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	IL6002109	A. BUILDING: _____ B. WING _____	R-C 05/13/2025

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S 000	Initial Comments First Revisit to Survey date April 25, 2025, Investigation of Facility Reported Incident of April 23, 2025/IL190775	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.3210t) 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure resident's right to be free of staff verbal and mental abuse of R1,	S9999		

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repeated resident (R12) to resident physical, verbal, and mental abuse of (R2), and resident (R12) to resident verbal abuse of (R10). R1, R2, R10, and R12 are four of 12 residents reviewed for abuse on the sample list of 12. These failures resulted in R1 and R2's continued sadness, anxiety, and tearfulness.

Findings include:

1. R1's current diagnoses sheet documents the following diagnoses: Diabetes Mellitus Type II, Without Complications, and bipolar disorder (definition: mental health condition characterized by shifts in mood energy, and activity levels, ranging from periods of intense "highs" mania, or hypomania, to periods of profound "lows" of depression), Unspecified.

R1's current Physician Order Sheet documents the following anti-depressant medication order: "Fluoxetine HCL 20 milligrams capsule, give four capsules, orally in the morning related to Bipolar Disorder, Unspecified."

R1's Minimum Data Set (MDS) dated 3/25/25 documents R1's Brief Interview of Mental Status (BIMS) score of 15 out of a possible 15, indicating no cognitive impairment.

R1's "Progress Note - Behavioral Health Progress Note, dated 4/16/25, signed by V10 (Nurse Practitioner) documents the following:
"Depression Screening:
Over the past two weeks, how often have you been bothered by any of the following problems?
Little interest or pleasure in doing things? Not at all

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Feeling down, depressed, or hopeless? Not at all
Trouble falling or staying asleep or sleeping too much? Several Days
Poor appetite or overeating? Several Days
Feeling bad about yourself? Not at all
Trouble concentrating on things, such as reading the newspaper or watching television? Not at all
Moving or speaking so slowly that other people could have noticed? Not at all
Or the opposite - being do fidgety or restless that you have been moving around a lot more than usual? Not at all
Thoughts you would be better off dead or of hurting yourself in some way? Not at all
MOOD BEHAVIOR TOTAL SCORE: 2 = Low Depression
Screen performed, negative for depression, no follow up required."

R1's Behavioral Tracking sheet, (three weeks post the above Nurse Practitioner Depression Assessment) documents the morning after R1's verbal and mental abuse, on 5/02/25, R1 presented with Anxiety, Agitation, Sadness and Tearfulness.

R1's Medication Administration Record (MAR) dated 5/1/25-5/31/25 documents R1's Blood glucose checks were scheduled Weekly (only) on Monday, one time a day at 5:00 am.
R1's same MAR documents R1 was to receive Insulin Aspart (fast-acting insulin), (according to Mayo Clinic this fast-acting insulin should be administered 5 to 10 minutes prior to a meal to prevent hypoglycemia), 100 Units per milliliter (ml), three ml pen, inject six unit, subcutaneous four times a day related to Type II Diabetes Mellitus, Without Complications. The same MAR documents R1 refused the dose of insulin on 5/1/25, indicated by V4 (Agency Licensed

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Practical Nurse/LPN) initials and a number 2. (In later interviews, R1 decline to accept insulin at 3:00 pm and requested her insulin be given closer to the supper mealtime).

