STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056425	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studebaker Healthcare Center	13226 Studebaker Rd Norwalk, CA 90650

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 one of three sampled residents (Resident 1) right to be free from verbal abuse when Certified Nurse Assistant (CNA) 1 cursed (used foul language) in front of Resident 1 while providing care.This deficient practice placed Resident 1 at risk for psychological harm, loss of dignity and feeling uncomfortable and had the potential to result in further abuse for Resident 1 and all residents in the facility. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke- loss of blood flow to a part of the brain) and post-traumatic stress disorder (PTSD- a disorder in which a person has difficulty recovering from experiencing or witnessing a traumatic event). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 1/26/2026, the MDS indicated Resident 1's cognition (ability to think, understand, learn, and remember) was intact and required maximal assistance (helper does more than half the effort) with toileting, bathing, and dressing. During a review of Resident 1's Change in Condition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status which without immediate intervention, may result in complications or death) dated 1/26/2026 at 9:08 p.m., the COC indicated Resident 1 was concerned about the use of foul language by CNA 1 in her presence. During a review of the facility's Investigation Summary and Conclusion Report dated 1/30/2026, the Investigation Summary and Conclusion Report indicated that CNA 1 used an inappropriate word inadvertently (doing something by accident) towards Resident 1 while inside the resident's room. During an interview on 2/5/2026 at 12:17p.m., with CNA 1, CNA 1 stated when she was in Resident 1's room, she spilled a cup of water and cursed in front of Resident 1. CNA 1 stated her using foul language in front of Resident 1 could make Resident 1 feel upset and uncomfortable. During an interview on 2/5/2026 at 3:17 p.m., with the Director of Nursing (DON), the DON stated CNA 1 used foul language in front of Resident 1 and Resident 1 stated she did not appreciate CNA 1 blurting that out in front of her. During a review of the facility's P&P titled Abuse Prevention and Prohibition Report dated 7/9/2024, the P&P indicated, Each resident has the right to be free from abuse. The P&P indicated the facility is committed to protecting residents from abuse by anyone including facility staff. During a review of the facility's P&P titled, Definitions: Abuse & Neglect dated 10/2023, the P&P indicated, Verbal abuse means 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.

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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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F609Based on interview and record review, the facility failed to report an abuse allegation to the California Department of Public Health (CDPH), for one of three sampled residents (Resident 2), when Resident 2 reported to the Director of Staff Development (DSD) that Certified Nurse Assistant (CNA) 2 made a sexually inappropriate gesture while providing him with personal care.This deficient practice placed Resident 2 at risk of embarrassment and anger and had the potential to place Resident 2 and all other residents at risk in the facility for sexual abuse.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2 had diagnoses including amyotrophic lateral sclerosis (ALS- a fatal neurological disordered characterized by progressive degeneration of nerve cells in the spinal cord and brain) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 11/7/2025, the MDS indicated Resident 2's cognition (ability to think, understand, learn, and remember) was intact and was dependent on activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily).During an interview on 2/5/2026 at 10:43 a.m., Resident 2 stated CNA 2, made an inappropriate sexual gesture in front of him. Resident 2 stated CNA 2 made a thrusting gesture with his pelvic area (part of the body between the legs) on the grey stool in his room, which he stated was offensive to him. Resident 2 stated he felt CNA 2 was making fun of his sexual orientation and this made him feel angry. Resident 2 stated he told the DSD what CNA 2 had done and because the DSD was a mandated reporter, the DSD should have reported it when he told her.During an interview on 2/5/2026 at 11:00 a.m., with the DSD, the DSD stated Resident 2 did tell her about CNA 2's inappropriate gesture but she did not report it. The DSD stated Resident 2 told her he felt as if CNA 2 was mocking his lifestyle because he is gay (attracted to one's same gender). The DSD stated she is a mandated reporter, and this allegation should have been reported for the resident's safety and to ensure a proper investigation was completed.During an interview on 2/5/2026 at 3:17 p.m., with the Director of Nursing (DON), the DON stated the DSD should have reported Resident 2's allegations immediately after Resident 2 told her. The DON stated Resident 2's allegation is a form of abuse and the alleged gesture made by CNA 2 could potentially have made him feel offended and embarrassed. The DON stated the allegation made by Resident 2 should have been reported so a proper investigation could have been done and so they could monitor Resident 2 for emotional distress.During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program, dated 7/9/2024, the P&P indicated, The facility will report allegations of abuse immediately, but no later than 2 hours after forming a suspicion- if the alleged violation involves abuse to the state survey agency, law enforcement, and the Ombudsman.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its abuse policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program by failing to investigate an allegation of sexual abuse for one of three sampled residents (Resident 2).This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect all residents in the facility from abuse.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including amyotrophic lateral sclerosis (ALS- a fatal neurological disordered characterized by progressive degeneration of nerve cells in the spinal cord and brain) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 11/7/2025, the MDS indicated Resident 2's cognition (ability to think, understand, learn, and remember) was intact and was dependent on activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily).During an interview on 2/5/2026 at 10:43 a.m., with Resident 2, Resident 2 stated Certified Nurse Assistant (CNA) 2, made an inappropriate sexual gesture in front of him. Resident 2 stated CNA 2 made a thrusting gesture with his pelvic area (part of the body between the legs) on the grey stool in his room which he stated was offensive to him. Resident 2 stated he felt as if CNA 2 was making fun of his sexual orientation and this made him feel angry. Resident 2 stated he told the Director of Staff Development (DSD) what CNA 2 had done and because he himself is a mandated reporter, the DSD should have reported it when he had told her.During an interview on 2/5/2026 at 11:00 a.m., with the DSD, the DSD stated Resident 2 did tell her about CNA 2's inappropriate gesture but she did not report it. The DSD stated Resident 2 told her he felt as if CNA 2 was mocking his lifestyle because he is gay (attracted to one's same gender). The DSD stated she is a mandated reporter, and this allegation should have been reported for the resident's safety and to ensure a proper investigation was completed.During an interview on 2/5/2026 at 12:11 p.m., with CNA 3, CNA 3 stated any inappropriate sexual gesture such as a thrusting gesture with their crotch, is considered a form of abuse and should be reported for the safety of the residents. CNA 3 stated an inappropriate sexual gesture could cause the residents to feel uncomfortable.During an interview on 2/5/2026 at 3:17 p.m., with the Director of Nursing (DON), the DON stated the DSD should have reported Resident 2's allegations immediately after Resident 2 told her. The DON stated Resident 2's allegation is a form of abuse and the alleged gesture made by CNA 2 could potentially have made him feel offended and embarrassed. The DON stated the allegation made by Resident 2 should have been reported so a proper investigation could have been done and so they could monitor Resident 2 for emotional distress.During a review of the facility's P&P titled, Definitions: Abuse & Neglect dated 10/2023, the P&P indicated, Verbal abuse means 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. During a review of the facility P&P titled Abuse Prevention and Prohibition Program dated 7/9/2024, the P&P indicated the facility promptly and thoroughly investigates reports of resident abuse. The P&P indicated if facility staff members are accused of committing abuse against a resident, they are suspended until the investigation is complete and the findings have been reviewed by the Administrator.