STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165373	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LONGVIEW HOME, INC	**1010 LONGVIEW ROAD MISSOURI VALLEY, IA 51555**

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** - Some	**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 resident and staff interviews, record review, facility policy review, and review of the facility's investigation, the facility failed to ensure residents were free from abuse and mistreatment for 6 of 7 residents reviewed. The facility reported a census of 95 residents. Findings include: 1. According to the Annual Minimum Data Set ((MDS) dated [DATE], Resident #2 admitted to the facility on [DATE]. The MDS documented the resident displayed severe cognitive impairment and also physical behavioral symptoms directed toward others and verbal behavioral symptoms directed toward others 1 to 3 days during the 7 day review period. The MDS indicated Resident #2 required limited assistance of one staff for bed mobility and transfers, and extensive assistance of one staff for toilet use, with frequent urine and bowel incontinence. The MDS listed the following Diagnoses: [REDACTED]. Review of Resident #2's care plan dated [DATE] revealed the resident experienced dementia and depression and could be a little anxious at times. The care plan encouraged staff return in a few minutes if the resident became combative during activities of daily living. The care plan also directed staff to monitor for adequate voiding every shift, toilet assistance with AM and PM cares, either before or after meals, and monitor for incontinence. The care plan guided staff to bathroom assistance if awake during the night. The care plan documented the resident walked with 1 staff assist with a walker as tolerated and a wheelchair for mobility. The care plan documented the resident had an altered thought process/cognitive loss: senile dementia Alzheimer's type with an initiation date of [DATE]. The care plan encouraged staff to ask yes/no questions to determine resident's needs, avoid rushing her with tasks, and use simple, 1 to 2 step commands for tasks. In an observation on [DATE] at 10:40 AM, the resident lay in bed sleeping. At 8:30 AM she was eating in the dining room. 2. According to the MDS dated [DATE], Resident #3 admitted to the facility on [DATE] and showed severe cognitive impairment and other behavioral symptoms not directed toward others on a daily basis. The MDS identified the behaviors significantly interfered with his care and participation in activities or social interactions. The MDS documented Resident #3 was dependent on 2 staff for bed mobility, required limited assistance of one staff for transfers, and extensive assistance of 2 staff for toilet use, and totally dependent on 1 staff personal hygiene. The MDS also documented Resident #3 as frequently incontinent of urine and bowel, with [DIAGNOSES REDACTED]. Resident #3's care plan with an initiation date of [DATE] documented the resident made sexual advances toward some female staff members and directed staff to remind him not to make comments and state that it is inappropriate. The care plan with an initiation date of [DATE], documented the resident experienced urinary incontinence and directed staff to monitor incontinent episodes, keep skin clean and dry, and try another staff or wait and try again in a few minutes if he would not allow incontinence care. The care plan documented the resident had a history of [REDACTED]. The care plan also offered he had a history of [REDACTED]. The care plan encourages staff to be prepared for sexual aggression during cares, document behaviors as they occur, redirect behaviors as they occur and use more than one staff member when providing cares if necessary. Observation on [DATE] at 10:50 AM revealed resident asleep in bed, and at 8:40 AM the resident was not in his room. 3. Review of an annual MDS with a reference date of [DATE] revealed Resident #4 admitted to the facility on [DATE]. The MDS documented the resident displayed moderate cognitive impairment and required extensive assistance of one staff for bed mobility and toilet use and extensive assistance of 2 staff for transfers. The MDS indicated he was frequently incontinent of urine and occasionally incontinent of bowel. The MDS listed the following Diagnoses: [REDACTED]. Review of Resident #4's care plan with an initiated date of [DATE] documented the resident had dementia and frequent urinary incontinence. The care plan directed if the resident became resistive to get another staff, or wait and try again in a few minutes. The care plan also documented altered thought process/ cognitive loss: history of dementia, [MEDICAL CONDITION] , and [MEDICAL CONDITION] with an initiated date of [DATE]. The care plan instructed staff to allow time for response, avoid rushing and cue, reorient, and supervise as needed. The care plan encourages staff to not argue with resident, use simple 1 to 2 step commands to tasks. The care plan