STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055742	A. BUILDING _____ B. WING _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR VILLA CARE CENTER	861 S. HARBOR BLVD ANAHEIM, CA 92805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the Abbreviated Survey for Complaint Number: CA00965048. The survey team entered the facility on 6/12/25 at 0647 hours. The facility identified the census as 93. The survey sample size was 4. Inspection was limited to the complaint investigated and did not represent the findings of a full inspection of the facility. * FOR COMPLAINT NUMBER: CA00965048, DEFICIENCIES WERE IDENTIFIED AND CITED AT F609, F610, AND F656. GLOSSARY AND DEFINITIONS: BIMS - Brief Interview for Mental Status (a standardized assessment tool used in healthcare settings, particularly in long term care facilities, to quickly evaluate a patient's cognitive function) CNA - Certified Nursing Assistant DON- Director of Nursing IDT - Interdisciplinary Team LVN- Licensed Vocational Nurse Graze - is a superficial skin injury and can be a single scratch or a grazed area of the skin.	F 000	Harbor Villa Care Center submits this response and plan of correction as a part of the requirements under state and federal law. This plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider. Either by the governmental agencies or third party.	7/11/25

ORANGE D. C. RECEIVED
JUL 3 2025 11:07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 7/3/25

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.

Accepted 7/7/25

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F 000	Continued From page 1 H&P - History and Physical MD - Medical Doctor MDS - Minimum Data Set (an assessment tool) P&P - Policies and Procedures PRN - as needed RN - Registered Nurse SBAR - Situation, Background, Assessment, and Recommendation (a communication tool used by nurses to structure and shareimportant patient information concisely and effectively) TAR - Treatment Administration Record	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609	What corrective action will be accomplished for those residents found to have been affected by the same deficient practice: On 6/12/25, after Administrator and DON were notified of the alleged abuse incident, immediate review of the incident was conducted. Upon review of 5/28/25 incident residents 1 and 2 were separated, monitored, and provided protective measures. Both resident 1 and 2 were assessed by the charge nurse, with no injuries identified. The physician, and responsible parties were notified of the incident. Resident 1 remains in the facility without any physical or psychological distress.	7/11/25

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F 609	Continued From page 2 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility P&P review, the facility failed to implement their P&P on Abuse Investigation and Reporting by failing to report an allegation involving the resident to resident physical altercation between two sampled residents (Residents 1 and 2) when Resident 1 alleged Resident 2 had hit him on the right cheek and Resident 1 had allegedly hit back Resident 2. This failure had the potential to put Residents 1 and 2 and other residents at risk of not being protected against the alleged abuse. Findings: Review of the facility's P&P titled Abuse Investigation and Reporting (undated) showed all the reports of the resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse ") shall be promptly reported to local, state and federal agencies (as defined by current regulations), and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.	F 609	On 6/12/25, the Administrator, DON, RN Supervisor, and charge nurse completed rounds and reviewed facility charts and current residents to determine if any other residents had been affected by the same deficient practice. No other residents were identified to have been affected. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: A comprehensive audit of current residents' records was conducted by the Medical Records Director (MRD), DON, and Administrator on 6/12/25 to assess for any unreported or delayed reports of alleged abuse. No additional incidents of unreported allegations were identified. What measures will be put in place or what systemic changes the facility will make to ensure the deficient practice does not recur: On 6/13/25, 6/26/25, 7/1/25, and 7/2/25 the DON initiated facility-wide in-service training for staff on the facility's Abuse Prevention Policy and Reporting Procedures, in accordance with federal and state regulations. The training emphasized the following: All allegations or suspicions of abuse must be reported immediately to the Administrator (Abuse Coordinator), DON, and appropriate state agencies.	7/11/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 609	Continued From page 3 1. Medical record review forResident 1 was initiated on 6/12/25. Resident 1 was admitted to the facility on 1/8/19, and was readmitted to the facility on 3/9/24. Review of Resident 1's H&P examination dated 8/24/24, showed Resident 1 was competent and able to make decisions. Review of Resident 1's MDS assessment dated 4/22/25, showed a BIMS Summary score of 15, which meant Resident 1 was cognitively intact. Review of Resident 1's Change In Condition notes dated 5/28/25 at 1825 hours,showed the following nursing observations, evaluation, and recommendations: Resident 1 was on his way to the kitchen when the hand of one of the residents that was confused and being moved by the staff accidentally grazed to his right cheek, the charge nurse was notified, the MD was made aware, the responsible party was made aware, no redness or swelling wasnoted on the right cheek, and the ice pack PRN and monitoring were ordered by the MD. 2. Medical record review for Resident 2 was initiated on 6/12/25. Resident 2 was admitted to the facility on 11/14/24, and readmitted on 5/15/25. Review of Resident 2's H&P examination dated 5/17/25, showed Resident 2 was competent and able to make decisions. On 6/12/25 at 0950 hours, a telephone interview was conducted with CNA 1 who was present at the time of the incident on 5/28/25. CNA 1 was asked to share the details of what happened last	F 609	Immediate protection of the resident involved is mandatory while the investigation is ongoing. Documentation of the incident, notification of responsible parties, and reporting to regulatory agencies must be completed promptly. Staff understanding of the difference between suspicion of abuse and confirmed abuse, reinforcing the obligation to report suspected abuse without delay. The Abuse Policy has been updated to include a mandatory reporting checklist to assist staff in ensuring compliance. The Abuse Coordinator (Administrator) will review all incident reports weekly for compliance with reporting protocols. How the facility will monitor its performance to ensure solutions are sustained: The Medical Records Director will conduct weekly audits of incident reports for 3 months starting the month of June to September 2025 to verify timely reporting and documentation of suspected abuse. Results of the audits and any identified deficiencies will be presented to the monthly QA Committee for review and further action. Quarterly QA meetings will continue to review trends, audit findings, and provide recommendations for ongoing compliance for a minimum of two quarters or until compliance is fully sustained. The Administrator (Abuse Coordinator) and DON will provide ongoing oversight to ensure that all reporting requirements remain in full compliance with regulations	7/11/25

