STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parmly on the Lake LLC	28210 Old Towne Road Chisago City, MN 55013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for 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** Based on observation, interview, and document review, the facility failed to protect 1 of 3 resident's (R74) right to be free from mental and physical abuse by staff. Findings include: R74's admission minimum data set (MDS) dated [DATE], indicated moderate cognitive impairment, did not have inattention, disorganized thinking, or an altered level of consciousness. R74 had delusions and hallucinations and verbal behavior symptoms for 4 to 6 days but not daily. Further, the behavior symptoms significantly interfered with activities or social interactions and significantly disrupted care or living environment. R74 wandered 1 to 3 days and behaviors symptoms were the same compared to prior assessment. R74 did not have impairment in range of motion, (ROM) used a walker and wheelchair and required partial to moderate assist with toileting hygiene, showering and bathing, lower body dressing, required substantial assistance with transferring, and supervision with walking 50 feet. R74's significant change MDS dated [DATE], indicated moderate cognitive impairment, was able to recall after cueing, did not have a change in mental status, did not have inattention, disorganized thinking, or an altered level of consciousness, did not have hallucinations or delusions, physical, verbal, or other behavioral symptoms, and did not reject care. Further, R74 had an improvement in behavior status compared to a prior assessment. R74's MDS indicated no impairment in ROM to upper extremities, used a walker, and a wheelchair, required substantial to maximal assistance with toileting hygiene, partial to moderate assistance for showering and bathing, set up assistance for upper body dressing, and supervision or touching assistance for personal hygiene. R74's Medical Diagnosis form indicated the following diagnoses: metabolic encephalopathy, Alzheimer's disease with late onset, chronic diastolic congestive heart failure, unspecified atrial fibrillation, unspecified dementia moderate with other behavioral disturbance, cognitive communication deficit, Parkinson's disease, and long-term use of anticoagulants. R74's Clinical Resident Profile, saved 6/10/25, indicated R74 was [AGE] years old. R74's care plan revised on 4/9/25, indicated R74 was hard of hearing and had bilateral hearing aids. Interventions indicated to speak clearly, repeat conversation as needed, assist resident with placing, removing, and storing of hearing aid. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R74's care plan dated revised on 4/25/25, indicated R74 had an alteration in skin integrity due to weakness, advanced age, Parkinson's, impaired mobility, and anticoagulation. Additionally, R74 had thin skin that was prone to bruising due to anticoagulation usage and frequently bumped arms into his wheelchair and other items and interventions indicated to document on skin condition and keep the physician or physician assistant informed of changes, monitor skin integrity daily during cares and weekly skin inspections by the nurse. R74's care plan revised 5/2/25, indicated R74 was a vulnerable adult and was at risk for decreased cognitive and physical abilities related to dementia with moderate behavioral disturbance and R74 experienced sundowning. Further R74 expresses feeling like he is having a nightmare but is awake and has become violent and swung objects at staff and is difficult to calm down and redirect. R74's goal was to remain free from abuse and or neglect and interventions included: allow space when R74 is upset, remove other residents from the surrounding area, remove objects of potential harm from residents nearby area, allow resident to express his frustrations, validate emotions, if resident becomes a danger to himself, residents, or staff call 911 to help deescalate the resident, monitor for signs of emotional distress or mood and behavior changes, resident will become agitated when he cannot hear. Ensure resident has his hearing aides in to allow for appropriate communication, safety monitoring will be implemented as needed to ensure resident's safety, staff will follow the facility vulnerable adult and abuse reporting policy, the local ombudsman, adult protection, police, and or state financial agencies will be notified of any suspected abuse or financial exploitation as needed, utilize de-escalation techniques with the resident. R74's care plan revised on 5/2/25, indicated R74 had an alteration in mood and behavior related to insomnia, cognitive communication deficit, urinary tract infection, as evidenced by anger at having to be in the facility, history of swearing, yelling, making statements of wanting to leave, putting self on the floor intentionally. Further, most behaviors seemed related to not wanting to be a resident at the facility. Interventions indicated to monitor and document mood, approach in a calm manner and provide resident with choices as appropriate, if resident becomes anxious remove from the crowded area. R74's Nursing Home Incident Reporting (NHIR) form dated 4/25/25, indicated R74 was combative and agitated, was swinging a foot pedal and metal shovel at staff and the nurse reported staff handled the situation unprofessionally and were unable to deescalate R74. Further, registered nurse (RN)-D and nursing assistant (NA)-G were immediately suspended and removed from the facility and immediate education to staff regarding abuse prohibition was completed among other interventions such as a full body skin assessment, monitoring orders for distress, and progress note every shift, hourly safety checks, notification of family, and R74 was evaluated by emergency medical services (EMS) and transferred to the hospital. Further, the form indicated R74 had old bruising noted to his hand, but had no signs or symptoms of physical injury. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R74's 5 day Investigation Report form dated 5/2/25, indicated R74 told the director of nursing (DON) he could not hear the staff because he did not have his hearing aids in and told the DON he felt like he was in a nightmare. The report indicated according to witness, NA-H, R74 was aggressive, swearing, hitting, and punching and going back and forth between units and screamed, Get me the fuck out of this place and would not calm down. The form indicated NA-H stated they tried to talk to R74 and get him to let go of the foot pedal but was swinging and hitting them with it and then R74 came back with a metal shovel. NA-H went back to her unit and let the nurse and the other NA handle the situation and R74 told EMS he was having a bad dream. The report further indicated licensed practical nurse (LPN)-E heard yelling and R74 was cussing at the nurse and swinging his foot pedal at staff and RN-D was trying to get the foot pedal away from R74 and was egging him on and wondering whether R74 would hit RN-D with the foot pedal. LPN-E stated RN-D swore at R74 and kept saying, You are going to jail, you are going to jail. LPN-E stated NA-G kept trying to get R74 back to his unit and threw a blanket over R74's head and grabbed the foot pedal away and shoved R74's head away from her to grab the foot pedal. Furthermore, RN-D stated R74 was angry and upset and swinging, yelling, and verbally abusing staff and kept going back and forth between stations. RN-D tried to do a pressure point on R74's wrist to get the foot pedal away and tried to lift his fingers off. RN-D called the police and denied touching other parts of R74's body and stated that was the aide. RN-D stated she did not engage in verbal arguments or call R74 names. Further, the form indicated NA-G stated R74 was screaming, loud, and combative and was hitting staff with something and R74 took the foot pedal that was on his wheelchair and was hitting staff with it. NA-G held R74's hands down and attempted to take away the foot pedal and shovel and threw a blanket over R74's head and NA-G was frustrated with the lack of immediate action from the nurse. The form indicated an allegation of abuse was substantiated against both RN-D, and NA-G who were immediately suspended at the time of the incident and ultimately terminated. A form, RN-D's Statement dated 4/24/25 at 12:15 a.m., completed by the director of nursing (DON) and the administrator indicated RN-D's statement. The form indicated R74 got into his wheelchair and wanted to get out of the facility and took off his foot pedal and started swinging it back and forth and knicked RN-D and they got it away from him. Further, RN-D lifted R74's fingers off the footrest by trying a pressure point that wasn't very successful and called the police about 11:30 p.m. The form further indicated RN-D tried to call the on call provider but there were issues with the phones and RN-D demonstrated on the DON's hand a pressure point and showed the actions of peeling her fingers off a pen and the form indicated RN-D used significant effort to get R74's hand off. Further the form indicated RN-D denied engaging in verbal arguments, or calling R74 a fucker. A form, NA-G's Statement dated 4/25/25 at 12:40 a.m., completed by the DON and administrator indicated NA-G's statement. The form indicated NA-G stated a guy was hitting staff and NA-G held his hands down and pushed him back to his unit and then the guy was back on their unit and had a shank or sharp shovel and there was a resident in a chair and NA-G grabbed it from behind and took it from him and then he took the leg off his chair and felt like he was going to hurt someone so through up like it over him and took the leg a chair. NA-G felt like she de-escalated the situation. Further, the form indicated NA-G got the item from behind so he couldn't hurt her and grabbed the leg of the chair. further, NA-G told the resident she may have to call the police if he didn't calm down and the resident wasn't calming down and denied calling resident a fucker, but the form indicated NA-G threw a blanket over R74's head and grabbed the foot pedal. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A form, LPN-E Statement Regarding the Incident, undated, indicated LPN-E reported an incident with a resident with a foot pedal where RN-D stated, I wonder if he will hit me with it and kept getting close to the resident and trying to grab it and the resident hit RN-D. Later, LPN-E heard a crash and the resident had a shovel and was yelling saying they were abusing him. The form further indicated LPN-E kept telling them to leave the resident and call an officer, but they kept engaging the resident and would not leave him alone. Additionally, NA-G grabbed the shovel and ripped it out of the resident's hands and the resident turned around and had the foot pedal and swung it at NA-G. LPN-E stated NA-G yanked it out of the resident's hand and grabbed the resident's head and forced his head down and stated the resident's middle finger was starting to bruise and looked