STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555301	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Poway	15615 Pomerado Rd Poway, CA 92064

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review, the facility failed to ensure Resident 7 was not abused. As a result, Resident 7 experienced abuse from two staff members. In addition, other residents who were cognitively impaired (problem with the ability to think, learn, remember, use judgement, and make decisions) had the potential to suffer abuse from the two staff members. Findings: On 9/4/24 at 9:50 A.M., an unannounced visit was made to the facility in response to a reported abuse incident. An observation was conducted on 9/4/24 at 12:49 P.M. Resident 7 was sitting in a wheelchair in the hallway with other residents. Resident 7 had a frown on her face and was hugging a doll. A review of Resident 7 ' s record was conducted. Per the facility ' s face sheet, Resident 7 was admitted to the facility on [DATE]. The Physician Progress Note, dated 8/8/24 indicated Resident 7 ' s diagnoses including senile dementia (a progressive decline leading to loss of memory, language, problem solving, other thinking abilities and loss of independence in daily activities). Resident 7 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 7/31/24, section C0700 through section C1000 indicated Resident 7 had short and long-term memory problem, memory/recall problem and had severely impaired daily decision making. (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: 555301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 - Actual harm

Residents Affected - Few

On 9/4/24 at 12:07 P.M., an interview was conducted with the Director of Nursing (DON), with the Administrator present in the facility ' s conference room. The DON stated that on 1/26/24, she and the administrator received a video call from an attorney who represented Resident 7 ' s family. The DON stated that the attorney informed the DON and the Administrator that Resident 7 ' s family placed a hidden camera in Resident 7 ' s room from 11/29/23 through 1/26/24, which showed assaultive behavior by staff, evidence of shoving and hitting Resident 7, and lack of compassion by staff. The DON stated that she ended the call and directed the issue to the facility ' s risk management (department; the facility ' s process of identifying and controlling threats to an organization). The DON stated that on 8/22/24, she was notified by the [health care system ' s] Chief Nursing Officer (CNO) of videos that involved Resident 7. The DON stated she first viewed the video footage on 8/22/24. The DON stated that she and the Administrator identified two CNAs (CNA 1 and CNA 2) in the video footage. The DON stated that in one video, a third staff member was observing (the abusive behavior toward Resident 7) in the room. The DON stated she was able to identify the third staff member as LN 3 and confirmed all three staff members were employed by the facility in November 2023.

A review of the videos from Resident 7 ' s room was conducted on 9/25/24 at 8:56 a.m. in the facility ' s conference room with the Administrator. The Administrator provided a laptop computer to view the eleven recorded videos. All eleven video footages were not identified with a date and/or time that indicated when the videos of the abuse incidents were taken/recorded. The Administrator identified CNA 1, CNA 2, and LN 3 on the videos.

The undated video number one showed Resident 7 lying in bed wearing only a bra. Resident 7 was speaking in Spanish (unable to understand what the resident was saying in the video), and CNA 1 placed her right hand over Resident 7 ' s mouth and told Resident 7, Shh. CNA 1 then turned/positioned Resident 7 on the right side in a rough manner, pulled out Resident 7 ' s brief from underneath Resident 7, wiped Resident 7 ' s perineum (peri; area of skin between the anus and genitals; private area between the thighs), then turned Resident 7 in a rough manner on to the left side after putting a new brief on Resident 7. Resident 7 was frowning and was communicating to CNA 1 in Spanish (unable to determine what the resident was saying), but CNA 1 was not responding. Video number one lasted one minute.

The undated video number two showed Resident 7 lying in bed. CNA 1 was standing near Resident 7 ' s left side with a vital sign machine (machine that takes temperature, heart rate, blood pressure and oxygen saturation [(oxygen level]). The blood pressure cuff was fastened on Resident 7 ' s left upper arm. CNA 1 placed a thermometer under Resident 7 ' s left underarm and the pulse oximeter (device to take oxygen level) on Resident 7 ' s left finger. Resident 7 moved her left arm and CNA 1 held Resident 7 ' s left arm down and tapped (to strike lightly, usually repeatedly) Resident 7 ' s right side of face with CNA 1 ' s right hand. CNA 1 told Resident 7, Calmate [calm down], do not move, while holding the resident ' s left arm down, Calmate, I told you. Video number two lasted two minutes and 47 seconds.

The undated video number three showed Resident 7 lying in bed and CNA 1 was putting a shirt on Resident 7. CNA 1 put Resident 7 ' s left arm through the sleeve, then resident ' s head. While Resident 7 ' s head was up, CNA 1 hit Resident 7 with an open hand at the back of Resident 7 ' s head. Video number three lasted 22 seconds.

