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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 02/05/2025 through 02/06/2025. Additional information was obtained offsite 02/07/2025 through 02/13/2025; therefore, the exit date was changed to 02/13/2025. The following intakes were investigated NC00226696, NC00223688, NC00225085, NC00226698, NC00225009, NC00224678, and NC0022601. Intake NC00226698 resulted in immediate jeopardy. 3 of the 9 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) Tag F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 01/27/25 and was removed on 02/08/2025.	F 000		
F 600 SS=J	A partial extended survey was conducted. Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. 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.	F 600		2/28/25

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

Electronically Signed | 02/27/2025

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F 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, interviews with staff, Nurse Practitioner (NP), Medical Director, Drug Enforcement Administration (DEA) agent, Adult Protective Services (APS) Supervisor, and hospital Social Worker the facility failed to protect Resident #1's right to be free from abuse. Resident # 1 was dependent on staff. On 01/27/2025, Resident #1's family member was visiting with the resident. The family member came out in the hallway and yelled that Resident #1 had a seizure. Nurse Practitioner (NP) and Nurse #1 responded immediately. Resident #1 was assessed and found to be leaning towards the right side of the bed. Resident #1 had vital signs which were within normal limits. The resident was transferred to the hospital via Emergency Medical Services (EMS) who noted the resident to have pinpoint pupils, a sign of an opioid overdose. At the hospital Resident #1 had a positive urine drug screen for Fentanyl (an opioid pain medication that can be lethal) and Methylenedioxymethamphetamine (MDMA) (an illegal stimulant commonly known as ecstasy). Resident #1 did not have a physician's order for Fentanyl. The resident was admitted to the hospital with severe dehydration, a side effect of MDMA. Resident #1 was hospitalized for 4 days. This deficient practice affected 1 of 3 residents reviewed for resident abuse. Immediate jeopardy began on 01/27/2025 when	F 600	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F600 1. Resident's family member reported to staff that the resident was having a seizure. Resident was assessed by facility staff. Facility called 911 and was transported to ER by EMS. Resident was admitted for dehydration and AMS. Resident had a positive drug screen for Fentanyl and MDMA. These medications are not listed on the resident MAR. 2. Current residents are at risk 3. Signs were placed at all entrances stating no firearms or illegal substances are permitted on the premises. All visitors will be required to enter from the front door and sign in on the kiosk. Sign-in	

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F 600	Continued From page 2 the facility failed to protect Resident #1's right to be free from abuse. Immediate jeopardy was removed on 02/08/2025 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: Resident #1 was admitted to the facility on 01/20/2025 with diagnoses which included cerebral vascular accident, dementia, seizure disorder, and hypertension. Review of Resident #1's baseline care plan dated 01/20/2025 revealed Resident #1 was care planned for being at risk for complications related to severe cognitive impairment with interventions to observe for changes in cognition. Resident #1's care plan also indicated she was receiving tube feedings and had a history of seizures. Review of Resident #1's physician's orders dated 01/20/2025 revealed Resident #1 had orders for: 1. NPO (nothing by mouth) 2. Keppra 1000 milligrams (mgs.) twice a day for seizures via feeding tube. 3. Acetaminophen 650 mgs. every 6 hours as needed for pain via feeding tube. There was no physician's order for Fentanyl. Review of the NP's visit note date 01/20/2025 revealed Resident #1 was receiving Osmolite (a nutritional formula use for tube feeding) 1.5 calories/milliliters (cal./mls.) four times day and	F 600	includes an acknowledgement that states: "Please sign your name below. Please be advised that when visiting, you are not permitted to bring firearms, illegal substances, or any other prohibited items onto the premises. We appreciate your cooperation in ensuring a safe and secure environment for all." Alert and oriented residents were verbally notified by the administrator/designee with 100% completion by 2/07/2025 that there is no tolerance for abuse including illegal substances. RPs for residents who are not alert /oriented were notified via phone by the administrator/designee with 100% completion by 2/07/2025. A receptionist will be assigned to monitor visitors as they enter and exit the building from 8A-8P 7 days a week. The receptionist will direct them to sign in and complete the acknowledgement with every visit. All employees were notified via the payroll messaging system that this is a no tolerance facility for firearms and illegal substances. Education will be included in new hire orientation and for all agency staff prior to shift. 4. Administrator/designee will review kiosk reports for acknowledgement compliance. Receptionist will remain on the current schedule with the responsibility of monitoring sign in/acknowledgement compliance for all visitors. Audits will be completed 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2.	

