STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the personal privacy of one of three sampled residents (Resident 2) was provided when Certified Nursing Assistant (CNA 1) entered Resident 2's room without knocking and began speaking to CNA 4 through a gap in the curtain, while CNA 4 was changing Resident 2's diaper and providing peri-care (the cleaning of genitals particularly for individuals with limited mobility and/or loss of bladder/bowel control). This deficient practice resulted in failing to provide Resident 2 with privacy during personal hygiene care. Findings: During a review of Resident 2's admission Record, dated 4/3/2026, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. The admission Record indicated Resident 2's diagnoses included hemiplegia (a form of paralysis that causes severe or complete loss of movement on one side of the body) and hemiparesis (weakness on one side of the body, affecting the arm, leg, and sometimes the face) following cerebral infarction (occurs when blood flow to part of the brain is blocked or a blood vessel bursts, resulting in loss of oxygen to the brain), syncope (fainting), and overactive bladder (a condition where the bladder muscles squeeze involuntarily, creating a sudden, urgent need to pee, even when the bladder is not full). During a review of Resident 2's History and Physical Examination (H&P - a comprehensive assessment of a resident's medical condition), dated 2/13/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 2/18/2026, the MDS indicated Resident 2 was dependent for toileting hygiene, shower/bathe, upper body dressing, lower body dressing, and personal hygiene (a helper does all of the effort of the activity). During a phone interview on 4/2/2026 at 11:25 a.m. with Registered Nurse (RN 1), RN 1 stated on 3/19/2026 at around 9 p.m., CNA 4 reported to RN 1 that CNA 1 was not at her assigned residents' area but in the conference room. RN 1 stated she asked CNA 4 to accompany RN 1 when speaking to CNA 1 because RN 1 need[ed] to have a witness. RN 1 stated: I saw [CNA 1] in the conference room with her cell phone. There (were) no more meal breaks at that time because it was near the end of shift, and it was the CNAs' last rounds to attend to patients. RN 1 stated she asked CNA 1 why CNA 1 was in the conference room, to which CNA 1 replied that CNA 1 was on her break. RN 1 stated she told CNA 1 there is no more scheduled breaks because the shift was almost ending, and it was the last rounds to do your tasks. RN 1 stated CNA 1 got offended and started to record RN 1 and CNA 4 with CNA 1's cell phone. RN 1 stated she left to obtain the nurse's phone (a specific phone that licensed nurses use in the facility to communicate to doctors and to facility upper management) and reported CNA 1's actions. RN 1 stated later during that same shift, CNA 4 reported to RN 1 that CNA 1 had recorded CNA 4 while CNA 4 was changing a resident. During a phone interview on 4/2/2026 at 7:43 p.m. with CNA 4, CNA 4 stated on 3/19/2026, some of the charge nurses were paging [CNA 1] and they couldn't find her. CNA 4 stated RN 1 asked CNA 4 to go with her because [RN 1] needed somebody to witness when [RN 1] talks to [CNA 1]. CNA 4 stated RN 1 spoke to CNA 1 about going back to her [assigned] station. CNA 4 stated CNA 1 took her phone and started videoing (recording) us. CNA 4 stated she went to Resident 2's room because the call light was on. CNA 4 stated Resident 2 is alert and wanted her diaper to be changed. CNA 4 stated, CNA 1 showed up right away inside [Resident (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2's] room and hold up [CNA 1's cell] phone. CNA 4 stated: I'm in the middle of changing [Resident 2's] diaper. [CNA 1] showed up and didn't even knock on the door. [CNA 1] went inside the room and acting like she is getting gloves. CNA 4 stated she already took out the old diaper and Resident 2 was naked on the bottom part, when CNA 1 entered Resident 2's room without knocking. CNA 4 stated she told CNA 1 to get out of here so that I can change my patient. CNA 4 stated Resident 2 was surprised and asked what CNA 1 was doing in Resident 2's room. When asked if the privacy curtain was pulled completely around Resident 2's bed, CNA 4 