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	06/01/2026

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 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 protect the resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm by one person towards another) and verbal abuse (the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or to their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability) for one of four sampled residents (Resident 1) when:1. On 5/22/2026, around 8:30 p.m., Resident 1, who was in the Facility Recreational Room, was approached by Visitor (VS) 1 who used verbal profanities towards Resident 1. VS 1 and Resident 1 continued to both use verbal profanity and derogatory slur towards each other as they walked down the hallway toward Resident 1's room, VS 1 was in front of Resident 1 and turned around and spat (the intentional, aggressive act of ejecting saliva, phlegm, or other mouth contents directly at another person) at Resident 1's face. After RN 1 witnessed the verbal altercation between Resident 1 and VS1, RN 1 stated she (RN1) did not ask VS 1 to leave the facility and VS 1 left when she was done the visitation with Resident 4. RN 1 stated she did not see when VS 1 left the facility.2.On 5/22/2026, around 8:30 p.m. after Resident 1 and VS 1 had both a physical and verbal altercation, the facility failed to follow it policy and procedures (P&P) titled, Visitation Rights, that indicated visitor who is subjected to abusing, exploiting or coercing a resident will be denied access or provided limited and supervised access to the resident until an investigation has cleared the visitor of all allegations.This deficient practice placed Resident 1 at risk of being subjected to continued physical abuse and verbal abuse.Findings:a. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 9/26/2025 with diagnoses including abnormalities of gait and mobility, metabolic encephalopathy (a change in brain function caused by a chemical imbalance in the body, not a direct physical injury to the brain), and cognitive communication deficits (a difficulty with talking, listening, reading, or writing, caused by a problem with brain function rather than a physical speech issue).During a review of Resident 1's History and Physical Examination (H&P - a comprehensive medical evaluation conducted upon admission), dated 9/30/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 1 had the ability to understand and to be understood. The MDS indicated Resident 1 had intact cognitive function. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting, showering, upper and lower body dressing, putting on and taking off footwear, and with personal hygiene.During a review of Resident 1's Change in Condition (COC) Evaluation, dated 5/22/2026 at 8:30 p.m., the COC Evaluation indicated verbal altercation towards other patient's power of attorney (POA - a legal document that grants a trusted person or the agent the legal authority to make critical decisions on behalf of person) with no injuries. The COC Evaluation's Summarize your observation, evaluation and recommendation section indicated Resident 1 reported verbal encounter with female resident's POA (VS 1), allegedly spit on his face, incident (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occurred in facility.During a review of Resident 1's Care Plan Report (CP), initiated on 5/22/2026, the CP's Focus indicated Resident 1 was at risk for emotional distress related to verbal altercation with another resident's family member; resident alleged that family spit on his face. The CP included interventions to assess Resident 1 for signs and symptoms of distress every shift and to encourage to express feelings and concerns.During a telephone interview on 6/1/2026 at 10:17 a.m. with Resident 1, Resident 1 stated about five months ago he (Resident 1) started having issues with VS 1. Resident 1 stated he (Resident 1) and Resident 4 are in a relationship but nothing physical. Resident 1 stated VS1 threatened him by saying that she (VS 1) will call to deport him (Resident 1) and by having her (VS 1) son beat up Resident 1. Resident 1 stated he was in constant fear. Resident 1 stated the facility's supervisors (unidentified staff) were aware of VS 1's threats and would just tell Resident 1 to go to his room. Resident 1 stated, on 5/22/2026, around 8 p.m., he (Resident 1) and Resident 4 were in the facility's activity room (Facility Recreational Room), sitting in the table across from each other, when VS 1 came in and began to yell at Resident 1 and Resident 4. Resident 1 stated VS 1 told that she did not want Resident 1 to speak to Resident 4. Resident 1 stated then he (Resident 1) left and walked towards his (Resident 1's) room and began to laugh because he (Resident 1) thought it was funny which made VS 1 madder. Resident 1 