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F 609	Continued From page 4 5/28/25, between Residents 1 and 2. CNA 1 stated he did not see what happened; however, Resident 1 told him Resident 2 had hit him, and Resident 1 had hit back Resident 2. On 6/12/25 at 1329 hours, an interview was conducted with LVN 1 who was the charge nurse on duty on the morning shift of 5/28/25. LVN 1 was asked if he knew about the incident between Residents 1 and 2. LVN 1 stated he knew a couple of weeks ago, there was an altercation between Residents 1 and 2. LVN 1 further statedthe altercation between Residents 1 and 2 was considered an abuse, it should have been reported, a change of condition should have been done forboth Residents 1and 2, and further monitoring for both residents should have been done. On 6/12/25 at 1509 hours, an interview was conducted with CNA 2 who was assigned to Resident 2 during the alleged incident of physical altercation between Residents 1 and 2 on 5/28/25. CNA 2 was asked to share the details of the allegedincident last 5/28/25, between Residents 1 and 2. CNA 2 stated Resident 1 was on a wheelchair behind Resident 2 who was asking for water. CNA 2 further stated Resident 2 swayed his left arm and touched Resident 1's cheek by accident whichmade Resident 1 to keep saying Resident 2 hit him. CNA 2 stated she reported to LVN 2 who was the charge nurse at the time. On 6/12/25 at 1520 hours, an interview and concurrentmedical record review was conducted with the DON. The DON was asked if the incident between Residents 1 and 2 should have been reported to the CDPH L&C Program and	F 609		

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F 609	Continued From page 5 law enforcement entities. The DON verified the allegedincident regarding physical altercation between Residents 1 and 2 should have been reported and thoroughly investigated. The DON acknowledged and verified the findings.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility P&P reviewed, the facility failed to thoroughly investigate an alleged incident involving the resident to resident physical altercation between two sampled residents (Residents 1 and 2) when Resident 1 alleged Resident 2 had hit him to the right cheek and Resident 1 had allegedly hit back Resident 2. This failure had the potential to put Residents 1 and 2 and other residents at risk of not being	F 610	What corrective action will be accomplished for those residents found to have been affected by the same deficient practice: On 6/25/25 upon notification of the alleged violation, the facility immediately initiated an investigation following the facility's Abuse Policy and Investigation Protocol. The involved resident (Resident 1) was assessed with no injuries noted, and protective measures were implemented during the immediate period of the alleged incident. The responsible parties (resident 1 is self-responsible, and responsible party for resident 2) were notified. The alleged perpetrator (resident 2) was discharged to a different facility on 6/17/25. On 6/25/26 and 6/26/25, the Administrator, DON, Medical Records Director, and Social Services reviewed current residents to ensure no other unresolved allegations were pending investigation. No other residents were identified as affected. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: A review of the incident/accident logs, grievance logs, and nursing notes was conducted on by the Administrator (Abuse Coordinator) DON, Medical Records Director, and Social Services on 6/25/25 to ensure that any previous allegations had been fully investigated, resolved, and documented appropriately. No additional concerns requiring investigation were identified.	7/11/25