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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 - Actual harm Residents Affected - Few	The undated video number four showed Resident 7 lying in bed. CNA 1 was standing near Resident 7 ' s left side. CNA 1 took a pillow and a doll from Resident 7 ' s right side and threw the pillow and doll on to the overbed table next to the right side of the bed. CNA 1 pulled down the white top sheet, exposed Resident 7 ' s legs, took the pillow from Resident 7 ' s right side, and hit resident on the face with the pillow. CNA 1 then threw the pillow at the foot of the bed. Resident 7 spoke to CNA 1 in Spanish (unable to determine what the resident was saying) and pulled the bottom of her hospital gown and covered her face. CNA 1 took the pillow from under Resident 7 ' s head and threw it at the foot of the bed. Video number four lasted 41 seconds. The undated video number five showed Resident 7 sitting in a wheelchair positioned at the left side of the bed, facing the head of the bed. CNA 1 stood in front of Resident 7 and lifted Resident 7 to a standing position by holding on to Resident 7 ' s left arm. Resident 7 wore a long sleeve shirt and a brief. As CNA 1 lifted Resident 7 off from the wheelchair and almost to a sitting position on the bed, CNA 1 unfastened the tape on the left side of Resident 7 ' s brief. CNA 1 sat resident on the bed, then hit Resident 7 with an open hand on the back of the head with her right hand and placed both hands on Resident 7 ' s head while CNA 1 forcefully pushed Resident 7 ' s head down to lay on Resident 7 ' s left side in bed. Resident 7 was frowning and speaking (unable to determine what the resident was saying) in Spanish. Video number five lasted 26 seconds. The undated video number six showed Resident 7 lying in bed exposed, wearing a long sleeve shirt and brief. CNA 1 was standing at the left side of the bed. CNA 1 pulled off Resident 7 ' s blanket and the pillow from Resident 7 ' s right side and threw the pillow toward the foot of the bed. Resident 7 grabbed a hospital gown, which was on the right side of bed, and CNA 1 grabbed it from Resident 7 and threw it on the floor. CNA 1 raised the height of the bed, pulled the pillow from Resident 7 ' s left side, and threw it on the overbed table on the right side of bed. CNA 1 unfastened Resident 7 ' s brief and stated to resident, Open your legs. Resident 7 was saying something in Spanish (unable to determine what the resident was saying) and tried to hold on to her brief with her right hand. CNA 1 slapped (contact with an open hand) Resident 7 ' s right hand that was holding on to the brief. Resident 7 was speaking in Spanish (unable to determine what the resident was saying), frowning, and crying. Video number six lasted 40 seconds. The undated video number seven showed Resident 7 lying in bed wearing only a brief. CNA 1 was changing Resident 7 ' s brief and was positioned standing at the left side of the bed. CNA 1 walked to the right side of the bed and pushed Resident 7 on the hip to turn the resident on to the left side. Resident 7 held on to the left bedrail and CNA 1 pushed Resident 7 ' s legs, which caused Resident 7 to sit up halfway, at the edge of the bed. CNA 1 pushed on resident ' s right shoulder as she pulled off a gray gown, then a blue gown from under Resident 7. CNA 1 grabbed Resident 7 ' s right arm and pushed Resident 7 to lay back down in bed and pulled Resident 7 ' s legs from a dangling position back to the center of the bed. CNA 1 threw the gowns on the floor and turned Resident 7 ' s body on to the left side. CNA 1 wiped Resident 7 ' s back and buttocks and removed the pad from under Resident 7 while pushing Resident 7 ' s right leg. CNA 1 then pushed Resident 7 ' s right leg again with CNA 1 ' s right hand while CNA 1 ' s left hand held on to Resident 7 ' s right arm. CNA 1 slapped Resident 7 ' s right upper thigh with her right hand. Video number seven lasted one minute. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Villas at Poway		STREET ADDRESS, CITY, STATE, ZIP CODE 15615 Pomerado Rd Poway, CA 92064	

