STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365973	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchaven Retirement Village	15100 Birchaven Lane Findlay, OH 45840

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 medical record review, staff interview, review of the Self-Reported Incident (SRI) documentation, review of witness statements, review of the facility investigation, and policy review, the facility failed to ensure residents were free from verbal abuse by staff. This affected one (Resident #67) of three residents (#04, #67, and #94) reviewed for abuse. The facility census was 93.Findings Include:Review of the medical record for Resident #67 revealed an admission date of 08/05/25. Diagnoses included neurocognitive disorder with Lewy bodies, major depressive disorder, cognitive communication deficit, abnormalities of gait and mobility, dementia, Parkinson's disease, restless leg syndrome, hypertension, benign prostatic hyperplasia, insomnia, sleep apnea, parasomnia, rapid eye movement (REM) sleep behavior disorder, and generalized muscle weakness.Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 03/24/26, for Resident #67 revealed a Brief Interview of Mental Status (BIMS) score was unable to be determined due to his cognitive state. Review of the MDS assessment revealed Resident #67's had both short-term and long-term memory problems and his cognitive skills for daily decision making were severely impaired. Further review of the assessment revealed Resident #67 required assistance with all functional abilities including hygiene, bathing, dressing, repositioning, transferring, toileting, and walking.Review of the facility-substantiated Self-Reported Incident tracking number 266894, dated 10/28/25, revealed on 10/28/25 at approximately 3:30 A.M., Certified Nursing Assistant (CNA) #500 became aggravated with Resident #67 and yelled in his ear and cursed at him. In addition to this verbal abuse, CNA #500 physically abused Resident #67 by grabbing his arm forcefully, shoving him out of his wheelchair, and aggressively throwing him into his bed. Further review of the SRI revealed Registered Nurse (RN) #240 was also verbally abusive to Resident #67. These events were witnessed by CNA #384 at the time of occurrence.Review of CNA #384's written statement of events, found in SRI tracking number 266894 investigation, revealed she was attempting to help Resident #67 safely to a wheelchair, when CNA #500 helped her. CNA #500 began to shout at Resident #67 in an aggressive tone forcing him to sit. CNA #500 then began to slam the wheelchair pedals shut aggressively. While attempting to assist Resident #67 to bed, CNA #500 stepped in and began to scream at Resident #67 to stand up right now in his ear. CNA #500 proceeded to grab his arm and forcefully shove him out of the chair in a very unsafe manner as the wheelchair was unlocked. CNA #500 continued shouting and arguing with Resident #67. CNA #500 proceeded to throw Resident #67 in bed. As CNA #500 was doing this, she was shouting at Resident #67 the entire time, we aren't going to do this and she was curing at him. CNA #500 threw Resident #67's legs into the bed very aggressively and Resident #67 stated please stop, and began to cry. At this time, RN #240 enters Resident #67's room, after Resident #67 was in bed, under the covers, and crying, and points his finger at Resident #67, and aggressively and loudly says, you're going to stop right now and stop right now, and repeats this at least five time in a screaming and aggressive tone. At this time, Resident #67 was still crying and not being combative. Review of the facility investigation revealed CNA #500 escalated behaviors in Resident #67 during the incident and was terminated on 10/31/25.During an interview on 04/09/26 at 12:24 P.M., with CNA #384, CNA #384 was able to recount the events that occurred on 10/28/25 at approximately 3:30 A.M., (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: 365973	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchaven Retirement Village	15100 Birchaven Lane Findlay, OH 45840

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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	and this recollection aligned with the written statement that she provided at the time of the event occurrence. CNA #384 stated that it was her belief that Resident #67 was verbally and physically abused by CNA #500 and verbally abused by RN #240. CNA #384 stated that when RN #240 was shouting at Resident #67, he was standing beside the resident's bed and was leaning over Resident #67 and was repeatedly shouting, you're going to stop right now and stop right now. CNA #384 stated that this event was upsetting for her to witness. During an interview on 04/09/26 at 12:35 P.M., RN #240 could not recall the incident or any details surrounding it.Interview on 04/09/26 at 1:33 P.M., with the Assistant Director of Nursing (ADON) #503, the Director of Nursing (DON), and the Administrator, revealed the facility investigated CNA #500 for verbal abuse and terminated her employment. Follow-up interviews conducted on 04/09/2026 at 1:33 PM, 2:05 PM, and 2:47 PM with the ADON #503, the Director of Nursing (DON), and the Administrator revealed the facility had not provided abuse education or training to staff following the substantiated allegation of verbal abuse.Review of the facility policy titled, Abuse, Neglect, and/or Misappropriation of Resident Funds or Property Policy, revised 01/20/25, revealed abuse means the willful infliction of intimidation, or punishment with resulting physical pain, verbal or mental anguish. Verbal abuse refers to any use of oral, written, gestured language that willfully includes disparaging and derogatory terms to residents. CMS defines mistreatment as the inappropriate treatment or exploitation of a resident. This includes abuse, which is previously defined.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365973	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026
