STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165442	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE	1922 FIFTH AVENUE NW , WAVERLY, Iowa, 50677

(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
F0000 x DC	INITIAL COMMENTS Correction date: 9/18/2025 The following deficiencies relate to the investigation of facility reported incident #1721281-M conducted on August 25, 2025 to August 27, 2025. Findings for facility reported incident #1721281-M will be sent to the facility at a later date under separate cover letter. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000	This plan of correction is submitted as the facility's credible allegation of compliance as of 9/18/2025	
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical record review, document review, policy review and staff interview, the facility failed to ensure residents were free from physical abuse when a Certified Nursing Assistant (CNA) tapped a resident on the head during care provision for 1 of 3 residents sampled (Resident #1). The facility identified a census of 87 residents.	F0600	Staff C was separated from residents immediately upon her admission of tapping the resident on the head. On 7/3/2025 Staff C was terminated from employment. Care plan for resident was updated to include interventions regarding behaviors during cares. CNA care sheets updated with bullet point to refer to educational material regarding interventions for any resident that may be combative with cares. A 5 minute meeting note was also hung in nursing areas with this information. All nursing department staff have been assigned 8 hours of dementia training to be completed not only upon hire but annually as well. Team Leaders were provided with access to reports in CE Solutions and will monitor staff monthly for compliance with completing continuing education courses and will report concerns with completion to the human resources department for corrective action with individual employees. Continuing education course "Identifying Elder Abuse and Neglect" was assigned in September 2025 and an additional course on Aggressive Behavior in the Elderly was assigned and is required to be completed by all staff by October 10, 2025. Team Leaders will monitor for completion compliance and report to QAPI Committee in October for review. QAPI Committee members will conduct random audits with nursing staff in all areas to determine their knowledge of the interventions for residents that may be combative with cares and how to identify abuse and report their findings to the QAPI Committee monthly for 3 months in order to ensure monitoring of compliance over time.	

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 reverse for further 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
Veronica Shea	Administrator	9-18-25

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

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F0600 SS = D	Continued from page 1 Findings include: The Minimum Data Set (MDS) Assessment dated 4/24/25 showed a Brief Interview for Mental Status (BIMS) score of 00/15 indicating severe cognitive loss. Resident #1 exhibited inattention (being easily distractible/having difficulty keeping track of what is said) which was continuously present and disorganized thinking (rambling or irrelevant conversation, illogical flow of ideas, or unpredictable switching from subject to subject) continually present. Resident #1 required moderate/partial assistance (helper does less than half the effort. The helper lifts, holds, or supports the trunk or limbs, but provides less than half the effort) with toileting for occasional incontinence of urine and personal hygiene. The MDS listed diagnoses of mild cognitive impairment of uncertain/unknown etiology, other amnesia, reduced mobility and chronic kidney disease. A Facility Investigation Note submitted to the Iowa Department of Inspection, Appeals and Licensing (DIAL) detailed on 7/02/25 Staff A, Registered Nurse (RN) called to inform Staff B, Director of Nursing (DON) of an allegation of abuse. At 4:30 AM, Staff C, CNA went in to assist Resident #1. Resident #1 became aggressive and started to hit and scratch Staff C. Staff C assisted the resident to sit down on her bed and stepped away to calm herself, then went to get Staff A. Staff A finished assisting Resident #1. Resident #1 was calm and compliant. At 5:45 AM, Staff C reported to Staff A when Resident #1 was aggressive earlier, she got frustrated and "tapped" Resident #1 on the head. Staff A asked why Staff C hadn't reported it earlier. Staff C responded, "she just spaced it out." Staff A informed Staff C that is not appropriate behavior and is abuse. Staff A stated she was aware. An undated Statement from Staff A documented at 5:45 AM Staff C came to Staff A and stated that during rounds a resident became aggressive, hitting and scratching at her. During this time, the staff member (Staff C) became frustrated and without thinking, tapped the resident on the head, sat the resident back down on the bed, stepped away to calm herself, then went to get her (Staff A) for assistance. Staff A requested Staff C write a statement and explain why she hadn't reported the incident at the time of the altercation. Staff C stated, "she just spaced it out." When Staff C finished writing her statement, Staff A sent her home. An undated, untimed Statement signed by Staff C, documented Resident #1 was hitting and scratching when she tried to change her brief. Staff C was trying to	F0600		

