STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555200	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Almond View Care Center	1224 E Street Williams, CA 95987

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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 - Some	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 ensure vulnerable demented residents were free from physical abuse and inappropriate sexual behaviors for 12 of 23 sampled residents when:1. Resident 8 was on top of Resident 7 with his genital (male private part) in her mouth.2. Resident 13 was holding Resident 23's hand over his penis and stroking it.3.Resident 11 was using his hand on Resident 14's hand to stroke his penis.4. a. Resident 4 struck Resident 11 in the face. b. Resident 4 grabbed Resident 1's wrist very aggressively. c. Resident 4 pushed Resident 6 to the ground. d. Resident 4 walked up to Resident 18 and pushed her forehead back. e. Resident 19 would not let go of Resident 4 hand then he grabbed Resident 19's arm. f. Resident 4 hit Resident 20 with his fist, on the left side of her forehead. g. Resident 4 swung to hit staff then struck Resident 21 instead, in the face. h. Resident 4 slapped Resident 22 and knocked her glasses off her face. 5. Resident 5 hit Resident 4 in the face causing a skin tear to his right cheek.6. Resident 10 struck Resident 9, leading to a fight.7. Resident 3 struck Resident 1 in the back of the head.8. Resident 2 hit Resident 1 on her left cheek.Due to the repeated resident to resident altercations, this resulted in resident injuries, nonconsensual sexual conduct, fear, anxiety (fear of the unknown), and put all the vulnerable residents with dementia at risk for abuse. Findings: A review of the facility policy titled Abuse, Neglect, and Exploitation, implemented February 2026, indicated it is the policy of the facility to protect the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The policy requires thorough investigation of all allegations, ongoing staff training on abuse prevention-including dementia management-and coordination with the Quality Assurance and Performance Improvement (QAPI) program. Staff are trained to identify behavioral symptoms that may increase the risk of abuse or neglect, and to assess, care plan, and monitor residents with behaviors that could lead to conflict or neglect. The policy mandates prompt reporting and response to all allegations, analysis of incidents to determine root causes, implementation of changes to prevent recurrence, and ongoing staff education on any revised procedures. The facility ensures communication and coordination of abuse-related issues with the QAPI program to support continuous quality improvement.1. A record review of Resident 8's Interdisciplinary Team (IDT, a group of multidisciplinary staff who develop resident plans of care) note, dated 8/1/25 at 2:46 pm, indicated, on 7/31/25 at 6:41 pm, Certified Nursing Assistant (CNA) noticed Resident 7's door was closed and went to open it. CNA 3 observed Resident 8 on top of Resident 7 with his penis (male private part) in her mouth. Resident 7 was asked about the event and stated this man came into my room and started talking to me about sex. He seduced me and put his dick into my mouth.A review of Resident 8's admission record indicated he was originally admitted to the facility on [DATE], then readmitted on [DATE] with diagnoses of psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), dementia (a progressive state of decline in mental abilities), and muscle weakness.A review of Resident 7's admission record indicated she was admitted to the facility on [DATE], with diagnoses of Alzheimer's, dementia, and difficulty walking.A record review of 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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7's Nurses Note, dated 8/1/25 at 7:04 pm, Resident 7 had increased anxiety and shouted out I was raped last night.A record review of Resident 7's Nurses Note, dated 8/2/25 at 5:31 pm, Resident 7 stated, I hate it here I want to leave.A record review of Resident 7's Social Service Notes indicated:-On 8/1/25 at 2:09 pm, Social Services (SS) asked Resident 7 if she felt safe, and Resident 7 stated, I am not sure, I don't think so.-On 8/2/25 6:28 pm, Resident 7 stated I hate it here.-On 8/3/25 at 8:56 pm, Resident 7 stated It was a male he raped me. Resident 7 appeared anxious.2. A record review of Resident 13's IDT note, dated 11/19/25 at 1:36 pm, indicated Resident 13 was the alleged aggressor of incident that occurred on 11/18/25 at 7:58 am, in station 200 hallway. CNA was doing room changes and noticed Resident 13 holding Resident 23's hand over his penis and stroking it. As soon as CNA turned the corner, she noticed Resident 13 attempts to cover up with a black blanket. When CNA asked Resident 13 what he was doing he became upset. A review of Resident 13 admission record indicated he was admitted to the facility on [DATE], with diagnoses that included Alzheimer's (a disease characterized by a progressive decline in mental abilities), dementia with other behavioral disturbance, and major depressive disorder.3.A record review of Resident 11's IDT note, dated 1/2/26 at 3:02 pm, indicated a Resident-to-Resident incident occurred on 1/1/26 at approximately 5:15 pm. Licensed Nurse (LN) was notified by CNA that she was picking up trays from dinner and saw Resident 11 was in the dining room with penis out and his hand on Resident 14's hand to stroke his penis. Residents