STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185125	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Health and Rehabilitation Center	1245 American Greeting Card Road Corbin, KY 40701

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. Based on interview, record review, facility document review, and facility policy review, the facility failed to protect the residents' right to be free from abuse other residents for 2 (Resident #10 and Resident #38) of 5 residents reviewed for abuse.Findings included: A facility policy titled, “Abuse, Neglect, Misappropriation and Exploitation Policy,” revised 01/2018, indicated, “Our facility does not condone or tolerate resident abuse (this includes verbal abuse, sexual abuse, physical abuse and mental abuse), neglect, misappropriation or exploitation under any circumstances by anyone, including staff members, other residents, consultants, volunteers, staff of other agencies serving or visiting the resident, family members, legal guardians, sponsors, friends, or other individuals.” 1. Record review revealed a document titled “admission Record” indicated the facility admitted Resident 10 on 04/03/2024. According to the admission Record, the resident had a medical history that included diagnoses of anxiety disorder and major depressive disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/04/2025, revealed Resident 10 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. Resident 10’s “Care Plan Report,” included a focus area initiated 12/10/2024, that indicated the resident had a potential for alteration in sleep cycle due to a history of insomnia for which the resident received medication. Interventions directed staff to provide a calm environment for the resident as much as possible. Record review of a document titled “admission Record” indicated the facility admitted Resident #19 on 07/23/2021. According to the admission Record, the resident had a medical history that included diagnoses of Parkinson’s disease, major depressive disorder and insomnia. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/08/2025, revealed Resident 19 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The MDS also indicated Resident #19 had no wandering behaviors and exhibited no physical behaviors directed toward others. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 19’s “Care Plan Report,” included a focus area initiated 11/07/2023 that indicated the resident had a physical altercation with another resident. Interventions directed staff to move the resident to another room where the bathroom had only one entrance to avoid any confusion. Record review of a facility document titled, “Initial Report,” dated 03/28/2025, revealed an alleged incident of resident-to-resident physical abuse that occurred on 03/28/2025 at 5:35 AM. Per the Initial Report, Resident 19 was in an adjoining bathroom and got confused and exited out the wrong bathroom door into Resident 10’s room, where Resident 10 was sleeping. The Initial Report revealed Resident 19 hit Resident #10. The Initial Report revealed Resident 10 had a small laceration above their right eyelid. The Initial Report revealed both residents were evaluated for any injuries and sent to emergency room (ER) for an evaluation. A facility document titled, “Final Report/5 Day Follow-up,” dated 04/02/2025, revealed Resident 19 was assessed in the ER and reviewed by psychiatry, who felt that the incident was due to ongoing confusion as a result of the resident’s dementia. The report revealed the facility placed Resident 19 on one-on-one (1:1) supervision and moved the resident to new room where they did not have to share a bathroom with another resident/room. Per the report, Resident 19 was seen by in-house psychiatry and medication changes were made. The report revealed Resident 10 had a superficial laceration and bruising to the left eyebrow that did not require repair. During an interview on 08/20/2025 at 9:30 AM, Resident 10 stated they remembered being hit in the face, but they did not remember any other information, just that they were punched. During an interview on 08/20/2025 at 9:48 AM, Registered Nurse (RN) 7 stated he understood that Resident 19 thought Resident 10 was in Resident 19’s bed. RN 7 stated Resident 19 then punched Resident 10 in the face. During a telephone interview on 08/20/2025 at 12:49 PM, RN 15 stated that when Resident 19 was in their bathroom, the resident must have gotten confused and went out the wrong bathroom door into Resident 10’s room and thought Resident 10 was in Resident 19’s bed. During a telephone interview on 08/20/2025 at 1:35 PM, State Registered Nurse Aide (SRNA) 16 stated she was completing rounds and heard Resident 19 in the bathroom and went down to the room and found Resident 19 in Resident 10’s room. SRNA 16 stated it appeared that Resident 19 got confused while in the adjoining bathroom and came out into Resident 10’s room and thought Resident 10 was in Resident 19’s bed. SRNA 16 stated she then saw Resident 10’s eye had a small laceration/scratch on the eyebrow area. SRNA 16 stated both residents were sent to the ER for an evaluation. During an interview on 08/20/2025 at 3:52 PM, RN 17 stated that she was notified by SRNA 16 that Resident 19 was found in Resident 10’s room. RN 17 stated when she entered the room, she found Resident 10 had a small amount of blood on their face, and the resident said that someone had hit them in the face. RN 17 stated Resident 10 had a laceration on their eyebrow. During an interview on 08/22/2025 at 3:35 PM, the Administrator stated she knew the incident happened between Resident 10 and Resident 19 but believed Resident 19 was confused and thought someone was in their bed. (continued on next page)

