

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2026
NAME OF PROVIDER OR SUPPLIER The Earlwood		STREET ADDRESS, CITY, STATE, ZIP CODE 20820 Earl Street Torrance, CA 90503	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect the residents' right to be free from sexual abuse for one of three sampled residents (Resident 1) after she reported an allegation involving Certified Nursing Assistant 1 (CNA 1) to CNA 2 on 5/28/2026. The facility failed to:1.Ensure CNA 1 was removed from providing care to Resident 1, after Resident 1 verbalized she does not want CNA 1 to take care of her on 5/28/2026 to CNA 2.These failures resulted in Resident 1 experiencing emotional distress and feeling unsafe in the facility.Findings:During a review of Resident 1's admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE], with the diagnosis including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), depression (persistent feelings of sadness, emptiness and a loss of interest) and anxiety (emotion characterized by feelings of tension, worried thoughts).During a review of Resident 1's History & Physical (H&P) dated 3/25/26, the H&P indicated, Resident 1 was alert and oriented to person, place and time.During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool) dated 5/5/26, the MDS indicated, Resident 1 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated, Resident 1 needed substantial/maximal assistance (helper does more than half the work), with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 1 was incontinent (inability to voluntarily control bladder or bowels) of bowel and bladderDuring a review of Resident 1's Change of Condition Evaluation ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status which without immediate intervention, may result in complications or death) dated 6/3/26 at 5:57 p.m., the COC indicated, Resident claimed CNA 1 told Resident 1 I will clean your vulva(external female genital organ).During a review of Resident 1's care plan titled Resident at risk for emotional distress due to resident allegation dated 6/3/2026, the Care Plan indicated a goal was for resident will not experience untoward (inappropriate, improper or unfavorable) outcomes due to trauma history. The Care Plan indicated interventions including monitor for emotional distress, psychological (emotional state) and psychiatrist (specializes in mental health) consult and social services (SS) to provide wellness visit.During a review of CNA 1's time card for the period of 5 /1/2026, through 5/31/2026, the record indicated on 5/31/26, CNA 1 clocked in at 3:01 p.m. and clocked out at 11:00 p.m. The time card indicated CNA 1 clocked back in on 5/31/26 at 11:30 p.m. and clocked out on 6/1/26 at 7:21 a.m., working a total of 14.80 hours.During a review of the Nursing Staffing Assignment and Sign-In Sheet dated 5/31/26, the document indicated the shift was from 3:00 p.m. to 11:00 p.m. The assignment showed that CNA 1 was assigned to and provided care for Resident 1.During a review of Resident 1's Toileting Log record dated 5/31/26, the record indicated resident was incontinent of urine. The log indicated resident received an incontinent brief (diaper) change at 2:59 p.m. for urinary incontinence, and CNA 1 performed the incontinent brief change.During a review of Resident 1's Toileting Log record dated 6/01/26, the record indicated resident had a bowel movement and urinary incontinence (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055032
		If continuation sheet Page 1 of 8

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 3:53 a.m., and that CNA 1 performed the incontinent brief change. During an interview on 6/6/26 at 7:28 a.m., with Resident 1, Resident 1 stated on 5/28/26, Resident 1 told CNA 2 she felt CNA 1 behaved in a strange manner when CNA 1 asked Resident 1 if she knew where her vulva was and can he clean it during a previous incontinent brief change. Resident 1 stated she told CNA 2 she no longer wanted CNA 1 to provide her care because the interaction made her uncomfortable. She stated feeling embarrassed sharing the information but stated she was tired of feeling afraid each time CNA 1 changed her incontinent brief. Resident 1 stated she told CNA 1 on 6/1/26, at approximately 2:30 a.m. during the 11p.m., to 7 a.m., shift, she wanted a female staff member to change her incontinent brief. She stated CNA 1 told her no female staff were available to assist her and she would have to wait a long time. Resident 1 stated she waited until she could no longer tolerate the discomfort and ultimately allowed CNA 1 to change her incontinent brief because she felt she had no other option. Resident 1 stated she felt angry and very upset CNA 1 continued to be assigned to her care after she informed CNA 2 on 5/28/26 that CNA 1 was weird and made her feel uncomfortable when CNA 1 asked Resident 1 if she knew where her vulva was and could CNA 1 clean it. She stated she now felt a sense of relief because the facility was finally listening to her concerns. During a telephone interview on 6/5/26 at 9:49 a.m., with CNA 2, CNA 2 stated on 5/28/26 around 3:00 p.m., Resident 1 told her (CNA 