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F 600	Continued From page 3 Resident #1 was tolerating the tube feedings without any gastrointestinal distress. The NP's note also revealed Resident #1 was very pleasant, alert and able to follow simple commands. Resident #1 kept her eyes closed during the conversation. Review of the nutritional assessment dated 01/22/2025 revealed Resident #1 was 66 inches tall and weighed 142.0 pounds (lbs.). Resident #1 was alert and received nothing by mouth. Resident #1 was receiving bolus (large volume of formula given at once, several times a day) tube feedings of 275 ml. of Osmolite 1.5 cal./mls. four times a day. Resident #1 was also receiving 75 ml. of water flushes before and after each bolus feeding. The assessment also indicated Resident #1 was receiving her estimated daily nutritional and water needs for calories, protein, and free water via from her tube feedings. Review of the facility physician's admission visit note dated 1/22/2025 revealed Resident #1 was sitting up in chair and in no acute distress. Resident #1's abdomen was soft, non-distended, and non-tender with a percutaneous endoscopic gastrostomy (PEG) (feeding tube) present in the left upper quadrant of her abdomen. No tremors or deficits were noted. Review of the admission Minimum Data Set (MDS) dated 01/27/2025 revealed Resident #1 had severely impaired cognition with no behaviors. Resident #1 was dependent with all Activities of Daily Living (ADL). The MDS also indicated Resident #1 was receiving tube feedings. Review of Resident #1's Medication	F 600	5. Results will be reported by the Administrator to the quality assurance meeting x3 month for further resolution as needed. Date of Completion 2/28/2025	

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Administration Record (MAR) for January 2025 revealed Resident #1 received her bolus tube feedings and water flushes as ordered by the physician each day while present in the facility. The MAR also indicated Resident #1's tube feeding residuals (amount of tube feeding remaining in the stomach after a tube feeding) were checked every shift and no residual feedings were obtained.

Review of Resident #1's electronic medical record (EMR) revealed Resident #1 did not go out of the facility on a leave of absence from 01/20/2025 to 01/27/2025. There was no evidence in Resident #1's medical and social history of drug abuse.

Review of a nursing note dated 01/27/2025 at 3:36 PM revealed Resident #1's family was in her room and called for the nurse and NP. The family member stated Resident #1 had a seizure. Resident #1 was difficult to arouse. The NP gave orders to transfer Resident #1 to the Emergency Room (ER). Resident #1 was transferred via Emergency Medical Services (EMS) to the ER on 01/27/2025 12:23 PM.

Review of the facility's initial allegation report completed by the Administrator on 01/27/2025 revealed the facility became aware of an incident involving Resident #1 when local law enforcement, the DEA Agent, and APS came to the facility to report that Resident #1's family member alleged the staff of the facility provided Resident #1 with Fentanyl and MDMA.

An interview was conducted with NA #1 on 02/05/2025 at 11:15 AM. NA #1 was not aware of any incident concerning Resident #1. NA #1

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stated that she only did vital signs on Resident #1 before starting her assigned rounds on 01/27/2025 around 8:00 AM. NA #1 revealed that she spoke to Resident #1 and asked to get Resident #1's blood pressure (BP). Resident #1 looked NA#1 and extended her arm for Resident #1's BP to be taken, then Resident #1 closed her eyes like she was going back to sleep. NA#1 took her vital signs, turned the lights out and left Resident #1's room.

