STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. BUILDING _____ B. WING _____	**11/15/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARAVILLA CARE CENTER	**8825 SOUTH 7TH STREET PHOENIX, AZ 85042**

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 -** 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 video footage review, clinical record reviews, staff and resident interviews, and policies and procedures, the facility failed to ensure two out of three sampled residents (#1 and #3) were free from abuse. The deficient practice could result in further abuse of residents. Findings include: -Review of the personnel record for a Licensed Practical Nurse (LPN/staff #76) revealed a hire date of (MONTH) 18, 2006. Review of the training records revealed staff #76 had received training for prevention of abuse and neglect in 2019. -Review of the personnel record for a Certified Nursing Assistant (CNA/staff #238) revealed a hire date of (MONTH) 24, 2010. Review of staff inservice sign-in sheets revealed that staff #238 attended directed inservice training for prevention of abuse and neglect on (MONTH) 9, 2019. -Review of the personnel record for a CNA/staff #239 revealed a hire date of (MONTH) 21, (YEAR). Review of the training records revealed staff #239 had received training for prevention of abuse and neglect in 2019. -Resident #1 was readmitted to the facility on (MONTH) 30, 2019, with [DIAGNOSES REDACTED]. Review of a behavioral care plan dated (MONTH) 13, 2019, revealed the resident would set herself on the floor when upset with staff, and was prone to romanticizing male staff relationships. Interventions included to use a soft approach with a smile, to use two staff to assist off the floor or escort the resident to her room when aggressive, and male staff to stay at arms length to prevent inappropriate touching. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 4, 2019, revealed the resident had short and long term memory problems and moderately impaired cognitive skills for daily decision making. The assessment also included that the resident required supervision for transfers and limited assistance for walking on the unit. Review of a nursing note dated (MONTH) 6, 2019, revealed that while reviewing video footage of another incident involving the resident, footage of subsequent staff treatment of [REDACTED]. The note included that the resident was interviewed and assessed to have no injuries or complaints of pain or discomfort. The resident's behavior was described as appeared to be doing well. Review of the facility's investigation report revealed that on (MONTH) 5, 2019, at approximately 8:00 p.m., the resident was involved in an altercation with another resident. The report included that during review of the video footage after the incident, two Certified Nursing Assistants (CNA/staff #238 and #239) appeared to be handling the resident in an inappropriate manner by removing her walker by snatching it from her, pulling on her legs to remove her from sitting in the threshold of a door, blocking her from entering the dining room and television rooms, blocking her from sitting in a chair that was placed in the hallway, and making body gestures that were considered inappropriate for interaction with this resident. The report included a statement written by a Licensed Practical Nurse (LPN/staff #76), which included she had asked the CNAs to keep the resident out of the dining area so she would not hurt anyone else and to allow the resident into the television room, but the CNAs told her that the resident had tried to attack another resident there. The report included a statement written by staff #238, which included that she thought she was following protocol by making sure the resident was not hurting anyone or self and by keeping the residents separated. The report included a statement written by staff #239, which included she was not making punching gestures to mock the resident, she was re-enacting the gestures of another resident who had said the resident was fighting, and the reason the resident's walker had been taken away until she calmed down was because the resident was known to use her walker as a weapon. The report included that the allegations of abuse against staff #238 and #239 were substantiated and the two staff members were terminated. During the survey, video footage from (MONTH) 5, 2019, was reviewed on (MONTH) 15, 2019. Review of the footage revealed the following scenario: Resident #1 was seated in the dining room and she began to do stretching motions of reaching for the ceiling and reaching for her toes. She stood up and began to walk toward the door. Resident #1 became involved in an altercation with another resident as she tried to walk between a table and the other resident's chair. A Certified Nursing Assistant (CNA/staff #88) rushed into the room and separated the residents, and two other CNAs (staff #238 and #239) tried to escort resident #1 out of the dining room. Resident #1 began to walk with her walker, then she collapsed herself to the floor. Staff assisted the resident to stand up, the resident walked a couple more steps, then she put herself on the floor again. Staff stood near while the resident pulled herself to a standing position using the door handle of the dining room door, then staff #238 and #239 