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F 610	Continued From page 6 protected against the alleged abuse. Findings: Review of the facility's P&P titled Abuse Investigation and Reporting (undated) showed all the reports of the resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse ") shall be thoroughly investigated by facility management. Findings of abuse investigations will also be reported. 1. Medical record review forResident 1 was initiated on 6/12/25. Resident 1 was admitted to the facility on 1/8/19, and readmitted on 3/9/24. Review of Resident 1's H&P examination dated 8/24/24, showed Resident 1 was competent and able to make decisions. Review of Resident 1's MDS assessment dated 4/22/25, showed a BIMS Summary score of 15 which meant Resident 1 was cognitively intact. Review of Resident 1's Change In Condition notes dated 5/28/25 at 1825 hours, showed Resident 1 was on his way to the kitchen when the hand of one of the residents that was confused and being moved by the staff accidentally grazed to his right cheek. 2. Medical record review forResident 2 was initiated on 6/12/25. Resident 2 was admitted to the facility on 11/14/24, and readmitted on 5/15/25. Review of Resident 2's H&P examination dated 5/17/25, showed Resident 2 wascompetent and	F 610	What measures will be put in place or what systemic changes the facility will make to ensure the deficient practice does not recur: On 6/13/25, 6/26/25, 7/1/25/, and 7/2/25 the DON conducted in-service training to staff on the facility's Abuse Prevention, Reporting, and Investigation policies, emphasizing: All allegations of abuse must be reported immediately. Prompt initiation of investigations upon receiving allegations. Documentation of each step of the investigation process. Implementation of protective measures during investigations. Timely reporting of findings and corrective actions taken. Abuse Binders were placed in each nursing station with an investigation checklist to guide staff with proper documentation and timely follow-up. The Administrator (Abuse Coordinator) will review all incident reports weekly to confirm that any allegations are promptly investigated and resolved according to policy. How the facility will monitor its performance to ensure solutions are sustained: The Administrator (Abuse Coordinator), DON, and Medical Records Director will audit all investigation files weekly for the month of June to September 2025 to ensure allegations are investigated promptly and thoroughly, with documentation completed accurately. Results will be reviewed during monthly QA meetings, and trends or gaps will be addressed immediately. Quarterly reviews will continue thereafter to ensure continued compliance with regulations. The Administrator and Medical Records Director will oversee ongoing compliance, ensuring all allegations are investigated and resolved promptly.	7/11/25

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F 610	Continued From page 7 able to make decisions. On 6/12/25 at 0950 hours, a telephone interview was conducted with CNA 1 who was present at the time of the incident on 5/28/25. CNA 1 was asked to share the details of what happened last 5/28/25, between Residents 1 and 2. CNA 1 stated he did not see what happened however, Resident 1 told him Resident 2 hit him, and Resident 1 hit back Resident 2. On 6/12/25 at 1329 hours, an interview was conducted with LVN 1 who was the charge nurse on duty on the morning shift of 5/28/25. LVN 1 was asked if he knew about the incident between Residents 1 and 2. LVN 1 stated he knew a couple of weeks ago there was an altercation between Residents 1 and 2. On 6/12/25 at 1509 hours, an interview was conducted with CNA 2 who was assigned to Resident 2 during the alleged incident of physical altercation between Residents 1 and 2 on 5/28/25. CNA 2 was asked to share details of the allegedincident last 5/28/25, between Residents 1 and 2. CNA 2 stated Resident 1 was on a wheelchair behind Resident 2 who was asking for water. CNA 2 stated Resident 2 swayed his left arm and touched Resident 1's cheek by accident whichmade Resident 1 to keep saying Resident 2 hit him. CNA 2 stated she reported to LVN 2 who was the charge nurse at the time. On 6/12/25 at 1520 hours, an interview and concurrent medical record review was conducted with the DON. The DON was asked for the investigation conducted for the incident on 5/28/25, for Residents 1 and 2. The DON was unable to provide evidence the incident on	F 610		

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F 610	Continued From page 8 5/28/25, between Residents 1 and 2 was investigated. There were no interviews conducted with the staff that were present or witnessing the incident such as the CNAs, LVNs, and RNs. The DON verified the allegedincident between Residents 1 and 2 on 5/28/25, should have been thoroughlyinvestigated. The DON acknowledged and verified the findings.	F 610		
F 656 SS=B	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656	What corrective action will be accomplished for those residents found to have been affected by the same deficient practice: On 6/13/25, the IDT (Interdisciplinary Team), including the Administrator, DON, MDS Coordinator, Social Services, and Dietary Manager, reviewed and updated the care plan of the identified resident to ensure it was comprehensive, addressing all assessed needs, goals, and interventions, including psychosocial, medical, and functional needs. The resident and responsible party were included in the care plan discussion, and documentation was completed in the medical record. On 6/13/25 the DON and MDS Coordinator reviewed other residents' active care plans for gaps or incomplete documentation. No other residents were found to have been affected by incomplete or non-comprehensive care plans. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: A facility-wide audit of all current residents' care plans was initiated on 6/13/2025 by the Medical Records Director, MDS Coordinator, and reviewed by the DON to ensure all plans reflected residents' current status, needs, goals, and preferences. Any identified discrepancies were corrected immediately, with the care plan updated, and responsible parties notified as appropriate. No additional concerns were identified.	7/11/25

