

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455996	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER The Renaissance at Kessler Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2428 Bahama Dr Dallas, TX 75211	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581</p> <p>Based on interviews, and record reviews, the facility failed to ensure each resident had the right to be free from abuse for four (Residents #1, #2, #3, #4) of 9 residents reviewed for Abuse.</p> <p>1. The facility staff failed to ensure Resident #1 did not hit Resident #2, which resulted in Resident #2 getting a skin tear to his face in the dining room on 09/14/24.</p> <p>2. The facility staff failed to ensure Residents #3 did not throw orange juice twice, at Resident #4, which resulted in Resident #4 hitting Resident #3 in the face and causing redness to Resident #3's face, in the dining room on 09/13/24.</p> <p>These failures could place residents at risk of injuries such as fractures, bruising, skin tears, and psychological harm resulting in decreased health and psycho-social well-being.</p> <p>Findings included:</p> <p>1. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a [AGE] year-old female who was admitted to the facility on [DATE] with a BIMS score of 14 (No cognitive impairment), with medically complex conditions including diagnoses of HTN (high blood pressure), renal insufficiency (poor function kidney), DM (Diabetes Mellitus), aphasia (language disorder), non-Alzheimer's dementia (cognitive loss), hemiplegia (one sided weakness), seizure disorder (brain condition causes jerking movements) and depression (sadness).</p> <p>Record review Resident #1's Care Plan dated 08/29/23 revealed, Resident exhibits verbally abusive behaviors at times and is at risk for harm and not having their needs met in a timely manner. Resident curses at residents. Target date 03/27/25: Resident's verbally abusive behavior will not result in harm or injury to self or others through the next review date.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Nurses Note dated: 09/15/2024 at 5:38 pm by RN A revealed, This writer was notified by staff of the above resident who got into an argument with another resident in the dinning [sic] room, Resident #1 was in another resident way to get to his table, Resident #1 refused to move out of the way but continued to argue with the other resident and approached the other resident and gave him a scratch to his left cheek. Both resident were separated for safety with no issues, head to toe assessment completed on the above resident. No noted new injuries or skin issues. Resident denies any pain or discomfort. Vital signs done - 128/74, 18, 97.7, 72, 98% on RA. Resident was educated on the importance of not causing any injuries to another resident. Resident verbalized understanding. FM called and notified, DON, ADON and Doctor aware.</p> <p>During an interview on 01/23/25 at 12:55 pm, Resident #1 was sitting in a scooter and stated a few months ago in the dining room, Resident #2 ran into her scooter because he said she would not move out of his way. She stated she was sitting at the table and Resident #2 just came and bumped her stomach into the table, then she pushed him. She stated he asked why did she hit him and she told him he should have apologized to her. She stated Resident #2 did not apologize and was not sure if he bumped into her on purpose so she pushed him. She stated they had not had any issues since then and they talked to each other and were now on friendly terms. She stated Resident #2 just talked to her today. She stated Resident #2 sat at a different table next to hers and when Resident #2 had to come by her to get to his table, she moved so he could get by without him having to ask.</p> <p>Record review of Resident #2's Annual MDS assessment dated [DATE] revealed a [AGE] year-old male who was admitted to the facility on [DATE] with a BIMS score of 12 (Moderate cognitive impairment). His diagnoses included Non-traumatic Brain Dysfunction (Brain injury), anemia (low iron), HTN (high blood pressure, aphasia (language disorder, cerebrovascular accident (Stroke), non-Alzheimer's dementia (Cognitive loss), seizure disorder brain condition causing jerking movements, depression (sadness), and psychotic disorder (mental disorder/ disconnect from reality).</p> <p>Record review Resident #2's Care Plan dated 01/05/24 revealed, Resident has impaired cognition and is at risk for a further decline in cognitive and functional abilities related to: CVA, DEMENTIA, DELUSION D/O, MDD. Target date: 03/30/2025. He will maintain current level of cognitive function without a decline through the next review.</p> <p>Record review of Resident #2's Nurses Note dated 09/15/2024 at 5:57 pm by RN A revealed, This writer was notified by staff of the above resident who got into argument with another resident in the dinning [sic] room, the other resident (Resident #2) was on his way to get to his table, the other resident (Resident #1) refused to move out of the way but continued to argue with him while approaching towards him and gave him a scratch to his left cheek. Both resident were separated for safety with no issues, head to toe assessment completed on the above resident. No noted new injuries or skin issues. Resident denies any pain or discomfort. Vital signs done - 126/70, 18, 97.6, 70, 98% on RA. Resident stated that he is own RP, DON, ADON and Doctor made aware.