STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055253	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. John of God Retirement	2468 South St Andrews Place Los Angeles, CA 90018

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** Based on observation, interview, and record review, the facility failed to ensure the California Department of Public Health (CDPH) was notified of an injury of unknown origin (an injury that was not witnessed and cannot be explained by the affected individual) for one of three sampled residents (Resident 4).This failure of not reporting the injury of unknown origin to CDPH within two hours delayed the investigation and placed Resident 4 at risk for further injuries.Findings:During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE]. Resident 4's diagnoses included irritable bowel syndrome (a condition that affects the stomach and intestines), anxiety (a mental health condition characterized by excessive, persistent, and uncontrollable worry that interferes with daily functioning), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 4's History and Physical (H&P), dated 1/31/2026, the H&P indicated Resident 4 did not have the capacity to understand and make decisions.During a review of Resident 4's Minimum Data Sheet ([MDS]- a resident assessment tool), dated 6/1/2026, the MDS indicated Resident 4's cognitive skills for daily decision making (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 4 required substantial/maximal assistance (helper does more than half the effort and helper lifts or hold trunk or limbs and provides more than half the effort) by staff for toileting hygiene and dressing. The MDS indicated Resident 4 was dependent (helper does all the effort) on staff for bed to chair transfers (the ability to transfer to and from a bed to a chair or wheelchair) and tub/shower transfers. The MDS indicated Resident 4's preferred language was Korean and needed or wanted an interpreter (to communicate with staff.During a review of Resident 4's change of condition record titled, Situation Background Assessment and Recommendation (SBAR), dated 6/1/2026, the SBAR indicated on 6/1/2026, Resident 4 had ecchymosis (is the medical term for a bruise a flat, purple or bluish-black patch that forms under the skin) to the anterior (front) left lower leg.During a review of facility's Five Day Investigation, unknown date, the five-day investigation indicated Resident 4 had a purplish discoloration to the left lower leg on 6/1/2026. The five-day investigation indicated the discoloration was of unknown origin.During a telephone interview on 6/12/2026 at 12:24 p.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated on 6/2/2026, Resident 4 complained of pain to her left leg. LVN 5 stated Resident 4's leg was bruised and swollen. LVN 5 stated he asked LVN 4 (who was Korean speaking) to translate. LVN 4 told LVN 5 that Resident 4 stated she was hit by a metal object. LVN 5 stated he reported the injury to the Director of Staff Development (DSD) and the Director of Nursing (DON). LVN 5 stated he did not notify the Administrator (ADM). LVN 5 stated he should have reported to the ADM because the ADM was the Abuse coordinator. LVN 5 stated this could have been potential abuse and needed to be reported within the time frame of two hours.During a concurrent interview and record review on 6/12/2026 at 3:05 p.m., with the ADM, the facility's Five Day Investigation, unknown date, was reviewed. The five-day investigation indicated on 6/1/2026, Resident 4 had a purplish discoloration to the left lower leg which was determined to be of unknown (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	origin. The ADM stated he was not aware until 6/3/2026 when Resident 4 reported Certified Nursing Assistant (CNA 3) hit her with a metal object. The ADM stated once he clarified the incident using a Korean translator of what happened and/or of the injury of unknown origin it was to be reported. The ADM stated the police, Ombudsman, and CDPH were to be notified within two hours. The ADM stated there was a delay in reporting. The ADM stated not reporting within the timeframe could cause a delay in keeping the residents safe.During a review of the facility's policy and procedure (P&P) titled, Unusual Occurrence Reporting, dated 3/2026, the P&P indicated as required by federal or state regulations, the facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of residents. The P&P indicated unusual occurrences are reported to appropriate agencies as required by current law and /or regulations within twenty-four (24) hours of an incident.During a review of the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigation, dated 3/2026, the P&P indicated all reports of resident abuse (including injuries of unknown origin) are reported local, state, and federal agencies. The P&P indicated the administrator or the individual making the allegation immediately reports to the following agencies (the Ombudsman, Law Enforcement, and the State responsible for surveying). The P&P indicated immediately was indicated to report within two hours of an allegation of abuse or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a care plan (a personalized document outlining a patient's health needs, medical history, and specific goals for care) for the use a Korean-speaking interpreter for one of three sampled residents (Resident 4) when Resident 4 expressed discomfort to her left lower leg.This failure of not implementing the care plan had the potential for Resident 4 to not effectively communicate with staff regarding her injury.Findings:During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE]. Resident 4's diagnoses included irritable bowel syndrome (a condition that affects the stomach and intestines), anxiety (a mental health condition characterized by excessive, persistent, and uncontrollable worry that interferes with daily functioning), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Patient 4's History and Physical (H&P), dated 1/31/2026, the H&P indicated Resident 4 did not have the capacity to understand and make decisions.During a review of Resident 4's Minimum Data Sheet ([MDS]- a resident assessment tool), dated 6/1/2026, the MDS indicated Resident 4's cognitive skills for daily decision making (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 4 required substantial/maximal assistance (helper does more than half the effort and helper lifts or hold trunk or limbs and provides more than half the effort) by staff for toileting hygiene and dressing. The MDS indicated Resident 4 was dependent (helper does all the effort) on staff for bed to chair transfers (the ability to transfer to and from a bed to a chair or wheelchair) and tub/shower transfers. The MDS indicated Resident 4's preferred language was Korean and needed or wanted an interpreter to communicate with staff.During a review of Resident 4's care plan titled, Impaired Communication Skills, dated 2/10/2024, the care plain indicated Resident 4 had a language barrier due to the resident speaking fluently in Korean. The care plan indicated staff was to utilize a translator, communication device, and communication board.During an interview on 6/12/2026 at 9:54 a.m., with Resident 4, interpreted by Resident 4's Family Member [FM 1]), Resident 4 stated on 6/1/20276, there was no interpreter for her to explain to staff what happened to her left lower leg. Resident 4 stated on the following day (6/2/2026) there was a Korean interpreter who asked her what happened to her leg. During a concurrent interview and record review on 6/12/2026 at 10:35 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 4's care plan titled, Impaired Communication Skills, dated 2/10/2024 was reviewed. The care plan indicated Resident 4 had a language barrier due to the resident being fluent in Korean. The care plan indicated the staff was to utilize a translator, communication device, and communication board. LVN 3 stated on 6/1/2026, Resident 4 pointed to her left leg to show bruising. LVN 3 stated Resident 4 was speaking in Korean, and she could not understand what Resident 4 was saying. LVN 3 stated she did not use an interpreter to translate what Resident 4 was saying. LVN 3 stated by not using an interpreter Resident 4 would not be able to communicate what happened to her leg and other concerns she may have had. LVN 3 stated it was important to use a translator so the facility would know whether the resident had fallen or was abused.During an interview on 6/12/2026 at 2:06 p.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated on 6/1/2026, Resident 4 pointed to her left leg indicating she was in pain. CNA 3 stated she did not use a Korean communication pamphlet nor asked staff to translate what happened to Resident 4's leg. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2026, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The P&P indicated to identify problem areas and their causes, and developing interventions that are targeted and meaningful to the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident. The P&P indicated to reflect the resident's expressed wishes regarding care and treatment goals.