

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/17/2026
NAME OF PROVIDER OR SUPPLIER  Diablo Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  3806 Clayton Road Concord, CA 94521	

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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews, the facility failed to ensure that two out of three sampled residents (Resident 1 and Resident 2), were protected from sexual abuse (non-consensual sexual contact of any type with a resident). Resident 1 and Resident 2 were sexually abused during care provided by Certified Nurse Assistant (CNA) 1. This failure resulted in Resident 1 and Resident 2 experiencing sexual abuse and emotional distress. Cross Reference to F610Findings:During a review of facility's admission Record (AR) printed on 03/10/2026, the AR indicated Resident 1 was admitted on [DATE], with diagnoses that included fracture of left lower leg and generalized muscle weakness. Resident 1's Minimum Data Set (MDS - resident assessment tool) dated 01/28/2026 indicated a Brief Interview for Mental Status (BIMS - a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information) score of 15 (BIMS score of 13 - 15, cognitively intact).During a concurrent observation, interview, and record review on 03/16/2026 at 12:59 p.m., with Resident 1 in her room, Resident 1 was sitting up in the middle on her bed. Resident 1 stated she was bothered by her experience during a diaper change, that she immediately wrote detailed personal notes. Resident 1 showed four pages of personal notes of the events that started on 02/24/2025, that she kept on the over bed table. Resident 1 stated it was past 7 p.m., CNA 1 assisted her when she needed diaper changed. Resident 1 stated her diaper was only soiled with urine. Resident 1 stated this was her first encounter with CNA 1. Resident 1 stated that during the diaper change, CNA 1 was on the left side of her bed. CNA 1 used wet wipes and wiped her vaginal area multiple times. Resident 1 stated CNA 1 asked her if it hurts, because she flinched when CNA 1 wiped her vaginal area. Resident 1 stated CNA 1 wiped her again, but this time, CNA 1 went deeper in between her lips[labia] and rubbed his finger within her clitoris. Resident 1 stated I told him he needed to stop, and it's not okay. Resident 1 stated she usually needed a skin barrier cream applied, but she asked CNA 1 not to apply the barrier cream, and she just wanted it done. Resident 1 stated later in the evening, her roommate's CNA, CNA 2, came to room to check on her roommates. Resident 1 stated she was familiar with CNA 2, and she asked CNA 2 on who could she tell what happened to her during diaper change. Resident 1 stated CNA 2 stated he would let the charge nurse know. Resident 1 stated she spoke to Registered Nurse (RN)1. Resident 1 stated she told RN 1 that she was inappropriately touched by CNA 1, and that she never wanted him to change her again.During an interview on 03/20/2025 at 05:23 p.m., CNA 2, CNA 2 stated he worked 02/24/2025 the afternoon shift (02:45 p.m. - 11:15 p.m.). CNA 2 stated he spoke to Resident 1, and Resident 1 seemed uncomfortable during their conversation about her diaper change. CNA 2 stated Resident 1 stated that she was not comfortable with CNA 1 during diaper change, and Resident 1 did not want CNA 1 to come back and change her again. CNA 2 stated he offered Resident 1's diaper change later in the evening, and Resident 1 agreed to have CNA 2 do the next diaper change. CNA 2 stated he told Resident 1 that he would report this to charge nurse. During an interview on 03/17/2026 at 09:06 a.m., with RN 1, RN 1 stated on 02/24/2025 at around 10 p.m., RN 1 administered Resident 1's medication. RN 1 stated that Resident 1 don't like that guy, pointing to the direction of CNA 1. RN 1 stated (continued on next page)</p>

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
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 1 did not want CNA 1 to change her diaper again. During an interview on 03/16/2026 at 05:33 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she worked the night shift on 02/25/2025 - 02/26/2025, from 11:30 p.m. to 7:30 a.m. LVN 1 stated on 02/26/25 at around 4:30 a.m., she was in Resident 1's room for medication pass. LVN 1 stated Resident 1 seemed emotional to her, and Resident 1 wanted to tell her something that happened on 02/24/2025 afternoon shift. LVN 1 stated Resident 1 told her that on 02/24/2025, Resident 1 stated she reported the sexual abuse to two staff, and Resident 1 felt that nothing happened. LVN 1 stated Resident 1 reported to her that during diaper change, LVN 1 stated Resident 1 was very clear that the diaper only had urine. CNA 1 wiped Resident 1 repeatedly, and one of these times CNA 1 touched and wiggled his finger in her vagina. LVN 1 stated after the medication pass, she immediately reported to the nurse supervisor (RN 2) on her shift. During an interview on 03/21/2025 at 07:44 a.m., with RN 2, RN 2 stated he worked on 02/25/2025 - 02/26/2025, from 11:30 p.m. to 07:30 a.m. RN 2 stated LVN 1 reported that Resident 1 reported a sexual abuse