STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195406	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor Nursing and Rehab Ctr, LLC	1411 Claiborne Avenue Shreveport, LA 71103

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 36921 Based on surveillance video and interviews, the facility failed to treat and care for each resident in a manner that promotes dignity and enhancement of his or her quality of life for 1 (#1) resident of 3 (#1, #2, #3) residents reviewed for abuse. S6 CNA (Certified Nurse Assistant) provided care to Resident #1 in a hurried manner, spoke to Resident #1 in a disrespectful manner and talked to other staff about Resident #1. The facility implemented corrective actions which were completed prior to the State Agency's investigation entry on 03/31/2025. It was determined to be a Past Noncompliance Citation. Findings: Review of Resident #1's room surveillance video on 04/01/2025 at 3:00 p.m. provided by Resident #1's family memeber's cellphone with Resident #1's family member who was present revealed: Surveillance video clip started on 02/12/2025 at 2:04 p.m. with a duration of about 5 minutes. At the start of the video S6 CNA walked passed the camera and stated; Just nothing else better to do; Just nothing else better to do. S8 CNA moved the overbed table and attempted to try to remove the cup of juice from Resident #1's right hand. S6 CNA then attempted to remove the cup of juice from Resident #1's right hand. Resident #1 moved hand away with the cup of juice in hand. S6 CNA then told Resident #1 waste it; I don't care; I don't have nothing to do with that. S6 CNA then walked out of the view of the camera. S8 CNA then moved the covers back and Resident #1 gave S8 CNA the cup of juice. S6 CNA removed linens from under Resident #1's right leg forcefully. Resident #1 was hollering you're hurting me. CNA staff was not touching Resident #1. Further review of surveillance video revealed S6 CNA continued to talk and carry on a conversation when S5 ADON (Assistant Director of Nursing) came to the door to check on the care of Resident #1. S6 CNA told S5 ADON that Resident #1 liked to fight; that's why I stopped helping other CNAs with him. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	While S6 CNA bathed Resident #1, S8 CNA asked for Resident #1's hand and called Resident #1's name. S6 CNA stood back and made hand gestures and all of sudden said I got to go; I got to get out of here. Resident #1's hand was on the side rail and S6 CNA removed Resident #1's hand and turned Resident #1 to the left side to remove the brief. Review of Resident #1's March 2025 Physician Orders revealed: 08/09/2024: Turning and repositioning program: Turn and reposition every 2 hours and as needed. 01/16/2025: incontinence care: Check for incontinence at least every two hours. Cleanse peri area/buttocks with Remedy essentials, cleanse, pat dry, apply Remedy prevent silicone cream as a preventative maintenance. Review of Resident #1's Care Plan revealed in part, Resident #1 had impaired physical mobility, had a self-care deficit, and was resistive to care related to anxiety with interventions to use draw sheet only per family request for turning and repositioning. During a telephone interview on 04/02/2025 at 11:00 a.m., S6 CNA reported becoming overwhelmed with the job. S6 CNA confirmed rushing while providing care for Resident #1, talking about Resident #1 to other staff while providing care, and speaking to Resident #1 in a disrespectful manner was a dignity issue. During an interview on 04/02/2025 at 9:27 a.m., S3 DON (Director of Nursing) reported when CNA staff provided care for Resident #1 they should talk in resident's eye view, should not converse among themselves while giving care, and care should not be provided in a hurried manner. S3 DON confirmed S6 CNA appeared agitated, care was carried out in a hurried manner, the manner in which S6 CNA spoke to Resident #1 and when S6 CNA talked about the resident while providing care was a dignity issue. During an interview on 04/03/2025 at 10:30 a.m., S1 Administrator reported care and monitoring for Resident #1 are reviewed daily in the facility's quality assurance meeting. On 04/03/2025 at 11:00 a.m., S2 Assistant Administrator presented the facility's QA (Quality Assurance) daily meetings from 02/14/2025 through 03/31/2025. Review of facility's QA meeting note revealed Resident #1's care concerns, grievances and issues with nursing and incident on 02/13/2025. During the survey, in-service records and QA monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility. Beginning