STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555117	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Healthcare Center - LA	3032 Rowena Ave 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the 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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to inform the attending physician (MD) of one of three sampled residents (Resident 2) behavioral Change of Condition (COC) on 8/24/2025. This deficient practice had the potential to result in a delay in care. Findings:During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 2/12/2025 with diagnoses including Parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), muscle wasting and atrophy (decrease in size or wasting away of a body part or tissue), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and depression (a mental illness that involves a persistent low mood, a loss of interest in activities, and affects daily functions like sleep, appetite, and concentration, leading to significant problems in a person's life, work, or relationships). During a review of Resident 2's History and Physical (H&P- a comprehensive evaluation by a healthcare provider that includes two main parts: a History where the doctor asks you about your symptoms, past illnesses, family health, and lifestyle, and a Physical where the doctor examines your body by checking your vital signs and inspecting different body systems) Examination dated 2/19/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Care plan (CP) created on 3/26/2025, the CP indicated Resident 2 behavior and scratched and pushed CNA using inappropriate racial comments. The CP interventions included to monitor resident behavior and notify MD if significant changes present. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 5/19/2025, the MDS indicated Resident 2 had the ability to understand and be understood. The MDS indicated Resident 2 requires partial assistance (helper does less than half the effort) with toileting, showering, lower body dressing, and putting on and taking off footwear, and required supervision assistance (helper provides verbal cues and or touching assistance as resident completes activity) with eating, and oral hygiene. During a review of Resident 2's CP created on 8/7/2025, the CP indicated Resident 2 noted with behavioral manifested by verbally aggressive towards staff, screaming and cursing, recent episode on 8/17/2025 refusing CNA care. The CP interventions indicated to approach the residents with respect, being supportive of their issues and problems and use non-threatening body language when approaching the resident. During a review of Resident 2's Progress Notes dated 8/24/2025 at 1:36 p.m., the Progress Notes indicated Resident 2 verbalized in the morning not wanting Certified Nursing Assistant (CNA) 2. Registered Nurse (RN) 2 offered to do her morning personal care such as changing her brief. After meals Resident 2 was offered to be changed by CNA 2 but Resident 2 refused. RN 2 and CNA 2 assisted Resident 2 back in bed and changed Resident 2. Per CNA 2 and RN 2 Resident 2 became aggressive during the transfer and clawed her (Resident 2) nails into RN 2 hand, RN 2 had a skin tear on her (RN 2) forearm. During a concurrent interview and record review on 9/2/2025 at 12:18 p.m. of Resident 2's text messages with the Adm, Resident 2 stated on 8/24/2025 around 2 p.m. was afraid of RN 2 who was from registry (an independent staff who works on a temporary, as needed basis, hired by healthcare facilities or patients through a nursing agency or registry) that came in with CNA 2. Resident 2 stated did not want CNA 2 and asked for another CNA. Resident 2 stated at around 2 p.m. RN 2 and CNA 2 came into Resident 2 room and shut the door, Resident 2 stated RN 2 told Resident 2 RN 2 and CNA 2 would be changing Resident 2. Resident 2 stated she told RN 2 and CNA 2 she (Resident 2) wanted to wait for the next shift, but RN 2 told her no and then proceeded to transfer Resident 2 who was at that time sitting up in her wheelchair next to her bed back into Resident 2's bed. Resident 2 stated RN 2 grabbed Resident 2's left arm and CNA 2 grabbed Resident 2 right arm and put her (Resident 2) back into bed. Resident 2 stated she (Resident 2) was upset because RN 2 and CNA 2 did not listen to her (Resident 2) request of wanting to wait to be changed by the next shift and then Resident 2 grabbed CNA 2 by her long hair. Resident 2 stated she (Resident 2) asked for RN 2 and CNA 2 to leave her (Resident 2) alone and they (RN 2 and CNA 2) refused, Resident 2 stated she (RN 2) scratched RN 2 and CNA 2 stated RN 2 was bleeding. Resident 2 stated she did ask RN 2 and CNA 2 multiple times to stop and she (Resident 2) would wait for the next shift, but all RN 2 said was grab an arm to CNA 2. Resident 2 stated this incident was traumatizing to her (Resident 2) because she asked RN 2 and CNA 2 to stop and they did not it was physical abuse. During an interview on 9/2/2025 at 1:06 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated on 8/24/2025 was working with Resident 2 from 3 p.m. to 