An interview was conducted with NA #2 on 02/05/2025 at 11:34 AM. NA #2 stated that on the morning of 01/27/2025 around 10:00 AM, she went into Resident #1's room to provide resident care and Resident #1 was asleep. NA #2 stated that she woke Resident #1, and Resident #1 smiled at her. NA #2 stated that she bathed, dressed, and provided mouth care for Resident #1. NA#2 also stated that shortly after that, she saw Resident #1's nurse go into Resident #1's room to give Resident #1 her medications and tube feeding. NA #2 further revealed that around 11:15 AM, she saw Resident #1's family members go into Resident #1 room. NA #2 stated that she went to lunch about 11:30 AM and when she came back from lunch around 12:00 PM, she was told that Resident #1 was sent to the hospital.

An interview was conducted with Nurse #1 on 02/05/2025 at 11:54 AM. Nurse #1 stated that on 01/27/2025 at approximately 11:00 AM she entered Resident #1's room and administered her medications and tube feeding. Nurse #1 stated that Resident #1 was lying in bed with her eye closed and Resident #1 was moving her sheets up closer to her face. Nurse #1 stated that Resident #1 tolerated her medications and tube

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feeding and voiced no complaints. Nurse #1 further stated that no family members were present during the medication administration or tube feeding. Nurse #1 stated that around 12:00 PM she was standing in the 100 hallway with the NP and a family member came out of Resident #1's room and yelled that Resident #1 was having a seizure. Nurse #1 stated she and the NP ran to Resident #1's room and found Resident #1 lying in bed and leaning towards her right side. The NP asked Resident #1 if she was in any pain and Resident #1 pointed to her head. Nurse #1 also stated she did not observe any facial drooping. Nurse #1 stated that the NP instructed her to call 911 and have Resident #1 sent to the ER. Nurse #1 stated she called EMS and then Nurse #1 and the NP lifted Resident #1 up in bed. Nurse #1 explained that EMS arrived, and they asked if Resident #1 was taking any narcotics and Nurse #1 said "No, Resident #1 only takes Tylenol for discomfort".

An interview was conducted with the NP on 02/06/2025 at 8:00 AM. The NP stated that she was very familiar with Resident #1. The NP stated that the family member also requested that Resident #1 be put back on Prozac (anti-depressant) and Hydroxyzine (anti-anxiety medication) for her behaviors. The NP stated that she researched Resident #1's hospital records, contacted Resident #1's previous Home Health Agency, and also reviewed Resident #1's discharge summary from another long-term care facility to find out more information about Resident #1's medications including the Prozac and Hydroxyzine. The NP stated that there was no documentation or records which indicated Resident #1 was ever ordered Prozac or Hydroxyzine. The NP also explained that during

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her 2nd conversation with Resident #1's family member, the family member stated that Resident #1 had been taking Oxycodone (pain medication) but later in the same conversation, the family member stated that Resident #1 did not take strong pain medications. The NP stated that she visited Resident #1 on 01/24/2025 and Resident #1 was sitting up in the chair in the hallway. The NP explained that Resident #1's hair was "beautiful", her eyes were open, she was pleasantly confused and followed all commands. The NP stated Resident #1 was having a very good day. The NP also stated that Resident #1 had no visitors on 01/24/2025 at the time the NP was in Resident #1's room. The NP explained that on the following Monday on 01/27/2025 at about 11:50 AM Resident #1's family member came out into the hallway and yelled that Resident #1 had just had a seizure. The NP further explained that she and Nurse #1 went into Resident #1's room and found Resident #1 leaning toward the right side of the bed away from the family members. The NP further stated that the family member stated that Resident #1 did something funny with her left hand. The NP asked the family member if Resident #1 lost consciousness and the family member replied, "No". The NP assessed Resident #1 and found Resident #1 to be alert and able to follow commands. The NP asked Resident #1 if she was having pain and Resident #1 held her chest with her hand but said that her head was hurting. The NP also revealed that Resident #1's vital signs were taken, and the vital signs were normal. The NP also stated that her assessment revealed Resident #1 was afebrile and had no facial drooping. The NP stated that she asked Nurse #1 to call EMS and have Resident #1 sent to the ER for evaluation of a possible stroke. The

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NP stated that she did not think Resident #1 had a seizure as Resident #1 did not have any signs or symptoms of seizure activity. The NP explained that EMS arrived, and they asked if Resident #1 was taking any narcotics and Nurse #1 said "No, Resident #1 only takes Tylenol for discomfort". The NP stated that Resident #1's medication list was given to EMS personnel.

