STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235224	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lenawee Medical Care Facility	200 Sand Creek Highway Adrian, MI 49221

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake 2997912.Based on observations/interviews and record review, the facility failed to preserve the dignity and right to make choices including the refusal of care for one resident (Resident #2) of three reviewed. Findings include:Review of Resident #2's (R2) clinical record, including the Minimum Data Set, dated [DATE] revealed R2 was an [AGE] year old male admitted to the facility on [DATE] with diagnoses of dementia, heart failure and adult failure to thrive. R2 scored 99 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS) and was receiving hospice care. Review of R2's behavior care plan that was in place on 4/18/26, dated 01/02/26 identified R2 was resistant to care and could be combative with caregivers. R2's behavior care plan interventions in place on 4/18/26 included: approach slowly and identify yourself prior to initiating care, provide calming sensory interventions such as music, hand fidget, comfort items. Use calm, respectful and reassuring communication. Use non-verbal cues (smiling, nodding, gentle gestures). Use short simple, one step at a time directions. Due to R2's cognition and inability to be interviewed, the reasonable person standard will be used for this citation. Review of the facility reported incident dated 4/18/26 at 06:50 pm, revealed that Licensed Practical Nurse (LPN) I notified Quality Assurance Manager (QAM) D via phone about an allegation of abuse that occurred at 10:40 am that day. It was reported that Certified Nursing Assistant (CNA) G was in training and was paired with CNA E and F. CNA G made the allegation that CNA E and CNA F held R2 down and gave him Titty Twisters. A Titty Twister is known to the general public as the act of pinching and twisting a person's nipple roughly to inflict pain. Review of the witness statement dated 4/20/26 with CNA G conducted by Director of Nursing (DON) B, Human Resources (HR) J and QAM D. CNA G stated that on 4/18/26 at approximately 10:30 am, prior to entering R2's room, CNA E warned CNA G that R2 was combative with care and upon entering the room R2 was lying in bed in preparation to have a brief change, and CNA F was already in the room. CNA G reported CNA E pushed on R2's shoulders to position R2 and that was when he began to get combative and refused to open his legs for care. CNA G then stated CNA E restricted R2's arms and CNA F held R2's legs. CNA G elaborated that she questioned CNA E about their methods of restraining R2 while providing care in which the CNA E replied that is how we have to do it. The written interview statement then reflected that at approximately 1:00 to 1:30 pm while sitting at the nurses' station with R2 and CNA E, CNA E said Titty Twister then performed the action on R2. CNA G statement revealed R2 looked surprised by CNA E's action. Review of the witness statement dated 4/20/26 with CNA E, conducted by DON B, HR J and QAM D, CNA E reported that on 4/18/26 at 10:30 am CNA F was already in the room and R2 needed his brief changed. The written statement reflected R2 was combative during care despite explaining care and that in her experience staff often have to hold him down to complete care due to R2's combative behavior. CNA E elaborated holding R2 down was for R2s safety and staff safety. According to the written statement when CNA E was question about the Titty Twister CNA E stated that was clearly a joke and denied making physical contact. Review of the witness statement dated 4/20/26 with CNA F, conducted by DON B, HR J and QAM D, CNA E reported that on 4/18/26 at 10:30 am she reported R2 became (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	combative during care, but care was required so she held R2's legs while CNA E restricted R2's arms.Review of witness statement dated 4/20/26 with Housekeeper H she reported she witnessed CNA E and CNA G at the nurses' station with R2. Housekeeper H stated while cleaning a room she could hear laughing at the nurses' station and overheard a comment, she then exited the room and asked about the comment that was made and CNA E replied Titty Twister.On 5/12/26 during an interview with QAM D she provided an untitled packet of papers that alleged the facility was in compliance as of 5/01/26, however the packet provided did not determine what the facility's deficient practice was. On 5/13/26 an updated and untitled packet of papers was provided and alleged a compliance date of 5/13/26 with F tag 600 though the written packet did not determine what type of abuse was inflicted upon R2. The information in part reflected CNA E and F were suspended pending investigation and prior to returning to work, the staff directly involved (CNA E and CNA F) were educated on professional boundaries, abuse prevention, resident rights, and appropriate management of combative residents without the use of force or restraint. On 5/12/26 at 1:49 pm, during an interview with CNA E she readily admitted that it was routine practice to restrain R2 during care. CNA E reported this was a normal standard and it was how everybody takes care of R2. CNA E elaborated on how terrible R2's behaviors are, that management knows about R2's behaviors and nobody does anything, thus they (staff) have no other choice but to hold him down. CNA E elaborated she was familiar with all the federal regulations and that staff are required to provide care and that is what they do. CNA E went on to say that she knows her rights and she has the right to work in an abuse free environment. Stating that staff only hold R2's arms and legs to protective themselves, again