11 p.m. LVN 2 stated Resident 2 asked LVN 2 to wipe her (Resident 2) hand because Resident 2 had a lot of blood on her (Resident 2) hand this was her (Resident 2)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to implement its policy and procedure (P&P) titled, Abuse, Reporting and Investigations, for one of three sampled residents (Resident 2) when on 8/24/2025 Resident 2 reported to the Administrator (Adm) that staff started fighting with me (Resident 2) physically (deliberately aggressive or violent behavior with the intention to cause harm by one resident towards another) was investigated for events that may constitute abuse. This deficient practice resulted in a delayed investigation of an alleged abuse and had the potential to place Resident 2 at risk for further abuse and psychosocial harm. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 2/12/2025 with diagnoses including Parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), muscle wasting and atrophy (decrease in size or wasting away of a body part or tissue), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and depression (a mental illness that involves a persistent low mood, a loss of interest in activities, and affects daily functions like sleep, appetite, and concentration, leading to significant problems in a person's life, work, or relationships). During a review of Resident 2's History and Physical (H&P- a comprehensive evaluation by a healthcare provider that includes two main parts: a History where the doctor asks you about your symptoms, past illnesses, family health, and lifestyle, and a Physical where the doctor examines your body by checking your vital signs and inspecting different body systems) Examination dated 2/19/2025, 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 5/19/2025, the MDS indicated Resident 2 had the ability to understand and be understood. The MDS indicated Resident 2 requires partial assistance (helper does less than half the effort) with toileting, showering, lower body dressing, and putting on and taking off footwear, and required supervision assistance (helper provides verbal cues and or touching assistance as resident completes activity) with eating, and oral hygiene. During a review of Resident 2's Progress Notes dated 8/24/2025 at 1:36 p.m., the Progress Notes indicated Resident 2 verbalized in the morning not wanting Certified Nursing Assistant (CNA) 2. Registered Nurse (RN) 2 offered to do her morning personal care such as changing her brief. After meals Resident 2 was offered to be changed by CNA 2 but Resident 2 refused. RN 2 and CNA 2 assisted Resident 2 back into bed and changed Resident 2. Per CNA 2 and RN 2, Resident 2 became aggressive during the transfer and clawed her (Resident 2) nails into RN 2's hand. RN 2 had a skin tear on her (RN 2) forearm. During a concurrent interview and record review on 9/2/2025 at 12:18 p.m. of Resident 2's text messages with the Adm, Resident 2 stated on 8/24/2025 around 2 p.m. she was afraid of RN 2 who was from the registry (an independent staff who works on a temporary, as needed basis, hired by healthcare facilities or patients through a nursing agency or registry) that came in with CNA 2. Resident 2 stated she did not want CNA 2 and asked for another CNA. Resident 2 stated at around 2 p.m. RN 2 and CNA 2 came into Resident 2 room and shut the door, Resident 2 stated RN 2 told Resident 2 RN 2 and CNA 2 would be changing Resident 2. Resident 2 stated she told RN 2 and CNA 2 she (Resident 2) wanted to wait for the next shift but RN 2 told her no and then proceeded to transfer Resident 2 who was at that time sitting up in her wheelchair next to her bed back into Resident 2's bed. Resident 2 stated RN 2 grabbed Resident 2's left arm and CNA 2 grabbed Resident 2's right arm and put her (Resident 2) back into bed. Resident 2 stated she (Resident 2) was upset because RN 2 and CNA 2 did not listen to her (Resident 2) request of wanting to wait to be changed by the next shift and then Resident 2 grabbed CNA 2 by her long hair. Resident 2 stated she (Resident 2) asked for RN 2 and CNA 2 to leave her (Resident 2) alone and they (RN 2 and CNA 2) refused. Resident 2 stated she did ask RN 2 and CNA 2 multiple times to stop and she (Resident 2) would wait for the next shift, but all RN 2 said was grab an arm to CNA 2. Resident 2 stated this incident was traumatizing to her because she asked RN 2 and CNA 2 to stop and they did not it, was physical abuse. Resident 2 stated she contacted the Adm via text to inform the Adm of the incident. Resident 2 reviewed text messages to the Adm and stated text was sent on 8/24/2025 at 2:02 p.m. and based on text the incident occurred around 1:30 p.m., Resident 2 stated she (Resident 2) told Adm she had told RN 2 and CNA 2 that she would wait for the next shift to change me (Resident 2) but they (RN 2 and CNA 2) started fighting with me physically. Resident 2 stated what I meant by RN 2 and CNA 2 physically fighting is that they were grabbing me against my will. It was abuse. Resident 2 stated the only response I (Resident 2) received from the Adm was if I had reported it to the charge nurse. Resident 2 stated she told the Adm she (Resident 2) did

