STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056351	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatsworth Park Health Care Center	10610 Owensmouth Chatsworth, CA 91311

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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policy and procedures (P&P) for ensuring the reporting of a reasonable suspicion of a crime in accordance with Section 1150B of the Act by failing to report an allegation of staff to resident physical and verbal abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) immediately but no later than two hours to the State Agency (California Department of Public Health [CDPH]) and the local law enforcement for one of four sampled residents (Resident 1).This deficient practice had the potential to result in the delay in implementing necessary actions to oversee the protection of the residents in the facility by the State Survey Agency (SSA). Findings:During a review of Resident 1's admission Record, the admission Record indicated that the facility originally admitted Resident 1 to the facility on 3/23/2023 and readmitted on [DATE] with diagnoses including osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of the vertebra (one of the bones that make up the spinal column), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 7/15/2025, the MDS indicated that Resident 1 had mildly impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and was dependent on staff with toileting hygiene, shower or bathing, dressing, personal hygiene, and mobility (movement).During an interview on 8/1/2025 at 12:35 p.m. with the Assistant Director of Nursing (ADON), the ADON stated that on 7/17/2025 at around 3:45 p.m., a third-party Clinical Evaluator (CE) informed her (ADON) and the MDS Coordinator (MDSC) that Resident 1 reported to the CE that he was held down by five facility staff and they were verbally aggressive to him. The ADON stated she immediately called the Director of Nursing (DON) on 7/17/2025 at 3:54 p.m. and the DON instructed the ADON to notify the Administrator (ADM). The ADON stated she notified the ADM at 3:56 p.m. and was told by the ADM that the ADM had already investigated this incident. During a concurrent interview and record review on 8/1/2025 at 1:25 p.m. with the ADM, reviewed Resident 1's Incident Summary and the facility's P&P on abuse investigation. The ADM stated that on 7/17/2025 he received a call from the ADON regarding Resident 1's claim of physical and verbal abuse, and he (ADM) informed the ADON that this matter had already been investigated. The ADM stated that the Incident Summary dated 7/1/2025 indicated Resident 1 had accused Certified Nursing Assistant 6 (CNA 6), Licensed Vocational Nurse 6 (LVN 6), LVN 3, and LVN 4 of being verbally and physically abusive toward him during care. The ADM stated that following a thorough investigation, it was concluded that Resident 1 was the aggressor in this encounter and that Resident 1 was verbally aggressive to staff. The ADM stated that the facility's Abuse Investigation Policy indicates that it is the policy of the facility to thoroughly investigate any and all reports of abuse, neglect and misappropriation of property and to immediately report the alleged or suspected abuse, neglect, or exploitation of the resident according to state regulations. The ADM stated that Resident 1's allegations of verbal and physical abuse by staff should have been reported immediately and by failing to report the allegations, it may have delayed the implementation of necessary actions to protect the residents in the facility. During a review of the facility's policy and procedure (P&P) titled, Abuse Investigation last revised on January 2025, the policy indicated the facility will thoroughly investigate any and all reports of abuse, neglect (failure to provide adequate care or services), and misappropriation of property (deliberate misplacement, exploitation [taking advantage of a resident], or wrongful, use of resident's belongings or money without the resident's consent). Immediately report the alleged or suspected abuse, neglect, or exploitation of the resident according to state regulations.