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F0600 SS = D	Continued from page 2 get the resident to stand up as the resident was hitting. Staff C was blocking the resident and tapped Resident #1 on the head, then sat (kind of guided) the resident back down to the bed, then asked Staff A to help her out. A Disciplinary Notice dated 7/03/25 at 10:00 AM documented on 7/02/25 Staff C reported to the nurse that while she was providing care to a resident, the resident became combative and she tapped the resident on the head. The resident was not injured. Staff C understood is dependent adult abuse and was reportable to DIAL. The Disciplinary Notice documented Staff C was being terminated 7/03/25. Staff C signed the document without dating. The Disciplinary Notice was signed 7/03/25 by Staff B on 7/03/25. A note handwritten on the bottom left corner of the document stated the staff member did not appear remorseful. States she is afraid if it happens again, she might swing on somebody. An 8/25/25 review of Staff C's Employee File revealed a Direct Care Worker (DCW) check showing Staff C with a current CNA certification as of 2/28/25. A Record Check Evaluation prior to employment documented Staff C was arrested and taken into custody on 8/02/23 and charged with a serious misdemeanor conviction for the possession of a controlled substance, marijuana first offense, but was cleared to work as a CNA on 4/17/25. Observation on 8/25/25 at 12:40 PM Resident #1 pushed herself away from the dining room table while seated in her wheelchair. Resident #1 verbalized she needed to, "go." Staff D and Staff E, CNA's assisted Resident #1 to walk to the bathroom, toilet and walk back to the lounge. Staff D and E provided Resident #1 with choices, and were patient with care. Observation on 8/25/25 at 1:44 PM Resident #1 sat in the recliner in the lounge with feet elevated. Resident #1 watched other residents and staff with a calm demeanor. An 8/25/25 at 2:07 PM review of the Care Sheet updated 7/29/25, under Behaviors and Preferences lacked documentation Resident #1 had any behaviors or direction to the staff on what to do for behaviors. The Care Sheet only noted Resident #1 could be hard to wake in the morning. Observation on 8/26/25 at 8:04 AM Resident #1 sat in the doorway of her room in the wheelchair and verbalized she was having a good morning. During interview on 8/25/25 at 12:33 PM Staff D	F0600		

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F0600 SS = D	Continued from page 3 explained when a resident has behaviors, they are to leave the resident alone in a safe environment, give time to calm down, then re-approach. If that doesn't work, they give more time, then have a different staff member re-approach. They also inform the nurse of the behaviors after the first failed attempt. Interview completed on 8/25/25 at 1:42 PM with Staff F, CNA who reported when a resident exhibits behaviors, she would use distraction to break the behaviors. She takes the resident to a calm environment to calm and quiet down, then re-approaches the resident at a later time. During interview on 8/25/25 at 1:49 PM Staff E reported if a resident has behaviors, she tries to approach them calmly; give the resident some time; try a second care giver and that usually works well. During an interview on 8/25/25 at 1:54 PM Staff G, Licensed Practical Nurse (LPN) explained when a resident is combative, they try to be sure the resident is safe. Re-approach a second time. If not successful, then they try a different aide to approach the resident. Sometimes a different face is all the resident needs and they respond. During an interview on 8/25/25 at 2:17 PM Staff H, CNA confirmed she worked the overnight of 7/01/25 to 7/02/25 with Staff C. Staff H reported she didn't know anything had happened to Resident #1 until after it happened. She never saw any agitation or aggression from Staff C but did note Staff C really didn't know how to communicate or talk to residents with dementia. Interview completed on 8/25/25 at 2:50 PM Staff I, RN verbalized Staff C was young and still learning the job. During interview on 8/26/25 at 9:05 AM Staff A explained it happened early in the morning between 4-5 AM during rounds. Staff C came and got her. Resident #1 was combative, hitting her and she needed help with care. They went down to Resident #1's room, but she couldn't recall who entered the room first. Resident #1 was sitting on the side of the bed and was calm. Staff A verbalized she assisted Resident #1 to lay down in bed. Staff A reflected looking back, Staff C didn't do anything after they went back into the room, she just stood there and watched her finish Resident #1's care. Resident #1 did not have any behaviors for her. Staff A further explained the aides usually get Resident #1 up to the toilet on rounds. If the resident refuses to go to the bathroom, then the staff provide a check and	F0600		