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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 - Actual harm Residents Affected - Few	The undated video number eight showed Resident 7 lying in bed wearing a long sleeve shirt and purple pants that were pulled up to Resident 7 ' s thigh. CNA 1 put pants on Resident 7, turned Resident 7 towards her, then grabbed and pulled Resident 7 ' s long hair up to elevate Resident 7 ' s head, and pulled Resident 7 ' s hair and head towards her (CNA 1). LN 3 entered Resident 7 ' s room and was talking (unable to determine what LN 3 was saying) to CNA 1. LN 3 was facing CNA 1 and Resident 7. The video showed LN 3 ' s back and part of the left side of LN 3 ' s face. As LN 3 was speaking with CNA 1 (unable to determine what LN 3 was saying), Resident 7 ' s head was still being pulled with resident ' s head raised up to CNA 1 ' s upper body. CNA 1 quickly lowered Resident 7 ' s head and fixed (straightened/smoothed over) Resident 7 ' s clothing. Resident 7 was frowning and speaking in Spanish during this video footage (unable to determine what the resident was saying). Video number eight lasted one minute. The undated video number nine showed Resident 7 lying in bed. CNA 1 walked to Resident 7 ' s right side of the bed and pulled the pad under Resident 7 towards her. CNA 1 took a brief from the foot of the bed and walked to Resident 7 ' s right side of the bed. Resident 7 sat up at the side of the bed and CNA 1 pushed Resident 7 ' s head back down in bed, in a rough manner with CNA 1 ' s left hand, then lifted Resident 7 ' s legs from dangling at the edge of the bed and placed them in bed. Video number nine lasted one minute. The undated video number 10 included a title which indicated Shaving cream was applied to Resident 7. Video number ten showed Resident 7 lying on her right side in bed without clothes or a brief. CNA 1 wiped Resident 7 ' s back, back of thighs, and buttock with a white cream. CNA 1 opened a blue pad and white pad, rolled them together and placed them under Resident 7. Video number 10 lasted one minute. The undated video number 11 showed Resident 7 lying in bed, positioned on her left side, facing towards CNA 2, who was standing next to the bed. CNA 2 replaced the pad and brief from under Resident 7. Resident 7 ' s right leg was crossed over the left leg and CNA 2 separated Resident 7 ' s legs open in a forceful manner and pushed Resident 7 ' s right leg with (CNA 2 ' s) right hand to keep Resident 7 ' s legs open. Resident 7 screamed Ahhhh and was crying out loud. Video number 11 lasted 39 seconds. A review of Resident 7 ' s care plans were conducted. Resident 7 ' s care plan for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) indicated .LTC [Long-term Care] ADL Function Rehab .Last Updated on 2/22/24 .Interventions . Provide Assistance to Support Level of Need .Assist With Oral Care/Grooming .Assist With Toileting/Peri Care .Assist With Dressing in Appropriate Clothes .Assist With Bathing to include Shower per Schedule . The care plan regarding Resident 7 ' s behavior indicated .LTC Behavioral Symptoms .Last Updated 9/30/22 . Interventions .Provide Care With Smile, Gentle Touch, Soft Reassuring Voice . During an interview on 9/25/24 at 10:12 A.M. with the DON, the DON acknowledged the abuse of Resident 7, and stated that the videos were devastating and shocking. The DON stated that Resident 7 .looked terrified and experienced pain as it was heard on the video. The DON further stated that CNA 1 and CNA 2 ' s employment at the facility were terminated on 9/18/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Villas at Poway		STREET ADDRESS, CITY, STATE, ZIP CODE 15615 Pomerado Rd Poway, CA 92064	

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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 - Actual harm Residents Affected - Few	During an interview on 10/1/24 at 12:52 P.M. with the DON, the DON stated LN 3 ' s employment at the facility had been terminated but did not recall exact date. Interviews of CNA 1, CNA 2 and LN 3 were not conducted due to CNA 1, CNA 2 and LN 3 were no longer employed at the facility. A review of facility records for CNA 1 titled, Evaluation Report, signed by CNA 1 and the DON on 10/21/23 was conducted. The evaluation report indicated, .Join Date: 1/5/2004 .Status .Active Full-Time . A facility letter addressed to CNA 1 dated 9/18/24 indicated, . After review and consideration of the information, it remains the decision . to terminate your employment effective, 9/18/24 . A review of facility records for CNA 2 titled, Evaluation Report, signed by CNA 2 and the DON on 11/13/23 was conducted. The evaluation report indicated, .Join Date: 9/8/2014 .Status .Active Full-Time . A facility letter addressed to CNA 2 dated 9/18/24 indicated, . After review and consideration of the information, it remains the decision . to terminate your employment effective, 9/18/24 . A review of facility records for LN 3 titled, Evaluation Report, signed by LN 3 and the DON on 11/17/23 was conducted. The evaluation report indicated, .Join Date: 8/30/2004 .Status .Active Full-Time . A facility letter addressed to LN 3 dated 9/5/24 indicated, .This letter is to notify you .to terminate employment .effective, 9/5/24 . A review of the facility ' s policy and procedure (P&P) titled, Abuse Prohibition - Alleged, revised on 10/22/22 was conducted. The P&P indicated, .to protect residents as dependent adults from abuse, neglect, involuntary seclusion, and misappropriation of property for all residents .Physical abuse includes .Assault, battery . Assault with . force likely to produce great bodily injury .Psychological/mental abuse includes fear, agitation .and other forms of serious emotional distress . If a photograph or recordin [sic] of a resident . that it is used demeans or humiliates a resident (s) . regardless of the residents [sic] cognitive status will be considered abuse .

