STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER Edgemoor Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 655 Park Center Drive Santee, CA 92071	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** Based on interview and record review, the facility failed to ensure Resident 1 (who resided on Unit C) was protected from mental abuse and intimidation and 63 other residents on two units (Unit A and Unit B) were protected from potential abuse when: 1. Certified nursing assistant (CNA) 1 responded to Resident 1's request for assistance with a raised voice, angry demeanor, and threatening and aggressive posturing on 1/6/26.2. Charge Nurse (CN) 1 and CNA 2 failed to report the incident between CNA 1 and Resident 1 as an allegation of abuse to the facility's administrator.4. The facility did not investigate and report the allegation of abuse to the state agency (California Department of Public Health, CDPH) for three days.5. The facility continued to assign CNA 1, with known behavioral issues, to provide care to 63 residents on Unit A and Unit B on 1/7/26 and 1/8/26 prior to beginning their investigation into the allegation of abuse on 1/9/26. As a result of these failures, Resident 1 expressed feeling scared, worried, and withdrawn from socialization due to her emotional distress. Furthermore, this failure to identify Resident 1's allegation as abuse posed an immediate jeopardy to the safety and well-being of the 63 other residents on Unit A and Unit B where CNA 1 had been assigned during the facility's three-day investigation and reporting delay.Findings: On 1/9/26, CDPH received a faxed SOC 341 (standardized abuse reporting form) from the facility dated 1/9/26. The SOC 341 indicated the facility was reporting an incident of psychological/mental abuse and verbal aggression that allegedly occurred between CNA 1 and Resident 1 on 1/8/26 7:00 PM. The SOC 341 further indicated, .On 10/6/26 [sic] resident reported to the charge nurse that [CNA 1] was aggressive to her because she did not say Hi to him when she asked him to get something from the fridge. She said that she felt defenseless because her wheelchair is slow and did not know what to do. On 2/3/26 at 2:55 P.M., an onsite visit was conducted to investigate a Facility Reported Incident (FRI) alleging CNA 1 was aggressive to Resident 1 because she did not say Hi to him when she asked CNA 1 to get something from the refrigerator for her. A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of quadriplegia (a form of paralysis that causes the loss of movement and feeling in all four limbs and the torso) due to motor vehicle accident. A review of Resident 1's Minimum Data Set Assessment (MDS, a comprehensive assessment tool) dated 12/30/25, indicated the resident's BIMS (Brief Interview for Mental Status) was 15 out of 15, indicating the resident was cognitively intact (no memory, focus, or judgment issues).On 2/3/26 at 3:19 P.M., an interview was conducted with Resident 1while in the dining hall.Resident 2, who was a witness to the incident on 1/6/26, was also present. Resident 1 was asked about the incident that involved CNA 1 on 1/6/26. Resident 1 stated she asked CNA 1 to get a food item out of the fridge, but CNA 1 told her, Are you gonna say hi to me if you want something from me? Resident 1 stated it was her first encounter with CNA 1. Resident 1 stated she was confused by his reply. CNA 1 then repeated in an angry manner, Are you gonna say hi to me if you want something from me? Resident 1 stated she was (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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	about it sooner. On 2/25/26 at 8:06 A.M., an interview with NS 1 was conducted. NS 1 stated she reported the incident that occurred between CNA 1 and Resident 1 to the ADM on speaker phone in the unit's medication room. NS 1 stated NS 4 and CN 1 were also present during the call. NS 1 stated she reported to the ADM what CNA 1 told her had happened. NS 1 stated CNA 1 went to get food for the resident and asked the resident her name. NS 1 stated CNA 1 told her Resident 1 replied to him that she did not have to tell him her name. NS 1 stated she reported to the ADM that CNA 1 did not engage in physical contact or raise his voice at Resident 1. NS 1 stated she did not tell the ADM Resident 1's statement of the incident. NS 1 stated she could not remember what Resident 1 told her. On 2/25/26 at 4:08 P.M., an interview was conducted with Social Worker (SW) 1. SW 1 stated what Resident 1 experienced with CNA 1 on 1/6/26 caused emotional and psychosocial distress.A review of the State Operations Manual revised 7/23/25, indicated, .Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.Examples of mental and verbal abuse include, but are not limited to.Yelling or hovering over a resident with the intent to intimidate; Threatening residents.depriving a resident of care. A review of facility policy titled Abuse and Criminal Activity Identification, Screening, Prevention, Response, Reporting and Investigation 300R, dated 1/30/2025, indicated, I. POLICY.All [Facility] employees, contracted workers and volunteers are mandated reporters.It is the Policy of [Facility] to: Assure that every staff member and contractor fully understands their responsibility, as mandated reporters under California law, 42CFR 483.12(c), .and other relevant laws, of known or suspected abuse and/or criminal activity directed against [Facility] residents. Provide assistance to [Facility] staff in carrying out this responsibility. The facility will facilitate the making of group reports, but will in no way impede an individual from making an individual report in compliance with the law. Respond to concerns about abuse and investigate them thoroughly with a resident-centered approach that includes assessment.III PROCEDURES.A. endure that effective measures are put in place to ensure that further potential abuse.does not occur while the investigation is in process.C. External Reporting.c. Time Frames Required: ii. For all abuse.report to law enforcement ([local] Sheriff) by phone immediately.Then fax the SOC341 form to the Ombudsman and to CDPH.This shall be accomplished within 2 hours of the observation or report of the act.reporting withing a 24-hour window may be permitted.D. Internal Reporting.a. Evidence of, suspicion of, or witnessed or suspected abuse or criminal activity must be reported to the Administrator.supervisory Nurse.e.ii. When staff are accused.the employee may be moved to another assignment or department if it is determined that there is risk to residents. The staff member.generally should not have contact with the resident during the period in which the alleged abuse is being investigated.F. Documentation a. The employee who witnesses or hears about the abuse completes the Abuse Report of Suspected Dependent Adult Elder Abuse Form SOC341/SOC-341/SOC 341 with as much information as possible.J. Prevention and Identification.c. Identification, Tracking, & Trending: . staff are educated on how to identify .behavior which may indicate potential abuse.K. Training All [Facility].staff are educated annually of their reporting obligations and the names and phone numbers of where to make a report. On 2/24/26 at 12:32 P.M., a meeting was conducted with the Administrator (ADM), the Director of Nursing (DON), and ADON 1. Two of the facility counsels joined the meeting via speaker phone. The facility was informed of Immediate Jeopardy (IJ) related to the facility's failure to protect residents from abuse and failure to identify CNA 1's mistreatment of Resident 1 as verbal abuse and intimidation. This resulted in Resident 1 experiencing psychosocial harm: Feeling scared and unsafe, withdrawn from socialization, and ongoing worry. In addition, the facility failed to keep residents in two other units safe and protected (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its written abuse policy titled Abuse and Criminal Activity Identification, Screening, Prevention, Response, Reporting and Investigation 300R, dated 1/30/2025, in accordance with required procedures when:1. The facility did not identify, report, or investigate an allegation of abuse in a timely manner.2. The facility did not thoroughly investigate the allegation at the time of its report. 3. The facility did not assess the risk to other residents when CNA 1 was assigned to provide resident care for two days after an abuse allegation was made.4. The facility did not identify Resident 1's increased fearfulness as a behavior which may indicate potential abuse.As a result, this failure placed Resident 1 and 63 other residents at risk for potential abuse.Cross reference F600, F609, and F610.Findings:On 1/9/26, CDPH received a faxed SOC 341 (standardized abuse reporting form) from the facility dated 1/9/26. The SOC 341 indicated the facility was reporting an incident of psychological/mental abuse and verbal aggression that allegedly occurred between CNA 1 and Resident 1 on 1/8/26 7:00 PM. The SOC 341 further indicated, .On 10/6/26 [sic] resident reported to the charge nurse that [CNA 1] was aggressive to her because she did not say Hi to him when she asked him to get something from the fridge. She said that she felt defenseless because her wheelchair is slow and did not know what to do.On 2/3/26 at 2:55 P.M., an onsite visit was conducted to investigate a Facility Reported Incident (FRI) alleging CNA 1 was aggressive to Resident 1 because she did not say Hi to him when she asked CNA 1 to get something from the refrigerator for her.A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of quadriplegia (a form of paralysis that causes the loss of movement and feeling in all four limbs and the torso) due to motor vehicle accident.A review of Resident 1's Minimum Data Set Assessment (MDS, a comprehensive assessment tool) dated 12/30/25, indicated the resident's BIMS (Brief Interview for Mental Status) was 15 out of 15, indicating the resident was cognitively intact (no memory, focus, or judgment issues).On 2/3/26 at 3:19 P.M., an interview was conducted with Resident 1while in the dining hall. Resident 2, who