

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/10/2025
NAME OF PROVIDER OR SUPPLIER University Park Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 230 E Adams Blvd Los Angeles, CA 90011	
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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Supervise and monitor the whereabouts of one of three sampled residents (Resident 2). Resident 2 had a history of inappropriate sexual behaviors, pulling off his pants, self-pleasuring throughout the day, and rubbing his genitals (genitalia- refers to reproductive organs/private parts) in the presence of residents residing in the facility according to Resident 2's care plan (CP) on (Resident 2) has altered behavior manifested by (m/b) invading roommate's space and episode of sexual inappropriate behavior (rubbing his crotch). 2. Protect one of three sampled residents (Resident 1) from sexual abuse (non-consensual sexual contact of any type or sexual harassment) by Resident 2 (Resident 1's roommate). On 10/29/2025 at 8:33AM, a Certified Nursing Assistant (CNA-unknown) informed Social Service Assistant (SSA) that Resident 2 had inappropriately attempted to touched Resident 1's leg according to Resident 2's care plan (CP) on (Resident 2) has altered behavior manifested by (m/b) invading roommate's space and episode of sexual inappropriate behavior (rubbing his crotch). 3. Develop/create a care plan upon admission that addressed Resident 2's inappropriate sexual behavior according to the facility policy and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered dated 1/16/2025. 4. Conduct an Interdisciplinary Team (IDT- a collaborative group of diverse health care professionals from different fields who work together) to develop a plan of care and interventions when on 10/2/2025 Resident 2 was noted with inappropriate sexual behavior according to the facility policy and procedures (P&P) titled, Care Planning - Interdisciplinary Team dated 1/16/2025. These deficient practices had increased potential for: 1. Resident-to-resident verbal and or physical altercation, and injury between Resident 2 and other residents in the facility. 2. Resident 2 to continue invading Resident 1's and the residents' personal space. 3. Resident 1 and other resident in the facility to suffer emotional or psychological distress, and/or emotional discomfort, fear to Resident 1 and other residents in the facility. A review of Resident 1's admission Record, indicated the facility admitted Resident 1 on 6/13/2023 with diagnoses including metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the body), unspecified dementia (a progressive state of decline in mental abilities), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial weakness on one side of the body, affecting the arm, leg and sometimes the face) following cerebral infarction(a stroke caused by a blocked blood vessel in the brain) affecting left non-dominant(less used) side and muscle weakness (generalized). A review of Resident 1's History and Physical (H&P) dated 8/22/2025, indicated Resident 1 did not have the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/1/2025, indicated Resident 1's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired (significant problems with thinking and memory). The MDS indicated Resident 1 had lower extremity (hip, knee, ankle, foot) impairment (loss of anatomical function). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene (practices and habits that maintain cleanliness and health of the body), showering/bathing, dressing, and personal hygiene. The MDS (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056206

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident 1 was dependent on staff to go from sitting to lying position and from lying position to a sitting position on the side of the bed and rolling left to right. The MDS indicated Resident 1 did not walk. A review of Resident 2's admission Record, indicated the facility admitted Resident 2 on 9/16/2025 with diagnoses including other encephalopathy (a general disturbance in brain function), psychotic disturbance(a state where a person loses touch with reality and has a hard time distinguishing it from reality) and mood disturbance (a mental health condition where a person's emotions are affected in a severe and prolonged way, going beyond normal ups and downs). A review of Resident 2's General Acute Care Hospital (GACH) 1 Discharge Summary provided to Skilled Nursing Facility (SNF) 2 by GACH 1 indicated that on 09/08/2025, SNF 1 placed Resident 2 on a 5150 (a temporary, 72-hour involuntary psychiatric hold) for danger to others. The GACH Discharge Summary indicated SNF 1 documented that Resident 2, has been sexually inappropriate, including episodes of pulling his pants down, attempting to engage in sexual activity with his male roommate, and frequently touching himself or self-pleasuring throughout the day. GACH 1 Discharge Summary indicated Resident 2 had a history of poor impulse control (acting without thinking about the consequences, driven by a desire for immediate gratification), poor judgement and sexually inappropriate behaviors that placed Resident 2 at a remained risk of harming others. A review of