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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** 46235 Based on observation, interview and record review, the facility failed to implement policies and procedures for abuse when: a licensed nurse (LN) did not report a witnessed abuse of one resident. (Resident 7). This failure resulted in an incomplete investigation and protection of residents from the perpetrators. Findings: Resident 7 was admitted to the facility on [DATE], per Resident 7 ' s face sheet. The Physician Progress Note, dated 8/8/24, indicated Resident 7 ' s diagnoses included senile dementia (a progressive decline leading to loss of memory, language, problem solving, other thinking abilities and loss of independence in daily activities). Resident 7 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 7/31/24, section C0700 through section C1000, indicated that Resident 7 had short and long-term memory problem, memory/recall problem, and had severely impaired daily decision making. An interview with certified nursing assistant (CNA) 5 was conducted on 9/4/24 at 10:50 A.M. CNA 5 stated that a witnessed physical abuse of a resident should be reported to the Director of Nursing (DON) and the Administrator right away. During an interview on 9/4/24 at 11:15 A.M. with licensed nurse (LN) 1, LN 1 stated that any physical abuse should be reported to the DON and the Administrator as soon as possible. On 9/4/24 at 12:07 P.M., an interview was conducted with the DON in the facility ' s conference room. The Administrator was present during this interview. The DON stated that on 1/26/24 she received a call from an attorney who represented Resident 7 ' s family. The DON stated that the attorney informed the DON and Administrator that Resident 7 ' s family had placed a hidden camera in Resident 7 ' s room from 11/29/23 through 1/26/24. The DON stated the attorney informed her that there were videos which showed staff ' s lack of compassionate care and abusive behavior. A review of the videos from Resident 7 ' s room was conducted on 9/25/24 at 8:56 a.m. in the facility ' s conference room with the Administrator. The Administrator provided a laptop computer to view the 11 recorded videos. The video footage did not include dates or times that indicated when the abuse incidents occurred. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	One undated video showed Resident 7 lying in bed wearing a long sleeve shirt and purple pants that were pulled up to Resident 7 ' s thigh. CNA 1 put pants on Resident 7, turned Resident 7 towards her, then grabbed and pulled Resident 7 ' s long hair up to elevate Resident 7 ' s head, and pulled Resident 7 ' s hair and head towards her (CNA 1). LN 3 entered Resident 7 ' s room and was talking (unable to determine what LN 3 was saying) to CNA 1. LN 3 was facing CNA 1 and Resident 7. The video only showed LN 3 ' s back and part of the left side of LN 3 ' s face. As LN 3 was speaking with CNA 1, Resident 7 ' s head was still being pulled with resident ' s head raised up to CNA 1 ' s upper body. CNA 1 quickly lowered Resident 7 ' s head and fixed (straightened/smoothed over) Resident 7 ' s clothing. Resident 7 was frowning and speaking in Spanish during this video footage (unable to determine what the resident was saying). A telephone interview was conducted on 10/1/24 at 12:52 P.M. with the DON. The DON acknowledged that LN 3 witnessed abuse of Resident 7, as shown in the video. The DON stated LN 3 was a mandated reporter and expected LN 3 to have reported the incident to her, the supervisor, or to the compliance hotline immediately. The DON further stated she expected all staff to report abuse immediately, per the facility ' s abuse policy. A review of the facility ' s policy and procedure (P&P) titled, Abuse Prohibition - Alleged, revised on 10/22/22 was conducted. The P&P indicated, . SUMMARY/INTENT .to protect residents as dependent adults from abuse . [Mandated Reporter] Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult . including administrators, supervisors, and any licensed staff .that provides care or services for elder or dependent adults . Reports can be made by anyone having knowledge of abuse or information regarding a resident ' s safety and/or well-being. An employee who has knowledge of resident abuse shall report this to their immediate supervisor .If the . abuse occurs within the facility, the facility will contact the California Department of Public Health within 24 hours .