stated VS1 was also walking in the hallway when she (VS1) turned around and spat at Resident 1's face, covering his (Resident 1's) face and glasses with her (VS 1's) spit. Resident 1 stated VS 1 attempted to hit Resident 1 but Certified Nursing Assistant (CNA) 1 intervened and stopped VS 1 from hitting Resident 1. Resident 1 stated he (Resident 1) was then sent to his room, but he (Resident 1) went to the nurses' front desk and wanted to contact the local police department. Resident 1 stated he (Resident 1) called the police.b. During a review of Resident 4's AR, the AR indicated the facility admitted Resident 4 on 12/30/2025 with diagnoses including diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness (generalized), and essential (primary) hypertension (HTN - high blood pressure).During a review of Resident 1's History and Physical (H&P - a comprehensive medical evaluation conducted upon admission), dated 12/31/2025, the H&P indicated Resident 4 was alert and oriented.During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had the ability to understand and be understood. The MDS indicated Resident 4 had intact cognition. The MDS indicated Resident 4 required supervision or touching assistance with toileting/tub/shower transfers, sit to stand, and chair to bed transfers. During an interview on 6/1/2026 at 12 p.m. with Resident 4, Resident 4 stated that she (Resident 4) and Resident 1 are friends, they get along well, and that they spend time together in the patio and in activities. Resident 4 stated on 5/22/2026, around 8 p.m., she (Resident 4) and Resident 1 were in the activity room (Facility Recreational Room) when VS 1 came in and yelled at Resident 4 and Resident 1. Resident 4 stated VS 1 did not like Resident 4 and Resident 1 talking to each other. Resident 4 stated Resident 1 then left the activity room (Facility Recreational Room), and Resident 4 and VS 1 also left but VS 1 and Resident 1 were still arguing while Resident 1 was walking down the hallway back to his (Resident 1) room. Resident 4 stated she (Resident 4) was telling at VS 1 to stop and that was when VS 1 spat at Resident 4. Resident 4 stated she saw Resident 1 with spit on his glasses and face. Resident 4 stated she saw VS 1 attempt to push Resident 1 when CNA 1 intervened and stopped VS 1 from pushing Resident 1. Resident 4 stated VS1 was not asked to leave the facility and that she left on her (VS1) own terms, when she (VS1) was ready. Resident 4 stated the next day the Administrator (ADM) called VS1 and informed that VS 1 was not allowed to come to the facility anymore.During an interview on 6/1/2026 at 12:59 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she (LVN 1) worked on 5/22/2026 and when she (LVN1) had just come back from lunch around 8 to 8:30 p.m., Registered Nurse (RN) 1 called LVN 1 and informed LVN1 that there had been an incident with another resident's family member (VS 1). LVN 1 stated she witnessed Resident 1 and VS 1 by the Facility Recreational Room talking but they were speaking in Spanish. LVN 1 stated she did not understand what they (Resident 1 and VS 1) were talking about but Resident 1's and VS 1's tone was higher and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	argumentative. LVN 1 stated then RN 1 asked them (Resident 1 and VS 1) to go into the Facility Recreational Room. LVN 1 stated then RN 1 instructed her (LVN1) to return to her station.During an interview on 6/1/2026 at 1:55 p.m. with RN 1, RN 1 stated that on 5/22/2026, around 8:30 p.m., she (RN 1) was made aware of the incident because Resident 1 approached RN 1 and stated that there was a verbal altercation with VS 1 and that VS 1 spat at his (Resident 1's) face. RN 1 stated Resident 1 walked away, and RN 1 followed Resident 1 (Resident 1). RN 1 stated Resident 1 was walking towards the Facility Recreational Room where VS 1 met up with them. RN 1 stated Resident 1 and VS 1 then began to yell at each other, RN 1 tried to de-escalate the situation by having VS 1 and Resident 1 go into the Facility Recreational Room. RN 1 stated after speaking to VS 1, she (RN 1) went to speak to Resident 1 and Resident 1 informed him that he (Resident 1) already called the police. RN 1 stated she (RN 1) did not ask VS 1 to leave the facility and VS 1 left when she (VS 1) was done visiting with Resident 4. RN 1 was not sure when VS 1 left the facility and stated that she (RN1) did not see when she (VS1) left but knows VS1 left the facility.During a concurrent telephone interview on 6/1/2026 at 3:36 p.m. with Resident 1, Resident 1 stated the incident of verbal yelling and spitting was about 30 minutes. Resident 1 stated he (Resident 1) and Resident 4 were in the activity room (Facility Recreational Room) (Resident 1) when Resident 1 stand up and walked out of the activity room. Resident 1 stated VS 1 told Resident 