STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	250 N. Verdugo Road Glendale, CA 91206

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 - 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** 48661 Based on observation, interview, and record review the facility failed to protect the resident's right to be free from sexual abuse (a non-consensual sexual contact of any type with a resident) by Certified Nurse Assistant (CNA) 1 on 2/21/2025, as evidenced by a video recording showing, CNA 1 pull his penis out and used Resident 1's hand, stroke his (CNA 1) penis. CNA 1 stated he stroked Resident 1's penis until he (Resident 1) ejaculated (the release of semen through the penis during orgasm [the height or peak of sexual arousal]) then used Resident 1's blanket to clean the resident. This deficient practice resulted in Resident 1 being sexually abused by CNA 1 on 2/21/2025. CNA 1's identified non-compliance resulting from the sexual abuse incident against Resident 1 on 2/21/2025, had a negative psychosocial (refers to the combined influence of psychological factors and the surrounding social environment on physical, emotional, and/or mental wellness) impact on Resident 1, as verbalized by Licensed Vocational Nurse (LVN) 2 that Resident 1 had been having a hard time sleeping after the sexual abuse incident. The Social Services Director (SSD) documented in Resident 1's records Resident 1's facial expression of disgust (a strong sense of dislike) was clearly defined (evident), as a result of the sexual abuse incident by CNA 1, during an SSD visit in Resident 1's room on 2/25/2025. Psychologist 1 wrote on his progress note dated 2/26/2025, Resident 1 displayed hopelessness, frustration, inconsistent sleep patterns, along with a noticeable lack of energy and difficulty concentrating, which have persisted for more than two weeks . which represented a clear departure from Resident 1's baseline (starting point) functioning. On 2/25/2025 at 4:33 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation [IJ, a situation in which the provider's noncompliance (not following rules) with one or more requirements of participation had caused or was likely to cause serious injury, harm, impairment, or death of a resident] regarding the facility's failure to ensure Resident 1 was free from non-consensual sexual contact. The surveyor notified the Administrator (ADM) of the IJ situation on 2/25/2025 at 4:33 PM, due to the facility's failure to protect Resident 1 against non-consensual sexual contact. On 2/26/2025 at 4:25 PM, the ADM provided an acceptable IJ Removal Plan (a detailed plan to address the IJ findings). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	250 N. Verdugo Road Glendale, CA 91206

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/26/2025 at 4:46 PM, while onsite and after the surveyor verified/confirmed the facility's full implementation of the IJ Removal Plan through observation, interview, and record review, and determined the IJ situation was no longer present, the IJ was removed onsite, in the presence of the ADM. After the IJ was removed, the surveyor verified that the facility's non-compliance remained at the lower scope and severity of isolated, actual harm, that is not immediate jeopardy. The IJ Removal Plan included the following information: o On 2/21/25 at around 1:30 to 3:30 AM, Resident 1 was assigned a different Certified Nurse Assistant (CNA 2). At around 5 AM, the ADM arrived at the facility and interviewed staff on duty. According to the Registered Nurse (RN) Supervisor, the police officers did not disclose any information surrounding the arrest of CNA 1. At around 5 AM, the ADM spoke with Emergency Contact (EC) 1, who informed the ADM of the allegation of sexual abuse towards Resident 1 by CNA 1. EC 1 indicated that this allegation was triggered by an installed hidden camera with audio and video recording capabilities. EC 1 recognized that she did not request permission nor made facility staff aware prior to installation of a hidden camera. o The ADM reported the incident to the California Department of Public Health (CDPH) and Ombudsman (an advocate for residents that act as an independent, fair mediator [bridge between two parties] to investigate complaints against organizations or government agencies) on 2/21/25. o The ADM reported initiation of sexual abuse allegation investigation to the Medical Director on 02/21/2025. o A change of condition documentation for sexual abuse allegation was completed on 2/21/25 by a licensed nurse on Resident 1 notifying his primary physician and responsible parties. A head-to-toe body assessment was conducted by a licensed nurse. No new skin discoloration or impairments