STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007181	A. BUILDING: _____ B. WING _____	C 05/04/2023

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S 000	Initial Comments Investigation of Facility Reported Incident of 04-25-2023/IL159086 - F600, F609, F610 A partial extended survey was conducted.	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 300.3240b) 300.3240g) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to investigate/prevent the abuse in 2 of 8 residents reviewed for abuse in the sample of 9.	S9999		

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S9999	Continued From page 2 This failure resulted in R1 and R2 being abused by V2, Former Administrator. Findings Include: 1. On 4/27/23 at 2:50 PM, V1, Director of Nurses (DON), stated she and V3, Minimum Data Set (MDS) Nurse, were standing at the nurse's station. V3 had just called V17, Regional Nurse Consultant, regarding an allegation of abuse with V2, Former Administrator and R2 that occurred on 3/9/23. V11, Activity Director, came to the nurse's station and stated yesterday (3/8/23) R1 was swinging his cane and V2 twisted the cane out of R1's hands. V1 stated she asked V11 why she did not report this on 3/8/23 and V11 stated because she didn't feel like it was abuse. V1 stated she notified V18, President of Operations of the allegations of abuse. On 4/27/23 at 1:56 PM, V11, Activity Director, stated the incident with R1 and V2, Former Administrator, occurred on 3/8/23. V11 stated R1's roommate came to her and told her R1 was throwing things. V11 went to R1's room, there were things all over the place, clothes, the bed side table was out in the middle of the floor, the nightstand had been moved and R1 was swinging his cane. V11 stated she asked R1 why he was swinging his cane, and he stated he was mad at the nurses, the aids, just mad at everyone. V11 stated R1 stated he was going to hit someone with the cane but never did, he just threatened to do it. V11 stated she went to V2 and requested he go and help her to get the cane away from R1 and to help R1 calm down. V11 stated she and V2 went into R1's room, V2 asked R1 what he was going to do with the cane? V2 then stated to R1, "you're not going to hit anybody." V2 then asked for the cane and R1 stated "no, you're not	S9999		

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S9999	Continued From page 3 going to get the cane." V2 then walked up to R1 and took the cane away from R1. V2 was holding onto R1's cane on both ends and R1 was holding the cane in the center. V2 then twisted the cane out of R1's hand. V11 stated she felt it was "excessive" but didn't see that it did any harm to R1. V11 stated R1 didn't act like it hurt. V11 stated R1 then picked up his cup and threw it at V2, grazing his left arm. V11 stated V2 stepped forward towards R1 and stated, "you can't act like this, hit people or throw things at people." V11 stated R1 was lying down flat on his bed and flinging his arms in the air and V2 walked over to R1 and stated, "what's wrong with you." V11 stated V2 then took his hands and placed them on R1's hands on R1's chest. V11 stated she felt V2 was trying to calm R1 down and no harm was being done. V11 stated she did not report the incident that day because she didn't feel it was abuse. V11 stated when she heard about the abuse between R2 and V2, she felt like she needed to report it to the DON. V11 stated she did not approve of how V2 dealt with R1, twisting the cane, and putting his hands down on R1's hands. V11 stated V2 is sterner with R1 and V2's approaches were not the best. On 4/28/23 at 9:00 AM, V11, Activity Director, stated the day before the incident with V2 and R2, there was an incident with V2 and R1. V11 stated she did not report the incident with V2 and R1 because she didn't feel that it was abuse, she felt that it was "inappropriate and excessive." On 4/28/23 at 2:10 PM, V1, DON, stated she assumed R1's abrasion occurred during the incident on 3/8/23 with V2. It was found during a skin assessment after the abuse allegation was reported on 3/9/23.	S9999		