allegation. RN 2 stated on 02/26/2025 at around 07:30 a.m., he visited Resident 1 in her room, and Resident 1 seemed distressed and tense. RN 2 stated Resident 1 recounted to him that during diaper change, CNA 1 wiped her repeatedly and seemed excessive. RN 2 stated that Resident 1 reported when CNA 1 wiped Resident 1's vaginal area, CNA 1 penetrated her with his finger. During a review of Resident 2's Progress Notes dated 03/04/2025, and printed on 03/16/2026, indicated At around 1600 [04:00 p.m.], while doing rounds, [Resident 1] reported about being uncomfortable with one of the CNA. This nurse allowed resident to verbalize feelings and concerns. Per [Resident 1], she was thinking and she felt that during her continent care CNA wiped her twice and the third time there's more pressure and she felt it was excessive and she felt something is off with the way she was cleansed by this specific CNA. 2. During a review of facility's AR printed on 03/16/2026, the AR indicated Resident 2 was admitted on [DATE], with diagnoses that included hemiplegia (paralysis) and hemiparesis (partial weakness) following bleeding within the brain not caused by head trauma affecting the left side of the body. Resident 2's MDS, dated [DATE], indicated a BIMS score of 14. During a concurrent observation and interview on 03/16/2026 at 01:26 p.m., with Resident 2, Resident 2 was sitting on her motorized wheelchair in the smoking area. Resident 2 recounted the event that she experienced on 02/25/2025, when CNA 1 helped her in the shower. Resident 2's face was flushed, and her eyes were teary, and she started shaking her hand. Resident 2 stated she was scheduled to have a shower in the afternoon. Resident 2 was on the patio, and CNA 1 took her back to her room to get ready for her shower. Resident 2 stated she was wearing a sweater because it was cold, and when CNA 1 removed her sweater, CNA 1 rubbed her breast. Resident 2 stated she swiped CNA 1's hand away and told CNA 1 to stop it. Resident 2 stated she was seated on a shower chair, and CNA 1 took her to shower room A. Resident 2 stated during shower CNA 1 tried to use the washcloth to wipe her breast area again. Resident 2 stated she asked CNA 1 to give her the washcloth, and she would clean her breast area. Resident 2 stated she could not reach her buttocks area. Resident 2 stated that CNA 1 cleaned her buttocks, CNA 1 was behind her in shower chair. Resident 2 demonstrated by lifting her arm and with her index finger extended. Resident 2 stated that while CNA 1 was cleaning her buttocks, CNA 1 inserted his finger in her anus. Resident 2 stated she was shocked, and all she could tell CNA 1 was that she was done, and to bring her back to her room. Resident 2 stated when she was brought to her room, CNA 1 used a towel to dry her breast area, and CNA 1 squeezed her nipples. Resident 2 stated she felt nervous during and after the event. Resident 2 stated she reported the event to Restorative Nurse Assistant (RNA) 1 on 02/26/2025. During an interview on 03/17/2026 at 02:07 p.m., with RNA 1, RNA 1 stated she worked on 02/26/2025 from 07:00 a.m. - 03:30 p.m. RNA 1 stated she was helping Resident 2 with combing her hair, and Resident 2 seemed emotional and was about to cry. RNA 1 stated Resident 2 started telling her experience during shower the day before (02/25/2025). RNA 1 stated Resident 2's shower schedule was during the afternoon shift. RNA 1 stated she checked the staffing schedule for 02/25/2025, and RNA 1 confirmed that CNA 1 was the staff who helped Resident 2 with her (continued on next page)</p>		

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	shower.During a review of Resident 2's Progress Notes printed on 03/16/2026, indicated On 2/26/25 at around 1130H [11:30 a.m.], resident informed staff that the previous day that there's a male CNA, who assisted her with her shower, and she was touched inappropriately. Resident alert and oriented.During an interview on 04/16/2025 at 12:10 p.m., with Ombudsman Representative (OR), OR stated she visited the facility on 03/07/2025. OR stated she spoke with Resident 2 in an office to give her privacy. OR stated during the interview, Resident 2 seemed fine until she recounted the events on 02/25/2025. OR stated that Resident 2 was distraught and cried.During a review of facility's policy and procedure (P&P) last Reviewed 1/2026 titled Abuse, Neglect, Exploitation or Misappropriation Prevention Program, the P&P indicated Policy Statement. Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect the residents for abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff.		