STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056111	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Griffith Park Healthcare Center	201 Allen Ave. Glendale, CA 91201

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 protect three of three (Resident 2, 3 and 4) to be free from sexual abuse (non-consensual [without the person's permission] sexual contact of any type with a resident who does not wish to engage in sexual activity or may not have the capacity to consent) when the facility failed to: 1.Monitor Resident 1 for aggressive behaviors and verbal threats as indicated in his care plan created on 4/28/26 after Resident 1 verbally threatened to harm his roommate when Resident 1 was transferred to a new room with Resident 3. 2. Maintain close supervision and vigilance at all possible times for Resident 1, who had a reported history of inappropriate sexual behavior toward females, as indicated in his care plan initiated on 3/28/26. 3. Monitor Resident 1's pacing and wandering as indicated in the resident's care plan developed on 5/4/26 after Resident 1 exhibited verbal aggression while pacing and wandering at night. As a result, the facility's staff did not prevent Resident 1 from frequently wandering into Resident 2's room, who was bed bound, and watching her while she was in bed. This made Resident 2 feel uncomfortable. Staff also did not prevent Resident 1 from wandering into Resident 4's room and touching his own genitals while looking at Resident 4. This made Resident 4 feel unsafe and afraid that the facility's staff were not monitoring their residents. The staff also did not prevent Resident 1 from exposing his genitals to his bedbound roommate, Resident 3, and putting Resident 3's toes in his mouth. This made Resident 3 feel disgusted and helpless due to being unable to move his body. These deficient practices caused Residents 2, 3, and 4 emotional distress and compromised their right to a safe and dignified living environment. Findings: 1. During a review of Resident 1's admission Record, the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including anxiety, psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/31/26, the MDS indicated Resident 1 had moderate cognitive impairment (some difficulty with memory and orientation) and required moderate assistance (helper does less than half the effort) for most cares such as dressing and toileting. During a review of Resident 1's Care Plan (CP) initiated on 3/28/26, the CP indicated, per hospital record, Resident 1 had a history of inappropriate behavior toward female staff and attempted to touch residents. The CP further indicated a goal for Resident 1 to have no episodes of inappropriate behavior toward female staff and/or attempting to touch residents. The CP also indicated interventions for staff to maintain close supervision and vigilance at all possible times, for Resident 1 to remain on 24-hour hourly monitoring, for Resident 1 to remain on 24-hour hourly location monitoring, and for staff to implement an hourly behavior monitoring log. During a review of Resident 1's Change in Condition Evaluation (CIC- a communication tool used by healthcare workers when there is a change of condition among the residents) dated 4/28/26 at 2:59 AM, the CIC indicated, Resident is going in roommates personal belongings and taking their belongings, threaten roommates and staff, resident is using foul language, showing signs of being a danger to other residents and staff, resident stated, ?I will beat your ass I (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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(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 - Minimal harm or potential for actual harm Residents Affected - Some	am a gangster I don't care about going to jail' and got in staff face. The CIC further indicated Resident 1 exhibited behavioral changes that included verbal aggression, being a danger to self and others, and other behavioral symptoms. The CIC further indicated Resident 1 exhibited dangerous behavior that included threatening to hit roommates and staff and stealing roommate's belongings. The CIC further indicated the description of Resident 1's behavioral changes included aggressive behavior. The CIC was created and signed by Licensed Vocational Nurse (LVN) 2. During a review of Resident 1's CP dated 4/28/26, the care plan indicated Resident 1 had the potential to be physically aggressive related to threatening residents and staff, anger, and poor impulse control. The CP indicated a goal that Resident 1 would not harm himself or others through the review date. The CP further indicated for staff to monitor, document, and report as needed any signs or symptoms of Resident 1 posing danger to self and others. During a review of Resident 1's Progress Notes (PN) from 4/28/26 to 5/1/26, the PN did not include documentation from licensed nurses monitoring Resident 1 related to the CIC of making verbal threats and going into roommate's belongings for five (5) shifts: 1. 