repeating staff has the right to work in a safe environment. Adding, in CNA Es opinion it was not safe and management was not doing anything about it. When quired if staff enlisted assistance from the Nurse, CNA E stated no. When queried if they tried leaving R2 alone and reapproaching him after R2 settle down, CNA E stated no. CNA E reiterated she knew the regulations and if she left R2 alone that would be neglect. When queried if R2 had the right to refuse care, CNA E said she had to provide care, and it was R2 right to not to be neglected. When CNA E was queried about giving R2 a Titty Twister CNA E reported she never physically touched R2. When it was explained this surveyor watched the video, CNA E then stated Well it was just a joke! When quired if using the reasonable person standard if touching another person's breast, male or female without consent then laughing would be as humiliating or degrading? CNA E repeated it was just a joke. Using the reasonable person standard, having your breast fondled, being laughed at by your caregivers is not promoting dignity, respect or a joke.During an interview with CNA G on 5/12/26 at 2:31pm, CNA G stated 4/18/26 was her third day in orientation and she was shadowing CNA E, CNA G stated while on the way to R2's room CNA E was complaining about how hard it was to take care of R2 and how R2 always fights them. CNA G stated R2 was on the bed and CNA F was already in the room and CNA E started the interaction being aggressive as if she were preparing for R2 to be aggressive in return. CNA G said she was just there to observe and learn and she the witnessed CNA E stern fully and forcefully take R2 by the shoulders and push down on R2 on the bed. CNA G stated after that interaction R2 became angry and was yelling, cussing and trying to hit and kick at them. CNA G stated CNA E held R2's arms down while CNA F held his legs. CNA G stated the interaction was crazy and she did not know what to do. CNA G said then a few hours later while sitting at the nurses' station with R2 and CNA E you could feel the tension between R2 and CNA E. CNA G stated R2 and CNA E were across from CNA G. CNA G stated at this time out of nowhere CNA E started laughing and yelled Titty Twister and then completed the action. CNA G stated CNA E was laughing and R2 looked shocked and then smiled. CNA G stated she gave a nervous laugh because the whole day CNA G felt confused and awkward. CNA G elaborated that later that day R2 went into another resident room and took their scarfs, at which time she reported she observed CNA E yank the scarfs out of R2's hands, R2 in turn replied Give me my s**t back and CNA E responded It's not your s**t and walked away. CNA G stated all of this was reported to a panel of people whom she had already given a statement to a few days after this happened. Using (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the reasonable person standard, it would not be acceptable behavior for a caregiver to yank items from a resident and use profanity foul language with a resident. On 5/13/26 at 9:53am during an interview with CNA F she reported she barely remembered anything about 4/18/26 aside from being suspended. CNA F stated it was a normal day, and her partner (CNA E) had an orientee with her (CNA G). CNA F stated they got transferred to the dementia unit unwillingly a few months ago and R2 was his normal aggressive self. CNA F elaborated they have to hold R2 down because he fights, kicks and spits at them. When queried if the asked the Nurse for assistance, CNA F stated no, there was no reason to get the nurse. Stating her and CNA E could handle it. When queried why they didn't stop the interaction, since R2's was trying to refuse services, CNA F stated they had to provide care and that was how they always did it. During a phone interview on 5/13/26 at 10:17 am, with Housekeeper H she reported she observed R2, CNA E and CNA G sitting at the nurses' station on 4/18/26, while entering a nearby room she was going to clean. Housekeeper H stated she thought she overheard CNA E say something pretty inappropriate followed by laughter, Housekeeper H stated she stepped out of the room and asked CNA E what did you say?' and CNA E replied Titty Twister and erupted in laughter again. Housekeeper H stated I guess I did hear it right the first time. On 5/12/26 at 1:00 pm, during an interview with QAM D she reported she conducted the investigation in collaboration with other management staff such as DON B and HR J and the facility's Abuse Prevention Coordinator /Nursing Home Administrator A. QAM D stated the facility did confirm that physical abuse had occurred. At this time, camera/video footage was viewed, the footage was dated 4/18/2026 and showed R2, and CNA E and CNA G sitting at the Nurses station. The footage showed CNA E touching and tickling R2's breast. Due to the angel of the camera and the fact that R2 wore a cowboy hat, R2's facial expression was difficult to read. Of note, there was no audio to the video. QAM D was queried about the video she agreed using the reasonable person standard it would be humiliating to be touched like that and laughed at. QAM D also acknowledged that R2 had the right to refuse care. Although record review of CNA E and CNA F files reflected education on professional boundaries, abuse prevention, resident rights, and appropriate management of combative residents without the use of force or restraint. CNA E and CNA F have failed to apply, implement and demonstrate an understanding of what they had been taught. On 5/13/26 at 12:25 pm during an interview with NHA A identified herself as the abuse prevention coordinator, QAM D participated in the interview the facility reported incident was reviewed. NHA A and QAM D agreed abuse had occurred.

