

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: 056115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Imperial Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11926 LA Mirada Blvd LA Mirada, CA 90638	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify the primary physician of Resident 2's fall in the bathroom. This failure had the potential to result in missed or delayed diagnosis and interventions for serious injuries. Findings: During a review of Resident 2's Face Sheet, the Face Sheet indicated the facility admitted the resident on 4/8/2026 with diagnoses including ataxia (poor muscle control) following cerebral infarction (loss of blood flow to a part of the brain), generalized muscle weakness, and repeated falls. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 4/12/2026, the MDS indicated Resident 2's cognitive skills for daily decision making (process of thinking) was intact. The MDS indicated Resident 2 required partial assistance (helper does less than half the effort) with toileting, bathing, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 2 had prior falls. During a review of Resident 2's Progress Note, dated 6/9/2026, the Progress Note indicated Licensed Vocational Nurse (LVN) 2 responded to a bathroom call light and observed Resident 2 sliding down into a seated position from the toilet chair and no impact to the floor was observed. During an interview on 6/11/2026 at 8:09 a.m. with Resident 2, Resident 2 stated that she had fallen approximately about six times in the past. Resident 2 stated that her knee frequently buckles, and during her last fall, while in the restroom her knee buckled, causing her to slide down the toilet to the floor while holding onto the side rails. The resident reported calling out for assistance and activated the call light for help. Resident stated a certified nursing assistant (CNA) came to the room in about five minutes and assisted her up. During a phone interview on 6/11/2026 at 1:34 p.m. with Registered Nurse (RN) 3, RN 3 stated when a resident experiences a fall, nursing staff must assess the resident and report the fall to the physician in accordance with facility protocol. RN 3 stated that timely physician notification was important so the physician can determine whether the resident has sustained any serious injuries. During a phone interview with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 2 was found in the restroom, almost sliding down to the floor and assisted the resident getting back in her wheelchair. LVN 1 stated that when the resident was found, the resident was leaning back on the toilet with her buttocks off the toilet seat and the resident's legs were touching the floor. LVN 1 stated according to facility policy, the circumstance met the definition of a fall, and the physician should have been notified. During an interview and record review on 6/15/2026 at 2:09 p.m. with the Director of Nursing (DON), the DON stated the last incident Resident 2's knee buckling resulting in a fall met the definition of a fall. The DON stated that after a fall it was necessary to assess the resident and notify the physician. The DON stated that notifying the physician was a required component of the SBAR process and was essential to ensure the physician was informed of the resident's condition, to determine the appropriate orders for follow-up care and providing optimal care to the resident. During an interview on 6/15/2026 at 2:28 p.m., with the DON, the DON stated that when Resident 2's knee buckled resulting in a fall the physician should have been notified. During a review of the facility's P&P titled, Falls and Fall Risk, Managing, revised 3/2020, the P&P indicated, The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.		

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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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 one of one sampled resident's (Resident 1) abuse allegation to the State Agency (California Department of Public Health [CDPH]), the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and local law enforcement when Resident 1 alleged he was grabbed by his right arm without his consent. This failure resulted in a delay of an onsite investigation and had the potential to result in further potential abuse to Resident 1. Findings: During a review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included anxiety disorder (a mental health condition characterized by intense, excessive, and persistent worry or fear about everyday situations), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/26/2026, the MDS indicated Resident 1's cognitive skills for daily decision making (process of thinking) was intact. The MDS indicated Resident 1 required substantial assistance (helper does more than half the effort) with toileting, bathing, lower body dressing, and putting on/taking off footwear. During a review of Resident 1's History and Physical (H&P), dated 5/23/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) Form, dated 5/28/2026, the SBAR indicated, on 5/28/2026, Resident 1 claimed an unidentified male staff member grabbed his arm without his consent. The SBAR indicated Resident 1 had PTSD and may have associated being touched without consent as a possible trigger. During an interview on 6/15/2026 at 11:24 a.m., with Registered Nurse (RN) 1, RN 1 stated, on 5/28/2026, Resident 1 informed her a male rehab staff member grabbed his arm without his consent. RN 1 stated the allegation was made towards the end of her shift at 3 p.m. and she endorsed Resident 1's allegation to RN 2. RN 1 stated she entrusted RN 2 with the endorsement and thought RN 2 reported Resident 1's abuse allegation to the Administrator (ADM) because she was at the end of her shift. RN 1 stated