The facility's state surveying agency reported abuse investigation documents: "Date: 5/8/2025 documents the following" Final Report Regarding Incident of 5/1/2025 at approximately 3:30 pm. " On 5/2/2025, it was reported to the nurse (unidentified) by (R1) reported (sic) on (sic) (V4 Agency Licensed Practical Nurse) was rude. Investigation: (R1) reported that agency nurse (V4, LPN) called her "crazy" when she started talking about her medication. (V4 LPN) stated that his comment to her was "that is crazy". PSRC (V6 Psychiatric Rehabilitation Services Coordinator) was present, and he thought that (V4 LPN) had also said "that's crazy" (clarified later in interview below), (V5 Certified Nursing Assistant) CNA recalls him saying something about "crazy". This occurred due to resident refusing her (brand name-blood glucose level check) and later came to nurses' station and stated that (V4 LPN) didn't even take her (R1) insulin. He then stated that's crazy. I (V4, LPN) just left and asked to get your (name brand, finger stick glucose measurement). (V4, LPN) stated that (R1) responded she had misspoken and then confirmed she didn't want to have her blood sugar (brand name-blood glucose level check) taken. After a thorough investigation including interview with resident, nurse, staff and fellow residents, the facility cannot substantiate the allegation. There was a witness that confirmed (V4, LPN) statement." This report was signed by V1 (Administrator/Abuse Prevention Coordinator). This conclusion does not reflect observations, interviews and record review conducted by this surveyor's abuse investigation

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noted below.

On 5/9/25 at 10:30 am V7 (Human Resource Director/HR) stated V7 was present when V4 (Agency Licensed Practical Nurse/LPN) was interviewed. V7 stated "Me, (V1 Administrator/Abuse Prevention Coordinator) and (V8 Business Office Manager/ BOM), all wrote statements. We all wrote statements because of everything he stated during the interview was inappropriate. He is a DNR (Do not return to the facility) because of his inappropriate comments and agitated behaviors during the interview regarding (R1's) allegation of abuse. (V1 Administrator Abuse Prevention Coordinator) has the statements."

On 5/9/25 at 10:40 am V1 (Administrator/Abuse Prevention Coordinator) confirmed V7's (HR) above interview. V1 then stated "When I interviewed him (V4), he was confrontational and intimidating. He would not write his statement (regarding R1's allegation). I wrote what I heard related to (R1's) allegation. The rest of my (V1) interview with him, was derogatory. He made comments like 'you know how it is working with those people.' He was focused on the that unit's psychiatric condition. I had to leave to maintain my professional approach. I left my office and (V7) finished the interview with him (V4, LPN). He then left my office and sat in the parking lot. At one point he came back into the building, and I told him he could not be here because of the investigation. He went back out and sat in his vehicle. I will tell you; I am always focused on the wellbeing of our residents. They are like family to me. There was no way he should be working with our residents. At the end of the day, he was still in the parking lot. (V9) from Maintenance rides with me. (V9 Maintenance Department) was not

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in my truck yet. I waited inside the building until (V8 BOM) could walk me out. I sat in my locked truck until (V9) was ready to leave. I was that uncomfortable. I was not going to let him come back at all. My heart guided me, and I could not let him come back to work here. I couldn't tell him that. He was already so intimidating. I only told him he was suspended with the plan to call him later about the termination from our facility. He cannot return here."

On 5/9/25 at 12:57 pm V20 (Psychiatric Rehabilitation Services Coordinator/PRSC) stated V20 talked to R1 every day and ask R1 how she is doing. "I would sit and talk to her. When she cries, it is a cry for help. I give her a hug. (R1) had not complained of mistreatment by staff or resident, to me. (R1) had talked about not getting her insulin medications and cried. I don't know if that was the same situation or not. She did not tell me who the nurse was." V20 also stated during a previous allegation of abuse investigated by the state surveying agency that had been cited on this original survey, "I (V20 PRSC) wrote a statement, and was called by (V1 Administrator/Abuse prevention Coordinator) after, and told I did it (wrote the statement) wrong." V20 also stated "I was told to be vague. (later interviews include the same comment, in regard to R1 allegation)."

