STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105762	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prosper Health and Rehabilitation Center	11375 Prosperity Farms Road Palm Beach Gardens, FL 33410

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to implement written policy and procedures to prevent abuse for 3 of 3 abuse allegations affecting Residents #33, #48, #101, #86, and #38, as evidenced by lack of communication by staff to management, lack of documentation of events, and lack of documentation of notification to management, physicians and families. The census at the time of survey was 98 residents. The finding included: (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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility’s policy titled, “Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Unknown Origin (ANEMMI)” with a revised date of 03/2025 included in part the following: Training and Prevention: c) what constitutes abuse, neglect, exploitation, misappropriation, mistreatment, and injury of unknown origin. Reporting policies and procedures established by the center. Reporting: Annually notifying covered individuals, of that individuals obligation to comply with the following reporting requirements a) each covered individual shall report to the state agency and one or more law enforcement entities for the political subdivision in which the facility is located nay reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from eh facility b) each covered individual shall report immediately, but no later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. Staff are required to report any allegation of ANEMMI to the facility risk manager, direct supervisor, and/or abuse coordinator immediately upon knowledge of the allegation. Allegations of possible ANEMMI will be reported to state agencies per the federal regulation timeframe. State agencies may include (but are not limited to): Abuse Hotline (Department of Children and Families) State Agencies (Agency for Health Care Administration) Local Law Enforcement. For alleged violations of ANEMMI including injuries of unknown source, the surveyor reviews whether the facility maintains evidence that alleged violations are thoroughly investigated. There is no specific investigation process that the facility must follow, but the facility must thoroughly collect evidence to allow the Administrator to determine what actions are necessary (if any) for the protection of resident. Depending upon the type of allegation received, it is expected that the investigation would include but is not limited to conducting observation of the alleged victim, including any identification of any injuries as appropriate, the location where the alleged situation occurred, interactions and relationships between staff and the alleged victim and/or other resident, and interactions/relationships between resident to other resident. Conducting interviews with as appropriate the alleged victim and representatives, alleged perpetrator, witnesses, practitioner, interviews with personnel from outside agencies such as other investigatory agencies and hospital or emergency room personnel. Conducting record review for pertinent information related to the alleged violation, as appropriate, such as progress notes, financial record, incident reports (if used), reports from hospital / emergency room records, laboratory or x-ray reports, medication administration records, photographic evidence, and reports from other investigatory agencies. Review of the facility’s policy, titled, “Documentation” with a revised date of 01/2024 included in part the following: The following information is to be documented in the resident medical record a) objective observations, b) medications administered, c) treatments or services performed, d) changes in resident’s condition. Documentation in the medical record will be objective (not opiniated or speculative), complete and accurate. 1.Review of the record revealed Resident #86 was initially admitted to the facility 06/19/24 with a primary diagnosis of “Unilateral Primary Osteoarthritis, Right Knee.” Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #86 had a Brief Interview for Mental Status (BIMS) score of 12, on a 0 to 15 scale, indicating the resident was moderately cognitively intact. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the record revealed Resident #38 was admitted to the facility 4/19/22 with a primary diagnosis of “Cerebral Atherosclerosis” (a condition where fatty deposits, called plaque, build up inside the arteries that supply blood to the brain) and a secondary diagnosis of Vascular Dementia, mild, with mood disturbance. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #38 had a Brief Interview for Mental Status (BIMS) score of 03, on a 0 to 15 scale, indicating the resident was severely cognitively impaired. An interview was conducted on 07/28/25 at 12:06 PM and when asked about her care, Resident #86 stated on Saturday 07/26/25 that Resident #38 came into her room and Resident #86 tried to re-route her back out when she was punched on both of her hands by Resident #38. Resident #86 stated they did not call a doctor or did imaging and had told them her right hand was in pain; and she had to request for ice herself because she was not given any by staff. Resident #86 stated she was asked by staff to write down her witness statement, “I had to use my injured hand to write it.” Review of Resident #38 and Resident #86’s electronic medical record (EMR) did not reveal documentation from staff of the incident that occurred 07/26/25. Further review of the record did not reveal physician orders or documentation related to this incident for the day of the incident. An interview was conducted on 07/28/25 at 3:23PM with the Administrator and the Director of Nursing (DON). When the resident-to-resident incident between Resident #86 and Resident #38 was discussed, the Administrator and the DON both stated they had not been made aware of the incident. When asked if they could provide documentation from the EMR regarding this occurrence, they were not able to find any documentation in the EMR. The incident had not been investigated because their staff had not made them aware of what had occurred on 07/26/25. On 07/29/25 at 8:55 AM, the Administrator was asked who had been educated on Abuse and Neglect when the incidents occurred and the Administrator stated that only staff involved were educated but the educations were not facility wide. During a follow up interview on 07/29/25 at 9:40AM, Resident #86 stated the police came to talk to her yesterday, asked her what happened and left. When asked for clarification on what staff she had told on 07/26/25 that she had been punched by another resident, Resident #86 stated she couldn’t remember her name, but it was the nurse who was taking care of her who was made aware. Resident #86 stated, “She came in right after it happened.” Review of the Investigation was conducted regarding the incident from 07/26/25, involving Resident #38 and Resident #38 which was reported on 07/28/25 after the surveyors had made the Administrator and DON aware. Witness statements from Staff O, Certified Nursing Assistant (CNA) and Staff D, Licensed Practical Nurse (LPN) were both added to the investigation. Both of these staff members were aware of Resident #86’s allegations the night the incident occurred. Review of the physician orders revealed two new orders: A diagnostic order for the right wrist and fingers named, “WRIST RT 3V* | FINGERS RT 3V”, documented it was sent on 07/28/25 at 4:06PM and another order that documented “apply ice pack to right finger for 20 minutes as needed, every 4 hours for discomfort for 3 Days” dated 07/29/25. Both orders were added 2-3 days after the incident had occurred. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A late entry note from Staff D dated 07/28/25 at 10:02 PM documented, “resident informed writer of alleged resident to resident altercation. Writer attempted to interview resident, and she was unwilling to give statement, writer attempted to do a head-to-toe assessment, and she refused. Writer then went into alleged perpetrator room and observed her resting in bed with assigned aide at bedside. MDs and families notified. ” No documentation was found to support the notification to the doctor or families made. An interview was conducted with the DON on 07/29/25 at 8:45AM who when asked to provide evidence that the family was notified of the incident for Resident #86, the DON was not able to obtain any documentation in the EMR. A phone interview was conducted on 07/30/25 at 12:00 PM with Staff O, Certified Nursing Assistant/CNA, who recalled the incident from 07/26/25 but was not aware of the incident until Monday 07/28/25. Staff O stated, “Resident #86 did not tell me anything happened on Saturday”. Staff O stated she had not worked with Resident #86 frequently but that night both Resident #38 and Resident #86 were on her assignment. Staff O stated that Resident #86 always makes allegations of other residents hitting her. Staff O stated she was assisting Resident #38 that night and stated she never got out of bed nor is she capable of walking by herself. When asked how she found out about the incident if she was not made aware by Resident #86, Staff O stated that on Monday 07/28/25, she saw the police show up and go into Resident #86’s room; the nurse pulled her aside and told her what happened and then she was asked by the DON to provide a statement. This statement was conflicting with the statement Staff O provided to the facility as part of their investigation. An interview was conducted on 07/30/25 at 1:12 PM with Staff P, Advanced Registered Nurse Practitioner (ARNP), who when asked if she was made