physical touch without Resident 1's consent could be seen as abuse and should be reported to the ADM, who was the facility's Abuse Coordinator. During a concurrent interview and record review on 6/15/2026 at 11:30 a.m., with RN 1, Resident 1's Progress Notes, dated 5/29/2026, 5/30/2026, 6/2/2026, and 6/3/2026, were reviewed. The Progress Notes indicated Resident 1 claimed he was assaulted. RN 1 stated Resident 1's allegation of his arm being grabbed and being assaulted had to be reported to the ADM immediately. RN 1 stated once the ADM was notified, the ADM was responsible for reporting the abuse allegation to the State Agency (California Department of Public Health [CDPH]), the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and local law enforcement. RN 1 stated abuse allegations were also reported to the ADM immediately to ensure a thorough investigation was conducted and to prioritize the residents' safety during the investigation. During a phone interview on 6/15/2026 at 1:36 p.m., with RN 2, RN 2 stated, on 5/28/2026, RN 1 informed her of Resident 1's abuse allegation of Resident 1's arm pulled without his consent. RN 2 stated she did not report Resident 1's abuse allegation to the ADM because she thought RN 1 reported it because Resident 1 initially notified RN 1. RN 2 stated she could have followed up with the ADM to ensure Resident 1's abuse allegation was reported. During an interview on 6/15/2026 at 3:42 p.m., with the ADM, the ADM stated, on 5/28/2026, she was not made aware of Resident 1's abuse allegation. The ADM stated she was not made aware of Resident 1's abuse allegation until (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/3/2026. The ADM stated she expected her staff to notify her of all abuse allegations immediately. The ADM stated she was the Abuse Coordinator for the facility, and she was responsible for reporting all abuse allegations to CDPH, the Ombudsman, and local law enforcement within two hours. The ADM stated there was miscommunication between RN 1 and RN 2 which resulted in the delay in reporting and investigating Resident 1's abuse allegation of nonconsensual touch on his arm, which put Resident 1 at risk for further potential abuse. During a review of the facility's Policy and Procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, revised 4/2024, the P&P indicated, If a resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 'Immediately' is defined as within two hours involving abuse or result in physical harm/serious bodily injury. The P&P indicated the Administrator or person making the allegation must immediately report to the state licensing agency, Ombudsman, and local law enforcement.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a person-centered care plan to address one of one sampled residents' (Resident 2) refusal to use the call light prior to toileting. This failure resulted in Resident 2 using the bathroom unassisted and sustaining a fall. Findings: During a review of Resident 2's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included ataxia (poor muscle control) following cerebral infarction (loss of blood flow to a part of the brain), generalized muscle weakness, and repeated falls. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 4/12/2026, the MDS indicated Resident 2's cognitive skills for daily decision making (process of thinking) was intact. The MDS indicated Resident 2 required partial assistance (helper does less than half the effort) with toileting, bathing, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 2 had prior falls. During a review of Resident 2's History and Physical (H&P), dated 4/9/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Fall Risk Assessment, dated 5/29/2026, the Fall Risk Assessment indicated Resident 2 was a high risk for falls. During a review of Resident 2's Interdisciplinary Team (IDT, a group of different disciplines working together for a common goal of a resident) Progress Note, dated 4/16/2026, the IDT Progress Note indicated on 4/16/2026, Resident 2 had an unwitnessed fall and was found lying on the floor on her right side. The IDT Progress Note indicated, The call light was available but not utilized. The IDT Progress Note indicated a recommendation to reinforce education on requesting assistance prior to transfers. During a review of Resident 2's IDT Progress Note, dated 6/1/2026, the IDT Progress Note indicated on 6/1/2026, Resident 2 had an unwitnessed fall in the restroom. The IDT Progress Note indicated, The call light was within reach but was not used. The IDT Progress Note indicated a recommendation to educate of fall incident and reinforced importance of using the call light and waiting for staff assistance before getting up, especially when toileting or performing tasks in the bathroom. During a review of Resident 2's Progress Note, dated 6/9/2026, the Progress Note indicated Licensed Vocational Nurse (LVN) 2 responded to a bathroom call light and observed Resident 2 sliding down into a seated position from the toilet chair [and] no impact to the floor was observed. The Progress Note indicated Resident 2 stated her legs were not getting stronger and continued to buckle during standing and walking attempts. During an interview on 6/11/2026 at 9:15 a.m., with Resident 2, Resident 2 stated, on 6/9/2026, she went to the restroom unassisted and when she attempted to transfer from the toilet to her wheelchair, her knees buckled and slid down the toilet chair. Resident 2 stated she could transfer from her wheelchair to the toilet on her own and does not call for assistance. During a phone interview on 6/11/2026 at 1:34 p.m., with Registered Nurse (RN) 3, RN 3 stated a fall could either be when a resident landed on the floor or if a resident lost their balance and slid down towards the floor. RN 