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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 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 medical record review, staff interview, review of facility submitted Self-Reported Incident (SRI), review of witness statements, review of the facility investigation, review of an email correspondence, review of the employee timecard punches, and policy review, the facility failed to implement their abuse policy when there were allegations of staff to resident physical and verbal abuse. This affected one (Resident #67) out of three residents reviewed for abuse, with the potential to affect 13 residents identified by the facility to reside on AB unit. The facility census was 93.Findings Include:Review of the medical record for Resident #67 revealed an admission date of 08/05/25. Diagnoses included neurocognitive disorder with Lewy bodies, major depressive disorder, cognitive communication deficit, abnormalities of gait and mobility, dementia, Parkinson's disease, restless leg syndrome, hypertension, benign prostatic hyperplasia, insomnia, sleep apnea, parasomnia, REM (rapid eye movement) sleep behavior disorder, and generalized muscle weakness.Review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #67 revealed a Brief Interview of Mental Status (BIMS) score was unable to be determined due to his cognitive state. Review of the MDS assessment revealed Resident #67 had both short-term and long-term memory problems and his cognitive skills for daily decision making were severely impaired. Further review of this MDS assessment revealed Resident #67 required assistance with all functional abilities including, but not limited to, hygiene, bathing, dressing, repositioning, transferring, toileting, and walking.Review of the medical record for Resident #67 revealed there was no documentation that he was assessed immediately when this incident occurred. Further review of the medical record for Resident #67 revealed there was no documentation that his physician or representative were notified regarding this incident. There were no progress notes documenting the incident.Review of the facility-substantiated SRI tracking number 266894, dated 10/28/25, revealed on 10/28/25 at approximately 3:30 A.M., Certified Nursing Assistant (CNA) #500 became aggravated with Resident #67 and yelled in his ear and cursed at him. In addition to this verbal abuse, CNA #500 physically abused Resident #67 by grabbing his arm forcefully, shoving him out of his wheelchair, and aggressively throwing him into his bed. Further review of this SRI revealed Registered Nurse (RN) #240 was also verbally abusive to Resident #67. These events were witnessed by CNA #384 at the time of occurrence.Review of CNA #384's written statement of events, found in SRI tracking number 266894 investigation, revealed she was attempting to help Resident #67 safely to a wheelchair, when CNA #500 to help her. CNA #500 began to shout at Resident #67 in an aggressive tone forcing him to sit. CNA #500 then began to slam the wheelchair pedals shut aggressively. While attempting to assist Resident #67 to bed, CNA #500 stepped in and began to scream at Resident #67 to stand up right now in his ear. CNA #500 proceeded to grab his arm and forcefully shove him out of the chair in a very unsafe manner as the wheelchair was unlocked. CNA #500 continues shouting and arguing with Resident #67. CNA #500 proceeds to throw Resident #67 in bed. As CNA #500 is doing this, she is shouting at Resident #67 the entire time, we aren't going to do this and she is curing at him. CNA #500 threw Resident #67's legs into the bed very aggressively and Resident #67 states please stop and begins to cry. At this time, RN #240 enters Resident #67's room, after Resident #67 was in bed, under the covers, and crying, and points his finger at Resident #67, and aggressively and loudly says, you're going to stop right now and stop right now, and repeats this at least five time in a screaming and aggressive tone. At this time, Resident #67 is still crying and not being combative. Interview on 04/09/26 at 12:24 P.M., with CNA #384 revealed there was no supervisor working the night this occurred, but she told Licensed Practical Nurse (LPN) #333, the unit nurse, approximately 10-15 minutes after the incident occurred. She stated that LPN #333 told her to write a statement and e-mail it to her and she would notify the DON and the Administrator. CNA #384 sent this requested written statement to LPN #333 within one hour of the incident occurring.Interview on 04/09/26 at 11:55 A.M. with the Assistant Director of Nursing (ADON) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Birchaven Retirement Village		STREET ADDRESS, CITY, STATE, ZIP CODE 15100 Birchaven Lane Findlay, OH 45840	