On 5/9/25 at 2:40 pm (R1) was lying in bed. R1 sat up in bed, when this surveyor let her know, I was from the state surveying agency, and would like to interview her about an allegation of abuse. R1's eyes welled up with tears, as she started sobbing, then unable to contain her tears, R1 started crying and could not talk for over one minute. R1 then stated while sobbing "It was a horrible situation all the way around with that

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nurse (V4 Licensed Practical Nurse). (V4 LPN) got really mad at me because I told him I don't get an (name brand, finger stick, glucose measurement) every day, I only get insulin. I told him I don't get insulin until closer to 5:00 pm, when we get our food. He was horrible and said, 'I am just putting you refused.' I repeated I still get insulin but not this early. I know I have to eat, or my blood sugar will drop, and I could end up in a coma or something. My doctors have made it clear not to take my insulin until close to when I am to eat. He was trying to give it at 3:00 pm. That is way too early. He is a nurse he should know that. I came around the corner about fifteen minutes later to ask (V6 PRSC) if he could get me salt water for my sore throat. That is what I was supposed to be using, whenever I needed it. As I turned the corner (R1 tears up), (V4 LPN) was in the med (medication) room. (V4 LPN) said really loud and mean. 'There is that crazy woman.' He said it real loud. Then he said to me I was not going to get my insulin; I had already refused it. He did not give it (insulin) to me that night. (V6 PRSC) and (V5, Certified Nursing Assistant) CNA heard it. They can tell you, he was mad, loud, mean and verbally abused me. He then called me crazy again. I have not seen him since, and hope I never do. I get upset every time I think of him. I can't stop crying."

On 5/9/25 at 3:05 pm V6 (PRSC) stated "(V4 Agency Licensed Practical Nurse/LPN) immediately raised his voice said to (R1) 'You're crazy' and then 'That's crazy.' He said both when she (R1) said something about her blood sugar check and a shot. (R1) internalized that as abuse and became tearful, and anxious. I think it was abuse. He (V4 LPN) could have handled it much better. (R1) was up by the nurse's station to ask me for salt water, she gets it for a sore throat. (V5

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Certified Nursing Assistant) CNA heard the same thing. He definitely called her crazy and was totally out of line. I have seen her (R1) tearful, when talking about it since." V6 also stated he was "rushed" to right his statement for the investigation, and "told to be brief."

On 5/13/25 at 10:30 am V4 (Agency Licensed Practical Nurse/LPN) stated on 5/1/25 V4 attempted to do a finger stick, blood glucose level, so V4, LPN could give R1 the insulin that was ordered. "I had a preconceived idea that her (R1's), (finger stick/blood glucose level) was supposed to be done, because she had an insulin order. She (R1) told me no, she wasn't supposed to get an (name brand, finger stick, blood glucose level), and she was not going to let me give her the insulin ordered. She told a CNA (later identified as V5 Certified Nursing Assistant) that I wouldn't give her the insulin. That was not true. I figure she refused and that was the end of it. I did not want to agitate her, so I left it at that, she refused." V4 LPN also stated "(V1) did explain to me that I was being suspended until an investigation into an allegation could be done. I did not say (R1) she was crazy. I only said that it was crazy that (R1) was saying I didn't give her insulin. I did not call her crazy. I told the Administrator that."

On 5/13/25 at 11:30 am V5 (Certified Nursing Assistant/CNA) said V5 was at the nurses' station with V6 (PRSC). V4 (Agency LPN was in the medication room. V4 had ear buds in his ears. V5 said she was not sure if he was listening to music, talking on the phone, or just talking to himself. V4 was rambling on and on for several minutes, before R1 came up to the nurse's station. V5 CNA stated "He (V4 LPN) was not professional when she (R1) asked him for

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something. I don't know if it was to do a blood draw, give her a shot of medications, or what exactly she needed. It was not anything I could get for her. He was loud, authoritative, and said, 'you're crazy'. I heard it plain as day. He may have been talking to somebody on the phone. I really don't know. He said it for sure. It really upset her (R1). He did not respond to her being so upset. He ignored her reaction. She was visibly upset. I wouldn't say she was crying. She had tears in her eyes and was frustrated. She was fidgety and anxious because she wanted whatever she needed, done. Even though she was upset. He continued to raise his voice and told her; she had refused it. She (R1) denied refusing whatever it was. I don't know that it was abuse. It was loud, when he told her she was crazy, that is all I can say. I would have reported it to (V1 Administrator) and let her decide if it was abuse. I believe (V6 PRSC) reported. It was a bad situation." V5 also stated she was 'rushed" to write her statement about the allegation, she was "told to be brief."

