| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 555114 | A. BUILDING _____ B. WING _____ | C 03/20/2025 |

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| DRIFTWOOD HEALTHCARE CENTER | 4109 EMERALD ST TORRANCE, CA 90503 |

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| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health during an abbreviated standard survey for one Facility Reported Incidents and one complaints.<br><br>Facility Reported Incident Numbers: CA00952206<br>Complaint Numbers: CA00952269<br><br>The inspection was limited to the specific Facility Reported Incident and Complaint investigated and does not represent the findings of a full inspection of the facility.<br>Deficiencies were issued for the Facility Reported Incident: CA00952206 and complaint number: CA00952269 at F600 and F610. | F 000 | **Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law.** | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure one of three | F 600 | **Free from Abuse and Neglect CFR(s): 483.12(a)(1)**<br><br>**Corrective action:**<br><br>• On 3/17/25 Resident 1 was placed with a 1:1 sitter to make the resident feel secure and safe.<br>• On 3/17/25 Resident 2 was on 1:1 staff to monitor his whereabouts.<br>• Torrance Police were notified on 3/17/25. Officer Garcia spoke to resident 2 to investigate the alleged sexual abuse.<br>• Resident 1 was sent to Torrance Memorial Medical Center ER on 3/18/25 for further evaluation. Resident | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/10/25

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.

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| F 600 | Continued From page 1<br>sampled residents (Resident 1) was free from sexual abuse.<br><br>This deficient practice resulted in Resident 2 entering Resident 1's room unbeknownst to staff on 3/17/2025 at approximately 11 p.m., unfastening her (Resident 1's) incontinent brief and touching her private area, causing Resident 1 to feel scared and helpless. This deficient practice had the potential for Resident 1 to suffer emotional consequences and for other residents in the facility to be subject to the same abuse.<br><br>Findings:<br><br>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on 3/30/2024 and readmitted on 3/7/2025 with diagnoses including muscle weakness.<br><br>During a review of Resident 1's History and Physical (H/P), dated 3/8/2025, the H/P indicated Resident 1 had the capacity to understand and make decisions.<br><br>During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 3/14/2025, the MDS indicated Resident 1's cognitive (ability to think, understand, learn, and remember) skills for daily decision making were intact. | F 600 | came back the same day with no unusual symptoms and trauma reported.<br>• Resident 2 was sent to LADMC on 3/18/25 for evaluation and no longer resides in the Facility.<br>• Resident 1 was seen and evaluated by the Psychiatrist on 3/19/25. Resident 1 had verbalized to the psychiatrist that she is coping well and feels safe in the Facility.<br>• Resident 1 was monitored for anxiety.<br>• IDT was initially done on 3/18/25 with spouse. Follow up IDT with Resident 1 and spouse on 3/21/25 regarding the outcome of the investigation giving emphasis on Resident 2 is no longer in the facility, copy of the video was sent to Torrance police for evidence, additional interventions done by the facility to prevent other resident entering resident room. Both Resident 1 and spouse had verbalized satisfaction and felt safe in the facility.<br><br>**How to identify potentially affected other:** | |

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| F 600 | Continued From page 2<br>During a review of Resident 1's Change of Condition ([COC] a significant change in resident's status that requires intervention) dated 3/17/2025, the COC indicated Resident 1 reported a sexual abuse encounter at approximately 11 p.m., on 3/17/2025.<br><br>During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was initially admitted to the facility on 1/23/2025 and readmitted on 3/3/2025 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremors) and dementia (a progressive state of decline in mental abilities).<br><br>During a review of Resident 2's H/P, dated 3/4/2024, the H/P indicated Resident 2 did not have the capacity to make decisions.<br><br>During a review of Resident 2's MDS, dated 3/7/2025, the MDS indicated Resident 2 had moderate cognitive impairment (a brain condition that causes subtle changes in thinking and memory, resulting in more difficulty with these functions than is expected for someone's age).<br><br>During an interview on 3/19/2025, at 11:45 a.m., Resident 1 stated on 3/17/2025 at night (approximately 11 p.m.) she was in her bed sleeping when she was awakened because she felt cold air on her private area and something cold on her left hip and groin area. Resident 1 stated her diaper was unfasted on the left side, and her pubic area was exposed and when she | F 600 | • On 3/25/25 all Department managers interviewed the Resident assigned to their ambassador rounds asking if another resident and specifically describing profile of Resident 2 entered their room. There was no other resident who entered their room.<br>• SSD and DON interviewed all current residents from room 1-26 on 3/25/25 and there was no other resident affected from the same deficient practice.<br>• Based on the Department Managers interview as well as preview of video surveillance, no other Resident was affected by this concern.<br><br>**Measures/Systemic change:**<br><br>• The Administrator gave in-service to 11-7 staff on 3/18/25 regarding Abuse reporting.<br>• Administrator gave in service to all Department Manager on 3/18/25 regarding Abuse.<br>• RN supervisor 1 was given 1:1 in- service on 3/20/25 by DON regarding Abuse giving emphasis on making sure that alleged victim will feel safe and | |

