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	08/01/2025

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 0600 Level of Harm - 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. (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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(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 - Few	Based on observation, interview, and record review, the facility failed to protect residents' rights to be free from physical abuse by a resident for one of three sampled residents (Resident 11) when Resident 12 struck Resident 11 on the left side of her face. This failure resulted in Resident 11 sustaining a left Zygomatic Arch (cheek bone area) fracture , Left Orbital (bone area around eye) wall fracture, and contusion (swelling) on the left side of her face. Findings: A record review of Resident 11's History and Physical (H & P, an assessment completed by a medical provider) dated 5/7/25 indicated, Resident 11 was admitted with multiple diagnoses including Vascular dementia (A usually progressive condition marked by the development of multiple cognitive deficits with abrupt or gradual onset that is caused by cerebrovascular disease), Dementia related behaviors, Cerebrovascular Accident (Stroke) in 2016, history of Panic Attacks (a sudden feeling or episode of panic), history of Possible Anxiety Disorder (any of various disorders in which anxiety is a predominant feature).During a concurrent observation and interview on 7/22/25 at 3:40 PM, in Resident 11's room, Resident 11 was observed lying in bed yelling loudly Who are you?! I don't want to be here! I don't want to be here! while attempting to climb out of her bed. COACH 1 (a person assigned to a resident for close supervision) was sitting at bedside and reassured Resident 11 she was in her room and it was time to rest. COACH 1 reported throughout the day, she assists Resident 11 with eating, dressing, incontinence (inability of the body to control the evacuative functions of urination or defecation) care, and preventing falls. At 3:46 PM, the Activity Therapist (ACT1) entered the room and introduced himself to Resident 11. Resident 11 yelled loudly Who are you? I'm scared! while holding on to his hand. ACT1 reassured resident she was safe and asked if she was in pain. Resident 11 stated, Yes! I hurt! My back, my leg, my face!. A review of the Resident 11's Minimum Data Set (MDS, a standard assessment tool) dated 5/20/25, indicated a Brief Interview of Mental Status (BIMS, a brief memory test to help determine cognitive function [includes thinking, learning, and decision making ability] score of 4 out of 15 (scores of 0-7 suggests severe cognitive impairment). A further review of Resident 11's MDS indicates Resident 11 has verbal behavioral symptoms not directed towards others that include rummaging, verbal/vocal symptoms like screaming, and disruptive sounds that occurred 1 to 3 days of the week. During a concurrent interview and record review on 7/24/25 at 2:09 PM with the Social Worker (MSW1), LHH MSW Resident Encounter Note dated 6/18/25 was reviewed. The resident encounter note indicated Resident 12 was transferred from a secured psych unit (this unit serves a psych population that requires. locked, psychiatric emergency, violent, self-harm, harm to others) from [Hospital A] with past behavioral history that included assault, wandering (a going about from place to place), suicidal ideation (the act of considering or planning suicide), and homicidal ideation (of, relating to, or tending toward homicide. Resident 12 always required a COACH at bedside and two personnel for direct care, due to assault risk at [Hospital A] and his history of violence (aggressive, assault, and combative), requiring wrist and vest restraints (a device that restricts movement) due to assault risk and history of endangerment or harm to others. Resident 12's former case manager reported Resident 12 had one episode of attacking someone with a pipe at a community clinic five years ago and he made occasional verbal threats. Recommendations from the [Hospital A] Registered nurse included providing space, when he is observed pacing or hyperventilating which provides relief. MSW1 stated resident encounter note was a brief summary of Resident 12's overall background, used to make recommendations for his care. During an interview on 7/23/25 at 3:01PM with Nursing Supervisor (SUP1), SUP1 stated the general practice for residents admitted with prior history of physical violence towards others requires a committee review and acceptance process. SUP1 stated Resident 12's preadmission screening (assessment to determine residents appropriateness prior to admission) was completed by the Clinical Nurse Specialist (an advanced practice registered nurse that provides consultation services for complex patient care needs) and Neuropsychologist (a doctor that is concerned with the integration of psychological observations on behavior and the mind). During an interview on 7/23/25 at 9:01 AM with the Clinical Nurse Specialist (CNS), the CNS stated Resident 12's behavior trigger (to cause an intense and usually negative emotional reaction in someone) was documented as Too much stimulation. The CNS stated Resident 12's identified triggers included, Too much stimulation, does not do well in groups, females were a trigger .and loud noises. He does well in a peaceful non stimulating environment. When asked what the patient population on the unit where both residents 11 and 12 resided, the CNS reported many residents have disruptive behaviors due to dementia with a wide range of functional abilities. The CNS added Resident 12 had a COACH for close