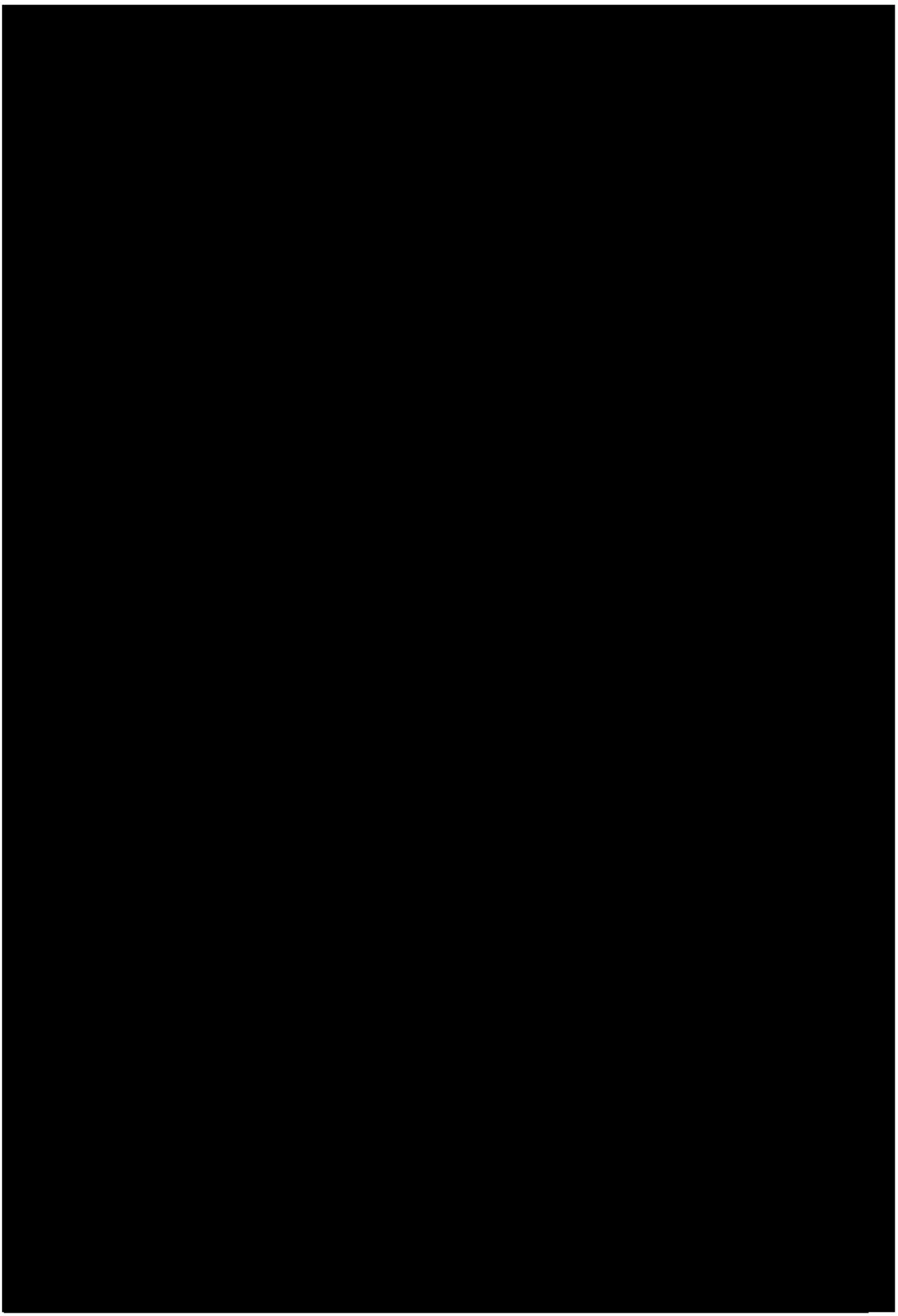

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2184	A. BUILDING: _____ B. WING _____	C 04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF EDGEWOOD	102 QUAIL TRAIL EDGEWOOD, NM 87015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on 04/22/24 for the state requirements of NMAC 7.8.2, Regulations for Assisted Living for Adults. Census [redacted] Complaint intake NM # [redacted] was investigated with no deficiencies cited. Complaint intake NM # [redacted] was investigated with no deficiencies cited. Complaint intake NM # [redacted] was investigated with deficiencies cited.	A 000		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following:	A 032		