4 to get up, and they (Resident 4 and VS 1) began to follow Resident 1 in the hallway. Resident 1 stated he (Resident 1) just laughed at VS 1 then in the hallway, near Resident 1's room, VS 1 kept yelling at Resident 1 when suddenly VS 1 turned around and spit on Resident 1's glasses and his entire face. Resident 1 stated he felt disabled because Resident 1 could not do anything since VS 1 was a woman. Resident 1 stated he (Resident 1) felt inferior to VS 1, he felt disrespected, he (Resident 1) felt awful because no one has ever spat at him. Resident 1 stated that after VS 1 spat at him (Resident 1), he cleaned his face with his hands, and it felt disgusting. Resident 1 stated that is when he went to speak to RN 1, informed RN 1 of the incident with VS 1, and asked for the police number. Resident 1 stated he is traumatized by this experience, and he feels like one day VS 1 would come and hurt him. Resident 1 stated the spitting was unhygienic and made him feel degraded and mistreated.During a telephone interview on 6/1/2026 at 4:15 p.m. with VS 1, VS 1 stated, on 5/22/2026, around 8 p.m., Resident 1 and Resident 4 were standing in the activity room (Facility Recreational Room). VS 1 stated Resident 1 started using vulgar language. VS 1 stated she (VS 1) did spit on Resident 1 and that she (VS 1) is not going to deny it. VS 1 stated she did threaten Resident 1 to call the immigration and called him (Resident 1) derogatory slur. VS 1 stated she (VS 1) knows she should have never done this, but she (VS 1) did spit at Resident 1. VS 1 stated she (VS 1) spit on Resident 1's face and told Resident 1 derogatory slur because she did not like the way Resident 1 was speaking to her. VS 1 stated the whole incident was about five minutes long. VS 1 stated they were in the hallway when she spit at Resident 1. VS 1 stated she was not asked to leave the facility after the incident and that VS 1 left the facility when she wanted.During an interview on 6/1/2026 at 4:33 p.m. with the Administrator (ADM), the ADM stated he is the abuse coordinator. The ADM stated that he (ADM) was aware of Resident 1 and VS 1 concerns and that VS 1 was not happy with a prior comment made by Resident 1. The ADM stated on 5/22/2026, he (ADM) was notified that there was a verbal disagreement between Resident 1 and VS 1 and that Resident 1 had called the police. The ADM stated the police informed him (ADM) that this may be considered a hate crime since VS 1 had verbalized calling Immigration and Customs Enforcement (ICE - is a federal law enforcement agency under the Department of Homeland Security) and made comments about Resident 1 that were derogatory slur. The ADM stated it was verbal abuse and both were cussing at each other. The ADM stated that VS 1 informed the ADM that she (VS 1) had threatened to call ICE on Resident 1. The ADM stated RN 1 spoke to Resident 1 and Resident 1 stated he felt threatened because VS 1 told Resident 1 she would get her brother to beat up Resident 1 and would also call ICE. The ADM stated VS 1 did tell him that she (VS 1) did in fact spit on Resident 1. The ADM stated for Resident 1 and VS 1 was verbal abuse, spitting is physical but ADM not sure (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because he (ADM) received different interviews. The ADM stated that when there are visitors and there is an allegation of abuse, the aggressor needs to be separated, should have gotten interview and monitored the visitor. The ADM stated the facility does not have the footage to show VS 1 was being monitored. The ADM stated not removing visitors after alleged abuse, can be a concern for escalating abuse and can put residents at risk for continued abuse.During a review of the facility provided P&P titled, Visitation Rights, revised on 4/29/2026, the P&P indicated the facility permits residents to receive visitors subject to the resident's wishes and the protection of the rights of other residents in the facility. The P&P's section IV. Temporary Limitation of Visitation Rights indicated:A.When the Facility has good cause to believe that a visitor has or is engaging in behavior that violates the Facility policy or places the health, safety or security of other residents at risk, the facility may temporarily restrict that individual from visiting the resident or take other measures consistent with state and federal law until the behavior in question ceases.C. A visitor who is subjected to abusing, exploiting or coercing a resident will deny access to providing limited and supervised access to the resident until an investigation has cleared the visitor of all allegations. If a visitor has been found to be abusing, exploiting or coercing a resident, they will be prohibited from visiting the resident.During a review of the facility P&P titled, Abuse, Prevention, Screening & Training Program, revised