STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056206	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Healthcare Center	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 - 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 observation, interview, and record review, the facility failed to protect the resident's right to remain free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of three sampled residents (Resident 1), when on 6/18/2026 at 8:45AM Resident 2 hit Resident 1 on his (Resident 1) head with an overhead table (an adjustable table designed to roll over a bed and provide a flat and stable surface). This failure resulted in Resident 1 who was bedbound (unable to leave one's bed), feeling scared and being subjected to physical abuse by Resident 2 (who had history of abusing other residents [Resident 3]) while under the care and supervision of the facility on 6/18/2026 at 8:45AM. The facility called 911 (emergency services number) and transferred Resident 1 to a general acute care hospital (GACH). Resident 1 sustained a blunt trauma (occurs when an external force impacts your body without piercing the skin), a closed head injury (brain is damaged without any object penetrating the skull), and scalp laceration (a deep cut or tear of the flesh). Cross reference F607 and F609Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 3/13/2026 with diagnoses including muscle weakness and muscle wasting and atrophy (the thinning, shrinking, or loss of muscle tissue). During a review of Resident 1's History and Physical (H&P- medical assessment of a resident's medical condition) dated 3/16/2026, the H&P indicated Resident 1 did not have the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 4/1/2026, the MDS indicated Resident 1 had the ability to understand others and required maximal assistance (helper does more than half the effort) for oral hygiene showers and toileting hygiene. During a review of Resident 1's Change of Condition (a sudden clinically important change from a patient's baseline in physical, cognitive [mental], behavioral, or functional domains) form dated 6/18/2026 8:45 AM, the Change of Condition SBAR (Situation, Background, Assessment Recommendation - a tool to share patient information in a clear, complete, concise and structured format; improving communication efficiency and accuracy) form indicated a voice (unidentified) of a scream was heard from Resident 1's room. The Change of Condition SBAR form indicated Resident 1 alleged that Resident 2 hit Resident 1's head with the overhead table. The Change of Condition SBAR form indicated Resident 1 was noted with bleeding and a laceration of approximately three inches (a unit of length) to the left side of the skull, and Resident 1 reported 3/10 pain (0 means no pain and 10 means having the worst pain). The Change of Condition SBAR form indicated the facility called 911 and Resident 1 was transferred to the GACH for further evaluation. During a review of Resident 1's Emergency Department (ED GACH notes) dated 6/18/2026 9:43 AM, the ED notes indicated Resident 1 was bedbound and presented to the ED with a blunt trauma. The ED notes indicated Resident 1 was struck in the head at the facility and had a head laceration that measured three centimeters in length. The ED notes indicated Resident 1's skin laceration was heavily contaminated (dirty) and was irrigated (watered) with extensive amounts of saline (cleaning solution) and repaired with two staples. The ED notes indicated Resident 1's diagnoses were blunt trauma, scalp laceration, and closed head injury. The ED note indicated Resident 1 needed to follow up on 6/28/2026 for the (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Actual harm Residents Affected - Few	removal of the staples. During a review of Resident 1's Intradisciplinary Team (IDT -group of diverse health care professionals from different fields) notes dated 6/19/2026 11:18 AM, the IDT notes indicated Resident 1 had poor memory and was bedbound. The IDT notes indicated on 6/18/2026 at 8:45 AM, staff (unidentified) heard that a resident (unidentified) screamed from Resident 1's room. The IDT notes indicated Resident 1 alleged Resident 2 hit Resident 1 with an overhead table. The IDT notes indicated Resident 2 claimed he (Resident 2) hit Resident 1 on Resident 1's head with the overhead table. The IDT notes indicated Resident 2 was placed under direct supervision until the local police arrived at the facility. During a Review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 4/15/2026 with diagnoses including schizoaffective disorder (mental disorder), insomnia (is a common sleep disorder that can make it hard to fall asleep or stay asleep), and anxiety (nervousness). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had the ability to understand others and was cognitively intact (able to independently make decisions regarding tasks of daily life). During a review of Resident 2's H&P dated 5/21/2026, the H&P indicated Resident 2 lacked capacity to make medical decisions. During a review of Resident 2's Care Plan Report dated 5/29/2026, the Care Plan Report indicated Resident 2 had potential to demonstrate verbal and physical abusive behaviors. The Care Plan Report indicated the nursing interventions were for the licensed nursing staff (in general) to intervene when Resident 2 became agitated before the agitation escalated. During a review of Resident 2's Change of Condition SBAR dated 6/15/2026 at 9:24 AM, the Change of Condition SBAR indicated Resident 2 was irritated and called Resident 3 names (unidentified names), threatened to beat Resident 3, and spit at Resident 3. The Change of Condition SBAR indicated Resident 2's spit landed on Resident 3's shirt. The Change of Condition SBAR indicated Resident 2 was verbally aggressive towards the staff (unidentified, [derogatory]) and with Resident 3. The Change of Condition SBAR indicated the facility moved Resident 2 to a different room (Resident 1's room) to avoid future issues. During a review of Resident 2's Care Plan Report dated 6/15/2026, the Care Plan Report indicated Resident 2 had aggressive behavior related to anger resulting in spitting that landed on resident's (Resident 3) shirt. The Care Plan Report indicated interventions to change rooms and for licensed nursing staff (in general) to assess and anticipate resident's needs such as comfort level. During a review of Resident 2's Behavior Related Incidents form dated 6/18/2026 8:45AM, Behavior Related Incidents form indicated Resident 2 hit stated he (Resident 2) pushed the overhead table and hit Resident 1 on the head. The Behavior Related Incidents form indicated that approximately 11 AM the local police arrived at the facility and took Resident 2 on a 5150-hold (involuntary 72-hour psychiatric [relating to mental illness or its treatment] hold) related to increased aggression towards others. During an observation and interview on 7/1/2026 2:32 PM with Resident 1 inside Resident 1's room, Resident 1 had staples on his left side of the head. Resident 1 stated he (Resident 1) was afraid on 6/18/2026 when Resident 2 was irritated and hit him (Resident 1) on the head with an overhead table. During an interview and a record review on 7/2/2026 at 12:23PM with the Director of Nursing (DON), Resident 2's 72 Hour Monitoring (refers to a structured observation and assessment window of three days used to track a patient's condition, safety, and response to treatment) form dated 6/15/2026 7:26 PM was reviewed. The DON stated the facility moved Resident 2 to Resident 1's room on 6/15/2026 because Resident 1 was verbally aggressive and spit at Resident 3 and required to be monitored for 72 hours every shift. The DON stated Resident 2 required supervision to prevent further abuse of other residents (in general). The DON stated Resident 2 required close supervision for aggressiveness and for spitting at Resident 3. The DON did not respond to the surveyor's question when asked if the staff (in general) provided supervision for Resident 2 to prevent him (Resident 2) from hitting Resident 1 on 6/18/2026 at 8:45AM. The DON stated Resident 2 was last monitored on 6/17/2026 at 11:40 PM according to Resident 2's 72 Hour Monitoring forms. The DON stated Resident 2's monitoring should have ended on 6/18/2026 7-3 shift. During a review of the facility's Abuse Prevention Program policy and procedure (P&P) dated 1/15/2026, the P&P indicated the residents have the right to be free from abuse, neglect, (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	misappropriation of resident property and exploitation (means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion). The P&P indicated that as part of the resident abuse prevention, the administration will protect the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual.