2. R2's current diagnoses sheet documents the following diagnoses: Bipolar Disorder (definition: mental health condition characterized by shifts in mood energy, and activity levels, ranging from periods of intense "highs" mania, or hypomania, to periods of profound "lows" of depression), Unspecified, and Anxiety Disorder Unspecified.

R2's Physician Order Summary sheet (POS) dated May 2025 documents the following antianxiety medication orders: Lorazepam Oral Tablet 0.5 MG (milligram), Give 0.25 tablet by mouth in the morning related to Anxiety Disorder, Unspecified and Lorazepam Oral Tablet 0.5 MG (milligram), Give one tablet by mouth in the evening related to Anxiety Disorder, Unspecified.

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R2's Same POS documents an order dated 5/9/25: Monitor left arm for pain, bruising, weakness, or changes in ROM (range of motion), every shift thru and including Monday. Report any problems to MD or NP (unidentified Physician or Nurse Practitioner), every shift until 05/13/2025.

R2's Minimum Data Set (MDS) dated 3/8/25 documents the following: R2's Brief Interview of Mental Status (BIMS) score of 15, out of a possible 15, indicating no cognitive impairment. The same MDS documents R2's Mood score as 00, out of 27, indicating no depressive symptoms at the time of the assessment.

R2's Behavioral Tracking sheet, documents on 5/9/25 the day of the physical and verbal abuse by R12, R2 presented with Anxiety, Sadness and Tearfulness. On 5/10/25 the day after the physical and verbal abuse, R2 presented with restless, anxious, and agitated. There was no documentation on the behavioral tracking sheet of any behaviors of depression 5/1/25 through 5/8/25.

The facility's state surveying agency reported undated abuse investigation submitted 5/13/25 to this surveyor, documents the following: "Summary: On 5/9/2025(An) Incident occurred involving (R2), (R10) and (R12). All residents were interviewed. (R2) was in the dining room and when (R12) tried to get her cups, he (R12) took hold of her arms and cursed at her. He also cursed at (R10) when she told him no that he could not go into the break room. He (R12) was removed from the dining room by staff (later identified as V15 Certified Nursing Assistant/CNA). CONCLUSION: (R12) has Vascular Dementia he is a new resident to the

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facility and is currently getting acclimated. He was removed from the area and has no other altercations with any residents since this incident. He was assessed by the NP (unidentified Nurse Practitioner) and will be assessed by (Psychiatric Service). He remains on visuals. Staff to monitor." This report is signed by V1 (Administrator/Abuse Prevention Coordinator).

R2's witness statements, written and signed by V1 (Administrator/Abuse Prevention Coordinator) documents the following: R2 stated she was seated in the dining room when R12 hurt R2 when R12 grabbed her wrist and arms. R2 also stated R12 called her a (B- expletive).

R10's witness statement, written and signed by V1 documents: R12 was yelling and trying to take R2's things, and called R2 a (B-expletive). R10 stated R10 told R12 not to go into the staff break room and he called R10 a (B-expletive).

R11's witness statement, written and signed by V1 documents: "(R12) tried to take (R2's) drinks, and grabbed her, and was calling the girl's names."

V15's (Certified Nursing Assistant/CNA) witness statement, written and signed by V1 documents: V15 did not initially see the incident until he heard resident yelling from the dining room. "He said he ran and found (R12) at (R2's) table and he (R12) had her (R2's) arms."

V21's (LPN) witness statement, signed by V21 documents the following: "During morning medication pass myself (sic) and CNA (night shift, V15, Certified Nursing Assistant) on Willows East, heard a commotion coming from the dining room. As we were heading to dining room a resident

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from Willows West (R11) approached and said that new guy (R12) is taking (R2's) drinks and calling her a (B-expletive). CNA (V15, night shift CNA) approached (R12) and removed him without difficulty from the dining room, at that time another resident (R10) approached this nurse saying she was coming down the hall to calm down as she had told this resident (R12) not to go into employee break room, and he was calling her a (B-expletive) also."