aware of the resident-to-resident incident that Resident #86 was involved in, Staff P stated she was made aware over the weekend by several nurses. She could not recall what nurses called her. Staff P stated she gave orders for imaging, Tylenol, Ibuprofen, and ice. Staff P stated Resident #86 had made similar allegations in the past. When asked if she documented her orders or the encounter, Staff P stated she did not document it but had given the orders to the nurses taking care of Resident #86. Staff P stated she would add a late entry note from during the weekend. Review of the late entry note entered by Staff P dated 07/30/25 at 10:23 PM documented, “…There was an incident on 7/26/25, which was reported to me over the weekend via phone by two nurses. [Resident #86] reported a resident attacked her. She reported the resident twisted her right index finger, x-ray of Right hand and wrist were ordered. Patient to apply ice to affected extremity. Patient also with complaints of right knee pain. No evidence of injury. Ice packs provided. Patient to apply ice pack 20 minutes on/off 20 minutes x 3 days. Tylenol / ibuprofen were recommended for pain if needed. These orders were provided to nurses over the weekend, during conversation regarding the incident. X-ray results discussed with patient today. No acute findings…” (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview was conducted on 07/30/25 at 1:58 PM and continued on 07/31/25 at 1:00 PM in person with Staff D, LPN. Staff D stated, “[Resident #86] approached the nurses’ station, and said I have just been beat up. I could not see any signs of injury. She stated, the resident who hit her was Resident #38, went to Resident #38’s room and the resident was lying in bed and Staff O was providing care to her.” Staff D stated she voiced to Staff O the allegation that Resident #86 had made against Resident #38; Staff O replied, how she has been in bed. Staff O stated she told her unit manager at the time, Staff Q, (LPN), who told her to get a witness statement from Resident #86. Staff D stated when she went into room and asked to assess Resident #86, the resident threw the paper and pen at her and Staff D left the room. Staff D stated that no statement was received from Resident #86. Staff D stated both residents' doctors and families were notified. The Power of Attorney (POA) for Resident #86 did not call back. Staff D couldn’t recall the name of the ARNP who she notified for Resident #86, she stated the ARNP replied by stating “Okay I will notify the primary attending and if she has any further questions she can reach out tomorrow, thanks. Staff D stated no orders were given on 07/26/25. When asked if she documented the incident or notification to the ARNP, Staff D stated she did not document anything and made a late entry note when the Administrator and DON talked to her about it on Monday, 07/28/25. When asked why she didn’t notify anyone else of the incident she stated she didn’t think the incident could have happened since Resident #38 was bed-bound and Resident #86 always makes allegations that other residents hit her. Staff D stated she understands it is not for her to determine if the incident happened or not and she should have reported it. Staff D stated, “From now on I’m going to document everything that happens.” A phone interview was conducted on 07/31/25 at 12:20PM with Staff Q, LPN, who when asked about the incident regarding Residents #38 and #86, Staff Q recalled that Staff D stated Resident #86 had made an allegation of being hit by another resident (Resident #38). Staff Q told Staff D to take a statement. She had been told by Staff D that Resident #86 kicked her out. Later Staff Q followed up with Resident #86 who refused to talk to her. She stated she also followed up with Resident #38 who was in bed all evening according to an interview Staff D had with Staff O. When asked if she notified anyone else of the incident, Staff Q stated she did not notify anyone else. When asked if she notified a nurse practitioner, she stated she did not call anyone. Staff Q stated she thought there was no way the incident could have happened, so she didn’t notify anyone. When asked about any abuse and neglect educations that were provided prior to this incident, she stated she should report any suspicions of abuse including allegations of abuse. When asked if the incident between Resident #86 and Resident #38 would be considered something to report, Staff Q stated yes, I should have reported it but didn’t because I thought there was no way that could have happened. When asked if Staff Q should have made that determination, Staff Q stated she understood she should have reported the incident, and it was not for her to determine if it happened. When asked if she had documented the incident, she stated she did not. During an interview on 07/31/25 at 3:37 PM, when asked if she was involved