stated there was a gap of about 1 to 2 feet where CNA 1 showed up. CNA 4 stated after she changed Resident 2, CNA 4 went to her assigned nursing station where she saw CNA 1. CNA 4 stated she told CNA 1, Next time, don't do that because we need to give residents some privacy. CNA 4 stated that CNA 1 took her cell phone out, pointed it to CNA 4, and videoed CNA 4. CNA 4 stated she reported to RN 1 and also sent a written statement via text to Director of Staff Development (DSD). CNA 4 stated: Patients have rights like privacy. We have to protect their dignity. During a concurrent observation and interview on 4/3/2026 at 9:08 a.m. with Resident 2, Resident 2 stated she recalled pressing her call light at nighttime for her diaper to be changed. Resident 2 stated when CNA 4 arrived in the room, CNA 4 forgot to slide the curtain all the way. Resident 2 stated when CNA 4 was changing Resident 2's diaper, Resident 2 saw a second person appear where there was a gap in the privacy curtain. Resident 2 stated, I saw the person there. Resident 2 was observed to be pointing at the foot of her bed on the right side from Resident 2's point of view while lying in bed. Resident 2 stated the second person who appeared began talking to CNA 4. Resident 2 stated she then told CNA 4, Can you please be mindful and not let anybody come here? When asked if Resident 2 had already been cleaned and changed when the second person appeared, Resident 2 stated: No, I was still being changed. I was already exposed. Resident 2 stated the second person left the room after Resident 2 asked for the privacy curtain to be closed. Resident 2 stated she felt embarrassed because [Resident 2] was exposed. Resident 2 stated: Some CNAs are more mindful of privacy. They knock on the door and ask for permission. That [second] person didn't knock on the door. During a phone interview on 4/3/2026 at 10:01 a.m. with CNA 3, CNA 3 stated when changing a resident's soiled diaper, First, I knock on the door. I introduce myself and close the curtain for privacy. CNA 3 stated if privacy is not given to residents when they are being cleaned and changed, it is possible they will feel sad even if the patient cannot talk. CNA 3 stated video recording is not allowed in the facility because it does not help with giving residents privacy. During a phone interview on 4/3/2026 at 10:24 a.m. with CNA 1, CNA 1 was asked if she had recorded with her cell phone while in the facility. CNA 1 stated: Yes, I did record. I felt threatened. There was [CNA 4] and one nurse. It took 2 people to come talk to me. I was feeling I was being ganged and harassed, and I feared for my life. When asked if CNA 1 recorded a resident in the facility, CNA 1 stated, That's not true. CNA 1 stated she recorded a nurse and a CNA in the conference room, and CNA 1 only recorded because they are harassing CNA 1. When asked if CNA 1 entered a resident's room while CNA 4 was providing direct care, CNA 1 stated, I went inside a resident's room to get some gloves. CNA 1 was asked if she had an assigned resident in the same room where CNA 4 was providing resident care, to which CNA 1 stated: It doesn't matter. Is there a law that I can't go to any patient's room to get gloves? During an interview on 4/3/2026 at 4:22 p.m. with the Director of Nursing (DON), the DON stated when nursing staff is providing peri-care, the nursing staff needs to explain what they are doing and provide privacy. DON stated a possible consequence if a resident is not given privacy during peri-care is emotional distress and feeling embarrassed. DON stated there is no recording with cell phones allowed in the facility because of the possibility of violating residents' privacy. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 1/1/2012, the P&P indicated, Residents of skilled nursing facilities have a number of rights under state and federal law. The Facility will promote and protect those rights. Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of residents' rights. The P&P further indicated, State and federal laws guarantee certain basic rights to all residents of the Facility. These rights include, but (continued on next page)

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	056380	A. Building B. Wing	04/03/2026