was a witness to the incident on 1/6/26, was also present. Resident 1 was asked about the incident that involved CNA 1 on 1/6/26. Resident 1 stated she asked CNA 1 to get a food item out of the fridge, but CNA 1 told her, Are you gonna say hi to me if you want something from me? Resident 1 stated it was her first encounter with CNA 1. Resident 1 stated she was confused by his reply. CNA 1 then repeated in an angry manner, Are you gonna say hi to me if you want something from me? Resident 1 stated she was still confused but also thought that maybe he was joking. Resident 1 then told CNA 1, I don't have to say hi to you if I don't want to. Resident 1 stated CNA 1 was coming out of the nurse's station walking toward the refrigerator at which point he turned around and yelled, If you don't say hi to me, you're not getting anything from me! Now you have to call your [assigned] CNA! Resident 1 stated CNA 1 charged toward her with his chest out and aggressive arm movements. Resident 1 stated CNA 1 charged toward her in a manner that looked like he wanted to physically fight her. Resident 1 stated she was scared when CNA 1 was verbally and physically aggressive and charging toward her with his threatening posture because her electric wheelchair moved slowly. Resident 1 stated she was worried she could not get away from him fast enough. CNA 1 then walked back into the nurse's station without getting what she requested out of the refrigerator. Resident 1 called for help and told CNA 2 and CN 1 what had happened. Resident 1 stated that she told CNA 2 and CN 1 that she was scared and did not feel safe with the way CNA 1 behaved toward her. Resident 2 stated that she witnessed the incident on 1/6/26 and that was what happened.A review of Resident 1's Interdisciplinary Progress Notes after the incident on 1/6/26 indicated:1/6/26 at 11:15 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER Edgemoor Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 655 Park Center Drive Santee, CA 92071	

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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 - Some	P.M., .Resident appeared to be in emotional distress at the time of incident.1/7/26 at 10:03 P.M., .Resident just verbalized that she still couldn't believe the incident from yesterday occurred.1/8/26 at 1:45 P.M., Therapist made two attempts before lunch and after lunch to speak with resident and assess psychosocial wellbeing, however both times resident was sleeping and did not respond to knock at door or calling out of name.1/8/26 at 7 P.M., .Resident was upset regarding the [facility's] action and verbalized that she will be reporting to Police and Ombudsman tomorrow. Resident stated that she's not safe with alleged PM CNA staff [CNA1]. 1/8/26 at 11:03 P.M., Resident still verbalized feeling upset r/t incident with staff.1/9/26 at 1:33 P.M. Resident refused to get OOB [out of bed]. Resident told CNA that she doesn't want to talk to anyone today.1/9/26 at 1:38 P.M. Attempted multiple times to talk with resident regarding grievances reported on PM shift, she declines to talk.1/9/26 at 10:40 P.M. Tried to talk to resident to follow up on alleged abuse but resident declined.1/9/26 at 11:05 P.M.resident declined to talk about it anymore when asked.1/10/26 at 10:27 P.M.Resident stayed in her room all shift and did not get up.A review of Social Work Progress Note dated 1/12/26, indicated, .The resident states she does not feel safe with the staff [CNA 1] from the SOC 341 being around her. The resident states she feels unsafe as she feel[sic] the alleged individual could lose their temper at any time not only with herself but other residents.A review of Resident 1's psychotherapy note dated 1/14/26, indicated, .The resident appeared disheveled. reported a recent interaction with a male CNA that elicited feelings of unsafety and a sense of being frozen during the incident. Subsequently, the resident endorsed spending three consecutive days in bed, primarily sleeping, citing significant fatigue.stating avoidance of social interaction to prevent retraumatization.The resident.agreed to continue working on reducing immobilization responses associated with fear.A review of facility's staff assignment for 1/6/26 through 1/13/26, indicated CNA 1 provided resident care on 1/7/26 on Unit A and on 1/8/26 on Unit B during the PM shift (3 P.M. to 11:30 P.M.).A review of facility's census for Unit A and B combined on 1/7/26 and 1/8/26 indicated a total census of 63 residents.On 2/4/26 at 4:20 P.M., a follow up interview was conducted with Resident 1 while inside the resident's room. Resident 1 stated a few minutes after the incident on 1/6/26, three nursing supervisors approached her and asked her if she would be willing to meet with CNA 1 to discuss the incident. Resident 1 stated she refused and told the nursing supervisors that she was too scared of CNA 1 to meet and talk with him. Resident 1 further stated she was worried about other residents, especially the more vulnerable ones, those who could not speak for themselves, and those