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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 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 observation, interview, and record review, the facility failed to implement its policies and procedures (P&P) titled Abuse Prevention Program with a reviewed date of 1/15/2026 and P&P titled Resident-to-Resident Altercations with a reviewed date of 1/15/2026, for three of three sampled residents (Resident 1, Resident 2, and Resident 3) by failing to: 1. Protect Resident 1 (who was bedbound) from physical abuse on 6/18/2026 at 8:45AM when Resident 2 (who was supposed to be on 72 hours monitoring for verbal aggression and spitting at Resident 3 on 6/15/2026) hit Resident 1 on his (Resident 1) head with an overhead table (an adjustable table designed to roll over a bed and provide a flat and stable surface), and caused a head laceration (a deep cut or tear of the flesh), and bleeding to Resident 1. 2. Ensure the Director of Nursing (DON), Administrator 1 (ADM1), and Licensed Vocational Nurse 1 (LVN1) reported to the Ombudsman, the California Department of Public Health (CDPH), and to the local police on 6/15/2026 at 9:30 AM when Resident 2 (who had a diagnosis of schizophrenia) threatened Resident 3 to beat him up (Resident 3) up and spit at Resident 3. 3. Ensure the facility investigated the physical and verbal abuse allegations between Resident 2 and Resident 3 on 6/15/2026. 4. Protect Resident 3 from verbal and physical abuse from Resident 2 on 6/15/2026. 5. Ensure all the facility's staff were able to identify all types of abuse. As a result, Resident 1 and Resident 3 were not protected from abuse from Resident 2, Resident 1 was taken to the hospital on 6/18/2026 via emergency services and was found with blunt trauma (external forces on your body injure you), closed head injury (brain is damaged without any object penetrating the skull), scalp lacerations (open cut). Resident 1 and Resident 3's allegations of physical and verbal abuse were not investigated and not reported to the Ombudsman, local police, and to CDPH, and placed other unidentified residents at potential for further abuse. Cross Reference F600 and F609Findings:During a Review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 3/13/2026 with diagnoses that included muscle weakness, muscle wasting, schizophrenia (mental disorder which leads to hallucinations, irrational thoughts, and behaviors), and wedge compression fracture of the fourth lumbar vertebra (the fourth bone in the lower back (the L4) cracked and collapsed in the front, making it shaped like a wedge rather than a square). During a review of Resident 1's Readmit H&P [history and physical] dated 3/16/2026, the H&P indicated Resident 1 did not have the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 4/1/2026, the MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from facility staff for toileting, showering, and upper body dressing. The MDS indicated Resident 1 was dependent on facility staff for personal hygiene and lower body dressing. During a review of Resident 1's situation background assessment and recommendation (SBAR: a form that is a documentation of a complete assessment in response to a change in condition) dated 6/18/2026 at 7AM, the SBAR indicated a resident (unidentified) to resident altercation that resulted in an open wound to Resident 1's head. The SBAR indicated that around 8:45 AM, a voice was heard from Resident 1's room and Resident 1 alleged that Resident 2 hit Resident 1's head with the overhead table. The SBAR indicated Resident 1 was bleeding with a laceration of approximately three inches to the left side of the skull. The SBAR indicated Resident 1 reported 3/10 pain and the facility called 911 and was transferred to the general acute care hospital (GACH) for further evaluation. During a review of Resident 1's GACH record ER dated 6/18/2026, the GACH ER record indicated Resident 1 was diagnosed with blunt trauma, closed head injury, scalp lacerations. During a review of Resident 2's admission record, the admission record indicated the facility admitted the resident on 4/15/2026 with diagnoses that included homelessness, schizoaffective disorder (a mix of psychosis [hallucinations or delusions] and extreme mood swings), and parkinsonism (any condition that causes a specific group of movement problems, like slowed motion, rigid muscles, shaking [tremors], and balance issues). During a review of Resident 2's Care (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan Report dated 4/21/2026, the care plan indicated a focus of [Resident 1] has behavior: intermittent episodes of yelling, agitation, restlessness, and attention seeking. Refusing to take PRN [whenever necessary] anti-anxiety as offered. The care plan report indicated the facility was to ensure Resident 2 had a psychiatric consult and was monitored closely to prevent harm to self and others. During a review of Resident 2's MDS dated [DATE], the MDS indicated the resident was cognitively intact. During a review of Resident 2's H&P dated 5/21/2026, the H&P indicated Resident 2 lacked the capacity to make decisions. During a review of Resident 2's Care Plan Report initiated