4/28/26 from 3 PM - 11 PM2. 4/28/26 from 11 PM - 7 AM3. 4/29/26 from 11 PM - 7 AM4. 4/30/26 from 7 AM - 3 PM5. 4/30/26 from 3 PM - 11 PM During a review of Resident 1's CIC dated 5/4/26 at 12:04 PM, the CIC indicated Resident 1 exhibited a change in condition related to insomnia/mood disorder, pacing in the hallway, [and] angry outburst. The CIC further indicated, Patient observed during shift exhibiting behavioral changes, including insomnia, pacing, and angry outburst. Patient noted to be standing and facing the hallways for extended periods, appearing restless and agitated. No incidents of physical aggression. During the shift, patient [had] difficulty sleeping, and an episode of angry verbal outburst. The CIC was created and signed by LVN 1. During a review of Resident 1's CP dated 5/4/26, the CP indicated Resident 1 was noted pacing in the hallways. The CP indicated a goal for Resident 1 to remain in his room or designated safe area and avoid standing or wandering in the hallway for prolonged periods during the shift. The CP indicated interventions to provide frequent check-ins and gentle reminders to return to his room or a safe area. During a review of Resident 1's PN dated 5/4/26 to 5/7/26, the PN did not include documentation from licensed nurses monitoring Resident 1 related to the CIC of pacing and having angry outbursts for two (2) shifts: 1. 5/6/26 from 3 PM - 11 PM2. 5/7/26 from 7 AM - 3 PM During a review of Resident 1's psychiatric note dated 5/11/26, the note indicated Resident 1 had a history of trying to touch female staff at his previous home. The note also indicated Resident 1 had a behavior of restlessly pacing but was easily redirectable. During a review of Resident 1's CIC dated 5/19/26 at 12:30 PM, the CIC indicated a change in condition related to two police department (PD) officers reporting that Resident 1 was allegedly performing oral sex with other residents. The CIC further indicated Resident 1's primary clinician recommended to transfer Resident 1 to a general acute care hospital (GACH) for further evaluation. During a review of Resident 1's CIC dated 5/19/26 at 4:30 PM, the CIC indicated a change in condition related to Resident 1 pacing the hallways, entering other residents' room without permission, entering a male resident's room and touching Resident 1's own private parts, making sexual remarks to female staff to come into his room, and attempting to touch another resident's foot. Resident 1 was placed on one-to-one (1:1) monitoring with a recommendation from Resident 1's primary clinician to transfer the resident to a GACH for psychiatric evaluation. 2. During a review of Resident 2's admission Record, the record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity) and major depressive disorder. During a review of Resident 2's Minimum Data Set, dated [DATE], the MDS indicated Resident 2 had intact cognition (good memory, accurate orientation, and minimal to no cognitive deficits) and required maximal assistance (helper does more than half the effort) for most cares such as toileting and dressing. Resident 2 was dependent on staff (helper does all the effort) for bathing. 3. During a review of Resident 3's admission Record, the record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including anxiety, bipolar disorder (mood swings that range from the lows of (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	depression to elevated periods of emotional highs), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 3's History and Physical (H&P) dated 4/9/26, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 was dependent (helper does all the help) for most cares such as toileting and bathing. 4. During a review of Resident 4's admission Record, the record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including a left leg fracture (broken bone) and difficulty walking. During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 had intact cognition and was dependent on staff for cares such as toileting and showering. During an interview on 5/20/26 at 10:37 AM with the Director of Nurses (DON), the DON stated that on 5/19/26, two officers from the local PD came to the facility and reported that they received an anonymous report alleging that Resident 1 performed oral sex with other residents in the facility. The DON stated Resident 1 was known to pace in the facility at night and was known to attempt to touch female staff. The DON stated that after interviews with other residents near Resident 1's room, the following was reported: A. Resident 4 reported that Resident 1 went to Resident 4's room and touched himself inappropriately in the morning of 5/19/26B. Resident 5 reported that Resident 1 was always gazing at females in the hallways.C. Resident 