STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555144	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Pauls Health Care Center	235 Nutmeg Street San Diego, CA 92103

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 - 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 observation, interview, and record review, the facility failed to ensure one of three residents (Resident 1) was free from physical abuse when:Certified nursing assistant (CNA) 6 did not respect Resident 1's request for CNA 6 to stop touching her and to get out of her room.CNA 6 was assigned to provide care to Resident 1 after the resident had a prior complaint regarding CNA 6 and did not want the CNA as a caregiver.The facility received multiple complaints from residents regarding CNA 6's provision of care. The facility did not implement increased supervision of CNA 6 while providing resident care.As a result of these deficient practices:Resident 1 defended herself by grabbing CNA 6's hair to make her stop. CNA 6 attempted to remove the resident's hand causing a skin tear to the resident's left upper arm.Resident 1 felt attacked by CNA 6 and that she had to fight for her life. Resident 1 experienced anxiety and fear after the incident.Resident 1 was prescribed an antibiotic (medication to treat bacterial infections) as a prophylactic (preventative) treatment for the left upper arm skin tear.Cross reference F684 and F656Findings:A review of Resident 1's Face Sheet, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses to include generalized muscle weakness, right eye blindness, unspecified urinary incontinence, and mild dementia.A review of Resident 1's minimum data set assessment (MDS, a comprehensive assessment tool), section GG, with Assessment Reference Date of 2/16/26, indicated the resident required substantial/maximal assistance from staff for personal hygiene and upper body dressing, and the resident was dependent on staff to provide toileting hygiene, bathing, and lower body dressing activities. A further review of the same MDS assessment indicated the resident's Brief Interview for Mental Status (BIMS, used to determine cognition) score was seven out of 15 which meant the resident had cognitive impairment.A review of Resident 1's undated ADL (activities of daily living) Care Plan Report indicated, .2 female CG's[care givers] at all times when providing care. A review of the facility's Report of Suspected Dependent Adult/Elder Abuse (SOC 341, a standardized form used to report allegations of abuse) dated 4/3/26, indicated, . [CNA 6] was in room doing a brief change on patient. As she was turning her [Resident 1], the patient grabbed [CNA 6]'s hair and started pulling it .In the process of attempting to remove pt's [patient's] hand from her [CNA 6] hair, [CNA 6] grabbed pt's. [left] upper arm, where patient sustained a bruise and skin tear.A review of Resident 1's Clinical Notes Report dated 4/3/26, indicated the resident had a skin tear on the left upper arm that measured 11 centimeters (cm) by 7 cm and had bruising around the skin tear that was actively bleeding.A review of Resident 1's Clinical Notes Report dated 4/7/26, indicated, .prophylactic ABT [antibiotic] due to skin tear @ [at] lft [left arm], and possible fluid collection, resident Primary Care.gave orders for Bactrim [antibiotic] 400 mg [milligrams]-80 mg for 10 days.A review of the facility's Employee Counseling/Disciplinary Notice Form for CNA 6 related to a previous incident involving Resident 1, dated 4/16/24, indicated, .Family [Resident 1's family] complaint regarding patient care [provided by CNA 6], being rude and attitude.Expected improvement: The violations mentioned above is unacceptable and will not be allowed to continue now or in the future.The incidents mentioned above are serious. CNA 6 refused to sign the form.A review of the facility's Employee (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	Counseling/Disciplinary Notice Form for CNA 6 involving an unsampled resident, dated 12/2/25, indicated, .On Saturday 11/29/25 you were assigned to a patient and the patient stated that you were very indifferent to him and speaking [foreign language] to another CNA while caring for him. This is considered a violation of resident rights. The behavior mentioned above is a violation of our guiding principles, our company policies, Standards of Conduct, and our Code of Conduct. The violations mentioned above is unacceptable and will not be allowed to continue now or in the future. The incidents mentioned above are serious.A review of