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M 000	Initial Comments On 11/06/23 through 11/08/23 the State Agency (SA) conducted an onsite Complaint Investigation (CI) for three (3) facility self-reported incidents. CI MS #23175 alleged that a resident had been verbally and physically abused by staff during a confrontation involving the resident's alleged excessive use of the call light system. CI MS #23206 alleged that a resident had been left lying in urine soaked linens and a urine soaked brief for over four (4) hours after the staff had verbally abused the resident for wetting the bed. The SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500 related to CI MS #23175 and CI MS #23206. CI MS #23252 alleged that a staff member had stolen cash money out of a resident's wallet. There was no licensure deficiencies cited for CI MS #23252. The facility was licensed for 150 beds and the resident census was 131.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written	M 500		

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statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;

3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or

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M 500	Continued From page 2 other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality,	M 500		

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M 500	Continued From page 3 including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and	M 500		

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M 500	Continued From page 4 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure that the rights of all residents were protected for two (2) of six (6) residents reviewed for resident rights/abuse and neglect. Residents #1 and #2. Findings include: Review of the facility policy titled "Standards of Conduct," dated June 19, 2012 revealed, "... PURPOSE: All employees shall be expected to accept responsibilities, adhere to acceptable personal conduct, and exhibit a high degree of personal integrity at all times. All employees are expected to respect the rights of all residents, resident families, and co-workers. All employees are expected to refrain from any behavior that might be harmful to co-workers, residents, resident families, and/or the facility..." Review of the facility policy titled " Resident Rights," reviewed March 11, 2022, revealed, "The Resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident ..." Resident #1: (CI MS #23206) An interview on 11/06/23 at 11:30 AM, with the Administrator (ADM), revealed that she had	M 500		

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completed an investigation into the incident and had found that the Certified Nursing Assistant (CNA) #1 that was assigned to care for Resident #1 (Res #1) had not assisted Res #1 and had left Res #1 wet from approximately 5:00 AM-9:00 AM on 10/26/23. The ADM stated that she reviewed the facility video tapes that had recorded the activities on the hallway for 10/26/23 from 5:00 AM-10:00 AM and saw on the video that the assigned CNA#1 had not gone into the room of Res #1 after 5:11 AM on 10/26/23. The ADM stated that she also interviewed all the staff that were working on that hall on 10/26/23 for the third and first shifts and through interviews the ADM concluded that Res #1 was not assisted by CNA #1 to change his wet bed linens. The ADM commented that she terminated CNA #1 from employment at the facility on 10/30/23 and CNA #1 was not allowed to return to work after 10/26/23. The ADM stated that Res #1 was left wet for such a long time that when he was changed by the day shift by CNA#2, the CNA reported that his brief fell apart because the brief was so full of "old" stale urine that had been left for a long while. The ADM stated that she could tell the difference between fresh urine and "old" stale urine that had been there for a while due to the odor and the color and the degree that the brief had absorbed the urine. The ADM stated that she began immediate in-services on Residents Rights and Abuse and Neglect of all staff following the incident. The ADM revealed that CNA #1 had also had a prior warning documented in her personnel records for failure to provide care to another resident on 09/19/23.

During an interview on 11/06/23 at 3:35 PM, with Licensed Practical Nurse (LPN) #1, she revealed she began work on 10/26/23 at 7:00 AM and that at approximately 9:00 AM, she went into Res #1's

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room to deliver his morning medications when Res #1 began to tell her that the CNA that had been assigned to care for him on the third shift had been "ugly" to him and had "yelled" at him for wetting the bed and soaking his bed linens. Res #1 told LPN#1 that the CNA was very rude and refused to assist him. LPN#1 stated that she confirmed that the bed linens of Res #1 were urine soaked at approximately 9:00 AM on 10/26/23 and that the clean linen was lying on the foot of Res #1's bed. LPN#1 reported the incident to the nurse supervisor, to the ADM, and to the morning CNA (CNA #2). LPN#1 verified that she had given a handwritten statement to the ADM and that her handwritten statement was an accurate account of what had been reported to her by Res #1 on 10/26/23.