Review of the ER physician's note dated 01/27/2025 at 1:39 PM revealed Resident #1 presented to the ER for evaluation of altered mental status (AMS) and possible seizure activity. Resident #1's family member was present and provided Resident #1's health information. The family member also revealed that when she arrived at the long term care facility today, Resident #1 was unresponsive, and her left arm had episodes of shaking which the family member thought was a seizure. The family member also stated that EMS personnel arrived at the facility and was concerned that Resident #1 had been given opioids (pain medication) because her pupils were pinpoint. The family member further explained that EMS administered Narcan (medication used to reverse an opioid overdose) and there were no changes to Resident #1's mental status. The family member also stated that Resident #1 should not be on any narcotic pain medications.

Review of the ER physician's physical examination dated 01/27/2025 at 1:39 PM revealed Resident #1 had decreased responsiveness and an altered mental state with chronic right-sided weakness from a previous stroke. Resident #1 had pin-point pupils, dry mucous membranes, and was moving extremities without difficulty. There was no abnormal tone or

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obvious gross motor or sensory deficits.

Review of the Comprehensive Metabolic Panel (a blood test that measure different substances in the blood) dated 01/27/2025 at 1:50 PM revealed Resident #1 had the following abnormal values which are indicators of severe dehydration:
1. Serum Sodium level of 168 milliequivalents per liter (mEq/l). Normal serum Sodium levels range from 135 to 145 mEq/l).
2. Blood Urea Nitrogen level of 67 milligrams/deciliter (mg/dl). Normal serum BUN levels range from 7-20 mg/dl.
3. Serum Creatinine level of 2.30 mg/dl/ Normal serum creatinine levels range from 0.6-1.1 mg/dl.

Review of Resident#1's urine drug screen dated 01/27/2025 at 1:51 PM revealed Resident #1 was positive for Fentanyl and MDMA.

Review of the ER physician's progress noted dated 01/27/2025 at 4:34 PM revealed Resident #1 was hypernatremic (elevated serum sodium level) raising concerns for severe dehydration and Resident #1's urine drug screen was positive for Fentanyl and MDMA. The ER physician contacted the hospital case manager and Adult Protective Services (APS) due to concerns with Resident #1's severe dehydration and positive urine drug screen.

A telephone interview was conducted with the hospital SW on 02/06/2025 at 9:25 AM. The SW confirmed Resident #1 had a positive urine drug screen for Fentanyl and MDMA while in the ER on 01/27/2025. The SW stated that the local police department, the DEA, and APS were notified. The SW stated that Resident #1 stayed in the hospital for 4 days and was discharged home with a

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family member. The SW also stated that Resident #1's family member did not want Resident #1 sent back to the nursing home.

An additional interview was conducted with the NP on 02/06/2025 at 10:00 AM. The NP stated that MDMA would cause severe dehydration, confusion, depression, anxiety and paranoia. The NP also stated that Fentanyl would cause sedation. The NP further added that these drugs could be fatal for anyone and just touching Fentanyl could be deadly. The NP also explained that these drugs would induce dehydration very rapidly; especially in the elder population and abnormal hand/arm movements could also be a result of taking these drugs.

A telephone interview was conducted on 02/06/2025 at 10:20 AM with the DEA agent who was investigating the report. The DEA agent stated that he and local law enforcement went to the facility on 01/27/2025 and conducted record interviews with all staff at the facility who were working on 01/27/2025. He also stated that he had no concerns with the staff at the facility. The DEA agent further revealed that there was a street drug circulating in the community which was in powder form and contained a mixture of Fentanyl and MDMA. The DEA agent also stated that his interviews with the staff included asking about the presence of a powder near or around Resident #1's nose, mouth, or gums. The DEA agent stated that no staff member observed a powder near or around Resident #1's nose, mouth, or gums. The DEA agent also explained that MDMA would make an individual dehydrate rapidly.