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S9999	Continued From page 4 R1 no longer resides in the facility. R1's Face Sheet, undated, documents R1 has a diagnosis of Post Traumatic Seizures, Altered Mental Status and Difficulty in Walking. R1's MDS, dated 2/17/23, documents R1 is cognitively intact. R1's Care Plan, dated 2/10/23, documents R1 has a behavior problem towards others and will throw things and swing his cane at staff when he gets.upset and is at risk for abuse/neglect. R1's Care Plan Interventions include providing a safe and secure environment. R1's Progress Note, dated 3/9/2023 at 6:09 PM: At approximately 4:20 PM, staff reported an allegation of physical abuse. The alleged perpetrator immediately suspended pending the results of the investigation. Physician/Ombudsman/Local Police Department/Resident representative notified. Investigation initiated. R1's Skin Condition Report, dated 3/9/23, documents R1 has an abrasion/scratch to the right wrist measuring 2.3 centimeters (cm) x 1 cm and to monitor the area. The Abuse Investigation Final Report dated 3/16/23 by V18, President of Operations, documents on 3/9/23, an allegation of staff to resident physical abuse was reported. The alleged perpetrator was V2, Former Administrator. V11, Activity Director, was asked about an occurrence between V2 and R1. V11 stated R1's roommate asked for assistance with R1. V11 responded and noted R1 waving his cane around. V11 stated she attempted to calm	S9999		

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S9999	Continued From page 5 R1 and asked him for the cane. V11 stated she asked V2 for help and he responded. V11 stated V2 asked R1 for the cane and R1 refused. V11 stated R1 had one hand on the middle of the cane swinging it. V11 stated V2 then twisted the cane, releasing the cane from R1's grasp. V11 stated R1 and V2 then had a conversation and R1 calmed down and apologized for his behavior. R1 was interviewed and stated he doesn't want to be at the facility anymore. R1 was asked if there was an occurrence with V2, and R1 stated he was trying to hit them with a cane because they aren't medical doctors and shouldn't be messing with the sores on his feet. In a subsequent interview, R1 stated the "bald guy" did take his cane, but he got it back and the "bald guy" did get hit with the cane. V2, was asked if there was an occurrence between him and R1 regarding R1's cane. V2 stated R1 was attempting to sling his cane towards V11. V2 stated he sat down to talk with R1 and R1 was swinging his cane around. V2 stated he "caught" the cane and took it from R1. V2 denied twisting the cane to remove it from R1. V2 was again interviewed and asked if he twisted the cane from R1's hands. V2 stated he pulled the cane. V2 stated R1 had the cane with his right hand swinging it. V2 stated he grabbed the top and bottom of the cane and pulled it up because the weak spot is between the index finger and thumb. Conclusion and action taken: V2 utilized previous behavior management training (CPI) to remove the cane from R1's possession. V2 is no longer employed at the facility. The Abuse Allegation Interview with R1 by V13, Regional Nurse Consultant, dated 3/10/23, documents R1 stated he didn't hurt anyone with the cane, it ended with his shoulder getting sprained and it was with the guy that runs this	S9999		

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S9999	Continued From page 6 place. 2. On 4/26/23 at 10:24 PM, V9, Office Manager, stated R2 was going out the south door and V2, Former Administrator went after him. R2 made it to the sidewalk at the south door. The door alarm was sounding. V2 was telling R2 that he needed to come back inside and R2 was refusing. R2 was yelling, cussing, "this place is f****** ridiculous, I will hit you with my wheelchair." R2 was stating this to V2. V2 then wrapped his left arm into R2's right arm. V9, stated V5, Agency LPN (Licensed Practical Nurse) stated to V2, "what are you doing." V9 stated V2 did not respond to V5 and kept going, trying to get R2 inside. V2 was walking R2 back inside through the south door, as R2 was walking towards the doorway, he put his left arm on the building to keep from going back inside. When R2 and V2 got back inside the building, they were in the hallway near the south hall door, V2 put R2 against the wall for approximately a minute. As V2 was holding R2 against the wall, R2's face was sideways touching the wall and V2 had his hands on R2's back. R2 was able to move his arms, his hands, and head. V2 let R2 go because R2 wasn't yelling anymore and had calmed down. V9 stated R2 and V2 kept going back and forth talking about getting R2 to another facility that allows smoking. V9 stated V2 then went back to his office and R2 was sitting at the south door in his four-wheel Rollator Walker. On 4/26/23 at 11:12 AM, V10, Assistant Director of Nurses (ADON) stated on 3/9/23, she was in her office, heard the south door alarm going off, she looked down the hallway and saw a bunch of people at the south door. V10 stated she saw R2 and V2 coming in the door with their arms hooked together. V2 had a stern facial expression when	S9999		

