STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055293	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Anita Convalescent Hospital	5522 Gracewood Ave. Temple City, CA 91780

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1) was free from sexual abuse (non-consensual [without the person's permission] touching of one person for the sexual gratification of another) on 6/19/2025 by failing to: 1. Protect Resident 1 from Resident 2 by ensuring Resident 2 was provided a one-to-one sitter (1:1, an intervention when a nurse or healthcare professional provides constant observation and support to a resident who is at risk of harm, such as one with cognitive [mental action or process of acquiring knowledge and understanding] impairments, challenging behaviors, or one who may fall or cause harm to himself/herself or to others) in accordance with the physician's order on 6/19/2025 from 11 PM to 11:20 PM. 2. Prevent abuse by ensuring facility licensed staff monitored and documented Resident 2's sexual inappropriate behavior of playing with his private area (a person's external sexual organs or genitals) on 6/12/2025 and developed and implemented interventions to prevent abuse to Resident 1 and other residents in the facility. 3. Notify and inform Resident 2's primary physician (MD) of Resident 2's sexual inappropriate behavior of playing with his private area on 6/12/2025 and obtain orders to protect Resident 1 and other residents residing in the facility from safety and sexual abuse. These deficient practices resulted in Resident 1 experiencing sexual abuse from Resident 2 on 6/19/2025 at around 11:20 PM. Resident 2 who was positive for human immunodeficiency virus (HIV, attacks cells that help the body fight infection, making a person more vulnerable to other infections and diseases) and who should have been supervised with a 1:1 Sitter, was observed by Licensed Vocational Nurse 1 (LVN 1) on top of Resident 1 in Resident 1's room. Resident 1's pants and diaper were pulled down above her knees. Resident 2 stated having sex with Resident 1. Resident 1 was started on HIV prophylaxis (prevention) medication on 6/21/2025 which could result in Resident 1 to suffer adverse side effects such as kidney and liver damage, depression [a mood disorder characterized by persistent feelings of sadness, loss of interest in activities, and a range of other symptoms that interfere with daily life], anxiety [excessive worry, fear, and unease that can interfere with daily life], and suicidal thoughts [thoughts, feelings, or ideas about ending one's own life]). Resident 1 experienced dysphoric (experiencing a state of unease, dissatisfaction, or generalized unhappiness) mood during a consult with psychologist (specializes in the study of mind and behavior or in the treatment of mental, emotional, and behavioral disorders) on 6/25/2025. (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 - Few	On 6/24/2025 at 5:38 PM, the California Department of Public Health (CDPH) called an Immediate Jeopardy situation (IJ, a situation in which the facility's noncompliance [not following rules] with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Resident) due to the facility's failure to protect Resident 1 from sexual abuse from Resident 2. The facility submitted an acceptable IJ Removal Plan (action to correct the deficient practice) to CDPH on 6/26/2025 at 4:50 PM. The IJ was removed on 6/26/2025, after the surveyor verified and confirmed the facility implemented the facility's IJ Removal Plan (a detailed plan to address the IJ findings) while onsite by observation, interview, and record review. The IJ was removed in the presence of the Director of Nurses (DON), Assistant Administrator, Clinical Director Regional, Assistant Administrator, Regional Infection Preventionist Nurse, Regional Director of Staff Development, Quality Assurance (QA), Assistant Director of Nurses (ADON), and Director of Staff Development (DSD). The acceptable IJ Removal Plan included the following information: 1. On 6/19/2025, Resident 2 was observed by the charge nurse on top of Resident 1. Immediately Resident 2 was pulled by the charge nurse to get off Resident 1 and was guided outside of the room. 2. Resident 2 was directed to his room by Licensed Vocational Nurse 1 (LVN 1) and was monitored by LVN 1 and Security guard 1 until the deputies from the local police department arrived at the facility. The deputies interviewed Resident 1. Resident 2 was handcuffed and was taken by the deputies for further investigation. 3. Resident 1 was transferred to the General Acute Care Hospital 1 on 6/20/2025 at 4:45 AM for evaluation by Sexual Assault Response Team (SART a multidisciplinary team that provides medical, legal, and emotional support to survivors of sexual assault) and received appropriate medical treatment. 4. Registered Nurse 1 (RN 1) notified Resident 1's family and physician on 6/20/2025 at 2:26 AM. RN 1 notified Resident 2's physician, family, and responsible party on 6/20/2025 at 12 AM. The Ombudsman (an independent advocate who helps residents navigate concerns, ensuring their rights are protected and their voices are heard), CDPH, and local law enforcement were notified. A thorough investigation was initiated by the Administrator on 6/20/2025. 5. Resident 1 was transferred back to the facility on 6/20/2025 with discharge instructions to provide prophylaxis medication for HIV, monitor for signs of medical deterioration such as fever, pelvic pain, abnormal vaginal/rectal bleeding. Psychosocial support visits by Social Services started on 6/20/2025 and will take place daily for 72 hours and as needed. 