2 reported that Resident 1 would go to Resident 2's room and stare at her from the door.D. Certified Nursing Assistant (CNA) 1 reported that Resident 1 invited CNA 1 into bed with him on 5/19/26. The DON further explained she was not aware of Resident 1's inappropriate behavior toward other residents and staff. The DON stated, We thought everything was fine. During an interview on 5/20/26 at 12:58 PM with CNA 1, CNA 1 stated that on 5/19/26 around 2 PM, Resident 1 told her, Hey, come to my bed. I'll give you hugs and kisses. CNA 1 stated Resident 1 liked to walk around the entire facility throughout the day and would stand by other residents' doors. During an interview on 5/20/26 at 1:34 PM with Resident 2, Resident 2 stated that Resident 1 had frequently come into her room uninvited for weeks. Resident 2 stated Resident 1 would stand at the foot of Resident 2's bed and mutter under his breath while staring at Resident 2. Resident 2 stated it made her feel very uncomfortable. During an interview on 5/20/26 at 1:40 PM with Resident 3, Resident 3 stated that Resident 1 would kiss Resident 3's feet while playing with his own genitals. The last time Resident 1 kissed Resident 3's feet was on 5/18/26 but Resident 1 had been inappropriate more than once. For multiple days, Resident 1 would stand at the foot of Resident 3's bed and would stare at Resident 3 while playing with his own genitals and talking to him. Resident 3 stated that when he asked Resident 1 to go away, Resident 1 would threaten him and say, What are you going to do to me? Resident 1 would lunge at Resident 3 as if he were trying to hit Resident 3 and say, You're not going to do anything. Resident 3 stated that he felt very uncomfortable and disgusted that Resident 1 kissed his feet. Resident 3 further explained that he felt helpless and unsafe in the facility because he was unable to move his body and the staff would not be able to help him in time. Resident 3 further stated, It's a little too late because it already happened. During an interview on 5/20/26 at 1:51 PM with Resident 4, Resident 4 stated he had concerns about lack of supervision of the residents that liked to wander in the facility. Resident 4 explained that, on 5/18/26, Resident 1 came into Resident 4's room and stared at Resident 4 while rubbing his genitals. Resident 4 stated he recognized Resident 1 as the same resident that always walked by his door in the hallways. Resident 4 stated that when he asked Resident 1 to leave his room, Resident 1 stated, You're not going to do anything. Resident 4 stated he was afraid to tell the staff about what happened with Resident 1 because he would get neglected or retaliated against by the staff whenever he brought up a concern. Resident 4 stated he felt very uncomfortable and did not feel safe being in the facility. During an interview on 5/20/26 at 2:49 PM and concurrent record review with Registered Nurse (RN) 1, Resident 1's care plans and Medication Administration Record (MAR) dated May 2026 were reviewed. RN 1 stated that Resident 1's care plan initiated on 4/28/26 for threatening residents and staff indicated to monitor, document, and report as needed any signs or symptoms of posing a danger to self and others as an intervention for Resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1's behaviors. RN 1 stated Resident 1's behavior monitoring did not begin until 5/4/26 and there was no documentation on behavior monitoring between 4/28/26 to 5/4/26 in Resident 1's MAR. RN 1 stated it was important to follow Resident 1's care plan to prevent further abuse from happening. RN 1further explained that staff was responsible for following the care plan to apply appropriate interventions and ensure resident safety. During an interview on 5/20/26 at 3:10 PM and concurrent record review with the DON, Resident 1's CIC dated 4/28/26 for threatening roommates and staff and stealing from roommates was reviewed. The DON stated she was not aware of the CIC because LVN 4 did not report the incident to her. The DON stated that if she knew about it, she would have pushed for an immediate psychiatric consult and pushed for the resident to be medically and psychologically evaluated in a general acute care hospital (GACH). The DON stated that because LVN 2 failed to notify her of the CIC, the facility was unable to apply appropriate interventions such as sending Resident 1 out for medical and psychological evaluation to prevent further abuse from happening. During an interview on 5/20/26 at 3:49 PM and concurrent record review with LVN 1, Resident 1's CICs, care plans, and progress notes were reviewed. LVN 1 stated she knew that Resident 1 changed rooms due to roommate incompatibility on 4/28/26, but she was not aware of a CIC for verbally threatening staff and roommates and stealing from roommates. LVN 1 stated that if she witnessed Resident 1 verbally threatening his