STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055161	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Crest Rehabilitation Center	909 Lucile Ave. Los Angeles, CA 90026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 43851 Based on interview and record review, the facility failed to report an allegation of staff to resident abuse to the State Survey Agency (SSA, the Bureau of Health Facility Licensing, Certification and Resident Assessment, within the Department of Health, which is responsible for nursing facility certification and for conducting surveys to determine compliance with Medicare and Medicaid requirements) and the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) within two hours for one of five sampled residents (Resident 1). This failure had the potential to result in a delay of an onsite inspection by the SSA and had the potential for Resident 1 to experience ongoing abuse. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted the resident on 7/30/2021 with diagnoses that included dementia (a progressive state of decline in mental abilities), type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), anxiety (a feeling of fear, dread, and uneasiness), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment tool) dated 5/2/2025, the MDS indicated the resident had severely impaired cognition (diminished ability to think, understand, and reason). The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) for eating, oral hygiene, and upper body dressing. The MDS indicated Resident 1 was dependent on help (helper does all the effort) for toileting hygiene, lower body dressing, putting on/taking off footwear, and personal hygiene. (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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(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	During a review of Resident 1's Situation Background Assessment Recommendation (SBAR, a communication tool used by healthcare workers when there is a change of condition among the residents) Summary for Providers documentation dated 5/15/2025 at 10:38 PM, the SBAR Summary for Providers documentation indicated the resident had an unwitnessed fall around 10 PM. The SBAR Summary for Providers documentation indicated Resident 1 was found in bed with a forehead laceration (a tear or cut in the skin) and skin tear (a wound that occurs when the outer layer of skin separates from the underlying layer) on her bilateral (both) elbows. The SBAR Summary for Providers documentation indicated Resident 1's was assessed and provided with wound care. The SBAR Summary for Providers documentation indicated Resident 1 was unable to be consoled (someone is too sad or upset to be comforted) and was noted to be grimacing (to make a facial expression of pain) with her fists clenched (hands with fingers curled tightly into the palm). The SBAR Summary for Providers documentation indicated Resident 1 was confused. The SBAR Summary for Providers documentation indicated Resident 1's physician was immediately notified and provided the recommendation to transfer the resident to the General Acute Care Hospital (GACH, a health facility that provides short-term, inpatient medical and surgical services for a wide range of conditions) 1 via 911 for further evaluation. During a review of Resident 1's After Summary Visit from GACH 1 dated 5/16/2025 at 3:19 AM, the After Summary Visit indicated Resident 1 was provided with treatment for the laceration and skin tears. The After Summary Visit indicated Resident 1 had a Computed Tomography (CT - diagnostic imaging procedure that uses a machine to create detailed images of the inside of the body) of her head which did not show any head bleed or skull fracture (break in bone). During a review of Resident 1's Nurse's Notes dated 5/16/2025 at 4 AM, the Nurse's Notes indicated Resident 1 returned to the facility from GACH 1 via gurney accompanied by two Emergency Medical Technicians (EMT's). The Nurse's Notes indicated Resident 1 was awake and talking. During a review of Resident 1's SBAR Summary for Providers documentation dated 5/16/2025 at 7:28 PM, the SBAR Summary for Providers documentation indicated the resident had an allegation of abuse. The SBAR Summary for Providers documentation indicated Resident 1's physician was notified and recommended to continue to monitor the resident for adverse effects of the alleged abuse. During a review of the document titled Report of Suspected Dependent Adult/Elder Abuse dated 5/16/2025, the document indicated on 5/15/2025 at 9:45 PM, Resident 1 was found on the floor next