

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05A396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Garfield Neurobehavioral Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1451 28th Avenue Oakland, CA 94601	

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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46658</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from abuse when Certified Nursing Assistant 1 (CNA 1) sexually abused Resident 1 twice in one day.</p> <p>This failure resulted in Resident 1 being sexually abused and had the potential for psychosocial harm.</p> <p>Findings:</p> <p>A review of Resident 1's admission record, dated 1/22/25, indicated Resident 1 was admitted to the facility on [DATE] for Huntington's disease (a disease in the brain which results in cognitive and functional decline) and paranoid schizophrenia (psychiatric disease which causes distrust of information and other people). The admission record indicated Resident 1 was conserved (court ordered arrangement which gives a conservator the power to make decisions for a person who is unable to do so for themselves) by family.</p> <p>A record review of Resident 1's minimum data set assessment (MDS, an assessment tool to guide resident care), dated 6/27/24, indicated Resident 1 was non-verbal, cognitively impaired, unable to make safe decisions, non-ambulatory (unable to move from one location to another independently) and was dependent on staff for all aspects of care including hygiene, toileting and feeding.</p> <p>During a record review of the facility map, the map indicated, on 8/18/25, Resident 1's room was located in a hallway two rooms away from the nurse's station. The nurse's station was located in a room at the end of the hallway.</p> <p>A record review of CNA 1's employment record indicated CNA 1 was employed at the facility from 8/8/22 to 10/23/24.</p> <p>During a record review of CNA 1's actual hours worked record titled, [CNA 1] 1/22/2024-1/22/25, the record indicated CNA 1 had worked at the facility on 8/18/24, from 3:15 p.m. to 10:57 p.m</p> <p>During a record review of facility staffing record titled, PM Shift (evening shift), dated 8/18/24, the staffing record indicated on 8/18/24, CNA 1 was assigned to Resident 1.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/30/24, at 10:45 a.m., with the Administrator (Admin) and the Director of Nursing (DON), the Admin stated, on 10/23/24, the facility received information from the police, that they had arrested CNA 1 and during a search of CNA 1's online storage account, found evidence that CNA 1 had sexually abused a resident. The police shared still images from the video which the DON was able to identify Resident 1 as the resident by identification of Resident 1's genitals and by wall postings and toys featured in Resident 1's room.</p> <p>During an interview on 11/1/24, at 10:00 a.m., with Resident 1's conservator, the conservator stated the police informed them of the sexual abuse. The conservator stated Resident 1 was not able to give consent to anything. The conservator stated Resident 1 would have rejected the advance by CNA 1 and would've knocked the guy's block off if he was able.</p> <p>During a record review of the police report of Resident 1's sexual abuse case titled, [City] Police Department Incident Report, dated 10/23/24, the report indicated police had searched CNA 1's online storage account and found on 8/18/24, CNA 1 had taken two videos of an adult patient .both videos began with an adult diaper covering the patients's genitals .[CNA 1] folded the adult diaper down and exposed the patient's flaccid penis. [CNA 1] then manipulated the patient's [genitals] and masturbated the patient's [genitals] .[CNA 1] was wearing clear disposable gloves in the first video and was bare handed in the second video. The report indicated the facility was able to determine Resident 1 was the patient depicted in the videos and confirmed CNA 1's employment with the facility. The report indicated CNA 1 was charged with Lewd Acts on a Dependent Adult by a Caretaker.</p> <p>During a review of facility policy and procedure (P&P) titled Resident's Rights, undated, the P&P indicated resident rights include the resident's right to the following: .be free from abuse.</p>