6. On 6/24/2025, the DON and Social Services Director completed a facility-wide audit of the wandering elopement assessment and behavior monitoring of all residents with documented sexual inappropriate and wandering behaviors. There were four (4) residents identified with sexually inappropriate behavior. There were also eleven residents identified with wandering and elopement risk. Wandering assessments were updated on 6/24/2025, care plans and orders were revised and updated as needed for 11 residents with wandering monitoring and 4 residents with sexually inappropriate behavior monitoring. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. The psychologist was informed on 6/24/2025 to reassess the four residents with sexually inappropriate behavior. This will be completed on 6/2025. 11 Care plans were revised and updated for the wandering residents and 4 care plans were revised for the sexually inappropriate care plans. No other residents have been identified as having been sexually abused. 8. The 11 residents that were identified at risk of wandering and elopement were reassessed by the ADON on 6/24/2025. 9. The DON and Designees will in-service all available licensed nurses and certified nursing assistants starting 6/24/2025 and ongoing on recognition and reporting sexual inappropriate behaviors, implementation and documentation of 1:1 supervision; monitoring and documenting wandering behaviors, proper notification to physician of behavioral changes. Staff members who are not currently working will be in-serviced and educated on their first shift back to work. Care plan development and updates for sexually inappropriate behavioral issues, abuse prevention and reporting requirements, change of condition will likewise be initiated as warranted. 10. Outside Resource Consultant 1 was contacted from an outside Behavioral Management Program and will be providing education on sexual and wandering behaviors on 6/2025 and ongoing. 11. Vendor 1 was contacted on 6/24/2025 and will provide further education to licensed and non-licensed staff on 6/25/2025 and ongoing regarding sexual and wandering behaviors. 12. Starting 6/24/2025, residents admitted and readmitted will be assessed to include sexually inappropriate behaviors and wandering and elopement risk. 13. Starting 6/24/2025, residents with sexually inappropriate behavior and wandering behavior will be monitored and logged in newly implemented Resident Visual Check Log daily on every 2-hour basis. The log will be completed by the CNA or the LVN assigned to the resident. The Care plan for the 11 residents identified with wandering behavior and 4 residents identified with sexually inappropriate behavior were updated based on the Behavior Management Policy and Procedure. 14. Starting 6/24/2025, residents who are newly assessed or reassessed and identified with sexually inappropriate behavior or identified at risk for wandering and elopement risk will be referred to psychologist or psychiatrist for evaluation. 4 residents were identified with sexually inappropriate behavior, and 11 residents were identified with wandering behavior. 15. Starting 6/24/2025, the licensed and certified nursing assistant staff on duty will ensure the safety of all residents pertaining to sexually inappropriate behavior and wandering behavior by conducting daily rounds on the unit while they are in the care of facility staff. 16. Starting 6/24/2025 and ongoing, DON/Designee or QA nurse will provide retraining and reeducation to licensed nurses capturing all shifts to identify resident's changes in sexually inappropriate behaviors and to address or intervene, to monitor, protect, prevent serious complications /illness and behavior management. 17. Starting 6/24/2025 and ongoing, Vendor 1 to provide further training to staff will be provided in behavior management. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	18. The Staff Development Coordinator/ DON or Designee will provide this in-service by 6/25/2025 and ongoing. This education will include sexually inappropriate behavior and wandering. The training will be included in the hire orientation packet for new hires and rehired employees. 19. The Unit Managers will ensure proper supervision of residents with behavioral issues and will review behavioral documentation monitoring on the electronic medical record (E-mar) each shift, and report concerns to the DON. The Social Services Director revised the facility's abuse prevention policy to include specific interventions for residents with sexual inappropriate behaviors and wandering behaviors. 20. Starting 6/24/2025 and ongoing, the DON and/or Designee is responsible and will audit 100% of residents with documented sexual inappropriate behaviors and wandering behaviors weekly for 4 weeks, then 50% monthly for 2 months to ensure 1:1 supervision is implemented as ordered, behaviors are properly documented, care plans are updated to reflect current behaviors, physician notifications occur as required, and appropriate interventions are in place The Unit Managers will conduct daily rounds on all shifts to ensure proper supervision of residents with behavioral issues. 21. The DON will report monitoring results to the Quality Assurance Performance Improvement (QAPI) committee monthly for three months. 