CNA 6's 2025 Annual Performance Evaluation completed on 2/6/26, covering the employment period of 1/1/25 to 12/31/25, indicated, .1. Customer Focus. [CNA 6], It has been observed that there are challenges regarding interactions with residents, particularly related to tone and attitude. A couple residents have asked that you not be assigned to them going forward because of this.3. Effective Communication.there are times when residents have expressed concerns regarding the way messages are conveyed. Moving forward, maintaining a consistently empathetic and clear communication approach will enhance resident satisfaction and trust.A review of the facility's Witness Statement form completed by CNA 6 regarding the incident between Resident 1 and CNA 6 dated 4/3/26, indicated, .[Resident 1] initially agreed to care, including a brief change. While providing care [Resident 1] suddenly became agitated yelling and using verbal aggression. [CNA 8] briefly entered to check on the situation, and I informed [CNA 8] I was managing [Resident 1]. As I repositioned [Resident 1] to complete hygiene care, she grabbed my hair and would not let go, pulling my head back and forth. I attempted to safely disengage and touch [sic] her hand asking her to release me. When I asked for her to let me go and she kept holding on, I called [CNA 7] for assistance. [CNA 7] came to help calm [Resident 1] and [Resident 1] eventually let go. After we noticed a skin tear.[Resident 1] has a history of claiming rape and abuse during changes.On 4/8/26 at 10:43 A.M., a concurrent observation and interview was conducted with Resident 2. Resident 2 was in her room, lying down in bed, awake, alert, and conversant. Resident 2 stated she had received care from CNA 6 in the past. Resident 2 stated CNA 6 would start taking off her clothes and brief without warning. Resident 2 stated CNA 6 did not provide any explanations prior to providing care. Resident 2 stated CNA 6 was rough and would push her hard back and forth during brief changes. Resident 2 stated CNA 6's care felt rushed. Resident 2 stated CNA 6 would not speak to her during care, except to say turn. Resident 2 stated CNA 6 would speak (foreign language) to another staff in front of her. Resident 2 stated she did not understand (foreign language). Resident 2 stated she felt disrespected by CNA 6's actions and CNA 6 needed to be more respectful. Resident 2 stated she was too old to be pushed around. Resident 2 stated she reported CNA 6's rough and disrespectful care to the Charge Nurse.A confidential interview was conducted with a responsible party (RP) for an unsampled resident. The RP requested to remain anonymous. The RP stated she did not want CNA 6 to provide care for her family member. The RP stated that she gave CNA 6 multiple opportunities to show care and compassion, and CNA 6 continued to be rude and indifferent. The RP stated that every time she would talk to CNA 6 about the care, CNA 6 would have a rude and dismissive attitude, and would make disrespectful facial gestures towards her.On 4/8/26 at 11:20 A.M., a concurrent observation and interview was conducted in Resident 1' room. Resident 1 was lying in bed, awake, and alert. Resident 1 had a gauze and bandage dressing around her left upper arm. Resident 1 had scattered bruises on both forearms that were light purplish to brown in color. Resident 1 stated she had reported the incident that occurred on 4/3/26 to the facility leadership. Resident 1 stated she did not want CNA 6 to touch her and to provide care. Resident 1 stated CNA 6 had been rude and rough in the past. Resident 1 stated that on Friday (4/3/26), CNA 6 came into her room alone. Resident 1 stated CNA 6 started to push her hard and fast without any explanation and was then trying to change her brief. Resident 1 stated she was screaming and yelling for help. Resident 1 stated she felt like she was fighting for her life. Resident 1 pointed to her left upper arm and stated CNA 6 caused this and that she bled a lot from the skin tear. Resident 1 stated CNA 6 made her feel like an object.On 4/8/26 at 5:03 P.M., an interview was conducted with the director of (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	nursing (DON). The DON stated the incident on 4/3/26 had a psychosocial (thoughts, emotions, and mental well-being) effect on Resident 1. The DON stated she had to check on the resident daily. The DON stated there should always be two CNAs for the care of Resident 1 as care planned.A review of the facility's Witness Statement form completed by Resident' 1's RP (RP 9) regarding the incident between Resident 1 and CNA 6 dated 4/3/26, indicated, .