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S9999	Continued From page 7	S9999		

he came through the door and started to walk closer to R2. As V2 and R2 made it through the door, they were saying something to each other, but she couldn't hear what was being said, they were both talking angrily. V10 stated she saw R2 against the wall but couldn't see if V2 was physically holding him, there were too many people standing in the way. V10 stated R2's face was against the wall. V10 stated V2 started walking towards his office and one of the CNAs got R2 situated and put him back in his Rollator Walker and began walking towards R2's room. V10 stated it wasn't right how V2 handled the situation. V10 stated that she and V3, MDS Nurse, called V13, Regional Nurse Consultant and V18, President of Operations and told them of the alleged abuse with V2. V10 stated she went to check on R2 and he was okay but mad, R2 was yelling at the CNA's (Certified Nurse Assistant) about the situation. V2 was in his office with his door shut.

On 4/26/23 at 4:14 PM, V11, Activity Director, stated she heard the door alarm go off and saw a bunch of CNAs down at the south hall door and V2, was running down the hall. V11 states R2 would go outside with the alarm sounding, stating he wanted to go out and smoke. V11 stated R2 was not allowed to go out and smoke because it's a smoke free facility, but R2 was alert and oriented, after the incident R2 was allowed to go outside to the sidewalk, after he signed a paper to go outside and would smoke.

On 4/26/23 at 4:38 PM, V8, CNA, stated she observed V2, grab R2's arm and R2 was holding onto the building and V2 was pulling R2 by the arm, V2 then grabbed R2's arms forcefully and pushed R2 up against the wall. R2 and V2 were yelling at each other in the hallway. V8 stated V2

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then went to his office shut the door and then left the building. V8 stated V2 should not have gone out and grabbed R2. After the incident R2 showed her his arms and he had scratches on his arms.

On 4/27/23 at 3:02 PM, V3, MDS Nurse, stated the door alarm went off, V3 turned down the hall and V2, had his arms locked with R2, coming back towards the building. R2 put his hand and wrists against the bricks wall by the south hall door and V2 was forcefully pulling R2's arm off the brick wall, "it wasn't gentle." V2 did not ask R2 to take his arm off the brick wall. V2 and R2 came to the door and V2 took R2 and placed him up against the hallway next to the door while V2's arms were still locked with R2's arm. V2 then took his arm out of R2's arm. V3 stated she "could see in V2's face, it was like a realization of handling the situation inappropriately." V3 stated she then notified V1, DON. V3, stated she was instructed by V13, Regional Nurse Consultant and V18, that V2 needed to leave the facility "right now." V3 stated V2 stated he was calling V18 as she followed V2 to the door.

On 4/27/23 at 3:33 PM, V3, MDS Nurse, stated things happened so quickly that they didn't have time to separate V2 and R2. V3 stated she was not aware that V2 had escorted R2 to his room.

On 4/27/23 at 3:35 PM, V2, DON, stated that V2 had only been at the facility for about two weeks and had an "authoritative demeanor, like he was an in-charge kind of person. He acted like military in general. In meetings he would say this is how it's going to be." V1 stated she was not aware and did not witness the incident with V2 and R2 until V3, MDS Nurse, reported it to her.