indicated Resident #4 had a history of [REDACTED]. The care plan encouraged staff to allow Resident #4 private time in his room when repeatedly touching himself and intervene if having an altercation. Staff are also instructed to redirect behaviors as they occur. Review of Resident #4's Electronic Health Record (EHR) revealed the following progress note: on [DATE] at 10:36 PM he continued with behaviors, more aggressive today. Resident #4 was ramming hard into staff with wheelchair pedals, setting off the front door alarm numerous times, banging into front windows, running into other resident's wheelchairs and putting his hands down pants often. Observation on [DATE] at 10:49 AM revealed Resident #4 was not in his room. 4. According to an MDS dated [DATE], Resident #5 was admitted to the facility on [DATE] and displayed severe cognitive impairment. The MDS indicated she had fluctuations of inattention and disorganized thinking and required extensive assistance of 2 staff for bed mobility and transfers. The MDS listed Resident #5 was totally dependent on staff for toilet use and was frequently incontinent of urine and bowel. The MDS listed the following Diagnoses: [REDACTED]. Review of Resident #5's care plan listed the following Diagnoses: [REDACTED]. The care plan had a focus section with an initiation date of initiated of [DATE], which documented Activities of Daily Living: dementia, [MEDICATION NAME] degeneration, depression. The care plan directed staff to watch for incontinence, offer peri-care assistance, monitor for adequate voiding every shift, offer toilet assistance with AM and PM cares and either before or after meals. Staff are also encouraged to offer toileting assistance on rounds during the night. The care plan also had a focus related to urinary incontinence: dementia, with a history of urinary tract infections, with an initiation date of [DATE]. The care plan directed staff to monitor for incontinence episodes, keep skin clean and dry. The care plan also had a focus related to altered thought process/cognitive loss: dementia with a date of [DATE]. The care plan encouraged staff to avoid rushing, don't argue with the resident and talk to resident during cares and explain what you are doing. Resident #5's care plan has a focus with a date of initiated of [DATE], which stated mood and/or behavior: she has a history of mild depression and episodes of verbal aggression. The care plan encouraged staff to be prepared for physical aggression during cares, allow the resident to have space should she become physically aggressive, inform her what will be done beforehand, redirect behaviors as they occur, and use more than one staff member when extremely combative. Review of progress notes revealed the following note: [DATE] at 2:15 AM resident was very combative during cares when CNA was changing her brief due to urinary incontinence. Resident was verbally abusive, attempted to scratch and bite during cares. Personal cares completed with 2 assistance of staff while calmly explaining why her brief needed changed. Observation on [DATE] at 8:30 AM revealed resident was eating her breakfast. 5. Review of Resident #6's quarterly MDS with a reference date of [DATE] revealed he was admitted to the facility on [DATE]. The MDS indicated he experienced mild cognitive impairment and required supervision for bed mobility, limited assistance of one staff for transfers, and extensive assistance of one staff for toilet use. The MDS documented the resident as frequently incontinent of urine and occasionally incontinent of bowel. The MDS listed the following Diagnoses: [REDACTED]. Review of Resident #6's MDS that was completed around the time of the incident, listed a

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

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.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) reference date of [DATE]. The MDS indicated he required limited assistance of 1 staff for bed mobility, transfers, and extensive assistance of 1 staff for toilet use. Review of Resident #6's care plan revealed a focus with a date of initiation of [DATE], which stated he had the following Diagnoses: [REDACTED]. The care plan directed staff to monitor for incontinence and provide peri cares while resident is standing. The care plan with an initiation date of [DATE] revealed the resident was incontinent of bowel and urine. Staff are to ask questions that require simple yes or no answers to determine resident's needs. Staff are to avoid rushing, talk to residents during cares and explain what you are doing. During an interview with Resident #6 on [DATE] at 10:40 AM, he was asked if anyone had been mean or unkind to him he said think so then stated no, no, no. When asked if anyone had sprayed him in the face with water or peri-wash he again think so, then no, no, no. He stated he did not remember a CNA in question and stated yea when asked if he felt he could talk to someone if anyone mistreated him. Review of the facility's investigation