immediately separated. When asked by social services what had happened this Resident 11 stated I put her hand on my penis to have her jack me off. I was hard.A review of Resident 11's admission record indicated he was admitted to the facility on [DATE], with diagnoses that included vascular dementia, other behavioral disturbance, major depressive disorder, and general anxiety.A review of Resident 14's admission record indicated she was admitted to the facility on [DATE], with diagnoses that included Alzheimer's, dementia with other behavioral disturbance and anxiety disorder.4.a. A review of Resident 4's admission record indicated he was admitted to the facility on [DATE] with diagnosis that included Alzheimer's, psychosis, and dementia.During an interview on 1/8/26 at 10 am, with CNA 2, CNA 2 stated, I heard [Resident 11] yelling out from his room. I went to his room and [Resident 4] was just coming out of the room. [Resident 11] told me [Resident 4] came over to him while he was lying in bed and started talking crap, then hit me in the face. CNA 2 stated [Resident 11] had a cut to his forehead. A review of Resident 11's Nurses Note dated 8/12/25 11:31 pm, indicated Resident 11 was noted to with a small 0.2-centimeter (cm, a unit of measurement) by 0.2 cm abrasion to his forehead.A review of Resident 4's Nurses Note dated 8/13/25 12:43 am, indicated Resident 4 had a 1cm abrasion to his right thumb with some bleeding.During an interview on 1/8/26 at 8:30 am, with Resident 11, Resident 11 stated, [Resident 4] came into my room and started yelling at me about being in his bed. Then [Resident 4] started hitting me. I yelled and someone came and got him out. [Resident 4] is not a nice guy. During an interview on 1/8/25 at 12:30 pm, with CNA 1, CNA 1 stated Resident 11 was afraid of Resident 4. During a concurrent interview and record review on 1/8/26 at 4:55 pm, with the Director of Nursing (DON), Resident 4's Watch List dated 8/12/25 was reviewed. The Watch List indicated that Resident 4 had been checked on at 10:15 pm and at 10:30 pm. The DON confirmed the physical abuse occurred at 10:30 pm right after he was checked on.4.b. A review of Resident 4's IDT note dated 7/14/25 at 2:02 pm, indicated on 7/12/25 at 5:30 pm, Resident 4 grabbed Resident's 1 wrists. Resident 4 was agitated and struck out. A review of Resident 1's admission record indicated he was admitted to the facility on [DATE] with diagnoses that included psychosis, dementia, anxiety, falls, and agitation. During an interview on 1/7/26 at 9 am, with CNA 1, CNA 1 confirmed Resident 4 and Resident 1 were in the dining room for dinner when, I heard a noise and looked over and saw Resident 4 standing up by Resident 1. CNA 1 stated Resident 4 was grabbing Resident 1's wrist aggressively. During a concurrent interview and record review on 1/7/26 at 10 am, with Social Services (SS), SS confirmed Resident 1 had been the victim of three resident to resident altercations on 6/6/25, 6/22/25, and 7/12/25. 4.c. During a review of Resident 4's IDT note dated 7/24/25 at 3:24 pm, a (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident-to-resident incident on 7/23/25 at 6:35 pm, a Licensed Nurse heard CNA call out for help, and upon arrival Resident 6 was laying on the floor on her back holding her head, crying. Resident 6 was sent out to the hospital for evaluation.A review of Resident 6's admission record indicated she was admitted to the facility on [DATE], with diagnoses that included diabetes, unspecified psychosis, and anxiety. During an interview on 1/7/26 at 12 pm, with CNA 1, CNA 1 stated, I was the hall monitor that day 7/23/25, and [Resident 4] was going in and out of rooms. I had just removed [Resident 4] from two different rooms. CNA 1 further stated, I was standing by [Resident 11] because she was afraid of [Resident 4] when I saw [Resident 6] approaching [Resident 4]. [Resident 6] came up to [Resident 4] and gave him a hug. [Resident 4] pushed [Resident 6] hard with full force and [Resident 6] fell to the ground. [Resident 6] hit her head then lay flat on the floor and started crying. During a concurrent interview and record review on 1/7/26 at 5 pm, with DON, Resident 4's, 15-minute Watch Log dated 7/23/25 was reviewed. The Watch Log indicated Resident 4 had been checked on 7/23/25 at 6:15 pm and again at 6:30 pm. The DON confirmed the physical abuse occurred at 6:35 pm right after Resident 4 was checked on.During a review of Resident 6's Social Service Note, dated 7/25/25 at 4:01 pm, indicated SS followed up with Resident 6. Resident 6 was noted to be agitated, and CNAs were attempting to redirect away from a peer. During a review of Resident 4's, Physician Progress Note, dated 7/18/25, indicated escalation of behavior and that Resident 4 was involved in an altercation with another resident two days ago without injuries to both parties. Reportedly Resident 4 was very intrusive regardless of other boundaries. 