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| F 600 | Continued From page 3<br>looked up, she saw a man who appeared to be a resident, wearing a knit cap with a pom-pom (round ball of yarn) on top of the cap, standing to the left side of her bed looking down on her. Resident 1 stated she screamed, and the resident opened the door and left her room leaving the door open. Resident 1 stated she called out for help and when Registered Nurse (RN) 1 came to her room, she told RN 1 that a man came into her room and unfastened her diaper and touched her private area. Resident 1 stated, RN 1 asked her, are you sure you weren't dreaming? You were probably sleeping, and then she (RN 1) left the room, as if she (RN 1) didn't believe her. Resident 1 stated, a Certified Nursing Assistant (CNA) came into her room, and she (Resident 1) told her what happened, and CNA 1 left the room. Resident 1 stated she saw Licensed Vocational Nurse (LVN) 1 in the hallway and called her, and LVN 1 came to her room and stayed with her. Resident 1 stated she told everyone who came in her room what happened, and she felt like they did not believe her and thought she was making it up.<br><br>On 3/19/2025, at 1:30 p.m., the facility's video surveillance was viewed with the Administrator (ADM) present. The ADM stated the incident reported by Resident 1 occurred on 3/17/2025 at approximately 11 p.m., and the video's date and time indicated the incident occurred on 3/16/2025 from 7:58 p.m., through 8:30 p.m., which was not accurate. The ADM stated the identity of the man seen in the video was Resident 2. The video's footage and sequence of events are as follows:<br><br>At 7:58 p.m., Resident 2 is seen, wearing a | F 600 | immediately provide another staff to stay with the resident.<br>• The Administrator and DON gave 1:1 in service to Supervisor 1 on 3/24/25 regarding Abuse giving emphasis on identifying alleged abuse, making sure that resident is safe by assuring and keeping the victim safe. Disciplinary action was given to Supervisor 1.<br>• The Administrator and DON gave 1:1 in-service to CNA 1 on 3/21/25 regarding abuse and giving emphasis in making sure that the victim of alleged abuse will not be left alone and immediately inform Supervisor.<br>• DON gave in-service to Nursing staff on 3/18/25, 3/20/25, 3/21/25 regarding Abuse Prevention and Management giving emphasis on making sure to let the victim feel safe and secure by having 1 staff to be with the resident.<br>• Dietary Supervisor gave in-service to kitchen staff on 3/18/25 regarding Abuse.<br>• Rehab Director gave in-service to Rehab staff on 3/21/25 regarding Abuse.<br>• Evening Hallway Monitoring was initiated on 3/22/23 from | |

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| F 600 | Continued From page 4<br>knitted cap with a pom-pom on the top of it, pushing a walker with a seat attached, entering Resident 1's room, closing the door behind him.<br><br>At 8:07 p.m., Resident 2 exits Resident 1's room<br><br>At 8:12 p.m., Resident 2 enters Resident 1's room and closes the door.<br><br>At 8:14 p.m., Resident 2 exits Resident 1's room.<br><br>At 8:15 p.m., RN 1 walks by Resident 1's room and turns her head to look into Resident 1's room, walks past the room toward the end of the hall.<br><br>At 8:16 p.m., RN 1 is seen in the doorway of Resident 1's room (not fully in the room) and is observed standing in the doorway talking to someone in the room, gesturing with her hands and then she leaves room.<br><br>At 8:19 p.m., CNA 1 is seen standing in the doorway of Resident 1's room, talking to someone in the room, CNA 1 then leaves the room.<br><br>At 8:30 p.m., LVN 1 enters room<br><br>During an interview on 3/19/2025, at 3 p.m., RN 1 stated on 3/17/2025 she was walking down the | F 600 | 9 PM to 7 AM. The RN Supervisor will assign staff to make rounds on the hallways to make sure that no resident will attempt to go in other residents' room and to check any resident room that is closed. Nursing Staff will document any findings every 30 minutes in the log between 9PM to 7 AM. The scheduler will assign Nursing Staff 30 min. Of their time to make the rounds. The assigned Nursing Staff will be designated in the sign in sheets. Medical Records and or Designee will audit the Binder daily for charting and documentation for completion weekly. Findings will be discussed in daily clinical meetings for necessary action.<br>• QAPI was initiated on 4/5/25 regarding Abuse.<br><br>**Monitoring:**<br><br>• DON will review the Evening Hall Monitoring Audit report for accuracy. Any negative trends will be discussed and reported in the monthly QA & A meeting for further intervention and compliance.<br><br>**Completed on 4/10/25** | |