on 5/29/2026, the care plan report indicated The resident has potential to demonstrate [verbally/physically] abusive behaviors r/t ineffective coping skills, poor impulse control, history of homelessness. The facility staff was to Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later, when the resident became agitated. During a review of Resident 2's SBAR dated 6/15/2026 at 9:24 AM, the SBAR indicated Resident 2 was irritated and called Resident 3 names (unidentified), threated to beat Resident 3, and spitted at Resident 3. The SBAR indicated Resident 2's spit landed on Resident 3's shirt. The SBAR indicated Resident 2 was verbally aggressive towards the staff (unidentified, [derogatory]) and with Resident 3. The SBAR indicated the facility moved Resident 2 to a different room [Resident 1's room] to avoid future issues. During a review of Resident 2's 72 Hour Monitoring note dated 6/15/2026 at 7:26 PM, the note indicated that on 6/15/2026 the resident was placed on 72-hour monitoring, due to a Room change due to verbal aggression & spitting on roommate. The 72-hour monitoring start indicated the monitoring was to end on 6/18/2026 at 7:26 PM. During a review of Resident 2's 72 Hour Monitoring note dated 6/17/2026 at 8:45 AM, the note indicated 72-hour monitoring continued due to a Room change due to verbal aggression & spitting on roommate. During a review of Resident 2's 72-hour monitoring notes, there was no note documenting the final 11 hours of the monitoring ordered to end on 6/18/2026 at 7:26 PM. During a review of Resident 2's INC-Behavior Related Incidents note dated 6/18/2026 at 9 AM, the note indicated At around 08:45AM a voice was heard of a scream coming from room [ROOM NUMBER]. Upon arrival to the room, resident's roommate [Resident 1] alleged that [Resident 2] hits him with the overhead table. Upon interviewing [Resident 2], he said he pushed the overheard table which hits [Resident 2] on the head. [Local law enforcement] was called, CDPH, and Ombudsman was notified. An order was received to transfer resident to 1 [GACH] for psych eval r/t increased aggression towards others. Resident was also placed on 72-hours 1:1 monitoring until he is transferred to the hospital. At about 10:00AM, resident moved closer to the exit door, as he remained on 1:1 monitoring. When resident noticed a slight distraction on the floor, he ran out of the facility and staff members went after him. Outside of the facility, resident made several attempts to go on the road as staffs continued to stop him for safety precaution as we continue to awaits police arrival. In the process, resident hits two staff members. The note indicated the resident was taken to a psychiatric hospital During a review of Resident 2's Progress Notes dated 6/18/2026 at 11:26AM, the Progress Notes indicated Resident 2 was transferred to a psychiatric urgent care on a 5150 hold (an emergency, involuntary 72-hour psychiatric hold) by the local police related to increased aggression towards others. During a review of Resident 3's admission record, the admission record indicated the facility admitted the resident on 7/23/2025 and readmitted the resident on 5/23/2026, with diagnoses that included schizophrenia and anxiety disorder. During a review of Resident 3's H&P dated 5/26/2026, the H&P indicated the resident did not have the capacity to understand or make decisions. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 required substantial/maximal assistance from facility staff for eating, toileting, and personal hygiene. During an interview on 7/2/2026 at 9:30AM with the Director of Nursing (DON) and Licensed Vocational Nurse (LVN1), the DON and LVN1 stated that spitting was not a form of abuse. LVN1 stated spitting was gross and disrespectful but there was no need to report as an abuse when Resident 2 spit at Resident 3. The DON stated she (DON) did not report the incident between Resident 2 and Resident 3 to the Ombudsman (an independent, (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	government-funded advocate who protects the rights of residents), local police, or to CDPH because spitting and name calling (derogatory) was not considered abuse. During an interview on 7/2/2026 at 9:45 AM with LVN 1, LVN1 used Google to search for spitting and stated that the Google search indicated a resident spitting at another resident was considered a form a physical abuse. The DON stated the physical abuse between Resident 2 and Resident 3 should have been reported and investigated. During an interview on 7/2/2026 at 11:20 AM with the administrator (ADM 2), ADM2 stated the expectation was for the staff to be able to identify the types of abuse and act accordingly. ADM2 