Observations on 11/07/23 at 10:00 AM-12:00 PM, along with the Assistant Administrator of the facility video from 10/26/23 from 5:00 AM-10:00 AM, revealed that at approximately 5:08 AM, CNA #1 entered the room of Res #1 with a stack of folded linens and came out of Res #1's room at approximately 5:11 AM, without the same stack of folded linens. The video observation revealed that CNA #1 went in and out of other rooms on "D" hall but never went back into Res #1's room from 5:11 AM-7:10 AM. CNA #1 was seen leaving the "D" hall, after the close of her shift, at approximately 7:10 AM on 10/26/23. LPN #2 was seen going in and out of all the rooms on "D" hall from approximately 5:00 AM-7:00 AM. The video revealed LPN #1 entering Res #1's room at approximately 9:07 AM and exiting at approximately 9:10 AM. At approximately 9:25 AM, the video revealed that CNA #2 entered Res #1's room and left at approximately 9:35 AM on 10/26/23. CNA #2 exited Res #1's room with a plastic bag filled with what appeared to be dirty

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linen. The Assistant ADM #1 identified all the workers pictured in the video of 10/26/23 from 5:00 AM - 10:00 AM.

In an interview on 11/07/23 at 3:10 PM, with CNA #1, she revealed that she had been assigned to the care of Res #1 on 10/25/23-10/26/23 during the third shift. CNA #1 stated that Res #1 was able to care for his own needs and that he could stand, and he could transfer from the bed to his wheelchair independently. CNA #1 stated that she did not yell at Res #1, and she did not refuse to care for him. CNA #1 stated that she went in to check Res #1 on 10/26/23 at approximately 5:00 AM and he was wet, and his linens were urine soaked. CNA #1 stated went and got clean linens and took to Res #1's room and he refused to get up out of the bed. Res #1 told CNA #1 that he did not want to get up and out of bed at 5:00 AM. CNA #1 stated that she left the clean linen on the foot of Res #1's bed and left the room at approximately 5:00 AM. The CNA confirmed that she reported to LPN#2 that Res #1 was wet and that he was refusing care or to get out of bed so she could change his linens. CNA #1 stated that she was called to an in-service at approximately 7:10 AM just after shift change. CNA #1 stated that she left the unit to go to the in-service at approximately 7:10 AM and on her way, she told the Director of Nursing (DON) that Res #1 was wet and refusing to get out of bed. CNA #1 confirmed that she did not go back into Res #1's room after she left the clean linen on the foot of his bed. CNA #1 confirmed that she did not change Res #1 after he was discovered to have wet his clothing and bed linens at approximately 5:00 AM on 10/26/23. CNA #1 confirmed that she gave a written statement to the ADM concerning the incident with Res #1. CNA #1 confirmed that she was terminated from employment at the

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M 500	Continued From page 8 facility as a result of the incident with Res #1 on 10/26/23. During an interview on 11/07/23 at 3:25 PM, with the Social Worker (SW), she revealed she was asked to speak with Res #1 concerning an incident of abuse and/or neglect by a CNA. The SW stated that Res #1 told her that a CNA on the night shift had spoken to him in a "sharp" manner and had yelled at him for wetting his bed. The SW stated that Res #1 was upset by the incident and reported that the CNA brought linen into the room and "threw it on the foot of the bed and told Res #1 that he could change the bed by himself." Res #1 told the SW that no one came to change his wet bed linens until the morning shift came and another CNA helped Res #1 and changed his bed linens. The SW verified that she gave a written statement to the ADM on 10/26/23 at approximately 12:15 PM after she talked to Res #1. In an interview on 11/07/23 at 3:30 PM, with CNA #2, she revealed that she went in to check on Res #1 at approximately 9:20 AM and Res #1 told her that the third shift CNA (CNA #1) had yelled at him and had refused to change his linens and had left the linens on the foot of his bed and told him that he would have to change his own linens. CNA #2 stated that Res #1 identified CNA #1 by her name. CNA #2 stated that she never had any issues with Res #1 refusing care and he had always been cooperative with her. CNA #2 confirmed that Res #1 stated that he had been wet and left to lie in urine-soaked linens for a long while because CNA #1 had refused to assist him. CNA #2 stated that she changed Res #1's brief and linens on 10/26/23 at approximately 9:20 AM, after she had taken his roommate to the breakfast table in the dining room. CNA #2	M 500		

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verified that she had given a written statement to the ADM that stated that the brief of Res #1 fell apart when she changed it due to the large amount of urine. CNA #2 stated that Res #1's linens were wet all the way through to the mattress pad.