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A 032	Continued From page 1 (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) B (3) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. and 8 B. (2) A. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation,	A 032		

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A 032	Continued From page 2 injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure for [redacted] (R [redacted]) of [redacted] (R #'s [redacted]) residents whose incident reports were reviewed for compliance that the facility: 1. Reported incidents of possible abuse, neglect, exploitation, or unusual occurrences that have threatened or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority within twenty-four (24) hours or by the next business day if it is a weekend or a holiday. 2. Conducted an internal investigation and submitted an investigation follow-up report to the Licensing Authority within five (5) business days from the date the incident occurred. 3. The internal investigation included specific plans/interventions for further actions in response to the incident to prevent further occurrences. These deficient practices could likely result in the residents being at risk of harm, injury, or death if incidents occur and there is no oversight by the Licensing Authority. The findings are: R[redacted] A. Record review of complaint intake NM #[redacted] received on 12/11/23 at 3:37 pm,	A 032		

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A 032	Continued From page 3 revealed: 1. Direct Care Staff (DCS) #1 somehow became R #1's Power of Attorney (POA) while [redacted] was living in the facility where DCS #1 worked. 2. R #1 reported [redacted] pension check had been lost and DCS #1's name was on [redacted] personal checks. DCS #1 had logged into some o[redacted] personal accounts online. R #1 reported DCS #1 went on a trip shortly afte[redacted] pension check had been lost. B. On 04/12/24 at 9:35 am, during an interview, Administrator #1 confirmed the allegations of exploitation for R[redacted] was never reported to the Licensing Authority, and the facility did not conduct and submit an investigation follow-up report to the Licensing authority within five (5) business days from the date the resident reported. C. On 04/12/24 at 1:18 pm, during an interview, DCS #3/House Manager stated the following: 1. R[redacted] told her that DCS #1 was stealing money from [redacted] (f[redacted] (exact date not recalled). 2. R[redacted] told her that DCS #1 was stealing by using one o[redacted] online accounts. (exact date not recalled) 3. R[redacted] told her that DCS[redacted] was buying groceries with [redacted] money for DCS #1 personal use. (exact date not recalled) 4. She told Administrator[redacted] about the allegations of exploitation reported by R[redacted] about DCS #1. (exact date not recalled) D. On 04/15/24 at 9:50 am, during an interview, R #1 state[redacted] did not have proof of a bank statement, credit card statement or any other evidence of DCS[redacted] stealing from [redacted] stated [redacted] suspected it, but did not have evidence. [redacted] also state[redacted] house had been broken into at	A 032	Residen[redacted] was discharged home and no longer resides at the facility. Direct Care Staff #4 was verbally counseled regarding the allegations made against her and was suspended without pay. She also received training regarding dementia care and interacting with residents who have dementia. She is no longer employed as a cook at this facility. A new house manager has been hired to replace Direct Care Staff #3 and has been trained regarding reporting of allegations of abuse, neglect, and exploitation. The facility will report incidents of abuse, neglect or exploitation to the licensing authority, together with a follow up report within 5 business days. An internal investigation will be conducted and any findings or plans for further actions will be included in the 5-day follow up report. An incident report log will be maintained by the administrator and reviewed monthly to ensure follow up is timely and to identify any trends or needs for further corrective action.	7/15/2024