on 4/29/2026, the P&P indicated the facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment and develops facility P&P, training programs, and screening and prevention systems to promote and environment free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment.The P&P's Procedure indicated, Abuse is defined as the willful, deliberate infliction of injury, unreasonable confinement, involuntary seclusion, physical or chemical restraint. Verbal abuse is defined as any use of oral, written, gestured communication, or sound that willfully includes disparaging and derogatory terms directed to residents within hearing distance, regardless of age, ability to comprehend, or disability. Physical abuse is defined as, but not limited to, hitting, slapping, punching, and/or kicking. The P&P's Prevention indicated:N. The facility ensures the health, safety and welfare of residents with regard to visitors.

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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 a physical abuse incident (deliberately aggressive or violent behavior with the intention to cause harm) to the State Survey Agency (SSA) no later than two hours for one of four sampled residents (Resident 1), as indicated in the facility's policy and procedure (P&P) titled, Reporting Abuse, when:On 5/22/2026, around 8:30 p.m., Resident 1, who was in the Facility Recreational Room, was approached by Visitor (VS) 1 who used verbal profanities towards Resident 1. VS 1 and Resident 1 continued to both use verbal profanity and derogatory slur towards each other as they walked down the hallway toward Resident 1's room, VS 1 was in front of Resident 1 and turned around and spat (the intentional, aggressive act of ejecting saliva, phlegm, or other mouth contents directly at another person) at Resident 1's face.This deficient practice had the potential to result in unidentified abuse and placed Resident 1 at risk for further abuse.Findings:a. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 9/26/2025 with diagnoses including abnormalities of gait and mobility, metabolic encephalopathy (a change in brain function caused by a chemical imbalance in the body, not a direct physical injury to the brain), and cognitive communication deficits (a difficulty with talking, listening, reading, or writing, caused by a problem with brain function rather than a physical speech issue).During a review of Resident 1's History and Physical Examination (H&P - a comprehensive medical evaluation conducted upon admission), dated 9/30/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 1 had the ability to understand and to be understood. The MDS indicated Resident 1 had intact cognitive function. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting, showering, upper and lower body dressing, putting on and taking off footwear, and with personal hygiene.During a review of Resident 1's Change in Condition (COC) Evaluation, dated 5/22/2026 at 8:30 p.m., the COC Evaluation indicated verbal altercation towards other patient's power of attorney (POA - a legal document that grants a trusted person or the agent the legal authority to make critical decisions on behalf of person) with no injuries. The COC Evaluation's Summarize your observation, evaluation and recommendation section indicated Resident 1 reported verbal encounter with female resident's POA (VS 1), allegedly spit on his face, incident occurred in facility.During a review of Resident 1's Care Plan Report (CP), initiated on 5/22/2026, the CP's Focus indicated Resident 1 was at risk for emotional distress related to verbal altercation with another resident's family member; resident alleged that family spit on his face. The CP included interventions to assess Resident 1 for signs and symptoms of distress every shift and to encourage to express feelings and concerns.During a telephone interview on 6/1/2026 at 10:17 a.m. with Resident 1, Resident 1 stated about five months ago he (Resident 1) started having issues with VS 1. Resident 1 stated he (Resident 1) and Resident 4 are in a relationship but nothing physical. Resident 1 stated VS1 threatened him by saying that she (VS 1) will call to deport him (Resident 1) and by having her (VS 1) son beat up Resident 1. Resident 1 stated he was in constant fear. Resident 1 stated the facility's supervisors (unidentified staff) were aware of VS 1's threats and would just tell Resident 1 to go to his room. Resident 1 stated, on 5/22/2026, around 8 p.m., he (Resident 1) and Resident 4 were in the facility's activity room (Facility Recreational Room), sitting in the table across from each other, when VS 1 came in and began to yell at Resident 1 and Resident 4. Resident 1 stated VS 1 told that she did not want Resident 1 to speak to Resident 4. Resident 1 stated then he (Resident 1) left and walked towards