stated all staff were mandated reporters and needed to report abuse within two hours. During an interview and a record review on 7/2/2026 at 12:23PM with the Director of Nursing (DON), Resident 2's 72 Hour Monitoring (refers to a structured observation and assessment window of three days used to track a patient's condition, safety, and response to treatment) form dated 6/15/2026 7:26 PM was reviewed. The DON stated the facility moved Resident 2 to Resident 1's room on 6/15/2026 because Resident 1 was verbally aggressive and spit at Resident 3 and required to be monitored for 72 hours every shift. The DON stated Resident 2 required supervision to prevent further abuse of other residents (in general). The DON stated Resident 2 required close supervision for aggressiveness and for spitting at Resident 3. The DON did not respond to the surveyor's question when asked if the staff (in general) provided supervision for Resident 2 to prevent him (Resident 2) from hitting Resident 1 on 6/18/2026 at 8:45AM. The DON stated Resident 2 was last monitored on 6/17/2026 at 11:40 PM according to Resident 2's 72 Hour Monitoring forms. The DON stated Resident 2's monitoring should have ended on 6/18/2026 7-3 shift. During a review of the facility's P&P titled Abuse Prevention Program with a reviewed date of 1/15/2026, the P&P indicated that facility residents had the right to be free from abuse. The P&P indicated facility administration was to protect resident from abuse from anyone. The P&P indicated the facility was to Identify and assess all possible incidents of abuse. During a review of the facility's P&P titled Resident-to-Resident Altercations with a review date of 1/15/2026, the P&P indicated All altercations. including those that may represent resident-to-resident abuse, shall be investigated and reported to the nursing supervisor, the director of nursing services and to the administrator. The policy indicated that if two residents were involved in an altercation, facility staff was to report incidents, findings, and corrective measures to appropriate agencies as outlined in our facility's abuse reporting policy.

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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 and investigate an allegation of physical and verbal abuse to the California Department of Public Health (CDPH), the Ombudsman (an official appointed to investigate individuals' complaints against maladministration), and the local police department, within two hours for two of three sampled residents (Resident 2 and Resident 3) by failing to: -Ensure the Director of Nursing (DON), Administrator 1 (ADM1), and Licensed Vocational Nurse 1 (LVN1) reported to the Ombudsman, CDPH, and to the local police on 6/15/2026 at 9:30 AM when Resident 2 (who had a diagnosis of schizophrenia) threatened Resident 3 to beat him up (Resident 3) up, was verbally aggressive, and spit at Resident 3. -Ensure the facility investigated the physical and verbal abuse allegations between Resident 2 and Resident 3 on 6/15/2026. -Ensure all the facility's staff were able to identify all types of abuse. These failures resulted in not reporting and not investigating and had the potential for Resident 3 to be at risk for further abuse.Cross Reference F600 and F607Findings:During a review of Resident 2's admission Record, the admission Record indicated the facility admitted the resident on 4/15/2026 with diagnoses that included homelessness, schizoaffective disorder (a mix of psychosis [hallucinations or delusions] and extreme mood swings), and parkinsonism (any condition that causes a specific group of movement problems, like slowed motion, rigid muscles, shaking [tremors], and balance issues). During a review of Resident 2's Care Plan Report dated 4/21/2026, the care plan indicated a focus of [Resident 1] has behavior: intermittent episodes of yelling, agitation, restlessness, and attention seeking. Refusing to take PRN [whenever necessary] anti-anxiety as offered. The care plan report indicated the facility was to ensure Resident 2 had a psychiatric consult and was monitored closely to prevent harm to self and others. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 5/5/2026, the MDS indicated the resident was cognitively intact (alert). During a review of Resident 2's History and Physical (H&P) dated 5/21/2026, the H&P indicated Resident 2 lacked the capacity to make decisions. During a review of Resident 2's Care Plan Report initiated on 5/29/2026, the Care Plan Report indicated The resident has potential to demonstrate [verbally/physically] abusive behaviors r/t [related to] ineffective coping skills, poor impulse control, history of homelessness. The facility staff was to Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later, when the resident became agitated. During a review of Resident 2's Situation, Background, Assessment Recommendation (SBAR- a tool to share patient information in a clear, complete, concise and structured format; improving communication efficiency and accuracy) dated 6/15/2026 at 9:24 AM, the SBAR indicated Resident 2 was irritated and called Resident 3 names (unidentified), threatened to beat Resident 3, and spitted at Resident 3. The SBAR indicated Resident 2's spit landed on Resident 3's shirt. The SBAR indicated Resident 2 was verbally aggressive towards the staff (unidentified, [derogatory]) and with Resident 3. The SBAR indicated the facility moved Resident 2 to a different room [Resident 1's room] to avoid future issues. During a review of Resident 2's 72 Hour Monitoring note dated 6/15/2026 at 7:26 PM, the note indicated that on 6/15/2026 the resident was placed on 72-hour monitoring, due to a Room change due to verbal aggression & spitting on roommate. The 72-hour monitoring start indicated the monitoring was to end on 6/18/2026 at 7:26 PM. During a review of Resident 2's 72 Hour Monitoring note dated 6/17/2026 at 8:45 AM, the note indicated 72-hour monitoring continued due to a Room change due to verbal aggression & spitting on roommate. During a review of Resident 2's 72-hour monitoring notes, there was no note documenting the final 11 hours of the monitoring ordered to end on 6/18/2026 at 7:26 PM. During a review of Resident 3's admission Record, the admission Record indicated the facility admitted the resident on 7/23/2025 and readmitted the resident on 5/23/2026, with diagnoses that included schizophrenia and anxiety (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disorder. During a review of Resident 3's H&P dated 5/26/2026, the H&P indicated the resident did not have the capacity to understand or make decisions. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 required substantial/maximal assistance from facility staff for eating, toileting, and personal hygiene. During an interview on 7/2/2026 at 9:30AM with the DON and LVN1, the DON and LVN1 stated that spitting was not a form of abuse. LVN1 stated spitting was gross and disrespectful but there was no need to report as an abuse when Resident 2 spit at Resident 3. The DON stated she (DON) did not report the incident between Resident 2 and Resident 3 to the Ombudsman (an independent, government-funded advocate who protects the rights of residents), local police, or to CDPH because spitting and name calling (derogatory) was not considered abuse. During an interview on 7/2/2026 at 9:45 AM with LVN 1, LVN1 used Google to search for spitting and stated that the Google search indicated a resident spitting at another resident was considered a form a physical abuse. The DON stated the physical abuse between Resident 2 and Resident 3 should have been reported and investigated. During an interview on 7/2/2026 at 11:20 AM with Administrator 2 (ADM 2), ADM2 stated the expectation was for the staff (in general) to be able to identify the types of abuse and act accordingly. ADM2 stated all staff (in general) were mandated reporters and needed to report abuse within two hours. During an interview and a record review on 7/2/2026 at 12:23PM with the DON, Resident 2's 72 Hour Monitoring (refers to a structured observation and assessment window of three days used to track a patient's condition, safety, and response to treatment) form dated 6/15/2026 7:26 PM was reviewed. The DON stated the facility moved Resident 2 to Resident 1's room on 6/15/2026 because Resident 1 was verbally aggressive and spit at Resident 3 and required to be monitored for 72 hours every shift. The DON stated Resident 2 required supervision to prevent further abuse of other residents (in general). The DON stated Resident 2 required close supervision for aggressiveness and for spitting at Resident 3. The DON did not respond to the surveyor's question when asked if the staff (in general) provided supervision for Resident 2 to prevent him (Resident 2) from hitting Resident 1 on 6/18/2026 at 8:45AM. The DON stated Resident 2 was last monitored on 6/17/2026 at 11:40 PM according to Resident 2's 72 Hour Monitoring forms. The DON stated Resident 2's monitoring should have ended on 6/18/2026 7-3 shift. During a review of the facility's P&P titled Abuse Prevention Program with a reviewed date of 1/15/2026, the P&P indicated that facility residents had the right to be free from abuse. The policy indicated to investigate and report any allegations of abuse within timeframes as required by federal requirements.