Resident 2's H&P dated 9/17/2025, indicated Resident 2 did not have capacity to understand and make decisions. The H&P indicated, Patient (Resident 2) was placed on 5150 hold for danger to others on 09/08/2025. Patient was a previous resident at SNF 1. He (Resident 2) has been sexually inappropriate, including episodes of pulling his pants down, attempting to engage in sexual activity with his male roommate, and frequently touching himself or self-pleasuring throughout the day. A review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was able to walk 50 feet on their own. The MDS indicated Resident 2 was independent and able to complete all activities by himself with or without assistive device, and with no assistance from a helper. The MDS indicated Resident 2 had no impairment in both upper and lower extremities. A review of Resident 2's Initial Psychiatric Evaluation dated 9/21/2025, indicated staff had reported Resident 2 had history of sexual inappropriateness. A review of Resident 2's care plan (CP) on Resident noted with inappropriate behavior of pulling off his pant in the hallway. initiated on 10/2/2025, CP the goal indicated, Resident will maintain appropriate behavior through review date. The CP interventions included to, Provide a safe environment. Teach resident safe practice (masturbation [stimulation of the genitals for sexual pleasure]). Transfer to the hospital for psych (psychiatry) evaluation . A review of Resident 2's Change of Condition (COC) Situation Background Assessment Recommendation (SBAR) document dated 10/2/2025 at 8 AM, indicated that on 10/2/2025 at 7:30AM, (Resident 2) was noted with inappropriate behavior of pulling off his pant in the hallway. The COC SBAR indicated a Please review and triage the attached HS802 physician was notified who gave an order to transfer Resident 2 to GACH 2 for psych evaluation. A review of Resident 2's CP on (Resident 2) has altered behavior manifested by (m/b) invading roommate's space and episode of sexual inappropriate behavior (rubbing his crotch) in the activity room initiated 10/29/2025, the CP goal indicated, Resident will demonstrate coping mechanisms. The CP interventions indicated, Continue to monitor behavior, provide redirection as needed, and ensure environmental safety. Document any recurrent or escalating behaviors. Psychiatry to evaluation for medication adjustment or behavioral intervention. A review of Resident 2's COC SBAR dated 10/29/2025 at 1:23PM, indicated that on 10/29/2025 at 1:23PM, (Resident 2) was noted approaching and invading his roommate's (Resident 1) personal space and episode of displaying behavior that was sexually inappropriate in nature (rubbing his crotch) in the activity room. The COC SBAR indicated Resident 2's attending physician was notified and referral to psychiatry will be made for further evaluation . A review of Resident 2's IDT Review record dated 10/29/2025 at 2:04PM, indicated, Behavior Concern: Risk of Resident-to-Resident Altercation or Injury Invading another resident's personal space may trigger verbal or physical aggression from peers, potentially leading to injury to self or others. Risk of Emotional or Psychological Distress to Others (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sexually inappropriate or intrusive behaviors may cause emotional discomfort, fear, or distress to roommates or other residents. Risk of Escalation of Inappropriate Behavior. A review of Resident 2's Social Service Note dated 10/29/2025 at 8:33AM, indicated SSA (Social Service Assistant) was informed that morning by staff (unidentified) that Resident 2 was exhibiting inappropriate behavior toward fellow roommate (unidentified). Resident 2 is observed doing inappropriate behavior to himself in his room by staff daily but this issue that occurred or happened this morning was wrong. During an interview on 11/10/2025 at 9:47AM, SSA stated that on 10/29/2025 a Certified Nurse Assistant (SSA could not remember CNA's name) informed SSA that she (CNA) saw Resident 2 being inappropriate with Resident 1 while Resident 1 was in bed and that Resident 2 was trying to touch Resident 1's leg. SSA stated the facility staff had witnessed Resident 2 having inappropriate behavior of masturbating (stimulate own genitals for sexual pleasure), and CNA would find Resident 2 being overly sexual with himself, touching himself inappropriately. SSA stated Resident 2's curtains should have been pulled for privacy, to have shown dignity. SSA stated Resident 2 should not have masturbated to where he exposed himself to others. SSA stated masturbation needed to be done in private and must not touch any resident including Resident 1 who cannot defend himself. SSA stated she immediately requested for a room change from Registered Nurse (RN) 1 immediately requested for due to the inappropriate behavior of Resident 2 towards Resident 1. SSA stated the facility should have ensured Resident 2 had to have roommates that were more alert (vigilant) and who could be able to speak up for themselves if they needed help. During an interview on 11/10/2025, at 10:29 AM Licensed Vocational Nurse (LVN)1 stated a CNA (unable to recall the name) witnessed Resident 2's one hand underneath Resident 1's