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F 656	Continued From page 9 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility P&P review, the facility failed to develop the comprehensive plans of care to reflect the individual care needs for residents (Residents 1 and 2). * The facility failed to develop a comprehensive person-centered care plan for Residents 1and 2 addressing the incident when Resident 1was grazed to his right cheek by Resident 2who was confused. This failure had the potential risk of not providing the appropriate, consistent, and individualized care to the residents. Findings: Review of facility's P&P titled Care Planning - Interdisciplinary Team (undated), showed the facility's Care Planning/ Interdisciplinary Team is responsible for the development of an	F 656	What measures will be put in place or what systemic changes the facility will make to ensure the deficient practice does not recur: On 6/13/25, 6/26/25, 7/1/25/, and 7/2/25 an in-service training was conducted by the DON for licensed nurses and IDT members on the requirements for developing and implementing a comprehensive care plan per federal and state regulations. Training emphasized: Care plans must address identified needs from resident assessments. Care plans must include measurable goals, specific interventions, and timelines. Involvement of residents and/or responsible parties in care-plan development. Timely updates to care plans when changes in condition occur. The MDS Coordinator conduct care plan audit to ensure completeness, resident-specific interventions, and timely updates. The IDT will conduct care plan reviews in weekly clinical meetings and quarterly care plan meetings with resident/family participation. How the facility will monitor its performance to ensure solutions are sustained: The DON and MDS Coordinator will conduct random audits of 5 resident care plans weekly for June to September 2025 to ensure compliance with comprehensive care plan requirements. Findings will be presented at the monthly QA meetings for review, trend monitoring, and corrective action planning if needed. Audits will continue quarterly thereafter to ensure ongoing compliance. The Administrator and DON will provide oversight to ensure care plans remain current, complete, and compliant with regulations.	7/11/25

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR VILLA CARE CENTER	861 S. HARBOR BLVD ANAHEIM, CA 92805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 10 individualized comprehensive care plan for each resident. Review of the facility's P&P titled Care Plans-Comprehensive (undated) showed an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation. 1. Our facilities Care Planning Interdisciplinary team in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 1. Medical record review for Resident 1 was initiated on 6/12/25. Resident 1 was admitted to the facility on 1/8/19, and was readmitted to the facility on 3/9/24. Review of Resident 1's H&P examination dated 8/24/24, showed Resident 1 was competent and able to make decisions. Review of Resident 1's MDS assessment dated 4/22/25, showed a BIMS Summary score of 15, which meant Resident 1 was cognitively intact. Review of Resident 1's Change In Condition notes dated 5/28/25 at 1825 hours, Resident 1 was on his way to the kitchen when the hand of one of the residents that was confused and being moved by the staff accidentally grazed on his right cheek. Review of Resident 1's care plan problem failed	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055742	A. BUILDING _____ B. WING _____	C 06/12/2025

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F 656	Continued From page 11 to show a care plan was initiated on the day of the alleged incident to address the incident when Resident 1's cheek was allegedlygrazed by the hand of Resident 2 who was confused. 2. Medical record review for Resident 2 was initiated on 6/12/25. Resident 2 was admitted to the facility on 11/14/24, and wasreadmitted on 5/15/25. Review of Resident 2's H&P examination dated 5/17/25, showed Resident 2 was competent and able to make decisions. Review of Resident 2's Care plan problem failed to show a care plan was initiated on the day of the alleged incident to address the incident when Resident 2's hand allegedly grazed the right cheek of Resident 1. On 6/12/25 at 1520 hours, an interview and concurrent medical record review for Residents 1 and 2 was conducted with the DON. The DON was asked to show if there was a care plan problem initiated for Residents 1 and 2 to address the alleged physical altercation between both residents when Resident 1's cheek was grazed by Resident 2. The DON verified the care plan problems related to the incident were both missed for Residents 1 and 2. The DON also acknowledged Resident 1's care plan problem related to the incident was just done on6/12/25, which was past due date from the alleged incident on 5/28/25.	F 656		