noted. o Resident 1 was placed on 72 hour every shift monitoring for a change of condition related to sexual abuse allegation. Plan of care (POC) was updated by licensed nurses to provide resident with 2 CNAs when providing care. o Resident 1 was placed under a one-to-one supervision and monitoring for 72 hours utilizing the one-to-one observation daily monitoring form to document supervision and monitoring effective 2/21/25, 3 to 11 shift to provide safe environment. o Resident 1 was seen by primary physician on 2/25/25 with no new orders. o The Psychiatrist (a medical doctor who specializes in mental health) assessed and evaluated Resident 1 on 2/25/25 and was found with no signs of agitation. Succeeding psychiatrist visits would be scheduled monthly for 3 months and as needed and would be coordinated with Resident 1's responsible party. o The SSD conducted visits to Resident 1 on 2/21/25, 2/24/25 and 2/25/25 to provide psychosocial (having to do with the mental, emotional, social, and spiritual needs of a residents) support. o Resident 1's POC was reviewed and updated on 2/24/25 by a licensed nurse to reflect current needs and monitoring: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	250 N. Verdugo Road Glendale, CA 91206

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	1.Providing one-to-one supervision and monitoring as needed 2. Body check assessment for unusual skin discoloration, cuts, abrasions 3. Psychology and psychiatry consult as needed 4. Psychosocial wellness visits (a healthcare visit focused on assessing and discussing an individual's mental, emotional, and social well-being) o A Quality Assurance Performance Improvement (QAPI, a data driven proactive approach to improvement used to ensure services were meeting quality standards) plan was developed surrounding Abuse Management and was discussed by the ADM, Director of Nursing (DON) and Medical Director on 2/21/25. This would be presented during the Quality Assurance Meeting (QAA- a process that ensures healthcare activities and products meet the required standards of excellence and compliance) on 2/26/25 at 1 PM . with emphasis on sexual abuse on male staff towards cognitively (anything related to thinking, learning, and understanding) impaired resident, with the following attendees: Medical director, ADM, Interdisciplinary team (IDT - a group of health care professionals from different specialties who work together to provide care). o CNA 1 was terminated by the ADM on 2/21/25 and reported to the CNA licensing body for gross misconduct (extremely serious and unacceptable behavior by an employee that could lead to immediate termination). o DON, Activities Director and EC 1 met on 2/21/25 and discussed recent alleged abuse event. IDT recommended one-to-one supervision, body check, psychiatry consult, and SSD to provide psychosocial wellness visit. o On 2/21 /25, the IDT members conducted an interview and observation to all other 120 residents and 44 cognitively impaired and 77 cognitively intact residents, utilizing the Sexual Screening Assessment tool regarding potential concerns surrounding sexual abuse with emphasis on sexual inappropriateness of staff/caregiver towards residents. No other residents were affected. o The Director of Staff Development (DSD) provided the initial in-service education to Department Manager, nursing staff (CNAs and Licensed Nurses) on 2/21/25 regarding Abuse prohibition and Management with emphasis on the following: a. Sexual abuse, with emphasis on sexual contact without consent towards cognitively impaired residents b. Identifying signs and symptoms of abuse to non-verbal residents such as moaning, grimacing, refusal of care, unexplained skin injuries and any unknown in origin incident. c. One-to-one supervision management maintaining resident psychosocial needs. d. Reporting and investigation of abuse allegations and providing a safe environment for all residents. e. Developing interventions to mitigate risk towards abuse incidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	250 N. Verdugo Road Glendale, CA 91206