blanket, and Resident 2's other hand was down Resident 2's own pants while masturbating. LVN 1 stated the incident between Resident 2 on Resident 1 happened inside Resident 1 and Resident 2's room and that the incident is considered sexual abuse. LVN 1 stated she notified RN 1 of the incident between Resident 1 and Resident 2 and did not know if anyone else was notified. LVN 1 stated any incidents of sexual abuse were reportable to the state and that she herself did not report to the state California Department of Public Health (CDPH). During an interview and record review on 11/10/2025 at 11:02 AM, with RN1stated Resident 2's Care Plan Report initiated on 10/29/2025 was reviewed. RN 1 stated the Care Plan Report indicated Resident 2 had a behavior of inappropriate sexual behavior (rubbing his crotch[genitals]) in the activity room while other residents were present and invading roommate's space. RN 1 stated the care plan report interventions included to monitor Resident 2's behavior and environmental safety (steps to protect people) and document any recurrent (repeated)or escalating (actions that get worse) behaviors. RN 1 stated, we (facility) had a vague inclination of what may or may not end up happening in the future and we had to be vaguer in the care plans with what we monitored, until we were more familiar with (Resident 2's) behaviors. RN 1 stated Resident 2 walks around by himself in the facility unescorted and unmonitored. RN1 stated Resident 2 had a lot of history of sexually inappropriate behavior when Resident 2's admission paperwork was reviewed. RN 1 stated that on 10/29/2025, around 10AM Resident 2 was moved to a room with residents who were alert. RN 1 stated that on 10/29/2025 at around 7AM to 8AM, a CNA (unidentified) reported (unidentified staff) the incident between Resident 1 and Resident 2. RN1 stated, I don't remember who that would have been on that day (10/29/2025) reported Resident 2 was walking around in Resident 1's spaces rubbing his crotch. RN 1 stated Resident 1 would not have been able to tell us anything; (Resident 1) is not alert. RN 1 stated she spoke to the Director of Nursing (DON) on 10/29/2025 and a registered nurse consultant (a registered nurse with extensive experience who provides expert advice). During an interview and record review on 11/10/2025 at 12:26 PM, with Licensed Vocational Nurse (LVN) 2, Resident 2' Care Plan Report initiated 10/2/2025 and medical record were reviewed. LVN 2 stated, the Care Plan Report indicated Resident 2 was noted with inappropriate behavior of pulling off his pants in the hallway. LVN 2 stated the care plan report interventions included to teach resident safe practice (masturbation). LVN 2 stated the care plan report interventions were not specific, they do not indicate what the safe (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	practices are needed. LVN 2 stated there was no care plan before 10/2/22025, that addressed Resident 2's inappropriate sexual behavior. and that a care plan should have been based on the hospital (GACH) records from 9/16/2025 (prior to admission). LVN 2 stated care plans have interventions to intervene before a behavior happens, to manage a behavior. LVN 2 stated an interdisciplinary team (meeting should have been done to identify concerns in Resident 2, to have been able to come up with a plan for Resident 2. LVN 2 stated an IDT was not done for the incident on 10/2/2025, for Resident 2 removing his pants in the hallway, that made sure the interventions are appropriate, realistic, and interventions had to be resident specific. LVN 2 stated if incidents happen and IDTs are not done, interventions are not created It would be a risk of an incident such as an altercation of some kind, abuse such as sexual assault, or sexual abuse. During an interview on 11/10/2025 at 3:36 PM the DON stated that she (DON), reviews preadmission records to make sure that the facility can take care of the residents, that we had the proper standards for resident care. The DON stated, we were trying to find a better placement for Resident 2 since he had some issues and things that he did. The DON stated there was no IDT conducted for incident on 10/2/2025, when Resident 2 pulled off his pants in the hallway and that Resident 2's behavior was inappropriate. The DON stated and IDT could have been done. The DON stated that interventions on Resident 2's care plan should have been more detailed. During a concurrent interview and record review on 11/10/2025 at 4:44 PM with the Administrator (ADM), Resident 2's GACH, dated 9/16/2025 medical records was were reviewed. The ADM stated when Resident 2 exposed himself it was not an appropriate behavior. The ADM stated if Resident 2 had exposed himself daily, we might have placed Resident 2 on a 1:1 (one staff member is providing focused, one -on-one attention to a single resident at a time), spoken to the Resident 2's doctor and Resident 2's conservator (a person given the legal authority to manage the personal care of another individual[the conservatee] who, is unable to manage their own affairs). The ADM stated Resident 2's conservator and the medical doctor would have determined if sending Resident 2 to a different level of care