

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S. Alvarado St Los Angeles, CA 90006	
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. Based on observation, interview and record review, the facility failed to protect the resident's right to be free sexual abuse (non-consensual sexual contact of any type with a resident) for one of one sampled resident (Resident 1) according to the facility's policy and procedures (P&P) titled, Abuse Prevention and Prohibition Program dated 6/25/2025. On 7/21/2026 at around 11PM, Resident 1 complained to Licensed Vocational Nurse (LVN) 1 that Certified Nursing Assistant (CNA) 1 sexually abused Resident 1. This deficient practice resulted in CNA 1 remaining in the facility and continued to provide care to residents on 7/21/2026 and 7/22/2026 for a total of 15 hours and 30 minutes increasing the potential risk for abuse for the residents in the facility. Findings; During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 7/10/2026 with diagnoses that included Diabetes Mellitus type 2 (DM-2 a long term condition, often developed due to poor lifestyle choices, characterized by difficulty in blood sugar control and poor wound healing) and paraplegia (loss of movement and/or sensation, to some degree, of the legs). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 7/10/2026, the MDS indicated Resident 1 had moderate cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 60 used wheelchair for mobility. The MDS indicated Resident 1 needed staff maximum assistance for eating and fully dependent on staff for eating and activities of daily living (ADL- sitting/standing, oral hygiene, personal hygiene toileting hygiene, shower/bath, lower body dressing, and toilet transfer). During an interview with CNA 1 on 7/24/2026 at 12:20pm, CNA 1 stated that on 7/21/2026 at around 11:02pm Resident 1 pushed the call light and CNA 1 went right away to help Resident 1. CNA 1 stated Resident 1 requested his incontinence brief to be changed. CNA 1 stated CNA 1 politely asked Resident 1 if Resident 1 was wet (urine), but Resident 1 got upset and told CNA 1 that CNA 1's job was to change Resident 1's incontinence brief. CNA 1 stated CNA 1 then uncovered Resident 1, however, Resident 1 refused for CNA 1 to change Resident 1's incontinence brief and threw the call light towards CNA 1 and asked CNA 1 to send someone else. CNA 1 stated that CNA 1 did not touch Resident 1 or Resident 1's incontinent brief and CNA 1 left Resident 1's room. CNA 1 stated CNA 1 informed LVN 1 of the afore mentioned incident. CNA 1 stated that on 7/21/2026 at around 11:30 pm, Registered Nurse (RN) 1 called CNA 1 and informed CNA 1 that Resident 1 was alleging that CNA 1 sexually abused Resident 1. CNA 1 stated RN 1 informed CNA 1 that CNA 1 was removed from Resident 1 and that CNA 1's assignment was changed to provide care to other residents for rest of the shift (11pm - 7pm shift). CNA 1 stated that CNA 1 completed/worked the entire shift on 7/21/2026 from 11 pm to 7 am (7/22/2026) and left the facility on 7/22/2023 at 7 am. CNA 1 stated that CNA 1 came back to the facility, to work and provided care to residents on 7/22/2026 from 11 pm till 7 am (7/23/2026). CNA 1 stated that on 7/24/2026, the Assistant Administrator (AADM) contacted CNA 1 and asked CNA 1 to come and meet with AADM at the facility (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in facility. CNA 1 stated she met with AADM on 7/24/2026) in the AADM in AADM's office regarding the incident with Resident 1 on 7/21/2026. CNA 1 sated that CNA 1 might have been suspended. During a telephone interview with Resident 1 on 7/24/2026 at 1:59pm, Resident 1 stated, that on 7/21/2026 at 11 pm, I needed to be changed so I push call light and I told her (CNA 1) that I need to be changed (provide incontinence [the loss of urine and feces control] care. She (CNA 1) argued why someone else didn't change me (Resident 1). Then she touched my penis (male body part that passes urine from inside of the body to outside) really hard. I reported it to night supervisor (licensed nurse), don't remember the name. She (CNA 1) did not open the (incontinence brief) but touched my penis. During a