2) CNA 1 had asked Resident 1 if she knew where her vulva was and could he clean it, which made her feel uncomfortable. Resident 1 told CNA 2 she no longer wanted CNA 1 to be her caregiver because of how the interaction made her feel. CNA 2 stated she immediately went to the Director of Staff Development (DSD) to report the incident because, based on Resident 1's description, it sounded sexual and she wanted to ensure CNA 1 no longer provided care to Resident 1. The DSD told her she would ensure CNA 1 was no longer scheduled with Resident 1. CNA 2 stated when she returned to work on 6/2/26 and visited Resident 1, Resident 1 told her CNA 1 had still been assigned to her on 5/31/2026 during the 11 p.m., to 7 a.m., shift. CNA 2 stated she then texted the Staffing Coordinator (SC) to ask why CNA 1 had been assigned to Resident 1 despite her report to the DSD on 5/28/2026 regarding Resident 1 did not want CNA 1 to be assigned to the resident as CNA 1 makes her feel uncomfortable. During an interview on 6/5/26 at 12:40 p.m., with the SC, SC stated the DSD told her on 5/28/26 not to schedule CNA 1 with Resident 1. The SC stated she forgot to inform the Registered Nurse Supervisor (RNS) of this instruction, which resulted in CNA 1 being assigned to Resident 1 on 5/31/26 and 6/1/26. She stated she dropped the ball and should have spoken with Resident 1 when the DSD informed her on 5/28/26 that Resident 1 no longer wanted CNA 1 as her caregiver. The SC stated the situation should not have occurred and that the facility should have looked deeper into the matter and initiated an investigation on 5/28/26 when the incident was first reported. She stated she would have been upset if she were Resident 1. During an interview on 6/5/26 at 12:10 p.m., with the DSD, DSD stated CNA 2 informed her on 5/28/26 that Resident 1 no longer wanted CNA 1 to be her caregiver. The DSD stated she did not ask CNA 2 for additional details and simply instructed the SC not to schedule CNA 1 with Resident 1. She stated she did not notify the Director of Nursing (DON) about the report on 5/28/26 because she did not take the concern seriously at that time. The DSD stated she should have spoken with Resident 1 on 5/28/26 when the incident was first reported and the facility should have initiated an investigation on 5/28/2026. She stated there was potential for harm to Resident 1 due to the failure to conduct a proper investigation into the alleged incident involving CNA 1. The DSD stated she would have felt scared if she were Resident 1, wondering whether CNA 1 would return to her room to provide care. During an interview on 6/6/26 at 10:23 a.m., with the Registered Nurse Supervisor (RNS), RNS stated she was responsible for creating the CNA schedule on 5/31/2026 for the 3-11 p.m. shift. RNS stated no one in the facility informed her that CNA 1 should not be scheduled to care for Resident 1; therefore, she assigned CNA 1 to the resident. The RNS stated she was unaware of the alleged incident involving Resident 1 and CNA 1. She stated had she known, she would not have scheduled CNA 1 to care for Resident 1 on the 3-11 p.m. shift on 5/31/26. The RNS stated she later learned CNA 1 told Resident 1 he wanted to clean her (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vulva. RNS stated word vulva sounds sexual and was offensive. RNS stated CNA 1 could have used a different word. During an interview on 6/6/26 at 9:04 a.m., the DON, the DON stated she became aware of the allegation on 6/3/26 after the Social Services Director informed her that Resident 1 felt uncomfortable with CNA 1 after CNA 1 asked Resident 1 do you know where your vulva is and can CNA 1 clean it. The DON stated she was not aware this concern had originally been reported to the DSD on 5/28/26 by CNA 2. She stated the facility dropped the ball and should have reported the allegation and initiated an investigation on 5/28/26 when Resident 1 informed CNA 2 she no longer wants CNA 1 take care of her because she felt uncomfortable. The DON stated there was a potential risk for Resident 1 to experience harm because the investigation was delayed. She stated she would have felt bad and uncomfortable if she were Resident 1 and had continued to receive care from CNA 1 after reporting an allegation of sexual abuse. The DON stated she thought the word vulva could be considered sexual to some people. During an interview on 6/6/26 at 11:15 a.m., with the Administrator (ADM) in training, the ADM stated he became aware of the allegation on 6/3/26. He stated he did not know that Resident 1 had reported the concern to CNA 2 on 5/28/26 or that the DSD had been informed. The ADM in training stated that if he had been notified on 5/28/26, the facility should have initiated its investigation and reported the incident to the appropriate agencies that same day. He stated CNA 1 should have been removed from the schedule on 5/28/26 when the allegation was first reported, and that CNA 1 should not have been assigned to Resident 1 after she expressed, she did not want him to be her caregiver. The ADM in training stated residents needed to feel safe in the facility, as it was their home, and the facility was responsible for ensuring residents felt safe when staff provided care. During a review of the facilities Policy and Procedure (P&P) titled Abuse Investigation and Reporting dated 2/2017 the P&P indicated, all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. During a review of the facilities Policy and Procedure (P&P) titled Residents rights dated 10/2025 the P&P indicated, federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to, a dignified existence, be treated with respect, kindness, and dignity, be free from abuse, neglect, misappropriation of property, and exploitation.