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	f. Behavior observation and monitoring. g. Utilization of Sexual Screening Assessment tool for incidents involving sexual abuse allegations. h. Utilization of Sexual Capacity Assessment tool for residents done during new admission and/or re-admissions. o As of 2/26/25, a total of 119 out of 153 actively employed facility staff were provided an in-service. The Inservice re-education would continue until 100% was achieved by 3/1/25. Any facility staff that were not re-educated due to vacation and or leave of absence would be provided re-education on abuse prevention and management before the start of their next shift by the DSD and/or designee. o Beginning 2/26/2025, the DSD and/or designee would facilitate background checks and at least two reference checks prior to hire and quarterly background checks thereafter. o Beginning 2/26/2025, the DSD and/or designee would conduct abuse training to facility staff upon hire and quarterly thereafter. o Beginning 2/26/25, the Sexual Screening Assessment tool would be utilized by licensed nurses for incidents involving sexual abuse allegations and as needed, as part of initial interventions. o Beginning 2/26/25, the IDT would conduct an abuse risk assessment during the scheduled quarterly care conference meetings to review any potential and/or risk of abuse, particularly sexual abuse. o Beginning 2/26/25, the Sexual Capacity Assessment tool for residents would be completed as part of the admission assessments for new admissions and/or re-admissions. o The Department Managers and other staff assigned would continue to complete daily Resident Care Room Rounds effective 02/21/2025 utilizing the Resident Care Room Rounds form, with emphasis on inquiring if residents may have been touched by residents or staff without their permission, daily Monday to Friday and would discuss findings during daily stand-up meeting for further review and interventions. o Beginning 2/26/25, licensed nurses would conduct verbal endorsement daily at the start of each shift with licensed nurses and CNAs and as needed to discuss and identify any potential concerns surrounding abuse prohibition that may potentially affect cognitively impaired residents. Any identified findings that need further investigation would be reported immediately to the facility ADM and/or Designee for immediate follow up. o The ADM and/or Designee would conduct random observation rounds weekly beginning 2/26/2025 and as needed to validate compliance on abuse prevention and management. Any findings would be discussed during the daily stand-up meeting for further recommendations and interventions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	250 N. Verdugo Road Glendale, CA 91206

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	o Beginning 2/26/25, Social Service and/or Designee, would conduct a resident council meeting twice within the next (30) days. The first meeting would be offered on 02/27/2025 and the subsequent offering would be held on 03/13/2025, then monthly and as needed to validate and identify further opportunities surrounding abuse prohibition. An invite would be provided to all Residents and any/all families acting as responsible parties willing to attend pending approval by the resident council president. Additionally, the Ombudsman Office would be notified of these and future scheduled meetings. o The ADM and/or designee would discuss any pattern of findings related to any alleged abuse investigation and conclusions with emphasis on sexual abuse allegations manifested by staff's inappropriate and unwelcome touching towards cognitively i mpaired to Medical Director and QAA committee monthly for further interventions and recommendations and or until the deficient practice was resolved. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted the resident on 10/29/2024, with diagnoses including cerebral infarction (stroke - a stroke happens when there is a loss of blood flow to part of the brain) encephalopathy (a disease, disorder, or damage that affects the brain's structure or function), adult failure to thrive (a decline caused by chronic diseases and functional impairments which could cause weight loss, decreased appetite, poor nutrition, and inactivity), and gastrostomy status (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). The AR indicated Resident 1 had two family members named as the responsible party (RP) as (RP 1) and emergency contact (EC) as (EC 1). During a review of Resident 1's History and Physical (H&P) dated 11/21/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 2/4/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was dependent (helper did all of the effort and the resident did none of the effort to complete the activity) on facility staff for all self-care and mobility. During a review of Resident 1's Communication Difficulties due to Neurological Impairments Care Plan (CP) dated 2/21/2025, the CP indicated a goal to improve the resident's ability to convey needs and understand instructions to promote safety and engagement in ADLs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	250 N. Verdugo Road Glendale, CA 91206