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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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake 2997912.Based on observations/interviews and record review, the facility failed to protect the resident's right to be free from of physical and mental abuse perpetrated by staff for one resident (Resident #2) of three reviewed. Resulting in R2 being abused by staff. Findings include:Review of Resident #2's (R2) clinical record, including the Minimum Data Set, dated [DATE] revealed R2 was an [AGE] year old male admitted to the facility on [DATE] with diagnoses of dementia, heart failure and adult failure to thrive. R2 scored 99 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS) and received hospice care. Review of R2's behavior care plan that was in place on 4/18/26, dated 01/02/26 identified R2 was resistant to care and could be combative with caregivers. R2's behavior care plan interventions in place on 4/18/26 included: approach slowly and identify yourself prior to initiating care, provide calming sensory interventions such as music, hand fidget, comfort items. Use calm, respectful and reassuring communication. Use non-verbal cues (smiling, nodding, gentle gestures). Use short simple, one step at a time directions. Review of the resident hospice care plans and hospice resident notes did not reflect any interventions that physical restraint was to be utilized when providing cares. Due to R2's cognition and inability to be interviewed, the reasonable person standard will be used for this citation. Abuse, is defined at S483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. 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 psychosocial 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. Neglect, as defined at S483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Sexual abuse, is defined at S483.5 as non-consensual sexual contact of any type with a resident. Willful, as defined at S483.5 in the definition of abuse, and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Review of the facility reported incident dated 4/18/26 at 06:50 pm, revealed that Licensed Practical Nurse (LPN) I notified Quality Assurance Manager (QAM) D via phone about an allegation of abuse that occurred at 10:40 am that day. It was reported that Certified Nursing Assistant (CNA) G was in training and was paired with CNA E and F. CNA G made the allegation that CNA E and CNA F held R2 down and gave him Titty Twisters. A Titty Twister is known to the general public as the act of pinching and twisting a person's nipple roughly to inflict pain. The allegation became reported due a group chat amongst new employees, the group chat reflected CNA G was disturbed by a series of events that she witnessed on 4/18/26 that involved R2, CNA E and CNA F. Review of the witness statement dated 4/20/26 with CNA G conducted by Director of Nursing (DON) B, Human Resources (HR) J and QAM D. CNA G stated that on 4/18/26 at approximately 10:30 am, prior to entering R2's room, CNA E warned her that R2 was combative with care and upon entering the room R2 was lying in bed in preparation to have a brief change, and CNA F was already in the room. CNA G reported CNA E pushed on R2's shoulders to position R2 and that was when he began to get combative and refused to open his legs for care. CNA G then stated CNA E restricted R2's arms and CNA F held R2's legs. CNA G elaborated that she questioned CNA E about their methods of restraining R2 while providing care in which the CNA E replied that is how we have to do it. The written interview statement then reflected that at approximately 1:00 to 1:30 pm while sitting at the nurses' station with R2 and CNA E , CNA E said Titty Twister then performed the action on R2. CNA G statement revealed R2 looked surprised by CNA E's action. Review of the witness statement dated 4/20/26 with CNA E, conducted by DON B, HR (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	J and QAM D, CNA E reported that on 4/18/26 at 10:30 am CNA F was already in the room and R2 needed his brief changed. The written statement reflected R2 was combative during care despite explaining care and that in her experience staff often have to hold him down to complete care due to R2's combative behavior. CNA E elaborated holding R2 down was for R2s safety and staff safety. According to the written statement when CNA E was question about the Titty Twister CNA E stated that was clearly a joke and denied making physical contact. Review of the witness statement dated 4/20/26 with CNA F, conducted by DON B, HR J and QAM D, CNA E reported that on 4/18/26 at 10:30 am she reported R2 became combative during care, but care was required so she held R2's legs while CNA E restricted R2's arms.Review of witness statement dated 4/20/26 with Housekeeper H she reported she witnessed CNA E and CNA G at the nurses' station with R2. Housekeeper H stated while cleaning a room she could hear laughing at the nurses' station and overheard a comment, she then exited the room and asked about the comment that was made and CNA E replied Titty Twister.On 5/12/26 at 1:00 pm, during an interview with QAM D she reported she conducted the investigation in collaboration with other management staff such as DON B and HR J and the facility's Abuse Prevention Coordinator /Nursing Home Administrator A. QAM D stated the facility did confirm that abuse had occurred. When queried what type of abuse was verified, QAM D stated physical and humiliation/mental. At this time, camera/video footage was viewed, the footage was dated 4/18/2026 and showed R2, and CNA E and CNA G sitting at the Nurses station. The footage showed CNA E fondling R2's right breast. Due to the angel of the camera and the fact that R2 wore a cowboy hat, R2's facial expression was difficult to read. Of note, there was no audio to the video. QAM D provided an untitled packet of papers that alleged the facility was in compliance as of 5/01/26, however the packet provided did not determine what the facility's deficient practice was. On 5/13/26 an updated and untitled packet of papers was provided and alleged a compliance date of 5/13/26 with F tag 600 though the written packet did not determine what type of abuse was inflicted upon R2. The information in part reflected CNA E and F were suspended pending investigation and prior to returning to work, the staff directly involved (CNA E and CNA F) were educated on professional boundaries, abuse prevention, resident rights, and appropriate management of combative residents without the use of force or restraint.On 5/12/26 at 1:49 pm, during an interview with CNA E she readily admitted that it was routine practice to restrain R2 during care. CNA E reported this was a normal standard and it was how everybody takes care of R2. CNA E elaborated on how terrible R2's behaviors are, that management knows about R2's behaviors and nobody does anything, thus they (staff) have no other choice but to hold him down. CNA E