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report allegation of sexual abuse for one of three sampled residents (Resident 1) to the California Department of Public Health (CDPH). The facility failed to:1.Implement its policy and procedures (P&P) titled, Abuse Investigation and Reporting dated 2/2017 which indicated, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management.This deficient practice resulted in a delay in reporting to CDPH and CDPH's investigation, and a potential risk for continued abuse, or mistreatment of Resident 1 and other residents in the facility.Findings:During a review of Resident 1's admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), depression (persistent feelings of sadness, emptiness and a loss of interest) and anxiety (emotion characterized by feelings of tension, worried thoughts).During a review of Resident 1's History & Physical (H&P) dated 3/25/26, the H&P indicated, Resident 1 was alert and oriented to person, place and time.During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool) dated 5/5/26, the MDS indicated, Resident 1 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated, Resident 1 needed substantial/maximal assistance (helper does more than half the work), with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 1 was incontinent (inability to voluntarily control bladder or bowels) of bowel and bladder. During a review of Resident 1's Change of Condition Evaluation ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status which without immediate intervention, may result in complications or death) dated 6/3/26 at 5:57 p.m., the COC indicated, resident claimed CNA 1 told Resident 1 I will clean your vulva(external female genital organ).During a review of Resident 1's care plan titled Resident at risk for emotional distress due to resident allegation dated 6/3/2026, the Care Plan indicated a goal was for resident will not experience untoward (inappropriate, improper or unfavorable) outcomes due to trauma history. The Care Plan indicated interventions including monitor for emotional distress, psychological (emotional state) and psychiatrist (physician who specializes in mental health) consult and social services (SS) to provide wellness visit.During a review of the facility's SOC 341 (Report of Suspected Dependent Adult/Elder Abuse) form, the SOC 341 indicated the police department was notified by telephone on 6/3/26 at 5:34 p.m. regarding the alleged incident between CNA 1 and Resident 1.During a review of the facility's Transmission (Fax) Verification Report, the report indicated the facility reported the alleged incident that occurred between CNA 1 and Resident 1 to the California Department of Public Health (CDPH) on 6/3/26 at 5:48 p.m.During a review of the facility's Transmission Verification Report, the report indicated the facility reported the alleged incident that occurred between CNA 1 and Resident 1 to the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) on 6/3/26 at 5:53 p.m.During an interview on 6/6/26 at 7:28 a.m., with Resident 1, Resident 1 stated on 5/28/26, Resident 1 told CNA 2 she felt CNA 1 behaved in a strange manner when CNA 1 asked Resident 1 if she knew where her vulva was and can he clean it during a previous incontinent brief change. Resident 1 stated she told CNA 2 she no longer wanted CNA 1 to provide her care because the interaction made her uncomfortable. She stated feeling embarrassed sharing the information but stated she was tired of feeling afraid each time CNA 1 changed her incontinent brief. Resident 1 stated she told CNA 1 on 6/1/26, at approximately 2:30 a.m. during the 11p.m., to 7 a.m., shift, she wanted a female staff (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member to change her incontinent brief. She stated CNA 1 told her no female staff were available to assist her and she would have to wait a long time. Resident 1 stated she waited until she could no longer tolerate the discomfort and ultimately allowed CNA 1 to change her incontinent brief because she felt she had no other option. Resident 1 stated she felt angry and very upset CNA 1 continued to be assigned to her care after she informed CNA 2 on 5/28/26 that CNA 1 was weird and made her feel uncomfortable when CNA 1 asked Resident 1 if she knew where her vulva was and could CNA 1 clean it. She stated she now felt a sense of relief because the facility was finally listening to her concerns. During a telephone interview on 6/5/26 at 9:49 a.m., with CNA 2, CNA 2 stated on 5/28/26 around 