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Nursing Progress Note dated 2/21/2025 timed at 9:25 AM, the Progress Note indicated that on 2/21/2025 at around 1:30 AM the resident's EC (EC 1) called the facility and asked who the nurse for Resident 1 was. The Progress Note indicated the Registered Nurse Supervisor (RNS 1) responded to EC 1's phone call and informed EC 1 that CNA 1 was assigned to Resident 1 during the 11 PM to 7 AM shift dated 2/21/25 timed at 1:30 AM. The Progress Note indicated that around 2 AM, six (6) police officers entered the facility looking for CNA 1 and questioned CNA 1. The Progress Note indicated the DON was notified, and the resident was assigned a new CNA. The Progress Note further indicated that at 3:30 AM, EC 1 arrived at the facility and stayed at Resident 1's bedside. The Progress Note indicated at 3:35 AM, the police officers left the facility with CNA 1. The Progress Note further indicated that at 4:15 AM, more police officers gathered Resident 1's personal belongings. The Progress Note indicated the ADM was notified at this time. The Progress Note indicated on the same day, 2/21/2025 at 6:30 AM, the ADM arrived at the facility and met with EC 1. The Progress Note indicated the ADM conducted an in-service (training that take place while someone was employed) regarding abuse and proper care with the residents to the staff in the facility and Resident 1's physician was notified. At 7:30 AM, the police forensics team (a group that examine and analyze evidence from a crime [an act that was against the law and harmful to society] scenes to develop objective findings that could assist in the investigation and prosecution of perpetrators of crime) continued their investigation. During a review of the Video Footage date-stamped dated 2/21/2025, from the hidden camera installed by family members in Resident 1's room on 2/25/2025 at 1:15 PM, the video footage showed Resident 1 in bed with CNA 1 wearing black scrub suit (a loose-fitting, usually two-piece garment clothing worn by healthcare personnel) holding a mobile phone on his right hand with the phone facing towards Resident 1's body. The video footage showed CNA 1 used his left hand to lift up his (CNA 1) shirt and pull down his (CNA 1) pants. The video footage showed CNA 1's penis was quickly displayed. The video footage showed CNA 1 took Resident 1's hand to stroke his (CNA 1) penis. The video footage showed after 11 seconds, CNA 1 used his left hand and typed on his phone and then pulled his (CNA 1) pants up. The video footage showed CNA 1 held Resident 1's hand and pushed Resident 1's hand and then placed a bed sheet and a personal blanket over Resident 1. The video footage showed the CNA 1 opened the bedside curtain and walked away. During a review of the local Police Department's (PD) Initial Report dated 2/21/2025 documented and timed at 12:20 AM, the Initial Report indicated on 2/21/2025 at Approximately 0200 (2 AM) hours, I (PD) responded to a radio call regarding a suspicious circumstance at the facility. The Initial Report indicated Officers arrived on scene, spoke to (EC 1), observed video footage (a section of recorded video or film, usually captured by a camera) of the crime as it (crime) occurred, and took the suspect (a person thought to be guilty of a crime) (CNA 1) into custody (a person was under arrest or being held by the police in a secure location). The Initial Report indicated the offense information included sexual battery (a crime that involves unwanted sexual contact with another person) on a medically institutionalized person (someone placed in a specialized institution for long-term care) and sexual battery involving unconscious person (someone who was not aware of their surroundings and could not respond to stimuli). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	250 N. Verdugo Road Glendale, CA 91206

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the same PD Initial Report dated 2/21/2025 documented and timed at 12:20 AM, the Initial Report indicated EC 1 noted Resident 1 seemed to shut off and not his usual self which caused EC 1 to install a hidden camera (in Resident 1's room) to capture any abuse or reason that caused the change in his (Resident 1) behavior. The Report indicated EC 1 stated at approximately 2 AM (2/21/2025), the video footage from the hidden camera showed a male nurse (CNA 1) sexually abusing Resident 1. The suspect was dressed in black scrubs with a ring to the left hand and a tattoo to the right wrist and showed CNA 1 pull his penis out and use Resident 1's hand to stroke his penis. The Initial Report indicated the video footage then showed Resident 1 move his hand away from CNA 1's penis then purposely reaching for Resident 1's hand and putting it around his penis once again to stroke himself. The video then showed CNA 1 grab Resident 1's penis