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F0600 SS = D	Continued from page 4 change. After that they left the room and continued to do resident rounds. About 1-1.5 hours later, Staff C came to her and stated she had "bopped" Resident #1 in the top of the head. She discussed why Staff C hadn't reported it when she asked her for help earlier. Staff C said she didn't think about it at the time. She instructed Staff C to go to the nurses' station, write a statement and not provide any more resident care. Staff C's demeanor was weird. She didn't seem to have any remorse in her voice, didn't say she was sorry or that she wished she hadn't done it. There was no expression. She didn't come off as feeling bad that it had happened. It was like, "I forgot to tell you I bopped her in the head. I didn't hit her hard. I just bopped her in the head. I just didn't think about it." Staff C made a waving motion with her hand, but Staff A didn't think to have her to demonstrate exactly how she had bopped Resident #1 in the head. She recalled asking Staff C if she understood how serious it was. Staff C stated yes. She understood what she had done. Staff A clarified at the end of the interview between "bopped" and "tapped." Staff A stated whatever she wrote in her original statement is what Staff C said to her. During an interview on 8/26/25 at 11:31 AM Staff J, Co-DON verbalized she came to work and Staff B, the on-call manager that night informed her they needed to do an investigation, but couldn't recall the exact conversation. In the moment, they all felt it was an isolated incident regarding Staff C. It seemed Staff C scared herself on how she handled it (with Resident #1) so she reported it. Staff C came forward and said she did it. Interview completed on 8/26/25 at 11:50 AM Staff B, she had been the on-call manager that morning. Staff A called her about 5:30 AM to 6:00 AM on 7/02/25. Staff A reported Staff C had tapped a resident on the head and Staff C had reported it in. Interview on 8/27/25 at 11:12 AM Staff J explained the staff complete on-line specific dementia training and the dependent adult abuse training. The resident behaviors are listed on the care sheets. Overall if a resident is combative, the staff are to ensure the resident is safe, leave them alone, give time to calm down and then re-approach at a later time. Staff J stated it is not appropriate for any staff to "bop or tap" a resident with their hand during care, that would be physical abuse. She expects if staff become frustrated they will lean on their peers and abuse should not occur. There is always someone else that can take a different approach to assist the resident.	F0600		

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F0600 SS = D	Continued from page 5 During an interview on 8/27/25 at 11:34 AM the Administrator voiced she had been out of the state when the incident occurred with Resident #1. She came in on Wednesday (7/03/25) morning, reviewed the 24-hour report, then went to the dementia unit to talk to Staff A. Staff A informed her Staff C had come up to the nurse's station and confess she had tapped Resident #1 on the head. This was Staff C's first CNA job. It is unfortunate that it (frustration with care) wasn't recognized as a limitation. She is asking leadership to notice if staff are having more burn out or struggling if they need different assignments or more training. It is never appropriate for a staff member to bop, tap or hit a resident. Staff are supposed to treat residents with kindness, dignity and respect while maintaining their rights. During an interview on 8/27/25 at 2:13 PM Staff C, voiced the early morning of 7/02/25 close to 6:00 AM she entered Resident #1's room. Resident #1 lay in a low bed and appeared to be sleeping. She raised Resident #1 bed up and tried to wake her up. Resident #1 was wet and she wanted to change her brief. She sat Resident #1 on the edge of the bed, placed her walker in front of her and put her right arm under Resident #1's left arm to assist her to stand from the bed. Resident #1 as she stood, leaned way forward. The walker fell over to the floor in front of the resident. Resident #1 started flailing her arms, hitting and scratching into the air and at her. Staff C verbalized she had a scratch on her forearm and on her right cheek from the resident. Staff C assisted Resident #1 to sit back down on the side of the bed. As she sat her down, she tapped Resident #1 on the top of her head with the open palm of her right hand. Staff C stated she tapped her like you would tap a dog on the head to get them to behave. Staff C demonstrated and the Surveyor did feel the "bonk" with her right hand, but did not have any lingering effects. Staff A was just outside the room, so she went to the doorway of Resident #1's room and called Staff A in. Staff C voiced Staff A assisted her to stand the resident. Staff C washed Resident #1 up and put a new brief on her. Then Staff A assisted the resident back into bed. Staff C finished doing rounds on three more residents in the dementia unit. After she completed rounds and emptied the garbage, she went to Staff A and said, "yo, I tapped Resident #1 on the head." She had spaced off reporting it earlier. Staff C stated she had tapped Resident #1 on the head without thinking about it. She was scared that if someone swung at her, she might swing back in a reaction. She got scared. It was just a reaction that happened. The Dependent Adult Abuse Prevention Policy, revised	F0600		