elaborated she was familiar with all the federal regulations and that staff are required to provide care and that is what they do. CNA E went on to say that she knows her rights and she has the right to work in an abuse free environment. Stating that the staff only restrain R2's arms and legs to protect themselves, again repeating staff has the right to work in a safe environment. Stating in CNA Es opinion it was not safe and management was not doing anything about it. When quired if staff enlisted assistance from the Nurse, CNA E stated no. When queried if they tried leaving R2 alone and reapproaching him after R2 settle down, CNA E stated no. CNA E reiterated she knew the regulations and if she left R2 alone that would be neglect. When queried if she referenced R2's care plan or Kardex for approaches, CNA E stated R2 did not have any behavior interventions in place on 4/18 or today.At this time CNA E and this surveyor went to R2's room. R2 was resting in bed, made eye contact but did not speak upon approach. CNA E went to R2's closet and there was a Kardex in place that listed approaches on how to care for and what approaches to try when/if R2 becomes combative. When queried about the Kardex again, CNA E stated someone must have just put it in R2's closet. When queried about restraining R2 for care, CNA E again reverted back to that was how they provided care to R2 based on R2's actions/behavior. CNA E stated she had the right to work in a nonviolent atmosphere. When CNA E was queried about giving R2 a Titty Twister CNA E reported she never touched R2. When it was explained this surveyor watched the video from 4/18/26, CNA E then stated Well it was just a joke! When queried if CNA E thought it was acceptable (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	to restrain a resident to provide care, CNA E stated absolutely. Again, CNA E reiterated how she needed to keep herself safe and had no other alternative. Using the reasonable person standard, a cognitively intact person would not find it acceptable to be held down during care, nor would the reasonable person find it funny or a joke to have their breast fondled and then laughed at by staff. During an interview with CNA G on 5/12/26 at 2:31pm, CNA G stated 4/18/26 was her third day in orientation and she was shadowing CNA E, CNA G stated while on the way to R2's room CNA E was complaining about how hard it was to take care of R2 and how R2 always fights them. CNA G stated R2 was on the bed and CNA F was already in the room and CNA E started the interaction being aggressive as if she were preparing for R2 to be aggressive in return. CNA G said she was just there to observe and learn and she the witnessed CNA E stern fully and forcefully take R2 by the shoulders and push down on R2 on the bed. CNA G stated after that interaction R2 became angry and was yelling, cussing and trying to hit and kick at them. CNA G stated CNA E held R2's arms down while CNA F held his legs. CNA G stated the interaction was crazy and she did not know what to do. CNA G said then a few hours later while sitting at the nurses' station with R2 and CNA E you could feel the tension between R2 and CNA E. CNA G stated R2 and CNA E were across from CNA G. CNA G stated at this time out of nowhere CNA E started laughing and yelled Titty Twister and then completed the action. CNA G stated CNA E was laughing and R2 looked shocked and then smiled. CNA G stated she gave a nervous laugh because the whole day CNA G felt confused and awkward. CNA G elaborated that later that day R2 went into another resident room and took their scarfs, at which time she reported she observed CNA E yank the scarfs out of R2's hands, R2 in turn replied Give me my s**t back and CNA E responded It's not your s**t and walked away. CNA G stated all of this was reported to a panel of people whom she had already given a statement to. The reasonable person would not expect items to be yanked out of their hands, or the use of profanity foul language from a caregiver.On 5/13/26 at 9:53am during an interview with CNA F she reported she barely remembered anything about 4/18/26 aside from being suspended. CNA F stated it was a normal day, and her partner (CNA E) had an orientee with her (CNA G). CNA F stated they got transferred to the dementia unit where R2 resides, unwillingly a few months ago and R2 was his normal aggressive self that day. CNA F elaborated they have to hold R2 down because R2 fights, kicks and spits at them. When queried if they asked the Nurse for assistance when R2 becomes combative or resistant to care, CNA F stated no, there was no reason to get the nurse. Stating she and CNA E worked well together and could handle it. When queried about interventions CNA F stated one of the interventions was to wear a face shield because R2 spits at them, but they don't do those interventions. When asked why, CNA F reported the afternoon shift asked her a few days ago about the interventions and CNA F stated she told them not to bother, they don't work and, in her opinion, may possibly trigger R2. CNA F elaborated management was aware of R2's behavior and did nothing about it. When queried if CNA F documented R2's behaviors for 4/18/26 or reported to the Nurse or management that she felt the behavior interventions listed for R2 were not effective or may trigger R2, CNA F stated Well I mean, don't know that was a long time ago. Of note, the behavior tracking for R2 on 4/18/26 had no documented behaviors. When queried if the facility provided dementia care training and abuse prevention training, CNA F stated yes, but it's all online and there was nothing offered for in person for training/education on dementia care and behaviors. The reasonable person would expect to be treated with dignity and respect and not be held down. During a phone interview on 5/13/26 at 10:17 am, with Housekeeper H she reported she observed R2, CNA E and CNA G sitting at the nurses' station on 4/18/26, while entering a nearby room she was going to clean. Housekeeper H stated she thought she overheard CNA E say something pretty inappropriate followed by laughter, Housekeeper H stated she stepped out of the room and asked CNA E what did you say?' and CNA E replied Titty Twister and erupted in laughter again. Housekeeper H stated I guess I did hear it right the first time. Based on interviews conducted on 5/12 and 5/13 with both CNA E and CNA F it was evident CNA E and CNA F received some training on dementia care however, they failed to apply, implement and demonstrate an understanding of what (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	they had been taught regarding professional boundaries, abuse prevention, resident rights, and appropriate management of combative residents without the use of force or restraint.On 5/13/26 at 12:25 pm during an interview with NHA A identified herself as the abuse prevention coordinator, QAM D participated in the interview. The facility reported incident was reviewed. NHA A and QAM D agreed abuse had occurred.