During an interview on 11/07/23 at 3:40 PM, with the DON, she revealed that she had not been told by CNA #1 that Res #1 was wet and refusing care. The DON stated that she had no knowledge of talking to CNA #1 on 10/26/23. The DON confirmed that she went and got CNA #1 off the unit just after 7:00 AM on 10/26/23, to attend an in-service, but did not discuss anything with CNA #1.

In an interview on 11/08/23 at 10:00 AM, with LPN #2, he revealed he had no recall of CNA #1 telling him that Res #1 was wet and refusing care on 10/26/23. LPN #2 confirmed that he was the nurse supervisor for third shift on the "D" hall and the medication nurse. LPN #2 stated that he went in and out of Res #1's room during the third shift but had no knowledge that Res #1 was wet. LPN #2 noted that Res #1 did not report any abuse or neglect to LPN #2 on 10/26/23. LPN#2 confirmed that he had provided the ADON with a written statement concerning the incident of 10/26/23 with Res #1.

In an interview and observation on 11/08/23 at 12:30 PM, with Res #1 revealed that a CNA, had talked rudely to him. Res #1 stated that he could not remember her name. He stated that the facility ADON had investigated the matter and had taken care of the situation, and that the CNA would not be allowed in his room again. Res #1 stated that he had no problems with any of the nurses.

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M 500	Continued From page 10 A record review of the Face Sheet for Res #1 revealed that he was admitted to the facility on 08/19/2022 with diagnoses that included Type 2 Diabetes, Insomnia, and Tina Cruise. Record review of Res #1's Minimum Data Set (MD'S) with an Assessment Reference Date (AR) of 08/31/23 revealed that Res #1 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated that Res #1 was cognitively intact. Record review of the Departmental Notes, Category: Nurses Notes dated 10/26/23 at 1:23 PM, revealed "700 am patient lying in bed asleep call light in reach ...10/26/23 at 1:52 PM Late Entry 0930 Resident made verbal complaint to this nurse that the overnight CNA refused to provide ADL Care and Assist W/Bed linen change. This nurse reported to unit manager and witness statement completed. AM CNA assisted resident W/ADL Care and Bed Linen change. Resident appeared to be slightly upset w/situation and this nurse ensured that it would be reported to the proper staff for follow up. Will continue to monitor resident." Signed by LPN #1. Record review of Res #1's care plan revealed that he was to receive one person assistance with all his Activities of Daily Living (ADL's) and that he was at times incontinent of bladder and wore adult briefs. The care plan outlined that Res #1 was to receive assistance every two (2) hours with toileting while awake. Resident #2: (CI MS #23175)	M 500		

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M 500	Continued From page 11 An interview on 11/06/23 at 11:30 AM, with the facility ADM, revealed that she had completed a full investigation of the incident involving Res #2. The ADM stated that even though Res #2 had a lower BIMS score of 8 indicating that he had moderate cognitive impairment, he was usually able to relay information to staff in a manner that they were able to understand his needs and issues. The ADM stated that she went to talk to the Res #2 immediately after the alleged incident and he told the ADM that two (2) staff came in his room the night before and took his call light away from him after they struggled with him to get it out of his hand. Res #2 stated that he had been to the dentist the day of the incident and had gotten back from the dentist later in the day. He stated that he used his call light system to summon assistance to his room to pull his privacy curtain, turn off the light in his room, and to open his door so he could see out into the hallway. Res #2 confirmed that he used his call light several times to ask for help and that the staff refused to assist him, and they took his call light from him and would not help him. Res #2 showed the ADM where the call light was in his hand and when the staff tried to force the call light out of his hand, it caught his little finger and hand and caused an abrasion and small cut and bruise. The ADM stated that the dried blood was on Res #2's finger when he showed it to her on 10/24/23. The ADM stated that she and the Assistant Administrator, pulled the video tapes from the hallway of "D" hall to see the activity of the staff. The ADM stated that the video tapes confirmed through audio and visual video that three (3) CNAs had gone in and out of Res #2's room numerous times during the second shift 6:00 PM-9:00 PM. The ADM confirmed that she pulled the records from the call light system to see how many times the call light had gone off and for how long and she was	M 500		