in the incident that happened Saturday 07/26/25, Staff N, Registered Nurse (RN), stated she was not working Saturday. Staff D told her about the incident on Monday 07/28/25 and went to assess Resident #86; she got orders for an x-ray and ice since there was already pain medications ordered. Staff N stated she was the one that contacted Staff P on Monday to notify her of the incident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review for Resident #48 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Transient Cerebral Ischemic Attack, Anxiety Disorder, Major Depressive Disorder Recurrent and Weakness. The MDS assessment dated [DATE] documented in Section C a BIMS score of 15, indicating an intact cognitive response. Record review for Resident #101 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Unspecified Dementia Unspecified Severity with Other Behavioral Disturbance, Muscle Weakness (Generalized), Depression, and Unspecified Mood (Affective Disorder). The MDS assessment dated [DATE] documented in Section C a BIMS score of 3, indicating severe cognitive impairment. Review of the Progress Note for Resident #48 with a created date of 07/28/25 with an effective date/time of 07/09/25 at 8:33 PM included in part the following: Late Entry: Resident #48 informed this writer that a male resident (Resident #101) was in her bed. Upon entering the room, Resident #101 was observed sitting on the side of Resident #48’s bed. Resident #101 was redirected to his room and then immediately transferred to another location on the other side of the building. Physician and family were notified. Administrator and DON were made aware. Record review for Resident #101 revealed no documentation of the incident on 07/09/25 involving the resident wandering into Resident #48’s room and crawling into her bed with her present and touching her. There was no documentation of the family or physician being notified. Review of the Report dated 07/09/25 filed by the Administrator involving Residents #48 and #101 documented the following: Staff D, Licensed Practical Nurse (LPN), became aware of the incident on 07/09/25 at 9:00 PM. Resident #48 stated that around 9:00 PM while lying in bed, she felt someone next to her. She identified Resident #101 as the perpetrator. She immediately got out of bed and went to notify the nurse on duty (Staff D, LPN). Resident was assessed by nursing supervisor, her mood was normal no distress noted, skin assessment was completed with no injuries noted. Resident #101 was immediately placed on close monitoring pending further investigation and was removed and relocated to another room on another unit in the facility. Resident #101 was confused and unable to respond to any questions. Psychiatric consult was initiated by the facility. Resident #48 was alert and oriented and able to provide police officer with a statement of events. Summary of the facility’s interviews with the participants included in part the following: Another nurse [Staff E, LPN] came to assist Staff D, LPN. Summary of corrective action(s) taken: Resident #101 was discharged to a memory care unit. Staff education was completed on Alzheimer’s and Dementia. Review of the in-service training from 07/09/25 for nursing staff, titled, “Abuse, Neglect, and Exploitations” by Centers for Medicare and Medicaid Services with no date, included in part, the following: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation involve abuse or result in serious bodily injury. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the computer based training titled, “Abuse, Neglect, Exploitation, Misappropriation of Property, Mistreatment and Injury of Unknown Source” with no date and was provided to all staff from 07/01/25 to 07/30/25 included in part the following: Facility Reporting and Investigation: Reporting requirements for any suspected occurrence of abuse: Within 2 hours if the events involve abuse or result in serious bodily injury. Reporting Abuse or Suspected Abuse: What to Do: Stay calm and ensure the resident is safe. Report immediately to your supervisor, charge nurse, or administrator. Document what you say or heard – include facts, not assumptions. Follow the facility’s abuse reporting policy. An interview was conducted on 07/28/25 at 9:30 AM with the Administrator who was asked if they have a memory care unit and she said no. She said they have residents with Dementia, but they do not wander. She added we don’t have locked units or wander guards. An interview was conducted on 07/30/25 at 8:55 AM with the Administrator and the Director of Nursing present, when the Administrator was asked about what education has been provided to staff on or after 07/28/25 when they were made aware of the two incidents that happened on 07/26/25, the Administrator stated they have only provided education to the direct staff involved. An interview was conducted on 07/30/25 at 