revealed the following: -On [DATE] at 8:00 PM new employee, Staff J Certified Nursing Assistant (CNA), reported to the Director of Nursing (DON) concerns with her training on [DATE] with Staff A CNA. Staff J stated that when Staff A would prove cares to Resident #2, that she tossed her back and forth in bed and sprayed peri wash near her face. Staff J stated Staff A to her that she was training her like a dog. Staff J stated while they provided cares for Resident #3, he had made sexual inappropriate comments to Staff A, she then responded with sexual inappropriate comments back. Staff A also sprayed peri wash near his face when providing cares. Staff J also reported there was an incident in the dining room where Resident #4 was touching himself. Staff A then went up to him and made similar motions on herself, over her clothing right in front of him. Staff J stated another staff member intervened and told Staff A to stop, reassured the resident and provided him privacy. -The DON reported this to the Administration at 8:30 PM on [DATE]. The Administrator, Assistant Administrator and DON discussed the events and reported to the facility immediately as Staff A was working. Staff A was terminated at 9:00 AM and Administration began to further investigate immediately and interviewed staff members that worked that day. -On [DATE] the Administrator and Assistant Administrator interviewed all working staff. On [DATE] and during the next few days, other staff who had worked with Staff A were interviewed by the DON and Administration. The staff were asked about the incidents, if they witnessed it, or had witnessed anything in the past with Staff A. The following employees listed are the ones who had knowledge of the situation or witnessed something in the past with Staff A: -Staff M CNA stated she did not witness the incidences, but in the past had heard Staff A cuss and make inappropriate comments to residents and to staff as well. -Staff P CNA stated that she did not witness the incident, but in the past had heard Staff A respond inappropriately to resident who makes inappropriate sexual comments. -Staff N CNA stated that she had not witnessed this incident, but stated Staff A would rush her work. -Staff J CNA per her statement and interview with the DON, on [DATE] (her first night of training) she had witnessed Staff A call residents names and spray Resident #5 with peri wash near her face to train her like a dog because she had been combative with cares. Staff J also stated that Staff A sprayed peri wash near Resident #3's face and Staff A told him she needed to clean his perverted mouth out. Staff J also stated Staff A told Resident #3 that Staff J will suck you dry when he was making inappropriate comments. Later in the shift Staff J stated that Staff A went up to Resident #4 as he touched himself in the dining room and made sexual gestures. Staff A stated to Staff J that she did that to embarrass him so he would stop acting that way. -Staff K CNA per her statement and interview with the DON, [DATE] she witnessed Staff A go up to Resident #4 in the dining room and try to embarrass him by telling him needed to pull his hands out of his pants. Staff K stated that Staff A went up to Resident #4 right away and removed him from the situation. Staff K stated she went to Staff A, stated that that was inappropriate in which Staff A got angry with her and left for her break. Staff K stated she did not witness any of the other incidents that occurred that night. -Staff L CNA per his statement and interview with the DON, on [DATE] he witnessed Staff A come in to Resident #6's room while he was on the toilet. Staff A then sprayed peri wash from Resident #6's peri area to his face. Staff L apologized to Resident #6, cleaned him up, and rinsed his mouth. Staff L stated he did not witness the other incidents that occurred that night. -Staff C CNA stated he did not witness these incidents, but was made aware of them and he notified the DON of his concerns on [DATE]. -All staff interviewed regarding the incident were educated on the Abuse Policy during the interviewing process starting on [DATE]. All staff were given a copy of the Abuse Policy for review when they worked their next shift starting on [DATE]. -The DON notified all of the resident's families involved: Resident #2, #3, #4, #5, and #6. -The Administrator and Social Worker interviewed all interviewable residents that Staff A took care of on that night. No concerns with Staff A were brought up regarding the incidents on the night of [DATE]. Three residents stated Staff A does work fast and seemed rushed when doing cares. Review of staff interviews revealed the following written statements: -On Wednesday [DATE]th 2019, Staff J CNA worked/trained with Staff A CNA. While training with Staff A she witnessed her call residents [***] and[***] . Staff J witnessed Staff A be rough with Resident #2 because she was not being cooperative, so Staff A left her and told her she could just go to bed with nothing