roommates, she would have notified the DON, CDPH, local PD, and local omb as a mandated reporter. LVN 1 further stated that Resident 1 was considered a danger to himself and others and therefore required further medical evaluation and PD involvement. During the same interview on 5/20/26 at 3:49 PM and concurrent record review with LVN 1, Resident 1's progress notes and Hourly Behavior Monitoring Binder were reviewed. LVN 1 stated the Behavioral Monitoring Binder was the facility's internal hourly monitoring log for residents with behavioral issues. LVN 1 stated that if any portion of the hourly behavioral monitoring sheet was blank, then monitoring was not done. The following dates and shifts were left blank (87 shifts):3/29/26: 11PM - 7 AM, 7 AM - 3 PM, 3 PM - 11 PM3/30/26: 11 PM - 7 AM, 3 PM - 11 PM3/31/26: 11 PM - 7 AM, 3 PM - 11 PM4/1/26: 11 PM - 7 AM, 3 PM - 11 PM4/2/26: 11 PM - 7 AM, 3 PM - 11 PM4/3/26: 11 PM - 7 AM, 3 PM - 11 PM4/4/26: 11 PM - 7 AM4/5/26: 11 PM - 7 AM4/6/26: 11 PM - 7 AM, 3 PM - 11 PM4/7/26: 11 PM - 7 AM, 3 PM - 11 PM4/8/26: 11 PM - 7 AM, 3 PM - 11 PM4/9/26: 11 PM - 7 AM, 3 PM - 11 PM4/10/26: 11 PM - 7 AM4/11/26: 11 PM - 7 AM4/12/26: 11 PM - 7 AM4/13/26: 11 PM - 7 AM4/14/26: 11 PM - 7 AM4/15/26: 11 PM - 7 AM4/16/26: 11 PM - 7 AM4/17/26: 11 PM - 7 AM4/18/26: 11PM - 7 AM, 7 AM - 3 PM, 3 PM - 11 PM4/19/26: 11PM - 7 AM, 7 AM - 3 PM, 3 PM - 11 PM4/20/26: 11 PM - 7AM4/21/26: 11 PM - 7AM4/22/26: 11 PM - 7AM4/23/26: 11 PM - 7AM4/24/26: 11 PM - 7AM, 3 PM - 11 PM4/25//26: 11PM - 7 AM, 7 AM - 3 PM, 3 PM - 11 PM4/26/26: 11PM - 7 AM, 7 AM - 3 PM, 3 PM - 11 PM4/27/26: 11 PM - 7AM4/28/26: 11 PM - 7AM4/29/26: 11 PM - 7AM, 3 PM - 11 PM4/30/26: 11 PM - 7 AM, 3 PM - 11 PM5/1/26: 3 PM - 11 PM5/3/26: 3 PM - 11 PM5/6/26: 3 PM - 11 PM5/7/26: 11 PM - 7 AM, 3 PM - 11 PM5/8/26: 11 PM - 7 AM, 3 PM - 11 PM5/9/26: 11PM - 7 AM, 7 AM - 3 PM, 3 PM - 11 PM5/10/26: 11PM - 7 AM, 7 AM - 3 PM, 3 PM - 11 PM5/11/26: 11PM - 7 AM, 3 PM - 11 PM5/12/26: 11PM - 7 AM, 3 PM - 11 PM5/13/26: 11PM - 7 AM, 3 PM - 11 PM5/14/26: 11PM - 7 AM, 3 PM - 11 PM5/15/26: 11PM - 7 AM, 3 PM - 11 PM5/16/26: 11PM - 7 AM, 7 AM - 3 PM, 3 PM - 11 PM17. 5/17/26: 11PM - 7 AM, 7 AM - 3 PM, 3 PM - 11 PM18. 5/18/26: 11PM - 7 AM, 3 PM - 11 PM19. 5/19/26: 11PM - 7 AM LVN 1 stated Resident 1's internal hourly monitoring binder and Progress Notes did not have complete monitoring documentation. LVN 1 stated it was important for staff to follow monitoring protocol for safety. During another interview with the DON on 5/20/26 at 4:53 PM, the DON stated that Resident 1's abuse could have been avoided if LVN 4 had reported Resident 1 being a danger to self and others on 4/28/26. The DON stated Resident 1 would have been hospitalized for medical and psychiatric evaluation and stabilization. The DON also explained that when there was a CIC, the staff was expected to monitor and document on the resident for 72 hours to ensure the resident no longer exhibited the behaviors in the CIC. During the same interview with the DON on 5/20/26 at 4:53 PM, the DON stated that prior to Resident 1's admission into the facility, she (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received report from the previous facility that Resident 1 had a history of exhibiting inappropriate behaviors toward female staff. The DON stated a care plan was initiated regarding Resident 1's behaviors and it was important to implement appropriate interventions to protect female staff and residents. During a phone interview on 5/21/26 at 8:35 AM with LVN 2, LVN 2 stated she could not remember the specifics of her documentation for the CIC created on 4/28/26. LVN 2 stated she only notified Resident 1's physician of his CIC. LVN 2 did not state that she notified CDPH, PD, omb, or the DON of Resident 1's verbal threats to harm his roommate. LVN 2 stated she could not remember which roommate Resident 1 verbally threatened because the incident happened a long time ago with a roommate that was no longer in the facility. During an interview with the Quality Assurance (QA) on 5/21/26 at 2:21 PM, the QA stated that on 5/19/26, Resident 1 said to her, With a behind like that, I'll follow you anywhere. The QA stated she did not know what prompted Resident 1 to say that to her. During another interview with the DON on 5/21/26 at 2:21 PM, the DON stated that Resident 1's internal behavioral monitoring binder was intended to be indefinite monitoring during Resident 1's stay in the facility because it was necessary for staff to monitor Resident 1 every hour to ensure he did not exhibit inappropriate behaviors toward female staff and residents. The DON stated the documentation should have been continuous and completed but it was not. The DON also stated the care plan should have been followed for Resident 1's reported inappropriate sexual behavior toward female staff but was not. The DON also stated that all staff hired into the facility were mandated reporters and should report every type of abuse, including verbal abuse, to CDPH, local PD, and ombudsman. During a review of the facility's P&P titled Abuse Prevention Program revised in December 2016, the P&P indicated the facility's residents had the right to be free from abuse. As part of the resident abuse prevention, the administration would protect the facility's residents from abuse by anyone including other residents or any other individual. The policy further indicated for the administration to identify and assess all possible incidents of abuse and investigate and report any allegations of abuse within timeframes as required by federal requirements.