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S9999	Continued From page 9 On 4/27/23 at 4:25 PM, V20, CNA/Transportation Coordinator, stated the door alarm was going off and V2 was "man handling" R2 back into the door. V2 had both hands on R2 forcing R2 back in the building, he was using his body to shove R2 back in the building. V2 then put R2 up against the wall, face first with his arms wrapped around R2's arms so R2 couldn't move and R2's arm was twisted behind his back. V20 stated R2 kept repeating to V2 "there's nothing to talk about." V2 was talking "very harsh" to R2. V20 stated she was in "shock that (V2) could do this." On 4/28/23 at 9 AM, V3, MDS Nurse, stated she looked outside of her window in her office when she heard the door alarm sounding and saw V2, locked with R2. Once V2 and R2 were inside, V2 had R2 against the wall. V2 separated himself from R2 and walked down the hall. She thought V2 was walking to his office. V3 stated the whole incident occurred within 2-5 minutes and she is not sure how long it was between the incident with R2 occurred and when V2 exited the facility. V3 stated she did not see V2 go all the way to his office after the incident with R2. On 4/28/23 at 9 AM, V1, DON, stated V3, MDS Nurse, reported the incident with V2 and R2 to her (V1). She and V3 called V13, and V18, but V18 did not answer at first. V1 stated V18 called V3 and instructed her to walk V2 out. V1 is unsure of how long V2 was in the building between when the incident with R2 occurred and V2 actually left the building. V1 stated V16, CNA, had to separate R2 and V2. V1 stated R2 discharged to a sister facility. V1 stated R2 did not have any family and was homeless, R2 wanted to smoke and was angry that V2 was making him come back into the building. V1 stated R2 had his own cigarettes and tried to go	S9999		

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S9999	Continued From page 10 smoke. V1 stated they tried to take R2's cigarettes but he hid them. V1 stated after a couple of weeks of R2 being in the facility, they got to know him and because of his cognition, it was determined that he was safe to sign himself out, and would walk to the tree, the same place where the incident with V2 started. V1 stated prior to the incident with V2 and R2, R2 didn't get far enough to smoke. R2 would stand at the door and yell for someone to let him out so he could go and smoke. R2 was allowed to go to the sidewalk off the property to smoke after the incident with V2. On 4/28/23 at 10:05 AM, V18, President of Operations, stated she completed the majority of the investigation involving R2 and V2, and R1 and V2. V18 stated she was notified the evening of 3/9/23 of the allegation between R2 and V2. V18 stated they don't substantiate or unsubstantiate allegations of abuse, they just list the facts at the conclusion of the investigation. V18 stated V2 was terminated because he didn't meet the expectations on how situations should be handled. V18 stated V2 had abuse training upon hire. V18 stated she would expect staff to report instances of abuse and ensure that the resident is safe and separate them. V18 stated if abuse involves staff, they are asked to leave the building or get out of the immediate area, and she would expect staff to have stayed with V2 until he left the building. V18 stated the incident between R1 and V2, it was her understanding that R1 was swinging his cane and V11, Activity Director, asked for assistance from V2 and V2 went with V11 to R1's room to help. R2's Face Sheet, documents R2 has a diagnosis of Atherosclerotic Heart Disease, Hypertension and Homelessness.	S9999		

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S9999	Continued From page 11 R2's MDS, dated 3/17/23, documents R2 is cognitively intact. R2's Care Plan, dated 2/28/23, documents R2 is at risk for abuse/neglect with an intervention to provide a safe and secure environment. R2's Progress Notes, document the following: On 3/9/2023 at 6:06 PM, at approximately 4:20 PM, staff reported an allegation of physical abuse. The alleged perpetrator immediately suspended pending the results of the investigation. Physician/Ombudsman/Local Police Department notified. Investigation initiated. On 3/9/2023 at 9:32 PM, Follow up assessment completed for alleged abuse. Resident is alert and oriented. R2 appears to have a sad, worried facial expression. R2 stated my pride is hurt worse than my arm. New injury noted on assessment. Abrasion to left forearm measurers 12.2 cm X 2.5 cm. Redness, inflammation noted at site. No bruising noted. No swelling noted. R2's Skin Condition Report, dated 3/9/23, documents R2 has an abrasion/scratch the left forearm measuring 12.2cm x 2.5cm. The Abuse Investigation Final Report dated 3/16/23 by V18, President of Operations, documents on 3/9/23 an allegation of staff to resident physical abuse was reported. The alleged perpetrator was V2, Former Administrator. R2 was assessed for physical and psychosocial distress. R2 was noted to have minor discoloration to his forearms. V3, MDS Nurse, was interviewed and stated she stepped out of her office, located on the south hall because she heard the south hall door alarming, and she observed V2 escorting R2 back into the	S9999		