on. Staff J stated she assisted Resident #2 to put her arms through her shirt, Resident #2 said thank you to Staff J. Staff J stated she witnessed Staff A spray Resident #3 in the face with peri wash and stated she needed to clean out his dirty, perverted mouth. Resident #2 made sexual comments and that's why Staff A sprayed peri was in his face. Staff J also stated she witnessed Staff A spray Resident #5 in the face with a water bottle. Staff A told Staff J she did that to train her like a dog because she was combative. Staff J witnessed Staff A make sexual gestures to Resident #4 as he had his own hands down his pants and told her she tried to embarrass him to get him to learn not to do that in the middle of the dining room. Staff A stated to Staff J that she is nice to them now, but give it 3 months and she will be more like Staff A. Staff K signed her written statement. -Staff K CNA indicated he witnessed Staff A around 8:00 PM on Wednesday ([DATE]), approach a resident in the dining room and tried to embarrass him by yelling that he needed to pull his hands out of his pants. Staff A told the resident he was being perverted. Staff K told Staff A that that was inappropriate and she went and handled the situation herself. Resident stopped his behaviors, but Staff A got angry and told Staff K that wasn't how we handle things, then left for her break. Staff K signed her written statement and dated it [DATE]. -Staff L CNA indicated he had assisted a male resident to bathroom and got him ready for bed during his [DATE] shift. As Staff L was waiting for the resident to finish using the bathroom, and Staff A opened the door to the hallway, walked into the room, grabbed the bottle of peri wash, and sprayed the resident from his genitals to his mouth, then walked out. Staff L apologized to the resident, wiped off the wash, and had him rinse his mouth. After the incident, Staff L meet with Staff C CNA and Staff K CNA about what he had witnessed. Staff L indicated the resident involved was Resident #6. Staff L signed his written statement. During a staff interview on [DATE] at 12:11 PM, Staff J CNA stated she trained a day with Staff A CNA the day the incidents happened. Staff J stated Staff A called the residents names such as[***] and [***] , but does not remember which residents. She stated the residents she spoke to in this manner lived on the North Hall. Staff J stated Staff A sprayed water in their faces with a spray bottle, was aggressive when changing residents would roll residents over and push them into the wall and not care that that happened. Staff J stated one resident screamed the whole time; Resident #5. Staff J stated Resident #5 would normally scream and holler but nothing like that when Staff A worked with her. Staff J stated Staff A sprayed water in Resident #5's face. Staff A stated she did this to train her like a dog. Staff J stated Staff A called every resident they helped names and some of those residents were cognitively impaired. Staff J stated Resident #3 would always make inappropriate comments and tried to grab females. She indicated Staff A told Resident #3 something sexually inappropriate, and Staff J stated this made her very uncomfortable. She also reported Staff A sprayed peri was in his mouth to clean out his mouth, while they were in his room. Staff J stated Resident # 4 was in the dining room with his hands down his pants, and Staff A approached the resident and made a sexually suggestive gesture toward him. Staff J stated Resident #4 did not respond because he does not talk. Staff J stated she talked to the DON because none of what Staff A did was right. She stated that was the first time meeting her on the 27th and had only worked with Staff A that one time. Staff J had her investigation statement read to her and affirmed it was true. During a staff interview on [DATE] at 2:11 PM Staff K CNA stated she saw Staff A throw things such as tooth cups, wet washcloths and emesis basins at residents, spray peri-wash on them, and act in a very disrespectful manner. Staff K reported this had been going on for a while, but she did not remember which residents. Staff K stated Staff A worked on North and East Hall, and Staff J and Staff L had also witnessed these behaviors. Staff K reported Staff A grabbed Resident #4's hands out of his pants, yelled in his face, and called him a pervert, idiot, molester, and retard. Staff K stated the resident and started to have more behaviors to make her mad. He started to run in to things, grab things and kept doing those things. Staff K stated Resident #4 was usually redirectable but after that incident, he would not stop. Staff K stated Staff A would nit-pick residents to irritate them on purpose. She would use their own pet peeves against them. Staff K had her statement from the investigation read to her and stated it is 100% accurate and true. During a staff interview on [DATE] at 2:49 PM Staff N CNA stated she had worked with Staff A and she was not a good employee. Staff N stated Staff A was loud toward residents and would tell them to shut