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews, the facility failed to identify and ensure that two out of three sampled residents (Resident 1 and Resident 2), were protected from sexual abuse (non-consensual sexual contact of any type with a resident). Resident 1 reported to staff members being sexually abused during care provided by Certified Nurse Assistant (CNA) 1. CNA 1 was not removed from the staffing schedule and was allowed to continue to care for other residents in the facility. These failures in a delay in implementing protective and preventative action resulted in Resident 2 experiencing sexual abuse. Cross Reference to F600Findings: During a review of facility's admission Record (AR) printed on 03/10/2026, the AR indicated Resident 1 was admitted on [DATE], with diagnoses that included fracture of left lower leg and generalized muscle weakness. Resident 1's Minimum Data Set (MDS - resident assessment tool) dated 01/28/2026 indicated a Brief Interview for Mental Status (BIMS - a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information) score of 15, (BIMS score of 13 - 15, cognitively intact). During a review of facility's AR printed on 03/16/2026, the AR indicated Resident 2 was admitted on [DATE], with diagnoses that included hemiplegia (paralysis) and hemiparesis (partial weakness) following bleeding within the brain not caused by head trauma affecting the left side of the body. Resident 2's MDS, dated [DATE], indicated a BIMS score of 14. During a concurrent observation, interview, and record review on 03/16/2026 at 12:59 p.m., with Resident 1 in her room, Resident 1 was sitting up on her bed. Resident 1 stated she was bothered by her experience during a diaper change, that she immediately wrote detailed personal notes. Resident 1 showed four pages of personal notes of the events that started on 02/24/25. Resident 1 stated it was past 7 p.m., CNA 1 assisted her when she needed her diaper changed. Resident 1 stated her diaper was only soiled with urine. Resident 1 stated this was her first encounter with CNA 1. Resident 1 stated that during the diaper change, CNA 1 was on the left side of her bed. CNA 1 used wet wipes and wiped her vaginal area multiple times. Resident 1 stated CNA 1 asked her if it hurts, because she flinched when CNA 1 wiped her vaginal area. Resident 1 stated CNA 1 wiped her again, but this time, CNA 1 went deeper in between her lips[labia] and rubbed his finger within her clitoris. Resident 1 stated I told him he needed to stop, and it's not okay. Resident 1 stated she usually needed a barrier cream applied, but she asked CNA 1 not apply the barrier cream, and she just wanted it done. Resident 1 stated later in the evening, her roommate's CNA, CNA 2, came into the room to check on her roommates. Resident 1 stated she was familiar with CNA 2, and she asked CNA 2 on who could she tell what happened to her during diaper change. Resident 1 stated CNA 2 stated he would let the nurse know. Resident 1 stated she spoke to Registered Nurse (RN)1. Resident 1 stated she told RN 1 that she was inappropriately touched by CNA 1, and that she never wanted him to change her again. Resident 1 stated the following day, she saw CNA 1 in the hallway. Resident 1 stated she felt like she was being gaslighted (a term used to describe that could someone to question the validity of their own thoughts, perception of reality, or memories), after she reported her experience during her diaper change, and that there was no consequence. Resident 1 wrote on her personal notes indicated 2/25/[2025] - [CNA 1] worked day shift! I guess no problem to be inappropriate with pts[patients]? Resident 1 stated that she reported her experience with CNA 1 to Licensed Vocational Nurse (LVN) 1 in the early morning hours of 02/26/2025. Resident 1 stated LVN 1 stated she would report this to her nurse supervisor. Resident 1 stated RN 2 visited her, and she reported her experience during diaper change that happened on 2/24/2025 with CNA 1. Furthermore, Resident 2 wrote on her personal notes that 02/26/2025 at around 09 a.m., Assistant Director of Nursing (ADON) 1 heard the prob [problem] said he'll handle it from here. Remove him from schedule until investigate. During an interview on 03/17/26 at 09:06 a.m., with RN 1, RN 1 stated it was about 10 p.m., on 2/24/25, when RN 1 administered Resident 1's medication. RN 1 stated that Resident 1 don't like that guy, pointing to the (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>direction of CNA 1. RN 1 stated Resident 1 did not want CNA 1 to change her diaper again. RN 1 stated she did not ask additional questions, because she was busy with medication pass. RN 1 stated that her main concern was that the incoming shift would know about Resident 1's request to have another CNA to change her diaper. During a review of facility's Nursing Staffing Assignment and Sign-In Sheet for 02/24/2025, CNA: 2:45 PM - 11:15 PM, indicated CNA 1 was on the schedule and signed for his assignment. The facility's Nursing Staffing Assignment and Sign-In Sheet for 02/25/2025, for CNA: 6:30 AM - 3:00 PM, indicated CNA 1 was on the schedule and signed for his assignment. The facility's Nursing Staffing Assignment and Sign-In Sheet for 02/25/2025, CNA: 2:45 PM - 11:15 PM indicated CNA 1 was on schedule and signed for his assignment. During an interview on 03/16/2026 at 05:33 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she worked the night shift on 02/25/2025 - 02/26/2025, from 11:30 p.m. to 7:30 a.m. LVN 1 stated on 02/26/25 at around 04:30 a.m., she was in Resident 1's room for medication pass. LVN 1 stated Resident 1 