and begin to stroke him (Resident 1). During a review of the same PD Initial Report dated 2/21/2025 documented and timed at 12:20 AM, the Initial Report indicated Officer 1 and Officer 2 observed the suspect (CNA 1) walking out of the facility lobby to the door and based on CNA 1's behavior and matching description, the police officers detained (to force someone officially to stay in a place) CNA 1. Officer 1 told CNA 1 they were conducting an investigation and to be honest and CNA 1 stated Resident 1 grabbed his (CNA 1) penis. CNA 1 stated he initially approached Resident 1 to check on him and noticed he had an erect penis (when a person's penis becomes hard and enlarged from an increase in blood flow) and felt sorry for Resident 1's physical condition and wanted to manipulate his penis sexually. The PD Initial Report indicated CNA 1 at first grabbed Resident 1's hand and used his hand to stroke his penis and when CNA 1 noted Resident 1 moved his hand away, CNA 1 grabbed Resident 1's hand and placed his hand back on his penis. The PD Initial Report indicated Officer 1 asked CNA 1 if he understood that Resident 1 was physically unable to move, fight back, or give consent and CNA 1 stated he was aware of the resident's condition and knew what he was doing was wrong but kept going. CNA 1 stated he stroked Resident 1's penis until he (Resident 1) ejaculated (the release of semen through the penis during orgasm [the height or peak of sexual arousal]) and then used Resident 1's blanket to clean the resident. During a review of the same PD Initial Report dated 2/21/2025 documented and timed at 12:20 AM, the Initial Report indicated evidence collected from Resident 1's room included: digital clock hidden camera with charging cable, a hot spot [from a wireless network operator] with charging cable, keys belonging to suspect's (CNA 1) vehicle (car), medical gown, blanket, wedge pillow (special triangle-shaped pillows that raise the top half of the body while lying in bed) case from the right side of Resident 1's body, bed sheet (over Resident 1), bed sheet (under Resident 1), soiled diaper, small blanket, a black back brace (a device worn to support the back), cloth from trash, paper towel from trash, plastic gloves, two possible DNA (an abbreviation for deoxyribonucleic acid - a molecule inside the body's cells that could be used to identify suspects and victims of crimes) swabs (a DNA sample from a person with a known connection to the crime scene) from left and right hands of CNA 1, two reference swabs from CNA 1, black jacket from CNA 1, blue scrub shirt from CNA 1, blue scrub pants from CNA 1, left and right shoe from CNA 1, two reference swabs from Resident 1, and two possible DNA from left and right hands of Resident 1. During a review of the same PD Initial Report dated 2/21/2025 documented and timed at 12:20 AM, the Initial Report indicated based on the video footage and statements from CNA 1, Officer 1 arrested CNA 1 for sexual battery on a medically institutionalized person and sexual battery involving an unconscious person. The PD Initial Report indicated CNA 1's mobile phone was given to assault detectives (officers who oversee crime scenes) for further investigation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	250 N. Verdugo Road Glendale, CA 91206

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Change of Condition (COC) dated 2/21/2025 at 2:17 AM, the COC indicated the resident had an alleged abuse. The COC indicated at 2 AM, a police officer interviewed LVN 1 regarding Resident 1's cognitive and physical abilities. The COC indicated at 3:30 AM the police officers took all of Resident 1's linen. The COC indicated at 7:30 AM a forensics team interviewed LVN 1 and swabbed the resident's skin. During a review of Resident 1's IDT Meeting Notes dated 2/21/2025 at 7:13 PM, the IDT Note indicated the meeting consisted of EC 1, the DON, the MDS Coordinator, a CNA (CNA 2), and the Social Services Director (SSD). The IDT Note indicated EC 1 stated she lost faith in everything after the incident between CNA 1 and Resident 1. The IDT Note indicated CNA 1 admitted to the police that the incident in question (sexual abuse) had happened more than once. The IDT Note indicated EC 1 stated the resident was acting strange on Tuesday (2/18/25) and was requesting to transfer the resident to another facility closer to family. During a review of Resident 1's Nursing Progress Note (PN) dated 2/21/2025 at 11:16 PM, the PN indicated the resident was on monitoring for alleged sexual abuse and was provided a one-to-one sitter (a person who takes care of someone side by side). The PN indicated the resident was noted to be having a hard time sleeping and the