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) up and stop being so loud. Staff N reported these were residents that had no control over their outbursts and actions commented Staff A should not have been working in long term care, she seemed mentally unfit. During a staff interview on [DATE] at 2:59 AM Staff M CNA stated when she first met Staff A she was fine, but as time went on began having an attitude towards people; she cussed at them and was exceedingly rude. Staff M stated Staff A had called residents [***] es to their face. She reported that one resident had sensitive feet, and Staff A had her in a hoyer lift and then hit the emergency button and made her feet hit the ground. She stated Staff A was not wanted on Main East Hall, so she and Staff A would switch assignments. Residents would tell Staff M they did not like Staff A and say the blonde is mean. She added Staff A was very rude and a lot of the residents did not want her at the facility and were relieved when she got fired. Her statement was read to her and she stated verified it was accurate. During a staff interview on [DATE] at 3:14 PM Staff O CNA reported he had worked with Staff A and said she could be mean at times, easily frustrated with things, and had a short fuse. He added if he felt she was frustrated he would tell her to leave the room. He reported she had been short with residents and did not sound nice when responding to residents, as if they were a bother. During a staff interview on [DATE] at 8:12 AM Staff C CNA stated Staff A was not good with residents because she had a poor attitude and was rough with the residents. He stated he never got along with her, she was short tempered for no reason and had no patience. He stated when he would work with her and she would become short, he would ask her to leave because of how she was acting. He stated he never witnessed Staff A spray peri wash in residents' faces, but Staff A did tell him about it. She told him she sprayed peri wash at residents because they were annoying and she mentioned Resident #6's name. Staff C stated once she told him that, he ripped her up one side and down the other and she never mentioned it after that. Staff C stated residents would talk to him when they needed to and one (now deceased) resident told him she was rude and rough, so he told the Director of Nursing of his concerns on [DATE]. In an interview on [DATE] at 9:41 AM Staff L CNA 2:26 PM stated Staff A always had an attitude, was a hot head, snapped quickly, and was not his favorite employee to work with. He stated Staff A would be kind of forceful and rude with residents. He reported One time he had assisted a resident to the bathroom when Staff A came in to restroom and sprayed peri-spray on him as he sat on the toilet. Staff L stated Staff A began at the genital area and swept upwards and he thought some had landed in the resident's mouth. Staff L stated it was Resident #6 and he apologized to the resident after Staff A left. Staff L stated he went to another coworker about the incident and talked to their boss also. When asked if Resident #6 would remember the incident he stated does not think so because of his mental capacity. Staff L verified his statement as accurate. During a staff interview on [DATE] at 8:42 AM Staff H CNA was asked what would she do if she saw or heard another staff member being mean or unkind to a resident. Staff H stated she would report to the DON or anyone available. She stated she would ask the other staff members to step out of the area and make sure the resident was safe. During a staff interview on [DATE] at 8:46 AM Staff I Licensed Practical Nurse (LPN) was asked what would she do if she saw or heard another staff member being mean or unkind to a resident. Staff I stated she would intervene right away and report the incident to her supervisor. Staff I stated she is responsible for reporting it because she is a mandatory reporter. During a staff interview on [DATE] at 10:09 AM the Assistant Administrator was asked what her part was in the investigation. She stated she helped the Administrator and the DON once all they came in to the facility that night. It was Thanksgiving so everyone was out of the facility. They reported to Staff A what other staff members told them, terminated her, and escorted her out of the building. During a staff interview on [DATE] at 10:54 AM the DON stated Staff A did not have prior disciplinary actions, she just had to give verbal counsel a couple times to Staff A. The DON reported the Administrator, Assistant Administrator and she completed an investigation, summoned Staff A to the office, counseled her, and then terminated her. When asked what her expectations are of staff if they were to notice other staff members being mean or unkind to residents, she stated she would want them to intervene immediately and let the charge nurse know what was going on. Review of Staff A's work schedule for [DATE] revealed she had