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| F 600 | Continued From page 5 | F 600 | | |

hallway when she heard someone in Resident 1's and Resident 3's room asking for help. RN 1 stated, she thought Resident 3 was asking for her diaper to be changed and left the room to call CNA 1 for assistance. RN 1 stated, she thought Resident 1 was asleep and didn't return to the room until CNA 1 and LVN 1 alerted her that Resident 1 reported to them that a man had been in her room and touched her private area.

During an interview on 3/19/2025, at 3:28 p.m., LVN 1 stated on 3/17/2025 at approximately 11 pm., while she was passing medications, she heard Resident 1 calling out from her room. LVN 1 stated Resident 1 appeared very upset and reported that a man had been in her room and touched her private area. LVN 1 stated, she asked Resident 1, "are you sure you were not asleep?" "You could have been sleeping." LVN 1 stated Resident 1 described the man who had been in her room as wearing a knitted hat with a pom-pom on top of it, who was using a walker with a seat attached. LVN 1 stated Resident 1 pointed to her (Resident 1's) left hip area and said, he touched her there. LVN 1 stated she called RN 1 into the room and reported the incident to her.

During an interview on 3/20/2025, at 11:46 a.m., CNA 1 stated on 3/17/2025 while she conducted her rounds, she was directed by RN 1 to assist Resident 1's roommate (Resident 3) who needed a diaper change. CNA 1 stated, when she went to the room Resident 1 was very upset and scared, and she kept repeating that a man came into her room and touched her private area. CNA 1 stated, Resident 1 gave her a description of a man

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| F 600 | Continued From page 6<br>wearing a knit cap. CNA 1 stated, she immediately left Resident 1's room to report the allegation of abuse to another staff member (LVN 1).<br><br>During an interview on 3/20/2025 at 12:06 p.m., the Director of Nurses (DON) stated she was not at the facility alleged abuse occurred, it was reported to her. The DON stated when she arrived at the facility, she spoke to Resident 2 who told her she was not ok and assured her that she (DON) was there for her. The DON stated she encouraged Resident 2 to go to the General Acute Care Hospital (GACH) to be evaluated.<br><br>During a review of the facility's policy and procedure (P/P) titled, "Abuse Preventions, Screening and Training Program" revised 2018, the P/P indicated the facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, and or mistreatment and develops facility policies, procedures, training programs, screening and prevention systems to promote an environment free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment. The administrator as abuse prevention coordinator is responsible for the coordination, and implementation of the facility's abuse prevention, screening and training program policies, sexual abuse is defined as non-consensual sexual contact of any type, sexual harassment, sexual coercion or sexual assault. The P/P indicated the administrator, or designated representative will provide a safe environment for the resident as indicated for the situation. | F 600 | | |

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| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to conduct thorough investigation for one of three sampled residents (Resident 1), when they did not interview other residents in the facility, following an allegation made by Resident 1 that Resident 2 came to her room, which was confirmed by the facility's video surveillance, and touched her private parts.<br><br>This deficient practice resulted in the inability of the facility to determine if Resident 2 had a behavior of entering other resident's rooms and touching them.<br><br>Findings: | F 610 | **Investigate / Prevent / Correct Alleged Violation CFR(s):483.12(c)(2)-(4)**<br><br>**Corrective action:**<br><br>• On 3/20/25 the Administrator reviewed video footage for other random nights (3/7/25 and 3/16/25) with DHS Surveyor and there was no evidence of resident 2 entering into any other resident's room. In addition, on 3/22/25, the Administrator and DON reviewed video footage on additional evenings (3/10/25, 3/12/25 and 3/14/25) and there was no evidence of any resident entering another resident's room.<br><br>**How to identify potentially affected other:** | |