[CNA 6] was on [Resident 1's] left side and [Resident 1] was yelling and resisting. [Resident 1] doesn't like [CNA 6], and she can only defend herself by pulling [CNA 6's] hair. [Resident 1] states she doesn't want [CNA 6] as her caregiver. She's too rough. [Resident 1] stated she was screaming like crazy for help when this occurred.On 4/9/26 at 5 P.M., a phone interview was conducted with RP 9. RP 9 stated that Resident 1 was very sensitive to touch especially on her right forearm. RP 9 stated Resident 1 was weak and had an atrophied (a partial or permanent shrinking of muscles) right hand. RP 9 stated Resident 1 preferred staff who were gentle and friendly, and staff who did not talk over her. RP 9 stated the facility and everyone including CNA 6, knew Resident 1 did not want CNA 6 as her caregiver. RP 9 stated Resident 1's request had been known for at least over a year. RP 9 stated she received a call from Resident 1 on the day of the incident with CNA 6. RP 9 stated Resident 1 sounded afraid and wanted her to come to the facility immediately. RP 9 stated that the incident was traumatic for the resident. RP 9 stated Resident 1 had been consistent with her recall of events. RP 9 stated Resident 1 expressed anger towards her because she (RP 9) was not at the bedside to protect her from CNA 6. RP 9 stated that after the incident, Resident 1's phone calls to her had noticeably increased. RP 9 stated Resident 1 repeatedly told her she was afraid and was having nightmares. RP 9 stated Resident 1 was scared that CNA 6 would come back to her room. RP 9 stated Resident 1 was vulnerable in bed and that there were a lot of things that went wrong that morning with CNA 6. RP 9 stated she did not understand why the request to not assign CNA 6 to Resident 1 was not honored. RP 9 stated, since the incident with CNA 6, Resident 1 was afraid every day.A review of the facility's Witness Statement form completed by licensed nurse (LN) 3 regarding the incident between Resident 1 and CNA 6 dated 4/7/26, indicated, .[CNA 6] knows she should not be taking care of [Resident 1] because of previous incidents.On 5/8/26 at 4:14 P.M., a phone interview was conducted with LN 3. LN 3 stated she was familiar with Resident 1. LN 3 stated she had provided care to Resident 1 days after the incident with CNA 6. LN 3 stated Resident 1 was experiencing a lot of anxiety, fear, and was constantly asking if CNA 6 was coming back to her room. LN 3 stated it was considered abuse when CNA 6 ignored the resident's plea to stop and to leave her room on 4/3/26. LN 3 stated it was known that CNA 6 could not provide care to Resident 1 due to previous interactions. LN 3 stated CNA 6 should have refused the assignment on 4/3/26, and should not have gone into Resident 1's room. LN 3 stated Resident 1 was direct and vocal with what she wanted and needed. LN 3 stated Resident 1 had made her wishes clear that she did not want CNA 6 to provide care to her prior to the incident on 4/3/26. LN 3 stated, Why would [CNA 6] agree to that assignment when [CNA 6] knows [Resident 1] doesn't like her? LN 3 stated she felt sorry for what had happened to Resident 1. LN 3 further stated she had never heard Resident 1 make abuse allegations about staff providing care.A review of the facility's Witness Statement form completed by LN 10 regarding the incident between Resident 1 and CNA 6 dated 4/7/26, indicated, .[CNA 7] called this nurse to help check [Resident 1]. When [I] walked into the room, [Resident 1] was yelling at [CNA 6] to get out. [Resident 1] stated [CNA 6] attacked her. [CNA 6] kept brushing [Resident 1's] hair while [Resident 1] yelling and screaming to [CNA 6] to get out. This nurse asked [CNA 6] to step out.[Resident 1] stated that [CNA 6] is very rough on her, she always comes in and throws me around. [CNA 6] cannot have many residents: [Resident 1, an unsampled resident, and Resident 3].On 5/11/26 at 8:16 A.M., a phone interview was conducted with LN 10. LN 10 stated she was the dayshift Charge Nurse on 4/3/26. LN 10 stated CNA 7 called her to Resident 1's room. LN 10 stated CNA 7 informed her that Resident 1 was pulling CNA 6's hair. LN 10 stated she went to Resident 1's room and saw CNA 6 brushing Resident 1's hair while Resident 1 was screaming for CNA 6 to stop and to get out of her room. LN 10 stated she saw Resident 1's left upper (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	arm actively bleeding from an open skin tear. LN 10 stated Resident 1's