4.d. A review of Resident 4's IDT note dated 10/28/25 at 11:27 am, indicated Resident 4 was the alleged aggressor of incident that occurred on 10/27/25 at 9:10 am, in the hallway, involving Resident 18. LN overheard yelling in the hallway and went to investigate. LN was notified that Resident 4 walked up to Resident 18 and pushed her forehead back.4.e. A review of Resident 4's IDT note, dated 10/31/25 at 3:27 pm, indicated a CNA reported that Resident 4 was seen walking out of his room holding Resident 19's hand. Resident 19 would not let go. CNA attempted to separate residents and then Resident 4 grabbed Resident 19's arm. CNA noticed this Resident 4 had a skin tear to right wrist. LN assessed skin tear to right wrist measuring 1.5 cm by 1.5 cm.4.f. A review of Resident 4's IDT note, dated 11/18/25 at 4:37 pm, indicated on 11/16/25 at 9 pm, Resident 4 entered Resident 20's room which was closed with a STOP sign across the doorway. Resident 20 stated Resident 4 walked into room, and she attempted to redirect him then he proceeded to turn his hand and hit her with his fist, on the left side of Resident 20's forehead.4.g. A review of Resident 4's IDT note, dated 1/5/26 at 11:48 am, indicated on 1/3/26 at 5:20 pm, Resident 4 was in the dining room attempting to eat food from Resident 21's food tray at the table when the CNA attempted to redirect. CNA observed Resident 4 became upset and swung to hit staff and accidentally struck Resident 21 in the face instead. Resident 21 had a 2 cm x 2 cm bruise underneath her right eye. 4.h. A review of Resident 4's IDT note, dated 1/8/26 at 2:53 pm, indicated on 1/7/26 at 5:30 pm, CNA reported to LN that Resident 4 slapped Resident 22 and knocked her glasses off her face. 5. During a review of Resident 5 and Resident 4's IDT note, dated 7/14/25 at 2:07 pm, indicated Resident 4 and 5 were in the dining room at dinner time, when CNA 1 heard Resident 4 call Resident 5 an idiot. Resident 5 hit Resident 4 in the face with a closed fist causing a skin tear to Resident 4's right cheek.During an interview on 1/7/26 at 8:30 am, with CNA 1, CNA 1 said, I was in the dining room and heard Resident 4 calling Resident 5 an idiot. Resident 4 stood up and then Resident 5 hit Resident 4 in the face with his fist.A review of Resident 5's admission record indicated he was admitted to the facility on [DATE], with diagnoses that included dementia, alcohol use, and anxiety. During a concurrent interview and record review on 1/7/26 at 9:45 am, with SS, SS confirmed Resident 4 had two altercations over the weekend. First incident occurred at 5:30 pm with Resident 1. Resident 4 was the aggressor. Second incident occurred at 6 pm with Resident 5. Resident 4 was the victim. During a concurrent interview and record review on 1/7/26 at 4 pm with DON, Resident 4's, 15-minute Watch Log dated 7/12/25 was reviewed. The Watch Log indicated Resident 4 had been checked on at 5:45 pm. and again at 6 pm. The DON confirmed the physical abuse (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	occurred at 6 pm right after he was checked on.6. A record review of Resident 9's IDT note, dated 8/4/25 at 11:42 am, indicated, staff upon arrival observed Resident 9 and Resident 10 were on the floor fighting. Resident 10 explained that Resident 9 started yelling when she came into her room. Resident 10 stated she then decked Resident 9. A review of Resident 10's admission record indicated she was admitted to the facility on [DATE], with diagnoses that included dementia, visual hallucinations (seeing things that are not real), and psychosis. A review of Resident 9's admission record, indicated Resident 9 was admitted to the facility on [DATE], with diagnoses that included dementia and difficulty walking. A review of Resident 9's medical record, dated 8/9/25 at 9:06 pm, indicated Resident 9 stated she avoids Resident 10, like the plague and that she can be overbearing. A review of Resident 10's Nursing Skilled Services note signed by LN on 8/5/25, indicated Resident 10 required supervision due to her frequent wandering into other resident rooms. 7. A review of Resident 1 and Resident 2's IDT notes, dated 6/9/25 3:12 pm, indicated that Residents 1 and 2 were watching a movie in the dining room after dinner and Resident 1 backed into Resident 2's wheelchair multi times. Resident 2 became upset saying, stop hitting my chair! then Resident 2 proceeded to slap Resident 1 on the left cheek. Resident 1 stated, she hit me in the face. Resident 2 stated, Resident 1 kept hitting my chair, so I hit her.A review of Resident 2?s admission record indicated she was admitted to the facility on [DATE], with diagnoses that included Alzheimer's, dementia, and muscle weakness.During an interview on 1/6/26 at 9 am., with Activities Assistant (AA 1), AA 1 said he was in the dining room and saw Resident 1 back her wheelchair up into Resident 2. Resident 2 immediately raised her arm up and hit Resident 1 on the cheek. 8. A review of Residents 1 and Resident 3's IDT note, dated 6/23/25 at 2:37 pm, indicated that Resident 1 was sitting at a table in the dining room when Resident 3 was being taken to the dining room by staff for dinner. Resident 3 was waiting behind Resident 1 when Resident 3 reached up and hit Resident 1 on the back of the head.A review of Resident 3's admission record indicated she was admitted to the facility on [DATE], with diagnoses that included Alzheimer's and anxiety.During an interview on 1/7/26 at 9 am with AA 2, AA 2 stated they were getting ready for a meal and Resident 1 was in her wheelchair heading towards the right side of the dining room and Resident 3 was being wheeled in behind her. Resident 1 stopped and Resident 1 and Resident 3 bumped into each other. Resident 3 hit Resident 1 on the back of her head. During a concurrent interview and record review on 1/8/26 at 4:30 pm, with DON, Resident 1's Care Plan dated June 2025 was reviewed. The DON confirmed that Resident 1 was the victim of three resident-to-resident physical altercations on 6/6/25, 6/22/25, and 7/12/25.During a concurrent interview and record review on 