A telephone interview was conducted with the

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APS supervisor on 02/06/2025 at 11:05 AM. The APS supervisor stated that APS received two referrals on 01/27/2025 regarding Resident #1. The first referral was in reference to Resident #1 being severely dehydrated and the second referral was in reference to Resident #1 having had a positive urine drug screen for Fentanyl and MDMA while being treated in the ER. The supervisor also stated that APS had conducted a facility visit at the nursing home as well as a hospital visit on 01/28/2025. The visits included document reviews of Resident #1 health records and multiple staff interviews.

An interview was conducted with the Administrator on 02/06/2025 at 2:30 PM. The Administrator stated that she had no knowledge of the incident occurring with Resident #1 until local law enforcement, the DEA agent, and APS arrived at the facility on 01/27/2025 and told her that Resident #1 had a urine drug screen at the hospital which was positive for Fentanyl and MDMA. The Administrator stated that the facility worked in cooperation with all agencies investigating the incident. The Administrator stated that Resident #1 was admitted to the facility on Monday 01/20/2025. The Administrator explained that Resident #1's family member randomly told her that Resident #1 was not on Oxycodone and that Resident #1 normally did not take Oxycodone, but another hospital had ordered it, and the family member stated that she had discussed Resident #1's medications with the NP. Resident #1's family member told the Administrator that she and the NP both agreed that Tylenol would be used for Resident #1's pain. The Administrator further stated that 2 days later an admission meeting was held with the family member and during the meeting the family

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member had several concerns about Resident #1's medications (Prozac, Hydroxyzine, and Oxycodone) not being ordered. The Administrator stated that later that afternoon she received a call from the NP regarding Resident #1. The NP told the Administrator the family member wanted Resident #1 placed back on Prozac and Hydroxyzine and that Resident #1 had not taken these medications in a very long time and the NP stated that she did not think Resident #1 needed them. The Administrator told the NP that she did not have to order the medications unless they were medically necessary. The Administrator further explained that the NP also told her that two days after the family member asked her not to give Resident #1 Oxycodone; the family member approached her again and asked her to order it. The Administrator revealed that the NP stated that she did not know what was going on with Resident #1's family member but she was not comfortable ordering any of these medications. The Administrator stated that the NP did not order the medications.

The Administrator was notified of immediate jeopardy on 02/06/2025 at 2:40 PM.

The facility provided the following credible allegation of immediate jeopardy removal plan.

Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:

The facility failed to protect Resident #1's right to be free from abuse.

On 01/27/2025, Resident #1 was being visited by

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a family member. The family member alerted the staff that Resident #1 was having a seizure. The Nurse Practitioner was in the facility. The NP and Nurse #1 went to access Resident #1. The NP gave orders to transfer Resident #1 to the emergency room for evaluation. Resident #1 was admitted to the hospital with a diagnosis of possible new stroke and dehydration.

Review of Resident #1's hospital records revealed a positive urine drug screen. Law enforcement and Adult Protective Services were notified by the hospital emergency room. Local law enforcement and local adult protective services (APS) notified the facility of the findings. The facility initiated an investigation when receiving this information.

Resident #1 was transferred from the facility to the hospital on 01/27/2025.

Current residents that have visitors are at risk. A review of current resident progress notes of the last 7 days was conducted by the nursing leadership team and reviewed for changes in condition and abnormal behaviors that have not been addressed. This review was completed on 02/06/2025.