On 5/9/25 at 1:50 pm R2 started crying. R2's boyfriend R3 was seated next to her. R2 stated "There was a problem this morning with the new guy (R12). I think his name is (R12). I was sitting at a table by myself, in the dining room. It was around 6:00 am. (R12) wheeled his wheelchair up behind me. (R3) was not out there at that time; he was taking a shower. (R12) first grabbed my shoulder from behind. It really scared me. (V15, night shift, Certified Nursing Assistant) is a CNA, pulled (R12's) chair away from me. (R12) then came right back to me. (R2, sobbing with tears running down her cheeks). I was afraid then. He (R12) invaded my space and physically abused me. He grabbed my arms and hurt this one. (R2 stands up from the bench she is seated on and takes her off a flannel exterior shirt). Can you see the red mark it left? (surveyor could not identify discoloration). (V3 Registered Nurse/Quality Assurance Nurse/RN/QA) looked at it (R2's arm) too. It still hurts. Not as bad as it was, but it hurts. Another CNA (Unidentified) and the Nurse (Unidentified) were in the dining room at the time. (R12) was taken away from me. He also called (R10), another resident a (fat, B- expletive). (R12) has somebody sitting with him in his room, so he can't hurt anyone else. I haven't seen him since early this morning. I am still on pins and needles about this." R2 continued to set next to

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R3, while R3 talked about the altercation. R2 remained tearful throughout both R2 and R3's interviews.

On 5/9/25 at 2:15 pm R3, stated "I was in the shower this morning when the new guy (R12) grabbed my girlfriends (R2's) arms, I could see she (R2) was really upset and tearing up. Her arm was red. Staff are keeping that guy (R12) away from everyone now."

On 5/9/25 at 3:05 pm V6 (PRSC) stated "This morning's situation with (R12) and (R2), I was here. I was not in the dining room. (V15, night shift, Certified Nursing Assistant) CNA was. I heard (R12) grabbed (R2's) arms. (V1 Administrator/Abuse Prevention Coordinator) called me and had me put him (R12) on a 1:1 (direct supervision by one staff member). He was taken to his room, where he remains."

On 5/13/25 at 1:55 pm V3 (QA/RN) stated " (V1 Administrator/Abuse Prevention Coordinator) called me that morning (5/9/25) and told me about the alleged abuse (physical, and verbal of R2 by R12). (V12 Licensed Practical Nurse/LPN) was doing (administering) meds (medication), so I did an assessment of (R2's) arms. (R2) was very emotional. (R2) said (R12) was trying to get her stuff on the table and he grabbed her arms. (R2) complained her arms were both sore from (R12) grabbing them. I did not see any bruising or anything except a small bruise, she said was from a blood draw. I talked to (V10 Nurse Practitioner). I put (V10's) order in (computer program) to monitor (R2's) arms for soreness, bruising, weakness and any limitations in range of motion." V3 also stated "I would have recognized this physical altercation as abuse, and reported immediately to (V1 Administrator/Abuse

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Prevention Coordinator), had I known about it before she (V1 Administrator/Abuse Prevention Coordinator) called me."

R12's Admission Assessment dated 5/6/25 documents R12 was only Oriented to "Person and Place."

On 5/13/25 at 2:20 pm V12 (LPN) stated V12 got in report at 6:00 am, shift change on 5/9/25, from V21 LPN (night nurse), that R12 was in the dining room yelling at both R2 and R10. V12 then stated, " I heard he called them both "(B-expletive). The residents had already been separated. (V6 PRSC) was (R12's) one on one (direct staff observation). (V6 PRSC) was with (R12) until he went to sleep. We continued him on increased visuals by all staff when he woke up at the end of the shift. I reported this all off, to the oncoming staff at shift change that afternoon. I did not see the order for monitoring (R2's) arms until the next day. When I saw her (R2) she was a little shaken up, on day one. The next day she wanted to talk to her sister and was tearful. (R10) did not seem to be affected at all." V12 then stated "I would consider this abuse scenario as abuse. It needed to be reported and investigated."