to her bed. The document indicated Resident 1 sustained a laceration on her forehead with bleeding and a left and right elbow skin tear. The document indicated Resident 1 was transferred to the GACH. The document indicated on 5/16/2025 at 5 PM, the Registered Nurse (RN) Supervisor overheard the Certified Nurse Assistant (CNA) who was outside the room heard Resident 1 say You pushed me to the (CNA) who was inside the room. The document indicated investigation was ongoing. During a review of a fax confirmation from the facility to the SSA dated 5/16/2025 at 6:59 PM, the fax confirmation indicated the facility notified the SSA of Resident 1's allegation of abuse. During a review of a fax confirmation from the facility to the Ombudsman dated 5/16/2025 at 7:04 PM, the fax confirmation indicated the facility was notified the ombudsman of Resident 1's allegation of abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of a document titled Summary of Investigation dated 5/20/2025, the document indicated on 5/15/2025 CNA 1 found Resident 1 on the floor. The document indicated CNA 1 immediately assessed the resident. The document indicated Resident 1 was conscious and talking in Spanish. The document indicated bleeding was noted on Resident 1's forehead. The document indicated CNA 1 assisted Resident 1 back to bed then notified the Licensed Vocational Nurse (LVN). The document indicated LVN assessed Resident 1, notified the Registered Nurse (RN) Supervisor, and provided treatment to the resident. The document indicated the RN Supervisor called 911 and notified Resident 1's physician and family. The document indicated Resident 1 received treatment for the laceration of the left forehead and a CT scan which was negative for fracture. The document indicated Resident 1 was returned to the facility on [DATE] at 2:30 AM. The document further indicated that on 5/16/2025 at 5:00 PM, during the investigation of Resident 1's incident, CNA 2 informed the RN Supervisor that she overheard the resident saying in Spanish you pushed me to the CNA who found her during the fall. During a telephone interview on 5/28/2025 at 2:21 PM with RN 1, RN 1 stated on 5/15/2025 between 9:45 PM - 10:00 PM Licensed Vocational Nurse (LVN) 1 had notified him that Resident 1 had fallen. RN 1 stated when he went into Resident 1's room, the resident was already back in bed and Certified Nurse Assistant (CNA) 1 was also there. RN 1 stated Resident 1 had skin tears to both of her elbows and a cut on her forehead. RN 1 stated he checked Resident 1's vitals and provided treatment to the resident's wounds. RN 1 stated 911 was called and Resident 1 was transferred to the GACH. RN 1 stated Resident 1 could not tell him how she fell . RN 1 stated no one told him about an allegation of abuse that night. RN 1 stated that it wasn't until the next day when CNA 2 came forward and told him and LVN 1 that she heard Resident 1 say I fell , and you pushed me when the resident fell on [DATE]. RN 1 stated he reported the allegation of abuse to the Administrator right away. During an interview on 5/28/2025 at 3:04 PM with CNA 2, CNA 2 stated she did not see Resident 1 fall on 5/15/2025, but heard the resident say in Spanish you pushed me, you pushed me when she fell . CNA 2 stated she did not remember the time that happened, but stated it was around nighttime. CNA 2 stated she told LVN 1 what she heard what Resident 1 was saying immediately after she heard the resident say it. CNA 2 stated the next day on 5/16/2025 she told LVN 1 and RN 1 again that Resident 1 said you pushed me, you pushed me the night the before. CNA 2 stated this was the second time she told LVN 1 that Resident 1 said You pushed me . CNA 2 stated she did not tell the Administrator what she heard Resident 1 said only LVN 1. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/2025 at 3:12 PM with LVN 1, LVN 1 stated on 5/15/2025 around 9:00 PM to 10:00 PM, CNA 1 called his attention and told him that Resident 1 had fallen. LVN 1 stated he immediately went to Resident 1's room. LVN 1 stated as he was going to Resident 1's room, CNA 2 told him something. LVN 1 stated he couldn't really understand what CNA 2 was telling him. LVN 1 stated he thought CNA 2 was telling him Resident 1 was calling for help. LVN 1 stated when he got to Resident 1's room, the resident was already back in bed. LVN 1 stated Resident 1 had a skin tear to her right and left elbow and a cut on her left forehead. LVN 1 stated Resident 1's vitals were checked, and treatment was provided to the resident's wounds. LVN 1 stated 911 was called and Resident 1 was sent to