

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER North Woods Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2532 Cadillac Dr Farwell, MI 48622	

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 0559</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 share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573</p> <p>This citation pertains to intake M100147294.</p> <p>Based on interview and record review, the facility failed to provide an advanced written notification of a room change and obtain consent for 1 (R4) of 1 resident reviewed, resulting in the potential of a nonconsensual room change and emotional distress for the resident.</p> <p>Findings include:</p> <p>Review of a Face Sheet revealed R4 admitted to the facility on [DATE] with pertinent diagnoses of dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, claustrophobia, and Alzheimer's.</p> <p>Review of an Interdisciplinary progress note dated 9/11/24 (Wednesday) at 6:44 PM for R4 revealed the resident was upset when staff tried to redirect her from entering another resident's room (room [ROOM NUMBER]). R4 became verbally and physically aggressive with staff, declined to let go of the door handle, was shouting at staff and attempting to hit and kick staff. After multiple attempts of redirecting, staff was able to move the resident who was tearful and continued to shout at staff. After approximately 10 minutes, R4 was calm and resting in wheelchair near the nurse's station. R4s nurse gave the resident an Ativan 20 minutes prior to the incident.</p> <p>Review of the Census Report revealed R4 resided in room [ROOM NUMBER] since her admission on 10/27/22 and had a recent room change to room [ROOM NUMBER] on 9/11/24. There was no documentation in the Electronic Medical Record (EMR) indicating why she had a room change or documentation showing the Power of Attorney (POA) was informed or consented to a room change.</p> <p>Review of an undated typed Witness Statement revealed HK O reported I witnessed (R4) become upset on 9/12/24 about a room in the 100 hall that used to be hers. She asked me to open the door, and I told her I could not as it wasn't hers anymore. She became upset and I told the nurse.</p> <p>In an interview on 10/1/24 at 11:00 AM, Certified Nursing Assistant (CNA) L reported since R4 had a room change, she keeps trying to go to her old room and gets very upset and agitated when she cannot go back to that room.</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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/1/24 at 11:43 AM, Licensed Practical Nurse (LPN) J reported she worked the night of 9/12/24 when R4 was upset she had a room change and could not go to her old room.</p> <p>In an interview on 10/1/24 at approximately 1:00 PM, Social Worker (SW) P reported she did inform R4's POA of the room change but could not find any documentation that they were informed. SW P reported she usually documents consent in the progress notes. She is aware R4 was having a hard time accepting the room change and kept going back to her old room but finally adjusted to her new room. SW P reported the facility moved R4 from the room because the residents were not compatible with one another. SW P could not say who was in the room first but felt it was for their safety. When asked if there were any altercations between the two residents, SW P could not say there were any. SW P reported R4's roommate was more [NAME] and proper than R4 was, and they just didn't get along.</p> <p>Review of the electronic medical record for R4 revealed no documentation there were any concerns with her roommate.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for 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** 37573</p> <p>This citation pertains to intake M100147294.</p> <p>Based on interviews and record review, the facility failed to protect the resident's right to be free from staff to resident verbal and physical abuse for one (R4) of 4 residents reviewed for abuse.</p> <p>Findings include:</p> <p>Review of a Face Sheet revealed R4 admitted to the facility on [DATE] with pertinent diagnoses of dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, claustrophobia, and Alzheimer's.</p> <p>Review of a facility investigation reflected the following information: (a) On 9/23/24 at 7:10 PM, a housekeeping staff member (HK O) reported to the Director of Nursing (DON), who is also the facility abuse coordinator, that she witnessed abuse on 9/12/24, (11 days after witnessing the incident of abuse) and (b) the incident involved Registered Nurse (RN) N holding R4's wrists down in the wheelchair and RN N told R4 I don't work in an insane asylum, I work in a nursing home.</p> <p>On 9/23/24 an allegation of abuse was reported to the State Agency when a nurse engaged in abusive behavior towards R4.</p> <p>RN N was then suspended pending investigation on 9/23/24.