review of CNA 1's electronic timecard for the month of 7/2026, indicated CNA 1 clocked in to work on the following dates and time: On 7/21/2026 - CNA 1 clocked in the facility at 10:44 pm and clocked out for the shift at 7:01 am. On 7/22/2026 - CNA 1 clocked in the facility at 10:57 pm and clocked out for the shift at 7:00 am. During a review of the facility's Nursing Staffing Assignment and Sign In Sheet dated 7/21/2026, indicated CNA 1 was assigned to provide care to a total 16 residents including Resident 1 on 7/21/2026 from 11pm to 7am. During a review of Resident 1's Nurse's Note dated 7/21/2026 at 11:40 pm, indicated Registered Nurse (RN) 1 documented that, Charge nurse (LVN 1) reported to RN supervisor (RN 1) that a resident (Resident 1) want to speak to supervisor. I went to speak to (Resident 1) and asked what he (Resident 1) wanted to speak to me about. (Resident 1) had a complaint about a CNA (CNA 1) allegedly touching him inappropriately in his penis. I told the resident that I was sorry about what he had experienced and I will assign a new CNA to the room (Resident 1). During a review of the facility's Nursing Staffing Assignment and Sign In Sheet dated 7/22/2026 from 11pm to 7 am, indicated CNA 1 was not assigned Resident 1, however, CNA 1 was assigned to provide care to 18 residents. During a review of the facility's 5-day summary report titled Report, dated 7/29/2026, indicated, After investigation was complete and based on the interviews and statements from resident, roommate and staff interviewed, It was determined that allegation could not be substantiated based on the fact that CNA was inside room for a very short period of time and did not get to touch patient that night. During an interview on 7/24/2026 at 3:14 pm with RN 1, RN 1 stated RN 1 and LVN 1 were working on 7/21/2026 from 11 pm to 7am. RN 1 stated that LVN 1 told RN 1 that Resident 1 accused CNA 1 of sexually abusing Resident 1 on 7/21/2026 at around 11:30 pm. RN 1 stated that, I (RN 1) changed (CNA 1's) assignment to provide care to other residents for rest of the shift. RN 1 stated that on 7/21/2026 at 11:30 pm, RN 1 telephoned and informed the Director of Nursing (DON) that Resident 1 was alleging that CNA 1 sexually abused Resident 1 and that CNA 1 was removed from Resident 1 and was reassigned to provide care to other residents. RN 1 stated the DON did not give RN 1 further guidance or instructions. During an interview on 7/24/2026 at 3:33 pm with AADM and the DON, the AADM stated, We are aware that we should have suspended the CNA (CNA 1) right away to protect (Resident 1) and we missed it. We suspended the CNA 1 today (7/24/2026). The DON stated, CNA 1 should have been suspended right after the sexual abuse allegation incident. The DON stated that on 7/24/2026, the facility Administrator called CNA 1 to come to the facility for a meeting regarding incident. The DON stated CNA 1 was removed from Resident 1, however, CNA 1 remained in the facility, and continued to provide care to other residents in the facility. The DON stated that on 7/21/2026 at around 11:30 pm, CNA 1 was removed from Resident 1, however, CNA 1 was reassigned to provide care for other residents in the facility. The DON stated CNA 1 was not suspended or removed from the facility and that CNA 1 worked the entire shift on 7/21/2026. The DON stated that on 7/21/2026 night, CNA 1 returned to work in the facility on 7/22/2026 and worked from 11pm to 7am. The DON stated, but I understand that per policy we should have suspended CNA 1 right after the incident (sexual abuse allegation). During a review of the (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's policy and procedures (P&P) titled, Abuse Prevention and Prohibition Program dated 6/25/2025, the P&P indicated, Facility Staff members accused of committing abuse, neglect or mistreatment against a resident are suspended until the investigation is complete and the findings have been reviewed by the Administrator. Staff members alleged to have committed abuse, neglect or mistreatment against a resident will not be reinstated to their regular assignment until the investigation is complete and the allegation is unsubstantiated.		