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	are not limited to, a resident's right to.privacy and confidentiality. During a review of the facility's job description for CNA titled, Certified Nursing Assistant Job Description, undated, the job description indicated the general job duties and responsibilities of certified nursing assistants include .provid[ing] assigned personal hygiene care in accordance with facility procedures.to maintain resident cleanliness, dignity, and comfort.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 1 and Resident 2) received care in accordance with professional standards of practice to attain or maintain the highest practicable physical, mental, and psychosocial well-being when: (A) On 3/13/2026, Resident 1 pressed the call light in order for Resident 1's soiled diaper and bed sheets to be changed. Certified Nursing Assistant (CNA 1) was Resident 1's assigned CNA. CNA 1 entered Resident 1's room, turned off the call light, exited the room and did not return to change Resident 1, in accordance with Resident 1's verbal request. Resident 1 called the facility's front desk and asked to be changed. Resident 1 waited about one hour before Resident 1's soiled diaper and bed sheets were changed by another CNA who was not assigned to Resident 1. (B) On 3/27/2026, Resident 3 asked CNA 1 to change Resident 3's soiled diaper to which CNA 1 replied no. CNA 1 was Resident 3's assigned CNA. Resident 3 reported the verbal exchange involving CNA 1 to Licensed Vocational Nurse (LVN 1), and Resident 3 requested to be cleaned and changed by another CNA who was not assigned to Resident 3. These deficient practices resulted in Resident 1 feeling upset at waiting about one hour for Resident 1's soiled diaper and bed sheets to be changed, and Resident 3 feeling very uncomfortable sitting in a soiled diaper. Findings: (A) During a review of Resident 1's admission Record, dated 4/3/2026, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE], and most recently re-admitted on [DATE]. The admission Record indicated Resident 1's diagnoses included bilateral osteoarthritis of the knee (when the lining of both knees are worn down over time and causes the bones to rub against each other), bilateral osteoarthritis of the hip (when the lining of both hips are worn down over time and causes the bones to rub against each other), and morbid obesity (a condition defined as being 100 pounds over a person's ideal body weight). During a review of Resident 1's History and Physical Examination (H&P - a comprehensive assessment of a resident's medical condition), dated 3/8/2026, the H&P indicated Resident 1 was re-admitted to the facility after sustaining a fall at home while using her wheelchair. The H&P indicated Resident 1 had the capacity to understand and make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/10/2026, the MDS indicated Resident 1 required moderate assistance for toileting hygiene, shower/bathe, and lower body dressing (a helper does less than half the effort). The MDS indicated Resident 1 required maximal assistance (a helper does more than half the effort) for bed to chair transfer (the ability to transfer to and from a bed to a chair/wheelchair) and toilet transfer (the ability to get on and off of a toilet). During an interview on 4/2/2026 at 9:38 a.m. with Resident 1, Resident 1 stated she uses the toilet only for bowel movements (passing stool out of the body), and Resident 1 uses an adult diaper for urinating. Resident 1 stated about a few weeks ago around 9 p.m., Resident 1 pressed the call light because her diaper and bed sheets were wet and needed to be changed. Resident 1 stated about 30 minutes after pressing the call light, CNA 1 came to Resident 1's room and turned off the call light. Resident 1 stated while CNA 1 was inside Resident 1's room, Resident 1 told [CNA 1] that [Resident 1] needed to be changed, but [CNA 1] just turned around and left Resident 1's room. Resident 1 stated, I thought [CNA 1] left to get supplies to change the mattress, but [CNA 1] never came back. Resident 1 stated she waited another 20-30 minutes, but when CNA 1 did not return, Resident 1 stated she had to call the front desk and let them know I needed to be