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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 46235

Based on observation, interview, and record review, the facility failed to ensure staff reported a witnessed physical abuse of a resident (Resident 7) who was cognitively impaired (problem with the ability to think, learn, remember, use judgement, and make decisions) to the facility's administration.

This deficient practice had the potential for actual and/or alleged abuse incidents to be unreported and not investigated. In addition, this failure had the potential for residents to be unprotected from abuse.

Findings:

A review of Resident 7 ' s clinical record was conducted.

Resident 7 was admitted to the facility on [DATE], per Resident 7 ' s face sheet. The Physician Progress Note, dated 8/8/24, indicated Resident 7 ' s diagnoses included senile dementia (a progressive decline leading to loss of memory, language, problem solving, other thinking abilities and loss of independence in daily activities).

Resident 7 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 7/31/24, section C0700 through section C1000, indicated that Resident 7 had short and long-term memory problem, memory/recall problem, and had severely impaired daily decision making.

An interview with certified nursing assistant (CNA) 5 was conducted on 9/4/24 at 10:50 A.M. CNA 5 stated that a witnessed physical abuse of a resident should be reported to the Director of Nursing (DON) and the Administrator right away.

An interview with licensed nurse (LN) 1 was conducted on 9/4/24 at 11:15 A.M. LN 1 stated that any physical abuse should be reported to the DON and the Administrator as soon as possible.

On 9/4/24 at 12:07 P.M., an interview was conducted with the DON in the facility ' s conference room. The Administrator was present during this interview. The DON stated that on 1/26/24 she received a call from an attorney who represented Resident 7 ' s family. The DON stated that the attorney informed the DON and Administrator that Resident 7 ' s family had placed a hidden camera in Resident 7 ' s room from 11/29/23 through 1/26/24. The DON stated the attorney informed her that there were videos which showed staff ' s lack of compassionate care and abusive behavior. The DON stated that she ended the call and directed the issue to the facility ' s risk management (department; the facility ' s process of identifying and controlling threats to an organization). The DON stated that on 8/22/24, the Chief Nursing Officer (CNO) notified her of videos that included Resident 7. The DON stated she first viewed the video footage on 8/22/24. The DON stated that she and the Administrator identified two CNAs in the video footage. The DON stated that in one video, a third staff member was observing (the abusive behavior toward Resident 7) in the room. The DON identified the third staff member as LN 3.

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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	A review of the videos from Resident 7 ' s room was conducted on 9/25/24 at 8:56 a.m. in the facility ' s conference room with the Administrator. The Administrator provided a laptop computer to view the 11 recorded videos. The video footage did not include dates or times that indicated when the abuse incidents occurred. One undated video showed Resident 7 lying in bed wearing a long sleeve shirt and purple pants that were pulled up to Resident 7 ' s thigh. CNA 1 put pants on Resident 7, turned Resident 7 towards her, then grabbed and pulled Resident 7 ' s long hair up to elevate Resident 7 ' s head, and pulled Resident 7 ' s hair and head towards her (CNA 1). LN 3 entered Resident 7 ' s room and was talking (unable to determine what LN 3 was saying) to CNA 1. LN 3 was facing CNA 1 and Resident 7. The video only showed LN 3 ' s back and part of the left side of LN 3 ' s face. As LN 3 was speaking with CNA 1, Resident 7 ' s head was still being pulled with resident ' s head raised up to CNA 1 ' s upper body. CNA 1 quickly lowered Resident 7 ' s head and fixed (straightened/smoothed over) Resident 7 ' s clothing. Resident 7 was frowning and speaking in Spanish during this video footage (unable to determine what the resident was saying). A telephone interview was conducted on 10/1/24 at 12:52 P.M. with the DON. The DON acknowledged that LN 3 witnessed Resident 7 being abused, as shown in the video. The DON stated that LN 3 was a mandated reporter and expected LN 3 to have reported the incident to her, the supervisor, or to the compliance hotline immediately. The DON further stated she expected all staff to report abuse immediately. A review of the facility ' s policy and procedure (P&P) titled, Abuse Prohibition - Alleged, revised on 10/22/22 was conducted. The P&P indicated, .Reports can be made by anyone having knowledge of abuse or information regarding a resident ' s safety and/or well-being. An employee who has knowledge of resident abuse shall report this to their immediate supervisor .If the . abuse occurs within the facility, the facility will contact the California Department of Public Health within 24 hours .