the GACH for further evaluation. LVN 1 stated at that time he did not have any concerns about abuse. LVN 1 stated on the next day 5/16/2025 at around 4:00 PM, CNA 2 told him that she heard Resident 1 was saying you pushed me when she fell the night before on 5/15/2025. LVN 1 stated when he realized this was what CNA 2 was telling him the night before he told RN 1 and they both informed the Administrator and Director of Nursing (DON). LVN 1 stated pushing was an allegation of abuse which should be reported to the SSA, ombudsman, and law enforcement within two hours. LVN 1 stated that the allegation of abuse should have been reported the night before, but he did not realize CNA 2 was telling him Resident 1 was saying she was pushed by staff. During an interview on 5/28/2025 at 3:51 PM with the Director of Nursing (DON), the DON stated she was informed by the Administrator that Resident 1 fell and had an allegation of abuse on 5/16/2025. The DON stated through investigation of Resident 1's fall she found that on the night the resident fell on [DATE] CNA 2 told LVN 1 that Resident 1 was saying you pushed me to CNA 1. The DON stated LVN 1 did not hear the abuse allegation and only heard that Resident 1 was asking for help. The DON stated the abuse allegation was reported to the Administrator and herself when CNA 2 told LVN 1 and RN 1 about the abuse allegation a second time on 5/16/2025. The DON stated Resident 1's abuse allegation should have been reported the night the Resident fell on [DATE]; but because there was the initial misunderstanding and miscommunication between CNA 2 and LVN 1 on 5/15/2025, the allegation did not get reported until LVN 1 received clarification of what happened by CNA 2 on 5/16/2025. The DON stated allegations of abuse should be reported to the SSA, the ombudsman, and law enforcement within two hours so the facility could act immediately. The DON stated there was a potential for further abuse if abuse allegations were not reported timely. During a review of the facility's Policy and Procedure (P&P) titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating reviewed 1/2025, the P&P indicated All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported .If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility; the local/state ombudsman; the resident representative; adult protective services (where state law provides jurisdiction in long-term care); law enforcement officials; the resident's attending physician' and the facility medical director. Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BasedBased on interview and record review, the facility failed to report an allegation of staff to resident abuse to the State Survey Agency (SSA, the Bureau of Health Facility Licensing, Certification and Resident Assessment, within the Department of Health, which is responsible for nursing facility certification and for conducting surveys to determine compliance with Medicare and Medicaid requirements) and the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) within two hours for one of five sampled residents (Resident 1). This failure had the potential to result in a delay of an onsite inspection by the SSA and had the potential for Resident 1 to experience ongoing abuse. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted the resident on 7/30/2021 with diagnoses that included dementia (a progressive state of decline in mental abilities), type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), anxiety (a feeling of fear, dread, and uneasiness), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment tool) dated 5/2/2025, the MDS indicated the resident had severely impaired cognition (diminished ability to think, understand, and reason). The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) for eating, oral hygiene, and upper body dressing. The MDS indicated Resident 1 was dependent on help (helper does all the effort) for toileting hygiene, lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 1's Situation Background Assessment Recommendation (SBAR, a communication tool used by healthcare workers when there is a change of condition among the residents) Summary for Providers documentation dated 5/15/2025 at 10:38 PM, the SBAR Summary for Providers documentation indicated the resident had an unwitnessed fall around 10 PM. The SBAR Summary for Providers documentation indicated Resident 1 was found in bed with a forehead laceration (a tear or cut in the skin) and skin tear (a wound that occurs when the outer layer of skin separates from the underlying layer) on her bilateral (both) elbows. The SBAR