22. The QAPI committee will evaluate the effectiveness of interventions and make changes as needed until substantial compliance is achieved and maintained. Cross reference F689 Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), depression and schizophrenia unspecified (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/26/2025, the MDS indicated Resident 1 had severe impairment with cognitive skills for daily decision making. Resident 1 required supervision or touching assistant (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) with bed mobility, transfer, walking, upper and lower body dressing, and toilet use. Resident 1 required substantial/ maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs but provides more than half the effort) with shower/ bathing self. During concurrent observation and interview on 6/23/2025 at 4:11 PM, Resident 1 was observed walking in the hallway. During the interview, Resident 1 was asked about the incident on 6/19/2025. Resident 1 stated, There is nothing to talk about. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the General Acute Care Hospital (GACH) Emergency Department History and Physical (ED H&P), dated 6/20/2025, the GACH ED H&P indicated Resident 1 had reported one of the residents (Resident 2) entered her room, lowered his pants, pinned her down, and started having sexual intercourse with her. The GACH ED H&P also indicated the SART nurse, Resident 1 does have positive findings on genitourinary (GU, it refers to the organs and systems involved in the production, storage, and excretion of urine and reproduction) examination evidence of sexual assault (any kind of sexual activity, contact, or experience that happens without one's consent). It also indicated, per SART nurse, there is confirmation that the offender (Resident 2) is HIV positive and Resident 1 was started on Post-Exposure Prophylaxis (PEP, a medication regimen taken after potential exposure to HIV to prevent infection). During a review of Resident 1's Physician's Order, dated 6/20/2025, the Physician's Order, indicated to start Emtricitabine-Tenofovir Disoproxil Fumarate (Truvada, prescription medication used to treat HIV-1 infection, and also to reduce the risk of HIV - 1 infection in high-risk individuals) oral tablet 200 to 300 milligrams (mg, unit of mass) on 6/21/2025. Give one tablet by mouth in the morning for HIV - 1 infection prophylaxis for 28 days. During a review of Resident 1's Physician's order, dated 6/20/2025, the Physician's Order indicated Psychology referral. During a review of Resident 1's Psychology Report, dated 6/25/2025, the Psychology Report indicated Resident 1 was seen following a referral made by the staff on 6/24/2025 due to a report that Resident 1 experienced a suspected sexual assault. The report indicated Resident 1's mood appeared dysphoric and responded to questions with brief, simple answers. The report also indicated Resident 1 became visibly irritable when asked about the incident, expressing frustration with the repetitive nature of the inquiries. Resident 1 declined to provide any specific details and eventually ceased to respond altogether. During a review of the Resident 1's Psychology Report, dated 6/26/2025, the Psychology Report indicated Resident 1 was tearful at one point during evaluation, stating it was caused by the topic of the assault being brought up repeatedly. 2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia (a mental disorder characterized by psychosis, where individuals experience a disconnect from reality), violent behavior (it is characterized by actions intended to cause physical harm or injury to others, or damage to property), and positive for HIV. During a review of Resident 2's Physician's Order, dated 6/3/2025, the Physician's Order indicated Resident 2 may have 1:1 sitter. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was moderately impaired with cognitive skills for daily decision making. Resident 2 also required supervision or touching assistance with toileting hygiene, shower/bathe self, change of position, and transfer. Resident 2 was independent for eating, oral hygiene, upper body dressing and personal hygiene. Resident 2 had episodes of wandering daily. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 2's Progress Notes, dated 6/20/2025 timed at 5:30 AM, the Progress Notes indicated at approximately 11:20 PM, charge nurse notified RN supervisor that Resident 2 was allegedly having sexually inappropriate behavior. CN stated that Resident 2 was on top of Resident 1. MD made aware and ordered Resident 1 to be transferred to GACH for further assessment. The facility notified the local police department who arrived at the facility around 1AM. The local police department took custody of Resident 2 and transferred Resident 2 to GACH for further investigation. During an interview on 6/24/2025 at 10 AM with Director of Nurses (DON), the DON stated Licensed Vocational Nurse 1 (LVN 1) called him on the phone on 6/19/2025 around 11:40 PM and notified him that LVN 1 found Resident 2 on top of Resident 1 in Resident 1's room. During an interview on 6/24/2025 at 12:35 PM with Quality Assurance Nurse (QAN), QAN stated the sexual abuse happened during change of shift, between 11 PM to 11:20 PM on 6/19/2025. QAN stated LVN 1 went to Resident 1's room upon hearing a screaming noise from Resident 1's room. QAN stated LVN 1 found Resident 2 on top of Resident 1. QAN stated LVN 1 removed Resident 2 from Resident 1's room right away. LVN1 then notified Registered Nurse Supervisor 1 (RNS 1) and reported to the DON, physicians, families, police, ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and public health. During an interview on 