who could become agitated through interactions with CNA 1 because of their psychiatric conditions. Resident 1 stated she stayed in bed for the next few days after the incident because she felt closed off and put shells around herself due to the incident. Resident 1 stated she refused to keep talking about the incident with staff because she did not want to be re-traumatized by thinking of or talking about it.On 2/10/26 at 12:14 P.M., an interview was conducted with DSD 1 and DSD 2. DSD 1 and DSD 2 stated the incident between Resident 1 and CNA 1 on 1/6/26 was emotional abuse and should have been addressed immediately. DSD 1 stated when Resident 1 told CNA 2 and CN 1 about the incident with CNA 1 on 1/6/26, they should have filled out the SOC 341 immediately and reported this incident to CDPH. DSD 1 stated the facility's investigation should have started immediately and should not have been delayed.On 2/10/26 at 4:23 P.M., a follow-up interview was conducted with CN 1. CN 1 stated what Resident 1 reported to her on 1/6/26 was verbal abuse. CN 1 stated she should have reported this immediately to the administrator, CDPH, and the police.On 2/24/26 at 1:39 P.M., an interview was conducted with the ADM who was also the abuse coordinator. The ADM stated according to the nursing supervisors, Resident 1 did not mention that the incident was abuse. The ADM stated she only interviewed CNA 1 regarding the (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incident that occurred on 1/6/26. The ADM stated she did not interview Resident 1. The ADM stated she spoke to nurse supervisors about the incident on 1/6/26 and they did not tell her that this was an abuse allegation. The ADM stated she would not consider this incident abuse. The ADM stated Resident 1 chose to file an internal complaint/grievance over asking the facility to report the incident to CDPH. The ADM stated she was not told by the nurse supervisors that Resident 1 was scared of CNA 1. The ADM stated no one reported to her that Resident 1 had experienced emotional distress.On 2/24/26 at 3:40 P.M., an interview with CNA 2 was conducted. CNA 2 was asked how she became aware Resident 1 needed help on 1/6/26. CNA 2 stated she heard Resident 1 screaming her name, which prompted her to run out of a resident's room. CNA 2 stated Resident 1 then told her [CNA 2], stay here, stay here, don't leave, and observed the resident's body was tense and shaking. CNA 2 explained that Resident 1 reported asking CNA 1 for food from the refrigerator. CNA 2 stated Resident 1 told her that CNA 1 said, Are you gonna say hi to me if you want something from me? while raising his voice. CNA 2 stated Resident 1 told her that when she did not say hi to CNA 1, his demeaner quickly changed. CNA 2 stated Resident 1 told her CNA 1's body language was intimidating and threatening. CNA 2 stated Resident 1 told her she felt fatigued, had refused to get up, and did not socialize after the incident. CNA 2 stated what happened to Resident 1 on 1/6/26 was abuse. CNA 2 stated she thought the nurse supervisors and the CN 1 who responded to the incident on 1/6/26 had appropriately reported the abuse allegation to the ADM. CNA 2 stated if she had known that the facility was not treating the incident as an abuse allegation, she would have said something about it sooner.On 2/25/26 at 8:06 A.M., an interview with NS 1 was conducted. NS 1 stated she reported the incident that occurred between CNA 1 and Resident 1 to the ADM on speaker phone in the unit's medication room. NS 1 stated NS 4 and CN 1 were also present during the call. NS 1 stated she reported to the ADM what CNA 1 told her had happened. NS 1 stated CNA 1 went to get food for the resident and asked the resident her name. NS 1 stated CNA 1 told her Resident 1 replied to him that she did not have to tell him her name. NS 1 stated she reported to the ADM that CNA 1 did not engage in physical contact or raise his voice at Resident 1. NS 1 stated she did not tell the ADM Resident 1's statement of the incident. NS 1 stated she could not remember what Resident 1 told her. On 2/25/26 at 4:08 P.M., an interview was conducted with Social Worker (SW) 1. SW 1 stated what Resident 1 experienced with CNA 1 on 1/6/26 caused emotional and psychosocial distress.A review of facility policy titled Abuse and Criminal Activity Identification, Screening, Prevention, Response, Reporting and Investigation 300R, dated 1/30/2025, indicated, I. POLICY.All [Facility] employees, contracted workers and volunteers are mandated reporters.It is the Policy of [Facility] to: Assure that every staff member and contractor fully understands their responsibility, as mandated reporters under California law, 42CFR 483.12(c), .and other relevant laws, of known or suspected abuse and/or criminal activity directed against [Facility] residents. Provide assistance to [Facility] staff in carrying out this responsibility. The facility will facilitate the making of group reports, but will in no way impede an individual from making an individual report in compliance with the