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(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	2. An “admission Record” revealed the facility admitted Resident 71 on 01/30/2023. According to the admission Record, the resident had a medical history that included diagnoses of dementia, mild intellectual disability, and depression. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/04/2025, revealed Resident 71 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. Resident 71's “Care Plan Report,” included a focus area initiated 04/04/2024, that indicated the resident had the potential for an alteration in mood/behavior and was noted with physical aggression, screaming, threatening, cursing, and frustration. Interventions directed staff to administer medications as ordered, observe and record any alterations in mood/behaviors, psychiatric consult as ordered, if resistant to care allow the resident to calm down and then reapproach, and invite the resident to activities of choice. An “admission Record” revealed the facility admitted Resident 38 on 12/30/2005. According to the admission Record, the resident had a medical history that included diagnoses of bipolar disorder, dementia, major depressive disorder, and anxiety disorder. A quarterly MDS, with an ARD of 08/11/2025, revealed Resident 38 had a BIMS score of 10, which indicated the resident had moderate cognitive impairment. An “Initial Report” dated 07/19/2025 revealed an allegation of resident-to-resident abuse that occurred on 07/19/2025 at 11:40 AM between Resident 71 and Resident 38. The report revealed the incident was witnessed by State Registered Nurse Aide (SRNA) 3. The report revealed Resident 71 slapped Resident 38 on the right side of their face and knocked their glasses off. Per the report, Resident 71 was immediately removed to their room by Registered Nurse (RN) 4 to calm down. During an interview on 08/20/2025 at 9:49 AM, SRNA 3 stated that she had witnessed the altercation between Resident 71 and Resident 38. She stated that the residents were in front of the nursing station on the [NAME] Unit. SRNA 3 stated that Resident 71 appeared to get upset that their chair was touching Resident 38’s chair and they were unable to go around the other resident. She stated Resident 71 backed up a little and slapped Resident 38 in the face. SRNA 3 stated Resident 38’s glasses fell off their face as a result. During an interview on 08/20/2025 at 10:23 AM, RN 4 stated that Resident 71 had episodes of anger. He stated that he did not directly witness the slap but removed Resident 71 to the resident’s room after the incident. During an interview on 08/20/2025 at 10:38 AM, LPN 5 stated that she was present during the altercation between Resident 38 and Resident 71 but did not witness Resident 71 making contact with Resident 38. She stated that she checked Resident 38’s jaw, which was a little red, but the redness went away in approximately an hour. She stated Resident 38 did not have a bruise, and there were no scratches. She stated that R 71 had a history of cursing when they did not get what they wanted. She stated that she reported the incident to the Director of Nursing (DON). Resident 71 was observed ambulating independently in their wheelchair on 08/20/2025 at 11:50 AM on the [NAME] Unit. (continued on next page)

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	185125	A. Building B. Wing	08/22/2025

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Hillcrest Health and Rehabilitation Center	1245 American Greeting Card Road Corbin, KY 40701

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/20/2025 at 11:54 AM, R 71 indicated they did not recall the incident that involved hitting R 38 but did know a resident by that name. R 71 denied ever striking another resident. During an interview on 08/18/2025 at 2:21 PM, R 38 indicated that they recalled R 71 hitting them. R 38 indicated that they did not feel safe in the facility because of that. The DON was interviewed on 08/20/2025 at 11:19 AM. She stated that she recalled the incident with Resident 38 and Resident 71, and the abuse had been verified.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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, record review, document review, and facility policy review, the facility failed to ensure staff reported an allegation of abuse timely to the Director of Nursing and/or Administrator for 2 (Resident #38 and Resident #81) of 4 sampled residents reviewed for abuse.Findings included: The facility policy titled, “Abuse, Neglect, Misappropriation and Exploitation Policy,” revised 01/2018, indicated, “All allegations involving suspected abuse, neglect, misappropriation or exploitation including injuries of an unknown source or misappropriation of resident property shall be reported immediately, but not later 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 do not involve abuse and do no result in serious bodily injury, to the Director of Nursing and/or the Administrator of the facility. The Director of Nursing, Administrator or Designee shall report such allegations to appropriate state and federal agencies, including law enforcement, as required.” 1. An “admission Record” revealed the facility admitted Resident #81 on 09/12/2022. According to the admission Record, the resident had a medical history that included a diagnosis of atherosclerotic heart disease. