STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055461	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Post Acute	909 S Lake Street Los Angeles, CA 90006

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 0600 Level of Harm - Actual harm 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** 49881 Based on interview and record review, the facility failed to protect the resident's right to be free form sexual abuse (deliberate, aggressive, or violent behavior with the intention to cause harm) for one of three sampled residents (Resident 2), who was subjected to Resident 1's sexual aggression, who had diagnoses of schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). The facility failed to: -Implement the facility's policy and procedure titled, Abuse Prevention Program-Abuse Prohibition, revised May 2024, which indicated the facility shall uphold resident's right to be free from sexual and physical abuse. -Implement the facility's policy and procedure titled, Behavior Assessment, Intervention, and Monitoring, revised May 2024, to ensure the interdisciplinary team would thoroughly evaluate Resident 1's new or changing behavioral symptoms, which occurred on 1/7/2025, in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition. -Ensure Social Services provided Resident 1 a psychosocial visit for 72 hours after Resident 1 displayed a new aggressive behavior and punched a staff member on 1/7/2025. As a result, five days later, on 1/12/2025 at about 9 PM, Resident 1 sexually abused Resident 2 (the roommate) when Resident 2's incontinent brief was removed by Resident 1. Resident 1 used her left hand signaling to Resident 2 to stop crying and Resident 1 placed her right fingers in Resident 2's vagina. Resident 2 cried loudly and was angry with distress (a state of emotional suffering). This deficient practice resulted in Resident 2 being subjected to physical and sexual abuse by Resident 1 while under the care of the facility. Based on the Reasonable Person Concept (the usual behavior of an average person under the same circumstances), due to Residents 2's severely impaired cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) and medical condition, an individual subjected to physical and sexual abuse may have physical pain, psychological (mental or emotional) effects including feelings of hopelessness (a feeling or state of despair or lack of hope), helplessness (the belief that there is nothing that anyone can do to improve a bad situation), and humiliation (the feeling of being ashamed or losing respect for own self). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on 6/17/2024 with diagnoses including schizoaffective disorder, depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and mild cognitive impairment of uncertain or unknown etiology (problems with a person's ability to think, remember, use judgement). A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/24/2024, indicated the resident's problems with ability to think, remember and use judgement had declined and now had moderate cognitive impairment for daily decision making. The MDS indicated the resident did not have any behaviors of hallucinations (seems to see, hear, feel, or smell something that does not exist) or delusions (false belief that someone holds onto, even when there was evidence that it was not true), physical behavioral symptoms directed towards others (hitting, kicking, grabbing, abusing others sexually) or verbal behavioral symptoms towards others (treating others, screaming at others, cursing at others). A review of the Change in Condition Evaluation dated 1/7/2025, indicated Resident 1 had physical aggression towards an employee and Resident 1 punched the employee's left upper arm. The note indicated Resident 1's family and physician were notified. A review of Resident 1's Behavior Problem care plan dated 1/7/2025 with a focus on physical aggression (patient punched nurse) indicated the goal was for Resident 1 to verbalize understanding of need to control physical / verbal / social / sexual inappropriate behavior for three months. The care plan interventions indicated to share with the resident other options for dealing with feelings, and when resident becomes agitated: intervene before agitation escalates; guide away source of distress; engage calmly in conversation; if response was aggressive -walk calmly away, and approach later. According to a review of Resident 1's Change of Condition (COC) Evaluation dated 1/12/2025 (five days later), there was an allegation of sexual abuse as Resident 1 inappropriately touched (any physical contact that was unwanted) Resident 2's (the roommate) pelvic area, which was witnessed by the assigned certified nursing assistant (CNA) 1. A review of the COC findings indicated at approximately 9 PM on 1/12/2025, CNA 1 heard a noise inside room [ROOM NUMBER]'s room, immediately went to the room, and witnessed Resident 1 touching the pelvic area of Resident 2. CNA 1 removed Resident 1 and took the resident to the nurses station. Resident 1 was transferred to another room for increased visual monitoring. A review of Resident 2's Admission Record indicated the facility admitted the resident on 7/22/2015 with diagnoses including hemiparesis (condition that causes weakness or an inability to move on one side of the body) following cerebral infarction (occurs as a result of disrupted blood flow to the brain) affecting left non-dominant side and unspecified dementia (a progressive state of decline in mental abilities). The Admission Record indicated the facility's Bioethics Committee (a group of people who ensure that human rights are respected) was Resident 2's responsible party. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 2's MDS dated [DATE], indicated the resident had severe cognitive impairment for daily decision making and did not have any behaviors of hallucinations or delusions, physical behavioral symptoms directed towards others or verbal behavioral symptoms towards others. The MDS indicated the resident required supervision or touching assistance with toileting and had impairment on both sides of the upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot). A review of Resident 2's COC Evaluation dated 1/12/2025, indicated Resident 2 was a victim of abuse (sexual) and a skin and psychosocial evaluation were done. The COC indicated Resident 2's skin was intact and showed no signs of emotional distress or psychosocial decline. During an interview with the Director of Nursing (DON) on 1/15/2025 at 10:11 AM, the DON stated Resident 1's behavior of punching the staff member on 1/7/2025 was a new behavior. During a concurrent review of the facility's policy titled, Behavioral Assessment, Intervention, and Monitoring, the DON stated per policy, the interdisciplinary team (IDT) should have thoroughly evaluated Resident 1's new or changing behavioral symptoms. The DON stated there was no documentation indicating the IDT met after Resident 1's physical aggression incident on 1/7/2025. The DON stated it was important to have the IDT meet and develop individualized interventions to address Resident 1's specific behavior. The DON stated there was a potential for physical or verbal altercation since Resident 1's new behavior was not addressed. The DON stated Resident 1 also should have been visited by Social Work for a psychosocial evaluation and emotional support for 72 hours. The DON stated and confirmed based on documentation, Resident 1 was not visited by the Social Work Department after the incident on 1/7/2025. During an interview on 1/15/2025 at 12:57 PM, the Social Service Director (SSD) stated she was not aware of Residents 1's aggressive behavior from 1/7/2025 and did not conduct a psychosocial visit for Resident 1. The SSD stated it was important a psychosocial visit for 72 hours was conducted to check on Resident 1 to see if there was any emotional distress or any other changes in behavior. The SSD stated when a resident displayed a new behavior like aggression, there should be an IDT meeting to discuss the behavior. During an interview on 1/15/2025 at 1:41 PM, the Quality Assurance Nurse (QA), stated it was important the IDT met to identify causes and come up with interventions on how to manage and monitor the Resident 1's new behavior. The QA stated it was important to have new interventions to ensure safety of Resident 1, staff, and other residents. The QA stated Resident 2 was a vulnerable resident because she was bedbound and could not speak for herself and could answer mostly yes or no questions. The QA stated if IDT would have met, IDT would have considered doing a room change for Resident 1 with a resident that was alert and oriented, could speak for themselves, and verbalize any concerns. On 1/15/2025 at 2:26 PM during an interview, the DON stated the allegation of Resident 1 touching Resident 2 inappropriately was a concern for sexual abuse. The DON stated Resident 2 was a vulnerable resident because she was bedbound and had dementia. The DON stated using a reasonable person concept she would have been emotionally distressed, uncomfortable, and felt unsafe if she was touched inappropriately. The DON stated it was important that all residents were free from abuse because it was the residents right. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/15/2025 at 3:02 PM CNA 1 stated between 8:30 to 9 PM on 1/12/2025 she was charting at the front desk near Resident 2's room when she heard Resident 2 screaming and crying. CNA 1 stated she rushed to Resident 2's room and saw Resident 2's privacy curtain closed. CNA 1 stated when she walked to the foot of Resident 2's bed and saw Resident 1 using her left hand to make a motion with one finger over her mouth telling Resident 2 to stop crying and Resident 1's right hand touching Resident 2's vagina. CNA 1 stated Resident 2's diaper was off, and the blankets were open (not covering Resident 2). CNA 1 stated Resident 2's expression was angry because she was crying very loud. CNA 1 stated she immediately removed Resident 1 from the room and informed the charge nurse (Licensed Vocational Nurse, LVN) 1 what she observed. CNA 1 stated she observed the charge nurse (LVN 1) ask Resident 1 if it was true what she (CNA 1) had said CNA 1 heard Resident 1 respond yes, she (Resident 2) likes to be touched. During a phone interview on 1/15/2025 at 3:22 PM, LVN 1 stated on 1/7/2025 at about 9:10 PM, she asked Resident 1 why she had removed Resident 2's diaper and touched Resident 2's private area. LVN 1 reported Resident 1 responded, Because she (Resident 2) wanted her (Resident 1) to. During an interview on 1/16/2025 at 9:22 AM, the Administrator (Admin) stated he learned about the allegation of Resident 1 inappropriately touching Resident 2 on 1/12/2025. Admin stated there was a concern for sexual abuse and based on his investigation Resident 1 was the perpetrator and Resident 2 was the victim. Admin stated based on the reasonable person concept, he would feel terrible if someone touched him inappropriately because it was demeaning. Admin stated all residents and staff have a right to be free from abuse because it was part of resident dignity and respect. A review of the facility's policy and procedure titled, Abuse Prevention Program-Abuse Prohibition, revised May 2024, indicated the facility shall uphold resident's right to be free from sexual, physical, and mental abuse, and involuntary seclusion. A review of the facility's policy and procedure titled, Behavior Assessment, Intervention, and Monitoring, revised May 2024, indicated the interdisciplinary team would thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition. The policy indicted the interdisciplinary team would evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Interventions and approaches would be based on a detailed assessment of physical, psychological, and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan would include, as a minimum: a description of the behavioral symptoms, including: frequency, intensity, duration, outcomes, location, environment and precipitating factors or situation, targeted and individualized interventions for the behavioral and/or psychosocial symptoms, the rationale for the interventions an approaches, specific and measurable goals for targeted behaviors; and how the staff would monitor for effectiveness of the interventions. The policy indicated the SSD / Designee would conduct a psychosocial visit with the resident for 72 hours to ensure their needs were being met and they were adhering to the established care plan.