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A 032	Continued From page 4 one point by other individuals (not DCS #1) who stole money from [redacted] R[redacted] E. On 04/16/24 at 9:10 am, during an interview, DCS #1 reported, she witnessed DCS #4 being aggressive with residents and reported it to the House Manager but could not recall exactly when. F. On 04/16/24 at 12:00 pm, during an interview, Administrator #1 reported: 1. She received a report (on unknown date) of DCS #4 speaking to residents (resident names unknown) in a harsh (cruel or severe) tone of voice (on unknown date). 2. She had a corrective conversation (verbal warning) with DCS #4 (on unknown date). 3. DCS #4 had two (2) written corrective actions (written warning) dated 09/01/23 and 10/16/23. G. Record review of DCS #4's Performance Improvement Warning (employee disciplinary form) dated 09/01/23 revealed: 1. R[redacted] family reported: a. During the week of 08/23/23 to 08/25/23, they [R[redacted] family] witnessed DCS #4 yelling at R[redacted] to get out of [redacted] kitchen. b. They [R[redacted] family] witnessed DCS #4 yelling and pointing her finger in R[redacted]'s face. 2. "This is one of multiple reports from staff, outside shower aides, and families of verbally abusive behavior." H. Record review of DCS #4's Performance Improvement Warning dated 10/16/23 revealed on 10/08/23: 1. DCS #4 was observed (by two unnamed staff) yelling and cussing at R[redacted]	A 032		

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A 032	Continued From page 5 2. DCS #4 told R[redacted] told you I don't have no more fuckin cookies!" 3. DCS #4 was suspended for three days due to the prior incident documented on the Performance Improvement Warning dated 09/01/23. 4. DCS #4 met with the facility's owner on 10/18/23, it was decided DCS #4 would remain as a cook, but would be terminated if this happens again. I. On 04/17/24 at 1:30 pm, during an interview, when asked what measures were taken after the incidents of verbal abuse with DCS #4 during the week of 08/23/23 to 08/25/23, and on 10/08/23, Administrator #1 stated: 1. DCS #4 received dementia training on 03/06/24. 2. She verbally counseled her on her behavior, exact dates not recalled. J. On 04/17/24 at 3:12 pm, during an interview, DCS #1 reported: 1. She witnessed DCS #4 yelling at R[redacted] when R[redacted] requested more food (exact date not recalled). 2. She witnessed on Easter of last year (04/09/23), DCS #4 yelling at R[redacted] "We don't have anymore food!" 3. DCS #1 reported that DCS #4 commonly yelled at staff and residents. K. Record review of DCS #4's employee file revealed DCS #4 completed a Dementia training on 03/06/24. L. On 04/18/24 at 9:29 am, during an interview, DCS #3/House Manager reported: 1. She knew about DCS #4's aggression towards residents.	A 032		

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A 032	Continued From page 6 2. DCS #9 reported to her (DCS #3/House Manager) an incident (exact date not recalled) that she witnessed about DCS #4 yelling at [name of R[redacted] There's no more fucking cookies!" 3. She witnessed DCS #4 yelling at R[redacted] "I already told you," while pointing her (DCS #4's) finger at R[redacted] very closely to her (R[redacted] face and felt this was verbal abuse (exact date not recalled). 4. DCS #8 reported she witnessed on 04/04/24, DCS #4 took a sandwich out of R[redacted] mouth whil[redacted] was eating, and sent R[redacted] to bed early. 5. DCS #8 reported she witnessed on 04/04/24, DCS #4 took away R[redacted] plate while [redacted] was eating, and sent R[redacted] to bed early. 6. She reported the incidents that occurred on 04/04/24 with R[redacted] and the incidents of verbal abuse to R[redacted] to Administrator #1 (exact date not recalled). M. On 04/18/24 at 10:00 am, during an interview, DCS #7 reported: 1. In October 2023, she witnessed DCS #4 telling R[redacted] in an irritated (showing or feeling slight anger), aggressive and rude tone of voice, "Get out of the kitchen [name of [redacted] we don't have any cookies." 2. DCS #7 had witnessed DCS #4 yelling towards R[redacted] often (exact dates not recalled). N. On 04/18/24 at 10:26 am, during an interview, Administrator #1 confirmed: 1. None of the incidents of verbal abuse with R[redacted] were not reported to the Licensing Authority. 2. She stated she has not had time to talk to DCS #4 yet regarding her (DCS #4) taking food away from R[redacted] and sending them to bed early. She stated, "I do not doubt [name of DCS #4] did this," referring to the incidents with R	A 032		