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F 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake 2997912.Based on observation, interview and record review the facility failed to ensure one resident (resident #2) was free from physical restraints, resulting in anger frustration. Findings include:Review of Resident #2's (R2) clinical record, including the Minimum Data Set, dated [DATE] revealed R2 was an [AGE] year old male admitted to the facility on [DATE] with diagnoses of dementia, heart failure and adult failure to thrive. R2 scored 99 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS) and received hospice care. Review of R2's behavior care plan that was in place on 4/18/26, dated 01/02/26 identified R2 was resistant to care and could be combative with caregivers. R2's behavior care plan interventions in place on 4/18/26 included: approach slowly and identify yourself prior to initiating care, provide calming sensory interventions such as music, hand fidget, comfort items. Use calm, respectful and reassuring communication. Use non-verbal cues (smiling, nodding, gentle gestures). Use short simple, one step at a time directions. Review of the resident hospice care plans and hospice resident notes did not reflect any interventions that physical restraint was to be utilized when providing cares. Due to R2's cognition and inability to be interviewed, the reasonable person standard will be used for this citation. Physical restraints are defined as: The right to be free from any physical . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with S483.12(a)(2). S483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. S483.12(a) The facility must- S483.12(a)(2) Ensure that the resident is free from physical . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Review of the facility reported incident dated 4/18/26 at 06:50 pm, revealed that Licensed Practical Nurse (LPN) I notified Quality Assurance Manager (QAM) D via phone about an allegation of abuse that occurred at 10:40 am that day. It was reported that Certified Nursing Assistant (CNA) G was in training and was paired with CNA E and F. CNA G made the allegation that CNA E and CNA F held R2 down and gave him Titty Twisters. A Titty Twister is known to the general public as the act of pinching and twisting a person's nipple roughly to inflict pain. Review of the witness statement dated 4/20/26 with CNA G conducted by Director of Nursing (DON) B, Human Resources (HR) J and QAM D. CNA G stated that on 4/18/26 at approximately 10:30 am, prior to entering R2's room, CNA E warned her that R2 was combative with care and upon entering the room R2 was lying in bed in preparation to have a brief change, and CNA F was already in the room. CNA G reported CNA E pushed on R2's shoulders to position R2 and that was when he began to get combative and refused to open his legs for care. CNA G then stated CNA E restricted R2's arms and CNA F held R2's legs. CNA G elaborated that she questioned CNA E about their methods of restraining R2 while providing care in which the CNA E replied that is how we have to do it. Review of the witness statement dated 4/20/26 with CNA E, conducted by DON B, HR J and QAM D, CNA E reported that on 4/18/26 at 10:30 am CNA F was already in the room and R2 needed his brief changed. The written statement reflected R2 was combative during care despite explaining care and that in her experience staff often have to hold him down to complete care due to R2's combative behavior. CNA E elaborated holding R2 down was for R2s safety and staff safety. Review of the witness statement dated 4/20/26 with CNA F, conducted by DON B, HR J and QAM D, CNA E reported that on 4/18/26 at 10:30 am she reported R2 became combative during care, but care was required to provide care so she held R2's legs while CNA E (continued on next page)

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	235224	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lenawee Medical Care Facility	200 Sand Creek Highway Adrian, MI 49221

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 0604 Level of Harm - Actual harm Residents Affected - Few	restricted R2's arms.On 5/12/26 at 1:00 pm, during an interview with QAM D she reported she conducted the investigation in collaboration with other management staff such as DON B and HR J and the facility's Abuse Prevention Coordinator /Nursing Home Administrator A. QAM D stated the facility did confirm that abuse had occurred. When queried what type of abuse was verified, QAM D stated physical and humiliation/mental. At this time, facility camera/video footage was viewed, the footage was dated 4/18/2026 and showed R2, and CNA E and CNA G sitting at the Nurses station. The footage showed CNA E fondling R2's right breast. Due to the angel of the camera and the fact that R2 wore a cowboy hat, R2's facial expression was difficult to read. Of note, there was no audio to the video. QAM D provided an untitled packet of papers that alleged the facility was in compliance as of 5/01/26, however the packet provided did not determine what the facility's deficient practice was. On 5/13/26 an updated and untitled packet of papers was provided and alleged a compliance date of 5/13/26 with F tag 600 though the written packet did not determine what type of abuse was inflicted upon R2. The information in part reflected CNA E and F were suspended pending investigation and prior to returning to work, the staff directly involved (CNA E and CNA F) were educated on professional boundaries, abuse prevention, resident rights, and appropriate management of combative residents without the use of force or restraint. On 5/12/26 at 1:49 pm, during an interview with CNA E she readily admitted that it was routine practice to restrain R2 during care. CNA E reported this was a normal standard and it was how everybody takes care of R2. CNA E elaborated on how terrible R2's behaviors are. Stating that management knows about R2's behaviors and nobody does anything, thus they (staff) have no other choice but to hold R2 down. CNA E elaborated she was familiar with all the federal regulations and that staff are required to provide care and that is what they do. CNA E went on to say that she knows her rights and she has the right to work in an abuse free environment. Stating that the staff only restrain R2's arms and legs to protect themselves, again CNA E repeated staff had the right to work in a safe environment and in CNA Es opinion it was not safe and management was not doing anything about it. When queried if staff enlisted assistance from the Nurse, CNA E stated no. When queried if they tried leaving R2 alone and reapproaching him after R2 settled down, CNA E stated no. CNA E reiterated she knew the federal regulations and if she left R2 alone that would be neglect. When queried if CNA E referenced R2's care plan or Kardex for approaches, CNA E stated R2 did not have any behavior interventions in place on 4/18 or today. At this time CNA E and this surveyor went to R2's room. R2 was observed resting in bed, made eye contact but did not speak upon approach. CNA E went to R2's closet and there was a Kardex in place that listed approaches on how to care for and what approaches to try when/if R2 becomes combative. When queried about the Kardex again, CNA E stated someone must have just put it in R2's closet. When queried about restraining R2 for care, CNA E again reverted back to that was how staff provided care to R2 based on R2's actions/behavior and CNA E had the right to work in a nonviolent atmosphere. When queried if CNA E thought it was ok to restrain R2 to provide care, CNA E stated it was absolutely ok and reverted back to her right to have violent free workplace. The reasonable person would find it unacceptable to being forcibly held down during care. During an interview with CNA G on 5/12/26 at 2:31pm, CNA G stated 4/18/26 was her third day in orientation and she was shadowing CNA E, CNA G stated while on the way to R2's room CNA E was complaining about how hard it was to take care of him and how R2 always fights them. CNA G stated upon entering the room, R2 was on the bed and CNA F was already in the room and CNA E started the interaction being aggressive as if she were preparing for R2 to be aggressive in return. CNA G said she was there to observe and learn but instead observed CNA E stern fully and forcefully take R2 by the shoulders and push down on R2 on the bed. CNA G stated after that interaction R2 became angry and was yelling, cussing and trying to hit and kick at them. CNA G stated CNA E held R2's arms down while CNA F held R2's legs. CNA G stated the interaction was crazy and she did not know what to do. On 5/13/26 at 9:53am during an interview with CNA F she reported she barely remembered anything about 4/18/26 aside from being suspended. CNA F stated it was a normal day, and her partner (CNA E) had (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lenawee Medical Care Facility	200 Sand Creek Highway Adrian, MI 49221