6/24/2025 at 12:37 PM with QAN, QAN stated Resident 2 required a 1:1 sitter in accordance with the physician's order because of the resident's wandering behavior. During an interview on 6/24/2025 at 3:05 PM with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated she had seen Resident 2 playing with his private area sometime this month (6/2025) but does not remember exactly what date. CNA3 stated she did not report the incident to the licensed nurse. During an interview on 6/24/2025 at 3:08 PM with CNA 2, CNA 2 stated she had seen Resident 2 playing with his private area in the restroom area during her shift but does not remember the date when this happened. CNA2 stated she had reported it the charge nurse (LVN 3) a few days after it happened. During an interview on 6/24/2025 at 3:20 PM with Security Guard 1 (SG1), SG 1 stated that on 6/19/2025 at around 11:20 PM, while SG 1 was near the entrance door, he heard LVN 1 scream, Hey get off her. SG 1 stated he followed where the voice was coming from and observed LVN 1 bringing Resident 2 out of Resident 1's room. SG 1 stated, The resident (Resident 2) was holding his pants. It was unbuttoned and unzipped, and I can see his penis. SG 1 stated, The resident (Resident 2) told me that he was having sex with that lady (Resident 1). During an interview on 6/24/2025 at 4:20 PM with RNS 1, RNS 1 stated LVN 1 reported to RNS 1 on 6/19/2025 around 11:20 PM that Resident 2 sexually assaulted Resident 1. RNS 1 stated immediately after receiving the report, she went to Resident 1's room with LVN 1. Resident 1 was observed on her bed with her pants and diaper pulled down above her knees. RNS 1 stated she observed Resident 2 standing with SG 1 in front of his room, across Resident 1's room. RNS 1 stated Resident 2 had an order for a 1:1 sitter but there were no staff assigned to supervise and sit with the resident. RNS 1 added there was no CNA providing 1:1 supervision for Resident 2 for the shift of 11 PM to 7 AM on 6/19/2025. RNS 1 added having a 1:1 sitter could have protected Resident 1 from sexual abuse from Resident 2. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review on 6/24/2025 at 4:30 PM with RNS 1, Resident 2's medical records were reviewed. RNS 1 stated there was a nursing progress note, dated 6/15/2025, which indicated that CNA2 observed and had reported to LVN 3 that Resident 2 was playing with his private area on 6/12/2025. RNS 1 stated Resident 2's sexual inappropriate behavior was a change of condition (COC, any noticeable alteration in a resident's physical or mental status that deviates from their baseline or established pattern, potentially indicating a new illness, worsening condition, or need for intervention) and should have been reported to the MD. RNS1 stated the nurses should have completed a COC report, monitored Resident 2 for 72 hours, and should have notified the MD in accordance with the facility's COC policy. During an interview on 6/24/2025 at 3 PM with the DON, the DON stated the facility did not have a process, such as having a 1:1 sitter log to monitor and ensure the resident requiring a 1:1 sitter was provided with a facility staff to supervise and sit with the resident at all times. The DON stated the facility should have had a 1:1 sitter log, which will be filled out at the beginning of each shift where information such as the name of the resident requiring a sitter, the name of the sitter assigned to the resident, and the date and shift the sitter was assigned will be entered. The DON stated having a 1:1 sitter for Resident 2 could have prevented the sexual assault on 6/19/2025. During an interview on 6/24/2025 at 7 PM with LVN 1, LVN 1 stated that on 6/19/2025 at around 11:20 PM, he found Resident 2 on top of Resident 1 after he heard a screaming noise from Resident 1's room. LVN1 stated he immediately pulled Resident 2 away from Resident 1 while LVN 1 screamed for assistance. LVN 1 stated SG 1 came to assist, and he instructed SG 1 to monitor Resident 2 while LVN 1 went to the nurses' station to report the incident to RNS 1. LVN 1 stated there was an order for Resident 2 to have a 1:1 sitter however Resident 2 was not assigned a sitter on 6/19/2025 for the 11 PM to 7AM shift. During an interview on 6/24/2025 at 7:28 PM with LVN 3, LVN 3 stated one of the CNAs (unnamed) who was assigned as 1:1 sitter to Resident 2 reported on 6/15/2025 that Resident 2 was playing with his private area in his room on 6/12/2025. LVN 3 stated CNA should have reported the incident on 6/12/2025. LVN 3 stated the RN Supervisor (unnamed) also heard Resident 2's sexual inappropriate behavior from the CNA and instructed LVN 3 to document the report on the nursing progress notes. LVN 3 stated a COC report and monitoring for Resident 2's sexual inappropriate behavior should have been done. LVN 3 stated it should have been also reported to MD so proper interventions could have been developed and implemented. During a review of the facility's Policy and Procedure (P&P) titled, Abuse Prevention and Prohibition Program, revised on 8/1/2023, the P&P indicated . each resident has the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The Facility has zero tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property .The Administrator is responsible for coordinating and implementing the Facility's abuse prevention policies, procedures, training program, and systems .This policy also identifies Special Considerations regarding the investigation of injuries of unknown origin and criminal sexual abuse. During a review