assisted the resident to walk a step or two before she put herself on the floor again. Staff #88 left the area and returned with a wheelchair, and the other two staff members stood near the resident while she sat on the floor against the dining room door for several minutes. A Licensed Practical Nurse (LPN/staff #76) entered the room. The resident stood herself up, and the four staff members assisted the resident into the wheelchair and tried to pick up the resident's walker. The resident continued to hold onto the walker while seated in the wheelchair, and one staff member supported the walker while another staff member pushed the resident's wheelchair toward her room. Several minutes passed, then Resident #1 walked out of her room with her walker. Staff #238 and #239 were in the hallway with the resident, and staff #238 closed the dining room door and stood in front of the door as the resident approached. The resident turned around and started walking toward another resident seated in a wheelchair in the hallway. Resident #1 reached out to touch the other resident, staff #238 and #239 rushed forward to intervene, and resident #1 collapsed herself to the floor. The other resident propelled his wheelchair into the television room. Resident #1 stood herself up using her walker and tried to walk into the television room, but staff #239 stood in the doorway of the room to block the resident. Resident #1 turned and started walking toward a chair in the hallway, and staff #238 rushed to the chair and sat down. As the staff member sat in the chair, staff #76 approached. The three staff members stood and talked with resident #1, who was standing with her walker. Then the resident moved to the dining room door and began to pound on the dining room door. Staff moved forward to intervene, and the resident collapsed herself to the floor. Staff #239 pulled the walker away from the resident and brought the wheelchair closer to the resident. Staff #238 held the dining room door shut. Staff #76, who had been standing and watching the interaction, left the area. The only people in the hallway at that point were resident #1, staff #238 and staff #239. The resident was sitting on the floor with her back against the dining room door, and staff #238 and #239 stood on the other side of the hall facing the resident. The resident reached out and pushed her wheelchair away, then she reached for her walker. Staff #239 moved the walker out of reach of the resident, then staff #239 started to do dancing and boxing motions in the direction of the resident. Staff #76 started to open the dining room door from the inside while the resident was sitting against it. Staff #239 reached forward and grabbed the resident's foot to pull her approximately 2.5 feet out of the doorway, while staff #238 moved forward to push against the resident's back as she slid out of the doorway.

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 -** Actual harm **Residents Affected -** Few	(continued... from page 1) Staff #76 was facing the interaction as the resident was being pulled by her foot. The three staff members talked in the hallway while the resident remained seated on the floor, then staff #76 walked away. Staff #238 and #239 stood on the other side of the hall facing the resident and began to do dancing motions toward the resident. Resident #1 was still seated on the floor, and she began to do stretching motions of reaching for the ceiling and reaching for her toes for several minutes. Staff placed the walker in front of the resident, she sat on the floor for several more minutes, then she started to stand herself up using the walker. Staff #238 brought the walker behind the resident and staff #239 forcefully pulled the walker out of the resident's hands as the two staff members forced the resident to sit in the wheelchair. Staff #76 walked up as this was happening, and while resident #1 slid herself out of the wheelchair and onto the floor. The three staff members stood near while the resident pulled herself up using her walker, then staff #76 walked away. Staff #238 and #239 followed while the resident began to walk. Staff #238 moved to block the door to the television room and the resident stopped. Then the resident started walking toward the chair in the hallway. Staff #239 quickly moved the chair out of the resident's reach, as staff #76 re-entered the hallway. The resident was still standing and staff #76 walked away. The resident began to do stretching motions while standing with her walker. The resident walked to the chair in the hallway and sat down while staff #238 and #239 stood by. An interview was conducted with staff #76 on (MONTH) 15, 2019 at 12:32 p.m. She stated she remembered resident #1 had gotten into a fight with another resident, and when she arrived on the scene, other staff members were trying to help resident #1 out of the dining room and into her room. She said she had heard that staff #238 and #239 had allegations of abuse against them, but she did not witness any abuse. Regarding the video footage which revealed that staff #76 was present when the resident's walker was pulled away from her and when the resident was pulled out of the doorway by her foot, staff #76 stated she had not reviewed the footage and she did not know what was on it. She again stated she did not