3 stated after a resident falls, the licensed nurse was responsible for assessing the resident and developing a care plan. RN 3 stated care plans were part of the licensed nurses charting to communicate to the rest of the staff and to develop and implement interventions to prevent further falls. During a phone interview on 6/11/2026 at 2:06 p.m., with LVN 1, LVN 1 stated Resident 2 knew how to operate the call light and educated to call for toileting assistance. LVN 1 stated although Resident 2 was educated on the importance of calling for assistance, Resident 2 would still transfer herself from the wheelchair to the toilet chair. LVN 1 stated, on 6/9/2026, he answered Resident 2's call light from the restroom and found her sliding off the toilet and almost hitting the floor. LVN 1 stated Resident 2's legs were on the floor; however, her buttocks did not touch the floor when he assisted her back into the wheelchair. LVN 1 stated he did not consider Resident 2 sliding off the toilet as a fall because she did not make full contact with the (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	floor. LVN 1 stated he assisted Resident 2 back to her wheelchair and assessed Resident 2 for any injuries. LVN 2 stated he did develop a care plan for the incident. During a concurrent phone interview and record review on 6/11/2026 at 2:20 p.m., with LVN 1, the facility's Policy and Procedure (P&P) titled, Falls and Fall Risk, Managing, revised 3/2020, was reviewed. The P&P indicated, A fall is defined as unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force. An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. LVN 1 stated according to the facility's P&P, Resident 2's incident on 6/9/2026 was considered a fall because he believed Resident 2 would have completely fallen to the floor if he had not assisted Resident 2 in time. LVN 1 stated he should have developed a care plan to implement interventions to prevent further falls. During an interview on 6/15/2026 at 2:14 p.m., with the Director of Nursing (DON), the DON stated care plans were developed to identify certain behaviors and changes in the resident's condition. The DON stated care plans were necessary to develop the appropriate interventions for Resident 2 to prevent further falls and other occurrences. During a concurrent interview and record review on 6/15/2026 at 2:47 p.m., with the DON, Resident 2's Care Plans, active on 6/15/2026, were reviewed. The care plans did not address Resident 2's refusal to use the call light prior to transfers and toileting. The DON stated Resident 2 did not want to use the call light to ask for assistance. The DON stated Resident 2 was at a high risk for falls and should have had a care plan to address that behavior. The DON stated the care plan was necessary to implement additional interventions such as more frequent visual checks to prevent further falls. During a review of the facility's P&P titled, Safety and Supervision of Residents, revised 7/2017, the P&P indicated, The care team shall target interventions to reduce individuals risks related to hazards in the environment, including adequate supervision and assistive devices. During a review of the facility's P&P titled, Falls and Fall Risk, Managing, revised 3/2020, the P&P indicated, The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, undated, the P&P indicated the interdisciplinary team developed and implemented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. The P&P indicated, The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of three sampled residents (Resident 1 and Resident 2) received care in accordance with professional standards of practice when the facility did not: 1. Obtain vital signs and conduct 72-hour monitoring after Resident 2 sustained a fall in the restroom on 6/9/2026. 2. Conduct 72-hour psychosocial monitoring after Resident 1 alleged his arm was grabbed without his consent on 5/28/2026. These failures had the potential for undetected changes in Resident 2's physical or neurological (how the brain, spinal cord, and nerves work) status and Resident 1's psychosocial condition. Findings: a. During a review of Resident 2's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included ataxia (poor muscle control) following cerebral infarction (loss of blood flow to a part of the brain), generalized muscle weakness, and repeated falls. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 4/12/2026, the MDS indicated Resident 2's cognitive skills for daily decision making (process of thinking) was intact. The MDS indicated Resident 2 required partial assistance (helper does less than half the effort) with toileting, bathing, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 2 had prior falls. During a review of Resident 2's History and Physical (H&P), dated 4/9/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Fall Risk Assessment, dated 5/29/2026, the Fall Risk Assessment indicated Resident 2 was a high risk for falls. During a review of Resident 2's Progress Note, dated 6/9/2026, the Progress Note indicated on 6/9/2026, Licensed Vocational Nurse (LVN) 2 responded to a bathroom call light and observed Resident 2 sliding down into a seated position from the toilet chair [and] no impact to the floor was observed. The Progress Note indicated Resident 2 stated her legs were not getting stronger and continued to buckle during standing and walking attempts. During a review of Resident 2's Progress Notes, dated 6/9/2026 through 6/15/2026, the Progress Notes did not indicate the licensed nurses monitored Resident 2 for any changes post-fall. During an interview on 6/11/2026 at 9:15 a.m., with Resident 2, Resident 2 stated, on 6/9/2026, she went to the restroom unassisted and when she attempted to transfer from the toilet to her wheelchair, her knees