of the facility's P&P titled, Notification of Change of Condition, revised on 6/1/2017, indicated its purpose is to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Definition: An acute change of condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. Clinically important means a deviation that, without intervention, may result in complications or death. (AMOA 2003) Procedure: I. The Licensed Nurse will notify the resident's Attending Physician when there is an: A. Incident/accident involving the resident; B. A significant change in the resident's physical, mental or psychosocial status, e.g., deterioration in health, mental or psychosocial status, life-threatening conditions or clinical complications. II. The Licensed Nurse will assess the resident's change of condition and document the observations and symptoms. Documentation: A. A licensed Nurse will document the following: i. Date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes. ii. The time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. iii. Update the Care Plan to reflect the resident's current status. B. A licensed Nurse will communicate any changes in required interventions to the IDT members involved in the resident's care. C. A licensed Nurse will document each shift for at least seventy-two (72) hours. D. Documentation pertaining to a change in the resident's condition will be maintained in the resident's medical record and on the 24-Hour Report.

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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 develop and implement comprehensive care plan for one of two residents (Resident 2) to address Resident 2's sexual inappropriate behavior of touching his private area noted on 6/12/2025. . This failure placed other residents in the facility at risk of being sexually abused (unwanted sexual activity perpetrated by another adult, often involving the use of force, threats, manipulation, or taking advantage of someone's vulnerability or incapacitation) by Resident 2 and vice versa. Findings: During a review of Resident 2's admission Record indicated Resident 2 was initially admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia (a mental disorder characterized by psychosis, where individuals experience a disconnect from reality), and violent behavior (it is characterized by actions intended to cause physical harm or injury to others, or damage to property). A review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 6/6/2025, indicated Resident 2 had moderate impairment (decisions poor, cues/supervision required) for cognitive skills for daily decision making. The MDS also indicated Resident 2 also needs supervision or touching assistance for toileting hygiene, shower/bathe self, change of position, and transfer and independent for eating, oral hygiene, upper body dressing and personal hygiene. During a review of the Progress Notes (PN) dated 6/15/2025 from Resident 2's record, PN indicated Resident 2's 1:1 sitter (a caregiver responsible for providing companionship and support to patients who require close observation due to medical conditions, safety concerns, or behavioral challenges), reported to charge nurse (CN) and Registered Nurse Supervisor (RNS) that on 6/12/2025 while in Resident 2's room, Resident 2 was playing with Resident 2's private area and asked the sitter to get closer to Resident 2. and Resident 2 was asking sitter to get closer to him and get him a water on the date of 6/12/2025, sitter then went out of Resident 2's room and asked the male Registered Nurse (RN) to went back to Resident 2' room with her, but Resident 2 stopped playing his private area right at the time sitter and male RN stepped into his room. PN indicated Resident 2's inappropriate sexual behavior was reported to LVN3 on 6/15/2025. During an interview on 6/24/2025 at 7:28 PM with LVN 3, LVN 3 stated one of the CNAs (unnamed) who was assigned as 1:1 sitter to Resident 2 reported on 6/15/2025 that Resident 2 was observed masturbating in the resident's room on 6/12/2025. LVN 3 stated CNA should have reported the incident on 6/12/2025. LVN 3 stated licensed nurse should have developed and implemented and resident centered care plan to address Resident 2's sexual inappropriate behavior noted on 6/12/2025 and interventions such as close monitoring of Resident 2 should have added in the care plan. (continued on next page)

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	055293	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Anita Convalescent Hospital	5522 Gracewood Ave. Temple City, CA 91780

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/24/2025 at 7:40 PM with Registered Nurse Supervisor (RNS) 2, RNS 2 stated it is important to report inappropriate sexual behavior of Resident 2 and licensed nurse should have developed, initiated and implemented a care plan to address Resident 2's sexual inappropriate behavior of touching his private area to ensure the Resident 2's safety and safety of other residents in the facility for potential of being abused. During a review of the facility's Policy and Procedure (P&P) titled Care Planning, revised on 6/12/2025, indicated the following a Licensed Nurse will initiate the Care Plan, and the plan will be finalized in accordance with OBRA (Omnibus Budget Reconciliation Act)/MDS guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgment on an as needed bases. The P&P also indicated the interdisciplinary team meeting (IDT) will revise the Comprehensive Care Plan as needed at the following intervals: ¢ To