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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 0604 Level of Harm - Actual harm Residents Affected - Few	an orientee with her (CNA G). CNA F stated they got transferred to the dementia unit unwillingly a few months ago and R2 was his normal aggressive self that day. CNA F elaborated they have to hold R2 down because R2 fights, kicks and spits at them. When queried if they asked the Nurse for assistance, CNA F stated no, there was no reason to get the nurse. Stating she and CNA E worked well together, and they were always able to handle R2 without enlisting the nurse's help. Using the reasonable person standard, a cognitively intact resident would not accept being held down, have their arms and legs held constricting their movement. On 5/13/26 at 3:00 pm during a phone interview with Director of Nursing (DON) B, she reported the facility was working on learning R2's preferences for care which included R2 being an active participant and offered no additional information. Based on interviews conducted on 5/12 and 5/13 with both CNA E and CNA F it was evident CNA E and CNA F had previously completed dementia care training however they failed to apply, implement and demonstrate an understanding of what was taught regarding professional boundaries, abuse prevention, resident rights, and appropriate management of combative residents without the use of force or restraint. The reasonable person would expect to receive care without the use of physical force and being held down. Review of the facility policy titled Restraint Free Environment dated 02/2022 reviewed 02/2026. Policy Statement: It is the policy of this facility that each resident shall attain and maintain his/her practical wellbeing in an environment that prohibits the use of restraints for discipline or convenience and limits the use of restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. The policy defined physical restraint as refers to any manual method or physical or mechanical or material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access of one's body. Physical restraints include but are not limited to .holding down a resident in response to a behavior symptom, or during a provision of care if the resident is resistive or refusing care.

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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 - 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** This Citation Pertains to Intake 2997912.Based on observations, interviews and record review, the facility failed to develop and or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act.for one resident (Resident #2) of three reviewed.Findings include:Review of Resident #2's (R2) clinical record, including the Minimum Data Set, dated [DATE] revealed R2 was an [AGE] year old male admitted to the facility on [DATE] with diagnoses of dementia, heart failure and adult failure to thrive. R2 scored 99 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS) and received hospice care. Thus, the reasonable person standard will be used for this citation. Review of the facility reported incident dated 4/18/26 at 06:50 pm, revealed that Licensed Practical Nurse (LPN) I notified Quality Assurance Manager (QAM) D via phone about an allegation of abuse that occurred at 10:40 am that day. It was reported that Certified Nursing Assistant (CNA) G was in training was in paired with CNA E and F. CNA G made the allegation that CNA E and CNA F held R2 down and gave him Titty Twisters. A Titty Twister is known to the general public as the act of pinching and twisting a person's nipple roughly to inflict pain. Review of the witness statement dated 4/20/26 with CNA G conducted by Director of Nursing (DON) B, Human Resources (HR) J and QAM D. CNA G stated that on 4/18/26 at approximately 10:30 am, prior to entering R2's room, CNA E warned her that R2 was combative with care and upon entering the room R2 was lying in bed in preparation to have a brief change, and CNA F was already in the room. CNA G reported CNA E pushed on R2's shoulders to position R2 and that was when he began to get combative and refused to open his legs for care. CNA G then stated CNA E restricted R2's arms and CNA F held R2's legs. CNA G elaborated that she questioned CNA E about their methods of restraining R2 while providing care in which the CNA E replied that is how we have to do it. The written interview statement then reflected that at approximately 1:00 to 1:30 pm while sitting at the nurses' station with R2 and CNA E , CNA E said Titty Twister then performed the action on R2. CNA G statement revealed R2 looked surprised by CNA E's action. Review of the witness statement dated 4/20/26 with CNA E, conducted by DON B, HR J and QAM D, CNA E reported that on 4/18/26 at 10:30 am CNA F was already in the room and R2 needed his brief changed. The written statement reflected R2 was combative during care despite explaining care and that in her experience staff often have to hold him down to complete care due to R2's combative behavior. CNA E elaborated holding R2 down was for R2s safety and staff safety. According to the written statement when CNA E was question about the Titty Twister CNA E stated that was clearly a joke and denied making physical contact. Review of the witness statement dated 4/20/26 with CNA F, conducted by DON B, HR J and QAM D, CNA E reported that on 4/18/26 at 10:30 am she reported R2 became combative during care, but care was required so she held R2's legs while CNA E restricted R2's arms.Review of witness statement dated 4/20/26 with Housekeeper H she reported she witnessed CNA E and CNA G at the nurses' station with R2. Housekeeper H stated while cleaning a room she could hear laughing at the nurses' station and overheard a comment, she then exited the room and asked about the comment that was made and CNA E replied Titty Twister.On 5/12/26 at 1:00 pm, during an interview with QAM D she reported she conducted the investigation in collaboration with other management staff such as DON B and HR J and the facility's Abuse Prevention Coordinator /Nursing Home Administrator A. QAM D stated the facility did confirm that physical abuse had occurred. On 5/13/26 at 12:25 pm during an interview with NHA A and QAM D the facility reported incident was reviewed. The facility reported incident dated 4/18/26 read in part, Type of alleged incident: Abuse Was the alleged incident verified (substantiated): Yes Suspected Crime: No Was law enforcement contacted: No. During the interview NHA A and QAM D each agreed abuse was inflicted upon R2. When queried why the local Police Department was not notified of the abuse neither NHA A or QAM D responded.

