STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056008	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Rehabilitation Hospital	533 S. Fairfax Ave Los Angeles, CA 90036

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Certified Nursing Assistant (CNA) 1 did not violate the resident's rights to be treated with respect and dignity for one of four sampled residents (Resident 1) by failing to ensure:1. CNA 1 did not record a video of Resident 1 without Resident 1 and/or Resident 1 Responsible Party 1's (RP 1) consent in multiple occassions.2. CNA 1 did not post a video of Resident 1 on social media3. CNA 1 did not take videos and use personal cellphone inside the facility and inside residents' room during working hours.These deficient practices violated Resident 1's right to be treated with respect and dignity and the potential to subject Resident 1 and other residents to humiliation (the act of being made to feel ashamed, embarrassed, or worthless, often publicly).Findings:During a review of the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and heart failure (a condition in which the heart does not pump blood as well as it should).During a review of Resident 1's History and Physical (H&P) dated 3/7/2026, the H&P indicated that, Resident (1) does not have the capacity to understand or make decisions.During a review of the Minimum Data Set (MDS - resident assessment tool) dated 3/14/2026, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was severely impaired. The MDS indicated Resident 1 was total dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Care Plan (CP) indicated the following:dated 3/9/2026, the CP indicated that Resident 1 has cognitive loss manifested by short term memory impairment, long term memory impairment and poor recall ability. The CP indicated interventions including providing pleasant interaction that is reassuring when residents are confused.Dated 3/9/2026, the CP indicated that Resident 1 has psychosocial impairment related to psychosis (heart failure (a condition in which the heart does not pump blood as well as it should), infection. The CP indicated interventions including to, staff will always approach resident in a calm and unhurriedly manner and to provide emotional support.During a review of a complaint submitted to District Office, received on 3/3/2026 at 2:50 p.m., a complaint received regarding CNA 1 who posted a video of Resident 1 on social media with two videos attached to the complaint intake.During an interview with Resident 1 on 3/17/2026 at 2:02 p.m., Resident 1 stated, there was an incident where a staff member took a video of himself while he was in the background and it was posted on social media (TikTok). Resident 1 stated, he was told about it just recently and he did not sign consent, and he did not give permission for him to be posted on social media.During an interview with Certified Nursing Assistant 1 (CNA 1) on 3/17/2026 at 2:10 p.m., CNA 1 stated, he had been taking videos and posting on his social media (TikTok) since November 2025. CNA 1 stated, he is aware that he is not allowed to use personal cellphone during work hours and staff are not allowed to take videos or photos inside residents' rooms.During a concurrent record review and follow-up interview with CNA 1 on 3/17/2026 at 2:37 p.m., CNA 1 reviewed his TikTok account with surveyor (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2026
NAME OF PROVIDER OR SUPPLIER Guardian Rehabilitation Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 533 S. Fairfax Ave Los Angeles, CA 90036	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and stated, his TikTok video was dated 12/13/2025 and another video was posted on 12/15/2025 and both videos were taken inside Resident 1's room and Resident 1 was seen laying on the bed in the background. CNA 1 stated his videos with Resident 1 on the background are still posted on his social media account. CNA 1 further stated, there are also videos on his social media account where he took his videos inside Activity Room/Dining Room, and some were taken in the facility hallways. CNA 1 stated, when he took the videos and posted it online, he did not ask for permission and consent from Resident 1.During a concurrent interview and record review with Director of Staff and Development (DSD) on 3/17/2026 at 2:48 p.m., DSD stated, staff are not allowed to use their personal cellphone during working hours, and staff are not allowed to take photos and videos inside residents' room. DSD stated, if photos or videos of residents are to be taken, they need to ask for permission and a consent needs to be signed. DSD stated, photos and/or videos of residents are to be used for medical purposes only. DSD reviewed CNA 1's TikTok account with surveyor and stated, the videos posted on CNA 1's TikTok account were dated 12/13/2025 and 12/15/2025 where the videos were taken inside Resident 1's room and Resident 1 was seen in the background. DSD stated, there are also videos posted on CNA 1's TikTok account where it was taken inside Activity Room/Dining Room and also in the hallway of the facility.During an interview with Director of Nursing (DON) on 3/17/2026 at 3:26 p.m., DON stated, she was aware of the incident where CNA 1 posted a video on his TikTok account where Resident 1 can be seen on the background while laying on his bed inside Resident 1's room. DON stated staff are not allowed to use personal cellphones during working hours unless it's emergency. DON further stated, staff are also not allowed to take photos and videos of residents without consent. DON stated, it is a type of abuse when staff takes videos and photos of residents without authorization and consent. DON further stated, there are no written consents on file when CNA 1 took videos of Resident 1 inside Resident 1's room and posted it on his TikTok account. During a review of facility's policy and procedure (P&P), titled, Abuse Reporting and Prevention reviewed on 1/26/2026, the P&P indicated that, Facility will monitor areas that have the potential to lead to abusive situations, areas include:. Taking photographs or records of a resident and/or his/her private space without the resident's or resident's responsible party's written consent is a violation of the resident's right to privacy and confidentiality.During a review of the facility's P&P titled, Uses and Disclosures of Protected Health Information: Verbal Agreement, reviewed on 1/26/2026, the P&P indicated that, the facility shall give a resident the opportunity to either verbally agree or object to the use or disclosure of protected health information (PHI) in a facility directory, to a clergyman, or to person(s) involved in the resident's care. Disclose resident's PHI that is directly relevant to the person's involvement with the resident's care, in the exercise of a professional judgment the disclosure is in the best interest of the resident.During a review of the facility's P&P titled, Cellular Phone Policy, reviewed on 1/26/2026, the P&P indicated that, It is the policy of this facility that cellular phone use is not permitted in resident care areas. Direct caregivers shall turn off or place their cellular phones on vibrate upon arrival to the facility.During a review of the facility's Job Description (JD) titled, Certified Nursing Assistant Job Description, reviewed on 1/26/2026, the JD indicated that, General Duties and Responsibilities: Do not disclose resident's protected health information and promptly report suspected or known violations of such disclosure to your supervisor.