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ARCADIA CARE AUBURN	304 MAPLE AVENUE AUBURN, IL 62615

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12 facility. V3 stated V2 and R2 were locked at the elbows with V2 walking slightly in front of R2. V3 stated V5, Agency LPN (Licensed Practical Nurse), was behind V2 and R2. V3 stated that V2 appeared to be pulling R2. V3 stated once R2 and V2 were inside the door, R2 was against the wall and R2 and V2 were still locked at the elbows. V3 stated V2 then stepped away from R2. V3 stated she immediately reported the incident. R2 was interviewed and stated he wanted to go out to smoke, he understands the facility is a non-smoking facility, but stated he could walk around the block or off the property to smoke. R2 stated he went out the south hall door and grabbed his cigarette to smoke and V2 came out to bring him back in the building R2 stated V2 grabbed both of his arms to bring him back in the building. R2 stated both were talking loudly to each other. In a subsequent interview, R2 denied being resistive with staff but he was pulling in the opposite direction of V2. R2 denied being up against the wall when he returned to the building. V2 was interviewed and stated R2 had been having behaviors most of the day on 3/9/23. V2 stated R2 was cursing and exit seeking to go outside to smoke. V2 stated R2 walked out of the south hall door, and he escorted R2 back into the facility. V2 stated R2 was resistive as he attempted to get him back in the facility. V2 denied placing R2 against the wall upon re-entering the facility. Conclusion and action taken: R2 was exhibiting exit seeking behaviors related to wanting to smoke. R2 exited the facility out the south hall door to smoke. V2 and other staff members responded to return R2 to the facility. V2 utilized previous behavior management training (CPI) to assist R2 to return to the facility. V2 is no longer employed at the facility.	S9999		

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S9999	Continued From page 13 The facility abuse investigation documents the following: Interview with V5, Agency LPN on 3/14/23 at 12:54 PM, with V13, Regional Nurse Consultant, V5 stated she was out back of the facility on break, V3, MDS Nurse, asked her (V5) to go around to the south hall exit door, a resident was attempting to leave. V5 stated when she rounded the facility, R2 was facing the road with his walker and V2 was behind him telling him to come inside, "we're not going to do this." V5 stated she approached R2, and he turned towards V2, V2 then grabbed R2's right arm and started pulling him towards the door. V5 stated V16, CNA, V7, CNA and V9, Office Manager, was there V5 stated she said "oh no we can't" to R2. V5 stated R2 had one hand on the walker and let go of the walker. V5 stated she placed the walker behind R2 because it had a seat on it. V5 stated R2 and V2 got to the threshold of the door and R2 grabbed the brick wall and before she could make contact with R2's hand, R2 pulled his hand off the brick wall rubbing his hand/forearm on the bricks. V5 stated once they were inside, she placed the walker beside R2 as R2 was against the wall on his front side, V2 had R2's right arm with his right arm and V2's left arm was across R2's shoulders. V5 stated she reported this to V3. V5 stated R2 was cursing but not combative. V5 stated this was R2's second or third attempt to go outside to smoke. Interview with V27, CNA, on 3/10/23 with V13, Regional Nurse, documents R2 hasn't really been out of his room today, he's been sleeping more. On 3/9/23, V2, Former Administrator, was agitated with R2 because R2 wanted to smoke. Interview with V28, CNA, on 3/10/23 with V13, Regional Nurse, documents V28 didn't notice any	S9999		

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changes with R2, he doesn't seem to be bothered by it, but she hasn't seen R2 out of his room today, he is usually up and in the hallways.

An undated, written statement, signed by V29, CNA, documents V29 witnessed V2 forcibly grabbing R2 by the wrist causing him to scrape his arm on the brick wall and then once inside, V2 put R2 against the wall like he was arresting him.

A written statement signed by V7, CNA, dated 3/9/23, documents she witnessed V2 grab a resident (does not name a resident) by the arm and forcibly walk him into the building. During the process V2 used force and the resident received scratches from the outer brick wall. Once inside the building, V2 forcibly escorted him (unnamed resident) to his room, where another employee split them apart.