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Lenawee Medical Care Facility	200 Sand Creek Highway Adrian, MI 49221

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake 2997912Based on observation, interview and record review, the facility failed to ensure the protection of residents from abuse for one (Resident #2) of three residents reviewed, resulting in the potential for continued abuse. Findings include:Review of Resident #2's (R2) clinical record, including the Minimum Data Set, dated [DATE] revealed R2 was an [AGE] year old male admitted to the facility on [DATE] with diagnoses of dementia, heart failure and adult failure to thrive. R2 scored 99 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS) and received hospice care. Thus, the reasonable person standard will be used for this citation. Review of the facility reported incident dated 4/18/26 at 06:50 pm, revealed that Licensed Practical Nurse (LPN) I notified Quality Assurance Manager (QAM) D via phone about an allegation of abuse that occurred at 10:40 am that day. It was reported that Certified Nursing Assistant (CNA) G was in training was in paired with CNA E and F. CNA G made the allegation that CNA E and CNA F held R2 down and gave R2 a Titty Twisters. A Titty Twister is known to the general public as the act of pinching and twisting a person's nipple roughly to inflict pain. Review of the witness statement dated 4/20/26 with CNA G conducted by Director of Nursing (DON) B, Human Resources (HR) J and QAM D. CNA G stated that on 4/18/26 at approximately 10:30 am, prior to entering R2's room, CNA E warned her that R2 was combative with care and upon entering the room R2 was lying in bed in preparation to have a brief change, and CNA F was already in the room. CNA G reported CNA E pushed on R2's shoulders to position R2 and that was when he began to get combative and refused to open his legs for care. CNA G then stated CNA E restricted R2's arms and CNA F held R2's legs. CNA G elaborated that she questioned CNA E about their methods of restraining R2 while providing care in which the CNA E replied that is how we have to do it. The written interview statement then reflected that at approximately 1:00 to 1:30 pm while sitting at the nurses' station with R2 and CNA E , CNA E said Titty Twister then performed the action on R2. CNA G statement revealed R2 looked surprised by CNA E's action. Review of the witness statement dated 4/20/26 with CNA E, conducted by DON B, HR J and QAM D, CNA E reported that on 4/18/26 at 10:30 am CNA F was already in the room and R2 needed his brief changed. The written statement reflected R2 was combative during care despite explaining care and that in her experience staff often have to hold him down to complete care due to R2's combative behavior. CNA E elaborated holding R2 down was for R2s safety and staff safety. According to the written statement when CNA E was question about the Titty Twister CNA E stated that was clearly a joke and denied making physical contact. Review of the witness statement dated 4/20/26 with CNA F, conducted by DON B, HR J and QAM D, CNA E reported that on 4/18/26 at 10:30 am she reported R2 became combative during care, but care was required so she held R2's legs while CNA E restricted R2's arms.Review of witness statement dated 4/20/26 with Housekeeper H she reported she witnessed CNA E and CNA G at the nurses' station with R2. Housekeeper H stated while cleaning a room she could hear laughing at the nurses' station and overheard a comment, she then exited the room and asked about the comment that was made and CNA E replied Titty Twister.On 5/12/26 at 1:00 pm, during an interview with QAM D she reported she conducted the investigation in collaboration with other management staff such as DON B and HR J and the facility's Abuse Prevention Coordinator /Nursing Home Administrator A. QAM D stated the facility did confirm that abuse had occurred. When queried what type of abuse was verified, QAM D stated physical and humiliation/mental. At this time facility camera/video footage was viewed, the footage was dated 4/18/2026 and showed R2, and CNA E and CNA G sitting at the Nurses station. The footage showed CNA E fondling R2's right breast. Due to the angel of the camera and the fact that R2 wore a cowboy hat, R2's facial expression was difficult to read. Of note, there was no audio to the video. QAM D provided an untitled packet of papers that alleged the facility was in compliance as of 5/01/26, however the packet provided did not determine what the facility's deficient practice was. On 5/13/26 (continued on next page)

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Lenawee Medical Care Facility	200 Sand Creek Highway Adrian, MI 49221

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an updated and untitled packet of papers was provided and alleged a compliance date of 5/13/26 with F tag 600 though the written packet did not determine what type of abuse was inflicted upon R2. The information in part reflected CNA E and F were suspended pending investigation and prior to returning to work, the staff directly involved (CNA E and CNA F) were educated on professional boundaries, abuse prevention, resident rights, and appropriate management of combative residents without the use of force or restraint.On 5/12/26 at 1:49 pm, during an interview with CNA E she readily admitted that it was routine practice to restrain R2 during care. CNA E reported this was a normal standard of practice and it was how everybody takes care of R2. CNA E elaborated on how terrible R2's behaviors are, that management knows about R2's behaviors and nobody does anything about R2, thus they (staff) have no other choice but to hold R2 down. CNA E elaborated she was familiar with all the federal regulations and that staff are required to provide care and that is what they do. CNA E went on to say that she knows her rights and she has the right to work in an abuse free environment and the staff only restrain R2's arms and legs to protect themselves. Again, repeating staff has the right to work in a safe environment and in CNA Es opinion, the facility was not a safe