3/10/26 at 3:21 pm, with Administrator (ADM), ADM was questioned about the multiple facility reported incidents that involved resident to resident altercations (a total of 25 from June 2025 to March 2026). ADM stated the QAPI team identified that there was an increase in the resident altercations on the dementia secure unit November 2025. ADM stated the team has attempted interventions and the facility hasn't been able to resolve, by providing dementia and culture change staff training. ADM stated they were doing all they could and really did not know how to address the complex issue. ADM confirmed the QAPI plans and intervention measures had not been changed since they started back in November 2025. ADM stated they have not reached out to their corporate clinical consultants to assist with coming up with a plan to address the ongoing resident altercations in the secure dementia unit.During a concurrent interview and record review on 6/4/26 at 10:15 am with DON, DON discussed the increase in resident-to-resident altercations occurring on the secured dementia unit between June 2025 and March 2026. The DON stated they received information about these incidents during morning meetings but did not track or trend the data to analyze contributing factors such as location, time of day, type of injury, direct^care staffing, or repeated resident involvement. The DON confirmed that adding three hall monitors during the evening shift recently had reduced the number of resident altercations.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the Minimum Data Set (MDS, resident assessment tool) assessment was accurately coded for wandering behavior (the act of moving from place to place with or without a specified course or known direction) for one of three sampled residents (Resident 12) when the Social Services (SS) did not follow required assessment procedures, relied solely on chart review.This failure resulted in inaccurate assessment coding and failure to fully identify the resident's behavioral needs. It had the potential for staff not to be fully informed of the residents' health status to determine the need for further assessment and care interventions.Findings:During a review of the facility's policy titled, Resident Assessment - Resident Assessment Instrument (RAI), revised [DATE], indicated, The facility makes a comprehensive assessment of each resident's needs, goals, life history and preferences using the resident assessment instrument (RAI) specified by Centers for Medicare & Medicaid Services (CMS); The assessment process will include document review and observation/interview as needed. During a review of the facility's policy titled, Wandering Residents, revised [DATE], indicated, The facility ensures that who exhibit wandering behavior receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering.; Documentation in the medical record will include: findings from nursing and social service assessments. During a review of Long -Term Care Facility CMS's Resident Assessment Instrument (RAI) 3.0 User's Manual, version, dated 10/2025, at the section: E0900: Wandering, indicated the Steps for Assessment are: 1. Review the medical record and interview staff to determine whether wandering occurred during the 7-day look-back period - Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction. Wandering may or may not be aimless. The wandering resident may be oblivious to their physical or safety needs. The resident may have a purpose such as searching to find something, but they persist without knowing the exact direction or location of the object, person or place. The behavior may or may not be driven by confused thoughts or delusional ideas (e.g., when a resident believes they must find their parent, who staff know is deceased). 2. If wandering occurred, determine the frequency of the wandering during the 7-day look-back period. During a review of Resident 12's medical record, indicated that Resident 12 was originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses which included unspecified psychosis (loss of contact with reality, involves disruptions in thought, perception, and behavior), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), unspecified severity, with other behavioral disturbance, and history of fall. Resident 12 was not her healthcare decision maker. During a review of Resident 12's admission MDS, dated [DATE], indicated Resident 12 had a brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 3 out of 15, indicating her cognition was severely impaired. The MDS further indicated that Resident 1 did not exhibit Wandering behavior in the section E - Behavior. During review of Resident 12's current care plan, the plan instructed staff to monitor and document behaviors per shift-wandering behaviors redirect as needed. The care plan further indicated interventions including administration of Ativan for anxiety and Seroquel for dementia with behavioral disturbance and noted an increase in aggressive behaviors toward staff when the resident was being redirected. The care plan also included a goal for Resident 12 to wander safely within the secured unit, with an initial date of [DATE] and a target date of [DATE].During a concurrent observation and interview on [DATE] at 10:36 am with Certified Nursing Assistant (CNA) 4, in the hallway of Station X, and in ROOM XX. Resident 12 was observed pacing in the hallway then entering ROOM XX and lying on Bed A. CNA 4 approached Resident 12 inside ROOM XX, and stated, This is not your