3:52 PM with Staff G, Registered Nurse (RN), who stated she has worked at the facility as and RN since 07/02/25 and before that she was a CNA at the facility for 8 years. She was the nurse who took care of both Residents #48 and #101 on 07/26/25. Staff G stated that on that night, Resident #101 went into Resident #48’s room to use the bathroom and Resident #48 woke up and she had alerted Staff F, Certified Nursing Assistant (CNA), who came into the room and tried to remove Resident #101 but was unable to do so, so she went to get Staff G and they both entered the bathroom, and she spoke to Resident #101 who had taken off his soiled underwear. Resident #101 refused to leave the bathroom and did not want to be touched; they waited until he was finished using the toilet. She spoke to Resident #48 and apologized for the incident and when Resident #101 was finished using the toilet, Staff F and herself were able to escort Resident #101 out of Resident 48’s bathroom and room. Resident #101 did not go back to his room until another Staff H, CNA, came and escorted Resident #101 back to his room. When asked if she documented the incident anywhere either in Resident #48 or Resident #101 medical record, she said no she did not. When asked if she reported the incident to anyone she said 'yes, the following Monday (07/28/25) she reported the incident to DON and the Administrator only after they had asked her about the incident'. When asked if she notified the family for each resident, she said 'no she did not notify the family for either resident'. She also acknowledged she did not notify the physician for either resident. When asked if she has had abuse training, she said yes and had completed it on the Master computer system. The new abuse training had just come out since the incident on 07/26/25 and she started it but has not finished it as of yet. The procedure when something like this happens, she was unaware she needed to inform the family, the physician and needed to report to the DON or Administrator. An interview was conducted on 07/31/25 at 8:40 AM with the Administrator who stated all staff do the abuse training on the computer system annually and they also provide in-service abuse training with each abuse allegation and that it targeted toward the nursing staff. The Administrator stated she feels their abuse education may not be effective, based on the most recent allegations of abuse that neither she nor the DON were made aware of by the staff involved. The Administrator stated she has been working on making a new abuse quiz with scenarios and will start implementing the abuse training with the new quiz today. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 07/31/25 at 8:50 AM with the Administrator, the [NAME] President of Risk Management (VPRM) and the [NAME] President of Operations (VOO), the VPRM acknowledged they chart by exception, and they will be providing direct education to the nurses involved in the abuse allegations regarding reporting, notifying family and physician and documentation being performed in a timely manner. The VOO added they are looking into changing the abuse training corporate wide. An interview was conducted on 07/31/25 at 12:51 PM with Staff D, LPN, who stated she has worked at the facility for 1 month. When asked about the incident on 07/09/25 involving Residents #48 and #101, the LPN stated Resident #48 approached her to inform her that Resident #101 was in her bed, she got the other nurse (Staff G RN) to help her get Resident #101 out of the bed and move him to a vacant room in another pod. She said she reported it to Resident #48’s daughter and the other nurse reported it to the son for Resident #101. She said she spoke with both nurse practitioners for each resident. The LPN stated she had reported it to the DON and the Administrator that same night and also spoke with a police officer. When asked if she documented the incident in the chart for each resident, she stated she believes so. When asked about abuse training, she said she took the computer-based abuse training upon hire and has not had any additional abuse training. 3. Record review for Resident #48 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission on [DATE] with diagnoses that included in part the following: Transient Cerebral Ischemic Attack, Anxiety Disorder, Major Depressive Disorder Recurrent and Weakness. The Minimum Data Set (MDS) assessment dated [DATE] documented in Section C that Resident #48 had a Brief Interview of Mental Status (BIMS) score of 15 on a 0-15 scale, indicating the resident was cognitively intact. Record review for Resident #33 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Unspecified Sequalae of Cerebral Infarction, Cognitive Communication Deficit, and Unspecified Dementia Unspecified Severity with Agitation. The MDS assessment dated [DATE] documented in Section C that Resident #33 had a BIMS