3:00 p.m., Resident 1 told her CNA 1 had asked Resident 1 if she knew where her vulva was and if he could clean it, which made her feel uncomfortable. Resident 1 told CNA 2 she no longer wanted CNA 1 to be her caregiver because the interaction made her feel uncomfortable. CNA 2 stated she immediately reported the incident to the Director of Staff Development (DSD) because she was a mandated reporter, and based on Resident 1's description, the interaction sounded sexual. She stated she wanted to ensure CNA 1 no longer provided care to Resident 1. CNA 2 stated the DSD told her she would make sure CNA 1 was no longer scheduled with Resident 1. CNA 2 stated when she returned to work on 6/2/26 and visited Resident 1, Resident 1 told her CNA 1 had still been assigned to her on 5/31/26 during the 11-7 shift. CNA 2 stated she then texted the Staffing Coordinator (SC) to ask why CNA 1 had been assigned to Resident 1 despite her report to the DSD on 5/28/26 that Resident 1 did not want CNA 1 assigned because he (CNA 1) made her feel uncomfortable. During an interview on 6/5/26 at 12:10 p.m., with the DSD, DSD stated CNA 2 informed her on 5/28/26 Resident 1 no longer wanted CNA 1 to be her caregiver. The DSD stated she did not ask CNA 2 for additional details and simply instructed the SC not to schedule CNA 1 with Resident 1. She stated she did not notify the Director of Nursing (DON) about the report on 5/28/26 because she did not take the concern seriously at that time. The DSD stated she should have spoken with Resident 1 on 5/28/26 when the incident was first reported and the facility should have initiated an investigation on 5/28/2026. She stated there was potential for harm to Resident 1 due to the failure to conduct a proper investigation into the alleged incident involving CNA 1. The DSD stated she would have felt scared if she were Resident 1, wondering whether CNA 1 would return to her room to provide care. During an interview on 6/6/26 at 9:04 a.m., the DON, the DON stated she became aware of the allegation on 6/3/26 after the Social Services Director informed her that Resident 1 felt uncomfortable with CNA 1 after CNA 1 asked Resident 1 do you know where your vulva is and can CNA 1 clean it. The DON stated she was not aware this concern had originally been reported to the DSD on 5/28/26 by CNA 2. She stated the facility dropped the ball and should have reported the allegation and initiated an investigation on 5/28/26 when Resident 1 informed CNA 2 she no longer wants CNA 1 take care of her because she felt uncomfortable. The DON stated there was a potential risk for Resident 1 to experience harm because the reporting and investigation was delayed. She stated she would have felt bad and uncomfortable if she were Resident 1 and had continued to receive care from CNA 1 after reporting an allegation of sexual abuse. The DON stated she thought the word vulva could be considered sexual to some people. During an interview on 6/6/26 at 11:15 a.m., with the Administrator (ADM) in training, the ADM stated he became aware of the allegation on 6/3/26. He stated he did not know that Resident 1 had reported the concern to CNA 2 on 5/28/26 or that the DSD had been informed. The ADM in training stated that if he had been notified on 5/28/26, the facility should have initiated its investigation and reported the incident to the appropriate agencies that same day. He stated CNA 1 should have been removed from the schedule on 5/28/26 when the allegation was first reported, and that CNA 1 should not have been assigned to Resident 1 after she expressed, she did not want him to be her caregiver. The ADM in training stated residents needed to feel safe in the facility, as it was their home, and the facility was responsible for ensuring residents felt safe when staff provided care. During a review of the facilities policy and procedure (P&P) titled Abuse Investigation and Reporting dated 2/2017 the P&P indicated, all reports of resident abuse, neglect, exploitation, misappropriation of resident (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. The P&P indicated An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious. bodily injury: or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate an alleged sexual abuse allegation for one of three sampled residents (Resident 1). The facility failed to: 1. Initiate or complete an investigation after learning that Certified Nursing Assistant (CNA) 1 allegedly made a sexually inappropriate comment to Resident 1 while providing perineal care cleaning of the genital area and anal areas). This deficient practice had the potential to place Resident 1 and other residents at risk for unaddressed abuse, psychological harm, and fear, and it violated Resident 1's right to be free from abuse. Findings: During a review of Resident 1's admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), depression (persistent feelings of sadness, emptiness and a loss of interest) and anxiety (emotion characterized by feelings of tension, worried thoughts). During a review of Resident 1's History & Physical (H&P) dated 3/25/26, the H&P indicated, Resident 1 was alert and