</p> <p>During an interview on 01/23/25 at 1:10 pm, Resident #2 was sitting in a manual wheelchair and stated Resident #1 had a motorized wheelchair and was in the dining room a few months ago. She was just right there at the table, but she did not want to listen because she was listening to music and they started yelling at each other. He stated then the staff came to the dining room to stop them. He said Resident #1 did not hit him and they got along with each other now and Resident #1 moved to give him space to his table.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the Facility's Provider Investigation Report dated 09/14/24 at 4:45 pm revealed, Resident #1 was blocking an aisle in the dining room and Resident #2 said Excuse me and asked Resident #1 if she could move up so he could get by. Resident #1 said No then Resident #2 attempted to move Resident #1's wheelchair. Resident #2 attempted to push her chair up a bit and Resident #1 became upset and started hitting Resident #1 in the face and cursing at him. Resident #2 grabbed Resident #1's hands and told her to stop hitting him in the face before he slaps her. Resident #2 said he did not hit women, then he let go of her hands and she scratched his cheek. Provider response: Both residents separated, Resident #1 placed on 1:1, Both residents referred to psych services physician notified, families notified yet both are their own RP, in-services started - abuse, residents with aggressive behaviors towards others. Findings: Confirmed.</p> <p>2. Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed, a [AGE] year-old male who was admitted to the facility on [DATE] with a BIMS Score of 11 (Moderate cognitive impairment). He had diagnoses of non-traumatic brain dysfunction(brain dysfunction) Anemia (low iron), HTN (high blood pressure), renal insufficiency (kidney failure), hyperlipidemia (aphasia, CVA (stroke), Non-Alzheimer's Dementia (Cognitive loss), Anxiety (increase and anxious , Depression (sadness) and Schizophrenia (mental illness).</p> <p>Record review Resident #3's Care Plan dated 01/13/25 revealed, Behavioral Problem: Resident has a behavior problem as evidenced by: altercation with another resident. Target date 01/24/25: The president's behavior will not interfere with the delivery of care or services or result in harm to self or others through the next review date.</p> <p>Record review of Resident #3's Nurses Note dated 09/13/24 at 3:50 pm by LVN B revealed, Resident escorted to north nurse's station from dining room by a nurse who heard him yelling and cursing his table mate while raising his right hand up. He was redirected by the nurse but instead he continued to curse her in Spanish, another resident who understood what he was saying asked him to stop the curse words and instead went to his table tried to curse him too. The other resident asked him what he was going to do and that is when Resident #3 cursed him and threw a glass of juice at him, so the victim swang [sic] at him at hit his mouth area on right side. The other nurse ran and removed Resident #3 out from dining room immediately, and brought him to north hall, and notified this writer. Resident is cursing out saying to be left alone and that he will fight the other patient. He is very agitated and cursing at staff loudly, does not want to listen to anybody Resident was asked if he was in pain denied pain. informed that he should not go to the dining room rather go to his room but refused and stayed at the public TV (television) area. At this time, he was quiet and served coffee. Redirected to voice his needs instead of being frustrated. Verbalized understanding. He then agreed to have head to toe assessment, no swelling to mouth area, no pain or discomfort, DON, Doctor were notified. FM was also notified. Resident had got self-up in WC. placed on 1:1. BP 136/85, 90, 20, 97.0.</p> <p>During an interview on 01/23/25 at 12:41 pm, Resident #3 was sitting in a wheelchair and gestured (shaking his hand sideways) saying he had not thrown orange juice at anyone and had not ever cursed at or hit anyone. He stated no one had hit him.</p> <p>Record review of Resident #4's Annual MDS assessment dated [DATE] revealed a [AGE] year-old male who was admitted to the facility on [DATE], his BIMS score was 15 (no cognitive impairment). He had diagnoses of amputation (body part removal), anemia (low iron), hypertension (high blood pressure), PVN (brain disorder), renal failure (kidney failure), neurogenic bladder (urinary disorder), diabetes (High blood sugar) and no psychiatric or mood disorders.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review Resident #4's Care Plan dated 08/14/23 revealed, The resident has an alteration in neurological status related to cerebral infarction. Target date 04/16/25: The resident, will be able to communicate needs daily through the review date.