

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Colonial Manor Nursing & Rehabilitation Home		STREET ADDRESS, CITY, STATE, ZIP CODE 307 Foster Street Rayville, LA 71269	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41829</p> <p>Based on observation and interviews, the facility failed to treat each resident with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 (#1) of 3 (#1, #2, #3) sampled residents reviewed. This failed practice occurred when S4Certified Nursing Assistant (CNA) did not assist resident #1 to the restroom after resident #1 requested to go to the restroom.</p> <p>Findings:</p> <p>Record review revealed resident #1 was admitted to the facility on [DATE] with diagnoses that included dementia unspecified severity with anxiety, encephalopathy unspecified, chronic systolic congestive heart failure, chronic obstructive pulmonary disease with acute exacerbation, seizures, insomnia, generalized muscle weakness, other lack of coordination, other abnormalities of gait and mobility, major depressive disorder recurrent, essential hypertension, atrial fibrillation, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, aphasia following cerebral infarction, needs for assistance with personal care, and cognitive communication deficit.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 01 which indicated resident #1 was severely cognitively impaired for daily decision making. Further review revealed resident #1 required limited physical assistance by one staff with bed mobility, transfers, eating, and toilet use. Resident #1 was occasionally incontinent of bowel and bladder. Resident #1 was unable to walk and used manual wheelchair for ambulation.</p> <p>Further record review revealed resident #1 had an active care plan care for self-care and mobility deficit and required assistance from staff with bathing, dressing, feeding, hygiene, and toileting. Intervention included to provide resident #1 with assistance with Activities of Daily Living (ADLs) as needed.</p> <p>During an interview on 09/23/2024 at 12:05 p.m., resident #1's family member reported she had reviewed the video camera footage from resident #1's room and observed S4CNA refuse to take resident #1 to the bathroom and told her to go ahead and use it or hold it because she was wearing a brief.</p> <p>Resident #1's family member allowed surveyor to review the video footage recordings on her cell phone. The video footage included audio and were dated and time stamped with the start of each video.</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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the video recordings revealed the following: On 08/26/2024 around 4:30 a.m., resident #1 was lying in the bed and S4CNA was noted to tell resident #1, better not get your butt back up as she covered resident #1's lower extremities and torso with a blanket. Resident #1 was noted to say, I need to go to the bathroom. S4CNA was noted tell resident #1, you have a pamper on, go ahead and use it or just hold it.</p> <p>On 09/24/2024 at 12:40 p.m., an interview with S1Administrator confirmed S4CNA should have assisted resident #1 to the rest room after resident #1 reported she needed to go to the bathroom. S1Administrator further confirmed S4CNA should not have told resident #1 to go ahead and use it because she was wearing a brief or to just hold it.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<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** 41829</p> <p>Based on observation, record review and interviews, the facility failed to protect the residents' right to be free from verbal and physical abuse and psychosocial harm by staff for 1 (#1) of 3 (#1, #2, #3) sampled residents.</p> <p>The actual harm resulted for resident #1, who was cognitively impaired, on 08/26/2024 at 2:28 a.m. when S4 Certified Nursing Assistant (CNA) was observed being verbally and physically abusive to resident #1 while providing care. Resident #1's family member observed S4CNA being verbally and physically abusive to resident #1 while reviewing video surveillance camera footage.</p> <p>Because this type of inappropriate, unwanted verbal and physical abuse would reasonably cause anyone to have 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 verbal and physical abuse.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be Past Noncompliance citation.</p> <p>Findings:</p> <p>Review of the facility's Abuse, Neglect and Exploitation Policy, dated 07/31/2024, revealed in-part:</p> <p>Policy: It is the policy of this facility to provide for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>Definitions:</p> <p>Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychological well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.