on 02/13/2025, the facility implemented the following actions to correct the deficient practice with a completion date of 02/25/2025: Incident investigation report started on 02/13/2025. Review of Resident #1's incident investigation report folder and corroborated with S9 Corporate Nurse revealed: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/13/2025 at 3:25 p.m., Resident #1's family member shared a video clip of CNAs providing care and stated the CNA was rough with his arm. The video was time stamped 02/12/2025. On 02/13/2025: S6 CNA was suspended from facility pending outcome of the investigation and Resident #1 was assessed and all the residents on Hall B were assessed. On 02/13/2025: Inservice on abuse/neglect and burnout initiated and continued on shift to shift for all staff. On 02/14/2025: Baseline interviews were started with all staff members regarding alleged/actual abuse-staff interview to verifiy that the staff knew who to report abuse to and if they were aware of any abuse allegations or actual abuse situations. On 02/14/2025: physician made aware of allegation and body audit of Resident #1. On 02/20/2025: Inservices on how to respond to the aggressive resident during care were initiated to licensed and unlicensed nursing staff and continued throughout all shifts by nursing administration. On 02/25/2025: Personnel action presented to S6 CNA - stated she was rushing while providing care to Resident #1 and did not slow down so he could understand the directions to decrease behaviors. She had been suspended from 02/13/2025 until 02/24/2025 and was moved to another hall because the abuse allegation was not substantiated with the information given in the videoclip provided by the family on 02/13/2025. On 02/25/2025: A care monitor reviewing dignity and privacy was initiated by S3 DON to monitor compliance from previous inservices and baseline interview.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 36921 Based on record review, surveillance video review and interviews, the facility failed to protect the resident's right to be free from physical, verbal abuse and psychosocial harm by a staff member for 1 (#1) of 3 (#1, #2, #3) residents reviewed for abuse. The actual harm occurred for Resident #1, who was cognitively impaired, on 02/13/2025 at 8:32 a.m. when S6 CNA (Certified Nurse Assistant) was observed on surveillance video verbally and physically abusing Resident #1 while providing care. Physical abuse occurred when S6 CNA pulled down on Resident #1's left contracted leg, forcefully snatched Resident #1's right arm from the right side rail and pushed Resident #1's right arm towards him, then snatched the diaper off Resident #1. Verbal abuse occurred when S6 CNA cursed at Resident #1 saying, God d-mn it and D-mn. While S6 CNA provided incontinent care, S6 CNA stated, I can't do this anymore, I refuse to do this ever again, you trying to hurt me. It can be determined a reasonable person would not expect that they would be harmed in his own home or a health care facility and would experience psychosocial harm - dehumanization and humiliation as a result of the verbal and physical abuse. The facility implemented corrective actions which were completed prior to the State Agency's investigation entry on 03/31/2025. It was determined to be a Past Noncompliance Citation. Findings: Review of the facility's Abuse/Neglect Policy with a revision date of 03/20/2025 revealed in part: Purpose: The purpose of the Abuse/neglect policy is to comply with the seven-step approach to abuse and neglect detection and prevention: 1. Screening 2. Training 3. Prevention 4. Identification 5. Investigation 6. Protection 7. Reporting and Response (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Policy: It is the policy of the facility that each resident will be free from abuse. This facility will not condone any form of resident abuse. Each resident residing in this facility has the right to be free from verbal, sexual, mental and physical abuse, including corporal punishment and involuntary seclusion, and use of photographs or recordings in any manner that would demean or humiliate a resident(s). Resident must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, family members or legal guardians, friends or other individuals. Each resident also has the right to be free from mistreatment, neglect, and misappropriation of property. Physical abuse includes hitting, slapping, pinching, biting, and kicking. It also includes controlling behavior through corporal punishment. Alleged violation - is the