

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555492	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Oak Glen Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 9246 Avenida Miravilla Cherry Valley, CA 92223	
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 - 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** 36038 Based on interview and record review, the facility failed to protect the resident's rights to be free from sexual abuse (non-consensual sexual contact of any type such as unwanted touching, groping or any other sexual activity forced upon a person without their consent) by a resident (Resident 1), for four of five sampled residents, (Residents 2, 3, 4, and 5), when the facility failed to reevaluate existing interventions to address Resident 1's inappropriate sexual behavior. This failure resulted in repeated incidents of inappropriate sexual behavior of Resident 1 towards multiple residents (Residents 2, 3, 4, and 5). Findings: On January 10, 2024, at 10:50 a.m., an unannounced visit was conducted to investigate an allegation of sexual abuse. A review of Resident 1's document titled ADMISSION RECORD, undated, indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses which included major depressive disorder (persistent feeling of sadness, hopelessness, and loss of interest). A review of Resident 1's Progress Notes, indicated: - Dated September 27, 2023, at 7:13 p.m., .Resident was seen kissing resident (Resident 3) who is confused . - Dated September 29, 2023, at 2:48 p.m., .he was noted to walk up and down the halls and was seen by the CN (charge nurse) looking into a female room (Resident 6 and 7's room) . - Dated October 8, 2023, at 10:18 p.m., .@ 1612 hrs. (at 4:12 pm.) Resident had a (sic) episode of inappropriate behavior of kissing resident (Resident 4) early this shift. CNA (Certified Nursing Assistant) saw resident by the lobby caught in the act of about kissing another resident (Resident 4) . - Dated October 13, 2023, at 2:12 p.m., .Res (resident) was seen attempting to touch a female resident (Resident 5) by the nursing station . (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 - Some	- Dated October 17, 2023, at 2:02 p.m., .Monitoring res for sexually inappropriate behavior. 1 (one) episode noted this shift. Res was seen by staff almost about to pull down his pants and show his private area to another res (Resident 5) . - Dated October 19, 2023, at 4:14 p.m., .resident was seen and heard asking a different female resident (Resident 3) if she wants a kiss . - Dated December 28, 2023, at 3:30 p.m., .Resident seen by staff at nurse ' s station standing over another resident (Resident 5) who was sitting in a wheelchair. Resident was seen kissing resident (Resident 5) and inappropriately touching on the outside of her clothes . - Dated January 5, 2024, at 12:15 p.m., .this CN (charge nurse) was walking past room (Resident 1's) when this CN saw through the crack in the door, (name of Resident 1) was bent over his roommates bed .saw (name of Resident 1)'s hand on his roommates (Resident 2) penis and (name of Resident 1) was stroking his roommates penis .His roommate was laying in bed with his underwear on, pants off, and his eyes were closed . A review of Resident 1's Psychiatry Note, indicated the following: - Dated October 10, 2023, at 10:10 a.m., .discussed incident in which pt (patient) witnessed kissing another female peer (Resident 3) .During the incident, pt's pers (sic) was noted wandering the hall and entering his room. Staff followed peer and witnessed pt kissing female peer (Resident 3). Staff also reported pt masturbating in the restroom and smearing semen on the walls and doorknobs . - Dated January 3, 2024, at 3:40 p.m., .Pt disclosed kissing a female peer (Resident 5) and admitted that it was unwanted .I don ' t know why I kissed her. I just did it and I knew it was wrong but I just didn't (did not) care. It's no big deal . On January 10, 2024, at 1:50 p.m., Licensed Vocational Nurse (LVN) 1 was interviewed. LVN 1 stated, she witnessed the incident between Resident 1 and Resident 2 on January 5, 2024. LVN 1 stated, she saw Resident 1 leaning over Resident 2, and rubbing Resident 2 ' s private area, while Resident 2 was sleeping. LVN 1 stated, Resident 1 had previous incidents with two female residents (Residents 3 and 5), where Resident 1 kissed both female residents, on September 27, 2023 and December 28, 2023. LVN 1 stated Resident 3 was incoherent, and Resident 5 had dementia (memory loss). On January 10, 2024, at 2:20 p.m., the Social Service Director (SSD) was interviewed. The SSD stated, she was familiar with Resident 1. The SSD stated, Resident 1 was caught kissing a female resident (Resident 5) on December 28, 2023. The SSD stated, it was not the first time, Resident 1 had previous incidents, where Resident 1 kissed a female resident (Residents 3), few months ago (September 27, 2023). The SSD stated, Resident 1 had another incident with a male resident, Resident 2, on January 5, 2024. The SSD stated the staff were monitoring Resident 1 every hour. During a review of Resident 1 ' s Care Plan (CP), the CP indicated: - Dated September 27, 2023, .Problem .Exhibits inappropriate behavioral symptoms .CNA (Certified Nursing Assistant)/SSA (Social Service Assistant) observed resident (Resident 1) kissing another resident (Resident 3) in his room .Monitoring whereabouts every 15 mins (minutes) x (for) 72 hrs (hours) then re-eval (re-evaluate) . (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	