STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555578	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holiday Manor Care Center	20554 Roscoe Blvd Canoga Park, CA 91306

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on interview and record review, the facility failed to implement its policy and procedure for ensuring the reporting of a reasonable suspicion of a crime in accordance with Section 1150B of the Act by failing to report to the State Survey Agency (SSA) an allegation of sexual abuse (any sexual activity that occurs without consent [permission]) within two (2) hours of the incident for one of four sampled residents (Resident 1). This deficient practice resulted in a delay of an onsite inspection by the SSA to ensure the safety of the other residents and had the potential to result in unidentified abuse. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility originally admitted Resident 1 on 9/19/2022 and readmitted Resident 1 on 12/2/2023 with diagnoses that included epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures [sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain]) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 9/20/2024, the MDS indicated that Resident 1 sometimes made self-understood and sometimes had the ability to understand others. The MDS further indicated that Resident 1's cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was moderately impaired, and Resident 1 needed moderate assistance from staff with lower body dressing, toileting hygiene, and independent with bed mobility (movement). During a review of Resident 2's Admission Record, the Admission Record indicated the facility originally admitted Resident 2 on 6/8/2022 and readmitted Resident 2 on 6/28/2023 with diagnoses that included psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and mood disorder (a mental health condition that primarily affects the emotional state). (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's MDS dated [DATE], the MDS indicated that Resident 2 usually made self-understood and usually had the ability to understand others. The MDS further indicated that Resident 2's cognition was severely impaired, and Resident 2 needed maximum assistance from staff with lower body dressing, moderate assistance with toileting hygiene, and setup or clean-up assistance with bed mobility. During a review of Resident 1's Change in Condition (COC- a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) Evaluation dated 11/22/2024 timed at 9:08 p.m., the COC Evaluation indicated the alleged abuse was started on 11/11/2024. The COC Evaluation indicated that Certified Nursing Assistant (CNA) saw another resident (Resident 2) in her (Resident 1) room half naked from waist to knee, kneeling on the floor beside the bed, and the resident (Resident 1) was also half naked from waist to the knee. The COC Evaluation indicated Resident 1's physician and family were notified on 11/22/2024 at 8:15 p.m. During a review of the Transaction Report (sent by the facility to the SSA) dated 11/22/2024, the Transaction Report indicated that the facility reported the alleged sexual abuse to the SSA via the facsimile (known as fax - the telephonic transmission of scanned printed material) on 11/22/2024 at 4:49 p.m. During an interview on 11/26/2024 at 11:43 a.m., with the Infection Preventionist (IP), the IP stated on 11/22/2024 at around 2:30 p.m., Activity Assistant 1 (AA 1) approached the IP and stated AA 1 heard a rumor from other Certified Nursing Assistants (CNA) that Resident 2 was in Resident 1's room but was unsure of what had happened. The IP stated she (IP) reported it to the Director of Nursing (DON) immediately and the DON started the investigation immediately. The IP stated per the facility's investigation, Certified Nursing Assistant 1 (CNA 1) was the assigned CNA for Resident 1 and both Resident 1 and Resident 2 were found in Resident 1's room. During an interview on 11/26/2024 at 1:15 p.m., with AA 1, AA 1 stated it was almost the end of her shift on 11/21/2024 when she (AA 1) heard two CNAs talking about Resident 1 and Resident 2 being in Resident 1's room. AA 1 stated she (AA 1) was not able to hear more about what happened and stated she (AA 1) informed the IP the following day, 11/22/2024, that she (AA 1) heard about a rumor of Resident 2 being in Resident 1's room. During an interview on 11/26/2024 at 3:12 p.m., with CNA 1, CNA 1 stated on 11/11/2024 between 2-2:30 p. m., CNA 1 noticed Resident 