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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. (continued on next page)

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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	Based on interview and record review, the facility failed to implement its policy and procedure (P&P) titled, Abuse, Reporting and Investigations, by failing to report an allegation of physical abuse (deliberately aggressive or violent behavior with the intention to cause harm by one resident towards another) to the State Survey Agency (SSA) no later than two hours for one of three sampled residents (Resident 2) when on 8/24/2025 Resident 2 reported to the Administrator (Adm) that staff started fighting with me (Resident 2) physically. This deficient practice had potential to result in unidentified abuse and placed Resident 2 at risk for further abuse. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 2/12/2025 with diagnoses including Parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), muscle wasting and atrophy (decrease in size or wasting away of a body part or tissue), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and depression (a mental illness that involves a persistent low mood, a loss of interest in activities, and affects daily functions like sleep, appetite, and concentration, leading to significant problems in a person's life, work, or relationships). During a review of Resident 2's History and Physical Examination dated 2/19/2025, 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 5/19/2025, the MDS indicated Resident 2 had the ability to understand and be understood. The MDS indicated Resident 2 requires partial assistance (helper does less than half the effort) with toileting, showering, lower body dressing, and putting on and taking off footwear, and required supervision assistance (helper provides verbal cues and touching assistance as resident completes activity) with eating, and oral hygiene. During a review of Resident 2's Progress Notes dated 8/24/2025 at 1:36 p.m., the Progress Notes indicated Resident 2 verbalized in the morning not wanting Certified Nursing Assistant (CNA) 2. Registered Nurse (RN) 2 offered to do her morning personal care such as changing her brief. After meals Resident 2 was offered to be changed by CNA 2 but Resident 2 refused. RN 2 and CNA 2 assisted Resident 2 back into bed and changed Resident 2. Per CNA 2 and RN 2 Resident 2 became aggressive during the transfer and clawed her (Resident 2) nails into RN 2's hand, RN 2 had a skin tear on her (RN 2) forearm. During a concurrent interview and record review on 9/2/2025 at 12:18 p.m. of Resident 2's text messages with the Adm, Resident 2 stated on 8/24/2025 around 2 p.m. Resident 2 was afraid of RN 2 who was from registry (an independent staff who works on a temporary, as needed basis, hired by healthcare facilities or patients through a nursing agency or registry) that came in with CNA 2. Resident 2 stated did not want CNA 2 and asked for another CNA. Resident 2 stated at around 2 p.m. RN 2 and CNA 2 came into Resident 2 room and shut the door, Resident 2 stated RN 2 told Resident 2 RN 2 and CNA 2 would be changing Resident 2. Resident 2 stated she told RN 2 and CNA 2 she (Resident 2) wanted to wait for the next shift, but RN 2 told her no and then proceeded to transfer Resident 2 who was at that time sitting up in her wheelchair next to her bed back into Resident 2's bed. Resident 2 stated RN 2 grabbed Resident 2's left arm and CNA 2 grabbed Resident 2 right arm and put her (Resident 2) back into bed. Resident 2 stated she (Resident 2) was upset because RN 2 and CNA 2 did not listen to her (Resident 2) request of wanting to wait to be changed by the next shift and then Resident 2 grabbed CNA 2 by her long hair. Resident 2 stated she (Resident 2) asked for RN 2 and CNA 2 to leave her (Resident 2) alone and they (RN 2 and CNA 2) refused. Resident 2 stated she did ask RN 2 and CNA 2 multiple times to stop, and she (Resident 2) would wait for the next shift, but all RN 2 said was grab an arm to CNA 2. Resident 2 stated this incident was traumatizing to her (Resident 2) because she asked RN 2 and CNA 2 to stop and they did not it was physical abuse. Resident 2 stated she (Resident 2) contacted the Adm via text to inform Adm of the incident. Resident 2 reviewed text messages to Adm and stated text was sent on 8/24/2025 at 2:02 p.m. and based on text the incident occurred around 1:30 p.m., Resident 2 stated she (Resident 2) told Adm she had told RN 2 and CNA 2 that she would wait for the next shift to change me (Resident 2) but they (RN 2 and CNA 2) started fighting with me physically. Resident 2 stated what I (Resident 2) meant by RN 2 and CNA 2 physically fighting is that they were grabbing me against my will it was abuse. Resident 2 stated the only response I (Resident 2) received from the Adm was if I had reported it to the charge nurse. Resident 2 stated told Adm she (Resident 2) reported the incident to the oncoming nurse Licensed Vocational Nurse (LVN) 2, and nothing else was said by the Adm. Resident 2 stated on 8/25/2025 at 7:38 a.m. she (Resident 2) asked the Adm via text that she wanted to file a police report. Resident 2 stated once again no response from the