</p> <p>Review of the work schedule revealed RN N worked 9/16, 9/20, 9/21, and 9/22 from 6:00 PM to 6:30 AM before being suspended pending an investigation into allegations of abuse.</p> <p>In an interview on 9/30/24 at 3:20 PM, Activities Aide (AA) G reported she worked the evening of 9/12/24 when around 8:00 PM she heard R4 yell and scream at the top of her lungs No I don't want to! AA G then stepped out of the office and witnessed R4 at the nurses' station holding on to the wheels of her wheelchair to keep it from moving. RN N was behind R4 grabbing her arms and holding them down. He told the resident not to hit. AA G approached R4 and asked if she wanted to go with her, and R4 agreed. AA G took R4 back to her room and the resident was still upset.</p> <p>In an interview on 10/1/24 at 8:07 AM, Housekeeping Manager (HKM) H reported that on 9/16/24 she was informed by HK O (who was working on 9/12/24) that she witnessed RN N restrain R4's arms, let R4 loose and then restrain R4 again. HK O also reported to HKM H she heard RN N tell R4 I don't work in a f*ck*ng mental institution, why am I dealing with this stuff!</p> <p>In an interview on 9/30/24 at 3:39 PM, the DON/Abuse Coordinator reported that HKM H informed her on 9/17/24 that housekeeper (HK O) reported RN N was observed holding down the arms of R4. The DON/Abuse Coordinator also reported that on 9/23/24 another housekeeper (HK K) reported to her that RN N was aggressive towards R4. The DON/Abuse Coordinator was able to figure out the incident reported by HK K occurred on 9/12/24 due to an interview with Licensed Practical Nurse (LPN J).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Interdisciplinary progress note dated 9/11/24 (Wednesday) at 6:44 PM for R4 revealed the resident was upset when staff tried to redirect her from entering another resident's room (room [ROOM NUMBER]). R4 became verbally and physically aggressive with staff, declined to let go of the door handle, was shouting at staff and attempting to hit and kick staff. After multiple attempts of redirecting, staff was able to move [the resident] to a common area. R4 was tearful and continued to shout at staff. After approximately 10 minutes R4 was calm and resting in wheelchair near the nurses station. R4's nurse gave the resident an Ativan 20 minutes prior to the incident.</p> <p>Review of R4's medical record revealed no progress notes or documentation on 9/12/24 regarding R4 having behaviors.</p> <p>Review of a Skin assessment dated [DATE] for R4 revealed she had scattered bruising to BUE (bilateral upper extremities) from recent behavioral episode where she became physically aggressive. STCP (short term care plan) initiated to monitor bruising. (R4) denies pain. Previous skin assessments do not show any bruising.</p> <p>Review of a Skin assessment dated [DATE] for R4 revealed Scattered bruising to BUE continues to improve.</p> <p>On 10/1/24 at 8:40 AM, an attempt to contact HK O for interview was made but HK O was not available and messages could not be left due to a voicemail response stating the mailbox was full.</p> <p>Review of an undated typed Witness Statement revealed HK O reported I witnessed (R4) become upset about a room in the 100 hall that used to be hers. She asked me to open the door, and I told her I could not as it wasn't hers anymore. She became upset and I told the nurse. The nurse (RN N) took her to the nurse's station, and she became more angry and started to yell and flinging her arms. (RN N) put her arms to her chest. (R4) got her arms free and started to reach for her wheelchair and (RN N) proceeded to restrain (sic) her arms again. He yelled I don't work in a f*ck*ng mental hospital; I work in a g*d d*mn nursing home. I don't get paid enough for this sh*t.</p> <p>In an interview on 10/1/24 at 11:00 AM, Certified Nursing Assistant (CNA) L reported she saw the tail end of the incident between RN N and R4 on 9/12/24. CNA L indicated she heard a commotion, walked towards the nursing station and saw the back of RN N leaning over R4 while she was sitting in her wheelchair. R4 was screaming and crying. The RN N then grabbed R4's wrists and crossed them over the front of R4's body. CNA L reported she approached the nurse with another CNA and told the nurse to take a break and walk away. R4 told CNA L that she hated RN N, and RN N hurt her wrists.</p> <p>In an interview on 10/1/24 at 11:23 AM, HK K reported she was down the hall near the soiled utility room and heard R4 screaming at the top of her lungs and she froze because it scared her. She saw RN N put his arms around R4's chair and restrain her arms in her chair. R4 was screaming, Get the h*ll off of me, you're hurting me at the top of her lungs. R4 tried to wheel away by putting her arms on the wheels of her wheelchair when RN N took her arm off the wheels and threw her arms on her stomach forcefully and told her she could not move. RN N was screaming in R4's face at this time but could not recall all he said but remembered he said, I don't have to quit. At that time an Activity Aide and a CNA came down and took R4 to her room and I overheard RN N say I don't work at a f*ck*ng mental institution; I work at a nursing home, and I don't get paid enough to deal with this sh*t.