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#503, the Director of Nursing (DON), and the Administrator revealed the DON was not notified of this incident until 10/28/25 at 5:54 A.M., two hours and 24 minutes after the incident occurred. The DON verified this incident occurred on 10/28/25 at approximately 3:30 A.M. and CNA #500 remained on the AB unit until she punched out on 10/28/25 at 6:09 A.M. A follow-up interview on 04/09/26 at 1:33 P.M. with ADON #503, the DON, and the Administrator verified there was no documentation in Resident #67's medical record to indicate he was assessed, per facility policy, including range of motion, full body assessment of resident signs of injury, and vital signs. Further interview with ADON #503, the DON, and the Administrator verified there is no documentation that Resident #67's physician or representative were contacted to notify of this incident of verbal and physical abuse. During an additional follow-up interview on 04/09/26 at 2:47 P.M. with ADON #503, the DON, and the Administrator verified the policy titled, Abuse, Neglect, and/or Misappropriation of Resident Funds or Property Policy, revised 01/20/25, stated that staff shall report all incidents immediately to their direct supervisor, a nurse supervisor should perform an initial assessment of the resident (including range of motion, full body assessment of resident signs of injury, and vital signs), the nurse supervisor shall contact the resident's attending physician and representative. If a staff member is accused or suspected of abuse, Birchaven Village shall immediately remove that staff member from direct resident contact until the investigation is complete. The incident will be documented in the nurses' notes. Documentation should include an accurate description of the incident, the results of the resident's range of motion, body assessment, and vital signs, notification of physician and responsible party, and treatment provided. Once the Administrator and ODH are notified, an investigation of the allegation or suspicion will be conducted. The investigation shall be completed, whenever practical, within twenty-four (24) hours after the Administrator, but in no event shall the investigation take longer than five (5) working days. Birchaven Village will provide staff training on the subject of abuse as appropriate. The ADON #503, the DON, and the Administrator verified there was no documentation in the medical record for Resident #67 including an accurate description of the incident, the results of the resident's range of motion, body assessment, and vital signs, notification of physician and responsible party, and treatment provided. Further interview with ADON #503, the DON, and the Administrator revealed these items are required per facility policy.Review of SRI incident number 266894, revealed an investigation regarding physical abuse by CNA #500 and verbal abuse by RN #240, toward Resident #67, were not investigated at all, and specifically were not investigated within the timeframe specified in the facility policy of no investigation taking longer than five working days.During the continued interview on 04/09/26 at 2:47 P.M. with ADON #503, the DON, and the Administrator verified the facility never investigated physical abuse by CNA #500 and verbal abuse by RN #240, toward Resident #67. Further interview verified all investigations were to be completed in five working days. Review of the facility investigation revealed an email correspondence from the Human Resources Director (HR) #504 to the DON and the Administrator, revealed concerns that RN #240 needed further education provided to him.During the continued interview on 04/09/26 at 2:47 P.M. with the ADON #503, the DON, and the Administrator verified the email from HR #504 to the DON and the Administrator. The DON stated that she believed RN #240 was provided with education, but could find no documentation to substantiate this claim.Review of the facility policy titled Review of the facility policy titled, Abuse, Neglect, and/or Misappropriation of Resident Funds or Property Policy, revised 01/20/25, revealed staff shall report all incidents immediately to their direct supervisor, a nurse supervisor should perform an initial assessment of the resident (including range of motion, full body assessment of resident signs of injury, and vital signs), the nurse supervisor shall contact the resident's attending physician and representative. If a staff member is accused or suspected of abuse, Birchaven Village shall immediately remove that staff member from direct resident contact until the investigation is complete. The incident will be documented in the nurses' notes. Documentation should include an accurate description of the incident, the results of the resident's range of motion, body assessment, and vital signs, notification of physician and responsible (continued on next page)

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Birchaven Retirement Village	15100 Birchaven Lane Findlay, OH 45840

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	party, and treatment provided. Once the Administrator and ODH (Ohio Department of Health) are notified, an investigation of the allegation or suspicion will be conducted. The investigation shall be completed, whenever practical, within twenty-four (24) hours after the Administrator, but in no event shall the investigation take longer than five (5) working days. Birchaven Village will provide staff training on the subject of abuse as appropriate.