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/27/2024, revealed Resident #81 had a Brief Interview for Mental Status (BIMS) of 12, which indicated the resident was cognitively intact. A review of progress notes dated 07/06/2025 at 2:57 AM indicated, “[Resident #81] stated to CNA (State Registered Nurse Aide [SRNA] #1) that hospital staff was mean to [Resident #81] during [Resident #81’s] admission and asked CNA where [Resident #81] could purchase a gun.” The progress note was entered by Registered Nurse (RN) #2. During an interview on 08/21/2025 at 8:43 AM, SRNA #1 stated she took care of Resident #81 on 07/05/2025. She stated Resident #81 told her that something had happened to Resident #81 at the hospital, and Resident #81 had a bruise on the top of their left hand. Resident #81 stated they wanted a gun for protection, and she told Resident #81 the resident did not need a gun for protection, and she would keep Resident #81 safe. Resident #81 then said to her, “Look at my hand and look at what they did to me at the hospital.” She reported it to RN #2, who was the nurse on duty that night, as soon as Resident #81 made the allegation to her. She could not remember what time it was when Resident #81 made the allegation of something happening at the hospital. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/20/2025 at 10:15 AM, RN #2 stated a SRNA came and told her what Resident #81 had said. Resident #81 told the SRNA that Resident #81 had been abused at the hospital. She made sure Resident #81 was safe, then she called the on-call nurse and told her what Resident #81 had reported as well. She could not remember who the SRNA was or who the on-call nurse was to whom she talked. The on-call nurse told her to leave a nurse's note for the social worker, and the social worker would talk to Resident #81. She stated she had received abuse training. She stated she would report any allegation of abuse to the on-call nurse or to a supervisor. She stated she was always supposed to report it immediately. She stated the on-call nurse told her just to make the note since the allegation of abuse did not involve any of their staff nor did it happen in the facility. During an interview on 08/20/2025 at 10:55 AM, MDS #11 could not remember what time RN #2 had called her on the night of 07/05/2025 and vaguely remembered what RN #2 had told her that Resident #81 had reported. She stated it was something about Resident #81 wanting a gun for protection because Resident #81 was worried about being robbed and about something that occurred at the hospital. She stated RN #2 told her that she had ensured Resident #81 was safe. She told RN #2 if Resident #81 was okay just to watch Resident #81 and make Resident #81 feel safe and comfortable. She did not report it to anyone else at that time. She could not remember if she ever reported it to anyone else. MDS #11 stated she had received abuse training. She stated she was supposed to report any allegation of abuse immediately by contacting the DON and/or Administrator. During an interview on 08/19/2025 at 2:20 PM, the Director of Social Services stated the allegation of abuse was reported to her by a staff member on July 8th. She stated a progress note dated 07/06/2025 at 2:57 AM revealed Resident #81 had reported the allegation to a CNA who reported it to RN #2 at that time. She talked to Resident #81 on 07/08/2025 sometime that morning, and Resident #81 told her that Resident #81 was at the hospital, and a man and two women came into the resident’s room, and the man held him down while the two women hit him on the hand over and over. She called the hospital on [DATE] and reported the allegation to a case manager. During a follow-up interview on 08/20/2025 at 10:46 AM, Director of Social Services stated they were reviewing the nurse’s note during their morning meeting on 07/08/2025 when they came across the note RN #2 had entered regarding Resident #81. The Administrator and Director of Nursing (DON) became aware during the morning meeting of the allegation of abuse made by Resident #81. She stated she had received abuse training, and she was to report abuse immediately. She stated she would report any allegation of abuse to the DON or Administrator. During an interview on 08/22/2025 at 1:51 PM, the DON stated they expected all staff to report abuse as soon as it happened. They had two hours to report abuse to the state in their initial report. When the allegation Resident #81 had made came to her that Resident #81 had been abused at the hospital, they wanted to know who, so she sent the Director of Social Services to talk to Resident #81 and get details while she started their initial report. She stated she was made aware of the allegation on 07/10/2025 and did not remember what time exactly. She stated there was obviously a breakdown somewhere, and staff did not report it properly on the morning of 07/06/2025. She did not remember becoming aware of the allegation on 07/08/2025 during the morning meeting. She would expect any allegation of abuse to be reported immediately and within two hours to the state. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/2025 at 2:18 PM, the Administrator stated that once abuse was reported the residents were protected first. They separated them, assessed them, and made sure they were safe. If it was reported to or witnessed by an aide, the aide would report it to the nurse, and the nurse would report it to a supervisor. It would then get reported to the Administrator or the DON. All staff should report any allegation of abuse immediately. After any allegation of abuse was reported, they had two hours to submit their initial report to the state survey agency and five days before the final report. She stated she could not remember when she was made aware of the allegation made by Resident #81. After she reviewed Resident #81’s file, she stated she was out sick during that time. She stated the DON had called her, but she did not recall any details. She would expect every staff member to report any allegation of abuse immediately so they could start their investigation. She did not know why the allegation made by Resident #81 was not reported timely. 