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/1/24 at 11:43 AM, Licensed Practical Nurse (LPN) J reported she worked the night of 9/12/24 when R4 was upset she had a room change and could not go to her old room. RN N yelled that we are not going to have this type of behavior, grabbed R4's arms and held them to the chair and then wheeled her towards her room. R4 was not screaming at that time but did tell him she didn't want to go. RN N then swore and said this is not an insane asylum. That was all LPN J heard. LPN J reported she did not think it was appropriate for him to hold the residents' arms down and to swear at her.</p> <p>Review of an Investigation Statement revealed the DON asked RN N on 9/17/24 about him holding R4's hands down when he stated the resident was upset and he was just trying to get her away from there and denied hurting her or stating he didn't work in a f*ck*ng insane asylum. He did say he was trying to work on his stress and anxiety levels and didn't understand why anyone would say this about him. On 9/23/24 at 7:20 PM, the DON interviewed RN N again regarding the events that night. She informed him of the allegation of abuse and suspended him this day.</p> <p>The timeline of events according to the DON/Abuse Coordinator was as follows: On 9/12/24 the incident of abuse between RN N and R4 occurred. On 9/13/24 skin assessments show scattered bruising on BUE. On 9/16/24, the Housekeeping Manager (HKM) H was told of the incident from HK O. On 9/17/24 HKM H informed the DON of the incident. On 9/17/24 the DON/Abuse Coordinator provided an all-staff education. That is when the DON/Abuse Coordinator was informed that RN N was more aggressive than originally thought. The facility did not report the allegation of abuse to the State Agency until 9/23/24.</p> <p>Review of a policy titled Abuse/Suspected Abuse; Crime Investigation & Reporting last reviewed 2/2023 revealed: It is the policy of this facility to encourage and support all residents, covered individuals, and families, to report any suspected acts involving resident mistreatment, neglect, exploitation, abuse, crimes, misappropriation of resident property or injuries of unknown source. Allegations of abuse and crime are thoroughly investigated and properly reported in accordance with Federal Regulation including the Elder Justice Act.</p> <p>Purpose: Residents have the right to be free from verbal, sexual, physical, psychological abuse, corporal punishment, involuntary seclusion, and crimes.</p> <p>2. Any person(s) witnessing or having knowledge of potential or actual abuse or crime must immediately report the incident to the Administrator and / or designee. In the case of a resident or family member, such a report can be made to the charge nurse or person assigned to receive complaints, who is responsible to follow through with reporting procedures.</p> <p>3. When allegations of resident (S483.5) mistreatment, abuse, crime, neglect, exploitation, misappropriation, or injuries of unknown source are reported, the administrator and designees will investigate the allegation with the assistance of appropriate personnel.</p> <p>8. In accordance with S483.12(b)(c) the facility will report all alleged violations to the state agency and to all other agencies as required and take all necessary corrective actions depending on the results of the investigations. The facility will reference The State Licensing and Regulatory Affairs ([NAME]) guidelines to make reporting determinations.</p> <p>9. Reports are submitted online into the MI-FRI system:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(1) Immediately but no later than 2 hours if the alleged violation involves abuse or results in serious bodily injury.</p> <p>(2) No later than 24 hours if the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; and does not result in serious bodily injury.</p> <p>11. Elder Justice Act Reporting Requirements:</p> <p>a. The facility will report any reasonable suspicion of a crime against any individual who is a resident of or receiving care from this facility.</p> <p>b. A report will be filed with at least one local law enforcement agency within two (2) hours of forming a suspicion if there is serious bodily injury and within twenty-four (24) hours of forming a suspicion if no serious bodily injury has occurred.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 37573</p> <p>This citation pertains to intake M100147294.</p> <p>Based on interviews and record review, the facility failed to ensure facility staff responded to (reported), and investigated, a witnessed staff to resident physical and verbal abuse timely for one resident (R4) of four residents reviewed for abuse, resulting in the staff member working several more shifts exposing (R4) and other vulnerable residents to further possible abuse.