facility staff member (LVN 2) ensured Resident 1 was safe and provided a calm environment. During a review of Resident 1's Risk for Safety Concerns related to Alleged Physical/Sexual Abuse CP dated 2/21/2025, the CP indicated a goal for the resident to remain safe. The CP interventions included assigning two (2) CNA's when providing care, monitor for any changes of condition, and to provide privacy to the resident when doing perineal care (cleaning the area between the genitals and anus, essentially washing your private parts). During a review of Resident 1's Physician's Order (PO) dated 2/24/2025 at 10:02 AM, the PO indicated a Psychiatric (a mental health assessment that could help diagnose and treat emotional, behavioral, or developmental disorders) and Psychology Evaluation (a process that assess a person's mental health and behavior). During a review of Resident 1's Social Service (SS) Note dated 2/25/2025 at 5:44 PM, the SS Note indicated the SSD conducted a psychosocial intervention visit. The SS Note indicated as the resident was nonverbal and SSD wanted to capture the resident's vocal tone, facial expressions, and bodily movements as communication regarding the events on the evening of 2/21/2025. The SS Note indicated the resident's facial expression for disgust was clearly defined. The SS Note further indicated Perhaps as a feeling of revulsion (a strong feeling of dislike) and disapproval around something unpleasant or offensive. The muscles of his face contracted, indicating the need to remove thoughts of the experience. The expression was in the form of a raised upper and lower lip, wrinkled nose, and lowered eyebrows, representing the emotional state of disgust of his experience. The SS Note indicated the resident closed his eyes and was still, as if the resident was sleeping. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	250 N. Verdugo Road Glendale, CA 91206

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Psychological Evaluation (PE) dated 2/27/2025 at 12:20 PM, authored by a Psychologist (Psychologist 1), the PE indicated Resident 1's cognitive functioning was severely impaired. The PE indicated Resident 1's behavior was guarded/irritable, was bed bound (confined to bed), and affect (a general term for feelings or emotions) observed was sad/agitated. The PE indicated communication with Resident 1 was difficult, challenging, and time-consuming as he is nonverbal and has difficulty with speech communication. The PE indicated Resident 1 was too cognitively impaired to participate or benefit from psychotherapy treatment at this time and psychological services were not recommended. The PE indicated Resident 1 displayed hopelessness, frustration, inconsistent sleep patterns, along with a noticeable lack of energy and difficulty concentrating, which have persisted for more than two weeks. The PE indicated These symptoms are not attributable (it is likely that it was caused by that event, situation or person) to the direct physiological effects of the (Resident 1's previously medical history) stroke or another medical condition and represent a clear departure from (Resident 1's) baseline (starting point) functioning. During an interview on 2/25/2025 at 7:36 AM, RNS 1 stated the police found a clock (hidden camera in the clock) that the resident's family (EC 1) placed in Resident 1's room. RNS 1 stated on 2/21/2025 at 1:30 AM, (EC 1) called the facility asking who Resident 1's nurses were and RNS 1 stated the nurses taking care of Resident 1 were CNA 1 and LVN 1. After a few minutes six (6) police officers entered the facility looking for CNA 1 and arrested CNA 1 right away. RNS 1 stated she was unaware what was going on and the police officers would not disclose any information. RNS 1 stated when the ADM arrived at the facility, he did not informed facility staff exactly what happened but did an in-service on physical/sexual abuse. RNS 1 stated Resident 1 could not talk or move and was a totally dependent resident. RNS 1 stated at 7:30 AM, the forensics came with the police and after they left the facility staff were able to enter Resident 1's room and completed a total body skin assessment. RNS 1 stated the resident's body was okay and had no bruising or bleeding including the resident's genitals (a person's external organs of reproduction). During a telephone interview on 2/25/2025 at 8:30 AM, EC 1 stated that Responsible Party (RP) 1 had the video clip on the cloud (a network of remote servers accessible through the internet where users could store data) and released the video to the police. EC 1 stated she did not want to continue with the telephone interview anymore and did not want to elaborate more on Resident 1's sexual