R1 denied the staff cussed at R1 when asked by V1. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact. R6's MDS dated [DATE] documents R6 as cognitively intact. R1's Concern/Compliment Form dated 11/20/24 documents R1 stated V4 and V5 were being mean, had bad attitudes, and moved R1 in a rough fashion. This form documents staff were re-educated on customer service and to remember to be nice, smile, and be patient. The facility's initial report to the Illinois Department of Public Health dated 11/22/24 documents on 11/22/24 at 7:08 PM V7 (R1's Family Member) posted on (social media platform) an allegation of abuse of R1 by V4 and V5 and the post was sent to V1 Administrator. This report documents V4 and V5 were suspended from work pending investigation results. V1's typed notes dated 11/20/24 documents that afternoon R6, resident council president, reported to V1 that R1 said V4 and V5 were rude to R1, expected R1 to do things for herself, and were rough when they repositioned R1 in bed. This note documents V1, V10 Social Services Director, and R6 spoke to R1 who voiced the same concerns as reported to R6. V1 and V2 Director of Nursing spoke with V4 and V5 who stated that R1 refused to let go of the bed rail when they attempted to reposition R1, R1 was upset and started screaming at them, and R1 kicked them out of R1's room. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V4's Time Card Report documents V4 worked on 11/20/24 from 5:57 AM until 9:59 PM, on 11/21/24 from 6:00 AM until 6:06 PM, and on 11/22/24 from 1:56 AM until 6:06 PM. V5's Time Card Report documents V5 worked on 11/20/24 from 5:57 AM until 6:13 PM. The facility's Daily Schedules dated 11/20/24, 11/21/24, and 11/22/24 document V4 and V5 worked on the Memphis (300) unit. The facility's Daily Census dated 11/24/24 document R1, R3, R4, R5, and R7-R38 reside on the 300 unit. On 11/25/24 at 11:14 AM V4 stated the Memphis unit is V4's primary unit. V4 stated around 6:00 AM on 11/20/24 R1's call light was on and R1 requested to be repositioned in bed. V4 and V5 assisted R1 with repositioning, but R1 wouldn't let go of the bed rail. V4 stated R1 needed to be scooted up in bed and V4 and V5 used a cloth pad to pull R1 up in bed. V4 stated R1 got upset with V4 and V5, you could just tell it in R1's voice that R1 was not happy with us. V4 stated V4 continued working and later that day the nurse told us that R1 no longer wanted V4 or V5 in R1's room, V4 and V5 went immediately to talk to V2 and that afternoon V1 spoke with V4 and V5 about the incident. On 11/25/24 at 11:25 AM V5 described R1's incident on 11/20/24 as described by V4. V5 stated R1 was not very happy with V4 and V5, and R1 said to V4/V5 that they were purposefully hurting R1, broke R1's back and ribs, and that R1's ribs popped. V5 stated V4/V5 stopped what they were doing, asked R1 how they could help, and exited the room to notify V11 Licensed Practical Nurse (LPN) of the situation. V5 confirmed V5 would consider R1's statements to be an abuse allegation. V5 stated that is why V5 reported to V11. V5 stated at 10:30 AM V11 said R1 no longer wanted V4 and V5 to provide R1's cares, and around 3:00 PM that day V1 and V2 discussed the incident and said this wouldn't be considered abuse that it would be considered a grievance. V5 stated V5 worked until 6:00 PM on 11/20/24 and received a call from V1 on 11/22/24 notifying of an abuse allegation and V5's suspension. On 11/25/24 at 2:02 PM-2:20 PM V1 Administrator stated around 2:00 PM on 11/20/24 R6 said R1 reported V4 and V5 were rude to R1, expected R1 to do things for herself, and they were rough with R1. V1 stated V1 spoke with R1 and R1 reported the same things that R6 told V1. V1 stated R1 denied being fearful of V4/V5 or that they intentionally hurt R1. V1 stated V1 interviewed V4 and V5 that day, who said that R1 would not let go of the siderail while they attempted to reposition R1. V1 stated on 11/22/24 at 7:08 PM V1 received a copy of V7's social media post alleging abuse of R1, and that is when V1 reported the incident to the state survey agency at 9:47 PM. V1 stated on 11/22/24 R1 told V1 that during the alleged incident R1 felt a pop in her ribs and was unable to shampoo R1's hair. V1 confirmed V4 and V5 were not suspended until the evening of 11/22/24. V1 stated V1 felt R1's concerns on 11/20/24 was not an abuse allegation and that it was more of a customer service issue since V1 investigated and R1 said that it wasn't intentionally done to hurt R1 and R1 was not fearful. V1 was asked what would be the expectation of staff if during cares R1 voiced to staff that the staff were intentionally hurting R1, R1 broke R1's back and ribs, and R1's rib popped. V1 confirmed this would be considered an abuse allegation. V1 stated V4 and V5 should have stopped providing R1's care and reported R1's allegation to V1. V1 was not aware of R1's statements made during R1's cares and confirmed if R1's statements were reported to V1 on 11/20/24 V1 would have initiated the steps implemented on 11/22/24.		