law. Respond to concerns about abuse and investigate them thoroughly with a resident-centered approach that includes assessment.III PROCEDURES.A. ensure that effective measures are put in place to ensure that further potential abuse.does not occur while the investigation is in process.C. External Reporting.c. Time Frames Required: ii. For all abuse.report to law enforcement ([local] Sheriff) by phone immediately.Then fax the SOC341 form to the Ombudsman and to CDPH.This shall be accomplished within 2 hours of the observation or report of the act.reporting withing a 24-hour window may be permitted.D. Internal Reporting.a. Evidence of, suspicion of, or witnessed or suspected abuse or criminal activity must be reported to the Administrator.supervisory Nurse.e.ii. When (continued on next page)

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	055008	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgemoor Hospital	655 Park Center Drive Santee, CA 92071

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff are accused.the employee may be moved to another assignment or department if it is determined that there is risk to residents. The staff member.generally should not have contact with the resident during the period in which the alleged abuse is being investigated.F. Documentation a. The employee who witnesses or hears about the abuse completes the Abuse Report of Suspected Dependent Adult Elder Abuse Form SOC341/SOC-341/SOC 341 with as much information as possible.J. Prevention and Identification.c. Identification, Tracking, & Trending: . staff are educated on how to identify .behavior which may indicate potential abuse.(i.e. increased fearfulness.).This policy was not implemented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026

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Edgemoor Hospital	655 Park Center Drive Santee, CA 92071

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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** Based on interview and record review, the facility failed to implement its written abuse policy titled Abuse and Criminal Activity Identification, Screening, Prevention, Response, Reporting and Investigation 300R, dated 1/30/2025, in accordance with required procedures and ensure that all alleged violations involving abuse are reported immediately, but not later than two hours after the allegation was made when:1. Charge Nurse (CN) 1 and Certified Nursing Assistant (CNA) 2 failed to report the incident between CNA 1 and Resident 1 as an allegation of abuse to the facility's administrator.2. The facility did not thoroughly investigate the allegation of abuse at the time of its report.As a result, this failure caused a delay in reporting the abuse allegation to the state agency (California Department of Public Health, CDPH) for three days.Cross reference F600, F609, and F610.Findings:On 1/9/26, CDPH received a faxed SOC 341 (standardized abuse reporting form) from the facility dated 1/9/26. The SOC 341 indicated the facility was reporting an incident of psychological/mental abuse and verbal aggression that allegedly occurred between CNA 1 and Resident 1 on 1/8/26 7:00 PM. The SOC 341 further indicated, .On 10/6/26 [sic] resident reported to the charge nurse that [CNA 1] was aggressive to her because she did not say Hi to him when she asked him to get something from the fridge. She said that she felt defenseless because her wheelchair is slow and did not know what to do.On 2/3/26 at 2:55 P.M., an onsite visit was conducted to investigate a Facility Reported Incident (FRI) alleging CNA 1 was aggressive to Resident 1 because she did not say Hi to him when she asked CNA 1 to get something from the refrigerator for her.A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of quadriplegia (a form of paralysis that causes the loss of movement and feeling in all four limbs and the torso) due to motor vehicle accident.A review of Resident 1's Minimum Data Set Assessment (MDS, a comprehensive assessment tool) dated 12/30/25, indicated the resident's BIMS (Brief Interview for Mental Status) was 15 out of 15, indicating the resident was cognitively intact (no memory, focus, or judgment issues).On 2/3/26 at 3:19 P.M., an interview was conducted with Resident 1while in the dining hall. Resident 2, who was a witness to the incident on 1/6/26, was also present. Resident 1 was asked about the incident that involved CNA 1 on 1/6/26. Resident 1 stated she asked CNA 1 to get a food item out of the fridge, but CNA 1 told her, Are you gonna say hi to me if you want something from me? Resident 1 stated it was her first encounter with CNA 1. Resident 1 stated she was confused by his reply. CNA 1 then repeated in an angry manner, Are you gonna say hi to me if you want something from me? Resident 1 stated she was still confused but also thought that maybe he was joking. Resident 1 then told CNA 1, I don't have to say hi to you if I don't want to. Resident 1 stated CNA 1 was coming out of the nurse's station walking toward the refrigerator at which point he turned around and yelled, If