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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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a thorough investigation was completed following an allegation of physical abuse (deliberately aggressive or violent behavior with the intention to cause harm by one resident towards another) for one of three sampled residents (Resident 2) when on 8/24/2025 Resident 2 reported to the Administrator (Adm) that staff started fighting with me (Resident 2) physically. This deficient practice had the potential to place Resident 2 at risk for further abuse. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 2/12/2025 with diagnoses including Parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), muscle wasting and atrophy (decrease in size or wasting away of a body part or tissue), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and depression (a mental illness that involves a persistent low mood, a loss of interest in activities, and affects daily functions like sleep, appetite, and concentration, leading to significant problems in a person's life, work, or relationships). During a review of Resident 2's History and Physical (H&P- a comprehensive evaluation by a healthcare provider that includes two main parts: a History where the doctor asks you about your symptoms, past illnesses, family health, and lifestyle, and a Physical where the doctor examines your body by checking your vital signs and inspecting different body systems) Examination dated 2/19/2025, 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 5/19/2025, the MDS indicated Resident 2 had the ability to understand and be understood. The MDS indicated Resident 2 requires partial assistance (helper does less than half the effort) with toileting, showering, lower body dressing, and putting on and taking off footwear, and required supervision assistance (helper provides verbal cues and touching assistance as resident completes activity) with eating, and oral hygiene. During a review of Resident 2's Progress Notes dated 8/24/2025 at 1:36 p.m., the Progress Notes indicated Resident 2 verbalized in the morning not wanting Certified Nursing Assistant (CNA) 2. Registered Nurse (RN) 2 offered to do her morning personal care such as changing her brief. After meals Resident 2 was offered to be changed by CNA 2 but Resident 2 refused. RN 2 and CNA 2 assisted Resident 2 back in bed and changed Resident 2. Per CNA 2 and RN 2 Resident 2 became aggressive during the transfer and clawed her (Resident 2) nails into RN 2 hand, RN 2 had a skin tear on her (RN 2) forearm. During a concurrent interview and record review on 9/2/2025 at 12:18 p.m. of Resident 2's text messages with the Adm, Resident 2 stated on 8/24/2025 around 2 p.m. was afraid of RN 2 who was from registry (an independent staff who works on a temporary, as needed basis, hired by healthcare facilities or patients through a nursing agency or registry) that came in with CNA 2. Resident 2 stated did not want CNA 2 and asked for another CNA. Resident 2 stated at around 2 p.m. RN 2 and CNA 2 came into Resident 2 room and shut the door, Resident 2 stated RN 2 told Resident 2 RN 2 and CNA 2 would be changing Resident 2. Resident 2 stated she told RN 2 and CNA 2 she (Resident 2) wanted to wait for the next shift but RN 2 told her no and then proceeded to transfer Resident 2 who was at that time sitting up in her wheelchair next to her bed back into Resident 2's bed. Resident 2 stated RN 2 grabbed Resident 2's left arm and CNA 2 grabbed Resident 2 right arm and put her (Resident 2) back into bed. Resident 2 stated she (Resident 2) was upset because RN 2 and CNA 2 did not listen to her (Resident 2) request of wanting to wait to be changed by the next shift and then Resident 2 grabbed CNA 2 by her long hair. Resident 2 stated she (Resident 2) asked for RN 2 and CNA 2 to leave her (Resident 2) alone and they (RN 2 and CNA 2) refused. Resident 2 stated she did ask RN 2 and CNA 2 multiple times to stop, and she (Resident 2) would wait for the next shift, but all RN 2 said was grab an arm to CNA 2. Resident 2 stated this incident was traumatizing to her (Resident 2) because she asked RN 2 and CNA 2 to stop and they did not it was physical abuse. Resident 2 stated she (Resident 2) contacted the Adm via text to inform Adm of the incident. Resident 2 reviewed text messages to Adm and stated text was sent on 8/24/2025 at 2:02 p.m. and based on text the incident occurred around 1:30 p.m., Resident 2 stated she (Resident 2) told Adm she had told RN 2 and CNA 2 that she would wait for the next shift to change me (Resident 2) but they (RN 2 and CNA 2) started fighting with me physically. Resident 2 stated what I (Resident 2) meant by RN 2 and CNA 2 physically fighting is that they were grabbing me against my will it was abuse. Resident 2 stated the only response I (Resident 2) received from the Adm was if I had reported it to the charge nurse. Resident 2 stated, told Adm she (Resident 2) reported the incident to the oncoming nurse Licensed Vocational Nurse (LVN) 2, and