his (Resident 1's) room and began to laugh because he (Resident 1) thought it was funny which made VS 1 madder. Resident 1 stated VS1 was also walking in the hallway when she (VS1) (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	turned around and spat at Resident 1's face, covering his (Resident 1's) face and glasses with her (VS 1's) spit. Resident 1 stated VS 1 attempted to hit Resident 1 but Certified Nursing Assistant (CNA) 1 intervened and stopped VS 1 from hitting Resident 1. Resident 1 stated he (Resident 1) was then sent to his room, but he (Resident 1) went to the nurses' front desk and wanted to contact the local police department. Resident 1 stated he (Resident 1) called the police.b. During a review of Resident 4's AR, the AR indicated the facility admitted Resident 4 on 12/30/2025 with diagnoses including diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness (generalized), and essential (primary) hypertension (HTN - high blood pressure).During a review of Resident 1's History and Physical (H&P - a comprehensive medical evaluation conducted upon admission), dated 12/31/2025, the H&P indicated Resident 4 was alert and oriented.During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 had the ability to understand and be understood. The MDS indicated Resident 4 had intact cognition. The MDS indicated Resident 4 required supervision or touching assistance with toileting/tub/shower transfers, sit to stand, and chair to bed transfers.During an interview on 6/1/2026 at 12 p.m. with Resident 4, Resident 4 stated Resident 1 and she (Resident 4) are friends, they get along well, and that they spend time together in the patio and in activities. Resident 4 stated on 5/22/2026, around 8 p.m., she (Resident 4) and Resident 1 were in the activity room (Facility Recreational Room) when VS 1 came in and yelled at Resident 4 and Resident 1. Resident 4 stated VS 1 did not like Resident 4 and Resident 1 talking to each other. Resident 4 stated Resident 1 then left the activity room (Facility Recreational Room), and Resident 4 and VS 1 also left but VS 1 and Resident 1 were still arguing while Resident 1 was walking down the hallway back to his (Resident 1) room. Resident 4 stated she (Resident 4) was telling VS 1 to stop and that was when VS 1 spat at Resident 4. Resident 4 stated she saw Resident 1 with spit on his glasses and face. Resident 4 stated she saw VS 1 attempt to push Resident 1 when CNA 1 intervened and stopped VS 1 from pushing Resident 1. Resident 4 stated VS1 was not asked to leave the facility and that she left on her (VS1) own terms, when she (VS1) was ready. Resident 4 stated the next day the Administrator (ADM) called VS1 and informed that VS 1 was not allowed to come to the facility anymore.During an interview on 6/1/2026 at 3:18 p.m. with the Director of Staff Development (DSD), the DSD stated, on 5/22/2026, around 9 p.m. to 10 p.m., the Administrator (ADM) asked him (DSD) to help the police officers who arrived at the facility around 10 p.m. The DSD stated he (DSD) was the one who reported the alleged abuse to SSA. The DSD reviewed the fax confirmation and stated it was faxed to SSA on 5/23/2026 at 1:26 a.m. The DSD stated if there is no physical abuse, the facility must report within 24 hours and if there is physical abuse, the facility must report within two (2) hours. The DSD stated he (DSD) was not aware of the allegation of spitting when he submitted the report to SSA. The DSD stated he received all the information from the police and did not speak to Resident 1 and/or other staff involved in the investigation. The DSD stated spitting is considered physical and added that the incident with Resident 1 and VS 1 occurred at 8:30p.m. and it involved spitting. The DSD stated he was made aware of incident around 10 p.m., then the police were in the facility for about two hours. The DSD stated he would have educated the staff that if it was spitting and it was considered physical, it must be reported within two hours. During a concurrent telephone interview on 6/1/2026 at 3:36 p.m. with Resident 1, Resident 1 stated the incident of verbal yelling and spitting was about 30 minutes. Resident 1 stated he (Resident 1) and Resident 4 were in the activity room (Facility Recreational Room) he (Resident 1) when Resident 1 stand up and walked out of the activity room. Resident 1 stated VS 1 told Resident 4 to get up, and they (Resident 4 and VS 1) began to follow Resident 1 in the hallway. Resident 1 stated he (Resident 1) just laughed at VS 1 then in the hallway, near Resident 1's room, VS 1 kept yelling at Resident 1 when suddenly VS 1 turned around and spit on Resident 1's glasses and his entire face. Resident 1 stated he felt disabled because Resident 1 could not do anything since VS 1 was a woman. Resident 1 stated he (Resident 1) felt inferior to VS 