STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555514	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Park Nursing Center	275 Garnet Way Upland, CA 91786

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 - Minimal harm or potential for 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. Based on interview, and record review, the facility failed to protect against physical abuse for one of three sampled residents (Resident 1) when a Certified Nursing Assistant (CNA 1) forcefully sat Resident 1 in the wheelchair by Resident 1's pants, then pushed the wheelchair into the room and closed the door behind Resident 1. This failure had the potential to cause physical injury, emotional distress, and a decline in Resident 1's sense of safety and wellˆbeing.Findings: An unannounced visit was made to the facility on May 12, 2026, at 1:28 PM, to investigate a facility reported incident regarding an allegation of physical abuse. A review of Resident 1's face sheet (a document that gives a summary of resident's information), undated, indicated an admission date of February 14, 2025. Resident 1 had diagnoses that included paranoid schizophrenia (a chronic mental health disorder characterized by intense, irrational suspicions (paranoia), auditory hallucinations, and delusions (false beliefs that someone or something is going to cause them harm)). A review of a Mental Health Worker's (MHW 1) witness statement dated April 24, 2026, indicated, the incident occurred on April 23, 2026, at approximately 6:45 PM, During [resident medication administration] [Resident 1] began yelling about smoking. [MHW 1] began to redirect [Resident 1] to calm down. [Resident 1] didn't want to calm down and began yelling at [another resident] . That's when [MHW 1] began clearing the hallway in order to settle down the hallway. Once [MHW 1] got the situation calmed down [Resident 1] began yelling again. [MHW 1] began to try and calm [Resident 1] back down. [Resident 1] then jumped back up yelling at [CNA 1] . [CNA 1] then said you guys baby [Resident 1] too much that's why she's like this. [Resident 1] then stood back up and started yelling again so [CNA 1] then grabbed [Resident 1] by the back of her pants and forcefully put her back into her chair and pushed her into her room . [CNA 1] then walked out and slammed the door . A review of CNA 1's statement, undated, indicated, . [CNA 1] was just writing to tell [Director of Staff Development-DSD] what happened with the [Resident 1] situation. The charge nurse was passing [medications] and [the CNAs] were finishing up [taking resident vital sign readings]. It was almost time for cigarette break and like [Resident 1] does every day it's a fight. This is just one of a whole bunch of situations at this time of the day on our shift. [Resident 1] was sitting at the nurse station or by her bedroom door and she [started] cussing out the [residents], calling them all kinds of [insults and curse words], . She jumps out of her chair cussing the [residents] out. They're getting her cigarettes and [CNA 1 was] giving all of her cigarettes to these [profane word] again. Most of the residents just walked past her and kept going. [One resident] turned around and came back at her and [Resident 1 was] standing up [Resident 1] falls, but she falls on the arm of the chair. Then she falls down into the seat of the chair. I ask the mental healthcare worker to just take [Resident 1] to her room for me. Their room is their space if they're angry just go to your room until you can calm down and get control. I don't go into their rooms except to check them when I first get to work that's their safe space from all of us. The healthcare worker tries to push her in. The healthcare worker tries to push her [in] . when [CNA 1] went to turn [Resident 1's wheelchair] around [Resident 1] jumped up again. [CNA 1] grabbed the back of [Resident 1's] pants, sat her down in the [wheelchair] and turned the [wheelchair] because if [the healthcare worker] had [pushed the wheelchair, Resident 1 would have (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 - Few	fallen] right onto . the floor . [CNA 1] backed [the wheelchair into the] room and came out . During a telephone interview with the Administrator (Admin) on May 13, 2026, at 9:34 AM, the Admin stated he was the abuse coordinator (leads and facilitates internal investigations, which involve collecting evidence, interviewing residents, staff, and witnesses, and determining whether the abuse allegation was substantiated or ruled out) for the facility. The Admin stated that, based on the investigation, he found that CNA 1 had physically abused Resident 1 when he forcefully sat Resident 1 in the wheelchair by Resident 1's pants. The Admin stated he was unable to substantiate the allegation of verbal abuse by CNA 1 because there was not enough evidence to show it happened. The Admin stated the facility failed to ensure their policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021, was followed by all staff. A review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021, indicated, Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation: The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff; .