STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145977	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Shore Rehabilitation	2425 East 71st Street Chicago, IL 60649

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** 44314 Based on interviews and record reviews, the facility failed to follow their abuse policy by failing to ensure resident was safe from abuse by failing to immediately report an allegation of sexual abuse made by R4 regarding employee (V23/CNA); facility failed to protect R4 from additional abuse/trauma by allowing V23 to continue to work after R4 reported the allegation of sexual abuse to a staff member; failed to protect R4 from harm when she initially reported to CNA, prior to incident on 1/11/24 that she did not want V23 to provide care for her anymore. This affected one resident (R4) of 5 residents reviewed for physical abuse. These failures resulted in V23 re-entering resident's room after R4 made an allegation of sexual abuse against V23. R4 expressed amplified feelings of anguish and panic, in addition to the trauma R4 experienced during the alleged incident. This was identified as an immediate jeopardy situation which began on 01/11/2024. On 01/24/2024, the administrator was notified of the immediate jeopardy. The immediate jeopardy was removed on 01/26/2024. However, the deficiency remains at the second level of harm until the facility determine the effectiveness of the implementation of the removal plan. Findings include: R4's Factsheet documents R4 is a [AGE] year-old female. R4's diagnoses are but not limited to major depressive disorder, weakness, post-traumatic stress disorder, and heart failure. R4' s BIMS (Brief Interview for Mental Status) dated 12/05/2023, notes R4 has a score 0f 15, indicating R4's cognition is intact. R4' s MDS (Minimum Data Set) dated 12/05/2023, notes R4 is dependent upon staff for care. R4's Care plan (dated 09/16/2024) documents R4 has an ADL self-care performance deficit r/t impaired balance. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/11/2024, R4, a bed ridden female resident alleged V23 (certified nursing assistant) was providing incontinence care to R4. R4 alleged when V23 was cleaning R4's vaginal area, V23 inserted and penetrated R4's vagina with his fingers. R4 alleged that R4 started screaming stating V23 is hurting her and V23 needs to stop and after that R4 put on her call light. V21 (certified nursing assistant) entered R4's room while V23 was still present. R4 told V21 that V23 hurt R4 and V21 asked V23 to leave R4's room. R4 was hysterical and reported to V21 that V23 penetrated his fingers into R4's vagina and R4 does not want V23 to provide care for R4. V21 left R4's room and told R4's nurse that V20 (licensed practical nurse) R4 had something to tell her. V21 went home, failing to report sexual abuse to the administrator and R4's nurse. R4 was left alone in her room, and V23 was still in the facility. R4 reported R4 was traumatized and frantic after the incident occurred, and 15 minutes later V23 re-entered R4's room, which caused R4 to experience a panic attack and additional trauma. R4 stated about 3 weeks prior to this incident, V23 rubbed R4's face and told her she was beautiful. R4 stated she reported this to staff and told staff R4 did not want V23 to provide care for her. Staff failed to report this abuse to the administrator, which potentially could have prevented R4 from any further sexual abuse. Facility's Final Investigation Report (dated 01/19/2024) states in part: On 01/11/2024, nurse manager received a phone call from R4's husband, who stated, The guy in the room just stuck his finger in my wife's vagina. According to the husband, R4 had called him to report that information. Nurse manager immediately went to R4's room to assess R4. R4 stated to nurse manager, the male C.N.A. just put his fingers in my vagina. Reassurance was provided, police were notified as well as provider who ordered resident to be sent to the ER for evaluation. Hospital records indicate alleged she was getting washed up for the night and a male attendant was cleaning her buttocks and peri area had bowel movement between crevices and peri area when she stated the male C.N.A. stuck his fingers in her vagina for a second or two. R4 also stated she saw another staff member walking past the room during the incident and yelled for assistance. R4 states she has had care performed by V23 (C.N.A) previously with no issues or concerns. Based on a complete and thorough investigation the facility has determined the allegation of sexual abuse is unfounded. It is believed resident perceived this sensation during ADL care when R4 was pushing the brief down between her legs to begin the process of changing her. R4 remains in the facility at this time without concern and will only have care provide by female staff. Her abuse risk assessment, sexuality assessment, and ADL care plans have been updated. R4's Health Status Note (dated 1/11/2024) documents, Informed by staff member R4 was mishandled. R4's Physician note (dated 1/15/2024) documents, R4's is a [AGE] year-old female patient who presents for medical evaluation. Thursday night R4 reported sexual assault. R4 stated she was being cleaned after urinating. R4 stated V23 was rough. R4 reports there was no bowel movement, only urine. R4 said V23 stated she was beautiful. R4 told V23 to stop and called for help. R4 reports having a panic attack, and 911 was called. R4 went out to local hospital. R4 stated a swab was done, unclear where, which showed she was having some bleeding. R4 reports also having scar tissue. R4 states she had nightmares about the event. Since this event happened, R4 has had some burning with urination. R4 stated she has never had anything like this happen before but does have PTSD (post-traumatic stress disorder) from witnessing her son's murder and recently worsened depression from her cousin's death from cancer. R4 ' s Hospital Records (dated 1/12/2024) documents, R4 is being treated for a urinary tract infection. There was mild blood noted on the swab, for gonorrhea and chlamydia rape kit. There was no active bleeding. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/13/2024, at 11:05 AM, V8 (Director of Nursing) stated, In the last sixty days, there have not been any other allegations of sexual assault. The police took the alleged perpetrator, V23 (certified nursing assistant) to jail. It is protocol to call the police. V27 (Night Supervisor) was writing down V23's statement. V27 called me and stated V23 had been arrested. I came in and the detectives arrested him. I thought they were going to release V23 that night. I just heard yesterday V23 was still incarcerated. I found out from one of his friends V23 is still in jail. R4 is alert and oriented. I interviewed R4. R4 told me she turned on her call light because she was wet. V23 came into the room. She told V23 she was wet. V23 asked her if she was wet. V23 went to go get a towel. V23 started to clean R4 up. V23 started washing up underneath her abdomen. As he was washing her, V23 stated she was dirty. She told V23 it was urine. V23 started to clean R4's vaginal area. While V23 was cleaning R4, V23 was explaining to R4 what V23 was doing. I also asked R4 if the door was open or closed. She stated it was open. R4 said V23 began cleaning her vagina area and inserted his fingers into her vagina area. R4 stated 'you're hurting me'. V23 said, I am trying to clean you. R4 stated she did not see a towel while V23 was doing this. V23 did have gloves on. R4 started screaming for V21 (Certified Nursing Assistant). V21 came into the room. R4 told V21 that V23 was hurting her. V21 said V21 asked V23 to leave. R4 asked V21 to put lotion on her legs. Then, R4 told V21 she does not want V23 cleaning her up. R4 told V21 that V23 put his hands in her vagina. V21 went to tell V20 (Licensed Practical Nurse) something was going on with R4 and V20 needed to follow up. R4 called her husband. The husband called the facility and spoke with V27 (Night Supervisor). V27 activated the abuse protocol. V27 called me, the police, and separated V23 to write V23's statement. V27 told me V23 was arrested. V21 stated about 9:30 PM, she was coming back upstairs from her locker. V21 was on her way to make sure R4 was alright before she left the facility. When V21 came up, V21 saw the linen cart in front of R4's room. V21 went into the room and V23 was adjusting R4 in bed. V21 did not hear any yelling in the hallway. I had social services go talk to other residents. Previously, I was told by R4 that V23 had rubbed her face and stated she was beautiful. R4 told her husband but does not recall if she mentioned this to a staff member. I have not had any other allegations from other residents concerning V23. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/13/2024, at 12:40 PM, R4 stated, It did not start yesterday. It started about a week ago. V23 always in came in my room and stated I was a beautiful young lady. He told me you're so beautiful my sister and started rubbing my face. I told him not to do it. Every time V23 came in my room, I told another aide I did not want him. But that day I did not have a choice. He did not knock before coming into my room. He came in my room, and I told him I was wet. He said I am going to change you. He asked if I had a bowel movement. I told him I urinated. He said I want you to be clean and smell good. I told him I do smell good. He got a towel and wiped under my belly. He told me I was dirty. I told him it is just urine. Then, he cleaned me between my legs on both sides. He said again I am dirty. I told him again is just urine. Then, he washed between the creases of my vagina. He did not use a towel; he threw it on the side. He put his fingers in my vagina and penetrated me. I started hollering. I screamed it hurt. I have a urinary tract infection as well. It hurt bad. After that, I saw another aide. I told V21 to come in. V21 asked me what was wrong. I told V21 that V23 touched me, and I started screaming and hollering. V21 told V23 to get out of my room. V23 said he did not do anything. I told V21 that V23 hurt me, and I had a panic attack. I called my husband because I was on the phone with my niece. My niece said call 911. My family came. The facility notified my family of the incident. The police came and V23 was in the waiting room. The police said let's arrest V23 before he leaves. V23 tried to come back in. I started screaming and the nurses came running in. I could not stop crying. The ambulance took me to the hospital. They did a swab and found out I was bleeding. V23 had penetrated me a bit. The hospital stated that after the swab I was bleeding. I have had a hysterectomy and I have not had a period in years. My husband does not touch me either. The detectives asked me piece by piece what V23 did. I am disabled and over 60. I am totally dependent, and I have a wheelchair. I had a very bad stroke because I saw my son get shot seven times in front of me. The police