</p> <p>Record review of Resident #4's Nurses Note dated 09/13/24 at 2:21 pm by LVN C revealed, Nurse was in the dining room for breakfast when she heard a resident yelling and cursing another resident stated while he was in the dining room for breakfast he heard a nurse telling another resident to stop yelling at another resident and to get his hand out of the residents face, then he stated the resident started cursing the nurse out in Spanish calling her MF (mother cuss word), and other words, and I understood what he was saying and I informed him not to say that and then he started cursing me out and pour a glass of juice on me and then I swing back at him and then the nurse ran over to us and removed him Nurse immediately removed the resident that was cursing, head to toe assessment completed, no redness are [sic] bruising are injuries noted. MD notified, DON notified, and resident notified he is his own RP.</p> <p>Interviews on 01/23/25 and 01/24/25 was attempted with Resident #4 but he was unavailable.</p> <p>Record review of the Facility's Provider Investigation Report dated 09/13/24 at 7:45 am revealed, Resident #3 was in the dining room fussing about another resident sitting in his space at the dining room table. Resident #4 argued that Resident #3 was always picking on someone who could not fight for themselves. Then Resident #3 wheeled himself to Resident #4 started threatening to throw orange juice at him and Resident #4 dared him then Resident #3 threw it at Resident #4. Resident #3 grabbed a second cup of juice and began to throw more at Resident #4. Then Resident #4 became upset and wheeled his wheelchair to Resident #3 and hit him in the face. Both residents were separated, assessed and Resident #3 was assessed by LVN B he had some redness to his cheek from being hit in the face. No other injuries. Provider response: Both residents separated, Resident #3 placed on 1:1, both residents referred to psych services, physicians notified, families notified yet both are own RP, Inservice started on abuse, de-escalation of aggressive behavior with a questionnaire and re-educated staff to ensure they were in the assigned areas as required. Both of their medications reviewed and discovered that Resident #3 had a recent GDR of his psychiatric medications, and his medication has been readjusted back to previous level. Findings: Confirmed.</p> <p>During an interview on 01/24/25 at 12:47 pm, Floor Tech D stated after Breakfast a few months ago, she saw Resident #1 and #2 arguing at each other. She stated Resident #1 said Boy I'll knock you out and Resident #2 said I wish you would. She stated they were both yelling, and Resident #1 was swinging her arms at Resident #2. She stated there was no one in the dining room, then LVN E came to the dining room and took Resident #2 away and Resident #1 remained in the dining room with her. She stated they had not had any issues getting along since then.</p> <p>Interview on 01/24/25 at 1:53 pm, CNA F stated Resident #3 was mad about some coffee or something, then went to Resident #4's table and they started fighting each other. She stated they were both cursing, and Resident #4 called Resident #3 the B-word and she saw Resident #4 hit #3 in the face. She stated LVN E was in the dining room at the time and told Resident #4 to back up, back up because he had a motorized wheelchair. She stated LVN E separated them and stated she could not remember Orange Juice being thrown but both of them made contact hitting the other's face. She stated Resident #3's face was a little red one side.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/24/25 at 2:12 pm, LVN E stated a few months ago in the dining room, somebody from the kitchen and other staff were getting the residents ready for breakfast. She stated she was doing blood pressure checks on some of the residents and Resident #3 got mad at another resident for taking his spot. She stated Resident #3 threw orange juice at Resident #4 then Resident #4 put his electric wheelchair in reverse and hit Resident #3 in the face. She stated Resident #3 had no skin alteration, skin tear or redness and then LVN B did Resident #3's skin assessment. She stated she took Resident #3 to his room to assess him and he had no injuries.</p> <p>Interview on 01/24/25 at 2:43 pm, CNA G stated a few months ago, Residents #1 and #2's breakfast trays were being passed out. She stated Resident #2 sat at the table next to Resident #1 and Resident #2 wanted Resident #1 to move over a little so he could get to his table. She stated then Resident #1 hit Resident #2 and was not sure who was watching the residents, but she alerted the nurses and they went to the dining room and intervened. She stated few months ago, around lunch during the 6:00 AM - 2:00 PM Shift, she saw the end part of Residents #3 and #4 incident. She stated by the time she went to the dining room the nurses had made it in there and was separating them. She stated the staff were passing out meals on the halls, when Residents #1, #2, #3 and #4's incidents occurred. She stated the facility normally had staff in the dining room but the days of these incidents, there were none in there. She stated Residents #1, #2, #3, and #4 had been getting along since then.