blood was on the bedsheets and on the resident's clothing. LN 10 stated the blood was alarming. LN 10 stated that she and the MDS Coordinator (MDSC) told CNA 6 to leave the room. LN 10 and the MDSC finished Resident 1's care. LN 10 stated Resident 1 calmed down after CNA 6 left the room. LN 10 stated it was required for two CNAs to take care of Resident 1. LN 10 stated Resident 1 strongly dislikes CNA 6. LN 10 stated she did not understand why CNA 6 took the assignment with Resident 1 and why CNA 6 was by herself with Resident 1. LN 10 stated CNA 6 should not have been assigned to provide Resident 1's care. LN 10 stated she was unsure who made the CNA assignments. LN 10 stated, Maybe night shift? LN 10 stated that it was abuse when CNA 6 did not stop and leave the room when Resident 1 told her to. LN 10 stated not honoring a resident's request to stop was a form of abuse. LN 10 stated that after the incident with CNA 6, Resident 1 was fearful that another incident would happen again. LN 10 further stated there were other residents in the facility who complained about the care CNA 6 provided to them. LN 10 stated as the charge nurse, she had not observed CNA 6 when she provided care to residents.On 5/11/26 at 10 A.M., an interview was conducted with CNA 3. CNA 3 stated she had taken care of Resident 1 many times over the years. CNA 3 stated she never had any problems with Resident 1. CNA 3 stated she built a rapport with Resident 1. CNA 3 stated Resident 1 can be forgetful but always had been pleasant with her. CNA 3 stated when she would be assigned to Resident 1, she would start by introducing herself and communicating with the resident what she would be doing. CNA 3 stated if Resident 1 was not ready for the care, she would respect resident's wishes. CNA 3 stated Resident 1 required two CNAs to provide care. CNA 3 stated she never heard Resident 1 screaming for help or alleging rape and abuse during care. CNA 3 stated she saw Resident 1 after the 4/3/26 incident. CNA 3 stated Resident 1 was quieter and did not want to talk. CNA 3 stated she thought Resident 1 was not her normal self. CNA 3 stated everyone knows that Resident 1 did not want CNA 6 to be her caregiver. CNA 3 stated that she had worked with CNA 6 before and that CNA 6 had an attitude that could be perceived as rude. CNA 3 stated she did not understand why CNA 6 did not speak up about being assigned to Resident 1 on 4/3/26. CNA 3 stated it was considered abuse when a staff did not stop touching them and leave when a resident requested that.A review of the facility's Witness Statement form completed by CNA 8 regarding the incident between Resident 1 and CNA 6 dated 4/3/26, indicated, .I heard [Resident 1] crying for help over and over. I knocked on the door as it was closed and came in and saw [CNA 6] attending to and changing [Resident 1]. After checking that everything is ok, I left to continue my own changes. [Resident 1] continued yelling asking me to come back and help her.On 5/11/26 at 12:52 P.M., a phone interview was conducted with CNA 8. CNA 8 stated she heard Resident 1 yelling for help on 4/3/26. CNA 8 stated she went to the resident's room, opened the door, and entered the room. CNA 8 stated she saw CNA 6 standing over Resident 1 and it looked like CNA 6 was getting ready to change Resident 1's brief. CNA 8 stated Resident 1 looked distressed and was yelling for help. CNA 8 stated that she offered to help CNA 6 who was alone in Resident 1's room but CNA 6 refused her help. CNA 8 stated she had been told by other staff that Resident 1 could get agitated during care. CNA 8 stated she trusted CNA 6 when she told her that Resident 1 was being cared for. CNA 8 stated she heard Resident 1 yelling and asking her to come back when she left the room. CNA 8 stated she had only worked at the facility for two months and did not know everyone. CNA 8 stated, after the incident, she found out that CNA 6 and Resident 1 had a history of not getting along. CNA 8 stated knowing this now, she would have done things differently and would not have left Resident 1 alone with CNA 6. CNA 8 stated she would have helped Resident 1. CNA 8 stated that if she were Resident 1, she would feel unsafe and violated when CNA 6 did not honor her request to stop and leave. CNA 8 stated, I harbor guilt that I didn't help [Resident 1].On 5/11/26 at 1:19 P.M., an interview was conducted with the MDSC. The MDSC stated she went to Resident 1's room to respond to the incident on 4/3/26. The MDSC stated it was not normal for Resident 1 to be yelling out for help. The