came and arrested V23. The detective interviewed my son in law. The staff were going to clean me up, but the police told them not to. My bed was still soaking wet because V23 did not clean me. The police asked me if I wanted V23 arrested, and I said yes. I did not have a roommate during this time. I was in the room by myself. I have had nightmares because I cannot have any men change me. I get scared and urinate all over myself. My family is looking for another facility. On 1/13/2024, at 2:00 PM, V26 (R4's Family Member) stated, R4 declined a rape kit. She stated the gentleman had gloves. I told her it did not matter. That is when the officer called on the portable radio to transfer R4 to do the rape kit. The officer left. All these people came in to ask if she was ok. I told the nurse she was not going to clean R4 up because R4 was going to the hospital and needed evidence. The nurse told me V23 (certified nursing assistant) came into the room to clean her. V23 told R4 she was pretty and rubbed on her face. When V23 went to clean R4, V23 told R4 that R4 had to be extra clean and inserted his fingers into R4. After this occurred, V23 was able to come back into the room to linger over R4 and tell R4 that V23 did not do anything to R4. I did not see anything but R4 called me and told me this happened. This is what R4 told me on the phone, and I called the facility and reported this to the night shift supervisor. On 1/13/2024, at 2:32 PM, V20 (Licensed Practical Nurse) stated, I was working the day this allegation occurred. I was working on the same floor as R4. I was her nurse for the day. She did not tell me anything. She reported this to V27 (Night Supervisor) and V28 (Staffing Coordinator) came up the elevator. V27 asked me if R4 was alert and oriented, I stated yes. I said R4 stated someone raped her. V27 and V28 went to go interview R4. I asked her if I could examine her. The family was there. When I attempted, the police stated I could not because the ambulance was on the way. The police called the fire department. R4 is alert and oriented. V27 informed me R4 was raped. This is what I meant by mishandled because I do not use words like that. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/17/2024, at 2:21 PM, V21 stated, I did not hear R4 screaming. R4 never reported to me she did not want V23 not to be her aide before the incident occurred. On 1/13/2024, at 2:39 PM, V21 (certified nursing assistant) stated, V23 was R4's aide the day of the allegation. I did not witness anything. But I did answer her (R4's) call light because she saw me walk by. When I got back on R4's unit, there was a cart by her door. I assumed she did not need changing. It was almost time to go home. I went to check on R4 to make sure she was alright. V23 was already done cleaning her up. I was wondering if V23 needed any help in there. I put some lotion on R4's legs. She asked where V23 was at. She told me V23 had fingered her. I said the nurse is right behind me. The nurse is coming in to give you your medication. When I walked out, I told V20 that R4 had something to tell her. After that, I went home. R4 is alert and oriented. On 1/17/2024, at 9:34 AM, V27 (night supervisor) stated, R4's husband told me to go see her (R4) right away. When I got there, she was hysterical. She told me during incontinence care, she felt uncomfortable with the way she was being changed. I went to see who was attending to her. I separated V23 from her to prevent harm. She pointed towards her incontinence brief. She stated the way she was wiped was inappropriate. She stated V23 was wiping her up and down and said that she was beautiful at the same time. She did not tell me V23 had penetrated her. I asked V23 for a statement, but he never gave me one. I have had no other complaints from any other residents about V23. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/17/2024, at 11:49 AM, V23 (certified nursing assistant) stated, I was covering day from 2:00 PM to 10:00 PM. The schedule was for me to work on the second floor. The assignment given to me by the charge nurse was to cover rooms . Just like all other residents in my care, I must make sure they are clean and dry. Mostly, by changing their diaper. I got to R4's room because the call light was on. I started attending to her. I asked her if she was ready to be changed. She said yes. My cart and my dirty linen cart were close to her room. I took the necessary material to her room. I soaked the towels and added some soap to water. The temperature must be ok before attending to her. Normally, I must start from the front. Her stomach was extended, and she helped me to lift her stomach so I could clean it. When I cleaned her, I showed her that she was clean. I cleaned between where her legs and torso meet down to her leg. I showed her just for her to know she is clean. There are reports residents say they are not cleaned well. That is why I did all of this. Next, I rolled her incontinence brief down before I started cleaning. I cleaned from her abdominal all the way down to the front of her vagina. I dried her with the other side of the towel at every step of the cleaning. I could not get the soiled brief off until after she rolled over. I cleaned the back of her buttocks. She cooperated with turning. I gave her a boost to turn. She did not complain of anything. I cleaned her buttock. I cleaned from the clean to dirtiest as I was taught. That was all I did. As I was cleaning, she had a very small bowel movement. I did not