was applicable. The ADM stated that if he knew of Resident 2's history of exposing himself and masturbating in front of other people, he would have been more vigilant from the beginning. The ADM stated the DON was responsible for screening residents prior to admission and was responsible for clinical oversight (a supervisor ensuring that patient care is safe and followed proper rules and methods). The ADM confirmed that none of the staff had reported any allegation of abuse of Resident 2 trying to touch Resident 1 inappropriately. ^ A review of policy and procedures (P&P) titled, Abuse Prevention Program dated 1/16/2025, indicated, Our residents have the right to be free from abuse . This includes but is not limited to . sexual abuse. As part of the resident abuse prevention, the administration will: Protect our residents from abuse by anyone including, but not necessarily limited to .other residents. A review of the facility P&P titled, Care Plans, Comprehensive Person-Centered dated 1/16/2025, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated, The comprehensive, person-centered care plan will; incorporate identified problem areas; incorporate risk factors associated with identified problems; reflect treatment goals, timetables and objectives in measurable outcomes; reflect current recognized standards of practice for problem areas and conditions. The P&P indicated, Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not just only symptoms and triggers. The P&P indicated, The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). A review of the facility P&P titled, Care Planning - Interdisciplinary Team dated 1/16/2025, indicated, Our facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. The A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS).		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report within 2 hours an allegation of resident-to-resident sexual abuse (non-consensual sexual contact of any type or sexual harassment) to the California Department of Public Health (CDPH) for one of three sampled residents (Resident 2). On 10/29/2025 at approximately 7AM-8AM Resident 2 had one hand down his pants and touching himself and with his other hand was trying to touch Resident 1's leg. This failure resulted in a delayed onsite inspection by the CDPH and had the potential for Resident 1 to experience ongoing abuse from Resident 2. A review of Resident 1's admission Record, indicated, the facility admitted Resident 1 on 6/13/2023 with diagnoses including metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the body), unspecified dementia (a progressive state of decline in mental abilities), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial weakness on one side of the body, affecting the arm, leg and sometimes the face) following cerebral infarction (a stroke caused by a blocked blood vessel in the brain) affecting left non-dominant (less used) side and muscle weakness (generalized). A review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/1/2025, the MDS indicated Resident 1's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired (significant problems with thinking and memory). The MDS indicated Resident 1 had lower extremity (hip, knee, ankle, foot) impairment (loss of anatomical function). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene (practices and habits that maintain cleanliness and health of the body), showering/bathing, dressing, and personal hygiene. The MDS indicated Resident 1 was dependent on staff to go from sitting to lying position and from lying position to a sitting position on the side of the bed and rolling left to right. The MDS indicated Resident did not walk. A review of Resident 1's History and Physical (H&P) dated 8/22/2025, the H&P indicated Resident 1 did not have the capacity (ability) to understand and make decisions. A review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 9/16/2025 with diagnoses including other encephalopathy (a general disturbance in brain function), psychotic disturbance (a state where a person loses touch with reality and has a hard time distinguishing it from reality) and mood disturbance (a mental health condition where a person's emotions are affected in a severe and prolonged way, going beyond normal ups and downs). A review of Resident 2's General Acute Care Hospital (GACH) 1 Discharge summary dated [DATE] (prior to admission to the skilled nursing facility [SNF]), provided to Skilled Nursing Facility (SNF) 2 by GACH 1 indicated Resident 2 was placed on a 5150 (a temporary, 72-hour involuntary psychiatric hold) for danger to others on 09/08/2025. The GACH Discharge Summary indicated SNF 1 documented that Resident 2 has been sexually inappropriate, including episodes of pulling his pants down, attempting to engage in sexual activity with his male roommate, and frequently touching himself or self-pleasuring throughout the day. The GACH Discharge Summary indicated Resident 2 had a history of poor impulse control (acting without thinking about the consequences, driven by a desire for immediate gratification), poor judgement and sexually inappropriate behaviors that placed (Resident 2) at a remained risk of harming others. A review of Resident 2's H&P