MDSC stated she saw CNA 6 in the room while Resident 1 continued to be upset. The MDSC stated she told CNA 6 to leave the room. The MDSC (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	stated she saw an open, bleeding skin tear on Resident 1's left upper arm. The MDSC stated blood was on the resident's gown and sheets. The MDSC stated she did not understand why CNA 6 did not leave the resident's room when Resident 1 told her to. The MDSC stated she did not know why CNA 6 was alone in the room with Resident 1 with the door closed. The MDSC stated Resident 1's ADL care required two CNAs at all times. The MDSC stated she did not know why CNA 6 was assigned to Resident 1. The MDSC stated CNA 6 was not supposed to take care of Resident 1 and that CNA 6 was well aware of that. The MDSC stated CNA 6 had other residents refusing her to provide care for them. The MDSC stated CNA 6 demonstrated rudeness and lacked accountability. The MDSC stated CNA 6 was a difficult employee. The MDSC stated CNA 6 should have been more closely supervised during the provision of care.On 5/11/26 at 2:35 P.M., an interview was conducted with the DON. The DON stated CNA 6 had a prior incident with Resident 1 in the year 2024. The DON stated CNA 6 was aware Resident 1 did not want to receive care from her since 2024. The DON stated Resident 1 had been adamant regarding this longstanding request not to have CNA 6 assigned to her. The DON stated CNA 6 should not have taken the assignment with Resident 1 on 4/3/26. The DON stated there should have been a clear process when making CNA assignments to ensure residents were not assigned CNAs they did not get along with. The DON stated CNA 6 did not follow the care plan for Resident 1 related to the resident's need for two caregivers during ADL care. The DON stated it was abuse when CNA 6 did not honor Resident 1's wishes to stop touching her and to leave the room. The DON further stated she never heard or received any reports that Resident 1 alleged rape or abuse during care. The DON stated based on CNA 6's history with residents, there should have been closer supervision of CNA 6 when she provided care to her residents. On 5/12/26 at 2 P.M., a phone call was made to CNA 6. CNA 6 did not respond to the interview request.A review of the facility's untitled letter to CNA 6 dated 4/10/26, indicated, .On April 3, 2026, while providing care to [Resident 1] .During that interaction, your response resulted in an injury to the resident, including a bruise and a skin tear to the resident's upper arm. The injury required medical evaluation, and the resident was placed on antibiotics as a precaution to prevent infection. Because of the seriousness of the incident, we were required to self-report.We also confirmed that you had previously been instructed not to provide care to this resident. While investigating, [DON] found there were prior requests from two other residents who asked not to have you.due to concerns about the way care was provided.Under California law, elder abuse includes physical abuse and neglect, including failure to protect a resident from harm and the failure to provide care in a safe and appropriate manner.Residents also have the right to be treated with dignity and respect and to be free from abuse.Additionally, your conduct is a violation of California Nursing Home Residents' Rights.The expectation is clear and is the foundation of care we provide.Your conduct is also in violation of.Standards of Conduct, and Codes of Conduct.Due to the severity of this incident, we have decided to terminate your at-will employment effective Friday, April 10, 2026.A review of the facility's undated employees' Standards of Conduct indicated, .I will respect others as human beings.A review of the facility's policy titled Resident Rights dated 2/20/24, indicated, .Employees shall treat all residents with kindness, respect, and dignity.1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to.b. be treated with respect, kindness and dignity; c. be free from abuse.A review of the facility's policy titled Dignity dated 2/20/24, indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.1. Residents are treated with dignity and respect at all times. 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences.3. Individual needs and preferences of the resident are identified through the assessment process.A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated 2/20/24, did not provide guidance related to abuse prevention.