</p> <p>Physical Abuse includes, but not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment.</p> <p>Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging or derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.</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>Record review revealed resident #1 was admitted to the facility 12/29/2023 with diagnoses that included dementia unspecified severity with anxiety, encephalopathy unspecified, chronic systolic congestive heart failure, chronic obstructive pulmonary disease with acute exacerbation, seizures, insomnia, generalized muscle weakness, other lack of coordination, other abnormalities of gait and mobility, major depressive disorder recurrent, essential hypertension, atrial fibrillation, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, aphasia following cerebral infarction, needs for assistance with personal care, and cognitive communication deficit.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 01 which indicated resident #1 was severely cognitive impaired for daily decision making. Further review revealed resident #1 required limited physical assistance by one staff with bed mobility, transfers, eating, and toilet use. Resident #1 was occasionally incontinent of bowel and bladder. Resident #1 was unable to walk and used manual wheelchair for ambulation.</p> <p>Review of the facility's investigation documentation of the 08/26/2024 incident revealed a summary of events that included: On Tuesday 08/27/2024 around 4:00 p.m. resident #1's family member came to the facility and informed S1Administrator and S2Assistant Administrator about S4CNA mistreating resident #1 while providing care during the early morning hours of 08/26/2024. Resident #1's family member reported she actually saw the incident on the camera footage from resident #1' room on the night of 08/26/2024, but she did not come to us immediately because she needed to take some time to herself. At this point it is Tuesday afternoon when she brought the footage to us. S1Admininstrator and S2Asssistant Administrator viewed the video footage from resident #1's family member's cell phone. The footage showed S4CNA in the room with resident #1. Resident #1was sitting in her wheelchair and S4CNA told her she was going to fall out of the chair if she didn't sit up more. S4CNA help to pull her up in the chair a couple of times. S4CNA then went on to tell resident #1 she was going to put her in the bed. It appeared, based on body language that resident #1 did not want to go to bed. S4CNA proceeded to use the front arm rest to push the wheelchair and resident #1. Resident #1 placed her hands on top of S4CNA's hands (on the arm rest of the wheelchair). S4CNA repeatedly stated, Get your hands off of me. S4CNA said this while pushing the wheelchair towards the bed. Resident #1 then lifts her foot up towards S4CNA's leg and S4CNA tells resident #1 not to kick her and she better not kick her. At this point resident #1 is holding her foot up between them. S4CNA proceeds to state, if you kick me I am going to beat your ass. S4CNA then gets resident #1 to the bedside and is telling her to stand up and get in the bed. Resident #1 doesn't appear to try to get up. S4CNA then lifts her to sit her on the side of bed. At this time resident #1 does not attempt to lay back. S4CNA tries to lay her down herself, but resident #1 still does not move. S4CNA then picks up resident #1's legs and quickly swings them around onto the bed to lay her down causing resident #1 to fall back into the bed/wall area. Resident #1 then speaks up and says a string of curse words that were hard to understand from the footage, but she was clearly upset based on the tone and words she used. S4CNA then told her to stay in the bed. S4CNA continued to cover her up with blankets after checking her brief to be sure it was dry. S4CNA then went back to the chair near the door and sat down. Nothing seems to happen further until closer to the end of S4CNA's shift. Resident #1 appears to want to go to the bathroom and S4CNA tells her to do it since she has a brief on. Resident #1 can be transferred to the toilet, although it is difficult for her, it is possible.