witness any abuse.An interview was conducted with staff #238 on (MONTH) 15, 2019 at 12:51 p.m. She stated resident #1 had been involved in an incident with another resident in the dining room, and staff #76 had instructed her to take resident #1 out of the dining room. She said resident #1 did not want to leave the dining room and kept collapsing to the floor. She said resident #1 was also blowing kisses at a resident in the television room, and the other resident was telling resident #1 to get away. She said she was trying to keep resident #1 from getting into another incident with another resident, and that is why she was trying to keep resident #1 out of the dining room and out of the television room. She said when staff #239 pulled the resident by her foot out of the doorway, she yelled at her coworker to stop, and she stopped. She said she had been trained in recognizing and reporting abuse, but she did not report the pulling by the foot because she did not think it was abusive. She said the video did not capture the overall feeling of the interaction with the resident, which was friendly and joking. She said the video showed laughing, but she and staff #239 were not taunting resident #1, they were joking with her. She said resident #1 was also laughing. An interview was conducted with the Director of Nursing (DON/staff #91) and the Administrator (staff #52) on (MONTH) 15, 2019 at 2:44 p.m. Staff #52 stated the expectation that if abuse was suspected, staff should first protect the residents, then report the allegations to their supervisor. He said the supervisor would notify the management team, who would come onsite or instruct staff on what to do regarding investigating and reporting the allegation. He stated he expected that allegations of abuse would be reported to the State Survey Agency within two hours. He said if an allegation of abuse was made against an employee, the employee would be suspended pending the results of the investigation. He said if an employee witnessed potential abuse and did not report it, there would also be an investigation conducted. He said the findings of abuse investigations involving staff members would be reported to the corporate office, who would advise the facility regarding the appropriate disciplinary action for the staff members. Regarding residents #2 and #3: -Resident #2 was admitted to the facility on (MONTH) 28, (YEAR) with [DIAGNOSES REDACTED]. Review of a Quarterly Minimum Data Set (MDS) assessment dated (MONTH) 15, 2019 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated that the resident had moderately impaired cognition. The MDS included that the resident had verbal behavioral symptoms directed at others 1-3 days of the seven day look back period. -Resident #3 was admitted to the facility on (MONTH) 12, 2019 with [DIAGNOSES REDACTED]. Review of the admission MDS assessment dated (MONTH) 21, 2019 revealed the resident was not able to be interviewed for the BIMS. It is noted that the resident had short and long term memory problems, and severely impaired cognitive skills. The assessment included that the resident is short tempered and easily annoyed, with physical behavioral symptoms directed towards others 1-3 days of the seven day look back period, and that those symptoms interfere with the resident's care and participation in activities and social interactions, and puts the resident at significant risk for physical illness or injury. It is also noted that the resident's symptoms put others at risk for physical injury, and intrude on the privacy or activity of others. It is included that the resident wanders daily. Review of a nurse's progress note, written by a Licensed Practical Nurse (LPN/ staff #128) dated (MONTH) 30, 2019 revealed that resident #3 was found inside resident #2's room and was sitting on the floor. The note included that resident #2 and resident #3 had an altercation inside resident #2's room. Resident #3 was wandering and entered resident #2's room. Resident #2 yelled for resident #3 to leave at which point resident #3 became physically aggressive, reaching out and scratching resident #2 on the chest. Resident #2 pushed resident #3 and resident #3 fell to the floor, sustaining a skin tear to the right elbow. A nurse's note written (MONTH) 30, 2019 by an LPN (staff #54) noted resident #2 had no injury to his skin at the time. A nurse's note entered on (MONTH) 30, 2019 by staff #54 states resident #3's skin tear remains to right elbow, covered in dressing. The resident was refusing vitals and neuro checks at that time. A wound assessment report from (MONTH) 30, 2019 was reviewed for resident #3. It notes a skin tear on the resident's right elbow. The cause stated was altercation with another resident. The wound measured 1.5 centimeters (cm) in length by 1 cm wide, with a depth of .2 cm. Video footage prior to the incident on (MONTH) 29, 2019 was reviewed on (MONTH) 15, 2019. Review of the footage revealed the following: Resident #3 was seen pacing the halls of her unit, she was observed walking from one side of the unit to the other several times. There was some activity off screen and several staff members were seen moving towards that activity. At the same time, resident #3 enters resident #2's room. The door to resident #2's room was open at the time. Resident #3 was inside