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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 medical record review, staff interview, review of the employee timecard punches, review of facility Self-Reported Incident (SRI), review of the facility investigation, and policy review, the facility failed to timely report alleged verbal and physical abuse. This affected one (Resident #67) out of three residents reviewed for abuse, with the potential to affect 13 residents identified by the facility to reside on the AB unit. The facility census was 93.Findings Include:Review of the medical record for Resident #67 revealed an admission date of 08/05/25. Diagnoses included neurocognitive disorder with Lewy bodies, major depressive disorder, cognitive communication deficit, abnormalities of gait and mobility, dementia, Parkinson's disease, restless leg syndrome, hypertension, benign prostatic hyperplasia, insomnia, sleep apnea, parasomnia, REM (rapid eye movement) sleep behavior disorder, and generalized muscle weakness.Review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #67 revealed a Brief Interview of Mental Status (BIMS) score was unable to be determined due to his cognitive state. Review of the MDS assessment revealed Resident #67 had both short-term and long-term memory problems and his cognitive skills for daily decision making were severely impaired. Further review of this MDS assessment revealed Resident #67 required assistance with all functional abilities including, but not limited to, hygiene, bathing, dressing, repositioning, transferring, toileting, and walking.Review of the facility-substantiated SRI tracking number 266894, dated 10/28/25, revealed on 10/28/25 at approximately 3:30 A.M., Certified Nursing Assistant (CNA) #500 became aggravated with Resident #67 and yelled in his ear and cursed at him. In addition to this verbal abuse, CNA #500 physically abused Resident #67 by grabbing his arm forcefully, shoving him out of his wheelchair, and aggressively throwing him into his bed. Further review of this SRI revealed Registered Nurse (RN) #240 was also verbally abusive to Resident #67. These events were witnessed by CNA #384 at the time of occurrence.Review of the facility investigation revealed Resident #240 had not yelled at Resident #67 but pointed at CNA #384 and CNA #500 telling them to stop and we are done with this.Review of the employee timecard revealed CNA #500 punched out on 10/28/25 at 6:09 A.M.Interview on 04/09/26 at 12:24 P.M., CNA #384 revealed there was no supervisor working the night this occurred, but she told Licensed Practical Nurse (LPN) #333, the unit nurse, approximately 10-15 minutes after the incident occurred. She stated that LPN #333 told her to write a statement and e-mail it to her and she would notify the Director of Nursing (DON) and the Administrator. CNA #384 sent this requested written statement to LPN #333 within one hour of the incident occurring.Interview on 04/09/26 at 11:55 A.M. with the Assistant Director of Nursing (ADON) #503, the DON, and the Administrator revealed the DON was not notified of this incident until 10/28/25 at 5:54 A.M., two hours and 24 minutes after the incident occurred. Further interview with ADON #503, the DON, and the Administrator, revealed CNA #500 remained on the unit after the incident occurred on 10/28/25 at approximately 3:30 A.M. until she punched out at 6:09 A.M.Review of the facility policy titled Review of the facility policy titled, Abuse, Neglect, and/or Misappropriation of Resident Funds or Property Policy, revised 01/20/25, revealed staff shall report all incidents immediately to their direct supervisor. Once the Administrator and ODH are notified, an investigation of the allegation or suspicion will be conducted. The investigation shall be completed, whenever practical, within twenty-four (24) hours after the Administrator, but in no event shall the investigation take longer than five (5) working days.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of the facility Self-Reported Incident (SRI), review of the facility investigation, review of witness statements, review of the employee timecard punches, and policy review, the facility failed to ensure an allegation of physical and verbal abuse were thoroughly investigated and to prevent potential further abuse. This affected one (Resident #67) out of three residents reviewed for abuse. The facility census was 93.Findings Include:Review of the medical record for Resident #67 revealed an admission date of 08/05/25. Diagnoses included neurocognitive disorder with Lewy bodies, major depressive disorder, cognitive communication deficit, abnormalities of gait and mobility, dementia, Parkinson's disease, restless leg syndrome, hypertension, benign prostatic hyperplasia, insomnia, sleep apnea, parasomnia, REM (rapid eye movement) sleep behavior disorder, and generalized muscle weakness.Review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #67 revealed a Brief Interview of Mental Status (BIMS) score was unable to be