</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>During an interview on 09/23/2024 at 12:05 p.m., resident #1's family member revealed there are 2 video cameras in resident #1's room which are motion activated. Resident #1's family member reported last Monday night (08/26/2024) she reviewed the video camera footage that was sent to an app on her cell phone. Resident #1's family member report she did not like how S4CNA treated resident #1 during the early hours of 08/26/2024. Resident #1's family member revealed she did not notify anyone at the facility until, 08/27/2024 at 4:00 p.m., when she met with S1Administrator and S2Assistant Administrator and showed them the video recordings of how S4CNA treated resident #1. Resident #1's family member reported they fired S4CNA. Resident #1's family member allowed surveyor to review the video footage recordings on her cell phone. The video footage included audio and were dated and time stamped with the start of each video.</p> <p>Review of the video recordings revealed the following: On 08/26/2024 at 2:28 a.m., resident #1 was sitting in manual wheelchair and S4CNA was in resident #1's room providing 1:1 observation. S4CNA tells resident #1, Get your butt over in that bed and stay in it. S4CNA was noted to be pushing resident #1's wheelchair backwards by holding on to the front wheelchair armrest. Resident #1 placed her hands on top of S4CNA's hands that were on the wheelchair armrest. S4CNA was noted to repeatedly tell resident #1 Get your hands off me. Resident #1 raised her left foot up off the foot rest and extended slowly towards S4CNA's legs. S4CNA was noted to repeatedly tell resident #1 don't you kick me as S4CNA was pushing resident #1 backwards in her manual wheelchair to the bed. Resident #1 raised her left leg up to put distance between them. S4CNA was noted to tell resident #1, woman if you kick me I will beat your ass, get up. S4CNA then stated, trying to help you and you trying to act stupid, gonna get you in the bed and you gonna stay there. S4CNA positioned the wheelchair next to the bed and stated, you want to get in the bed or not. Resident #1 did not appear to want to go to bed. S4CNA was noted to reposition resident #1 up in the wheelchair and allowed her to stay in the wheelchair and continued to provide 1:1 monitoring. Resident #1 did not attempt to hit or kick S4CNA.</p> <p>On 08/26/2024 at 4:12 a.m., S4CNA was noted to tell resident #1, sit up you, you gonna fall out of the wheelchair as she physically assisted resident #1 up in the wheelchair by lifting resident #1 under her arms. Resident #1 was noted to say, Leave me alone.</p> <p>On 08/26/2024 at 4:27 a.m., S4CNA positioned resident #1's wheelchair against her bed and assisted resident #1 to a standing position by holding on to her left arm. S4CNA was noted to tell resident #1, Sit down, don't you feel better now you are in bed. Resident #1 had sat upright on the side of the bed with her feet resting on the floor. S4CNA was noted to yell at resident #1, lay down!</p> <p>On 08/26/2024 at 4:28 a.m., S4CNA was noted to yell at resident #1 again, lay down as S4CNA physically pushed back resident #1's left shoulder to get her to lay down in the bed. Resident #1 did not appear to want to lay down and did not lay back. S4CNA was observed to grab resident #1 by the ankles and forcefully lifted them up and put both of her lower extremities in the bed. This caused resident #1 to fall backward on the left side of the bed and resident #1 was noted to hit her left/back side of her head against the cinder block wall located next to the bed. Resident #1 responded by saying, you son of a bitch. S4CNA was noted to tell resident #1, better not get your butt back up as she covered resident #1's lower extremities and torso with a blanket. At 4:30 a.m. S4CNA is noted to check resident #1 brief to see if she was wet. Resident #1 is noted to say, I need to go to the bathroom. S4CNA was noted tell resident #1, you have a pamper on, go ahead and use it or just hold it.</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>During an interview on 09/25/2024 at 1:25 p.m., S1Administrator confirmed S4CNA verbally and physically abused resident #1. S1Administrator further confirmed a reasonable person would have become very upset being treated the way S4CNA treated resident #1.</p> <p>During the survey, in-service records, S4CNA employee file, resident (BIMS >7 and BIMS<7) assessments for abuse and neglect, resident progress notes, resident skin assessments, resident council minutes, Quality Assurance (QA) monitoring records were reviewed along with interviews with staff and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility.</p> <p>The facility implemented the following actions to correct the deficient practice with the completion date of 09/05/2024:</p> <ul style="list-style-type: none"> -S4CNA was terminated on 08/27/2024. -All Staff education/in-service on Abuse/Neglect Policy and Procedure was completed on 08/28/2024. -Resident interviews for potential abuse or neglect completed weekly for 2 weeks -BIMS of 8 or above (indicating moderately impaired cognition to cognitively intact) interview for all residents in building completed 08/28/2024 and 09/05/2025. -Residents who are in the hospital on 08/29/2024 completed on return 08/30/2024. -BIMS of 7 or lower (indicating severe cognitive impairment) verbally completed 08/28/2024 with resident/staff. -BIMS of 7 or lower completed and progress note entered completed 09/04/2024. -QA Agenda updated to include Abuse/Neglect Training and Resident Monitoring (Added to 3rd Quarter meeting 08/28/2024) -Resident Council Meeting Agenda updated for Resident Rights/Abuse/Neglect Reporting. -Residents in Council Meeting educated on Abuse/Neglect and how to report to if necessary was completed 09/04/2024. -Resident Body Assessments Completed 08/29/2024 and 09/05/2024 -All of the above monitoring for completion by S1Administrator and S2Assistant Administrator with completion date 09/05/2024, no evidence of abuse found, verified by documentation. -Continued Future Monitoring for Plan of Correction as follows will be verified by S1Administrator, S2Assistant Administrator, or designee: <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>-Resident Interviews/Education for potential abuse or neglect to be completed once quarterly; Residents with BIMS 8 and above written interviews, Residents with BIMS of 7 or below behavior notes/Staff monitoring in progress notes (October 2024 - December 2024, January 2025 - March 2025, April 2025 - June 2025 and July 2025 - September 2025).</p> <p>-Staff/Resident In-Service Education to be provided monthly on the Abuse/Neglect policy and reporting procedures:</p> <p>-Monthly in-services for Staff beginning September 2024 and will continue each month until August 2025</p> <p>-Monthly Resident council meetings will review and educate residents on abuse, neglect, and resident right policies beginning September 2024 and will continue each month until August 2025</p> <p>-Resident Interviews, Staff in-services, and Resident Council Minutes will be provided as part of QA quarterly meeting agenda beginning August 2024 (3rd quarter 2024) and continue through September 2025 (3rd quarter 2025).</p> <p>-Resident skin assessments are completed weekly on all residents and will continue to be completed weekly and are verified by treatment nurse, S6Licensed Practical Nurse (LPN), or designee. These will be monitored for any specific changes related to potential abuse or neglect through August 2025.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41829</p> <p>Based on record review and interviews, the provider failed to ensure an alleged violation involving verbal and physical abuse that was reported to the Administrator by resident #1's family member was reported immediately, but no later than 2 hours after being made aware, to the State Survey Agency in accordance with State Laws for 1 (#1) of 3 (#1, #2, #3) sampled residents.</p> <p>Findings:</p> <p>Review of the facility's Abuse, Neglect and Exploitation Policy, dated 07/31/2024, revealed in-part:</p> <p>Policy: It is the policy of this facility to provide for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>Definitions:</p> <p>Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychological well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.</p> <p>Physical Abuse includes, but not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment.</p> <p>Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging or derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.</p> <p>Reporting/Response</p> <p>A. The facility will have written procedures that include:</p> <p>1. Reporting of all alleged violations to the administrator, state agency, adult protection services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes:</p> <p>a. Immediately, but no later than 2 hours after the allegation is made, if the event that cause the allegation involve abuse or result in serious bodily injury, or</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>Record review revealed resident #1 was admitted to the facility on [DATE] with diagnoses that included dementia unspecified severity with anxiety, encephalopathy unspecified, chronic systolic congestive heart failure, chronic obstructive pulmonary disease with acute exacerbation, seizures, insomnia, generalized muscle weakness, other lack of coordination, other abnormalities of gait and mobility, major depressive disorder recurrent, essential hypertension, atrial fibrillation, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, aphasia following cerebral infarction, needs for assistance with personal care, and cognitive communication deficit.