Interview with V2, Former Administrator, dated 3/9/23 at 5:44 PM, documents, V2 stated the staff had trouble with R2 all day. V2 stated R2 had been cursing at him because he would not let R2 go outside to smoke. V2 stated R2 walked out the south hall door and he (V2) had to escort R2 back into the facility. V2 stated R2 was resistive. V2 stated R2 raised his hands up and he (V2) had to put his hands up to defend himself. V2 stated this occurred inside R2's room. V2 stated V16, CNA, came in to R2's room during that time. V2 stated R2 kept sitting by the door, making comments that he was going to harm someone if he didn't get out. V2 stated the staff on south hall just stood there with "saucer eyes." V2 stated R2 kept saying he was going to leave throughout the day. V2 stated once R2 was back in the facility, he doesn't know if he "V2 was a little more excessive when trying to walk R2 back in but R2 was being resistive. V2 stated no other staff members were

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outside with him, R2 was only in the yard area and did not make it to the road from the south hall door. V2 denied placing R2's chest against the wall like he was being arrested.

Interview with V2, dated 3/15/23 at 2:31 PM, with V13, Regional Nurse Consultant, documents V2's intent was to bring R2 back into the facility for his safety. V2 stated when R2 came back into the facility, he was belligerent, threatening staff and him. V2 stated R2 was stating "I will kill a mother f**** if someone touches me, punch you in the face and throw my walker at you." V2 stated he attempted to re-assure R2 and calm him down but R2 continued to threaten. V2 stated he was not trying to push R2 against the wall, he had his left hand on the wall and R2's left shoulder against the wall.

Interview with R2, dated 3/10/23 with V13, Regional Nurse Consultant, documents he wanted to go smoke, R2 knew it was a smoke free facility, but he can walk around the block or off the property and smoke a cigarette. "I know what I'm doing with my life. I went out of the door, grabbed my cigarette and was starting to walk to smoke. The guy, the administrator guy, ran to get me and tried to forcefully get me back in the building. He grabbed both of my arms and was pulling and pushing me into the building. It didn't have to be like that. I was able to get my right arm out of his grip but he's a bigger guy than me, so he still had my left arm in his hand. We were both yelling. He tried to push me up against the wall, but I used self-defense."

Interview with R2, dated 3/10/23 at 12:36 PM by V18, President of Operations, documents R2 stated he exited the south hall door because he wanted to smoke, he was not going to be around

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the facility. R2 stated he had his clothes and a coat on, he walked to the door and out it. R2 stated within 5 minutes V2 came rushing out and grabbed him by both arms. Writer asked R2 to re-enact how V2 had his arms, R2 held writer's forearms just above the wrists. R2 stated he was not being resistive or fighting. R2 stated he was pulling in the opposite direction of V2. R2 stated once they were back into the facility, he sat in his walker and told V2 he wasn't going to his room, V2 kept wanting him to go to his room while he (R2) was saying he was going back outside. R2 stated as they were coming back into the building, he grabbed the brick wall. R2 stated nobody overpowers him or has authority over him and V2 was strict.

On 4/28/23 at 10:30 AM, the outside area just outside the south hall door was observed. The tree and sidewalk were approximately 40 feet from the building and approximately 45 feet from the road to the building. The road was not heavily traveled during the observation.

On 4/28/23 at 10:20 AM, V19, Current Administrator, stated V11, Activity Director, should have reported the incident regarding V2 and R1 and they would have been the one to decide if it was or was not abuse. V19 stated she teaches the staff that even if they aren't sure if it's abuse, but it doesn't look right or feel right, they should report it.

On 4/28/23 at 1 PM, V6, Medical Director, stated the incident that occurred with R1 and V2, Former Administrator, should have been reported on 3/8/23, when it occurred. V6 stated he had worked with V2 prior and wouldn't have expected this. V6 stated he wouldn't expect R1 or R2 to have been treated this way by V2. V6 stated R2

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S9999	Continued From page 17 has Heart Disease, Diabetes, had been homeless but was harmless. V6 stated he would expect the facility to protect its residents. V2, Former Administrator's, Corrective Action Form, dated 3/16/23, documents V2 was terminated on 3/16/23 for poor job performance, employee failed to meet expectations regarding resident behavior management. The Abuse Prevention and Reporting policy, dated 11/2016, documents this facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. (B)	S9999		