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report resident-to-resident verbal abuse to the California Department of Public Health (CDPH- the state agency responsible for providing regulatory oversight of healthcare facilities), local police department (PD), and the local ombudsman (omb- an independent, impartial official who investigates and helps resolve complaints or concerns about an organization's services, practices, or compliance) as written in their policy titled, Abuse Investigation and Reporting when Resident 1 made verbal threats to physically beat his roommate on 4/28/26. This deficient practice compromised the protection of residents, denied timely intervention by oversight and law enforcement authorities, and increased the potential for further harm.Findings: During a review of Resident 1's admission Record, the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including anxiety, psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/31/26, the MDS indicated Resident 1 had moderate cognitive impairment (some difficulty with memory and orientation) and required moderate assistance (helper does less than half the effort) for most cares such as dressing and toileting. During a review of Resident 1's Change in Condition Evaluation (CIC- a communication tool used by healthcare workers when there is a change of condition among the residents) dated 4/28/26 at 2:59 AM, the CIC indicated, Resident is going in roommates personal belongings and taking their belongings, threaten roommates and staff, resident is using foul language, showing signs of being a danger to other residents and staff, resident stated, ?I will beat your ass I am a gangster I don't care about going to jail' and got in staff face. The CIC further indicated Resident 1 exhibited behavioral changes that included verbal aggression, being a danger to self and others, and other behavioral symptoms. The CIC further indicated Resident 1 exhibited dangerous behavior that included threatening to hit roommates and staff and stealing roommates belongings. The CIC further indicated the description of Resident 1's behavioral changes included aggressive behavior. The CIC was created and signed by Licensed Vocational Nurse (LVN) 2. During an interview on 5/20/26 at 3:10 PM and concurrent record review with the DON, Resident 1's CIC dated 4/28/26 for threatening roommates and staff and stealing from roommates was reviewed. The DON stated she was not aware of the CIC because LVN 4 did not report the incident to her. The DON stated that if she knew about it, she would have pushed for an immediate psychiatric consult and pushed for the resident to be medically and psychologically evaluated in a general acute care hospital (GACH). The DON stated LVN 4 was a mandated reporter and should have reported Resident 1's verbal abuse to CDPH, local PD, and the local omb as written in their policy. The DON stated that because LVN 2 failed to notify her of the CIC, the facility was unable to apply appropriate interventions such as sending Resident 1 out for medical and psychological evaluation to prevent further abuse from happening. During an interview on 5/20/26 at 3:49 PM and concurrent record review with LVN 1, Resident 1's CICs, care plans, and progress notes were reviewed. LVN 1 stated she knew that Resident 1 changed rooms due to roommate incompatibility on 4/28/26, but she was not aware of a CIC for verbally threatening staff and roommates and stealing from roommates. LVN 1 stated that if she witnessed Resident 1 verbally threatening his roommates, she would have notified the DON, CDPH, local PD, and local omb as a mandated reporter. LVN 1 further stated that Resident 1 was considered a danger to himself and others and therefore required further medical evaluation and PD involvement. LVN 1 stated that Resident 1's progress notes did not contain documentation of notifying CDPH, local PH, and local ombudsman. During another interview with the DON on 5/20/26 at 4:53 PM, the DON stated that any abuse, including verbal abuse, should be reported to the appropriate agencies (CDPH, PD, and omb) so that proper investigations can be initiated and should be reported up the chain of command (to the (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON) to implement appropriate interventions for the resident experiencing or causing abuse. During a phone interview on 5/21/26 at 8:35 AM with LVN 2, LVN 2 stated she could not remember the specifics of her documentation for the CIC created on 4/28/26. LVN 2 stated she only notified Resident 1's physician of his CIC. LVN 2 did not state that she notified CDPH, PD, omb, or the DON of Resident 1's verbal threats to harm his roommate. LVN 2 stated she could not remember which roommate Resident 1 verbally threatened because the incident happened a long time ago and she believed the roommate was no longer in the facility. During a review of the facility's Policy and Procedure (P&P) titled, Abuse Investigation and Reporting and dated July 2017, the P&P indicated, All alleged violations involving abuse. will be reported by the facility Administrator, or his designee, to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility; the local/state ombudsman; the resident's representative of record;. law enforcement officials; the resident's attending physician; the facility medical director. The P&P also indicated, an alleged violation of abuse. will be reported immediately, but not later than two hours if the alleged violation involves abuse.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 properly supervise Resident 1, allowing the resident to enter the rooms of three of three sample residents (Residents 2, 3, and 4) and engage in inappropriate behavior, which occurred as a result of inadequate monitoring by failing to: 1.Monitor Resident 1 for aggressive behaviors and verbal threats as indicated in his care plan created on 4/28/26 after Resident 1 verbally threatened to harm his roommate when Resident 1 was transferred to a new room with Resident 3. 2. Implement a care plan of Resident 1's inappropriate sexual behaviors of touching his genital area in front of Resident 4 as Resident 1 had previously performed prior to his admission to the facility. 3.Monitor Resident 1's pacing and wandering as indicated in the resident's care plan developed on 5/4/26 after Resident 1 exhibited verbal aggression while pacing and wandering at night. As a result, the facility's staff did not prevent Resident 1 from frequently wandering into Resident 2's room, who was bed bound, and watching her while she was in bed. This made Resident 2 feel uncomfortable. Staff also did not prevent Resident 1 from wandering into Resident 4's room and touching his own genitals while looking at Resident 4. This made Resident 4 feel unsafe and afraid that the facility's staff were not monitoring their residents. The staff also did not prevent Resident 1 from exposing his genitals to his bedbound roommate, Resident 3, and putting Resident 3's toes in his mouth. This made Resident 3 feel disgusted and helpless due to being unable to move his body. These deficient practices caused Residents 2, 3, and 4 emotional distress and compromised their right to a safe and dignified living environment.Findings: a. During a review of Resident 1's admission Record, the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including anxiety, psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/31/26, the MDS indicated Resident 1 had moderate cognitive impairment (some difficulty with memory and orientation) and required moderate assistance (helper does less than half the effort) for most cares such as dressing and toileting. During a review of Resident 1's Care Plan (CP) initiated on 3/28/26, the CP indicated, per hospital record, Resident 1 had a history of inappropriate behavior toward female staff and attempted to touch residents. The CP further indicated a goal for Resident 1 to have no episodes of inappropriate behavior toward female staff and/or attempting to touch residents. The CP also indicated interventions for staff to maintain close supervision and vigilance at all possible times, for Resident 1 to remain on 24-hour hourly monitoring, for Resident 1 to remain on 24-hour hourly location monitoring, and for staff to implement an hourly behavior monitoring log. During a review of Resident 1's Change in Condition Evaluation (CIC- a communication tool used by healthcare workers when there is a change of condition among the residents) dated 4/28/26 at 2:59 AM, the CIC indicated, Resident is going in roommates personal belongings and taking their belongings, threaten roommates and staff, resident is using foul language, showing signs of being a danger to other residents and staff, resident stated, ?I will beat your ass I am a gangster I don't care about going to jail' and got in staff face. The CIC further indicated Resident 1 exhibited behavioral changes that included verbal aggression, being a danger to self and others, and other behavioral symptoms. The CIC further indicated Resident 1 exhibited dangerous behavior that included threatening to