2. An admission Record revealed the facility admitted Resident #71 on 01/30/2023 with diagnoses that included dementia, mild intellectual disability, and depression. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/04/2025, revealed Resident #71 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. An admission Record revealed the facility admitted Resident #38 on 12/23/2024 with diagnoses that included bipolar disorder, dementia, major depressive disorder, and anxiety disorder. A quarterly Minimum Data Set (MDS), with an ARD of 05/13/2025, revealed Resident #38 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment. Review of the “Long Term Care Facility – Self-Reported Incident Form Initial Report” indicated an allegation of resident-to-resident abuse was witnessed by State Registered Nurse Aide (SRNA) #3 on 07/19/2025 at 11:40 AM between Resident #71 and Resident #38. The incident was reported to the Administrator on 07/19/2025 at 2:39 PM. The facility reported the incident to the state agency on 07/19/2025 at 3:49 PM, which was not within the two-hour regulatory timeframe. During an interview on 08/20/2025 at 9:49 AM, SRNA #3 stated that she had witnessed the altercation between Resident #71 and Resident #38. She stated it was in front of the nursing station on the [NAME] Unit. Resident #71 appeared to get upset that they were unable to get around the other resident, so repositioned their own wheelchair and slapped Resident #38 in the face. Resident #38’s glasses fell off their face as a result. The event occurred during meal time, and several other staff were present offering feeding assistance to various residents and passing trays. She stated she made the nurse aware of the incident. During an interview on 08/20/2025 at 10:23 AM, Registered Nurse (RN) #4 stated that Resident #71 had episodes of anger. He stated that he did not directly witness the slap, but removed Resident #71 to the resident’s room. He stated that he let the assigned nurse, Licensed Practical Nurse (LPN) #5, process the situation and handle reporting the abuse to administration. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/20/2025 at 10:38 AM, LPN #5 stated that she was present during the altercation between Resident 38 and Resident #71 but did not witness the Resident #71’s hand make contact with Resident #38’s face. She stated that she checked Resident #38’s jaw, which was a little red, but the redness went away in approximately an hour. It did not bruise and there were no scratches. She stated that Resident #71 had a history of cursing when they did not get what they wanted. She stated that she did report the incident to the Director of Nursing (DON), but it may have been over an hour after the incident occurred. She stated that she did receive abuse training and had been educated to report abuse immediately. She stated the reason she took longer to report was due to becoming occupied with another person. Resident #71 was observed ambulating independently in their wheelchair on 08/20/2025 on the [NAME] Unit. Resident #71 was interviewed on 08/20/2025 at 11:54 AM. They indicated they did not recall the incident that involved hitting Resident #38 but did know a resident by Resident #38’s name. Resident #71 denied ever striking another resident. Resident #38 was interviewed on 08/18/2025 at 2:21 PM. Resident #38 indicated that they did recall Resident #71 hitting them. During an interview on 08/22/2025 at 1:51 PM, the DON stated that she expected all staff to report abuse as soon as it happened. She stated the facility had two hours to report abuse to the state in their initial report. She would expect any allegation of abuse to be reported immediately and within two hours to the state. In a follow-up interview on 08/22/2025 at 3:16 PM, the DON stated that the incident with Resident #71 and Resident #38 was reported to her late, so she informed the Administrator (ADM) that she would be unable to report the incident timely. The nurse who reported to her was educated after the fact about reporting. She reiterated that she expected staff to report immediately. In an interview on 08/22/2025 at 2:18 PM, the ADM stated that once abuse was reported, the resident was protected first; they separated the residents, assessed them, and made sure they were safe. If abuse was reported to or witnessed by an aide, the aide would report it to the nurse, and the nurse would report it to a supervisor. It would then get reported to the ADM or the DON. After any allegation of abuse was reported, the facility had two hours to submit the initial report to the state agency and five days to submit the final report. She stated she would expect every staff member to report any allegation of abuse immediately so they could start their investigation. In a follow-up interview on 08/22/2025 at 3:58 PM, the ADM stated that it did not meet expectations for an incident that occurred and was witnessed at 11:40 AM to be reported to the state agency at 3:49 PM the same day. She stated she was not sure why the allegation was reported late.