buckled and slid down the toilet chair. During a phone interview on 6/11/2026 at 1:34 p.m., with Registered Nurse (RN) 3, RN 3 stated a fall could either be when a resident landed on the floor or if a resident lost their balance and slid down towards the floor. RN 3 stated after a resident falls, the licensed nurse was responsible for assessing the resident, conducting a complete body check and checking vital signs. RN 3 stated checking vital signs were important because abnormal vital signs, such as low heart rate or blood pressure, could have caused the fall. RN 3 stated not only can abnormal vital signs cause a fall, but the fall could also cause abnormal vital signs from internal bleeding. RN 3 stated any abnormalities would then be reported to the physician. RN 3 stated after a fall, the licensed nurses would monitor the resident for 72 hours because a resident might suffer changes in their physical or neurological (how the brain, spinal cord, and nerves work) status. RN 3 stated during the 72 hours, if any changes were identified, the physician would immediately be notified. During a phone interview on 6/11/2026 at 2:06 p.m., with LVN 1, LVN 1 stated, on 6/9/2026, he answered Resident 2's call light from the restroom and found her sliding off the toilet and almost hitting the floor. LVN 1 stated Resident 2's legs were on the floor; however, her buttocks did not touch the floor when he assisted her back into the wheelchair. LVN 1 stated he did not consider Resident 2 sliding off the toilet as a fall because she did not make full contact with the floor. LVN 1 stated he assisted Resident 2 back to her wheelchair and assessed Resident 2 for any injuries. LVN 1 stated he did not obtain a set of vital signs. LVN 1 stated he endorsed the oncoming shift to keep an eye on Resident 2 but did not specifically say Resident 2 fell on the floor. During a concurrent phone interview and record review on 6/11/2026 at (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2:20 p.m., with LVN 1, the facility's Policy and Procedure (P&P) titled, Falls and Fall Risk, Managing, revised 3/2020, was reviewed. The P&P indicated, A fall is defined as unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force. An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. LVN 1 stated according to the facility's P&P, Resident 2's incident on 6/9/2026 was considered a fall because he believed Resident 2 would have completely fallen to the floor if he had not assisted Resident 2 in time. LVN 1 stated he should have obtained Resident 2's vital signs and informed the oncoming nurse so the 72-hour monitoring could be conducted. During an interview on 6/15/2026 at 2:32 p.m., with the Director of Nursing (DON), the DON stated obtaining vital signs after a fall was necessary to help determine the cause of the fall such as low blood pressure or low heart rate. The DON stated the vital signs would be reported to the physician, who would give orders to monitor or treat Resident 2. The DON stated monitoring Resident 2 for 72 hours would ensure any changes were identified and reported immediately. During a review of the facility's P&P titled, Acute Condition Changes, undated, the P&P indicated when a resident had a change in condition, the nurse was responsible for assessing, documenting, and reporting the resident's vital signs. The P&P indicated, The staff will monitor and document the resident/patient's progress and responses to treatment.b. During a review of Resident 1's Face Sheet, the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder (a mental health condition characterized by intense, excessive, and persistent worry or fear about everyday situations), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event). During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1's cognitive skills for daily decision making was intact. The MDS indicated Resident 1 required substantial assistance (helper does more than half the effort) with toileting, bathing, lower body dressing, and putting on/taking off footwear.During a review of Resident 1's H&P, dated 5/23/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) Form, dated 5/28/2026, the SBAR indicated, on 5/28/2026, Resident 1 claimed an unidentified male staff member grabbed his arm without his consent. The SBAR indicated Resident 1 had PTSD and may have associated being touched without consent as a possible trigger.During a review of Resident 1's Progress Notes, dated 5/28/2026 through 6/3/2026, the Progress Notes did not indicate Resident 1's psychosocial well-being was monitored. During an interview on 6/15/2026 at 12:06 p.m., with the Social Services Director (SSD), the SSD stated after an abuse allegation was made, the social services and nursing departments would monitor the resident's psychosocial wellbeing for 72 hours. The SSD stated the social services department was not made aware of Resident 1's abuse allegation until 6/3/2026. The SSD stated Resident 1 psychosocial wellbeing should have been monitored after Resident 1 made his abuse allegation on 5/28/2026. The SSD stated the 72-hour monitoring would ensure Resident 1 felt, necessary resources were offered, and other interventions were implemented. During an interview on 6/15/2026 at 2:59 p.m., with the DON, the DON stated 72-hour monitoring following an abuse allegation was necessary to assess Resident 1's safety. The DON stated the 72-hour monitoring would allow Resident 1 to express any feelings or concerns related to the abuse allegation and for the staff to provide psychosocial support and additional resources. During a review of the facility's P&P titled, Abuse and Neglect, revised 7/2017, the P&P indicated, The staff will monitor individuals who have been abused at least until their medical condition, mood, and function have stabilized.		