terminology used when a verbal allegation of resident abuse, neglect, or misappropriation of resident property has been made either by a resident, family member, visitor or employee. An alleged violation may also be triggered by an observation of an injury of unknown origin (i.e., bruise or skin tear) that the resident or staff member cannot explain. Mistreatment means inappropriate treatment or exploitation of a resident. Review of Resident #1's room surveillance video with audio was viewed on Resident #1's sister cellphone with Resident #1's sister present. The surveillance video clip started on 02/13/2025 at 8:32 a.m. with a duration of about 5 minutes and revealed the following: S6 CNA could be seen pulling down on Resident #1's left contracted leg and Resident #1 could be heard saying, That hurt me. Two voices, male and female, could be heard saying, God d-mn it, God d-mn it and S6 CNA stated, D-mn. Then S6 CNA forcefully snatched Resident #1's right arm from the right side rail and pushed Resident #1's right arm towards him. S7 CNA was holding him over and Resident #1 could be heard saying, You are not going to pull me out, you are not going to pull me out. S6 CNA said, I'm not and snatched diaper off of Resident #1. While S6 CNA provided incontinent care she said, I can't do this anymore. Resident #1 stated, I'm sorry if I hurt your feelings, I'm sorry if I hurt your feelings, I'm sorry if I hurt your feelings. S6 CNA then stated, I refuse to do this ever again, you trying to hurt me. Review of Resident #1's medical record revealed the following diagnoses but not limited to neurological conditions, hemiplegia following cerebral infraction affecting left non-dominant side, non-Alzheimer's dementia, anxiety disorder, bipolar disorder, schizophrenia, metabolic encephalopathy, muscle wasting and atrophy, to the left shoulder, right lower leg, and left thigh, age related cognitive decline, insomnia, and adjustment disorder with anxiety. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Quarterly and State Optional MDS (Minimum Data Set) assessment date 01/08/2025 revealed a BIMS (Brief Interview of Mental Status) of 99; indicating resident was unable to complete the interview. Further review revealed Resident #1 required extensive assistance with two person physical assist for bed mobility, transfer and was always incontinent of urine and bowel. Review of Resident #1's March 2025 Physician Orders revealed: 08/09/2024: Turning and repositioning program: Turn and reposition every 2 hours and as needed. 01/16/2025: incontinence care: Check for incontinence at least every two hours. Cleanse Peri area/buttocks with remedy essentials cleanse, Pat dry, apply Remedy prevent silicone cream as a preventative maintenance. Review of Resident #1's Care Plan revealed in part, Resident #1 had impaired physical mobility, had a self-care deficit, and was resistive to care related anxiety - with interventions to use draw sheet only - per family request for turning and repositioning. During an interview on 04/01/2025 at 2:35 p.m., Resident #1's sister reported the surveillance video on 02/13/2025 at 8:32 a.m. revealed S6 CNA manhandled Resident #1 while providing care and she would call that abuse. During a telephone interview on 04/02/2025 at 11:00 a.m., S6 CNA reported she was not Resident #1's primary CNA and she assisted other CNAs with ADL (activities of daily living) care as he was a two person assist with everything except feeding. S6 CNA reported in the video she was assisting S7 CNA with morning care. S6 CNA reported trying to loosen Resident #1 fingers off the rail. S6 CNA reported the video was edited and did not show when he grabbed her hand and she tried to loosen his grip. During a telephone interview on 04/01/2025 at 2:30 p.m., S7 CNA reported Resident #1 was a two person assist with all ADLs, but was able to feed self. S7 CNA reported she received in-service/training on identifying rough handling, yelling, and cursing during patient care was considered abuse and S6 CNA should have been reported immediately to the Administrator. During an interview on 04/02/2025 at 4:40 p.m., S1 Administrator reported on 03/14/2025 Resident #1's sister made an allegation of abuse of her brother (Resident #1) that occurred on 02/13/2025 during morning care and she had a video. S1 Administrator reported an investigation was started for alleged abuse on 03/14/2025. S1Administrator requested the video from Resident #1's sister and on 03/15/2025 about noon (around lunch) Resident #1's s sister provided the video to S3 DON (Director of