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F0600 SS = D	Continued from page 6 11/03/23, included the following definitions: a. Staff: includes employees. b. Abuse: is the willful inflection of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. It includes verbal, physical and mental abuse. c. Willful: means the individual must have acted deliberately, not that he/she must have intended to inflict injury or harm. d. Physical injury to, or injury which is at a variance with the history given of the injury, unreasonable punishment, or assault of a dependent adult which involves a break of skill, care, and learning ordinarily exercised by a caretaker in similar circumstances. The Policy directed the Resident Rights would be posted and resident's or resident representative would be given a copy of the resident right statement and an explanation of their right on admission and annually thereafter. The Facility Resident Bill of Rights documented as a resident of the facility, you have the right to a dignified existence. This facility must treat you with respect and dignity and care for you in a manner and in an environment that promotes maintenance or enhance of your quality of life. You have the right to be treated with dignity and respect.	F0600		
F0610 SS = E	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	F0610	An interdisciplinary approach will be taken for each investigation which will include the Administrator, DONs or designee, Social Services Director and any other departmental team lead dictated by the nature of the investigation. A lead will be determined by the Administrator. The Abuse Investigation Policy (Employee to Resident) Policy has been updated to reflect these changes. A binder of support tools has been provided to each nurses' station with resources to use to aid floor nurses in the event that a manager is not present at the time of the situation. Included are Abuse Non Witness Statement forms, Abuse - Investigative Protocol Checklist, Abuse - Complaint Statement and a Witness Statement Form. These will provide a guideline to floor nurses on what information needs to be gathered at the time of the event. Assessments will be completed on any resident that could have been potentially impacted in the area as deemed necessary by the on call manager. Administrator will be kept up to date on the results of the investigation and other members will be included to determine the next steps in the process and what path the investigation needs to take. The QAPI Committee will review the investigation notes and process after each investigation has been completed to ensure that a thorough investigation has been completed.	

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F0610 SS = E	Continued from page 7 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 clinical record review, policy review, facility investigation review and staff interview the facility failed to complete a thorough investigation after a Certified Nursing Assistant (CNA) reported physical abuse which occurred on the dementia unit affecting 24 of 25 residents (Resident #2, #3,#4, #5, #6, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25 and #26). The facility reported a census of 87 residents. Findings include: A Facility Investigation Note submitted to the Iowa Department of Inspection, Appeals and Licensing (DIAL) detailed on 7/02/25 Staff A, Registered Nurse (RN) called to inform Staff B, Director of Nursing (DON) of an allegation of abuse. At 4: 30 AM, Staff C, Certified Nursing Assistant (CNA) went in to assist Resident #1. Resident #1 became aggressive and started to hit and scratch Staff C. Staff C assisted the resident to sit down on her bed and stepped away to calm herself, then went to get Staff A. Staff A finished assisting Resident #1. Resident #1 was calm and compliant. At 5:45 AM, Staff C reported to Staff A when Resident #1 was aggressive earlier, she got frustrated and "tapped" Resident #1 on the head. Staff A asked why Staff C hadn't reported it earlier. Staff C responded, "she just spaced it out." Staff A informed Staff C that is not appropriate behavior and is abuse. Staff A stated she was aware. The Facility Investigation lacked documentation of resident assessment, or resident and staff interviews regarding abuse. An 8/25/25 Resident Roster review and Brief Interview for Mental Status score review (BIMS is a quick cognitive assessment in a 0-15 scale used in long-term care facilities to assess a resident's cognitive function. The score helps staff to detect early symptoms of cognitive decline. A 13-15 score indicates intact cognition; A 8-12 score indicates a moderate cognitive decline and a score of 7 or less indicates severe cognitive impairment) revealed the following: a. A BIMS score less than 7: Residents #2, #3, #4, #5, #9, #10, #11, #12, #13, #14, #15, #16, #17, #19, #20, #21, #22, #23, #24, #25, #26.	F0610		