</p> <p>Interview on 01/24/25 at 3:33 pm, Dietary Aide H stated a few months ago they were just about to start serving lunch and she was walking out of the kitchen. She stated Resident #1 was in her wheelchair and Resident #2 passed by and when he moved her up, she jumped up and started cursing. She stated she did not see Residents #1 and #2 hitting each other but they were hollering and cursing. She stated she then she got RN A and a CNA to come to the dining room because there was no staff in there.</p> <p>Interview on 01/24/25 at 3:42 pm, Weekend Receptionist I stated a while ago around lunch, the residents were going into the dining room and they had not started eating yet. She stated none of the nurses or CNA's were in the dining room because they were bringing residents to the dining room. She stated she was just coming out of the housekeeper's closet and was walking by the dining room and saw a housekeeper and RN A headed to the dining room. She stated she saw Resident #1 hitting Resident #2 and he had a scratch on his face and left arm and maybe his right arm also. She stated she helped separate them and Resident #2 said he was trying to get by and said Excuse me to Resident #1 but she did not move. She stated Resident #2 said he pushed Resident #1's chair forward because she was in the center of the area where he sat. She stated Residents #1 and #2 had not had any other issues since then.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/24/25 at 5:28 pm, the DON stated a few months ago in the dining room, the staff reported Resident #1 hit Resident #2 and Resident #2 told Resident #1 to stop hitting him because he did not hit women. She stated the staff saw Resident #1 hit Resident #2 because one of the residents was blocking the other one from getting to their table. She stated it was reported they were both verbally abusive to each other and that Resident #1 had a scratch on his cheek. She stated a few days after she assessed Resident #1 and she did not see anything on his cheek and Resident #1 had no injuries. She stated Residents #1 and #2 had been getting along fine since then. She stated a few months ago staff reported Resident#4 was taking up for another resident who was in Resident #3's chair in the dining room. She stated Resident #3 said he did not like that resident in his seat then Resident #4 said Don't talk to that resident like that. She stated then Resident #3 started yelling at Resident #4 and they started yelling at each other. She stated then Resident #3 threw orange juice at Resident #4 and could not remember if anyone was hit. She stated Resident #4 hit Resident #3 then LVN E was able to separate them .</p> <p>Interview on 01/24/25 at 6:06 pm, the Administrator stated this past September 2024, the staff said Resident #2 asked Resident #1 to move, and Resident #1 started hitting at him and contact was made. She stated Resident #1 went to hitting him in the face and he said stop and grabbed her hands to stop her from hitting him. She stated the staff intervned and assessed Residents #1 and #2 and they had no injuries. She stated this incident was confirmed because of what the residents told her and review of the staff witness statements. She stated this past September 2024, staff reported Resident #3 threw orange juice at Resident #4 and said something in Spanish about a staff. She stated after Resident #3 threw orange juice Resident #4 hit Resident #3 in the face resulting in Resident #3 having redness to his face. She stated when she went to talk to Residents #3 and #4, Resident #3's face was no longer red and Resident #4 had no skin issues. She stated they had not had any issues since then. She stated it was discovered Resident #3 just had a GDR of his medications. She stated this was probably why Resident #3 was acting the way he was and his Doctor put him back on his previous medication dosage and he was doing much better. She stated everyone was responsible for ensuring the residents did not abuse each other but said she was ultimately responsible because she was the abuse coordinator.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's Abuse and Neglect policy dated 10/24/22 and revised 09/06/24 revealed, Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect . Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse .Verbal Abuse means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, within hearing distance regardless of their age, ability to comprehend, or disability. Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. III. Prevention of Abuse, Neglect: The facility will make every effort to prevent and prohibit all types of abuse, neglect, misappropriation of resident property and VI. Prevention of Resident: The facility must make efforts to ensure all residents are protected from physical and psychological harm, as well as additional abuse, during and after the investigation.</p>		