see this when I was cleaning the front. I cleaned her everywhere. When I remove the dirty incontinence brief, I noticed the bed pad was wet as well. Even it is not wet, she had been on it for some time. I needed to change it. I changed it along with the brief. That was all I did. I closed the new brief on both sides. There was no complaint or screaming and I left. I had no other staff because she only requires one person because she can be cooperative with care. When I was cleaning her, I did not stick my fingers inside of her vagina at all. I did not touch her inappropriately in any way. This was not the first time I had taken care of her. She did not complain. More than three weeks ago, I saw her crying. I asked her what the problem was. I encouraged her not to cry. That was all. I did not touch her face. I patted her on the arm. I did not mean any harm to her; just to encourage her. I did not touch her on the face or anything. On the day of the allegation, I was doing my charting in the dining room. Before that, V27 called me, she came with another person. I was trying to let V28 (Staffing Coordinator) know it would be good for them to have four aides on the floor at a time because the floor is too heavy. I did not know something was going on. After some time, V28 called me and told me there was a complaint against me. The husband called the police. V28 told me to continue my charting in the dining room. The police came. They arrested me there and took me away. The police asked me to get up and they handcuffed me to the back. They took me to a police station. I was there for some hours. I was taken to another police station. They told me it was the second district. They searched me. I was in jail from the 11th until the 13th. They told me there was no charge against me. On the second day, two detectives came. They took me upstairs in a room. They wanted to interrogate me. They read some of my rights to me including taking a lawyer. On 1/17/2024, at 1:30 PM, V8 (Director of Nursing) stated, The detective informed me the alleged perpetrators are held for 48 hours and then they are let go. When I talked to R4, she told me she could not recall reporting the face rubbing to anyone. She reported to the detective as well. V23 has been taking care of her for a while and she has never reported anything like this to staff before. If she had reported this, V23 would not have been taking care of her. Currently, R4 does have a urinary tract infection. Some burning and bleeding may occur. On 1/17/2024, at 1:55 PM, R4 stated, I do not remember names of the staff I talked to about the face touching. I do not remember what staff member I said I did not want V23 to be my aide before the incident occurred. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/17/2024, at 2:57 PM, V28 (Staff Coordinator) stated, V27 and I knocked on the door and went in the room. R4 was in the room lying in bed. I came in and asked her what was going on. She said V23 was fingering her. I asked her what you mean fingering you? Was V23 in the process of cleaning you? She stated he was, but he started fingering me. I asked if he stopped when you asked him. She said that he stopped. I said he is the aide, are you sure it was fingering or cleaning? Do you think he was cleaning you because you had a bowel movement. She said no he was fingering me. She made a [NAME] with her finger of him going in and out of her vagina. I looked at V27 and told her we must call V1 (Administrator). We let V1 know, and we did not leave. At this time, we noticed R4's call light was next to her. I asked her if she put her call light on in the process of this. She said no. She said she called her husband. She never pulled the call light or told us. The husband called the facility and told us. She said she called her husband. I told her the call light is next to her and it is to alert us. We told her he would not be back. We told him not to go by her room or in it. At this time, were coming down the elevator. The receptionist stated the police were coming. V27 called V1 and the V8. The police did not come right away. I have not heard any complaints from the residents about V23. On 1/18/2024, at 9:21 AM, V29 (Police Detective) stated, If a victim has signed complaint, then the offender can be placed into custody. This is not new; this can happen at any point. Police hold them for 72 hours before the alleged perpetrator is in front of a judge. On 01/22/2024 at 10:01am V1 (Administrator) stated, I am the abuse prevention coordinator. All facility employees receive abuse prevention training upon hire and as needed. When a resident reports being sexually abused, we have to make sure the alleged perpetrator is not around. For instance, when a resident says an alleged perpetrator sexually abused them, we have to immediately remove the alleged perpetrator from the premises. After that, we have to assess the victim. The nurse on duty must assess the resident and do the interview of what occurred. The nurse must determine who needs to be called, for example the law enforcement, determine if the resident needs to be sent to the hospital, family and physician notification. The investigation process must be started immediately, and we must make sure the resident is safe. Staff must report the abuse allegation immediately to me. When a resident reports being sexually abused by a staff member, and the perpetrator leaves the victims room, the alleged perpetrator must be sent home immediately, the perpetrator must leave