hit roommates and staff and stealing roommate's belongings. The CIC further indicated the description of Resident 1's behavioral changes included aggressive behavior. The CIC was created and signed by Licensed Vocational Nurse (LVN) 2. During a review of Resident 1's CP dated 4/28/26, the care plan indicated Resident 1 had the potential to be physically aggressive related to threatening residents and staff, anger, and poor impulse control. The CP indicated a goal that Resident 1 would not harm himself or others through the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review date. The CP further indicated for staff to monitor, document, and report as needed any signs or symptoms of Resident 1 posing danger to self and others. During a review of Resident 1's Progress Notes (PN) from 4/28/26 to 5/1/26, the PN did not include documentation from licensed nurses monitoring Resident 1 related to the CIC of making verbal threats and going into roommate's belongings for five (5) shifts: 1. 4/28/26 from 3 PM - 11 PM2. 4/28/26 from 11 PM - 7 AM3. 4/29/26 from 11 PM - 7 AM4. 4/30/26 from 7 AM - 3 PM5. 4/30/26 from 3 PM - 11 PM During a review of Resident 1's CIC dated 5/4/26 at 12:04 PM, the CIC indicated Resident 1 exhibited a change in condition related to insomnia/mood disorder, pacing in the hallway, [and] angry outburst. The CIC further indicated, Patient observed during shift exhibiting behavioral changes, including insomnia, pacing, and angry outburst. Patient noted to be standing and facing the hallways for extended periods, appearing restless and agitated. No incidents of physical aggression. During the shift, patient [had] difficulty sleeping, and an episode of angry verbal outburst. The CIC was created and signed by LVN 1. During a review of Resident 1's CP dated 5/4/26, the CP indicated Resident 1 was noted pacing in the hallways. The CP indicated a goal for Resident 1 to remain in his room or designated safe area and avoid standing or wandering in the hallway for prolonged periods during the shift. The CP indicated interventions to provide frequent check-ins and gentle reminders to return to his room or a safe area. During a review of Resident 1's PN dated 5/4/26 to 5/7/26, the PN did not include documentation from licensed nurses monitoring Resident 1 related to the CIC of pacing and having angry outburst for two (2) shifts:1. 5/6/26 from 3 PM - 11 PM2. 5/7/26 from 7 AM - 3 PM During a review of Resident 1's psychiatric note dated 5/11/26, the note indicated Resident 1 had a history of trying to touch female staff at his previous home. The note also indicated Resident 1 had a behavior of restlessly pacing but was easily redirectable. During a review of Resident 1's CIC dated 5/19/26 at 12:30 PM, the CIC indicated a change in condition indicating an allegation that Resident 1 was performing oral sex with other residents as reported by two police department officers. The CIC further indicated Resident 1's primary clinician recommended to transfer Resident 1 to a general acute care hospital (GACH) for further evaluation. During a review of Resident 1's CIC dated 5/19/26 at 4:30 PM, the CIC indicated a change in condition related to Resident 1 pacing the hallways, entering other residents' room without permission, entering a male resident's room and touching Resident 1's own private parts, making sexual remarks to female staff to come into his room, and attempting to touch another resident's foot. Resident 1 was placed on one-to-one (1:1) monitoring with a recommendation from Resident 1's primary clinician to transfer the resident to a GACH for psychiatric evaluation. b. During a review of Resident 2's admission Record, the record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity) and major depressive disorder. During a review of Resident 2's Minimum Data Set, dated [DATE], the MDS indicated Resident 2 had intact cognition (good memory, accurate orientation, and minimal to no cognitive deficits) and required maximal assistance (helper does more than half the effort) for most cares such as toileting and dressing. Resident 2 was dependent on staff (helper does all the effort) for bathing. c. During a review of Resident 3's admission Record, the record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including anxiety, bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 3's History and Physical (H&P) dated 4/9/26, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 was dependent (helper does all the help) for most cares such as toileting and bathing. d. During a review of Resident 4's admission Record, the record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including a left leg fracture (broken bone) and difficulty walking. During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 had intact cognition and was dependent on staff for cares such as toileting and showering. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/26 at 10:37 AM with the Director of Nurses (DON), the DON stated that on 5/19/26, two officers from the local PD came to the facility and reported that they received an anonymous report alleging that Resident 1 performed oral sex with other residents in the facility. The DON stated Resident 1 was known to pace in the facility at night and was known to attempt to touch female staff. The DON stated that after interviews with other residents near Resident 1's room, the following was reported:A. Resident 4 reported that Resident 1 went to Resident 4's room and touched himself inappropriately in the morning of 5/19/26B. Resident 5 reported that Resident 1 was always gazing at females in the hallways.C. Resident 2 reported that Resident 1 would go to Resident 2's room and stare at her from the door.D. Certified Nursing Assistant (CNA) 1 reported that Resident 1 invited CNA 1 into bed with him on 5/19/26.The DON further explained she was not aware of Resident 1's inappropriate behavior toward other residents and staff. The DON stated, We thought everything was fine. During an interview on 5/20/26 at 12:58 PM with CNA 1, CNA 1 stated that on 5/19/26 around 2 PM, Resident 1 told her, Hey, come to my bed. I'll give you hugs and kisses. CNA 1 stated Resident 1 liked to walk around the entire facility throughout the day and would stand by other residents' doors. During an interview on 5/20/26 at 1:34 PM with Resident 2, Resident 2 stated that Resident 1 had frequently come into her room uninvited for weeks. Resident 2 stated Resident 1 would stand at the foot of Resident 2's bed and mutter under his breath while staring at Resident 2. Resident 2 stated it made her feel very uncomfortable. During an interview on 5/20/26 at 1:40 PM with Resident 3, Resident 3 stated that Resident 1 would kiss Resident 3's feet while playing with his own genitals. The last time Resident 1 kissed Resident 3's feet was on 5/18/26 but Resident 1 had been inappropriate more than once. For multiple days, Resident 1 would stand at the foot of Resident 3's bed and would stare at Resident 3 while playing with his own genitals and talking to him. Resident 3 stated that when he asked Resident 1 to go away, Resident 1 would threaten him and say, What are you going to do to me? Resident 1 would lunge at Resident 3 as if he were trying to hit Resident 3 and say, You're not going to do anything. Resident 3 stated that he felt very uncomfortable and disgusted that Resident 1 kissed his feet. Resident 3 further explained that he felt helpless and unsafe in the facility because he was unable to move his body and the staff would not be able to help him in time. Resident 3 further stated, It's a little too late because it already happened. During an interview on 5/20/26 at 1:51 PM with Resident 4, Resident 4 stated he had concerns about lack of supervision of the residents that liked to wander in the facility. Resident 4 explained that, on 5/18/26, Resident 1 came into Resident 4's room and stared at Resident 4 while rubbing his genitals. Resident 4 stated he recognized Resident 1 as the same resident that always walked by his door in the hallways. Resident 4 stated that when he asked Resident 1 to leave his room, Resident 1 stated, You're not going to do anything. Resident 4 stated he was afraid to tell the staff about what happened with Resident 1 because he would get neglected or retaliated against by the staff whenever he brought up a concern. Resident 4 stated he felt very uncomfortable and did not feel safe being in the facility. During an interview on 5/20/26 at 2:49 PM and concurrent record review with Registered Nurse (RN) 1, Resident 1's care plans and Medication Administration Record (MAR) dated May 2026 were reviewed. RN 1 stated that Resident 1's care plan initiated on 4/28/26 for threatening residents and staff indicated to monitor, document, and report as needed any signs or symptoms of posing a danger to self and others as an intervention for Resident 1's behaviors. RN 1 stated Resident 1's behavior monitoring did not begin until 5/4/26 and there was no documentation on behavior monitoring between 4/28/26 to 5/4/26 in Resident 1's MAR. RN 1 stated it was important to follow Resident 1's care plan to prevent further abuse from happening. RN 1further explained that staff were responsible for following the care plan to apply appropriate interventions and ensure resident safety. During an interview on 5/20/26 at 3:10 PM and concurrent record review with the DON, Resident 1's CIC dated 4/28/26 for threatening roommates and staff and stealing from roommates was reviewed. The DON stated she was not aware of the CIC because LVN 4 did not report the incident to her. The DON stated that if she knew about it, she would have pushed for an immediate psychiatric consult and pushed for (continued on next page)

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