1's room was almost closed, but she (CNA 1) knew that Resident 1 was in bed 30 minutes before and Resident 1's room door was open at that time. CNA 1 stated when she (CNA 1) opened the door, she (CNA 1) observed Resident 2 kneeling down with both knees on the floor next to Resident 1's bed and was half naked, not wearing pants. CNA 1 stated she (CNA 1) observed Resident 1 lying in bed half naked, not wearing pants. CNA 1 stated she (CNA 1) told Resident 2 he shouldn't be there and observed both residents putting their pants on and stated she (CNA 1) did not think anything bad happened. CNA 1 stated she (CNA 1) did not report what she saw to anyone until she (CNA 1) was called by the DON on 11/22/2024. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/27/2024 at 11:30 a.m., with the DON, the DON stated the facility did not receive any reports related to the incident of Resident 1 and Resident 2 being found half naked in Resident 1's room on 11/11/2024 until 11/22/2024 around 3 p.m. when it was reported to her (DON). The DON stated CNA 1 had reported that she (CNA 1) witnessed Resident 2 in Resident 1's room and both residents were half naked and not wearing the lower parts of their clothing and CNA 1 did not report what she witnessed to anyone at the facility until 11/22/2024. The DON stated she (DON) was informed by CNA 1 that CNA 2 was also a witness to the incident between Resident 1 and Resident 2. During an interview on 11/27/2024 at 1:27 p.m., with CNA 2, CNA 2 stated on 11/11/2024 between 2:30 p.m. and 3 p.m. she (CNA 2) was passing the hallway and saw Resident 2 and CNA 1 inside Resident 1's room and went inside to ask if they needed help. CNA 2 stated she (CNA 2) then saw Resident 2 kneeling on the floor near Resident 1's bed. CNA 2 stated she (CNA 2) saw Resident 2 with his pants off because she (CNA 2) was able to see Resident 2's buttocks and saw Resident 1 in bed and unable to recall if Resident 1 was wearing pants. CNA 2 stated she (CNA 2) asked CNA 1 if CNA 1 had reported the incident and stated that CNA 1 had told her (CNA 2) that CNA 1 had reported it. CNA 2 stated she (CNA 2) did not report it to any licensed nurse because she (CNA 2) thought the incident was already reported. CNA 2 stated if both Resident 1 and Resident 2 were found naked in the lower half of their bodies, it should have been reported. During an interview on 11/27/2024 at 1:51 p.m., with CNA 1, CNA 1 stated she (CNA 1) should have reported the incident between Resident 1 and Resident 2 on 11/11/2024 and her responsibility was to report. During an interview on 11/27/2024 at 3 p.m., with the DON, the DON stated she (DON) received the very first report of the incident that occurred on 11/11/2024 between Resident 1 and Resident 2 being found half naked in Resident 1's room on 11/22/2024 between 2:40 p.m. and 3 p.m. from the Director of Staff Development (DSD). The DON stated CNA 2 was another witness of the incident between Resident 1 and Resident 2. The DON stated that the facility was not able to report the incident on 11/11/2024 when it occurred because the staff that witnessed the incident did not report it to the Administrator (ADM) nor the DON. The DON further stated that staff should not judge if alleged abuses happened or not and the staff's responsibility was to report alleged abuses to the DON or the ADM, or Registered Nurse Supervisors immediately. The DON stated that staff should not assume if an incident was reported or not by another witness staff and each staff who witnessed an incident, related to any types of abuse, had the responsibility to report it immediately. The DON stated more reports are better than no reports at all. The DON stated the incident between Resident 1 and Resident 2 should have been reported immediately and within two (2) hours to initiate (start) the investigation. During a review of the facility's policy and procedure (P&P) titled, Abuse Reporting and Investigation, last reviewed on 7/30/2024, the policy indicated, The facility will report ALL allegations of abuse as required by law and regulations to the appropriate agencies within two (2) hours. The facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect (failure to provide adequate care or services), exploitation (the act of using someone or something unfairly for your own advantage), misappropriation (the act of stealing or using something in a way that is not intended by the owner) of resident property, or injuries of an unknown source when appropriate.