1, he felt disrespected, he (Resident 1) felt awful because no one has ever spat at him. Resident 1 stated after VS 1 spat at him (Resident 1), he cleaned his face with his hands, and it (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	felt disgusting. Resident 1 stated that's when he went to speak to RN 1, informed RN 1 of the incident with VS 1, and asked for the police number. Resident 1 stated he is traumatized by this experience, and he feels like one day VS 1 would come and hurt him. Resident 1 stated the spitting was unhygienic and made him feel degraded and mistreated.During an interview on 6/1/2026 at 4:15 p.m. with VS 1, VS 1 stated, on 5/22/2026, around 8 p.m., Resident 1 and Resident 4 were standing in the activity room (Facility Recreational Room). VS 1 stated Resident 1 started using vulgar language. VS 1 stated she (VS 1) did spit on Resident 1 and that she (VS 1) is not going to deny it. VS 1 stated she did threaten Resident 1 to call the immigration and called him (Resident 1) derogatory slur. VS 1 stated she (VS 1) knows she should have never done this, but she (VS 1) did spit at Resident 1. VS 1 stated she (VS 1) spit on Resident 1's face and told Resident 1 derogatory slur because she did not like the way Resident 1 was speaking to her. VS 1 stated the whole incident was about five minutes long. VS 1 stated they were in the hallway when she spit at Resident 1. VS 1 stated she was not asked to leave the facility after the incident and that VS 1 left the facility when she wanted. During an interview on 6/1/2026 at 4:33 p.m. with the Administrator (ADM), the ADM stated he is the abuse coordinator. The ADM stated ADM was aware Resident 1 and VS 1 concerns and that VS 1 she was not happy with a prior comment made by Resident 1. The ADM stated on 5/22/2026 he (ADM) was notified that there was a verbal disagreement between Resident 1 and VS 1 and that Resident 1 had called the police. The ADM stated the police informed him (ADM) that this may be considered a hate crime since VS 1 had verbalized calling Immigration and Customs Enforcement (ICE - is a federal law enforcement agency under the Department of Homeland Security) and made comments about Resident 1 that were derogatory slur. The ADM stated it was verbal abuse and both were cussing at each other. The ADM stated that VS 1 informed the ADM that she (VS 1) had threatened to call ICE on Resident 1. The ADM stated RN 1 spoke to Resident 1 and Resident 1 stated he felt threatened because VS 1 told Resident 1 she would get her brother to beat up Resident 1 and would also call ICE. The ADM stated VS 1 did tell him that she (VS 1) did in fact spit on Resident 1. The ADM stated for Resident 1 and VS 1 was verbal abuse, spitting is physical but ADM not sure because he (ADM) received different interviews. The ADM stated because it was only thought of as verbal abuse, he (ADM) thought he had 24 hours to report. The ADM stated physical abuse must be reported within two (2) hours. The ADM confirmed the abuse report was faxed to SSA on 5/23/2026 at 1:26 a.m. During a review of the facility's Transmission Verification Form, dated 5/23/2026, the Transmission Verification Form indicated the facility faxed the abuse report to SSA on 5/23/2026 at 1:26 a.m. During a review of the facility's P&P titled, Reporting Abuse, revised on 4/29/2026, the P&P indicated the purpose of the policy is to ensure compliance with federal and state laws and regulations regarding reporting of incidents and suspected incidents of abuse, neglect and mistreatment of residents. The P&P indicated the facility will report known or suspected instances of physical abuse to the proper authorities. The P&P indicated, in addition, a written report shall be made to SSA within two (2) hours of the observation, knowledge, or suspicion of the physical abuse. During a review of the facility P&P titled, Abuse, Prevention, Screening & Training Program, last revised on 4/29/2026, the P&P indicated the facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment and develops facility P&P, training programs, and screening and prevention systems to promote and environment free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment.The P&P's Procedure indicated, Abuse is defined as the willful, deliberate infliction of injury, unreasonable confinement, involuntary seclusion, physical or chemical restraint. Verbal abuse is defined as any use of oral, written, gestured communication, or sound that willfully includes disparaging and derogatory terms directed to residents within hearing distance, regardless of age, ability to comprehend, or disability. Physical abuse is defined as, but not limited to, hitting, slapping, punching, and/or kicking. The P&P's Prevention indicated:N. The facility ensures the health, safety and welfare of residents with regard to visitors.