changed. Resident 1 stated, I waited a long time like over an hour and I was so upset. Resident 1 stated, My diaper and bed sheets were soaked and wet. My mattress was all wet, too. Resident 1 stated, I was so upset, but another CNA helped me. I waited for an hour before I was cleaned and dry. During a phone interview on 4/2/2026 at 11:25 a.m. with Registered Nurse (RN 1), RN 1 stated Resident 1 is alert and verbalizes her needs well and the staff can understand [Resident 1's] needs. RN 1 stated that on 3/13/2026 at around 9 p.m., RN 1 was sitting at the front desk when Resident 1 called stating Resident 1 needed a CNA. RN 1 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she paged CNA 1, who is Resident 1's assigned CNA. RN 1 stated some minutes later, CNA 2 approached RN 1 and reported that Resident 1 was not being changed. RN 1 stated she went to Resident 1's room and saw right away that [Resident 1] was soaking wet [and] the bed sheet was really wet. RN 1 stated Resident 1 reported to RN 1 that CNA 1 came in the room, turned off the call light, turned her back on [Resident 1] and then left. RN 1 stated Resident 1 told CNA 1 that Resident 1 needed to be changed. RN 1 stated she paged CNA 1 again and went to look for CNA 1. RN 1 stated she found CNA 1 inside the conference room looking at her cell phone. RN 1 stated she told CNA 1 about Resident 1's complaints. RN 1 stated she and CNA 1 were walking down the hallway toward Resident 1's room when CNA 1 got offended and said RN 1 was ganging on [CNA 1]. RN 1 stated she replied to CNA 1, I'm not ganging on you. I'm questioning you about your patients. RN 1 stated CNA 1 replied, I'm going home. RN 1 stated CNA 1 left the facility prior to the shift ending, and RN 1 had to ask another CNA to clean Resident 1. RN 1 stated she reported the incident involving Resident 1 and CNA 1 to the Administrator (ADMIN), Director of Nursing (DON), and Director of Staff Development (DSD) via text using the nurse's phone. RN 1 stated the nurse's phone is a specific phone that licensed nurses use in the facility to communicate to doctors and to upper management, including ADMIN, DON, and DSD. When asked if RN 1 documented the incident involving Resident 1 and CNA 1 on 3/13/2026, RN 1 stated she documented a late entry progress note. During a review of Resident 1's Nursing Progress Notes, dated 3/21/2026, the Nursing Progress Notes indicated the following: Late entry - 03/13/26. At approximately past 2200 [10:00 p.m.] on 3/13/26, [Resident 1] was found with a visible soaking wet diaper and wet bedsheet. Incontinence care was provided promptly and the patient was made clean, dry, and comfortable. Bedding was changed. No (acute) distress, noted. During a phone interview on 4/2/2026 at 4:37 p.m. with LVN 1, LVN 1 stated several weeks ago, LVN 1 recalls CNA 1 being paged overhead to attend to [Resident 1]. LVN 1 stated about 20 minutes later, LVN 1 saw Resident 1's call light was still on, so LVN 1 had CNA 1 paged again. LVN 1 stated she then noticed the call light was off, so LVN 1 asked Resident 1 if Resident 1 had been cleaned and changed. LVN 1 stated Resident 1 replied that [Resident 1] told [CNA 1] that [Resident 1] needed to be changed and that [CNA 1] ignored her. When asked if LVN 1 reported what Resident 1 had said, LVN 1 stated: Yes, I reported this to [RN 1] right after I spoke with [Resident 1]. LVN 1 stated she could not find CNA 1 and later heard that CNA had walked out of the facility. LVN 1 stated she had to ask another CNA (name not indicated) to clean and change Resident 1. During a phone interview on 4/2/2026 at 5:15 p.m. with CNA 2, CNA 2 stated she recalled an incident involving Resident 1 about 3 weeks ago. CNA 2 stated when she was making rounds (visually checking on the residents) at about 9:30 p.m., CNA 2 asked Resident 1 if Resident 1 was okay. CNA 2 stated Resident 1 replied that she was just waiting to be changed. CNA 2 stated about 50 minutes later, CNA 2 heard a page overheard regarding Resident 1. CNA 2 stated she went to Resident 1's room and Resident 1 reported to CNA 2 that CNA 1 came in, turned off the call light and left. CNA 2 stated Resident 1 was upset, and Resident 1 told CNA 2, Look at my bed. It is all wet. CNA 2 stated, I