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A 032	Continued From page 7 [redacted]. She stated she did not report the incidents to the Licensing Authority. O. On 04/18/24 at 1:32 pm, during an interview, R[redacted] [name of family member] stated: 1. During a visit with R[redacted] exact date not recalled, family member observed DCS #4 yelling at R[redacted] "Its almost lunch, you don't need a cookie!" 2. DCS #3/House Manager was present during the incident and witnessed DCS #4 yelling at R[redacted] exact date not recalled. P. On 04/18/24 at 1:47 pm, during an interview, DCS #9 reported: 1. DCS #9 had observed (couldn't recall the exact date) DCS #4 yelling at R[redacted] "I'm not giving you anymore fucking cookies!" 2. DCS #9 had observed DCS #4 loudly yelling at R[redacted]on multiple occasions (couldn't recall exact date). 3. DCS #9 had observed (couldn't recall exact date) DCS #4 use profanity like, "fuck," when talking to the residents (exact resident names not recalled). 4. DCS #9 had observed (couldn't recall exact date) DCS #4 be verbally abusive to both residents and staff, stating DCS #4 is "very verbally abusive." 5. DCS #9 stated she reported (exact date not recalled) DCS #4's behaviors to DCS #3/House Manager and Administrator #1. Q. On 04/18/24 at 2:17 pm, during an interview, DCS #10 reported: 1. DCS #10 witnessed DCS #4 being mean and yelling at R[redacted] multiple times before (exact date not recalled). 2. DCS #10 witnessed on an unknown date (different incident from the one reported by	A 032		

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A 032	Continued From page 8 DCS #9) DCS #4 yell at R[redacted] "No, there's no coffee ready yet!" when F[redacted] asked for a cookie and coffee. 3. DCS #10 witnessed DCS #4 yell at a resident (she could not recall which resident) who didn't want to eat, "You have to eat all your food; you're not getting up until you're done!" 4. DCS #10 believed DCS #4 was verbally abusive, and stated DCS #4 gets "mad and bugged (annoyed or bothered) with residents, especially with [redacted] 5. DCS #10 reported (can't recall exact date) DCS #4's behaviors to DCS #3/House Manager. R. On 4/19/24 at 10:04 am, during an interview, DCS #8 stated she observed: 1. DCS #4 (couldn't remember exact dates) yelling at [redacted]et out of the kitchen, go to your room!" 2. DCS #8 stated DCS #4 is verbally abusive to the residents. 3. DCS #8 stated she reported (exact date not recalled) DCS #4's behaviors to DCS #3/House Manager .	A 032		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights	A 033		

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A 033	Continued From page 9 shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor;	A 033		

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A 033	Continued From page 10 and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s);	A 033		

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A 033	Continued From page 11 (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (1) (11) a Based on record review and interview, the facility failed to ensure for [redacted] residents sampled for possible abuse that: 1. Residents were free from emotional, and verbal abuse. 2. DCS with multiple allegations of verbal abuse were able to continue working in the facility. These deficient practices could likely result in the residents being at risk of harm if they are verbally	A 033		