3. R10's current diagnoses sheet documents the following diagnoses: Mild Intellectual Disabilities, Major Depressive Disorder, Recurrent, Unspecified, Adjustment Disorder With Mixed Disturbance of Emotions and Conduct. and Generalized Anxiety Disorder.

R10's Physician Order Summary sheet (POS) dated May 2025 documents the following medications: Mirtazapine Oral Tablet 15 MG, Give 1 tablet by mouth at bedtime, related to Major

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Depressive Disorder , Recurrent, Unspecified, Venlafaxine HCl Extended Release 24 Hour, Oral Capsule, 150 MG, Give 1 capsule by mouth one time a day for Depression and additional Venlafaxine HCl Extended Release 24 Hour 75 MG, Give 1 tablet by mouth one time a day for Depression.

R10's (MDS) dated 2/27/25 documents the following: R10's Brief Interview of Mental Status score of 13, out of a possible 15, indicating no cognitive impairment.

R10's Behavioral Tracking sheet, documents on 5/9/25 the day of the verbal abuse by R12, R10 was sad and tearful.

The facility's state surveying agency reported undated abuse investigation submitted 5/13/25 to this surveyor, documents the following: "Summary: On 5/9/2025(An) Incident occurred involving (R2), (R10) and (R12). All residents were interviewed. (R2) was in the dining room and when (R12) tried to get her cups, he (R12) took hold of her arms and cursed at her. He also cursed at (R10) when she told him no that he could not go into the break room. He (R12) was removed from the dining room by staff (later identified as V15, Certified Nursing Assistant/CNA). CONCLUSION: (R12) has Vascular Dementia he is a new resident to the facility and is currently getting acclimated. He was removed from the area and has no other altercations with any residents since this incident. He was assessed by the NP (unidentified Nurse Practitioner) and will be assessed by Bespoke (Psychiatric Service). He remains on visuals. Staff to monitor." This report is signed by V1 (Administrator/Abuse Prevention Coordinator).

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On 5/13/25 at 1:25 pm R10 was seated in her wheelchair adjacent to Willows unit offices. R10 stated she can't remember any details, though she does remember a new guy called her a (B-expletive) in the dining room, one day, and she did not like that.

On 5/13/25 at 1:35 pm R11 stated R10 is his girlfriend. R11 also stated "I was in the dining room with (R2 and R10) when (R12) started yelling and acting up." R11 stated "(R12 grabbed (R2's) arms and started shaking them real fast. (R2) started yelling for help. (R12) then called (R2 and R10), a (B-expletives). I went out (of the dining room) and told (V15, night shift CNA). (V15) moved (R12) to his own table. (R12) went right back over to (R2's) table. I saw it all. (V15 CNA) then took (R12) out of the dining room to his (R12's) room. He has not acted up since. My girlfriend (R10) was upset at the time. It does not seem to bother her now."
R11's MDS dated 3/31/25 documents R11's BIMS score as 15 out of a possible 15, indicating no cognitive impairment.

The facility policy "Abuse Prevention Program" dated February 2021 documents the following: "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its

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control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents."

The same policy documents:
"This facility is committed to protecting our residents from abuse by anyone including but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. This facility will not knowingly employ or otherwise engage individuals who have had a disciplinary action taken against a professional license by a state licensure body as a result of a finding of abuse, neglect, or mistreatment of residents or a finding of misappropriation of resident property."

The same policy documents:
"Definitions
The following definitions are based on federal and state laws, regulations and interpretive guidelines.
*Abuse: Abuse is the willful injection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.
*Physical Abuse includes hitting, slapping,

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S9999	Continued From page 17 pinching, kicking, and controlling behavior through corporal punishment. *Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, or saying things to frighten a resident, such as telling a resident that he/she will never to be able to see his/her family again. *Mental Abuse includes, but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s), harassment, humiliation and threats of punishment or deprivation. "B"	S9999		