you don't say hi to me, you're not getting anything from me! Now you have to call your [assigned] CNA! Resident 1 stated CNA 1 charged toward her with his chest out and aggressive arm movements. Resident 1 stated CNA 1 charged toward her in a manner that looked like he wanted to physically fight her. Resident 1 stated she was scared when CNA 1 was verbally and physically aggressive and charging toward her with his threatening posture because her electric wheelchair moved slowly. Resident 1 stated she was worried she could not get away from him fast enough. CNA 1 then walked back into the nurse's station without getting what she requested out of the refrigerator. Resident 1 called for help and told CNA 2 and CN 1 what had happened. Resident 1 stated that she told CNA 2 and CN 1 that she was scared and did not feel safe with the way CNA 1 behaved toward her. Resident 2 stated that she witnessed the incident on 1/6/26 and that was what happened.On 2/4/26 at 3:41 P.M., an interview with CN 1 was conducted. CN 1 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated CNA 1 was floated to Resident 1's unit around 7:30 P.M. on the day the incident happened (1/6/26). CN 1 stated CNA 1 was assigned to answer call lights while other CNAs and staff were making rounds. CN 1 stated this resulted in no other staff being present in the dining hall and nurse's station at the time of the incident which happened around 8:20 P.M. When the incident happened, CN 1 stated, she was called to the dining room where she saw Resident 1 and Resident 2 sitting close to each other. CN 1 stated Resident 1 was, very shaken about it, shaking and visibly in distress. CN 1 stated Resident 1 told her she was scared. CN 1 stated Resident 1 told her, Don't leave me here with him [CNA 1], he's there.On 2/10/26 at 12:14 P.M., an interview was conducted with Director of Staff Development (DSD) 1 and DSD 2. DSD 1 and DSD 2 stated the incident between Resident 1 and CNA 1 on 1/6/26 was emotional abuse and should have been addressed immediately. DSD 1 stated when Resident 1 told CNA 2 and CN 1 about the incident with CNA 1 on 1/6/26, they should have filled out the SOC 341 immediately and reported this incident to CDPH. DSD 1 stated the facility's investigation should have started immediately and should not have been delayed.On 2/10/26 at 4:23 P.M., a follow-up interview was conducted with CN 1. CN 1 stated what Resident 1 reported to her on 1/6/26 was verbal abuse. CN 1 stated she should have reported this immediately to the administrator, CDPH, and the police.On 2/24/26 at 3:40 P.M., an interview with CNA 2 was conducted. CNA 2 stated she heard Resident 1 screaming her name, which prompted her to run out of a resident's room. CNA 2 stated Resident 1 then told her [CNA 2], stay here, stay here, don't leave, and observed the resident's body was tense and shaking. CNA 2 explained that Resident 1 reported asking CNA 1 for food from the refrigerator. CNA 2 stated Resident 1 told her that CNA 1 said, Are you gonna say hi to me if you want something from me? while raising his voice. CNA 2 stated Resident 1 told her that when she did not say hi to CNA 1, his demeaner quickly changed. CNA 2 stated Resident 1 told her CNA 1's body language was intimidating and threatening. CNA 2 stated Resident 1 told her she felt fatigued, had refused to get up, and did not socialize after the incident. CNA 2 stated what happened to Resident 1 on 1/6/26 was abuse. CNA 2 stated she thought the nurse supervisors and the CN 1 who responded to the incident on 1/6/26 had appropriately reported the abuse allegation to the ADM. CNA 2 stated if she had known that the facility was not treating the incident as an abuse allegation, she would have said something about it sooner.On 2/25/26 at 8:06 A.M., an interview with NS 1 was conducted. NS 1 stated she reported the incident that occurred between CNA 1 and Resident 1 to the ADM on speaker phone in the unit's medication room. NS 1 stated NS 4 and CN 1 were also present during the call. NS 1 stated she reported to the ADM what CNA 1 told her had happened. NS 1 stated CNA 1 went to get food for the resident and asked the resident her name. NS 1 stated CNA 1 told her Resident 1 replied to him that she did not have to tell him her name. NS 1 stated she reported to the ADM that CNA 1 did not engage in physical contact or raise his voice at Resident 1. NS 1 stated she did not tell the ADM Resident 1's statement of the incident. NS 1 stated she could not remember what Resident 1 told her. A review of facility policy titled Abuse and Criminal Activity Identification, Screening, Prevention, Response, Reporting and Investigation 300R, dated 1/30/2025, indicated, I. POLICY.All [Facility] employees, contracted workers and volunteers are mandated reporters.It is the Policy of [Facility] to: Assure that every staff member and contractor fully understands their responsibility, as mandated reporters under California law, 42CFR 483.12(c), .and other relevant laws, of known or suspected abuse and/or criminal activity directed against [Facility] residents. Provide assistance to [Facility] staff in carrying out this responsibility. The facility will facilitate the making of group reports, but will in no way impede an individual from making an individual report in compliance with the law. Respond to concerns about abuse and investigate them thoroughly with a resident-centered approach that includes assessment.C. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	External Reporting.c. Time Frames Required: ii. For all abuse.report to law enforcement ([local] Sheriff) by phone immediately.Then fax the SOC341 form to the Ombudsman and to CDPH.This shall be accomplished within 2 hours of the observation or report of the act.reporting withing a 24-hour window may be permitted.D. Internal Reporting.a. Evidence of, suspicion of, or witnessed or suspected abuse or criminal activity must be reported to the Administrator.supervisory Nurse.F. Documentation a. The employee who witnesses or hears about the abuse completes the Abuse Report of Suspected Dependent Adult Elder Abuse Form SOC341/SOC-341/SOC 341 with as much information as possible.K. Training All [Facility].staff are educated annually of their reporting obligations and the names and phone numbers of where to make a report.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Findings:On 1/9/26, the state agency (California Department of Public Health, CDPH) received a faxed SOC 341 (standardized abuse reporting form) from the facility dated 1/9/26. The SOC 341 indicated the facility was reporting an incident of psychological/mental abuse and verbal aggression that allegedly occurred between CNA 1 and Resident 1 on 1/8/26 7:00 PM. The SOC 341 further indicated, .On 10/6/26 [sic] resident reported to the charge nurse that [CNA 1] was aggressive to her because she did not say Hi to him when she asked him to get something from the fridge. She said that she felt defenseless because her wheelchair is slow and did not know what to do.On 2/3/26 at 2:55 P.M., an onsite visit was conducted to investigate a Facility Reported Incident (FRI) alleging CNA 1 was aggressive to Resident 1 because she did not say Hi to him when she asked CNA 1 to get something from the refrigerator for her.A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of quadriplegia (a form of paralysis that causes the loss of movement and feeling in all four limbs and the torso) due to motor vehicle accident.A review of Resident 1's Minimum Data Set Assessment (MDS, a comprehensive assessment tool) dated 12/30/25, indicated the resident's BIMS (Brief Interview for Mental Status) was 15 out of 15, indicating the resident was cognitively intact (no memory, focus, or judgment issues).On 2/3/26 at 3:19 P.M., an interview was conducted with Resident 1while in the dining hall. Resident 2, who was a witness to the incident on 1/6/26, was also present. Resident 1 was asked about the incident that involved CNA 1 on 1/6/26. Resident 1 stated she asked CNA 1 to get a food item out of the fridge, but CNA 1 told her, Are you gonna say hi to me if you want something from me? Resident 1 stated it was her first encounter with CNA 1. Resident 1 stated she was confused by his reply. CNA 1 then repeated in an angry manner, Are you gonna say hi to me if you want something from me? Resident 1 stated she was still confused but also thought that maybe he was joking. Resident 1 then told CNA 1, I don't have to say hi to you if I don't want to. Resident 1 stated CNA 1 was coming out of the nurse's station walking toward the refrigerator at which point he turned around and yelled, If you don't say hi to me, you're not getting anything from me! Now you have to call your [assigned] CNA! Resident 1 stated CNA 1 charged toward her with his chest out and aggressive arm movements. Resident 1 stated CNA 1 charged toward her in a manner that looked like he wanted to physically fight her. Resident 1 stated she was scared when CNA 1 was verbally and physically aggressive and charging toward her with his threatening posture because her electric wheelchair moved slowly. Resident 1 stated she was worried she could not get away from him fast enough. CNA 1 then walked back into the nurse's station without getting what she requested out of the refrigerator. Resident 1 called for help and told CNA 2 and CN 1 what had happened. Resident 1 stated that she told CNA 2 and CN 1 that she was scared and did not feel safe with the way CNA 1 behaved toward her. Resident 2 stated that she witnessed the incident on 1/6/26 and that was what happened.On 2/4/26 at 3:41 P.M., an interview with CN 1 was conducted. CN 1 stated CNA 1 was floated to Resident 1's unit around 7:30 P.M. on the day the incident happened (1/6/26). CN 1 stated CNA 1 was assigned to answer call lights while other CNAs and staff were making rounds. CN 1 stated this resulted in no other staff being present in the dining hall and nurse's station at the time of the incident which happened around 8:20 P.M. When the incident happened, CN 1 stated, she was called to the dining room where she saw Resident 1 and Resident 2 sitting close to each other. CN 1 stated Resident 1 was, very shaken about it, shaking and visibly in distress. CN 1 stated Resident 1 told her she was scared. CN 1 stated Resident 1 told her, Don't leave me here with him [CNA 1], he's there.On 2/10/26 at 4:23 P.M., a follow-up interview was conducted with CN 1. CN 1 stated what Resident 1 reported to her on 1/6/26 was verbal abuse. CN 1 stated she should have (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER: Edgemoor Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE: 655 Park Center Drive Santee, CA 92071	