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A 033	Continued From page 12 abused and not treated with dignity and respect. The findings are: A. On 04/16/24 at 9:10 am, during an interview, Direct Care Staff (DCS) #1 reported: 1. She witnessed DCS #4 (on unknown date) being aggressive with residents (resident names unknown) while moving them to another location in the facility. 2. She reported the incident with DCS #4 to DCS #3/House Manager (on unknown date). B. On 04/16/24 at 10:00 am, during an interview, Administrator #1 reported: 1. She received a report (on unknown date) of DCS #4 speaking to residents (resident names unknown) in a harsh (cruel or severe) tone of voice (on unknown date). 2. She had a corrective conversation (verbal warning) with DCS #4 (on unknown date). 3. DCS #4 had two (2) written corrective actions (written warning) dated 09/01/23 and 10/16/23. C. Record review of DCS #4's Performance Improvement Warning (employee disciplinary form) dated 09/01/23 revealed R #9's family reported: 1. During the week of 08/23/23 to 08/25/23, they [R #9's family] witnessed DCS #4 yelling at R [redacted] to get out of [redacted] kitchen. 2. They [R #9's family] witnessed DCS #4 yelling and pointing her finger in R [redacted] face. D. Record review of DCS #4's Performance Improvement Warning dated 10/16/23 revealed on 10/08/23: 1. DCS #4 was observed (by two unnamed staff) yelling and cussing at R [redacted] 2. DCS #4 tol[redacted] I told you I don't have	A 033	Direct Care Staff #4 was verbally disciplined regarding the allegations made against her on 9/1/2023 and again on 10/16/23 and was suspended without pay following the second disciplinary warning. She also received training regarding dementia care and interacting with residents who have dementia. She is no longer employed as a cook at this facility. A new house manager has been hired to replace Direct Care Staff #3 and has been trained regarding reporting and investigation of allegations of abuse, neglect, and exploitation. All facility staff will be re-trained regarding recognizing signs of abuse and neglect and their duty to report any such suspicions. The facility will report incidents of abuse, neglect or exploitation to the licensing authority, together with a follow up report within 5 business days. An internal investigation will be conducted and any findings or plan for further actions will be included in the 5-day follow up report. An incident report log will be maintained by the administrator and reviewed monthly to ensure follow up is timely and to identify any trends or needs for further corrective action.	7/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2184	A. BUILDING: _____ B. WING _____	C 04/22/2024

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A 033	Continued From page 13 no more fuckin cookies!" 3. DCS #4 was suspended for three days due to the prior incident documented on the Performance Improvement Warning dated 09/01/23. 4. DCS #4 met with the facility's owner on 10/18/23, it was decided DCS #4 would remain as a cook, but would be terminated if this happens again. E. On 04/17/24 at 3:12 pm, during an interview, DCS #1 reported: 1. She witnessed (exact date not recalled) DCS #4 yelling at [redacted] requested more food. 2. She witnessed on 04/09/23, DCS #4 yelled at [redacted] "We don't have anymore food!" 3. DCS #1 reported DCS #4 commonly yelled at staff and residents. F. On 04/18/24 at 9:29 am, during an interview, DCS #3/House Manager reported: 1. DCS #3 knew about DCS #4's aggression towards residents. 2. DCS #9 reported to her (DCS #3/House Manager) an incident (exact date not recalled) that she witnessed about DCS #4 yelling at [name of [redacted] "There's no more fucking cookies!" 3. DCS #3 witnessed (exact date not recalled) DCS #4 yelling at [redacted] "I already told you" while pointing her (DCS #4's) finger at [redacted] very closely to her (R [redacted] face and felt this was verbal abuse. 4. DCS #3/House Manager stated she observed R [redacted] appearing to be in shock after after DCS#4 yelled a [redacted] nd quietly went to [redacted] room. 5. DCS #3 was notified by DCS #8 of an incident that occurred on 04/04/24 with DCS #4 taking food from R [redacted] to bed early.	A 033		

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A 033	Continued From page 14 6. DCS #3 reported (exact date not recalled) the incidents on 04/04/24 and verbal abuse to R [redacted] to Administrator #1. G. On 04/18/24 at 10:00 am, during an interview, DCS #7 reported: 1. In October 2023 (exact date not recalled), DCS #7 witnessed DCS #4 telling R [redacted] in an irritated (showing or feeling slight anger), aggressive and rude tone of voice to "Get out of the kitchen [name of R [redacted] we don't have any cookies." 2. DCS #7 had witnessed (exact dates not recalled) DCS #4 yell towards R [redacted] often. 3. DCS #7 reported R [redacted] seemed sad, hurt, upset, and put [redacted] head down when DCS#4 had yelled at [redacted] H. Record review of R [redacted] Physician's Assessment dated [redacted] 21 revealed R [redacted] had a [redacted] I. Record review of R [redacted] hysician's Assessment date [redacted] 2021 revealed R [redacted] had [redacted] J. Record review of R [redacted] Neuropsychological Evaluation date [redacted] /20 revealed R [redacted] had [redacted] K. On 04/18/24 at 10:22 am, during an interview, R [redacted] state [redacted] did not remember when asked separate questions about whether DCS #4 took [redacted] sandwich out of [redacted] hand, or i [redacted] dinner was taken away from [redacted] or i [redacted] was forced to bed early by DCS #4. L. On 04/18/24 at 10:22 am, during an interview, R [redacted] did not respond when asked separate	A 033		

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A 033	Continued From page 15	A 033		

questions about whether DCS #4 ever took food from [redacted] go to bed early, or if [redacted] had any concerns about DCS #4.