determined due to his cognitive state. Review of the MDS assessment revealed Resident #67 had both short-term and long-term memory problems and his cognitive skills for daily decision making were severely impaired. Further review of this MDS assessment revealed Resident #67 required assistance with all functional abilities including, but not limited to, hygiene, bathing, dressing, repositioning, transferring, toileting, and walking.Review of the facility-substantiated SRI tracking number 266894, dated 10/28/25, revealed on 10/28/25 at approximately 3:30 A.M., Certified Nursing Assistant (CNA) #500 became aggravated with Resident #67 and yelled in his ear and cursed at him. In addition to this verbal abuse, CNA #500 physically abused Resident #67 by grabbing his arm forcefully, shoving him out of his wheelchair, and aggressively throwing him into his bed. Further review of the SRI revealed Registered Nurse (RN) #240 was also verbally abusive to Resident #67. These events were witnessed by CNA #384 at the time of occurrence. Further review of the SRI tracking number 266894 revealed no investigation regarding Resident #67 being physically abused by CNA #500 nor did it include investigation regarding Resident #67 being verbally abused by RN #240. Review of CNA #384's written statement of events, found in SRI tracking number 266894 investigation, revealed she was attempting to help Resident #67 safely to a wheelchair, when CNA #500 to help her. CNA #500 began to shout at Resident #67 in an aggressive tone forcing him to sit. CNA #500 then began to slam the wheelchair pedals shut aggressively. While attempting to assist Resident #67 to bed, CNA #500 stepped in and began to scream at Resident #67 to stand up right now in his ear. CNA #500 proceeded to grab his arm and forcefully shove him out of the chair in a very unsafe manner as the wheelchair was unlocked. CNA #500 continues shouting and arguing with Resident #67. CNA #500 proceeds to throw Resident #67 in bed. As CNA #500 is doing this, she is shouting at Resident #67 the entire time, we aren't going to do this and she is cursing at him. CNA #500 threw Resident #67's legs into the bed very aggressively and Resident #67 states please stop and begins to cry. At this time, RN #240 enters Resident #67's room, after Resident #67 was in bed, under the covers, and crying, and points his finger at Resident #67, and aggressively and loudly says, you're going to stop right now and stop right now, and repeats this at least five time in a screaming and aggressive tone. At this time, Resident #67 is still crying and not being combative.Review of the facility investigation revealed Resident #240 had not yelled at Resident #67 but pointed at CNA #384 and CNA #500 telling the CNA's to stop and we are done with this. The investigation revealed RN #240 was not suspended during the investigation and physical abuse had not been thoroughly investigated. The investigation revealed CNA #500 was terminated on 10/31/25 related to the incident.Review of the employee timecard revealed CNA #500 punched out on 10/28/25 at 6:09 A.M.During an interview on 04/09/26 at 12:24 P.M. with CNA #384, CNA #384 was able to recount the events that occurred on 10/28/25 at approximately 3:30 A.M., and this recollection aligned with the written statement that she provided at the time of the event occurrence. CNA #384 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that it was her belief that Resident #67 was verbally and physically abused by CNA #500 and verbally abused by RN #240. CNA #384 stated that when RN #240 was shouting at Resident #67, he was standing beside the resident's bed and was leaning over Resident #67 and was repeatedly shouting, you're going to stop right now and stop right now. CNA #67 stated that this event was upsetting to her to witness. During an interview on 04/09/26 at 12:35 P.M., RN #240 could not recall the incident or any details surrounding it.Interview on 04/09/26 at 2:47 P.M., the ADON #503, the Director of Nursing (DON), and the Administrator revealed that the facility had not completed an investigation regarding Resident #67 being physically abused by CNA #500 nor did it include investigation regarding Resident #67 being verbally abused by RN #240. Review of the facility policy titled, Abuse, Neglect, and/or Misappropriation of Resident Funds or Property Policy, revised 01/20/25, revealed abuse means the willful infliction of intimidation, or punishment with resulting physical pain, verbal or mental anguish. Verbal abuse refers to any use of oral, written, gestured language that willfully includes disparaging and derogatory terms to residents. CMS defines mistreatment as the inappropriate treatment or exploitation of a resident. This includes abuse, which is previously defined. An investigation of the allegation or suspicion will be conducted. The investigation shall be completed, whenever practical, within twenty-four (24) hours after the Administrator, but in no event shall the investigation take longer than five (5) working days.