saw [Resident 1's] bed was wet. CNA 2 stated she went to RN 1 and reported what Resident 1 told CNA 2 about CNA 1. CNA 2 stated leaving [a resident] soaked [in urine] can cause skin breakdown. During an interview on 4/3/2026 at 9:19 a.m. with RN 2, RN 2 stated the responsibilities of certified nursing assistants include answering call lights and changing residents when their diapers become soiled. RN 2 stated a possible consequence of leaving a resident in a soiled, wet diaper is that the skin can breakdown and it can lead to infection. During a phone interview on 4/3/2026 at 10:01 a.m. with CNA 3, CNA 3 stated the responsibilities of certified nursing assistants include taking care of patients. CNA 3 stated, We feed the patients. We wash the patients and make sure they are clean and dry. When asked what could possibly happen if a resident is left in a wet diaper, CNA 3 stated the urine is so strong that it will break skin. During a phone interview on 4/3/2026 at 10:24 a.m. with CNA 1, CNA 1 was asked if she recalled Resident 1, to which CNA 1 stated, I don't know who that is. Who is that? When asked if CNA 1 had any issues with any of CNA 1's assigned residents, CNA 1 stated: Patients are always going to complain about (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	something. If you are sitting in a nursing home and can't leave, you'll find a reason to complain about something. A lot of them are bedbound. When asked if CNA 1 left any of CNA 1's assigned residents in a soiled diaper for about an hour, CNA 1 stated, No, that's a lie. CNA 1 stated, No one has never complained since I have been doing this. During an interview on 4/3/2026 at 4:22 p.m. with the DON, the DON stated it is part of the standard of practice and job duties of certified nursing assistants to answer call lights and make sure all [residents'] needs are attended to, including changing residents' diapers. The DON stated if a resident is waiting to be changed and sitting in a soiled diaper, possible consequences include a risk for skin breakdown, feeling not comfortable and in distress, and a risk for fall because a resident might try to get out of bed or wheelchair and walk to the bathroom. (B) During a review of Resident 2's admission Record, dated 4/3/2026, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE], and most recently re-admitted on [DATE]. The admission Record indicated Resident 2's diagnoses included bilateral osteoarthritis of hip (when the lining of both hips are worn down over time and causes the bones to rub against each other), malignant neoplasm of prostate (cancer in the prostate), and type 2 diabetes mellitus (a condition where the body cannot properly use or make enough of the hormone called insulin, leading to high blood sugar levels). During a review of Resident 2's History and Physical Examination (H&P - a comprehensive assessment of a resident's medical condition), dated 2/1/2026, the H&P indicated Resident 2 has the capacity to understand and make medical decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 3/30/2026, the MDS indicated Resident 2 is dependent for toileting hygiene (a helper does all of the effort of the activity). The MDS indicated Resident 2 required substantial assistance for shower/bathe and lower body dressing (a helper does more than half the effort of the activity). During a phone interview on 4/2/2026 at 11:25 a.m. with RN 1, RN 1 stated on 3/27/2026 at approximately 9:45 p.m., CNA 1 told RN 1 that CNA 1 needed to go out of the facility for a few minutes and that DSD was aware. RN 1 stated after CNA 1 had left the facility, RN 1 learned through LVN 1 that Resident 2 reported that he had asked to be changed by [CNA 1] at around 8:40 p.m. and [CNA 1] had responded no. RN 1 stated Resident 2 was later cleaned and changed by another CNA. During a phone interview on 4/2/2026 at 4:37 p.m. with LVN 1, LVN 1 stated Resident 2 is in a wheelchair due to muscle weakness and Resident 2 is incontinent. LVN 1 stated approximately a week ago at around 8:30 p.m., LVN 1 was a witness to an incident involving Resident 2 and CNA 1. LVN 1 stated it happened right next to my desk. LVN 1 stated Resident 2 was in his wheelchair and approached LVN 1 at the nursing station