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop an individualized written care plan for one of three residents (Resident 1) that addressed Resident 1's preference not to have care provided by certified nursing assistant (CNA) 6 after the resident made a complaint about CNA 6.This deficient practice had the potential to cause distress to Resident 1. Cross reference F 600.Findings:A review of Resident 1's Face Sheet, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses to include generalized muscle weakness, right eye blindness, unspecified urinary incontinence, and mild dementia.A review of the facility's Employee Counseling/Disciplinary Notice Form for CNA 6 related to a previous incident involving Resident 1, dated 4/16/24, indicated, .Family [Resident 1's family] complaint regarding patient care [provided by CNA 6], being rude and attitude.Expected improvement: The violations mentioned above is unacceptable and will not be allowed to continue now or in the future.The incidents mentioned above are serious. CNA 6 refused to sign the form.A review of the facility's Report of Suspected Dependent Adult/Elder Abuse (SOC 341, a standardized form used to report allegations of abuse) dated 4/3/26, indicated, . [CNA 6] was in room doing a brief change on patient. As she was turning her [Resident 1], the patient grabbed [CNA 6]'s hair and started pulling it .In the process of attempting to remove pt's [patient's] hand from her [CNA 6] hair, [CNA 6] grabbed pt's. [left] upper arm, where patient sustained a bruise and skin tear.On 4/8/26 at 11:20 A.M., an interview was conducted with Resident 1 while inside the resident's room. Resident 1 stated that on 4/3/26, CNA 6 came into her room alone, and was then trying to change her brief. Resident 1 stated she did not want CNA 6 to touch her and to provide care.On 4/9/26 at 5 P.M., a phone interview was conducted with Resident 1's RP (RP 9). RP 9 stated the facility and everyone including CNA 6 knew Resident 1 did not want CNA 6 as her caregiver. RP 9 stated Resident 1's request had been known for at least over a year. RP 9 stated she did not understand why the request to not assign CNA 6 to Resident 1 was not honored. On 5/8/26 at 4:14 P.M., a phone interview was conducted with LN 3. LN 3 stated she was familiar with Resident 1. LN 3 stated it was known that CNA 6 could not provide care to Resident 1 due to previous interactions. LN 3 stated CNA 6 should have refused the assignment on 4/3/26, and should not have gone into Resident 1's room. LN 3 stated Resident 1 was direct and vocal with what she wanted and needed. LN 3 stated Resident 1 had made her wishes clear that she did not want CNA 6 to provide care to her prior to the incident on 4/3/26. LN 3 stated, Why would [CNA 6] agree to that assignment when [CNA 6] knows [Resident 1] doesn't like her? On 5/11/26 at 8:16 A.M., a phone interview was conducted with LN 10. LN 10 stated that on 4/3/26 she went to Resident 1's room and saw CNA 6 brushing resident's hair while Resident 1 was screaming for CNA 6 to stop and to get out of her room. LN 10 stated that she and the MDS Coordinator (MDSC) told CNA 6 to leave the room. LN 10 stated Resident 1 calmed down after CNA 6 left the room. LN 10 stated Resident 1 strongly disliked CNA 6. LN 10 stated Resident 1's choice and request not to have CNA 6 should have been care planned.On 5/11/26 at 1:19 P.M., an interview was conducted with MDSC. The MDSC stated that on 4/3/26 she went into Resident 1's room and saw CNA 6 there. The MDSC stated she did not know why CNA 6 was assigned to Resident 1 on 4/3/26. The MDSC stated CNA 6 was not supposed to take care of Resident 1 and that CNA 6 was well aware of that. The MDSC stated the incident on 4/3/26 could not happen again. The MDSC stated the facility had to create a process of care planning and communication to include residents' choices and preferences regarding their caregivers. The MDSC stated the facility did not have a care plan for Resident 1's preference to not have CNA 6 provide her care. On 5/11/26 at 2:35 P.M., an interview was conducted with the director of nursing (DON). The DON stated CNA 6 had a prior incident with Resident 1 in the year 2024. The DON stated CNA 6 was aware Resident 1 did not want to receive care from her since 2024. The DON stated Resident 1 had been adamant regarding this longstanding (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	request not to have CNA 6 assigned to her. The DON stated CNA 6 should not have taken the assignment to provide care to Resident 1 on 4/3/26. The DON stated Resident 1's preference of not having CNA 6 as her caregiver should have been included in Resident 1's care plan. The DON stated the facility did not currently have a clear process for communicating residents' preferences regarding their caregivers.A review of the facility's policy titled Care Plans, Comprehensive Person-Centered dated 2/20/24, indicated, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .7. The comprehensive, person-centered care plan.j. describes the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555144	A. Building B. Wing	05/11/2026