M. On 04/18/24 at 10:26 am, during an interview, Administrator #1 reported:

1. She (Administrator #1) received a second hand report from DCS #3/House Manager reporting that on 04/04/24 DCS #8 witnessed DCS #4:

a. Taking food from R[redacted] and sent R[redacted] to bed early.

b. Taking food from R[redacted] and sent R[redacted] to bed early.

2. She (Administrator #1) stated she did not doubt DCS #4 took food away from R[redacted] and R[redacted] and sent R[redacted] and R[redacted] to bed early on [redacted]24, had not had time to do anything about it.

3. She (Administrator #1) was aware of DCS #4 yelling at residents.

4. DCS #4 was still working at the facility.

N. On 04/18/24 at 1:47 pm, during an interview, DCS #9 reported:

1. She (DCS #9) had observed (couldn't recall the exact date) DCS #4 yelling at [redacted], "I'm not giving you anymore fucking cookies."

2. She (DCS #9) observed R[redacted] head down and walk away when DCS #4 had yelled at [redacted]

3. She (DCS #9) had observed DCS #4 loudly yelling at R[redacted] on multiple occasions (couldn't recall exact date).

4. She (DCS #9) had observed (couldn't recall exact date) DCS #4 use profanity like "fuck" when talking to the residents (exact resident names not recalled).

5. She (DCS #9) had observed (couldn't recall exact date) DCS #4 be verbally abusive to

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A 033	Continued From page 16 both residents and staff, stating DCS #4 is "very verbally abusive." 6. She (DCS #9) stated she reported (exact date not recalled) DCS #4's behaviors to DCS #3/House Manager and Administrator #1. O. On 04/18/24 at 2:17 pm, during an interview, DCS #10 reported: 1. She (DCS #10) witnessed (exact date not recalled) DCS #4 being mean and yelling at R [redacted] multiple times before. 2. She (DCS #10) witnessed on an unknown date (different incident from the one reported by DCS #9) DCS #4 yell at R [redacted] "No, there's no coffee ready yet!" when R [redacted] asked for a cookie and coffee. 3. She (DCS #10) witnessed DCS #4 yell at a resident (she could not recall which resident) who didn't want to eat, "You have to eat all your food; you're not getting up until you're done!" 4. She (DCS #10) believes DCS #4 is verbally abusive, and gets "mad and bugged (annoyed or bothered) with residents, especially wit[redacted] 5. She (DCS #10) reported (can't recall exact date) DCS #4's behaviors to DCS #3/House Manager. P. On 04/19/24 at 10:04 am, during an interview, DCS #8 observed the following: 1. DCS #4 (couldn't remember exact dates) yelling at R [redacted] "Get out of the kitchen, go to your room!" 2. DCS #8 reported R [redacted] was avoiding interactions with DCS #4. 3. On 04/04/24, DCS #8 witnessed DCS #4 take a sandwich out of R [redacted] hand a [redacted] was taking a bite o[redacted] sandwich and removed R [redacted] dinner plate telling R [redacted] "You're done, you're going to bed," despite R [redacted] telling DCS #4 "I'm	A 033		

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A 033	Continued From page 17 not done." 4. On 04/04/24 DCS #8 witnessed DCS #4 take away R[redacted] unfinished dinner plate as [redacted] was eating telling [redacted] "You're done eating," and sent R[redacted] to bed early. 5. DCS #8 stated DCS #4 was verbally abusive to the residents. 6. DCS #8 stated she reported (exact date not recalled) DCS #4's behaviors to DCS #3/House Manager.	A 033		