The kiosk will be audited on 02/07/2025 for the last seven days of visitors and the residents identified were audited for signs and symptoms of acute episodes. This is completed by the Administrator and Director of Nursing.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

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F 600	Continued From page 14 Education was started by the Director of Nursing on 02/06/2025 to current staff including all departments on monitoring for behaviors of any visitors outside of the normal expected behaviors both physical and mental. This education will be completed on 02/06/2025. Employees not receiving this education will not be allowed to work until the education is received. The Staff Development Coordinator will track the education to ensure that current staff have received. Education was started by the Director of Nursing on 02/06/2025 to current staff including the abuse policy of what is considered abuse and who to report suspected abuse to and that there will be no tolerance for illegal substances. This education will be completed on 02/06/2025. Employees not receiving this education will not be allowed to work until education is received. The Staff Development Coordinator will track the education to ensure that current staff have received. Education to agency staff will be completed when they enter for their shift by the charge nurse on duty. A statement is being added to the kiosk that visitors sign in on when they enter the building that states that I acknowledge the statement: No firearms or illegal substances while on premises. This statement was added to the kiosk that visitors use to sign in on 02/06/2025 by the Striv360 company. The Striv360 company is who is responsible for making changes to the kiosk. A member of corporate leadership team communicates the changes that are needed for the Striv360 kiosk. All visitors are required to sign in at the front door. This is the only entrance that visitors are allowed to access. The	F 600		

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Administrator of the facility gets a notice of all kiosk sign ins by email and monitors to ensure the acknowledgement has been checked. The Administrator can login to the kiosk system and ensure that the acknowledgement was checked by all visitors that sign in.

A sign is being placed in the front entrance that states no firearms and no illegal substances while on the premises. This sign was placed on 02/06/2025 by the maintenance director. The signage placed was created and laminated. This signage was placed on all doors that someone could enter the facility from. This sign was placed on doors by the maintenance director on 02/07/2025.

Alert and oriented residents will be notified by the Administrator or designate on 02/07/2025 that there is no tolerance for abuse including illegal substances. This will be done verbally. Resident that are not alert and oriented, the responsible parties will be notified by telephone by the Administrator or designee on 02/07/2025.

Staff members will be notified via mass message that is sent to the employee's cell phone via the payroll system regarding there will be no tolerance for abuse including illegal substances. This will be completed 02/07/2025 by the Human Resource Manager.

Alleged Date Of IJ Removal: 02/08/2025

On 02/10/2025 the credible allegation for the immediate jeopardy removal was validated and the IJ removal date of 02/08/2025 was confirmed.

A review of the audit tool of current resident's

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progress notes was conducted on 02/10/2025. This review included changes in resident condition and any abnormal behaviors. No new changes in condition or abnormal behaviors were found.

A review of the audit tool of the kiosk visitor log was conducted on 02/10/2025. The audit revealed that all residents who had visitors were monitored for signs and symptoms of acute episodes. No residents were identified as having acute episode.

A review of the in-service education records was conducted on 02/10/2025. The education was provided to all staff in the facility on monitoring for behaviors of any visitors outside of the normal expected behaviors both mental and physical. The education also included the facility's abuse policy and what is considered to be abuse and who to report suspected abuse to. The education also included that the facility has no tolerance for illegal substances. The education was provided by the Director of Nursing. Employees who had not received this education were not allowed to work until the education was completed. The Staff Development Coordinator has been responsible for tracking the education to ensure compliance. Agency staff completed the education when they entered the facility for their shift by the charge nurse.

A review of the kiosk acknowledgement statement was conducted on 02/10/2025 and revealed when visitors sign in on the kiosk upon entry into the facility they acknowledge the following statement on the kiosk. "No firearms or illegal substances while on premises".

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A review of the front entrance door was conducted on 02/10/2025 and revealed an 8 inch by 10 inch laminated sign which read, "No firearms and no illegal substances while on the premises".

Interviews with alert and oriented residents revealed they received education regarding there is no tolerance for abuse in the facility including the use of illegal substances. Interviews with responsible parties revealed they had received education regarding no tolerance for abuse in the facility including the use of illegal substances.

Interviews with nursing staff, therapy staff, housekeeping staff, dietary staff, and the administrative staff revealed they had received email notification from the facility regarding no tolerance for abuse and the use of illegal substances. The staff also stated they had received education on monitoring residents and visitors behaviors and to report any suspicious behaviors immediately to Administration. Staff also reported that they had received education on the abuse policy including what is considered to be abuse and who to report suspected abuse to.