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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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and facility document and policy review, the facility failed to provide evidence of a thorough abuse investigation for an allegation of resident-to-resident abuse involving 1 (Resident #71) of 4 residents reviewed for dementia care and 1 (Resident #38) of 6 residents reviewed for abuse. Specifically, after staff witnessed Resident #71 slap Resident #38 on the face on 07/19/2025, the facility failed to ensure all potential witnesses to the incident were identified and interviewed and interviews or assessments of other residents who may have had contact with Resident #71 were conducted during the investigation to determine if other residents may have also been affected.Findings included: A facility policy titled, Abuse, Neglect, Misappropriation and Exploitation Policy, last revised on 01/2018, indicated, ABUSE AND/OR RESIDENT NEGLECT INVESTIGATION 1) When an incident or suspected incident of resident abuse or neglect is reported, the Administrator or Director of Nursing will appoint a representative to investigate the incident. 2) A thorough investigation shall be completed. 3) Results of the investigation may be documented in an Investigative Summary report format or on a Resident Abuse Investigation Report Form. 4) For resident to resident altercations: -Separate and ensure both residents are protected from further harm -Assess both residents for injuries -Provide appropriate medical attention as needed -Contact family, doctor, Administrator -Interview both residents, if interviewable, and document in an Investigative Summary report format -Review the resident's medical record for signs that led up to the event -Interview any witnesses to the incident.During an interview on 08/22/2025 at 2:18 PM, the Administrator (ADM) stated that during an abuse investigation, facility staff would also conduct interviews with other residents who had a Brief Interview for Mental Status (BIMS) score of 8 or above (those with moderate cognitive impairment and those that were cognitively intact) and conduct skin assessments on residents with a BIMS score below 8 (those with severe cognitive impairment).An admission Record revealed the facility admitted Resident #71 on 01/30/2023. According to the admission Record, the resident had a medical history that included diagnoses of dementia, mild intellectual disability, and depression.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/04/2025, revealed Resident #71 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment.Resident #71's Care Plan Report included a focus area, initiated 04/04/2024, that indicated the resident had the potential for an alteration in mood/behavior and was noted with physical aggression, screaming, threatening, cursing, and frustration. Interventions directed staff to administer medications as ordered, observe and record any alterations in mood/behaviors, psychiatric consult as ordered, if resistant to care allow the resident to calm down and then reapproach, and invite the resident to activities of choice.An admission Record revealed the facility admitted Resident #38 on 12/30/2005. According to the admission Record, the resident had a medical history that included diagnoses of bipolar disorder, dementia, major depressive disorder, and anxiety disorder. A quarterly MDS, with an ARD of 08/11/2025, revealed Resident #38 had a BIMS score of 10, which indicated the resident had moderate cognitive impairment.An Initial Report, dated 07/19/2025, revealed an allegation of resident-to-resident abuse occurred on 07/19/2025 at 11:40 AM between Resident #71 and Resident #38. The report revealed Resident #71 slapped Resident #38 on the right side of their face and knocked their glasses off. The report revealed the incident was witnessed by State Registered Nurse Aide (SRNA) #3. The report did not reflect any other identified witnesses.A Final Report/5 Day Follow-Up revealed the facility's investigation included an interview with one witness (SRNA #3), an interview with the alleged perpetrator (Resident #71), and an interview with the alleged victim (Resident #38). The 5 Day Follow-Up report indicated that the altercation occurred in an area utilized by some residents for meals and was within sight of any staff coming and going through the area; however, the facility's investigation documentation revealed no evidence of attempts to identify or interview additional potential witnesses. The investigation documentation further revealed there was no evidence that interviews or skin assessments of other residents who may have had contact with Resident #71 were conducted during the investigation to determine if other residents may have also been affected.During an interview on 08/20/2025 at 9:49 AM, SRNA #3 stated that she had witnessed the altercation between Resident #71 and Resident #38. She stated the incident occurred in front of the nursing station on the [NAME] Unit during mealtime, and several other staff were present, offering feeding assistance to various residents and passing trays.During an interview on 08/20/2025 at 10:23 AM, RN #4 stated that at least five other staff were present as witnesses to the altercation that occurred on 07/19/2025 The Director of Nursing (DON) was interviewed on 08/20/2025 at