the facility immediately and be suspended immediately so the resident was abused feels safe. The alleged perpetrator is never allowed to re-enter the victims room. The alleged perpetrator is never allowed to continue to work once the abuse is reported. The alleged perpetrator is not allowed to keep working once abuse was reported and they must leave the facility and they are immediately removed from the schedule. When R4 reported being sexually assaulted, they removed the staff member and R4 was sent to the hospital. V23 (certified nursing assistant/alleged perpetrator) was not immediately sent home by the staff, he was removed from the facility by the police. Per the facility police, the perpetrator should have been sent home immediately, but he was not, he was removed from the building by the police. We don't allow the alleged perpetrator to continue to work. When a resident reports abuse, it is the responsibility of the person who the victim reported the abuse to, to report the abuse allegation to me. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/22/2024 at 11:12am V8 (Director of Nursing) stated, The event occurred on 01/11/2024 and the detectives returned to the facility the next day and interviewed R4. R4 stated R4 never had a problem with V23 (certified nursing assistant) in the past except R4 stated to the detectives V23 rubbed her face and called her beautiful in the past and she reported this to her husband and a staff member, but she could not remember who the staff member was. R4 could not remember for sure if R4 reported the face rubbing to a staff member. On 01/11/2024, V27 (night supervisor) received a call from R4's husband informing V27 R4 was sexually abused. When V27 received the call from the husband, V27 rushed to the 2nd floor to interview the resident. R4's nurse on duty, V20, did not assess R4 because V20 was not made aware of the sexual abuse allegation. V27 assessed and interviewed R4 after R4's husband notified her the alleged abuse occurred. V20 (licensed nurse practitioner) did not assess or interview R4 the time R4 reported the incident. V27 was notified by R4's husband the incident occurred and then V27 went to interview R4. Police removed V23 from the facility, because R4's husband called the police and reported the sexual abuse allegation. On 01/22/2024 at 11:20am V30 (social worker) stated, I have been following up with R4. R4 has not expressed any anxiety or any feeling of distress. I follow up with R4 and she says she is fine and she's doing good. R4 wants to discharge to another facility so she can be close to her son. R4 is doing good, and we have been following up with her since the incident occurred on 01/11/2024. Abuse Prevention Policy (undated) states: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Internal Reporting Requirement and Identification of Allegations; Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or the designated individual in the administrator's absence. The surveyor confirmed through observation, interview, and record review the facility took the following actions to remove the Immediate Jeopardy: 1. On 01/24/2024, V1 (Administrator) informed surveyor V23 (certified nursing assistant/alleged perpetrator) no longer works in the facility. R4 remains in-house, having her needs met without further concern. V1 stated R4 receives care from female staff to ensure R4's safety and comfort. 2. The social service and nurse managers have conducted a comprehensive review to identify other residents who may be at risk for abuse. The staff conducted interviews of residents and staff to determine if there have been other residents who were affected by the alleged perpetrator or any other staff. 3. On 01/24/2024, the administrator and the director of nursing started reeducating/ in-servicing staff on how to effectively respond to allegations of abuse and maintain the safety of residents by immediately removing the accused person from the facility and not allow the accused to return into the facility until a thorough investigation is completed. 4. On 01/24/2024, staff were in-serviced on the importance of reporting allegations in detail for immediate intervention, including prompt notification to family/responsible parties, physicians and Np's, and police. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145977	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Shore Rehabilitation	2425 East 71st Street Chicago, IL 60649

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(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	5. On 01/24/2024, the facility started providing an in-service and training to in-house staff, agency nurses and agency certified nursing assistants and PRN staff regarding abuse, abuse prevention and reporting, emphasizing on the importance of immediately removing the alleged perpetrator with no re-access to the floors and specific focus on reporting detailed information on what is alleged. The in-service was completed on 01/25/2024. 6. The new hires will be educated during the core orientation process, prior to starting. If unable to reach the employee, the employee will not be allowed to return to work until education is completed. 7. V21 (certified nursing assistant) received 1:1 education regarding abuse, abuse prevention and immediate detailed reporting. Based on observation, interview, and record reviews conducted on 01/26/2024, the facility completed all measures on the abatement plan. Therefore, the abatement plan could be approved on 01/25/2024.