- Dated January 5, 2024, .Problem .Exhibits behavioral symptoms of allegedly inappropriate sexual touching and kissing of male resident (Resident 2) .Intervention .Administer medication as ordered. Monitor for side effects and notify the physician if observed .Observed and document changes in behavior, including frequency of occurrence and potential triggers . Further review of Resident 1's Care Plan, indicated Resident 1's care plan did not reflect appropriate intervention to prevent Resident 1's inappropriate behavior. There was no documentation the Interdisciplinary Team (IDT - team members from different discipline working together to assess, coordinate, and manage each resident's care) re-evaluated Resident 1's frequency monitoring. On January 10, 2024, at 4:20 p.m., during a concurrent interview and review of Resident 1's Care Plan, dated September 27, 2023, with the Interim Director of Nursing (IDON), the IDON stated, when the current interventions were not working, the IDT had to reevaluate and changed the interventions. The IDON stated, Resident 1's care plan should have been updated to reflect the changes in resident's condition. The IDON stated, the IDT was responsible for making sure the interventions were implemented and reevaluated. On January 11, 2024, at 11:12 a.m., the Mental Health Doctor (MHD) was interviewed. The MHD stated, he was familiar with Resident 1. The MHD stated, he told the staff to keep an eye on him for risk of Resident 1 doing inappropriate behaviors to other residents. On January 11, 2024, at 11:39 a.m., CNA 2 was interviewed. CNA2 stated, she cared for Resident 1 and she monitored the resident every hour. CNA2 stated, she would not know what the resident was doing in between each hour and when she was doing care to other residents. CNA2 stated, Resident 1 walked around the facility. CNA2 stated, when Resident 2 (who was kissed by Resident 1 on September 27, 2023) passed away in December 2023 (December 11, 2023), we stopped monitoring Resident 1. On January 19, 2024, at 2:50 p.m., during a concurrent interview and review of Resident 1's Care Plan, dated September 28, 2023 and January 5, 2024, with the Minimum Data Set Nurse (MDSN), the MDSN stated, she was part of the IDT. The MDSN stated, Resident 1 ' s care plan did not reflect the appropriate interventions for resident 's inappropriate behavior. The MDSN stated, the interventions implemented were not effective since Resident 1 had repeated inappropriate behavior which affected two female residents (Residents 3 and 5) on September 27, 2023, and December 28, 2023, and one male resident (Resident 2) on January 5, 2024. The MDSN stated, the IDT should have revised the care plan if the interventions were not effective. On February 20, 2024, at 1:11 p.m., Licensed Vocational Nurse (LVN) 1 was interviewed. LVN 1 stated, she observed Resident 1 trying to peek at female residents' rooms, watching female residents (Residents 6 and 7). On February 20, 2024, at 3:11 p.m., CNA 3 was interviewed. CNA 3 stated, Resident 1 was keeping an eye on all the ladies, following the female residents. CNA 3 stated, Resident 1 would sneak when the staff were not watching. CNA 3 stated, Resident 4 reported that Resident 1 was trying to kiss her. On February 20, 2024, at 4 p.m., LVN 2 was interviewed. LVN 2 stated, Resident 1 was like a ticking time bomb, taking opportunities to attack. LVN 2 stated, even though the staff was monitoring Resident 1's behavior, they could not control the resident. LVN 2 stated, he noticed the gap with the monitoring, which could give opportunities for the resident to do his inappropriate behavior. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	A review of Resident 1 ' s Monitoring Log, indicated the following: - From September 27 to September 30, 2023, Resident 1 was monitored every 15 minutes - From September 30 to October 31, 2023, Resident 1 was monitored every hour - From December 28, 2023, to January 3, 2024, Resident 1 was monitored every hour. Further review of Resident 1's Monitoring Log, indicated there was no documented evidence Resident 1 was monitored from November 1, 2023, to December 28, 2023. On February 20, 2024, at 4:30 p.m., during a concurrent interview and review of Resident 1's Monitoring log, the IDON stated, there was no documentation Resident 1's whereabouts were monitored from November 1, 2023, to December 27, 2023. The IDON stated, the IDT should think of an approach for the resident's inappropriate behavior. The IDON stated, if the resident had behavior, the frequency of monitoring should be adjusted. A review of the facility policy and procedure titled, Resident to Resident Altercations, dated September 2022, indicated, .All altercations, including those that may represent resident to resident abuse, are investigated and reported .Behaviors that may provoke a reaction by resident or others include .sexually aggressive behavior such as making sexual comments, inappropriate touching/grabbing .If two residents are involved in an altercation, staff .make any necessary changes in the care plan approaches to any or all of the involved individuals .document in the resident's clinical record all interventions and their effectiveness . A review of the facility policy and procedure titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021, indicated, .Residents have the right to be free from abuse Protect resident from abuse .by anyone including but not necessarily limited to .other residents .		