Summary for Providers documentation indicated Resident 1's was assessed and provided with wound care. The SBAR Summary for Providers documentation indicated Resident 1 was unable to be consoled (someone is too sad or upset to be comforted) and was noted to be grimacing (to make a facial expression of pain) with her fists clenched (hands with fingers curled tightly into the palm). The SBAR Summary for Providers documentation indicated Resident 1 was confused. The SBAR Summary for Providers documentation indicated Resident 1's physician was immediately notified and provided the recommendation to transfer the resident to the General Acute Care Hospital (GACH, a health facility that provides short-term, inpatient medical and surgical services for a wide range of conditions) 1 via 911 for further evaluation. During a review of Resident 1's After Summary Visit from GACH 1 dated 5/16/2025 at 3:19 AM, the After Summary Visit indicated Resident 1 was provided with treatment for the laceration and skin tears. The After Summary Visit indicated Resident 1 had a Computed Tomography (CT - diagnostic imaging procedure that uses a machine to create detailed images of the inside of the body) of her head which did not show any head bleed or skull fracture (break in bone). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Nurse's Notes dated 5/16/2025 at 4 AM, the Nurse's Notes indicated Resident 1 returned to the facility from GACH 1 via gurney accompanied by two Emergency Medical Technicians (EMT's). The Nurse's Notes indicated Resident 1 was awake and talking. During a review of Resident 1's SBAR Summary for Providers documentation dated 5/16/2025 at 7:28 PM, the SBAR Summary for Providers documentation indicated the resident had an allegation of abuse. The SBAR Summary for Providers documentation indicated Resident 1's physician was notified and recommended to continue to monitor the resident for adverse effects of the alleged abuse. During a review of the document titled Report of Suspected Dependent Adult/Elder Abuse dated 5/16/2025, the document indicated on 5/15/2025 at 9:45 PM, Resident 1 was found on the floor next to her bed. The document indicated Resident 1 sustained a laceration on her forehead with bleeding and a left and right elbow skin tear. The document indicated Resident 1 was transferred to the GACH. The document indicated on 5/16/2025 at 5 PM, the Registered Nurse (RN) Supervisor overheard the Certified Nurse Assistant (CNA) who was outside the room heard Resident 1 say You pushed me to the (CNA) who was inside the room. The document indicated investigation was ongoing. During a review of a fax confirmation from the facility to the SSA dated 5/16/2025 at 6:59 PM, the fax confirmation indicated the facility notified the SSA of Resident 1's allegation of abuse. During a review of a fax confirmation from the facility to the Ombudsman dated 5/16/2025 at 7:04 PM, the fax confirmation indicated the facility was notified the ombudsman of Resident 1's allegation of abuse. During a review of a document titled Summary of Investigation dated 5/20/2025, the document indicated on 5/15/2025 CNA 1 found Resident 1 on the floor. The document indicated CNA 1 immediately assessed the resident. The document indicated Resident 1 was conscious and talking in Spanish. The document indicated bleeding was noted on Resident 1's forehead. The document indicated CNA 1 assisted Resident 1 back to bed then notified the Licensed Vocational Nurse (LVN). The document indicated LVN assessed Resident 1, notified the Registered Nurse (RN) Supervisor, and provided treatment to the resident. The document indicated the RN Supervisor called 911 and notified Resident 1's physician and family. The document indicated Resident 1 received treatment for the laceration of the left forehead and a CT scan which was negative for fracture. The document indicated Resident 1 was returned to the facility on [DATE] at 2:30 AM. The document further indicated that on 5/16/2025 at 5:00 PM, during the investigation of Resident 1's incident, CNA 2 informed the RN Supervisor that she overheard the resident saying in Spanish you pushed me to the CNA who found her during the fall. During a telephone interview on 5/28/2025 at 2:21 PM with RN 1, RN 1 stated on 5/15/2025 between 9:45 PM - 10:00 PM Licensed Vocational Nurse (LVN) 1 had notified him that Resident 1 had fallen. RN 1 stated when he went into Resident 1's room, the resident was already back in bed and Certified Nurse Assistant (CNA) 1 was also there. RN 1 stated Resident 1 had skin tears to both of her elbows and a cut on her forehead. RN 1 stated he checked Resident 1's vitals and provided treatment to the resident's wounds. RN 1 stated 911 was called and Resident 1 was transferred to the GACH. RN 1 stated Resident 1 could not tell him how she fell . RN 1 stated no one told him about an allegation of abuse that night. RN 1 stated that it wasn't until the next day when CNA 2 came forward and told him and LVN 1 that she heard Resident 1 say I fell , and you pushed me when the resident fell on [DATE]. RN 1 stated he reported the allegation of abuse to the Administrator right away. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/2025 at 3:04 PM with CNA 2, CNA 2 stated she did not see Resident 1 fall on 5/15/2025, but heard the resident say in Spanish you pushed me, you pushed me when she fell . CNA 2 stated she did not remember the time that happened, but stated it was around nighttime. CNA 2 stated she told LVN 1 what she heard what Resident 1 was saying immediately after she heard the resident say it. CNA 2 stated the next day on 5/16/2025 she told LVN 1 and RN 1 again that Resident 1 said you pushed me, you pushed me the night the before. CNA 2 stated this was the second time she told LVN 1 that Resident 1 said You pushed me . CNA 2 stated she did not tell the Administrator what she heard Resident 1 said only LVN 1. During an interview on 5/28/2025 at 3:12 PM with LVN 1, LVN 1 stated on 5/15/2025 around 9:00 PM to 10:00 PM, CNA 1 called his attention and told him that Resident 1 had fallen. LVN 1 stated he immediately went to Resident 1's room. LVN 1 stated as he was going to Resident 1's room, CNA 2 told him something. LVN 1 stated he couldn't really understand what CNA 2 was telling him. LVN 1 stated he thought CNA 2 was telling him Resident 1 was calling for help. LVN 1 stated when he got to Resident 1's room, the resident was already back in bed. LVN 1 stated Resident 1 had a skin tear to her right and left elbow and a cut on her left forehead. LVN 1 stated Resident 1's vitals were checked, and treatment was provided to the resident's wounds. LVN 1 stated 911 was called and Resident 1 was sent to the GACH for further evaluation. LVN 1 stated at that time he did not have any concerns about abuse. LVN 1 stated on the next day 5/16/2025 at around 4:00 PM, CNA 2 told him that she heard Resident 1 was saying you pushed me when she fell the night before on 5/15/2025. LVN 1 stated when he realized this was what CNA 2 was telling him the night before he told RN 1 and they both informed the Administrator and Director of Nursing (DON). LVN 1 stated pushing was an allegation of abuse which should be reported to the SSA, ombudsman, and law enforcement within two hours. LVN 1 stated that the allegation of abuse should have been reported the night before, but he did not realize CNA 2 was telling him Resident 1 was saying she was pushed by staff. During an interview on 5/28/2025 at 3:51 PM with the Director of Nursing (DON), the DON stated she was informed by the Administrator that Resident 1 fell and had an allegation of abuse on 5/16/2025. The DON stated through investigation of Resident 1's fall she found that on the night the resident fell on [DATE] CNA 2 told LVN 1 that Resident 1 was saying you pushed me to CNA 1. The DON stated LVN 1 did not hear the abuse allegation and only heard that Resident 1 was asking for help. The DON stated the abuse allegation was reported to the Administrator and herself when CNA 2 told LVN 1 and RN 1 about the abuse allegation a second time on 5/16/2025. The DON stated Resident 1's abuse allegation should have been reported the night the Resident fell on [DATE]; but because there was the initial misunderstanding and miscommunication between CNA 2 and LVN 1 on 5/15/2025, the allegation did not get reported until LVN 1 received clarification of what happened by CNA 2 on 5/16/2025. The DON stated allegations of abuse should be reported to the SSA, the ombudsman, and law enforcement within two hours so the facility could act immediately. The DON stated there was a potential for further abuse if abuse allegations were not reported timely. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating reviewed 1/2025, the P&P indicated All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported .If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility; the local/state ombudsman; the resident representative; adult protective services (where state law provides jurisdiction in long-term care); law enforcement officials; the resident's attending physician' and the facility medical director. Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.