work environment due to R2 and facility management was not doing anything about it. When quired if CNA E enlisted assistance from the Nurse, CNA E stated no. When queried if staff tried leaving R2 alone and reapproaching later giving R2 time to settle down, CNA E stated no. CNA E reiterated she knew the federal regulations and if she left R2 alone that would be neglect. When queried if she referenced R2's care plan or Kardex for approaches, CNA E stated R2 did not have any behavior interventions in place on 4/18 or today. At this time CNA E and this surveyor went to R2's room. R2 was resting in bed, made eye contact but did not speak upon approach. CNA E went to R2's closet and there was a Kardex in place that listed approaches on how to care for and what approaches to try when/if R2 becomes combative. When queried about the Kardex again, CNA E stated someone must have just put it in R2's closet. When queried about restraining R2 for care, CNA E again reverted back to that was how they provided care to R2 based on R2's actions/behavior and she had the right to work in a nonviolent atmosphere. When CNA E was queried about giving R2 a Titty Twister CNA E reported she never touched R2. When it was explained this surveyor watched the video from 4/18/26, CNA E then stated Well it was just a joke! CNA E reported she was suspended after her shift that day 4/18 but returned to work a few days later. CNA E reported still being assigned to care for R2 and works full time on the facility's dementia unit. During an interview with CNA G on 5/12/26 at 2:31pm, CNA G stated 4/18/26 was her third day in orientation and she was shadowing CNA E, CNA G stated while on the way to R2's room CNA E was complaining about how hard it was to take care of him and how R2 always fights them. CNA G stated R2 was on the bed and CNA F was already in the room and CNA E started the interaction being aggressive as if she were preparing for R2 to be aggressive in return. CNA G said she was just there to observe and learn and she the witnessed CNA E stern fully and forcefully take R2 by the shoulders and push down on R2 on the bed. CNA G stated after that interaction R2 became angry and was yelling, cussing and trying to hit and kick at them. CNA G stated CNA E held R2's arms down while CNA F held his legs. CNA G stated the interaction was crazy and she did not know what to do. CNA G said then a few hours later while sitting at the nurses' station with R2 and CNA E you could feel the tension between R2 and CNA E. CNA G stated R2 and CNA E were across from CNA G. CNA G stated at this time out of nowhere CNA E started laughing and yelled Titty Twister and then completed the action. CNA G stated CNA E was laughing and R2 looked shocked and then smiled. CNA G stated she gave a nervous laugh because the whole day CNA G felt confused and awkward. CNA G elaborated that later that day R2 went into another resident room and took their scarfs, at which time she reported she observed CNA E yank the scarfs out of R2's hands, R2 in turn replied Give me my s**t back and CNA E responded It's not your s**t and walked away. CNA G stated all of this was reported to a panel of people whom she had already given a statement to. On 5/13/26 at 9:53am during an interview with CNA F she reported she barely remembered anything about 4/18/26 aside from being suspended for a few days. CNA F stated it was a normal day, and her (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	partner (CNA E) had an orientee with her (CNA G). CNA F stated they got transferred to the dementia unit, where R2 resides, unwillingly a few months ago and R2 was his normal aggressive self that day. CNA F elaborated they have to hold R2 down because R2 fights, kicks and spits at them. When queried if they asked the Nurse for assistance, CNA F stated no, there was no reason to get the nurse, she and CNA E could handle it. When queried about interventions CNA F stated one of the interventions was to wear a face shield because he spits at them, but they don't do those interventions. When asked why, CNA F reported the afternoon shift asked her a few days ago about the interventions and CNA F stated she told them not to bother, they don't work and, in her opinion, may trigger R2. CNA F elaborated management was aware of R2's behavior and did nothing about it. When queried if the facility provided dementia care training and abuse prevention training, CNA F stated yes but it's all online and there was nothing offered for in person for training/education on dementia care and behaviors. When queried if CNA F documented R2's behaviors for 4/18/26 or reported to the Nurse or management that she felt the behavior interventions listed for R2 were not effective or may trigger R2, CNA F stated Well I mean, don't know that was a long time ago. Of note, the behavior tracking for R2 on 4/18/26 had no documented behaviors. During a phone interview on 5/13/26 at 10:17 am, with Housekeeper H she reported she observed R2, CNA E and CNA G sitting at the nurses' station on 4/18/26, while entering a nearby room she was going to clean. Housekeeper H stated she thought she overheard CNA E say something pretty inappropriate followed by laughter, Housekeeper H stated she stepped out of the room and asked CNA E what did you say?' and CNA E replied Titty Twister and erupted in laughter again. Housekeeper H stated I guess I did hear it right the first time. On 5/13/26 at 12:25 pm during an interview with NHA A who identified herself as the facility's abuse coordinator and QAM D the facility reported incident was reviewed and acknowledged by NHA A and QAM D that abuse had occurred. When queried what was done to ensure the protection of R2 and other at-risk residents who received care from CNA E and CNA F NHA A reported they had been re-educated. Based on interviews conducted on 5/12 and 5/13 with both CNA E and CNA F it was evident CNA E and CNA F had failed to apply, implement and demonstrate an understanding of what was taught regarding professional boundaries, abuse prevention, resident rights, and appropriate management of combative residents without the use of force or restraint.