</p> <p>Findings include:</p> <p>Review of a Face Sheet revealed R4 admitted to the facility on [DATE] with pertinent diagnoses of dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, claustrophobia, and Alzheimer's.</p> <p>Review of a facility investigation reflected the following information: (a) On 9/23/24 at 7:10 PM, a housekeeping staff member (HK O) reported to the Director of Nursing (DON), who is also the facility abuse coordinator, that she witnessed abuse on 9/12/24, (11 days after witnessing the incident of abuse) and (b) the incident involved Registered Nurse (RN) N holding R4's wrists down in the wheelchair and RN N told R4 I don't work in an insane asylum, I work in a nursing home.</p> <p>On 9/23/24 the facility reported an allegation of abuse to the State Agency when a nurse engaged in abusive behavior towards R4 on 9/12/24.</p> <p>Review of the work schedule revealed RN N worked 9/16, 9/20, 9/21, and 9/22 from 6:00 PM to 6:30 AM, prior to the facility suspending him pending an investigation into allegations of abuse.</p> <p>The facility suspended RN N pending investigation on 9/23/24.</p> <p>In an interview on 9/30/24 at 3:20 PM, Activities Aide (AA) G reported she worked the evening of 9/12/24 when around 8:00 PM she witnessed RN N behind R4 grabbing her arms, holding them down and telling the resident not to hit. AA G stated that RN N said he was going to call the DON to tell her about the situation and that is why AA G did not report the incident of abuse.</p> <p>In an interview on 10/1/24 at 8:07 AM, Housekeeping Manager (HKM) H reported that on 9/16/24 a housekeeper who worked on 9/12/24 (HK O) informed her that she witnessed RN N restrain R4's arms, let R4 loose and then restrain R4 again. HK O also reported to HKM H she heard RN N tell R4 I don't work in a f*ck*ng mental institution, why am I dealing with this stuff!. HK O did not tell anyone at the time of the incident because she was new and was unsure what to do. HK O reported to HKM H that the incident was weighing her down, so she called HKM H at work on 9/16/24. HKM H said she reported this incident right way to the DON/Abuse Coordinator.</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 - Some</p>	<p>Review of the Facility Investigation Interview with the perpetrator RN N revealed the DON asked the RN N on 9/17/24 when she was made aware of RN N holding R4's hands down. RN N stated the resident was upset and I was just trying to get her away from there, I didn't hurt her. He denied stating that he said he didn't work in a f*ck'ng insane asylum and said that and that he was trying to work on his stress and anxiety levels. He doesn't know why anyone would say that. Resident was verified as being upset and having behaviors that night. There were no other comments made to indicate that RN N had acted any other way than preventing [name of resident (R4)] from hurting herself or others.</p> <p>On 9/23/24 the (DON) interviewed RN N at (approximately) 7:20 PM about the same incident and made RN N aware that there is now an allegation of abuse related to that same night. (DON) asked him about him yelling at a resident that you do not work in a mental hospital. RN N denied it and asked why people would say that. He stated I'm not lying. Ask (LPN J) she will vouge (sic) for me. (LPN J) was right there. She knows exactly what happened. (DON) suspended RN N pending investigation.</p> <p>Review of a Witness Statement dated 9/27/24, CNA Q stated upon returning from my break there was distress going on over her (R4) trying to return to her old room. Myself and activities removed her from area into her room where we had been able to calm her down, toilet and prepare for evening did not have anymore issues with her thru out rest of night. I did witness her arms being restricted from hitting nurse. (sic)</p> <p>In an interview on 9/30/24 at 3:39 PM, the DON/Abuse Coordinator reported that HKM H informed her on 9/17/24 that housekeeper (HK O) reported she observed RN N holding down the arms of R4 on 9/12/24. The DON/Abuse Coordinator did not report the allegation of abuse to the State Agency on 9/17/23. The DON reported that it seemed reasonable if the resident was striking out to hold R4 so other residents didn't get hit. The DON realized the situation was more of a concern when another housekeeper came to her on 9/23/24 and reported different information, and she said she felt he was aggressive. The DON reported she called RN N again on 9/23/24 to talk about the incident again and to inform him that another staff member expressed concerns he was aggressive. RN N is not to return to work due to the lying and the verbal altercation. She said she cannot prove he was physically aggressive but can for sure say he was verbally abusive.</p>		