room, I'll take your back to your room. Resident 12 replied, No! When (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed, CNA 4 stated, [Resident 1] does this all the time. I tried to take her back to her room and redirected her, but she wouldn't cooperate. We just have to keep trying, until she would follow our instructions. CNA 4 further explained that the resident assigned to Bed A was currently hospitalized and added, Otherwise, there might be an altercation, referring to Resident 12's behavior of entering other resident's beds. At 10:40 am, observed Resident 12 got up, followed CNA 4 out of ROOM XX and proceeded to enter another resident's room, ROOM TT.During a concurrent interview and record review on [DATE] at 11:06 am, with MDS Nurse, the MDS Nurse stated she primarily completed medical sections of the MDS while Social Services completed behavioral sections. A review of Resident 12's care plan, medical diagnoses, and MDS dated [DATE], the MDS Nurse stated she recalled Resident 12 aimlessly walking around the station and assumed she was a wanderer based on her care plan and diagnoses, but acknowledged the resident may not have demonstrated wandering during the seven^day look^back period. When asked how the assessment should be completed, the MDS Nurse stated she would observe the residents on the unit, interview staff, and review behavior monitoring records. She further stated, I would assume that it's wrong code and we could go back and change it. we don't have an audit system to audit every single MDS assessment; usually it happened when an issue was identified during survey, and we would go back and fix it even after the resident was discharged . The MDS Nurse confirmed the [DATE] MDS Section E wandering assessment was completed by SS. During a concurrent interview and record review on [DATE] at 11:58 a.m. with SS, Resident 12's record was reviewed; the SS stated she recalled the resident was intrusive and exhibited behaviors every other day. When asked how wandering was assessed, the SS stated she only reviewed the resident's chart, including behavior monitoring records in the Medication Administration Record (MAR), and did not observe the resident or interview nursing staff, stating, We don't have to; that's how I was taught. A review of Resident 12's behavior monitoring records from [DATE] to [DATE] (the 7^day look^back period) indicated multiple documented episodes of anxiety, mood swings, and non^redirectable aggression, which the SS confirmed; a nursing progress note dated [DATE] at 2:49 am, documented the resident was Out of room throughout shift and required redirection from other residents' rooms, which the SS also confirmed. After reviewing the CMS RAI Manual guidance on wandering assessment, the SS stated she would not code wandering unless the word wandering was explicitly written in the record and confirmed she would still code No wandering even after reviewing the manual definition.During a concurrent interview and record review on [DATE], at 12:51 pm, with Director of Nursing (DON), Resident 12's MDS section E, dated [DATE], was reviewed. The DON stated the expectation for the MDS nurse while performing Wandering assessment is to review the residents' MARs, observe the residents and interview the staff. When informed the DON of the SS comment on how she was taught and coded Resident 12's wandering assessment, the DON confirmed Resident 12 did exhibit wandering behavior and stated that the SS was inaccurate and she needed to be reeducated.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents in the secured dementia unit (unit that is a specialized residential setting for individuals with Alzheimer's (a disease characterized by a progressive decline in mental abilities) or dementia (a progressive state of decline in mental abilities) that uses secured perimeters, such as locked exterior doors or fenced areas, to prevent wandering while maintaining a safe, structured environment) had sufficient and competent nursing staff and were available to provide nursing and related services to meet the residents' needs when:1 Acuity (complexity and intensity rather than just resident numbers) levels for dementia residents and increased resident altercations were not considered when scheduling Certified Nursing Assistants (CNA) staff in the secured dementia unit.2. Direct care staff did not receive specialized training for advanced stages of dementia.This resulted in vulnerable residents experiencing physical abuse, inappropriate sexual behavior, injuries, anxiety and fear. Refer to F600.Findings:1. A review of the facility's detailed monthly census report for the secured dementia unit, ending July 2025 and dated 4/15/26, showed the unit maintained an average daily census of 41 residents, with a full capacity of 42 residents.A review of Facility Reported Incidents (FRIs)from June 2025 through March 2026 indicated that the California Department of Public Health (CDPH) received 25 allegations of resident to resident abuse, including three allegations involving sexual abuse.A review of the 25 FRIs indicated:1. Resident 8 was on top of Resident 7 with his genital (male private part) in her mouth.2. Resident 13 was holding Resident 23's hand over his penis and stroking it.3.Resident 11 was using his hand on Resident 14's hand to stroke his penis.4. a. Resident 4 struck Resident 11 in the face. b. Resident 4 grabbed Resident 1's wrist very aggressively. c. Resident 4 pushed Resident 6 to the ground. d. Resident 4 walked up to