of resident#2's room for less than a minute when a Certified Nursing Assistant (CNA), later identified as staff #89, was seen entering resident #2's room. Shortly after staff #89 enters resident #2's room, additional staff are seen entering the room, later identified as CNA/ staff #88 and LPN/ staff #128. Staff #89 and staff #128 are seen exiting the room with resident #3 and accompany her back to her room. Review of the facility's investigation report revealed that on (MONTH) 29, 2019, at approximately 7:30 p.m., there was a resident to resident altercation between resident #2 and resident #3. A written witness statement from staff #89 provided details of the incident- another resident in the hall was having a medical issue and required the attention of multiple staff members. Staff #89 was the assigned hall monitor and was instructed by the nurse to assist with the resident. There was no hall monitor at the time of the incident between resident #2 and resident #3 because staff #89 and the other CNA and the nurse from the hall were in another resident's room. Staff #89's statement continues to state that staff #89 heard a scream coming from resident #2's room and staff #89 immediately went to see what happened. Staff #89's statement reports resident #3 was on the floor when he arrived, and he called for additional staff to assist. Staff #89 notes that he and staff #128 assisted resident #3 to her room and staff #128 took additional necessary action. A witness statement completed by staff #128 was reviewed. Staff #128 reports that resident #3 was sitting on the floor of resident #2's room when she arrived, and staff #128 separated the residents and noted a skin tear on resident #3's right elbow. Staff #128 reports she provided treatment to the wound and completed the investigation of the incident. The resident interview of incident form was completed by staff #54 on (MONTH) 30, 2019 with resident #2. Resident #2 reported that resident #3 got in his face and was cussing at him. He asked her to leave. He pushed her and she fell down and got hurt. Resident #2 reported that he sustained a scratch in the altercation. Staff #54 completed an abuse assessment at that time and noted no sign of injury, no redness/scratches or bruising on the resident's skin at the time of the assessment. The resident interview of incident form for resident #3 was completed by staff #128 on (MONTH) 29, 2019. The resident was not able to answer any of the questions on the form.

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) Resident #3 was observed on (MONTH) 15, 2019 at 9:58 am. The resident was pacing the halls of her assigned unit, speaking softly to herself. Resident #3 was not interviewable, and attempts to engage her in conversation were not successful. The resident walked away each time she was approached. An interview was conducted with resident #2 on (MONTH) 15, 2019 at 2:03 pm. Resident #2 stated he remembers the incident and stated he was in his bed after dinner one evening and an old woman came into his room. He said he asked her to leave, and she would not. Resident #2 got up from his bed and stated when he did so, resident #3 put her hand up with her index finger out, as if she was accusing him of something, and resident #3's index finger contacted resident #2 on his chest. Resident #2 stated that following that contact, he pushed resident #3 back as if to push her out of his room, and resident #3 fell down to the floor. Resident #2 stated several staff members came to his room and removed resident #3 immediately after she fell . Resident #2 said he did not know if resident #3 was injured. Resident #2 stated the nurse examined him and the red mark on his chest from where resident #3 had scratched him did not have broken skin and the red mark had faded by the following morning. An interview was conducted with the Director of Nursing (DON/staff #91) and the Administrator (staff #52) on (MONTH) 15, 2019 at 2:44 p.m. The administrator stated that in any situation with an allegation of abuse, the facility's first priority is to protect the residents. The administrator stated that when investigating an allegation of resident to resident abuse, both residents should be safe and protected first, and then an investigation can occur. The administrator stated the building has a lot of staff who are available to intervene if needed to a resident to resident abuse situation. He stated there are hall monitors who can assist with supervision and to be another person to assist with redirection as needed. The administrator did state that the hall monitor might be called to help with a situation and then the hall would be unmonitored for the time the assigned hall monitor is assisting other residents. The administrator stated there are other staff members in the building who can be called over to assist when needed. The administrator stated all altercations between residents that result in an injury would be considered abuse. The facility's policy regarding abuse prohibition states that each resident has the right to be free from verbal, sexual, physical and mental abuse. It also states the resident has the right to be free from mistreatment, neglect and misappropriation of property. The policy states that residents will not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident.