swollen. Further, the statement indicated the resident kept stating stop abusing me and RN-D kept egging the resident on and the RN-D was stating you're going to jail and the resident said to call them and RN-D grabbed the residents shirt and said you little fucker. Further, the form indicated LPN-E stated they were antagonizing the resident. Additionally, the form indicated LPN-E stated NA-G threw a blanket over the resident's head. LPN-E could not recall if she saw bruises on R74's hands before the incident but thought they were already there except for the one on R74's middle finger on the right hand that was purplish. A form, NA-H Statement, undated, indicated R74 was aggressive and swearing, hitting, and punching and screaming get me out of the fucking place. The form indicated R74 was swinging it and hit himself too. The form further indicated maybe it looked worse than when it really was. NA-H stated they pulled R74's hands away and did not remember if anybody shoved R74's head and took away a foot pedal and put it at the nurses station. NA-H was on north when staff got the metal shovel and saw LPN-E, RN-D, and NA-G arguing amongst themselves and LPN-E stated it was getting abusive but NA-H did not know what happened because she wasn't present. Further, the form indicated NA-H was asked whether R74 was taunted and NA-H did not know and added they might have been, but could not identify who was talking in a way that sounded like they were taunting and further the document indicated NA-H stated, I think the other two were in heat at the moment, you know, I don't think anybody meant too many things. NA-H later in the statement indicated she thought there may have been swearing and that it was both of them. RN-D's personnel file was reviewed and indicated a letter from the facility to RN-D dated 5/9/25, indicating RN-D was suspended on 4/25/25, and the facility was not able to reach RN-D and requested RN-D contact the facility by 5/23/25, or would take the no communication as a voluntary resignation. An additional letter dated 5/19/25, indicated a discussion occurred indicating RN-D's employment was terminated due to substantiated abuse. NA-G's personnel file was reviewed and indicated a letter from the facility to NA-G dated 4/30/25, that indicated NA-G was terminated immediately due to substantiated abuse of a vulnerable adult. R74's progress notes from 3/25/25, indicated R74 yelled and swore and was easily agitated, climbed out of his chair and was transported out of the facility for suicidal ideations while throwing himself out of the wheelchair. R74's progress notes from 3/26/25, indicated R74's physician indicated R74 had behavior changes due to prednisone use and ordered to discontinue current prednisone (a steroid medication used to reduce inflammation) order. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R74's progress notes from 3/27/25, indicated R74 had increased confusion and restlessness, and agitation and a one time dose of seroquel (an antipsychotic) was ordered. R74's progress notes from 4/5/25, indicated R74 yelled and screamed and pounded on the wall, punching out, resisted cares, was physically aggressive. R74's progress note dated 4/10/25, indicated a urine culture was pending. RN-D's progress note dated 4/25/25 at 12:09 a.m., indicated R74 was yelling out and wanting out and was swinging at RN-D with his fist and verbally abusive. RN-D's note indicated R74 was left in bed and then R74 got up on his own and came out to the nursing area and hallways yelling he was kept against his will and grabbed a wheelchair pedal and started swinging it. The note further indicated they took the pedal away but R74 hit a staff person's wrist. R74 was brought down to the Park area and R74 grabbed a plant that had a garden tool in it and stated, now I am going to get you. RN-D was concerned R74 may hurt other residents and called 911 and was taken to the hospital to be evaluated. R74's progress notes following the incident on 4/25/25 at 12:09 a.m., indicated R74 was calm and had no further behaviors on 4/25/25. R74's progress notes on 4/26/25 at 1:51 a.m., indicated R74 was agitated and irritated and declined neuro and vital sign checks. R74's progress notes were reviewed following 4/26/25, to 6/10/25, and no further behaviors were documented. R74's Weekly Skin Inspection form completed by the director of nurse dated 4/25/25 at 2:21 a.m., and locked on 4/25/25 at 4:07 a.m., indicated, Patient has redness to right side of groin with moist area, house stock powder applied. Patient has 2+ pitting edema in top of bilateral feet. Bruising to 1 x 3 & 3 x 2 to right antecubital, 3 x 2 & 2.2x 1.2 & 2.3 x 1.4 to right wrist. 1.3 x 1.1 and 1 x 0.3 on right forearm, 3.5 x 2.5 & 0.5 x 0.5 & 0.8 x 0.4 left hand. A Fairview Health note dated 4/24/25 at 3:10 p.m., indicated from 3/27/25 to 3/29/25, R74 had a couple of falls and had possible dactylitis (an inflammation of the joints causing them to swell and appear sausage shaped) of the right middle finger and prednisone was discontinued. R74's After Visit Summary form dated 4/25/25, indicated R74 was seen for agitation and a history of dementia and quetiapine (an antipsychotic) was given on 4/25/25 at 12:43 a.m., and instructions indicated to continue with normal cares. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/9/25 at 6:32 p.m., R74 stated he made a lot of friends at the facility and stated the help was doing their duty and further stated if you were decent with them, you received much better care. R74 further stated he wasn't satisfied at first and added he was [AGE] years old and had freedom all those years. R74 stated early spring time he had to go to the bathroom and pressed the button to get service, but nobody came and then a lady came and asked what he wanted and R74 stated he had to go to the bathroom. R74 stated the lady wouldn't help him by herself and had to get somebody else. R74 stated he blew up at her and they were going down the hall throwing things at each other. R74 stated he ended up at the police department, but didn't get held and stated there were two staff persons and they were no longer at the facility. R74 stated they were trying to get him to shut up and further stated all he wanted to do was get some help. R74 stated that night she pushed too far and hit him and was throwing stuff at him and R74 stated he threw right back. R74 stated he did not know their names and stated he felt safe and since she's out of here, R74 stated he was back to living in heaven again. During observation on 6/10/25 at 12:36 p.m., R74 was with family member (FM)-A down the hallway and no behaviors were observed. During observation on 6/11/25 at 8:53 a.m., R74 was in his wheelchair in his room next to his television and did not have any behaviors. Phone calls were placed and messages left to NA-H on 6/10/25 at 3:43 p.m., 6/11/25 at 8:04 a.m., and again on 6/11/25 10:44 a.m., however was not able to interview NA-H. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/10/25 at 3:57 p.m., LPN-E stated she was working on a different unit on 4/24/25, and stated about 10:45 p.m., the pharmacy dropped off medications and she heard yelling from Park station and was yelling at the aide stating you guys abused me enough tonight. LPN-E stated NA-H was trying to talk to R74 and R74 was not violent. Further, NA-H asked to close the doors to keep R74 contained on their unit and R74 went through the doors about 11:00 p.m., had a foot pedal and was screaming and RN-D stated she wondered if R74 would hit her with the foot pedal and went up to R74, put her hand close to the foot pedal and R74 hit RN-D and she grabbed the foot pedal. R74 was fine with NA-H, but then 10 minutes later, LPN-E stated she heard yelling again and a loud bang and RN-D was in the hallway and LPN-E stated RN-D stated, I don't care we can do this all night and walked off. LPN-E stated there was a flower pot that had a gardening shovel and R74 was holding it and was backed up against the wall and looked petrified and LPN-E stated this was not R74's normal behavior and said to call an officer and RN-D walked off. R74 came to LPN-E's unit and LPN-E stated she walked with him and again told RN-D to call 911 and RN-D walked off and R74 still had the gardening shovel and they came around the north station and NA-G came out of the nurse's office. LPN-E stated to NA-G to be careful and not approach and let R74 cool off and NA-G insisted this was her unit and reached over and pulled the shovel from behind and yanked it back wards. LPN-E stated R74 got the foot pedal and started swinging it at her and NA-G backed up and threw a blanket on R74 and NA-G pushed his head down to the right. LPN-E stated NA-G was about to start fighting R74 and R74 was so worked up he was starting to hyperventilate. LPN-E stated she told R74 he was safe and R74 broke down crying and then RN-D came back and tried pushing R74 in his wheelchair and LPN-E told RN-D to call 911. LPN-E stated RN-D and NA-G kept coming back and attacking R74. LPN-E stated RN-D was trying to push R74 and LPN-E stated RN-D told R74 he was going to fucking jail and RN-D grabbed R74's shirt and LPN-D stated RN-D told R74 he was fucking going to jail and yanked R74 back in his chair and pushed him forward with his shirt and called him a fucker. LPN-E stated R74 kept screaming they abused him and LPN-E stated R74 was abused. LPN-E stated R74 had behaviors prior, but not like this and added that R74 was so happy now. LPN-E stated the director of nursing (DON) called her that night and both the DON and the administrator came in to the facility. LPN-E stated she worked through an Agency and stated the facility conducted training for the staff and had staff sign papers and thought she had signed paperwork on the night the incident occurred. A call was placed to NA-G on 6/11/25 at 8:28 a.m., and initially the call seemed to connect but then ended. A call was placed back to NA-G on 6/11/25 at 8:30 a.m., and went to voicemail and a message was left requesting a return call, but did not receive a return call. A call was placed to RN-D on 6/11/25 at 8:36 a.m., and a message was left, but did not receive a return call. During interview on 6/11/25 at 9:43 a.m., NA-I stated signs of abuse included hitting, leaving bruises, or taking things from residents and added they do Med Trainer online and don't have a strict meeting or learning. NA-I stated she had not heard anything from R74 and stated R74 was a sweet guy and kept to himself and had behaviors when he first came and now was the best person in the building. RN-I stated the facility comes around with pieces of paper they sign and discuss and stated she hadn't signed anything the last couple of months related to abuse that she could remember and then later stated she signed something a few months prior, but could not recall what it was for. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/11/25 at 10:02 a.m., NA-A stated R74 did not tell her he was abused and normally liked to joke around and was sweet. NA-A stated for abuse training the facility has them complete a questionnaire and answer questions and sign a paper form and if there was an incident put something in Med Trainer. NA-A stated she had to do a couple by the end of this month and thought about a month or two ago she had to sign something but could not recall what. NA-A stated R74 had behaviors in the beginning when first admitted for the first week or so and now has been a different person. During interview on 6/11/25 at 11:42 a.m., the administrator and director of nursing (DON) stated they completed immediate education and assigned online education as well including for staff who received the immediate education. The administrator stated the DON received the call and then called her and stated the staff members did not provide care and were sitting in the lobby and were pulled in for statements and RN-D, and NA-G were suspended. R74 was sent to the hospital and told EMS he had a nightmare. The DON stated R74 received seroquel (an antipsychotic) in the hospital. The administrator stated they interviewed RN-D first at 12:15 a.m., and R74 was agitated and yelling and swinging a foot pedal. The administrator stated both RN-D and NA-G admitted to not de-escalating the situation and egging R74 on. The administrator stated NA-G and RN-D both forcefully grabbed the foot rest and NA-G threw a blanket over R74's head and when NA-G said that, that was abuse to us and explained that was not ok and suspended NA-G. The administrator stated R74 did not have any injuries and the DON completed a skin check and determined R74 didn't have any injuries. The administrator stated RN-D egged R74 on and called R74 a fucker and dared him to hit her and with the egging behavior both RN-D and NA-G were walked out of the facility and they completed a full skin check on R74 and checked other residents. RN-D had not interacted with anyone else. The administrator further stated they completed immediate education and facility wide education. The facility wide education assigned contained caring for residents with dementia and elder abuse training and assigned it for the whole assisted living facility and nursing home. The first training was person centered care for persons with dementia and the second education was identifying and reporting elder abuse. The administrator stated they did not have video monitoring and another resident was watching television and went into their room and did not witness anything. During interview on 6/11/25 at 1:39 p.m., the administrator stated she brought in a list of employees and the course name that indicated completed, however there was no date of completion on the form of the list of employees who received training. The administrator stated everyone was trained and they completed verbal education and assigned training to all staff. The administrator stated she would provide the education staff completed along with the dates education was completed. During interview on 6/11/25 at 2:50 p.m., the administrator stated they had a new system through Med Trainer and had used Google Sheets and they ran the reports and identified a handful of staff that needed to complete their education and would be calling all those staff members today to educate them and further stated they would not be using Med Trainer and would go back to Google Sheets. The administrator stated they needed to call and get ahold of NA-J and a few other people for education. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/11/25 at 3:30 p.m., the administrator provided a form, that indicated at the top, Course due Employee full name, Course Name, Assignment date, Assignment Status, Completion Date, and Google Sheets Education and Education. The administrator stated the employees in red were new hires and hadn't worked yet but all the staff on the top of the form with a 6/11/25, date had been educated today on Elder Abuse. The form indicated there were 11 employees who were assigned the course, Identifying and Reporting Elder Abuse on 4/25/25, and had a pending assignment status and were educated on 6/11/25. The form indicated NA-J had not yet received education among other staff. Later, the administrator provided an updated form that indicated 42 employees including seasonal and on-call employees were provided education on 6/11/25. During interview on 6/11/25 at 4:13 p.m., RN-A stated she heard R74 had talked about being abused through hearsay and added R74 states he feels safe and was sweet and gave bear hugs. RN-A stated R74 was never combative with her. During interview on 6/12/25 at 2:02 p.m., the administrator stated she expected staff who were assigned education to complete the education or do an alternative education like reviewing the policy and completing a verbal education and further stated they completed immediate education and contacted staff 6/11/25, and completed a verbal education. The regional director of operations (RDO)-G stated unfortunately they used a new system and would be going back to the old way. A policy, Abuse Prohibition/Vulnerable Adult Policy, dated 4/2025, indicated the purpose of the policy was to protect residents against abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members, or legal guardians, friends or other individuals, or self-abuse. Further, abuse is 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 and includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Further, under a heading, Investigation/Protection indicated corrective action based on the investigation will be completed such as change of procedure, training, discipline or discharge of staff.