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| F 610 | Continued From page 8<br><br>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on 3/30/2024 and readmitted on 3/7/2025 with diagnoses including muscle weakness.<br><br>During a review of Resident 1's History and Physical (H&P), dated 3/8/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.<br><br>During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 3/14/2025, the MDS indicated Resident 1's cognitive (ability to think, understand, learn, and remember) skills for daily decision making were intact.<br><br>During a review of Resident 1's Change of Condition ([COC] a significant change in resident's status that requires intervention) dated 3/17/2025, the COC indicated Resident 1 reported a sexual abuse encounter at approximately 11 p.m., on 3/17/2025.<br><br>During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was initially admitted to the facility on 1/23/2025 and readmitted on 3/3/2025 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremors) and dementia (a progressive state of decline in mental abilities). | F 610 | • On 3/25/25 all Department managers interviewed the Resident assigned to their ambassador rounds asking if another resident and specifically describing profile of Resident 2 entered their room. There was no other resident who entered their room.<br>• SSD and DON interviewed all current residents from room 1-26 on 3/25/25 and there was no other resident affected from the same deficient practice.<br>• Based on the Department Managers interview as well as preview of video surveillance, no other Resident was affected by this concern.<br><br>**Measures/Systemic change:**<br><br>• The Administrator was given 1:1 in-service by Governing Board Member on 4/6/25 regarding Abuse Investigation giving emphasis on conducting thorough investigation to include interviewing other residents.<br>• The DON was given 1:1 in-service by the Administrator on 4/7/25 regarding Abuse Investigation giving emphasis on conducting thorough | |

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| F 610 | Continued From page 9<br><br>During a review of Resident 2's H/P, dated 3/4/2024, the H/P indicated Resident 2 did not have the capacity to make decisions.<br><br>During a review of Resident 2's MDS, dated 3/7/2025, the MDS indicated Resident 2 had moderate cognitive impairment (a brain condition that causes subtle changes in thinking and memory, resulting in more difficulty with these functions than is expected for someone's age).<br><br>During an interview on 3/19/2025, at 11:45 a.m., Resident 1 stated on 3/17/2025 at night (approximately 11 p.m.) she was in her bed sleeping when she was awakened because she felt cold air on her private area and something cold on her left hip and groin area. Resident 1 stated her diaper was unfasted on the left side, and her pubic area was exposed and when she looked up, she saw a man who appeared to be a resident, wearing a knit cap with a pom-pom (round ball of yarn) on top of the cap, standing to the left side of her bed looking down on her. Resident 1 stated she screamed, and the resident opened the door and left her room leaving the door open. Resident 1 stated she called out for help and when Registered Nurse (RN) 1 came to her room, she told RN 1 that a man came into her room and unfastened her diaper and touched her private area. Resident 1 stated, RN 1 asked her, are you sure you weren't dreaming? You were probably sleeping, and then she (RN 1) left the room, as if she (RN 1) didn't believe her. Resident 1 stated, a Certified Nursing Assistant (CNA) came into her room, and she | F 610 | investigation to include interviewing other residents.<br>• The Administrator gave in-service to Department Managers on 4/7/25 regarding Abuse Investigation, giving emphasis on conducting thorough investigation to include interviewing other residents.<br>• On 4/9/25 the SOC 341 was updated that includes steps to follow for immediate action, SOC 341 Forms, Interview Forms, Local Law enforcement number and Cover sheets for CDHP and Ombudsman for reporting.<br>• On 4/9/25 and 4/10/25 DON gave in-service to the Department Manager regarding the SOC 341 Binder in case they will be the assigned Manager of the Day for the weekend.<br>• On 4/9/25 DON gave in-service to RN supervisor regarding the SOC 341 Binder giving emphasis on immediate action and steps to do during alleged abuse incidents giving emphasis on interviewing alleged victim, alleged abuser, roommates and other resident who is involved and or affected | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555114 | A. BUILDING _____ B. WING _____ | C 03/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| DRIFTWOOD HEALTHCARE CENTER | 4109 EMERALD ST TORRANCE, CA 90503 |