address changes in behavior and care; the Care Plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's Attending Physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs. ¢ The Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 2) who had episodes of wandering (moving aimlessly from place to place without a specific destination or purpose) was supervised by failing to provide a one to one sitter (1:1, an intervention when a nurse or healthcare professional provides constant observation and support to a resident who is at risk of harm, such as one with cognitive [mental action or process of acquiring knowledge and understanding] impairments, challenging behaviors, or one who may fall or cause harm to himself/herself or to others) in accordance with the physician's order on 6/19/2025. This deficient practice resulted in Resident 2 wandering into Resident 1's room on 6/19/2025 around 11:20 PM. Resident 2 was observed by Licensed Vocational Nurse 1 (LVN 1) on top of Resident 1 in Resident 1's room. Resident 1's pants and diaper were pulled down above her knees. Resident 2 stated having sex with Resident 1. Cross reference F600 Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), depression and schizophrenia unspecified (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/26/2025, the MDS indicated Resident 1 had severe impairment with cognitive skills for daily decision making. Resident 1 required supervision or touching assistant (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) with bed mobility, transfer, walking, upper and lower body dressing, and toilet use. Resident 1 required substantial/ maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs but provides more than half the effort) with shower/ bathing self. 2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia (a mental disorder characterized by psychosis, where individuals experience a disconnect from reality), violent behavior (it is characterized by actions intended to cause physical harm or injury to others, or damage to property), and positive for HIV. During a review of Resident 2's Wandering and Elopement (a person leaving a safe area or a responsible caregiver without permission or supervision) Risk Assessment, dated 6/3/2025, the Wandering and Elopement Risk Assessment indicated Resident 2 had a significant actual risk. During a review of Resident 2's Physician's Order, dated 6/3/2025, the Physician's Order indicated Resident 2 may have 1:1 sitter. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was moderately impaired with cognitive skills for daily decision making. Resident 2 also required supervision or touching assistance with toileting hygiene, shower/bathe self, change of position, and transfer. Resident 2 was independent for eating, oral hygiene, upper body dressing and personal hygiene. Resident 2 had episodes of wandering daily. During a review of Resident 2's Progress Notes, dated 6/20/2025 timed at 5:30 AM, the Progress Notes indicated at approximately 11:20 PM, charge nurse notified RN supervisor that Resident 2 was allegedly having sexually inappropriate behavior. CN stated that Resident 2 was on top or Resident 1. During an interview on 6/24/2025 at 10 AM with Director of Nurses (DON), the DON stated Licensed Vocational Nurse 1 (LVN 1) called him on the phone on 6/19/2025 around 11:40 PM and notified him that LVN 1 found Resident 2 on top of Resident 1 in Resident 1's room. During an interview on 6/24/2025 at 12:35 PM with Quality Assurance Nurse (QAN), QAN stated the sexual abuse happened during change of shift, between 11 PM to 11:20 PM on 6/19/2025. QAN stated LVN 1 went to Resident 1's room upon hearing a screaming noise from Resident 1's room. QAN stated LVN 1 found Resident 2 on top of Resident 1. QAN stated LVN 1 removed Resident 2 from Resident 1's room right away. LVN1 then notified Registered Nurse Supervisor 1 (RNS 1) and reported to the DON, physicians, families, police, ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and public health. During an interview on 6/24/2025 at 12:37 PM with QAN, QAN stated Resident 2 required a 1:1 sitter in accordance with the physician's order because of the resident's wandering behavior. During an interview on 6/24/2025 at 3 PM with the DON, the DON stated the facility did not have a process, such as having a 1:1 sitter log to monitor and ensure the resident requiring a 1:1 sitter was provided with a facility staff to supervise and sit with the resident at all times. The DON stated the facility should have had a 1:1 sitter log, which will be filled out at the beginning of each shift where information such as the name of the resident requiring a sitter, the name of the sitter assigned to the resident, and the date and shift the sitter was assigned will be entered. The DON stated having a 1:1 sitter for Resident 2 could have prevented the sexual assault on 6/19/2025. During an interview on 6/24/2025 at 3:20 PM with Security Guard 1 (SG1), SG 1 stated that on 6/19/2025 at around 11:20 PM, while SG 1 was near the entrance door, he heard LVN 1 scream, Hey get off her. SG 1 stated he followed where the voice was coming from and observed LVN 1 bringing Resident 2 out of Resident 1's room. SG 1 stated, The resident (Resident 2) was holding his pants. It was unbuttoned and unzipped, and I can see his penis. SG 1 stated, The resident (Resident 2) told me that he was having sex with that lady (Resident 1). During an interview on 6/24/2025 at 7 PM with LVN 1, LVN 1 stated that on 6/19/2025 at around 11:20 PM, he found Resident 2 on