worked the North Hall on the night of the alleged incidents. The North Hall is where the residents resided on the night of the alleged incidents. Review of the November schedule revealed she worked 9 of her 17 shifts on the North Hall. Review of Staff A's employee file contained a concern report dated [DATE] that indicated the problems were conduct, attitude, work not satisfactory, and lacked cooperation. The report stated: Staff A ate a resident's magic cup off a tray, upset when co-worker is taking time with a resident-trouble with teamwork-rolls eyes-upsets easily with assignment adjustments-makes comments to co-workers that promotes lack of teamwork-negative attitude. Staff A's response was she did not eat the magic cup, that she stated this smells good, I want to eat it. Action taken-encouraged positive communication and teamwork. Verbal counsel given with warning that if negative attitude and teamwork does not improve that her employment will end. Resident care should always come first and to stop score keeping with co-workers. The report was signed by the DON and Staff A. Review of the facility's Abuse Prevention, Identification, Investigation, and Reporting Policy revealed a policy statement: All residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptom. Residents must not be subjected to abuse by anyone, including, by not limited to, facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. The policy defined assault of a dependent adult as the commission of any act which is generally intended to cause pain or injury to a dependent adult, or which is generally intended to result in physical contact which would be considered by a reasonable person to be insulting or offensive or any act which is intended to place another in fear of immediate physical contact which will be painful, injurious, insulting or offensive, coupled with the apparent ability to execute the act. The policy defined caretaker as a person who is a staff member of a facility or program who provides care, protection, or services to a dependent adult voluntarily, by contract, through employment or by order of the court. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Physical abuse includes but is not limited to hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. All allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator or designated representative. The policy stated upon receiving a report of an allegation of resident abuse, neglect, exploitation or mistreatment, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. During an interview on [DATE] at 12:00 PM Resident #7 recalled Staff A, CNA, was rough with her during cares. Resident #7 stated she required help turning and Staff A would push her against the side rails in a rough manner. She stated Staff A was never mean to her, she felt Staff A liked her. Resident #7 stated Staff A would get in a rush and be rough. Resident #7 stated Staff A brought her boyfriend to meet her one time. During an interview on [DATE] at 9:55 AM, Resident #2 stated she remembered Staff A. The resident stated Staff A would wipe her too hard. Resident #2 stated Staff A appeared rushed and would be rough when getting her cleaned up and wiping her down. Resident #2 recalled Staff A spraying her in the face when she was getting cleaned up during bed baths. Later, Resident #2 revealed she didn't feel safe in the situation. She stated it made her feel bad and it hurt. In an interview on [DATE] at 10:54 AM, Staff B, CNA, stated if she saw a staff member being abusive toward a resident she would remove the resident from the situation, call the state and notify the DON. Staff B stated she is current on her dependent adult abuse training. In an interview with Staff C, CNA, on [DATE] at at 11:03 AM reported he would make sure the resident was in a safe environment and tell the employee to leave. He stated he would report the staff member and situation to the DON, charge office RN, leading nurse, or med-aide about what occurred. In an interview on [DATE] at 11:05 AM, Staff D, CMA, reported if she saw a staff member act in an abusive way toward a resident she would tell her supervisor and administrator immediately. She stated she never worked with the staff member. Staff D stated she is current on her dependent adult abuse training. During an interview on [DATE] at 11:21 AM Staff E, LPN, stated if she saw a resident hurt a resident she would remove the resident, take the resident to safety, and report the staff member to the state and to administration. She reported she is current with her dependent adult abuse training. During an interview on [DATE] at 11:52 AM Staff F, CNA reported he if a staff member being abusive towards a resident, he would intervene and report the situation to the nurse supervisor. He reported he is current with his dependent adult abuse training. In an interview on [DATE] at 11:55 AM Staff G, housekeeper and laundry staff, stated she is required to have the

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