oriented to person, place and time. During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool) dated 5/5/26, the MDS indicated, Resident 1 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated, Resident 1 needed substantial/maximal assistance (helper does more than half the work), with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 1 was incontinent (inability to voluntarily control bladder or bowels) of bowel and bladder. During a review of Resident 1's Change of Condition Evaluation ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status which without immediate intervention, may result in complications or death) dated 6/3/26 at 5:57 p.m., the COC indicated, Resident claimed CNA 1 told Resident 1 I will clean your vulva (external female genital organ). During an interview on 6/6/26 at 7:28 a.m., with Resident 1, Resident 1 stated on 5/28/26, Resident 1 told CNA 2 she felt CNA 1 behaved in a strange manner when CNA 1 asked Resident 1 if she knew where her vulva was and can he clean it during a previous incontinent brief change. Resident 1 stated she told CNA 2 she no longer wanted CNA 1 to provide her care because the interaction made her uncomfortable. She stated feeling embarrassed sharing the information but stated she was tired of feeling afraid each time CNA 1 changed her incontinent brief. Resident 1 stated she told CNA 1 on 6/1/26, at approximately 2:30 a.m. during the 11p.m., to 7 a.m., shift, she wanted a female staff member to change her incontinent brief. She stated CNA 1 told her no female staff were available to assist her and she would have to wait a long time. Resident 1 stated she waited until she could no longer tolerate the discomfort and ultimately allowed CNA 1 to change her incontinent brief because she felt she had no other option. Resident 1 stated she felt angry and very upset CNA 1 continued to be assigned to her care after she informed CNA 2 on 5/28/26 that CNA 1 was weird and made her feel uncomfortable when CNA 1 asked Resident 1 if she knew where her vulva was and could CNA 1 clean it. She stated she now felt a sense of relief because the facility was finally listening to her concerns. During an interview on 6/5/26 at 12:10 p.m., with the DSD, DSD stated CNA 2 informed her on 5/28/26 that Resident 1 no longer wanted CNA 1 to be her caregiver. The DSD stated she did not ask CNA 2 for additional details and simply instructed the SC not to schedule CNA 1 with Resident 1. She stated she did not notify the Director of Nursing (DON) about the report on 5/28/26 because she did not take the concern seriously at that time. The DSD stated she should have spoken with Resident 1 on 5/28/26 when the incident was first reported and the facility should have initiated an investigation on 5/28/2026. She stated there was potential for harm to Resident 1 due to the failure to conduct a proper investigation into the alleged incident involving CNA 1. The DSD stated she would have felt scared if she were Resident 1, wondering whether CNA 1 would return to her room to provide care. During an interview on 6/6/26 at (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9:04 a.m., the DON, the DON stated she became aware of the allegation on 6/3/26 after the Social Services Director informed her that Resident 1 felt uncomfortable with CNA 1 after CNA 1 asked Resident 1 do you know where your vulva is and can CNA 1 clean it. The DON stated she was not aware this concern had originally been reported to the DSD on 5/28/26 by CNA 2. She stated the facility dropped the ball and should have reported the allegation and initiated an investigation on 5/28/26 when Resident 1 informed CNA 2 she no longer wants CNA 1 take care of her because she felt uncomfortable. The DON stated there was a potential risk for Resident 1 to experience harm because the investigation was delayed. She stated she would have felt bad and uncomfortable if she were Resident 1 and had continued to receive care from CNA 1 after reporting an allegation of sexual abuse. The DON stated she thought the word vulva could be considered sexual to some people. During an interview on 6/6/26 at 11:15 a.m., with the Administrator (ADM) in training, the ADM stated he became aware of the allegation on 6/3/26. He stated he did not know that Resident 1 had reported the concern to CNA 2 on 5/28/26 or that the DSD had been informed. The ADM in training stated that if he had been notified on 5/28/26, the facility should have initiated its investigation and reported the incident to the appropriate agencies that same day. He stated CNA 1 should have been removed from the schedule on 5/28/26 when the allegation was first reported, and that CNA 1 should not have been assigned to Resident 1 after she expressed, she did not want him to be her caregiver. The ADM in training stated residents needed to feel safe in the facility, as it was their home, and the facility was responsible for ensuring residents felt safe when staff provided care. During a review of the facilities policy and procedure (P&P) titled Abuse Investigation and Reporting dated 2/2017 the P&P indicated, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.		