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported this immediately to the administrator, CDPH, and the police.On 2/24/26 at 1:39 P.M., an interview was conducted with the ADM who was also the abuse coordinator. The ADM stated according to the nursing supervisors, Resident 1 did not mention that the incident was abuse. The ADM stated she only interviewed CNA 1 regarding the incident that occurred on 1/6/26. The ADM stated she did not interview Resident 1. The ADM stated she spoke to nurse supervisors about the incident on 1/6/26 and they did not tell her that this was an abuse allegation. The ADM stated she would not consider this incident abuse. The ADM stated Resident 1 chose to file an internal complaint/grievance over asking the facility to report the incident to CDPH. The ADM stated she was not told by the nurse supervisors that Resident 1 was scared of CNA 1.On 2/24/26 at 3:40 P.M., a follow up interview with CNA 2 was conducted. CNA 2 stated she heard Resident 1 screaming her name, which prompted her to run out of a resident's room. CNA 2 stated Resident 1 then told her [CNA 2], stay here, stay here, don't leave, and observed the resident's body was tense and shaking. CNA 2 explained that Resident 1 reported asking CNA 1 for food from the refrigerator. CNA 2 stated Resident 1 told her that CNA 1 said, Are you gonna say hi to me if you want something from me? while raising his voice. CNA 2 stated Resident 1 told her that when she did not say hi to CNA 1, his demeaner quickly changed. CNA 2 stated Resident 1 told her CNA 1's body language was intimidating and threatening. CNA 2 stated Resident 1 told her she felt fatigued, had refused to get up, and did not socialize after the incident. CNA 2 stated what happened to Resident 1 on 1/6/26 was abuse. CNA 2 stated she thought the nurse supervisors and the CN 1 who responded to the incident on 1/6/26 had appropriately reported the abuse allegation to the ADM. CNA 2 stated if she had known that the facility was not treating the incident as an abuse allegation, she would have said something about it sooner.On 2/25/26 at 8:06 A.M., an interview with Nursing Supervisor (NS) 1 was conducted. NS 1 stated she reported the incident that occurred between CNA 1 and Resident 1 to the ADM on speaker phone in the unit's medication room. NS 1 stated NS 4 and CN 1 were also present during the call. NS 1 stated she reported to the ADM what CNA 1 told her had happened. NS 1 stated CNA 1 went to get food for the resident and asked the resident her name. NS 1 stated CNA 1 told her Resident 1 replied to him that she did not have to tell him her name. NS 1 stated she reported to the ADM that CNA 1 did not engage in physical contact or raise his voice at Resident 1. NS 1 stated she did not tell the ADM Resident 1's statement of the incident. NS 1 stated she could not remember what Resident 1 told her. A review of facility's staff assignment for 1/6/26 through 1/13/26, indicated CNA 1 provided resident care on 1/7/26 on Unit A and on 1/8/26 on Unit B during the PM shift (3 P.M. to 11:30 P.M.).A review of facility's census for Unit A and B combined on 1/7/26 and 1/8/26 indicated a total census of 63 residents.A review of the State Operations Manual revised 7/23/25, indicated, .In response to allegation of abuse.the facility must.Prevent further potential abuse.during the investigation.thoroughly collect evidence to allow the Administrator determine what actions are necessary .for the protection of residents.A review of facility policy titled Abuse and Criminal Activity Identification, Screening, Prevention, Response, Reporting and Investigation 300R, dated 1/30/2025, indicated, I. POLICY.Respond to concerns about abuse and investigate them thoroughly with a resident-centered approach that includes assessment.III PROCEDURES.A. ensure that effective measures are put in place to ensure that further potential abuse.does not occur while the investigation is in process.D. Internal Reporting.a. Evidence of, suspicion of, or witnessed or suspected abuse or criminal activity must be reported to the Administrator.supervisory Nurse.e.ii. When staff are accused.the employee may be moved to another assignment or department if it is determined that there is risk to residents.F. Documentation a. The employee who witnesses or hears about the abuse completes the Abuse Report of Suspected Dependent Adult Elder Abuse Form SOC341/SOC-341/SOC 341 (continued on next page)

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