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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 observation, interview, and record review, the facility failed to report allegation of sexual abuse within two hours to the Department of Public Health and Adult Protection Services (APS) for one of one sampled resident (Resident 1), according to the facility's policy and procedures (P&P) titled, Abuse Prevention and Prohibition Program dated 6/25/2025. This deficient practice had the potential for Resident 1 and other residents in the facility to experience/suffer abuse. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 7/10/2026 with diagnoses that included Diabetes Mellitus type 2 (DM-2 a chronic condition, often developed due to poor lifestyle choices, characterized by difficulty in blood sugar control and poor wound healing) and paraplegia (loss of movement and/or sensation, to some degree, of the legs). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 7/10/2026, the MDS indicated Resident 1 had moderate cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated that Resident 60 used wheelchair. MDS indicated that Resident 1 needed maximum assistance for eating and fully dependent on staff for eating and activities of daily living (ADL- sitting/standing, oral hygiene, personal hygiene toileting hygiene, shower/bath, lower body dressing, and toilet transfer). During a review of a document, Intake Report (document faxed by facility to California Department of Public Health [CDPH]), a telephone report was made to law enforcement on 7/23/2026 at 1:40 am regarding the Alleged sexual abuse incident. Intake Report indicated, On July 21, 2026, during the 11pm-7am shift, female C.N.A. responded to call light in room [ROOM NUMBER]A. Resident asked C.N.A. to change his diaper. According to the resident, C.N.A. allegedly touched his penis while checking his diaper. C.N.A. denies open/remove diaper and did not expose any part of the resident's body. Resident allegedly told C.N.A. to stop touching him and after a short discussion between the two, the C.N.A. left the room without changing the resident. C.N.A. states resident no longer wanted diaper changed so she left the room. Resident requested to speak to RN Supervisor, and after describing the alleged incident, another C.N.A. changed his incontinent brief. During an interview with CNA 1 on 7/24/2026 at 12:20pm, CNA 1 stated that on 7/21/2024 at around 11:02pm Resident 1 pushed the call light and CNA 1 went right away to help Resident 1. CNA 1 stated Resident 1 requested his incontinence brief to be changed. CNA 1 stated CNA 1 politely asked Resident 1 if Resident 1 was wet (urine), but Resident 1 got upset and told CNA 1 that CNA 1's job was to change Resident 1's incontinence brief. CNA 1 stated CNA 1 then uncovered Resident 1, however, Resident 1 refused for CNA 1 to change Resident 1's incontinence brief and threw the call light towards CNA 1 and asked CNA 1 to send someone else. CNA 1 stated that CNA 1 did not touch Resident 1 or Resident 1's incontinent brief and CNA 1 left Resident 1's room. CNA 1 stated CNA 1 informed LVN 1 of the aforementioned incident. CNA 1 stated that on 7/21/2026 at around 11:30 pm, Registered Nurse (RN) 1 called CNA 1 and informed CNA 1 that Resident 1 was alleging that CNA 1 sexually abused Resident 1. CNA 1 stated RN 1 informed CNA 1 that CNA 1's assignment was changed for rest of the shift (11pm - 7pm shift). CNA 1 stated that CNA 1 completed/worked the entire shift on 7/21/2026 from 11 pm to 7 am (7/22/2026) and left the facility on 7/22/2023 at 7 am. CNA 1 stated that CNA 1 came back to the facility, to work and provided care to residents on 7/22/2026 from 11 pm till 7 am (7/23/2026). CNA 1 stated that CNA 1 was in the facility the same day (7/24/2026) to meet with the Assistant Administrator (AADM) regarding the incident and might have been suspended. During an interview on 7/24/2026 at 1:07 pm with Licensed (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vocational Nurse (LVN) 2, LVN 2 stated, Any type of abuse occurred in the facility should be reported to department of public health and law enforcement within 2 hours. During a telephone interview with Resident 1 on 7/24/2026 at 1:59pm, Resident 1 stated, that on 7/21/2026 at 11 pm, I needed to be changed so I push call light and I told her (CNA 1) that I need to be changed (provide incontinence [the loss of urine and feces control] care. She (CNA 1) argued why someone else didn't change me (Resident 1). Then she touched my penis really hard. I reported it to night supervisor (licensed nurse). I don't remember the name. She (CNA 1) did not open the (incontinence brief) but touched my penis. During an interview on 7/24/2026 at 3:14 pm with Registered Nurse (RN) 1, RN 1 stated RN 1 and LVN 1 were working on 7/21/2026 from 11 pm to 7am. RN 1 stated that LVN 1 told RN 1 that Resident 1 accused CNA 1 of sexually abusing Resident 1 on 7/21/2026 at around 11:30 pm. RN 1 stated RN 1 telephoned and informed the Director of Nursing (DON) that Resident 1 was alleging that CNA 1 sexually abused Resident 1 and that CNA 1 was removed from Resident 1 and was reassigned to provide care to other residents. During an interview on 7/24/2026 at 3:33 pm with AADM (Assistant Administrator) and DON, AADM stated, We (facility) are aware that we should have reported the sexual abuse incident to department of public health and law enforcement within 2 hours, per policy. But we missed it (Resident 1 alleging that CNA 1 sexually abused Resident 1), DON stated, We understand the sexual abuse allegation occurred on 7/21/2026 at around 11:30 pm but we didn't report to the department of public health until 7/23/2026 at around 2:22 pm. I understand that per our (facility) policy we should have reported the incident to public health department and law enforcement within 2 hours. During a review of the facility's policy and procedures (P&P) titled, Abuse Prevention and Prohibition Program dated 6/25/2025, the P&P indicated, Special Considerations for Reporting Suspected Incidents of Criminal Sexual Abuse - The Administrator then acts to ensure the following steps are taken: The proper authorities and individuals are notified immediately or within two (2) hours, including but not limited to law enforcement, the Attending Physician, the resident's representative, the state survey agency, and adult protective services.		