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the comprehensive assessment and care plan were followed for one of three residents (Resident 1).As a result, Resident 1's activities of daily living (ADL) care was not provided in a manner that was consistent with her minimum data set assessment (MDS-a comprehensive assessment tool) and written ADL care plan. This had the potential to risk the resident's safety and to cause discomfort.Findings: A review of Resident 1's Face Sheet, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses to include generalized muscle weakness, right eye blindness, unspecified urinary incontinence, and mild dementia.A review of Resident 1's minimum data set assessment (MDS, a comprehensive assessment tool), section GG, with Assessment Reference Date of 2/16/26, indicated the resident required substantial/maximal assistance from staff for personal hygiene and upper body dressing, and the resident was dependent on staff to provide toileting hygiene, bathing, and lower body dressing activities.A review of Resident 1's undated ADL (activities of daily living) Care Plan Report indicated, .2 female CG's[care givers] at all times when providing care. A review of the facility's Witness Statement form completed by CNA 6 regarding an incident between Resident 1 and CNA 6 dated 4/3/26, indicated, .[Resident 1] initially agreed to care, including a brief change. While providing care [Resident 1] suddenly became agitated yelling and using verbal aggression. [CNA 8] briefly entered to check on the situation, and I informed [CNA 8] I was managing [Resident 1].A review of the facility's Witness Statement form completed by CNA 8 regarding an incident between Resident 1 and CNA 6 dated 4/3/26, indicated, .I heard [Resident 1] crying for help over and over. I knocked on the door as it was closed and came in and saw [CNA 6] attending to and changing [Resident 1]. After checking that everything is ok, I left to continue my own changes. [Resident 1] continued yelling asking me to come back and help her.On 4/8/26 at 3:40 P.M., a concurrent interview and record review was conducted with the minimum data set coordinator (MDSC). The MDSC reviewed Resident 1's MDS assessment dated [DATE], including section GG. THE MDSC stated when a resident's MDS assessment was coded as dependent, it meant the resident required assistance from two or more staff. The MDSC reviewed Resident 1's written undated ADL care plan. The MDSC stated Resident 1 required two caregivers at all times for toileting, bathing, and upper and lower body dressing. The MDSC stated CNAs were supposed to review their residents' plan of care on the Resident Summary. The MDSC stated the residents' care plans had to be followed to ensure resident safety. The MDSC stated Resident 1's ADL care plan was not followed when there was only one CNA (CNA 6) providing care on 4/3/26.On 4/8/26 at 4:15 P.M., an interview was conducted with the director of staff development (DSD). The DSD stated Resident 1's requirement for two caregivers should always be followed, otherwise the resident's safety and comfort would be at risk.On 4/8/26 at 5:03 P.M., an interview was conducted with the director of nursing (DON). The DON stated it was very important to follow Resident 1's ADL care plan. The DON stated there should have been two CNAs to provide Resident 1's ADL care on 4/3/26. The DON stated CNA 6 should have allowed CNA 8 to help her instead of declining CNA 8's offer to help.On 5/11/26 at 12:52 P.M., a phone interview was conducted with CNA 8. CNA 8 stated on 4/3/26 she went to Resident 1's room. CNA 8 stated she saw CNA 6 standing over Resident 1. CNA 8 stated she offered to help CNA 6 who was by herself in the room with Resident 1. CNA 8 stated CNA 6 refused her help. CNA 8 stated CNA 6 told her that Resident 1 was being cared for. A review of the facility's policy titled Care Plans, Comprehensive Person-Centered dated 2/20/24, indicated, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment.3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.