seemed emotional to her, and Resident 1 wanted to tell her something that happened on 02/24/2025 afternoon shift. LVN 1 stated Resident 1 told her that on 02/24/2025, Resident 1 stated she reported the abuse to two staff, and Resident 1 felt that nothing happened. LVN 1 stated Resident 1 reported to her that during diaper change, LVN 1 stated Resident 1 was very clear that the diaper only had urine, CNA 1 wiped Resident 1 repeatedly, and one of this time CNA 1 touched and wiggled his finger in her vagina. LVN 1 stated after the medication pass, she immediately reported to the nurse supervisor (RN 2) on her shift. During an interview on 03/21/2025 at 07:44 a.m., with RN 2, RN 2 stated he worked on 02/25/2025 - 02/26/2025, from 11:30 p.m. to 7:30 a.m. RN 2 stated LVN 1 reported that Resident 1 made a report of sexual abuse allegations. RN 2 stated on 02/26/2025 at around 07:30 a.m., he visited Resident 1 in her room. RN 2 stated Resident 1 seemed distressed and tense. RN 2 stated Resident 1 recounted to him that during diaper change, CNA 1 wiped her repeatedly and seemed excessive. RN 2 stated that Resident 1 reported when CNA 1 wiped Resident 1's vaginal area, CNA 1 penetrated her with his finger. RN 2 stated after she spoke to Resident 1, RN 2 reported this to the supervisor in the building. RN 2 stated he reported this information to the Director of Staff Development (DSD). RN 2 stated he would also call the Administrator (ADM) 1 to report. RN 2 stated DSD stated that he would report Resident 1's allegations to the ADM 1. RN 2 stated DSD stepped out of the office and called ADM 1. During an interview on 03/20/2025 at 12:21 p.m., with ADON 1, ADON 1 stated that Resident 1's complaint was costumer care complaint. ADON 1 stated that Resident 1 requested not to have CNA 1 assigned to care for her. ADON 1 stated that he called RN 1 to ask about Resident 1's concern that CNA 1 was rough during incontinence care. RN 1 confirmed that Resident 1 reported a concern during incontinence care and requested that CNA 1 would not be assigned to care for Resident 1. During a concurrent observation and interview on 03/16/2026 at 01:26 p.m., with Resident 2, Resident 2 was sitting on her motorized wheelchair in the facility's smoking area. Resident 2 started recounting the event that she experienced on 02/25/2025, when CNA 1 helped her in the shower. Resident 2's face was getting flushed, her eyes were teary, and she started shaking her hand. Resident 2 stated she was scheduled to have a shower in the afternoon. Resident 2 was on the patio, and CNA 1 took her back to her room to get ready for her shower. Resident 2 stated she was wearing a sweater because it was cold, and when CNA 1 removed her sweater, CNA 1 rubbed her breast. Resident 2 stated she swiped CNA 1's hand away and told CNA 1 to stop it. Resident 2 stated she was seated on a shower chair, and CNA 1 took her to shower room A. Resident 2 stated during shower CNA 1 tried to use the washcloth to wipe her breast area again. Resident 2 stated she asked CNA 1 to give her the washcloth, and she would clean her breast area. Resident 2 stated she could not reach her buttocks area. Resident 2 stated that CNA 1 cleaned her buttocks, CNA 1 was behind her in shower chair. Resident 2 demonstrated by lifting her arm and with her index finger extended, Resident 2 stated while CNA 1 was cleaning her buttocks, CNA 1 inserted his finger in her anus. Resident 2 stated she was shocked, and all she could tell CNA 1 was that she was done, and to bring her back to her room. Resident 2 stated when she was brought to her room, CNA 1 used a towel to dry her chest area, and (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>CNA 1 squeezed her nipples. Resident 2 stated she felt nervous during and after the event. Resident 2 stated she reported to Restorative Nurse Assistant (RNA) 1 the following day. During a review of Resident 2's Progress Notes printed on 03/16/2026, indicated On 2/26/25 at around 1130H [11:30 a.m.], resident informed staff that the previous day that there's a male CNA, who assisted her with her shower, and she was touched inappropriately. Resident alert and oriented. Resident claims that she feels safe in the facility. The CNA she alleged to be inappropriate with her was advised to stop working in the facility. During a review of facility's undated policy and procedure titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation, the P&amp;P indicated Policy Statement. All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigation are documented and reported. Policy Interpretation and Implementation. Reporting Allegations to the Administrator and Authorities. 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspension must be reported immediately to the administrator and other officials according to state law. 6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. Investigating Allegations 1. All allegations are thoroughly investigated. The administrator initiates investigations. 5. The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility. 6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.</p>		