dated 9/17/2025, indicated Resident 2 did not have capacity to understand and make decisions. The H&P indicated, Patient (Resident 2) was placed on 5150 hold for danger to others on 09/08/2025. Patient was a previous resident at SNF1. He (Resident 2) has been sexually inappropriate, including episodes of pulling his pants down, attempting to engage in sexual activity with his male roommate, and frequently touching himself or self-pleasuring throughout the day. A review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was able to walk 50 feet. The MDS indicated Resident 2 was independent and able to complete all activities by himself (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with or without assistive device, and with no assistance from a helper. The MDS indicated Resident 2 had no impairment in both upper and lower extremities. A review of Resident 2's Initial Psychiatric Evaluation dated 9/21/2025, the Psychiatric Evaluation indicated staff had reported Resident 2 had history of sexual inappropriateness. A review of Resident 2's Social Service Note dated 10/29/2025 at 8:33AM, The Social Service Note indicated Social Service Assistant (SSA) was informed that morning by staff (unidentified) that Resident 2 was exhibiting inappropriate sexual behavior toward fellow roommate (unidentified).^ Resident 2 was observed by staff doing inappropriate behavior to himself in his room daily but this issue that happened morning was wrong.^ During an interview on 11/10/2025 at 9:47AM, SSA stated that on 10/29/2025 a Certified Nurse Assistant (SSA could not remember CNA's name) informed SSA that she (CNA) saw Resident 2 being inappropriate with Resident 1 while Resident 1 was in his bed that Resident 2 was trying to touch Resident 1's leg. SSA stated the facility staff had witnessed Resident 2 having inappropriate behavior of masturbating (stimulate own genitals for sexual pleasure), and CNA would find Resident 2 being overly sexual with himself, touching himself inappropriately. SSA stated Resident 2's curtains should have been pulled for privacy, to have shown dignity. SSA stated she did not know if the incident between Resident 1 and Resident 2 that occurred on 10/29/2025 was reported to the state department. During an interview on 11/10/2025, at 10:29 AM Licensed Vocational Nurse (LVN)1 stated a CNA (unable to recall the name) witnessed while in Resident 1 and Resident 2's room, Resident 2's one hand underneath Resident 1's blanket, and Resident 2's other hand was down Resident 2's own pants while masturbating. LVN 1 stated the incident between Resident 2 on Resident 1 happened inside Resident 1 and Resident 2's room and that the incident is considered sexual abuse. LVN 1 stated she notified RN 1 of the incident between Resident 1 and Resident 2 and did not know if anyone else was notified. LVN 1 stated any incidents of sexual abuse were reportable to the state and that she herself did not report to the state California Department of Public Health (CDPH). During an interview on 11/10/2025 at 11:02 AM, RN 1 stated Resident 2 walks around by himself in the facility unescorted and unmonitored. RN1 stated Resident 2 had a lot of history of sexually inappropriate behavior when Resident 2's admission paperwork was reviewed. RN 1 stated that on 10/29/2025 at around 10AM, Resident 2 was moved to a room with residents who were alert. RN 1 stated that on 10/29/2025 at around 7AM to 8AM, a CNA (unidentified) reported to (unidentified staff), the incident between Resident 1 and Resident 2. RN 1 stated any physical, sexual behavior from one resident towards another resident had to be reported to CDPH. During an interview on 11/10/2025 at . with Certified Nurse Assistant (CNA)1, CNA 1 stated any type of abuse witnessed, I would report it immediately to the administrator. During an interview on 11/10/2025 at 3:36 PM with the Director of Nursing (DON), the DON stated reporting of abuse is anytime a resident is abused and reported within a 2-hour time frame to CDPH.^The DON stated all facility staff were mandated reporters, if something had occurred and staff felt that they could not get something done by the administrative team, they are supposed to have reported to CDPH. The DON confirmed that she (DON) was not aware of the incident that occurred 10/29/2025 between Resident 1 and Resident 2 was anything sexual and that the incident was not reported to CDPH. During a concurrent interview on 11/10/2025 at 4:44 PM with the Administrator (ADM), stated that he (ADM) was the abuse coordinator and if a resident was doing something that affected other residents that he deemed (considered) to be harmful then that would be abuse and would report it immediately. The ADM stated abuse reporting would have had to be within two hours to CDPH. The ADM stated Resident 2 inappropriately exposing himself was not an appropriate behavior. A review of the facility's Policy and Procedures (P&P) titled Abuse Investigation and Reporting dated 1/16/2025, the P&P indicated All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. The P&P indicated An alleged violation of abuse, neglect, exploitation or mistreatment (continued on next page)		

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