asking for LVN 1 to call CNA 1 so that Resident 2's soiled diaper can be changed. LVN 1 stated she called CNA 1 twice overhead. LVN 1 stated when CNA 1 approached LVN 1, LVN 1 told CNA 1 to change Resident 2. LVN 1 stated Resident 2 was still at the nursing station and asked CNA 1 why CNA 1 did not change Resident 2 when he had asked CNA 1 earlier. LVN 1 stated CNA 1 basically gave excuses that CNA 1 was on break and that she was busy. LVN 1 stated CNA 1 then told Resident 2, Do you want me to change you, yes or no? LVN 1 stated, I started to look for another CNA because [Resident 2] was getting frustrated. I asked [Resident 2] if he wanted someone else to change him and he said yes. LVN 1 stated she requested another CNA to help clean and change Resident 2. LVN 1 stated she reported the incident involving CNA 1 and Resident 2 to RN 1. During a phone interview on 4/3/2026 at 10:24 a.m. with CNA 1, CNA 1 stated CNA 1 did not know or recall Resident 2. When asked if there was an argument or an incident involving Resident 2, CNA 1 stated: [Resident 2] is right in front of nursing station. There was no argument with [Resident 2]. When asked if CNA 1 ever left her shift early without permission, CNA 1 stated: If I have a family emergency or I'm taking care of personal things, I leave for just 30 minutes. I didn't abandon anyone because these [nurses] are licensed. You didn't go to school to just pass out Advil. During an observation and interview on 4/3/2026 at 11:48 a.m. with Resident 2, Resident 2 was observed sitting in his wheelchair and able to move around in the hallway by himself. When asked if something had happened to Resident 2 involving being cleaned and changed, Resident 2 stated, Yeah, that was something that should not happen. She was supposed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to do her duty to help me. When asked to clarify who was supposed to help Resident 2, Resident 2 stated CNA 1. Resident 2 stated: I asked [CNA 1] to clean me because I had an accident. Some kind of diarrhea so my diaper was dirty. I asked [CNA 1] if she could help me and she said no. Resident 2 stated he told LVN 1 about CNA 1 refusing to clean and change Resident 2. Resident 2 stated: I wasn't very happy about it. Most of the time, the other nurses treat me with dignity and respect. When I ask them to help me, they help me. That is why I was surprised [CNA 1] said no. Resident 2 stated, [CNA 1] made me feel very uncomfortable. That thing never happened to me. Resident 2 stated he did not want CNA 1 to be assigned to him because it will remind [Resident 2] of what happened. During an interview on 4/3/2026 at 4:22 p.m. with DON, DON was asked about the 3/27/2026 incident involving Resident 2 and CNA 1. DON stated DON recalled RN 1 sending a text that another CNA was changing CNA 1's patients because [CNA 1] was nowhere to be found. DON stated the facility has a buddy system in which certified nursing assistants work in pairs and can cover each other if one CNA is preoccupied with another resident. DON stated it's not fair to one CNA if that CNA is doing all the work of the other CNA because it can lead to delayed care for the residents. DON stated the CNA who is covering another CNA's patients will have an increased workload and will be in a rush when providing services which affects patient care. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 1/1/2012, the P&P indicated the following: Residents of skilled nursing facilities have a number of rights under state and federal law. The Facility will promote and protect those rights. Residents have freedom of choice, as much as possible, about how they wish to live their everyday lives and receive care. Employee are to treat all residents with kindness, respect, and dignity and honor the exercise of residents' rights. During a review of the facility's job description for CNA titled, Certified Nursing Assistant Job Description, undated, the job description indicated the general job duties and responsibilities of certified nursing assistants include [NAME][ing] rounds,.answer residents' call lights promptly,.and provide assigned personal hygiene care in accordance with facility procedures.to maintain resident cleanliness, dignity, and comfort.