score of 4 on a 0-15 scale, indicating severe cognitive impairment. An interview was conducted on 07/28/25 at 11:37 AM with Resident #48 who was asked if she feels safe in the facility, she replied, “No, just the other night a male resident [Resident #33] came into my room and used my bathroom, and his diaper was partially down, and he was exposed.” Resident #48 reported that this incident happened on Saturday, 07/26/25. When asked if she had advised staff, she reported that she went to the nurse’s station and three staff members (Staff F, G and H) had to come into her room to assist Resident #33 out of her bathroom. Record review for Resident #33 and Resident #48 revealed no documentation of the incident on 07/26/25 involving Resident #33 going into Resident #48’s bathroom and had exposed himself to her when he pulled down his diaper to use the toilet. For both residents, there was no family or physician notification of the incident. (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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/28/25 at 3:18 PM, the Administrator and the Director of Nursing (DON) were asked about the incident on 07/26/25 involving Resident #33 going into Resident #48’s room to use the bathroom and Resident #33 was wearing a diaper that was partially down exposing himself to Resident #33 and that Resident #48 had reported this to Staff F, G and H who assisted Resident #33 out of the room. The Administrator and DON both stated they were not aware of the situation. They both acknowledged there was no documentation of the incident in the residents’ record. A telephone interview was conducted on 07/31/25 at 11:10 AM with Staff F, Certified Nursing Assistant (CNA), who stated she has worked at the facility for 3 years. Staff F stated that on 07/26/25 around 11:20 PM, she was talking at the nursing station and Resident #48 approached the nursing station and asked her to help her get Resident #33 out of her room, he was in her bathroom. When she went to the room of Resident #33, the resident refused to leave stating he was using the bathroom, so she shut the door. She notified Staff G, Registered Nurse (RN), that Resident #33 refused to leave the bathroom. Staff G said to get Staff H, CNA, to assist her in removing Resident #33 and he was able to get Resident #33 out of the bathroom. When asked if she reported the incident to anyone, she said no because the nurse already knew about it. When asked if she had received any training on abuse, she said she did it on the computer and the in-service but was unable to remember the dates. A telephone interview was conducted on 07/31/25 at 11:25 AM with Staff H, CNA, who stated he has worked at the facility since December 2024. When asked about the incident on 07/26/25 with Residents #48 and #33, he stated he was called by another CNA to help get Resident #33 out of Resident #48’s bathroom. Staff H stated he put on gloves and escorted Resident #33 out of the Resident #48’s room. When asked if he had reported this to anyone, he said he did not know there was any issue to report, he just knew Resident #33 was confused. When asked about abuse training, he said he just had an in-service yesterday. An interview was conducted on 07/28/25 at 3:15 PM with the Director of Nursing (DON) who stated she has been in the DON (Abuse Coordinator) role for about 1 year and the Administrator (Risk Manager) who has been at the facility for 3 years. When asked about documentation for an allegation of abuse between Residents #48 and #101, they stated the only documentation for each resident on the day of the incident was a skin assessment done on 07/09/25 for both residents involved. The Administrator and the DON were asked about the incident involving Resident #33 going into Resident #43’s room and was wearing a brief and had pulled down exposing himself to Resident #33 on 07/26/25 and that Resident #33 had reported this to staff who ushered Resident #33 out of the room, they both stated they were not aware of the situation. They both acknowledged there was no documentation of the incident in the resident’s record. The Administrator and the DON were asked about the incident involving Resident #38 and Resident #86 on 07/26/25 where Resident #86 reported to staff that Resident #38 had punched her in the hand and she was asked to produce a written statement for them and was being provided ice for her hand. They both stated they were not aware of the incident. When asked about documentation in the record for each resident involving the incident, they both acknowledged there was no documentation in either of the resident’s record. The Administrator and the DON were asked about the incident involving Resident #81 who had allegation of abuse on 07/09/25 by staff member toward him, the Administrator and DON stated they were aware and acknowledged there was no documentation in the resident’s record.