Nursing). S1 Administrator reported on 03/15/2025 he watched the video from 02/13/2025 of S6 CNA and S7 CNA with Resident #1 and it revealed S6 CNA was rough with Resident #1 while providing care and abuse was substantiated. S1 Administrator reported S6 CNA was suspended on 03/14/2025 and was terminated on 03/17/2025. During an interview on 04/03/2025 at 10:30 a.m., S1 Administrator reported care and monitoring for Resident #1 are reviewed daily in the facility's quality assurance meeting. On 04/03/2025 at 11:00 a.m., S2 Assistant Administrator presented the facility's QA (Quality Assurance) daily meetings from 02/14/2025 through 03/31/2025. Review of facility's QA meeting note revealed Resident #1's care concerns, grievances and issues with nursing and incident on 02/13/2025. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During the survey, in-service records and QA monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility. Beginning on 03/14/2025, the facility implemented the following actions to correct the deficient practice with a completion date of 03/21/2025: Incident investigation report started on 03/14/2025. Review of Resident #1's incident investigation report folder and corroborated with S9 Corporate Nurse revealed: On 03/14/2025 at 12:10 p.m., Resident #1's sister made an allegation that Resident #1 was abused during care, incident investigation report started within two hours of an allegation of abuse. On 03/14/2025: S6 CNA was suspended from facility and residents on Hall A were assessed and interviewed by administrative nursing team members for injuries. S6 CNA had not provided care for Resident #1 since 02/13/2025. On 03/14/2025: S3 DON notified physician of the allegation of abuse. In-services on 03/14/2025 on Abuse and Neglect-define abuse, verbal abuse, report, baseline staff interviews were initiated regarding abuse and neglect. On 03/17/2025: the Police were notified and police report initiated. On 03/17/2025: S6 CNA was terminated, S7 CNA reviewed video of care on 02/13/2025 and reeducated on abuse. On 03/18/2025: Inservice on removing residents' hands off the assist handles - you cannot pry (forcefully remove) the residents' hands off assist handles. Do not bend fingers back. Do not grab the arm. On 03/20/2025: Revision to Abuse policy #5 Investigation and Protection when there is a witnessed or alleged abuse event. On 03/21/2025: In-service on reporting abuse/investigation and protection/employee interview and workplace violence. On 03/21/2025: Baseline employee questionnaire was implemented regarding the changes to the policy/procedure of resident protection. Plan of action and/or return demonstration by S3 DON revealed after reviewing the video with S7 CNA, retraining on abuse was provided on 03/17/2025. S3 DON and S7 CNA discussed grabbing residents hand off the assist handle was considered physical abuse and if S6 CNA was the person cursing in the video that was considered verbal abuse. This should be reported immediately. S7 CNA verbalized understanding and signed on 03/18/2025. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Post Event Sustained Monitoring-alleged/inappropriate physical encounter 03/15/2025 through 03/27/2025. QAPI (Quality Assurance and Performance Improvement) monitoring Staff/resident Interview Post event sustained monitoring-alleged/inappropriate physical encounter from 02/24/2025 through 03/27/2025-3x week for 6 weeks in an effort to sustain facility compliance related to alleged/inappropriate physical abuse encounters at the facility, monthly thereafter. Negative findings will be addressed by facility administration immediately with plan of action in place. Effectiveness of this QAPI will be discussed weekly in QA minutes for 6 weeks as well. Monitoring: Employee interview: protection of the resident with new guidelines 03/21/2025 through 03/27/2025. Date facility asserts the likelihood for serious harm to any resident no longer exists: 03/21/2025.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 36921 Based on record reviews, surveillance video review and interviews, the facility failed to implement policies and procedures to ensure an allegation of abuse was reported to administration in a timely manner per the facility's policy for 1 (#1) of 3 (#1, #2, #3) residents reviewed for abuse. S7 CNA (Certified Nurse Assistant) failed to recognize and report physical and verbal abuse during incontinent care provided by S6 CNA. The facility implemented corrective actions which were completed prior to the State Agency's investigation entry on 03/31/2025. It was determined to be a Past Noncompliance Citation. Findings: Review of facility's Abuse/Neglect Policy with a revision date of 03/20/2025 revealed in part: Purpose: The purpose of the Abuse/Neglect policy is to comply with the seven-step approach to abuse and neglect detection and prevention. Policy: It is the policy of the facility that each resident will be free from abuse. This facility will not condone any form of resident abuse. Each resident residing in this facility has the right to be free from verbal, sexual, mental and physical abuse . Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, family members or legal guardians, friends or other individuals. Each resident also has the right to be free from mistreatment, neglect, and misappropriation of property. Physical abuse includes hitting, slapping, pinching, biting, and kicking. It also includes controlling behavior through corporal punishment. Alleged violation is the terminology used when a verbal allegation of resident abuse, neglect, or misappropriation of resident property has been made either by a resident, family member, visitor or employee. An alleged violation may also be triggered by an observation of an injury of unknown origin (i.e., bruise or skin tear) that the resident or staff member cannot explain. Mistreatment means inappropriate treatment or exploitation of a resident. Immediately means as soon as possible, but ought not to exceed 24 hours after discovery of the incident, in the absence of a shorter State time frame requirement. *Immediately for purposes of reporting a crime resulting in serious body injury means covered individual shall report immediately, but no more than 2 hours after forming the suspicion. 6. Reporting and Response It is the policy of this facility that abuse allegations (abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Internal Reporting: a. Employees must always report any abuse or suspension of abuse immediately to the Administrator or his or her designee of the facility . Review of Resident #1's medical record revealed the following diagnoses but not limited to neurological conditions, hemiplegia following cerebral infraction affecting left non-dominant side, non-Alzheimer's dementia, anxiety disorder, bipolar disorder, schizophrenia, metabolic encephalopathy, muscle wasting and atrophy, to the left shoulder, right lower leg, and left thigh, age related cognitive decline, insomnia, and adjustment disorder with anxiety. Review of Resident #1's Quarterly and State Optional MDS (Minimum Data Set) assessments dated 01/08/2025 revealed a BIMS (Brief Interview of Mental Status) of 99; indicating Resident #1 was unable to complete the interview. Further review of Resident #1's Quarterly and State Optional MDS assessments revealed Resident #1 required extensive assistance with two person physical assist for bed mobility, and transfer and was always incontinent of bladder and bowel. Review of Resident #1's March 2025 Physician Orders revealed: 08/09/2024: Turning and repositioning program: Turn and reposition every 2 hours and as needed. 01/16/2025: incontinence care: Check for incontinence at least every two hours. Cleanse peri area/buttocks with Remedy essentials, cleanse, pat dry, apply Remedy prevent silicone cream as a preventative maintenance. Review of Resident #1's Care Plan revealed in part, Resident #1 had impaired physical mobility, had a self-care deficit, and was resistive to care related to anxiety with interventions to use draw sheet only per family request for turning and repositioning. Review of Resident #1's room surveillance video with audio was viewed on Resident #1's sister cellphone with Resident #1's sister present. The surveillance video clip started on 02/13/2025 at 8:32 a.m. with a duration of about 5 minutes and revealed the following: S6 CNA could be seen pulling down on Resident #1's left contracted leg and Resident #1 could be heard saying, That hurt me. Two voices, male and female, could be heard saying, God d-mn it, God d-mn it and S6 CNA stated, D-mn. Then S6 CNA forcefully snatched Resident #1's right arm from the right side rail and pushed Resident #1's right arm towards him. S7 CNA was holding him over and Resident #1 could be heard saying, You are not going to pull me out, you are not going to pull me out. S6 CNA said, I'm not and snatched diaper off of Resident #1. While S6 CNA provided incontinent care she said, I can't do this anymore. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1 stated, I'm sorry if I hurt your feelings, I'm sorry if I hurt your feelings, I'm sorry if I hurt your feelings. S6 CNA then stated, I refuse to do this ever again, you trying to hurt me. During a telephone interview on 04/01/2025 at 2:30 p.m., S7 CNA reported after receiving an in-service/training on identifying rough handling, yelling and cursing during patient care was considered abuse, S7 CNA should have reported S6 CNA immediately to the Administrator. During an interview on 04/02/2025 at 4:40 p.m., S1 Administrator reported on 03/15/2025 he watched the video from 02/13/2025 of S6 CNA and S7 CNA with Resident #1 and it revealed S6 CNA was rough with Resident #1 while providing care and abuse was substantiated. S1 Administrator reported S6 CNA was suspended on 03/14/2025 and was terminated on 03/17/2025. During an interview on 04/03/2025 at 10:30 a.m., S1 Administrator reported care and monitoring for Resident #1 are reviewed daily in the facility's quality assurance meeting. On 04/03/2025 at 11:00 a.m., S2 Assistant Administrator presented the facility's QA (Quality Assurance) daily meetings from 02/14/2025 through 03/31/2025. Review of facility's QA meeting note revealed Resident #1's care concerns, grievances and issues with nursing and the incident on 02/13/2025. During the survey, in-service records and QA monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility. Beginning on 03/14/2025, the facility implemented the following actions to correct the deficient practice with a completion date of 03/21/2025: Incident investigation report started on 03/14/2025. Review of Resident #1's incident investigation report folder and corroborated with S9 Corporate Nurse revealed: On 03/14/2025 at 12:10 p.m., Resident #1's sister made an allegation that Resident #1 was abused during care, incident investigation report started within two hours of an allegation of abuse. On 03/14/2025: S6 CNA was suspended from facility and residents on Hall A were assessed and interviewed by administrative nursing team members for injuries. S6 CNA had not provided care for Resident #1 since 02/13/2025. On 03/14/2025: S3 DON notified physician of the allegation of abuse. In-services on 03/14/2025 on Abuse and Neglect-define abuse, verbal abuse, report, baseline staff interviews were initiated regarding abuse and neglect. On 03/17/2025: the Police were notified and police report initiated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195406	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor Nursing and Rehab Ctr, LLC	1411 Claiborne Avenue Shreveport, LA 71103

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/17/2025: S6 CNA was terminated, S7 CNA reviewed video of care on 02/13/2025 and reeducated on abuse. On 03/18/2025: Inservice on removing residents' hands off the assist handles - you cannot pry (forcefully remove) the residents' hands off assist handles. Do not bend fingers back. Do not grab the arm. On 03/20/2025: Revision to Abuse policy #5 Investigation and Protection when there is a witnessed or alleged abuse event. On 03/21/2025: In-service on reporting abuse/investigation and protection/employee interview and workplace violence. On 03/21/2025: Baseline employee questionnaire was implemented regarding the changes to the policy/procedure of resident protection. Plan of action and/or return demonstration by S3 DON revealed after reviewing the video with S7 CNA, retraining on abuse was provided on 03/17/2025. S3 DON and S7 CNA discussed grabbing residents hand off the assist handle was considered physical abuse and if S6 CNA was the person cursing in the video that was considered verbal abuse. This should be reported immediately. S7 CNA verbalized understanding and signed on 03/18/2025. Post Event Sustained Monitoring-alleged/inappropriate physical encounter 03/15/2025 through 03/27/2025. QAPI (Quality Assurance and Performance Improvement) monitoring Staff/resident Interview Post event sustained monitoring-alleged/inappropriate physical encounter from 02/24/2025 through 03/27/2025-3x week for 6 weeks in an effort to sustain facility compliance related to alleged/inappropriate physical abuse encounters at the facility, monthly thereafter. Negative findings will be addressed by facility administration immediately with plan of action in place. Effectiveness of this QAPI will be discussed weekly in QA minutes for 6 weeks as well. Monitoring: Employee interview: protection of the resident with new guidelines 03/21/2025 through 03/27/2025. The facility implemented corrective actions which were completed prior to the State Agency's investigation entry on 03/31/2025. It was determined to be a Past Noncompliance Citation.