abuse incident with CNA 1. During an observation in Resident 1's room on 2/25/2025 at 8:58 AM, Resident 1 was sitting up in bed with his face turned to the right side and a blanket covering the resident's body. The resident did not respond verbally or acknowledge a presence during the introduction, including eye contact. During an interview on 2/25/2025 at 9:17 AM, the ADM stated EC 1 sent the ADM a text message (an electronic communication sent and received by mobile phone) on 2/21/2025 at 4 AM to discuss an urgent matter and he (ADM) informed (EC 1) he (ADM) would be at the facility in one hour. The ADM stated he (ADM) contacted RNS 1 who informed him (ADM) that the police were in the facility and arrested CNA 1. The ADM stated the police interviewed LVN 1 to ask about Resident 1's cognitive status and photographed a 360 view (to capture a complete, panoramic image of a person from all angles, essentially allowing the viewer to see them as if they were rotating around the subject giving a full perspective of their appearance from every direction) of LVN 1. The ADM stated after concluding the interview with LVN 1, the police arrested CNA 1 around 1:30 AM to 2 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	250 N. Verdugo Road Glendale, CA 91206

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During the same interview on 2/25/2025 at 9:17 AM, the ADM stated he arrived at the facility on 2/21/2025 to meet with EC 1 at 5 AM. The ADM stated EC 1 was woken up at midnight due to an activity notification on the hidden camera she installed in Resident 1's room that the facility was unaware of. The ADM stated EC 1 stated the video footage showed a nurse fondling (stroke or caress lovingly or erotically) or engaging in sexual activity with Resident 1. The ADM stated he did not have a recorded copy of the video because the PD told EC 1 not to give the video footage to anyone. The ADM stated he was unable to have any conversations with the PD or verify what was on the video because the event was still under investigation. During the same interview on 2/25/2025 at 9:17 AM, the ADM stated the SSD, MDS Coordinator (MDSC), and the DON created a tool to screen interviewable and non-verbal/cognitively impaired (someone had difficulty with thinking, learning, remembering, understanding, or making decisions, often due to a problem with their brain function) residents for physical/sexual abuse. The ADM stated they screened all the residents in the entire building to check if any other residents may be affected by the alleged sexual abuse. The ADM stated CNA 1 was terminated on 2/21/2025. During an interview on 2/25/2025 at 10:48 AM, LVN 1 stated due to Resident 1's history of stroke (when blood flow to the brain was blocked or a blood vessel in the brain bursts) the resident could not really move his left side and only had right-handed strength and could only grip with his right hand. LVN 1 stated Resident 1 was unable to defend himself because he could not talk, yell, or move fast. During a telephone interview, conducted on 2/25/2025 timed at 11:41 AM, the detective (Detective 1) in charge of Resident 1's sexual abuse police investigation stated she was unable to disclose any information at this date and time, because the investigation was ongoing, and CNA 1 was still in custody. During another attempt for a telephone interview conducted on 2/25/2025 timed at 12:30 PM with EC 1, EC 1 declined to be interviewed and would not respond to any more questions with regards to the sexual abuse incident against Resident 1. During a concurrent observation and interview in Resident 1's room in the presence of LVN 2 on 2/25/2025 at 3:16 PM, Resident 1 did not look at LVN 2 upon introduction but when LVN 2 held Resident 1's hand, Resident 1 gripped LVN 2's hand tightly. LVN 2 stated Resident 1 was not able to speak and would not be able to verbally express if something was bothering him. During an electronic mail (e-mail) exchange with EC 1's attorney, another attempt was made to contact EC 1 on 2/25/2025 at 4:35 PM. The Attorney wrote that EC 1 declined further interviews from CDPH. During a telephone interview on 3/6/2025 at 9:11 AM, a clarification of the PD Initial Report documented with date and time of 2/21/2025 at 12:20 AM was clarified with Detective 1. Detective 1 was asked why the PD Initial Report was [NAME]/ed at 12:20 AM. Detective 1 stated the PD Call for Service (CFS- a request for police assistance with an emergency or issue) came around 12:20 AM and the detectives that responded to the scene were called around 2 AM on 2/21/2025 for in depth interviewing of the suspect (CNA 1) and facility staff at the facility. During a review of the facility[TRUNCATED]