top of Resident 1 after he heard a screaming noise from Resident 1's room. LVN1 stated he immediately pulled Resident 2 away from Resident 1 while LVN 1 screamed for assistance. LVN 1 stated SG 1 came to assist, and he instructed SG 1 to monitor Resident 2 while LVN 1 went to the nurses' station to report the incident to RNS 1. LVN 1 stated there was an order for Resident 2 to have a 1:1 sitter however Resident 2 was not assigned a sitter on 6/19/2025 for the 11 PM to 7AM shift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, Physician Orders, revised on 5/1/2024, the P&P indicated orders will be carried out completely and noted in a timely manner. During a review of the facility's P&P titled, Abuse Prevention and Prohibition Program, revised on 8/1/2023, the P&P indicated . each resident has the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The Facility has zero tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property . The Facility is committed to protecting residents from abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies providing services under arrangement, family members, legal guardians, surrogates, sponsors, friends, and visitors. Prevention: The Facility maintains adequate staffing on all shifts to ensure that the needs of each resident are met.

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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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on interview and record review, the facility failed to ensure that 524 out of 552 direct care staff (all facility staff who directly provide program and/or nursing services to residents) and indirect care staff (provide essential support services that do not involve direct, hands-on patient care like housekeeping, dietary, laundry, maintenance, and clerical staff) were in services/ trained on April 2025 on the rights of the residents and facility responsibilities when caring for the residents based on the facility's policy. This deficient practice can affect the staff's knowledge about their Resident's Rights when providing care for their residents. Findings: During a record review of the undated In-Service Calendar, the in-service calendar indicated Resident Rights in- service was scheduled in April 2025. During a concurrent interview and record review on 6/25/2025 at 3PM with Director of the Staff Development 1 (DSD 1), The In-service Binder for 2025 was reviewed. The Resident Rights In- Service dated 4/4/2025 indicated, 23 staff from the night shift (11 PM to 7AM) staff and 5 staff from 6 AM-2:30PM shift attended the in service. DSD 1 stated there were 28 staff that signed the attendance sheet meaning 524 staff did not attend the in serive for Resident's Rights conducted on 4/4/2025. The DSD stated it is impossible for the DSD to keep track of all 500 plus staff to ensure all active/ current staff have completed the in-service for Resident Rights. During a concurrent interview and record review on 6/26/2025 at 10:50 AM with Director of the Staff Development Consultant (DSDC), the Resident Rights In- Service dated 4/4/2025 was reviewed. DSDC stated that Resident Rights In- service was only provided to the 11 PM- 7AM shift. There were no sign-in sheets in the in-service binder for 7 AM-3 PM shift and 3PM-11:30 PM shift. DSD 1 stated DSD 1 cannot find the sign-in sheets for 4/4/2025 in service 7 AM-3 PM shift and 3PM-11:30 PM in the in-service binder which means the in-service was incomplete and it was not provided to the staff in the other shifts 7 AM-3 PM shift and 3PM-11:30 PM. During an interview on 6/26/2025 at 10:52 AM with DSDC, DSDC stated the Resident Rights in-service was not provided to all the staff on 4/4/2025 and it could have a significant impact on the residents because the staff were not educated about the residents' rights. DSDC stated all the staff on the floor needed to be educated regarding the Resident Rights and the staff needed to understand the Resident's rights, because the Residents consider the facility as their home and facility staff need to honor and respect the residents' rights. During an interview on 6/26/2025 at 10:59 AM with DSD 1, DSD 1 stated the entire facility staff needed to have the training regarding residents' rights annually and as needed because if not, the staff will be unaware of the information regarding the Resident's rights which included the resident's right not to be abused (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish), and the residents have every right to receive or decline care. DSD 1 stated if the in-service was incomplete, the staff might not respect the Resident's Rights. (continued on next page)

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/2025 at 11:30 AM with DSDC, DSDC stated it is not okay to have incomplete attendance of in-service, because it meant that it was not provided to the entire facility staff. DSDC stated it should have been provided to all the staff because the staff needs to understand the Resident rights. During a record review of facility's policy and procedure (P&P) titled, Facility education & In-Service Training dated 7/2019, P&P indicated, the Director of Staff Development will be responsible for the assessment of the educational needs of the staff, planning, implementation of the program and the evaluation of the staff learning. It is the responsibility of the department heads to be aware of mandatory in-services to plan for all staff to attend these in- services. The Director of Staff Development shall monitor mandatory in-services to ensure all staff are represented. Lack of staff attendance will be reported to the administrator and department heads. The following required services will be offered during the year for all skilled nursing facility employees Which included Resident Rights, Civil rights, Responsibilities and complaint procedures