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on facility documentation, clinical record review, staff interviews and policy review, the facility failed to implement their policy regarding the timeframe for reporting an allegation of abuse for one out of three sample residents (#1). The deficient practice could result in further abuse allegations not being reported timely. Findings include: -Resident #1 was readmitted to the facility on (MONTH) 30, 2019, with [DIAGNOSES REDACTED]. Review of the facility's investigation report revealed that on (MONTH) 5, 2019, at approximately 8:00 p.m., the resident was involved in an altercation with another resident. The report included that on (MONTH) 6, 2019, during review of the video footage, two Certified Nursing Assistants (CNA/staff #238 and #239) appeared to be handling the resident in an inappropriate manner by removing her walker by snatching it from her, pulling on her legs to remove her from sitting in the threshold of a door, blocking her from entering the dining room and television rooms, blocking her from sitting in a chair that was placed in the hallway, and making body gestures that were considered inappropriate for interaction with this resident. However, review of the State data system revealed that the allegations of abuse were not reported to the State Survey Agency until (MONTH) 6, 2019 at 1:56 p.m. Video footage from (MONTH) 5, 2019, was reviewed on (MONTH) 15, 2019. Review of the footage revealed that a Certified Nursing Assistant (CNA/staff #238) blocked the resident's entry to the dining and television rooms while doing dancing gestures toward the resident, quickly sat in a chair to prevent the resident from sitting in the chair, and forced the resident to sit in a wheelchair while another staff member pulled the resident's walker out of her hands. Footage revealed that another CNA (staff #239) blocked the resident's entry to the dining and television rooms while doing dancing gestures toward the resident, grabbed the resident's foot and pulled her from sitting in a doorway, did boxing gestures in the direction of the resident, and forcefully pulled the walker out of the resident's hands while another CNA forced the resident to sit in a wheelchair. Footage revealed that a Licensed Practical Nurse (LPN/staff #76) was present when the resident was forced into the wheelchair and the walker was pulled away and when the resident was pulled away from the doorway by her foot. An interview was conducted with staff #76 on (MONTH) 15, 2019 at 12:32 p.m. She said she had heard that staff #238 and #239 had allegations of abuse against them, but she did not witness any abuse. Regarding the video footage which revealed that staff #76 was present when the resident's walker was pulled away from her and when the resident was pulled out of the doorway by her foot, staff #76 stated she had not reviewed the footage and she did not know what was on it. She again stated she did not witness any abuse. She further stated that no one at the facility had spoken with her about staff members being expected to immediately report suspicions of abuse. An interview was conducted with staff #238 on (MONTH) 15, 2019 at 12:51 p.m. She stated resident #1 had been involved in an incident with another resident in the dining room, and staff #76 had instructed her to take resident #1 out of the dining room. She said resident #1 did not want to leave the dining room and kept collapsing to the floor. She said she blocked the resident from sitting in the chair because she had hoped the resident would keep walking to her room. She said when staff #239 pulled the resident by her foot out of the doorway, she yelled at her coworker to stop, and she stopped. She said she had been trained in recognizing and reporting abuse, but she did not report the pulling by the foot because she did not think it was abusive. An interview was conducted with the Director of Nursing (DON/staff #91) and the Administrator (staff #52) on (MONTH) 15, 2019 at 2:44 p.m. Staff #52 stated the expectation that if abuse was suspected, staff should first protect the residents, then report the allegations to their supervisor. He said if an employee witnessed potential abuse and did not report it, there would also be an investigation conducted. He said he expected that allegations of abuse would be reported to the State Survey Agency within 2 hours. Review of the facility's abuse prohibition policy revealed that each resident had the right to be free from abuse, mistreatment and neglect by anyone, including facility staff. All staff would receive training on recognizing abuse, intervening to protect the resident, and reporting suspicions of abuse. Suspected abuse would be reported within two hours to the Administrator, the DON, or if neither was in the facility, allegations would be reported to the charge nurse or supervisor. The facility would ensure that allegations of abuse were reported to the State Survey Agency and other appropriate agencies within two hours of discovery.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on facility documentation, clinical record review, staff interviews and policy review, the facility failed to ensure an allegation of abuse was reported within the required timeframe for one out of three sample residents (#1). The deficient practice could result in further abuse allegations not being reported timely to the State Survey Agency. Findings include: -Resident #1 was readmitted to the facility on (MONTH) 30, 2019, with [DIAGNOSES REDACTED]. Review of the facility's investigation report revealed that on (MONTH) 5, 2019, at approximately 8:00 p.m., the resident was involved in an altercation with another resident. The report included that on (MONTH) 6, 2019, during review of the video footage, two Certified Nursing Assistants (CNA/staff #238 and #239) appeared to be handling the resident in an inappropriate manner by removing her walker by snatching it from her, pulling on her legs to remove her from sitting in the

