STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555929	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laguna Honda Hospital & Rehabilitation Ctr D/P Snf	375 Laguna Honda Blvd. San Francisco, CA 94116

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. Based on interview and record review, the facility failed to report four allegations of abuse, within two hours, to the California Department of Public Health (the Department). This failure had the potential to leave residents vulnerable to further abuse. Findings: A review of Form SOC 341 Report of Suspected Dependent Adult/Elder Abuse, dated 5/27/25, submitted by the facility to the Department on 5/27/25, at 17:53, indicated Residents 1 and 2 had been involved in a resident-to-resident sexual abuse. The report indicated Resident 2 was standing at bedside of Resident 1. Resident 2 attempting to open Resident 1's brief with his right hand, his left hand in his pants. When redirected, Resident 2 became physically aggressive towards the staff. The incident happened on 5/25/25 at 12:30 AM. Review of Resident 1's admission record, indicated, Resident 1 had a had stroke, with right sided weakness, Dysphagia, (difficulty swallowing), Aphasia, (difficulty with talking) and Neurocognitive disorder. Has a BIMS (Brief Interview for Mental Status) score of 0, daughter is decisionmaker. Review of Resident 2's admission record, indicated, Resident 2 has a diagnosis of Dementia associated with alcoholism with behavioral disturbance, non-intractable epileptic spasms (severe form of epilepsy that is resistant to antiepileptic drugs) and age related macular degeneration (causes loss of vision) of both eyes. During an interview and record review on 6/5/25, at 1:42PM, with Registered Nurse Manager, RNM1, per RNM 1, the incident happened in the middle of the night, when Resident 2 was observed by staff wandering and standing by his roommate's bedside. When charge nurse came, Resident 2 was trying to open his roommate's' brief. Resident 2 stated, this is my wife. Staff separated them, Resident 2 got physically aggressive. They moved Resident 1 to Isolation room temporary, till next day we placed him in a room where he is now. Both did not remember anything. Resident 2 has a new roommate who has a coach all the time. Both residents have a BIMS score of 0, cognitively impaired. Per RNM 1, the incident was reported by AM charge nurse, and reported to the team, but the team decided it was not reportable, MD decided it should be reported so the report was done late. During an observation on 6/5/25 at 1:45 PM, Resident 2 observed in the great room sitting, by himself, no activity, introduced myself, no response then got up used his walker. (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	Observed Resident 1 in bed, smiling when introduced myself, no other response. During an interview on 6/5/25 at 3:35 PM, with Assistant Nursing Home Administrator (NHAA), NHAA stated, as the covering Abuse Coordinator, all staff are mandated reporter, they receive annually training on abuse and reporting. If they see an abuse, they need to report. They need to report within 2 hours of incident, as indicated in policy and procedure. CDPH phone number are posted all over the station, they can all anytime. During a phone interview on 6/6/25 at 9:16AM, with Registered Nurse (RN) 1, RN 1 stated they were the charge nurse that shift, got a call from staff, Resident 2 was wandering, he opened the blanket of roommate, his hand trying to open his roommate's brief, we separated them and Resident 2 became aggressive and was threatening. Called supervisor and Resident 1 was moved to another room, while Resident 2 was monitored that night. He was able to sleep, would get up to bathroom. This incident was reported to the team, but per the team it was not reportable. I documented what happened and reported to the team. Review of facility Policy and Procedure, abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response, dated, 4/25, indicated, Policy:2. All LHH employees, contractors and volunteers are mandated reporters of alleged incidents of abuse and/or suspicion of incidents of abuse. 4. LHH employees, contractors, and volunteers shall report alleged violations to the California Department of Public Health (CDPH), the Ombudsman and Nursing Operations within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is mmade,if the events that cause the allegation involve abuse or result in serious bodily injury. Findings: During an interview on 6/4/2025 at 2:14PM with Patient Care Assistant 1(PCA1), PCA1 stated, I've been working as Resident 3's PCA since he was admitted , I've known him for a long time. I was working last 5/27/2025 from 7am to 3:30pm. I saw Resident 3 and Resident 4 sitting in front of the TV at the dining area, when suddenly Resident 4 went beside Resident 3 and started rubbing her hands to his face, to his neck then to his chest going down inside his pants. I asked what are you doing Resident 4! then she stopped and said that she was only kissing his hands. I reported to our team leader, RN2 but she replied to me that it's okay to touch because they are friends. When we had our huddle last 5/28/2025 I told the team about the incident, I know that I am a mandated reporter of abuse, but I don't know if this is reportable or not. During an interview on 6/5/2025 at 10:21AM with Social Worker (MSW) 1, MSW 1 stated, Resident 3 and Resident 4 have a long friendship. The incident was reported by one PCA seeing Resident 4 doing inappropriate touching to Resident 3 happened last 5/27/2025. It was reported during our morning huddle last 5/28/2025 and she did not know if it is reportable or not. As a mandated reporter of abuse we need to report it in 2 hours, but it took time to report. During Interview on 6/5/2025 at 10:23AM with Social Worker (MSW)2, MSW 2 stated, that as per PCA the incident happened last 5/27/2025 and it was reported to us during our morning huddle on 5/28/2025, but it was only last 5/30/2025 that I reported to CDPH and other agencies. There's a delay of reporting because we tried to reach out to the family of Resident 3, they live out of state. The family has been very happy what was happening with the friendship between Resident 3 and Resident 4, however I know it's my mistake not to report it right away. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Clinical Progress note dated 5/29/2025 at 10:13am, the Clinical Progress Note indicated Discussed with Family 1and Family 2 wanted to set up boundaries and report only if boundaries were not respected. I and others expressed to team that although family did not think this was reportable/not abuse, since these issues were raised and we were made aware, it should be reported. Addendum: S2 nurse manager reported to me that she discussed the situation that came to light today with abuse officer at LHH (also LHH CEO) and they did not deem information learned today as reportable after reviewing situation and CMS guidelines. No report being made at this time. A review of Clinical Progress Note dated 5/30/2025 at 4PM, The Clinical Progress Note indicated an allegation of abuse was reported on 5/30/2025. On 5/27/2025 at 12:45PM a staff observed that a co-resident inappropriately touched Resident 3. Staff intervened when this was observed and both resident were kept separated. A resident to resident abuse investigation was initiated. Incident was reported to the following: CPDH at 2:47PM, Ombudsman at 2:05PM, Nursing Operations at 2:42PM, DON at 2:32pm, Abuse coordinator at 2:32PM, SFSD at 2:37pm, SOC 341 faxed to CDPH at 4:16pm.