Resident 18 and pushed her forehead back. e. Resident 19 would not let go of Resident 4 hand then he grabbed Resident 19's arm. f. Resident 4 hit Resident 20 with his fist, on the left side of her forehead. g. Resident 4 swung to hit staff then struck Resident 21 instead, in the face. h. Resident 4 slapped Resident 22 and knocked her glasses off her face. 5. Resident 5 hit Resident 4 in the face causing a skin tear to his right cheek.6. Resident 10 struck Resident 9, leading to a fight.7. Resident 3 struck Resident 1 in the back of the head.8. Resident 2 hit Resident 1 on her left cheek.A review of Resident 4's nursing notes indicated that between July 2025 and January 2026, Resident 4 was involved in nine resident-to-resident altercations. On 7/12/25 at 6:00 pm, while in the dining room, Resident 4 struck Resident 5 with a closed fist, resulting in a small skin tear to Resident 5's right cheek. On 7/23/25 at 6:35 pm, Resident 4 and Resident 6 had an alteration and when residents were found by CNA, Resident 6 was lying flat on her back while holding her head crying. Resident 6 was sent to the hospital for further evaluation.A review of the July 2025 staffing schedules for Nursing Station 300, the secured dementia unit, showed that on 7/12/25 there was no diningˆroom CNA assigned during the evening shift and only one hallˆmonitor CNA. On 7/23/25, the evening shift again had no diningˆroom CNA assigned and one hallˆmonitor CNA. These dates correspond to two residentˆtoˆresident altercations involving Resident 4 that occurred during the evening hours.During an interview on 1/7/26 at 12 pm with CNA 1, CNA 1 stated, I was the hall monitor on 7/23/25, and [Resident 4] was going in and out of rooms. I had just removed [Resident 4] from two different rooms. CNA 1 further stated, I was standing near [Resident 11] because [Resident 11] was afraid of [Resident 4] when I saw [Resident 6] approaching [Resident 4]. [Resident 6] came up to [Resident 4] and gave a hug. [Resident 4] pushed [Resident 6] hard with full force, causing [Resident 6] to fall to the ground and hit their head. [Resident 6] then lay flat on the floor and began crying.During a concurrent interview and record review on 1/7/26 at 9:45 am with SS, SS confirmed Resident 4 had two altercations over the weekend. First incident occurred at 5:30 pm with Resident 1. Resident 4 was the aggressor. Second incident occurred at 6 pm with Resident 5. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 4 was the victim.During a concurrent interview and record review on 1/7/26 at 10 am with Social Services (SS), SS confirmed Resident 1 had been the victim of three resident to resident physical altercations on 6/6/25, 6/22/25, and 7/12/25. During a concurrent interview and record review on 1/7/26 at 4 pm with Director of Nursing (DON), Resident 4's, 15-minute Watch Log dated 7/12/25 was reviewed. The Watch Log indicated that Resident 4 had been checked on at 5:45 pm. and again at 6 pm. The DON confirmed the physical abuse occurred at 6 pm right after he was checked on.During concurrent interview record review on 3/17/26 at 11:10 am with Scheduler (Sched), Sched stated that standard staffing assignments for Nursing Station 300, the secured dementia unit, included: four CNAs on the day shift (6:00 am-2:30 pm) and evening shift (2:00 pm-10:30 pm); two Hall Monitor CNAs, one assigned from 8:00 am-5:00 pm and one from 12:00 pm-8:30 pm; and two CNAs assigned to the dining room-one on the morning shift and one on the evening shift. Sched confirmed that the staffing schedules did not consistently have enough CNAs to fill all assigned shifts.A review of the staffing schedules and signˆin sheets for the Nursing Station 300 secured dementia unit indicated:For the day shift (6:30 am-2:30 pm), no CNA staff were scheduled for the dining room on 6/22/25 and from 10/2/25 through 10/5/26. On the following dates, only one CNA-rather than the expected two-was scheduled for the dining room: 7/12/25, 7/23/25, 8/01/25, 8/12/25, 9/12/25, 9/15/25, 9/23/25, 9/29/25, 9/30/25, 10/1/25, 10/6/25, 10/7/25, 10/27/25, 12/17/25, 12/28/25, 1/1/26, 1/3/26, 1/4/26, 1/7/26, 1/9/26, 1/15/26, 2/05/26, and 3/02/26.For the evening shift (2:00 pm-10:30 pm), only one hallˆmonitor CNA-rather than the expected two-was scheduled on 6/6/25, 7/12/25, 7/23/25, 7/31/25, 9/12/25, 9/23/25, 9/30/25, 10/1/25, 10/3/25, 10/4/25, 10/5/25, 10/10/25, 10/23/25, 10/27/25, 10/31/25, 9/18/25, 12/17/25, 1/1/26, 1/3/26, 1/4/26, 1/7/26, 1/9/26, 1/15/26, and 3/2/26.During an interview on 12/18/25 at 11:41 am with CNA 5, CNA 5 stated that they sometimes had to rush while providing care to residents on the secured dementia unit in order to redirect residents and prevent potential altercations.During an interview on 3/10/26 at 10:29 am with Registered Nurse (RN) 1, RN 1 stated there were two RNs and one hall monitor assigned to assist on the secured dementia unit. RN 1 explained that four CNAs were assigned, along with activity staff who were also certified as CNAs. When asked whether Resident 4 triggered other residents, RN 1 stated this occurred 1000%, depending on Resident 4's mood and the day of the week. RN 1 further stated they believed Resident 4's behaviors were related to pain that the resident was unable to verbally express.During an interview on 3/10/26 at 10:50 am with CNA 6, CNA 6 stated that Resident 12 would get up, enter other residents' rooms, and take their food. CNA 6 further stated that Resident 12 had scratched them and that Resident 12 liked to scratch