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) threshold of a door, blocking her from entering the dining room and television rooms, blocking her from sitting in a chair that was placed in the hallway, and making body gestures that were considered inappropriate for interaction with this resident. The report included that staff #238 and #239 were terminated from employment. However, review of the State data system revealed that the allegations of abuse were not reported to the State Survey Agency until (MONTH) 6, 2019 at 1:56 p.m. Video footage from (MONTH) 5, 2019, was reviewed on (MONTH) 15, 2019. Review of the footage revealed that a Certified Nursing Assistant (CNA/staff #238) blocked the resident's entry to the dining and television rooms while doing dancing gestures toward the resident, quickly sat in a chair to prevent the resident from sitting in the chair, and forced the resident to sit in a wheelchair while another staff member pulled the resident's walker out of her hands. Footage revealed that another CNA (staff #239) blocked the resident's entry to the dining and television rooms while doing dancing gestures toward the resident, grabbed the resident's foot and pulled her from sitting in a doorway, did boxing gestures in the direction of the resident, and forcefully pulled the walker out of the resident's hands while another CNA forced the resident to sit in a wheelchair. Footage revealed that staff #76 was present when the resident was forced into the wheelchair and the walker was pulled away and when the resident was pulled away from the doorway by her foot. Review of the employee file for a Licensed Practical Nurse (LPN/staff #76) revealed a disciplinary report dated (MONTH) 15, 2019. The report included that staff #76 received a written warning for failing to follow through on an abuse and neglect incident that occurred on (MONTH) 5, 2019, with the expectation that the employee would recognize and follow the abuse and neglect policy of the facility. However, an interview was conducted with staff #76 on (MONTH) 15, 2019 at 12:32 p.m. She said she had heard that staff #238 and #239 had allegations of abuse against them, but she did not witness any abuse. Regarding the video footage which revealed that staff #76 was present when the resident's walker was pulled away from her and when the resident was pulled out of the doorway by her foot, staff #76 stated she had not reviewed the footage and she did not know what was on it. She again stated she did not witness any abuse. She further stated that no one at the facility had spoken with her about staff members being expected to immediately report suspicions of abuse. An interview was conducted with staff #238 on (MONTH) 15, 2019 at 12:51 p.m. She stated resident #1 had been involved in an incident with another resident in the dining room, and staff #76 had instructed her to take resident #1 out of the dining room. She said resident #1 did not want to leave the dining room and kept collapsing to the floor. She said she blocked the resident from sitting in the chair because she had hoped the resident would keep walking to her room. She said when staff #239 pulled the resident by her foot out of the doorway, she yelled at her coworker to stop, and she stopped. She said she had been trained in recognizing and reporting abuse, but she did not report the pulling by the foot because she did not think it was abusive. An interview was conducted with the Director of Nursing (DON/staff #91) and the Administrator (staff #52) on (MONTH) 15, 2019 at 2:44 p.m. Staff #52 stated the expectation that if abuse was suspected, staff should first protect the residents, then report the allegations to their supervisor. He said if an employee witnessed potential abuse and did not report it, there would also be an investigation conducted. He said he expected that allegations of abuse would be reported to the State Survey Agency within 2 hours. He said the findings of abuse investigations involving staff members would be reported to the corporate office, who would advise the facility regarding the appropriate disciplinary action for the staff members. Review of the facility's abuse prohibition policy revealed that each resident had the right to be free from abuse, mistreatment and neglect by anyone, including facility staff. All staff would receive training on recognizing abuse, intervening to protect the resident, and reporting suspicions. Suspected abuse would be reported within two hours to the Administrator, the DON, or if neither was in the facility, allegations would be reported to the charge nurse or supervisor. The facility would ensure that allegations of abuse were reported to the State Survey Agency and other appropriate agencies within two hours of discovery.