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for one of three sampled residents (Resident 2) by failing to respect Resident 2's right to refuse care. This deficient practice had the potential to result in Resident 2's rights to be violated. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 2/12/2025 with diagnoses including Parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), muscle wasting and atrophy (decrease in size or wasting away of a body part or tissue), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and depression (a mental illness that involves a persistent low mood, a loss of interest in activities, and affects daily functions like sleep, appetite, and concentration, leading to significant problems in a person's life, work, or relationships). During a review of Resident 2's History and Physical (H&P- a comprehensive evaluation by a healthcare provider that includes two main parts: a History where the doctor asks you about your symptoms, past illnesses, family health, and lifestyle, and a Physical where the doctor examines your body by checking your vital signs and inspecting different body systems) Examination dated 2/19/2025, 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 5/19/2025, the MDS indicated Resident 2 had the ability to understand and be understood. The MDS indicated Resident 2 requires partial assistance (helper does less than half the effort) with toileting, showering, lower body dressing, and putting on and taking off footwear, and required supervision assistance (helper provides verbal cues and or touching assistance as resident completes activity) with eating, and oral hygiene. During a review of Resident 2's Progress Notes dated 8/24/2025 at 1:36 p.m., the Progress Notes indicated Resident 2 verbalized in the morning not wanting Certified Nursing Assistant (CNA) 2. Registered Nurse (RN) 2 offered to do her morning personal care such as changing her brief. After meals Resident 2 was offered to be changed by CNA 2 but Resident 2 refused. RN 2 and CNA 2 assisted Resident 2 back in bed and changed Resident 2. Per CNA 2 and RN 2 Resident 2 became aggressive during the transfer and clawed her (Resident 2) nails into RN 2 hand, RN 2 had a skin tear on her (RN 2) forearm. During a concurrent interview and record review on 9/2/2025 at 12:18 p.m. of Resident 2's text messages with the Adm, Resident 2 stated on 8/24/2025 around 2 p.m. was afraid of RN 2 who was from registry (an independent staff who works on a temporary, as needed basis, hired by healthcare facilities or patients through a nursing agency or registry) that came in with CNA 2. Resident 2 stated did not want CNA 2 and asked for another CNA. Resident 2 stated at around 2 p.m. RN 2 and CNA 2 came into Resident 2 room and shut the door, Resident 2 stated RN 2 told Resident 2 RN 2 and CNA 2 would be changing Resident 2. Resident 2 stated she told RN 2 and CNA 2 she (Resident 2) wanted to wait for the next shift, but RN 2 told her no and then proceeded to transfer Resident 2 who was at that time sitting up in her wheelchair next to her bed back into Resident 2's bed. Resident 2 stated RN 2 grabbed Resident 2's left arm and CNA 2 grabbed Resident 2 right arm and put her (Resident 2) back into bed. Resident 2 stated she (Resident 2) was upset because RN 2 and CNA 2 did not listen to her (Resident 2) request of wanting to wait to be changed by the next shift and then Resident 2 grabbed CNA 2 by her long hair. Resident 2 stated she (Resident 2) asked for RN 2 and CNA 2 to leave her (Resident 2) alone and they (RN 2 and CNA 2) refused. Resident 2 stated she did ask RN 2 and CNA 2 multiple times to stop, and she (Resident 2) would wait for the next shift, but all RN 2 said was grabbed an arm to CNA 2. Resident 2 stated this incident was traumatizing to her (Resident 2) because she asked RN 2 and CNA 2 to stop and they did not it was physical abuse. During an interview on 9/2/2025 at 1:54 p.m. with CNA 2, CNA 2 stated worked on 8/24/2025 from 7 a.m. to 3 p.m. and was assigned Resident 2 but around 8 a.m. Resident 2 called the receptionist and asked not to have CNA 2. CNA 2 stated she was told Resident 2 was going to be reassigned but that did not occur instead RN 2 took over her care in the morning. CNA 2 stated around 2:30 p.m. was pulled aside by RN 2 and told Resident 2 needed to be changed and RN 2 would assist CNA 2. CNA 2 stated when RN 2 and CNA 2 entered Resident 2's room Resident 2, Resident 2 stated she (Resident 2) had urine running down her (Resident 2) leg, CNA 2 stated Resident 2 was in the wheelchair for about one and half hours, CNA 2 stated Resident 2 was soaked and reeked of urine. CNA 2 stated offered to change Resident 2 and Resident 2 became aggressive. CNA 2 stated she (CNA 2) and RN 2 assisted Resident 2 back into bed and then Resident 2 grabbed CNA 2 by the hair and began to pull on CNA 2's hair