people. CNA 6 reported that many residents had complained about Resident 12's behaviors.During an observation on 3/10/26 at 11 am in activities room, Resident 10 was observed walking around the room and moving chairs. Resident 10 attempted to move the state computer stand; however, staff had positioned it out of the resident's reach. Resident 10 then picked up another resident's cup of liquid, and staff intervened before the resident could drink from it. Two staff members were present during the observation-one CNA and the Activities Director (AD) dealing with eight residents after an activity was completed.During an interview on 3/17/26 at 3:21pm with CNA 7, when asked, CNA 7 stated that their primary role was providing activities. When asked about staffing, CNA 7 stated the unit would benefit from having at least one additional staff member to assist with resident supervision. CNA 7 further stated that a typical shift consisted of one activities staff member and the Activities Director.During an interview on 3/17/2026 at 2:35 pm with CNA 8, CNA 8 stated that the facility needs more eyes on the residents due to the high number of residents who wander (walk without a planned destination or purpose).During an interview on 4/7/2026 at 1:49 pm with CNA 9, CNA 9 stated that sometimes we do not have enough staff due to not being able to fill callˆoffs. CNA 9 further stated that the facility had been shortˆstaffed (less than scheduled) over the past several months on both weekdays and weekends.During an interview on 4/15/2026 at 10:25 am with CNA 5, CNA 5 stated the facility was shortˆstaffed at least twice per month, occurring mostly on the evening shift. CNA 5 further stated (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that during the day shift, she has been assigned 10-12 residents to care for and on the evening shift 10-15 residents.During an interview on 4/15/26 at 10:32 am, with AD, when asked about the number of CNA staff that AD has. AD stated, CNA activity staff do activities for the entire facility. There are two CNA staff dedicated to the dementia unit. When asked whether two staff were sufficient for that unit, the AD responded, No, two is not enough. AD stated when there are only two CNA activity staff scheduled, the residents' quality of life and quality of care was hard to meet and was important. AD stated they used to schedule three CNA activity assistants in the past.2. During an interview 3/10/26 at 10:50 am with CNA 6, when asked about training, CNA 6 stated that at the start of their employment they received general orientation but did not receive any specialized dementiaˆcare training.During an interview on 4/15/26 at 10:32 am, AD stated there was no additional specialized dementia training for staff in the secured unit. AD explained the type of activities they provide could be improved, which could help reduce resident altercations.During an interview on 4/15/2026 at 11:50 am with the Director of Staff Development (DSD), DSD stated that no specialty dementia training had been provided to staff working on the secure dementia unit. The DSD explained that they offer behavioral training during allˆstaff meetings to address care concerns and review updated policies and procedures.During an interview on 6/4/26 at 9:30 am with DSD, DSD explained that Resident 4 had mood swings and at times did not like to be redirected and did not like anyone in his personal space. DSD stated Resident 4 required a lot of CNA and Nursing resource time to calm him down during his multiple episodes. DSD confirmed that having more direct care staff in the secure dementia unit has helped especially during the 12-8:30 pm times. DSD confirmed the dementia unit had a long hallway and one hall monitor was not enough especially when they are dealing with a resident who required redirection. DSD stated administrative staff did discuss resident issues during the Interdisciplinary Team meetings and morning reports although they did not track time of day, occurrences, injuries, repeated resident altercations, time of day, location etc. DSD confirmed 15 min checks may not work since some of the altercations happened right after the check and one on one observation worked better. DSD stated earlier identification and intervention with Resident 11 who had sexual behaviors with staff, then had an episode with Resident 14 could have been avoided. During an interview on 6/4/26 at 9:50 am, with Licensed Nurse (LN 2), LN 2 stated the facility previously had only one hall monitor, and additional monitors had only recently been added to the schedule. LN 2 stated it had given the staff the ability to redirect and diffuse resident to resident interactions and altercations. LN 2 stated she could not recall a recent one. LN 2 confirmed that Residents 4, 10, 11, and 12 often require substantial staff time due to dementiaˆrelated behaviors, which can pull both licensed nurses and CNAs away from the needs of other residents. LN 2 also stated the hallway is long, with the dining room located at the far end, making it difficult to observe residents adequately. LN 2 described Resident 4 as very quick and aggressive and stated that relocating Resident 4 from the dementia unit to room [ROOM NUMBER] with continuous one-to-one supervision had helped the unit. LN 2 stated, We needed more staff resources for hallways and activities for residents.During a concurrent interview and record review on 6/4/26 at 10:15 am with DON, DON discussed the increase in resident-to-resident altercations occurring on the secured dementia unit between June 2025 and March 2026. The DON stated they received information about these incidents during morning meetings but did not track or trend the data to analyze contributing factors such as location, time of day, type of injury, directˆcare staffing, or repeated resident involvement. The DON confirmed that adding three hall monitors during the evening shift recently had reduced the number of resident altercations.