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able to confirm that between 6:13 PM-9:08 PM Res #2's call light system had come on 21 times and two (2) of those times the call light system cord had been pulled out from the wall. The ADM stated that the call light system that they have in the facility records the information as it occurred. The ADM stated that she had substantiated through her investigation that a second shift CNA (CNA #3), a contract agency CNA, had taken Res #2's call light system from him and that through the audio recording heard CNA #3 telling two (2) other CNA's (CNA #4 and CNA #5), both also contract agency CNAs, that she would show them how to handle the "damn thing." The ADM stated that she called the agency that the three (3) CNA 's worked for (a private contract Staffing agency) and talked to the owner and told her what had happened and that she never wanted those three (3) CNAs to work at the facility again. The ADM stated that she fully believes that CNA #3 hurt Res #2's hands by jerking the call light system from his hands and pulled it out of the wall.

An interview on 11/06/23 at 1:00 PM, with Registered Nurse (RN) #1, revealed that she was the supervisor for "D" hall on second shift on 10/23/23. She stated that just before shift change at approximately 6:45 PM on 10/23/23, she received a text message from the medication nurse, (LPN #3) asking if she could come to Res #2's room. RN #1 went to the room of Res #2 where there were CNA #4 and CNA #5. RN #1 stated that Res #2 was agitated and upset and was excessively using his call light system. When RN #1 entered Res #2's room, he had his shirt up over his head and was yelling at LPN #3 and the CNA #4 and CNA #5. He told RN #1 that they "had done him wrong" and that they had "jumped on him." RN #1 stated that LPN #3 and the two CNAs stayed in the room and that she assisted

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	16CO	A. BUILDING: _____ B. WING _____	C 11/07/2023

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M 500	Continued From page 13 Res #2 to put on another shirt out of his closet and to adjust his curtain and light. RN #1 stated that Res #2 told her he did not want to eat that he had been to the dentist that day and did not feel like eating. RN #1 took his supper tray out of the room at his request and left his room at approximately 7:00 PM on 10/23/23 and went home at the end of the shift at 7:00 PM. RN #1 stated that Res #2 did not want his nighttime meds at that time. An observation on 11/07/23 of the facility video, was made along with the Asst. ADM #1. The Asst. ADM #1 identified all the employees by name as the video was viewed from 10:00-12:00 PM on 11/07/23. The video showed that Res #2's call light was used on numerous occasions on 10/23/23 from 6:13 PM-9:08 PM. The Asst. ADM #1 had a timeline that he had made verifying that the call light system was used 21 times for Res #2 between 6:13 PM and 9:08 PM on 10/23/23. The video revealed CNA #4 and CNA #5 going in and out of Res #2's room and in the hallway outside of Res #2's room on "D" hall. CNA #4 and CNA #5 were seen going into Res #2's room with CNA #3. CNA #3 was not assigned to "D" hall or to Res #2's room. CNA # 3, CNA #4 and CNA #5 went into Res #2's room and then came out and the audio was heard for the three (3) talking in the hallway. CNA #3 could be heard to say, "let me show you how to do this damn thing." CNA #3 went in Res #2's room alone at 8:45 PM and came out and went up the hall and came back down wearing plastic gloves and obtained a wipe from another resident's room and goes into Res #2's room with the wipe and plastic gloves and came out and disposed of the gloves on top of a plastic bag lying on the floor in front of another resident's room. CNA #3 left the floor and the call light of Res #2 does not sound again	M 500		

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after 9:08 PM on 10/23/23. Asst. ADM #1 confirmed that he and the ADM had watched the video and had matched the times the call light was documented as being unplugged from the wall to the times that CNA #3 was in Res #2's room.

During an interview and observation on 11/07/23 at 12:15 PM, of Res #2, along with the facility ADM, revealed that he was alert and aware. Res #2 said that he had just gotten that call light system placed at his bedside earlier that morning. Res #2 stated that his call light had not worked for a while. Res #2 stated "that is new as of today. The old one didn't work because those girls hurt me with it."

An interview on 11/07/23 at 12:40 PM, with CNA #5 revealed that she worked for an agency and that she had not worked at the facility since 10/23/23. She stated that Res #2 was excessively using his call light system on second shift on 10/23/23. She stated that he grabbed her finger and bent it back and was yelling and agitated. She stated that the RN supervisor (RN#1) was called by the unit medication nurse (LPN#3) to come down to Res #2's room because he was loud and agitated. She stated that he calmed down with RN#1 but soon became agitated after RN #1 left the facility at 7:00 PM. CNA #5 stated that Res #2 used his call light system repeatedly from supper time until after 9:00 PM. She stated that a CNA #3 came from another unit and told them to unplug Res #2's call light and they would not do it. CNA #5 did not report the incident to anyone at the facility.