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F0610 SS = E	Continued from page 8 b. A BIMS of 8-12: Resident #6, #8, and #18, c. A BIMS of 13-25: Resident #20. Interview completed on 8/25/25 at 3:08 PM Staff K, RN reported in an abuse situation, she would separate the staff member from the resident, question both the resident and the staff member, then call the state hotline number. During an interview on 8/25/25 at 3:13 PM Staff L, Licensed Practical Nurse (LPN)/Health Services Supervisor verbalized in an abuse situation she would ensure the resident's safety, send the staff member involved home, assess the resident head to toe and call the abuse hotline right away, then fill out an incident report with follow-up at 8, 16, and 24 hours. Interview on 8/26/25 at 8:37 AM Staff G, LPN voiced she is the primary day shift nurse on the dementia unit. On 7/02/25 she was told in morning report a CNA had provided care or attempted to provide care to Resident #1. Staff C had tapped Resident #1 somewhere but she didn't know where. The aide came back and reported it to the nurse. Staff G reviewed her documentation and had completed a follow-up assessment and a head injury flowsheet on Resident #1. She was not asked to do any assessment on any other residents in the dementia unit. She didn't believe that any other residents residing on the hallway had any assessment or follow up after the incident. Staff G voiced possibly Residents #3, #6 and #8 might be able to report if something had happened to them, but none of the other residents on the unit could. If an abuse occurred, she would immediately separate the staff member from the resident, do a full head to toe assessment on the resident with a head injury flow sheet if applicable, fill out a skin assessment to check for bruising and any other injuries, call DIAL within two hours, call the Director of Nursing (DON) or the on-call nurse depending on the time of day, fill out an incident report, and notify the physician and the family. In some cases, she may also notify the psychiatric provider. Interview completed on 8/26/25 at 9:05 AM Staff A explained she went down to Resident #1's room, completed a head to toe assessment with a head injury flow sheet assessment, called the doctor and the DON. She reported off to Staff G that morning. Staff A verbalized she did not go do a physical head to toe assessment on any other residents after the incident with Resident #1. Staff A further explained they verbally designate a certain wing for each CNA in the	F0610		

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F0610 SS = E	Continued from page 9 unit when they come on shift for rounds, but if there is a call light or a need the aide may work other hallways/rooms. Staff C worked the A hallway that night. Staff A voiced there were no residents that have the mental capacity to report if something happened to them in the unit. None of the residents have a high enough BIMS (Brief Interview for Mental Status, is a screening tool used in long-term care facilities to assess a resident's cognitive function. The score helps staff to detect early symptoms of cognitive decline) score for that. During an interview on 8/26/25 at 11:31 AM Staff J, DON reported she and Staff B, DON interviewed Staff A and other staff after the incident with Resident #1. When questioned why the facility investigation did not have any documentation of any other staff interviews, Staff J responded they had done a lot of investigations lately, so maybe they didn't talk to the staff. If they would have talked to other staff, then it would have been documented in the investigation. Staff J further reported no other residents were assessed that night/day after the incident with Resident #1. Staff J reviewed the resident roster for the dementia unit and stated possibly Resident #6 may be able to remember, but that would be giving a lot of the benefit of the doubt, after further review, Staff J stated there weren't really any residents that would be able to recall if something had been done to them. In the moment they all felt it was an isolated incident, so no head to toe assessments were done on residents (in the dementia unit). They never did any resident interview for other areas that Staff C had worked to ask about resident treatment. Interview completed on 8/26/25 at 11:50 AM Staff B voiced she didn't believe that any other residents back on the unit were assessed after resident #1's incident. Staff C admitted she tapped Resident #1 on the head. They didn't believe they had any reason to think any other residents were affected. Staff B reviewed the list of residents residing in the dementia unit. She responded, "probably not," when asked if any of the residents could report if they had been mistreated. Staff B verbalized they had not done any other resident interviews in other areas that Staff C had worked to see if any other residents had been affected. An interview on 8/27/25 at 11:12 AM Staff J explained when there is suspected abuse, she expects the nurse to assess the resident involved, complete an incident report, notify the physician and the family. When they do investigations, they just do them off the top of their head. They do not have any investigation	F0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165442	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE	1922 FIFTH AVENUE NW , WAVERLY, Iowa, 50677

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F0610 SS = E	Continued from page 10 checklist or tools to use. It would be nice to be able to ensure they are covering everything and that all departments are doing what they need to do for an investigation. During an interview on 8/27/25 at 11:34 AM the Administrator voiced the DON's do the investigations and it gets to be a lot so they have one person take lead on the investigation. She considers the investigation for Resident #1 closed at this time. She would have expected the nurse to look at other residents. In hindsight, it would have been good to go back and look at the residents that Staff C had contact with, especially residents that required one assist as Staff would have been the only resident in the room with them. The investigation was lacking because Staff C admitted what happened and the DON's thought it was an isolated situation. They are reviewing and will be making changes going forward. The Dependent Adult Abuse Prevention Policy, revised 11/03/23, included the following definitions: a. Staff: includes employees. b. Abuse: is the willful inflection of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. It includes verbal, physical and mental abuse. c. Willful: means the individual must have acted deliberately, not that he/she must have intended to inflict injury or harm. The Dependent Adult Abuse Prevention Policy, under Procedure directed, a thorough investigation would be implemented.	F0610		