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have an effective Quality Assurance and Performance Improvement (QAPI) program, when the committee did not monitor, evaluate and track outcomes of a performance improvement plan to ensure sustainability to reduce resident to resident altercations in the secure dementia unit (a specialized residential setting for individuals with Alzheimer's (a disease characterized by a progressive decline in mental abilities) or dementia (a progressive state of decline in mental abilities) that uses secured perimeters to prevent wandering while maintaining a safe, structured environment).This resulted in repeated resident to resident altercations, injuries, nonconsensual sexual conduct, fear, and anxiety. Refer to F600 and F725. Findings:A review of the facility's policy titled Quality Assurance and Performance Improvement (QAPI), implemented in September 2024, indicates that the facility will maintain an effective, comprehensive, dataˆdriven QAPI program that monitors indicators of quality of care, quality of life, and all services provided; identifies quality deficiencies; and develops and implements corrective action plans. The policy requires regular review and analysis of data collected from multiple sources-including staff, residents, families, and departmental reports-and outlines procedures for feedback, data collection, monitoring, and adverse event surveillance. It directs the QAPI committee to prioritize identified problems, establish subcommittees as needed, and ensure that care and services meet accepted standards of quality. The program further requires the facility to conduct at least one performance improvement project (PIP) annually in a highˆrisk or problemˆprone area, with additional clinical or nonˆclinical PIPs initiated as necessary. A Review of facility-reported incidents revealed California Department of Public Health (CDPH), received 25 facility-reported incidents (FRIs) from June 2026 through March 2026. The reported incidents included 25 allegations of resident-to-resident abuse, three of these allegations involved sexual abuse. A review of the facility's detailed monthly census report for the period ending July 2025, dated April 15, 2026, showed that the secured dementia unit had an average daily census of 41 residents, with a full capacity of 42. A review of the 25 FRIs, indicated:1.Resident 8 was on top of Resident 7 with his genital (male private part) in her mouth.2. Resident 13 was holding Resident 23's hand over his penis and stroking it.3. Resident 11 was using his hand on Resident 14's hand to stroke his penis.4. a. Resident 4 struck Resident 11 in the face. b. Resident 4 grabbed Resident 1's wrist very aggressively. c. Resident 4 pushed Resident 6 to the ground. d. Resident 4 walked up to Resident 18 and pushed her forehead back. e. Resident 19 would not let go of Resident 4 hand then he grabbed Resident 19's arm. f. Resident 4 hit Resident 20 with his fist, on the left side of her forehead. g. Resident 4 swung to hit staff then struck Resident 21 instead, in the face. h. Resident 4 slapped Resident 22 and knocked her glasses off her face. 5. Resident 5 hit Resident 4 in the face causing a skin tear to his right cheek.6. Resident 10 struck Resident 9, leading to a fight.7. Resident 3 struck Resident 1 in the back of the head.8. Resident 2 hit Resident 1 on her left cheek.Resident 4 was involved in 8 resident to resident altercations where he was the perpetrator and one incident as a victim. Resident 1 was the victim of three altercations. A review of the QAPI meeting minutes dated 11/21/25, indicated that the facility identified an increase in residentˆtoˆresident incidents as a significant problem. The root causes were determined to include insufficient staff education, a higher number of residents who ambulate and pace in the hallways, and the need for enhanced dementiaˆspecific activities. The stated goal was to reduce these incidents. The improvement plan outlined the implementation of a cultureˆchange inˆservice for staff, assignment of a hall monitor, and increased activity staffing. The evaluation plan reflected that the Assistant Director of Nursing would conduct monthly followˆup to monitor progress and effectiveness of the interventions. A review of the QAPI meeting minutes dated January 2026 indicated that, on 11/10/25, the facility identified an increase in residentˆtoˆresident incidents over a twoˆmonth period and implemented corrective measures that included cultureˆchange initiatives, (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	occurring on the secured dementia unit between June 2025 and March 2026. The DON stated they received information about these incidents during morning meetings but did not track or trend the data to analyze contributing factors such as location, time of day, type of injury, direct˄care staffing, or repeated resident involvement. The DON confirmed that adding three hall monitors during the evening shift recently had reduced the number of resident altercations.