STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055002	A. Building B. Wing	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Manor Healthcare	11723 Fenton Avenue Lake View Terrace, CA 91342

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an incident of a physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of three sampled residents (Resident 1). This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect Resident 1 from further abuse. Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 12/11/2024 and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), schizoaffective disorder bipolar type (a mental illness that can affect thoughts, mood, and behavior), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's History and Physical (H&P), dated 5/14/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 6/7/2025, the MDS indicated Resident 1 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS further indicated Resident 1 required moderate assistance from staff for upper body dressing and was dependent on staff for toileting hygiene, showers, lower body dressing. During a review of Resident 1's Care Plan (CP), initiated on 7/7/2025, the CP indicated Resident 1 was at risk for injury and emotional distress related to alleged physical abuse by staff. During an interview on 7/21/2025 at 9:15a.m. with Resident 1, Resident 1 stated prior to 6/30/2025 (Resident 1 could not indicate the exact date of the incident), one of the staff members entered the resident's room and pushed Resident 1, who was sitting in his wheelchair into the restroom. Resident 1 further stated he informed the staff member that she was causing him pain, but the staff member continued to push his wheelchair into the restroom while Resident 1 was resisting the transfer by holding the door frame of the restroom door. During an interview on 7/21/2025 at 12:31p.m. with Registered Nurse (RN) 1, RN 1 stated on 7/7/2025, Resident 1 approached RN 1 in the nursing station and reported a staff member knocked him down and pushed his legs intentionally. RN 1 further stated after the abuse report staff members were interviewed as part of facilities internal abuse investigation. During an interview on 7/21/2025 at 1:40p.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated prior to 6/23/2025 (CNA 1 could not indicate the exact date), Resident 1 had informed her that a staff member had pushed him into the restroom causing pain. CNA 1 further stated she did not report the incident. CNA 1 stated pushing a person and causing pain can be considered a potential form of a physical abuse and she should have reported the incident to her supervisor. CNA 1 further stated failure to report the incident could potentially result in Resident 1 experiencing further abuse. During a follow up interview on 7/21/2025 at 3:11p.m. with RN 1, RN 1 stated pushing a person and causing pain was a potential incident of a physical abuse. RN 1 further stated CNA 1 should have reported the incident to the charge nurse and supervision. The RN 1 stated the failure to report the incident had the potential for harm, injury, and further abuse to Resident 1. During an interview on 7/21/2025 at 3:30p.m. with the Administrator, the Administrator stated a report from a resident stating that a person pushed him and caused pain is a potential physical abuse that required investigation. The Administrator stated staff should have reported the incident so the facility could investigate. The Administrator further stated the failure to report the incident on the same day the complaint was made by Resident 1 had the potential for ongoing abuse of Resident 1. During a review of the facility-provided policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, last reviewed on 1/31/202, the P&P indicated, If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to the other officials according to the state law.Physical abuse: Includes, but not limited to hitting, slapping, pinching and kicking.All employees are mandated reporters.