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 01 which indicated resident #1 was severely cognitive impaired for daily decision making. Further review revealed resident #1 required limited physical assistance by one staff with bed mobility, transfers, eating, and toilet use. Resident #1 was occasionally incontinent of bowel and bladder. Resident #1 was unable to walk and used manual wheelchair for ambulation.</p> <p>During an interview on 09/23/2024 at 9:30 a.m., S1Administrator revealed resident #1's family member came to the facility on [DATE] at 4:00 p.m. and informed her and S2Assistant Administrator that she did not like how S4 Certified Nursing Assistant (CNA) treated resident #1 while providing care during the early hours of 08/26/2024. Resident #1's family member reported S4CNA made rude comments and handled resident #1 roughly while she performed her care. S1Administrator and S2Assistant Administrator viewed the video footage dated 08/26/2024 from 2 video cameras placed in resident #1's room by the family on resident #1's family member's cell phone.</p> <p>Review of the dated and time stamped video recordings revealed the following:</p> <p>On 08/26/2024 at 2:28 a.m., resident #1 was sitting in manual wheelchair and S4CNA was in resident #1's room providing 1:1 observation. S4CNA tells resident #1, Get your butt over in that bed and stay in it. S4CNA was noted to be pushing resident #1's wheelchair backwards by holding on to the front wheelchair armrest. Resident #1 placed her hands on top of S4CNA's hands that were on the wheelchair armrest. S4CNA was noted to repeatedly tell resident #1 Get your hands off me. Resident #1 raised her left foot up off the foot rest and extended slowly towards S4CNA's legs. S4CNA was noted to repeatedly tell resident #1 don't you kick me as S4CNA was pushing resident #1 backwards in her manual wheelchair to the bed. Resident #1 raised her left leg up to put distance between them. S4CNA was noted to tell resident #1, woman if you kick me I will beat your ass, get up. S4CNA then stated, trying to help you and you trying to act stupid, gonna get you in the bed and you gonna stay there. S4CNA positioned the wheelchair next to the bed and stated, you want to get in the bed or not. Resident #1 did not appear to want to go to bed. S4CNA was noted to reposition resident #1 up in the wheelchair and allowed her to stay in the wheelchair and continued to provide 1:1 monitoring. Resident #1 did not attempt to hit or kick S4CNA.</p> <p>On 08/26/2024 at 4:12 a.m., S4CNA was noted to tell resident #1, sit up you, you gonna fall out of the wheelchair as she physically assisted resident #1 up in the wheelchair by lifting resident #1 under her arms. Resident #1 was noted to say, Leave me alone.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/26/2024 at 4:27 a.m., S4CNA positioned resident #1's wheelchair against her bed and assisted resident #1 to a standing position by holding on to her left arm. S4CNA was noted to tell resident #1, Sit down, don't you feel better now you are in bed. Resident #1 had sat upright on the side of the bed with her feet resting on the floor. S4CNA was noted to yell at resident #1, lay down!</p> <p>On 08/26/2024 at 4:28 a.m., S4CNA was noted to yell at resident #1 again, lay down as S4CNA physically pushed back resident #1's left shoulder to get her to lay down in the bed. Resident #1 did not appear to want to lay down and did not lay back. S4CNA was observed to grab resident #1 by the ankles and forcefully lifted them up and put both of her lower extremities in the bed. This caused resident #1 to fall backward on the left side of the bed and resident #1 was noted to hit her left/back side of her head against the cinder block wall located next to the bed. Resident #1 responded by saying, you son of a bitch. S4CNA was noted to tell resident #1, better not get your butt back up as she covered resident #1's lower extremities and torso with a blanket.</p> <p>During an interview on 09/25/2024 at 1:25 p.m., S1Administrator confirmed S4CNA verbally and physically abused resident #1 on 08/26/2024.</p> <p>Review of the incident investigation report to State Survey Agency revealed S1Aministrator submitted the report on 08/28/2024 at 5:51 p.m. The incident occurred on 08/26/2024 at 3:30 a.m. The incident was discovered on 08/27/2024 at 4:00 p.m.</p> <p>On 09/24/2024 at 12:32 p.m., an interview with S1Administrator confirmed she did not submit the incident investigation report to the State Survey Agency until 08/28/2024 at 5:51 p.m. and not within 2 hours of being informed of the alleged abuse allegation.</p>