| (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 |
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| F 610 | Continued From page 10<br>(Resident 1) told her what happened, and CNA 1 left the room. Resident 1 stated she saw Licensed Vocational Nurse (LVN) 1 in the hallway and called her, and LVN 1 came to her room and stayed with her. Resident 1 stated she told everyone who came in her room what happened, and she felt like they did not believe her and thought she was making it up.<br><br>During an interview 3/19/2025 at 12:30 p.m., Resident 4 (Resident 2's Roommate) stated Resident 2 liked to walk around in the room and leave the room at night, but he was not sure where he went when he left the room.<br><br>On 3/19/2025, at 1:30 p.m., the facility's video surveillance was viewed with the Administrator (ADM) present. The ADM stated the incident reported by Resident 1 occurred on 3/17/2025 at approximately 11 p.m., and the video's date and time indicated the incident occurred on 3/16/2025 from 7:58 p.m., through 8:30 p.m., which was not accurate. The ADM stated the identity of the man seen in the video was Resident 2. The video's footage and sequence of events are as follows:<br><br>At 7:58 p.m., Resident 2 is seen, wearing a knitted cap with a pom-pom on the top of it, pushing a walker with a seat attached, entering Resident 1's room, closing the door behind him.<br><br>At 8:07 p.m., Resident 2 exits Resident 1's room<br><br>At 8:12 p.m., Resident 2 enters Resident 1's | F 610 | with the incident within 24 hours of the incident.<br>• The Administrator and or designee will review any video footage as necessary within 72 hours of the incident. Other Residents who are affected and or involved with the incident will be interviewed by the Administrator and or Designee within 5 days of investigation.<br>• The Administrator and or designee will provide a written report of the results of all abuse investigation and appropriate action taken to CDPH or local laws with in 5 working days of the reported allegation.<br><br>**Monitoring:**<br><br>When there is an alleged abuse incident, the Supervisor will conduct thorough interviews with staff, residents involved as well as other residents that could have been affected by the allegation. The Administrator and DON will utilize available equipment and tools to investigate thoroughly. Results will be documented, discussed and reported in the monthly QA & A | |

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| F 610 | Continued From page 11<br>room and closes the door.<br><br>At 8:14 p.m., Resident 2 exits Resident 1's room.<br><br>At 8:15 p.m., RN 1 walks by Resident 1's room and turns her head to look into Resident 1's room, walks past the room toward the end of the hall.<br><br>At 8:16 p.m., RN 1 is seen in the doorway of Resident 1's room (not fully in the room) and is observed standing in the doorway talking to someone in the room, gesturing with her hands and then she leaves room.<br><br>At 8:19 p.m., CNA 1 is seen standing in the doorway of Resident 1's room, talking to someone in the room, CNA 1 then leaves the room.<br><br>At 8:30 p.m., LVN 1 enters room<br><br>During a review of the facility's Investigative Report, dated 3/21/2025, the Investigative Report indicated, Resident 2 entered Resident 1's room, per Resident 1's witnessed account and confirmed via video footage. The facility took appropriate and immediate action and provided timely reporting to all agencies and interested parties, this appears to be an isolated, unavoidable, unanticipated and unexpected incident involving Resident 2. | F 610 | meeting for further intervention and compliance.<br><br>Completion Date: 4/10/25 | |

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| F 610 | Continued From page 12<br><br>During an interview on 3/25/2025, at 9:45 a.m., the Director of Nursing (DON) stated the facility had concluded their investigation. The DON stated she and the Administrator (ADM) did not interview all interview able residents in the facility to inquire if Resident 2 or any other residents had entered their rooms without consent. The DON stated she and the ADM determined conducting interviews with staff, Resident 1, Resident 2 and their respective roommates was sufficient to determine that the incident on 3/17/2025 was an isolated event. The DON stated failure to interview other residents in the facility resulted in their investigation not being thorough, which could lead to unrecognized acts of abuse. The DON stated it was important to interview the residents to ensure no other allegation of abuse were occurring.<br><br>During a review of the facility's policy and procedure (P/P) titled, "Abuse Reporting and investigations" revised 3/2018, the P/P indicated the facility promptly reports and thoroughly investigates allegations of abuse. | F 610 | | |