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide behavioral health training to the 452 out of 552 direct care staff (all facility staff who directly provide program and/or nursing services to residents) and indirect care staff (provide essential support services that do not involve direct, hands-on patient care like housekeeping, dietary, laundry, maintenance, and clerical staff) in the facility as required and determined by the facility assessment and facility policy. This deficient practice can affect the staff's knowledge when providing proper care for their 49 residents who have behavioral health issues and/ or concerns. Findings: During a record review of the facility's undated Annual In-Service Calendar, the in-service calendar indicated Behavioral Health Training in- service was scheduled in November 2024. During a record review of the Facility assessment dated [DATE], the Facility Assessment indicated that specialty unit: Unit A is the secure unit where the residents with dementia/ behavior are housed and the unit has 47 bed capacity. During a concurrent interview and record review on 6/26/2025 at 11:37 AM with Director of the Staff Development 1 (DSD 1), the facility's In-service Binder for 2024 was reviewed. The Behavioral Health Training In- Service dated 12/3/2024 indicated, there were 1 night shift staff, 14 evening shift staff and 75 morning shift staff attended the in service, total of 100 staff signed the attendance sheet. DSD 1 stated the in-service was incomplete because the attendance was majority of the morning shift. DSD stated if there were no night shift staff documented in the attendance, it means, there are other 452 staff that were not provided in-service about the behavioral health, and we did not follow up with the other shifts. During a concurrent interview and record review on 6/26/2025 at 11:39AM with DSD 1, the Behavioral Health Training in- service was dated 11/2024 was reviewed. DSD 1 stated Behavioral Health Training was provided to all the staff annually and as needed, aside from being part of orientation when the staff was newly hired. DSD 1 stated, the entire 452 staff did not receive education about behavioral health. It can affect the quality of care that staff provides for the residents with behaviors. During a concurrent interview and record review on 6/26/2025 at 11:59 AM with the Director of Nursing (DON), the Behavioral Health Training In- Service dated 12/3/2024 was reviewed. The Behavioral Health Training In- Service did not have a lesson plan included in the in-service binder. The DON stated the in-service was incomplete because the lesson plan was missing. The DON also stated, the participants were mainly the morning and evening shift, but not all evening shift staff and there were no staff for the night shift. The in-service training was not provided for all the 552 staff, and none of the 452 staff attended the in service, and did not receive the training they needed. The DON stated the facility have residents that have behavioral health concerns and/ or issues and these residents or other residents in the facility can get hurt, because it was unnoticed and not managed. (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/2025 at 2:14 PM with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated, it is important to have in service so all the staff will know what care is necessary for the residents. I do not know what the effect on the resident will be if there was no in-service provided to us regarding Resident's behavioral health. During an interview on 6/26/2025 at 2:32 PM with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated, if the behavioral health in-service was not provided to all the staff, there was a possibility that we will not be able to identify the inappropriate behaviors of the residents, and the resident's safety will be at risk. During a record review of facility's policy and procedure (P&P) titled, Facility education & In-Service Training dated 7/2019, P&P indicated, The Director of Staff Development will be responsible for the assessment of the educational needs of the staff, planning, implementation of the program, and the evaluation of staff learning. > Course content for the in-service program for all staff will be designed to provide an environment that enhances residents and employee safety and well-being. > An attendance record for each in-service shall be maintained by the Staff Development Department. It will include the title of the subject being presented, date and number of hours for the program, the name and title of the instructor, and signatures of all persons attending. > Individual lesson plans will be filed with the attendance record for each in-service. > Topics for CNA in-services recommended yearly, in addition to the required dementia-specific in-services, include but are not limited to the following: Managing Behavior. During a record review of facility's P&P titled, Behavior-Management revised date 6/26/2025, P&P indicated, the facility is responsible for providing behavioral health care and services that create an environment that promotes emotional and psychosocial well-being met each resident's needs and include individualized approaches to care.