An interview on 11/7/23 at 1:10 PM, with CNA #4, revealed that she worked for a contract agency and that she had been assigned to work with Res

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M 500	Continued From page 15 #2 on 10/23/23 on the second shift. She stated that Res #2 had been to the dentist earlier on 10/23/23 and that he came back to the facility agitated. She stated that Res #2 excessively used his call light system from approximately 6:00 PM-9:00 PM and that CNA #3 had come down to the room of Res #2 and told her and CNA #5 that she was going to show them how to handle this "damn" thing. CNA #3 told us "to take his call light out of the wall" and we said "no" we don't do that. CNA #4 stated that she did not report the situation to anyone, and they did not see her do anything, but that CNA #3 came into another resident's room where she was working and got a wipe and left out. CNA #4 confirmed that CNA #3 was alone in Res #2's room with him and that she was not assigned to work that area. CNA #4 stated that she was an agency contract worker and that she had given her statement to the facility ADM and to her boss at the agency. She stated that she had not worked at the facility since the incident of 10/23/23 with Res #2. An interview on 11/7/23 at 1:55 PM, with owner of the staffing agency, revealed that she was called by the facility ADM and told that they watched a video of the hallways and heard CNA #3 telling CNA #4 and CNA #5 to unplug the call light system. She stated that CNA #3 was heard cussing in ear range of residents and that she did admit to cussing but had said it was not in range of a resident's hearing. The Owner stated that she found it hard to believe that CNA #3 would neglect or abuse a resident. Agency Owner stated that CNA #3 was a very good employee and that she had facilities to call and specifically ask for her to work because she was so dependable and hard working. Agency Owner stated that she provided extensive training and that she had regular in-services on abuse and	M 500		

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neglect and Resident Rights. The Owner stated that all CNA #3, CNA #4, and CNA #5 all were agency contract workers and would not be sent back to work at the facility. She stated that she had talked to all three and had re-in-serviced.

An interview on 11/7/23 at 2:10 PM, with CNA #3, revealed that she was an agency contract worker and had not worked at the facility since 10/23/23. She stated that the facility ADM had called her agency and told them that they did not want her back because she was accused of unplugging a resident's call light. CNA #3 denied that she unplugged Res #2's call light and she stated that she would never abuse a resident or neglect them. She stated that when she went to the unit to check on Res #2, she saw blood on his hands, and she went and found a wipe in another resident room and took it and wiped off Res #2's hands and wiped the blood off. She stated that she told his assigned CNA's that he had blood on his hands so they could get the nurse to come. She stated that she did not report the incident to anyone except the two (2) CNA 's that were assigned to that hall.

An interview on 11/07/23 at 2:50 PM, with LPN#3 revealed that she was the unit medication nurse on 10/23/23 on first and second shift. She stated that Res #2 was agitated during the supper meal on 10/23/23 and that she texted the RN supervisor (RN#1) to come down to Res #2's room and see if she could calm him down. She stated that no one ever told her that Res #2 had blood on his hands or needed assistance. She stated that she had told the CNAs to check on Res #2 and she called the 7:00 PM-11:00 PM nurse supervisor and told her that Res #2 was agitated and was excessively using his call light system and the nurse supervisor made no

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M 500	Continued From page 17 comment. The Nurse Supervisor later told the SA that she went to Res #2's room after 9:00 PM and that he was asleep, so she did not go into his room. Record review of the Face Sheet of Res #2 revealed that he was admitted to the facility on 10/12/21 with diagnoses that included Hypothyroidism, Aphasia following a nontraumatic intracerebral hemorrhage, and Dysarthria following nontraumatic intracerebral hemorrhage. Record review of the MDS dated 10/26/23, documented that Res #2 had a BIMS score of 7, which indicated moderate cognitive impairment. Record review of the facility's incident investigation revealed that the ADM had documented on her investigation: "Interviews were done with the staff. Camera footage was watched, and it was determined that aide, CNA #3 is the person that pulled the call light cord out of Res #2's hands and the clip on the cord made small cuts on the outside of his pinky fingers."	M 500		